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

Over time, society has developed ethical and legal frameworks arising from a perceived need for the protection of sensitive personal information. There are also legal and ethical frameworks for the protection of 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 the professional contractual and moral duty of confidentiality.

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

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

This information sheet aims to assist therapists to:

- Understand the principles upon which client confidentiality arises
- Identify situations where confidentiality may need to be breached
- Identify situations where legal or other professional advice should be sought and which advice would be appropriate
- Make appropriate decisions concerning breaching confidentiality which are within the law and comply with the BACP’s Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP 2007) (the Ethical Framework).

The legal basis for confidentiality in counselling
Legal rights to confidentiality are enforceable by legal orders e.g. injunctions or actions for breach of contract, damages, orders for compensation.

1. 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. 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)

2. Statutory provisions (e.g. Data Protection Act 1998, Human Rights Act 1998 Article 8 – right to private life, etc see list at the end of the Information Sheet)

3. Contracts i.e. between:
   - Therapist and client
   - Therapist and agency/organisation
   - Therapist or agency and statutory bodies

The practice basis for confidentiality on 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.

1. Practice guidance e.g. the Ethical Framework (BACP 2007:1–4)
2. Professional Codes of conduct e.g. the Ethical Framework (BACP 2007:4–8)
3. 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 sometimes the outcomes from a disciplinary hearing are more likely to prevent a repetition by the therapist.

**Basic rights of the client**

These are:

- To know the extent and limitations of the confidentiality that they are being offered by the therapist
- To be told the circumstances in which the therapist may wish to breach confidentiality and to have an opportunity to discuss and negotiate this with the therapist at the outset of their work together
- To have a clear therapeutic contract with terms which they fully understand, accept and support (Dale, H. 2003)
- To know who will make, keep and have access to their notes and records, how they will be kept, for how long they will be retained and for what purposes they may be retained/destroyed/disclosed. (For further details see Bond, T. and Jenkins, P. 2007.)
- To be informed of circumstances when the therapist may have to or is about to breach their confidentiality (unless there are cogent, defensible reasons why this cannot be the case, e.g. in cases of terrorism, certain child protection or mental incapacity)
- To know how, why and to whom information will be given by the therapist
- To know the import of and/or see what is being said about the client if that client so wishes

Please refer to the Ethical Framework (BACP 2007:3), in particular the sections on, fidelity, autonomy, beneficience, non-maleficience, and justice.

**Exceptions to the duty of confidentiality**

**Crime**

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

S115 of the Crime and Public Disorder Act 1998 enables people to pass confidential information between agencies in order to protect vulnerable communities and develop inter-agency policy and joint strategies. Home Office guidelines envisage that the information that is exchanged routinely will not be about identifiable people. However, personally identifiable information may also be included where this is consistent with the Act. Counselling agencies working with addicts or offenders should refer to the relevant Home Office guidelines. Note that, whilst the legislation creates a power to disclose, it does not impose an automatic obligation on therapists to do so.

**Balance of public interest**

In some situations, client needs or the public interest may potentially outweigh the duty of confidentiality:

1. 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 patient, posed a risk of serious harm to the public. Despite the introduction of the Human Rights Act, a case based on similar circumstances would be likely to reach the same conclusions in favour of disclosure. For a discussion of risk of suicide, please see section below.

2. The balance of public interest favours the prevention and detection of serious crime over the protection of confidences. Therefore the law provides protection against any liabilities for breach of confidence when reporting serious crime to the authorities. 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 2003: 35).

**Statutory obligations to disclose**

1. The Terrorism Act 2000, s 38B makes it a criminal offence for a person to fail to disclose, without reasonable excuse, any information which 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 about specified activities related to money and property used to assist terrorist activities which they have gained through the course of a trade, profession, business or employment.

2. 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 immediately above.

3. Child protection – please refer to the separate section below.

The law will usually protect someone who discloses confidences in response to public duty or a statutory requirement. However, a therapist is wise to take reasonable care in ensuring the accuracy of what is reported and that they honestly believe what they are reporting. A false accusation that is not honestly believed which damages someone’s social standing or business could lead to the therapist being sued for defamation even if the disclosure was made as though based on the balance of public interest or as a statutory duty.

**Court orders**

A court may order disclosure, or order the therapist to attend court and to bring notes and records with them. Refusal to answer the questions of the court may constitute contempt of the court. Death does not end the duty of confidence. Therapists required to appear in the Coroner’s Court to give evidence relevant to the cause of death (e.g. following a possible suicide) may face an ethical dilemma which may on occasion be resolved by discussion with the Coroner prior to the court appearance.

Therapists may be asked to produce a report for court relating to work with a client. Consent should be obtained direct from the client wherever possible and in writing. Clients may ask to see the reports written about them, and in accordance with the legislation on Human Rights, Data Protection, Freedom of Information, the principles of Autonomy, Beneficence and Justice in the Ethical Framework and other legislation listed at the end of this Information Sheet, clients should have access to their reports in the same way as records, unless there is a cogent reason in their interest or that of the public not to do so, see the notes below and Bond, T. and Jenkins, P. (2007).

**Requirements to produce counselling records**

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

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

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

i. the quality of the client’s consent, as refusal would almost certainly result in the case being dropped;

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

iii. the courts tend to view any factual changes in the client’s account as evidence of the unreliability of the allegations rather than as evidence of rape trauma causing partial and progressive recall which would be a counselling interpretation.
The courts and the Crown Prosecution Service may consider that any objections to current practice are outweighed by the difficulty of judging rape trials and that the court should have all known sources of information made available to it including counselling notes, particularly if these contain the first allegation of rape or sexual assault. This is a situation where the counsellor may consider it appropriate to request that a judge reviews the notes and only releases those parts directly relevant to the case.

See the statutes and guidance listed at the end and Bond, T. and Jenkins, P. (2007).

**Disclosures to enhance the quality of service provided**

Technically, it may constitute a breach of confidence when counsellors discuss cases in counselling supervision, training and research. It is best practice to obtain the client’s consent. Even if this has not been obtained, the public interest in the proper training and supervision of counsellors, and in the development of a professional body of knowledge probably outweighs the public interest in confidentiality to the extent of making defensible discussions which protect the identity of clients (Cohen, K.1992: 22–3).

**Child protection**

A ‘child’ is defined as a person under the age of eighteen. The Children Act 1989 (CA 1989) in conjunction with subsequent legislation including the Children Act 2004, places a statutory duty on health, education and other services to co-operate with local authorities in child protection. There is a statutory duty to work together, including information sharing, in conducting initial investigations of children who may be in need or subject to abuse and in the more detailed core assessments carried out under s 47 of the CA 1989. The guidance in Part 1 of Working Together to Safeguard Children (DfES 2006) sets out the standards and procedures with which local authorities are to comply, explaining the procedures and what is expected of professionals, including information sharing. It carries the force of statute under s 7 of the Local Authorities Social Services Act 1970.

For details of the assessment process see the Framework for Assessment of Children in Need and their Families (DH 2000). Other useful references are What to do if you are worried that a child is being abused, DfES (2006) and Sharing Information: Practitioner’s Guide (DfES 2006) and its supporting materials, available from the website http://www.everychildmatters.gov.uk. The relevant law and child protection procedures for England and Wales are fully set out in the guidance documents listed above. Scotland and Northern Ireland have separate procedures and guidance.

Referral in child protection matters may also raise issues of consent.

Adults, children over 16, and children who are under 16 but ‘Gillick competent’ may refuse to consent to a referral or to co-operate with assessments.

Therapists working with children and young people should have supervision with a person suitably qualified and experienced in child protection matters. If there is a concern that a child may be at risk of serious harm and the therapist does not have consent from the child or from a person with parental responsibility for the child to make a referral, then the therapist will have to decide whether to make a referral anyway, without consent. Those working within government, organisational or agency settings should already have policies and procedures in place to follow. For those that work independently, this is a matter for supervision, and where necessary for expert professional advice on child protection law and practice, which should be available from the legal department of the local authority, the department of social services, specialist lawyers, e.g. Children Panel solicitors, the Department of the Official Solicitor, CAFCASS duty officers, and professional organisations e.g. GMC, BMA, BPS, UKCP and BACP. The ‘Disclosure Checklist’ below in this information sheet will also be helpful in thinking these decisions through.

**Clients at risk of suicide or serious self-harm**

Responding appropriately to suicidal clients creates one of the most challenging situations encountered by counsellors. For further discussion see Reeve, A. and Seber, P. (2007). 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 amongst 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 in pre-counselling information or to build in an appropriate agreement in the counselling contract. As there is no general duty to rescue in British law (see Menlowe, M. and McCall Smith, A. 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 (Bond, T. 2000: 104–5).

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 Ethical Framework, 2007: 6) at para 13 and also the possible consequences for their client of either referral or non-referral.

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

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

Counsellors’ professional responsibility requires that they must act within the area 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 other professional advice.

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

Mental capacity and consent issues in information sharing

Explicit and Implicit consent

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

Information sharing in a health team or agency

Consent may be given for others, e.g. those in a healthcare team, to share patient or client information. This is usually subject to professional codes of conduct and agency/organisational restrictions, e.g. in working with children and families the guidance made under the Children Act 1989 and Children Act 2004 apply; in a GP surgery or hospital setting the GMC guidance applies – for a list of useful references please see those listed at the end of this Information Sheet. 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. These are:

Principle 1 – Justify the purpose(s) for using confidential information
Principle 2 – Only use it when absolutely necessary
Principle 3 – Use the minimum that is required
Principle 4 – Access should be on a strict need-to-know basis
Principle 5 – Everyone must understand his or her responsibilities
Principle 6 – Understand and comply with the law

In 2006, the DH produced the Caldicott Guardian Manual, and the Department of Health set up the National Confidentiality and Security Advisory body in the year 2000, beginning to develop protocols for information sharing between agencies and organisations, for example in child abuse investigations under the Children Act 1989 as amended by Every Child Matters and the Children Act 2004. Relevant resources are listed at the end of the Information Sheet.

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 upon 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 sixteen have the mental capacity and legal power to give or withhold consent in medical and health care 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 it. Relevant publications and websites are listed at the end of this Information Sheet.

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 that make the decision, and
- Communicate their wishes.

Adults can appoint another person to act on their behalf under a Lasting Power of Attorney and to make decisions about their health and welfare under parts of the new Mental Capacity Act 2005 (MCA) which came into force on 1 October 2007.

Therapists may be asked to assist clients in developing plans or expressing their wishes for present or future healthcare arrangements. Whilst they have mental capacity, some clients may wish to make an ‘advance directive’ (otherwise known as an ‘advance statement’ or ‘living will’) about the forms of medical treatment to which they may (or may not) consent if they should subsequently lose capacity to decide for themselves. Advance directives refusing treatment are legally binding, provided that they are made whilst the person had capacity, without duress, and the circumstances to be applied are clear. From 1 October 2007, sections 24–26 of the MCA empower (subject to safeguards) those who wish to do so to make ‘advance decisions’ concerning their wish to refuse specified treatment.

Children and young people under the age of eighteen: consent issues

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

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

Parental responsibility is defined in the glossary in this information sheet. Every mother (married or not) of a child born to her; and 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, but will be lost only by death or adoption. Unmarried fathers may currently acquire parental responsibility for their biological child in one of several ways including:

- Marrying the child’s mother
- Being named with the mother’s consent on the child’s birth certificate as the father
- Entering into a written parental responsibility agreement with the child’s mother
- Various court orders

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

- Adoption
- Parental responsibility agreement with civil partner
- Various court orders

Local authorities may acquire parental responsibility for a child through a care order.

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

- 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 under 16, if they have sufficient age, maturity and understanding of the issues involved and the consequences of consent (i.e. the child is ‘Gillick competent’ 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).
- A Direction of the High Court.

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

Making a decision about breaching confidentiality

In each case where a therapist considers breach of confidentiality, it is necessary to be able to justify the action both to ourselves and to others if the decision is challenged. There are no hard and fast rules here, each decision has to be made on its own merits.

Therapists need to consider all the factors set out in this information sheet, and where appropriate to seek legal or other professional advice. In addition, it is advisable to take all issues of potential breach of confidentiality to supervision, whenever possible, and to discuss them fully and openly with the supervisor.

Disclosure checklist

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

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

Conclusion

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

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

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

A new book in BACP’s Legal Resources series is in the process of publication. Confidentiality and Record Keeping: Recording Confidences by Tim Bond and Barbara Mitchels contains further explanations of the law and examples of good practice developed in response to current law. This book is planned to be available in the autumn of 2008.

Glossary of terms used in this information sheet

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 health care team, or a counselling organisation with group supervision.

Client records Generic term which includes all notes, records, memoranda, correspondence, photographs, artifacts and video or audio recordings relating to an identifiable client, whether factual or process related, and in whatever form they are kept.
Data Defined in section 1(1) of the Data Protection Act 1998 to mean information held about a person which is processed automatically, is part of a relevant filing system, or is part of an accessible record. Data may therefore include: computer-based records and certain manual records, tape, video and audio recordings, laboratory results, notes, memoranda etc. The term ‘Data’ otherwise denotes a collection of statistical or other information gathered in the course of research. (Also see personal data and sensitive personal data below).

Data controller Defined in section 1(1) of the Data Protection Act 1998 to mean a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed.

Data processor Defined in section 1(1) of the Data Protection Act 1998 to mean any person (other than an employee of the data controller) who processes the data on behalf of the data controller.

Data subject Defined in section 1(1) of the Data Protection Act 1998 to mean an individual who is the subject of personal data.

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

Explicit consent Term used in the Data Protection Act 1998, to mean consent which is absolutely clear and specific about what it covers, i.e. not implied from surrounding circumstances. Explicit consent may be given orally, but for the avoidance of doubt, it is always best confirmed in writing wherever possible. Wherever the DPA refers to explicit consent in a record, then it must be in writing. See the Data Protection Act 1998 – Legal Guidance at http://dataprotection.gov.uk. The NHS Guidance interprets explicit consent to mean ‘signed consent with no ambiguity and a full statement of the purposes for which it was given.’ See http://www.ussimg.freeserve.co.uk/Guidance/managing_personal_data.htm

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.

‘Gillick Competent’ – referring to a child under the age of 16 years, this means the ability 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 which 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.

Health care team The health care 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 sixteen have the mental capacity and therefore the legal power to give or withhold consent in medical and health care matters. This presumption is rebuttable, for example in the case of mental illness. There is no one test for mental capacity to consent. Assessment of mental capacity is situation specific, and will depend upon 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.

Parental responsibility. The legal basis for decision making in respect of children under the age of eighteen, 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, CA 1989 s 2(9).

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 Information relating to a specific individual.

Processing Defined in section 1(1) of the Data Protection Act 1998 to mean, in relation to information or data, obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data, including –
(a) organisation, adaptation or alteration of the information or data; (b) retrieval, consultation or use of the information or data; (c) disclosure of the information or data by transmission, dissemination or otherwise making available, or (d) alignment, combination, blocking, erasure or destruction of the information or data.

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

Relevant filing system Defined in section 1 (1) of the Data Protection Act 1998 as any set of information that is structured either by reference to individuals or to criteria relating to individuals in such a way that specific information relating to an individual is readily accessible. In a relevant filing system, data about specific individuals can be located by a straightforward search.

Sensitive personal data Defined in section 2 of the Data Protection Act 1998 as information relating to a specific individual which 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.

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.

About the authors

Professor Tim Bond is a Fellow of BACP and a specialist in professional ethics for the psychological therapies and other roles. He is a member of BACP Professional and Ethical Practice Committee and writes extensively on ethical issues.

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References to Legal Cases cited in the text

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W v Edgell and others [1990] 1 All ER 835; Ch 359 (CA) affirming [1989] 1 All ER 801.

Acts and Rules

Access to Health Records Act 1990

Access to Medical Reports Act 1988

Children Act 1989

Children Act 2004


Children (Scotland) Act 2005

Children and Adoption Act 2006

Court of Protection Rules 2007. SI 2007 No 1744

Data Protection Act 1998

Data Protection (Processing of Sensitive Personal Data) Order 2000

Data Protection (Subjects Access Modification) (Health) Order 2000


Drug Trafficking Offences Act 1986

Drug Trafficking Act 1994

Education Act 2002

Family Law Act 1996


Family Law Reform Act 1969

Freedom of Information Act 2000

Health and Social Care (Community and Health and Standards) Act 2003

Human Rights Act 1998

Local Authorities Social Services Act 1970
Mental Capacity Act 2005
Mental Health Act 2007
Money Laundering Regulations 2007 SI no 2157

Police and Criminal Evidence Act 1984
Proceeds of Crime Act 2002
Terrorism Act 2000
Vulnerable Witnesses (Scotland) Act 2004

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It should be noted that this information sheet offers broad guidance, which sets out professional good practice, but it should not be substituted for legal and for other professional advice applicable to your particular circumstances.

BACP is aware that law and practice are always in a process of development and change. If you have evidence that this information sheet is now inaccurate or out of date feel free to contact us. If you know of any impending changes that affect its content we would also be pleased to hear from you.