Good Practice in Action 030
Legal Resource

Safeguarding vulnerable adults within the counselling professions in England and Wales

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Contents

Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP *Ethical Framework for the Counselling Professions* (BACP 2018) in respect of safeguarding vulnerable adults in England and Wales.

Purpose

The purpose of this resource is to provide information for therapists and counselling service providers in respect of legal issues relating to safeguarding in the context of therapeutic work with vulnerable adults in England and Wales. Northern Ireland is included where mentioned specifically in the text. Some references are included for UK-wide resources to assist readers working across jurisdictions. The law in Scotland is different and will be the subject of a separate resource.

Using the Legal Resources

The *Ethical Framework for the Counselling Professions* establishes a contractual commitment between BACP members and BACP. These Legal Resources are solely intended to support good practice by offering general information on principles and policy applicable at the time of publication and are not contractually binding.

The Legal Resources should not be used to constitute legal advice in specific cases, nor are they sufficient on their own to resolve legal issues arising in practice. As practice issues and dilemmas arising from work with clients are often complex, we 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.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. Please be alert for any changes that may affect your practice, as organisations and agencies may change their practice and policies in response to changing circumstances.

References in this resource were up to date at the time of writing but there may be changes to the law, government departments, government policies and guidance, websites and web addresses, and it is important for you to keep informed of any changes that may affect your practice.

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

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

Introduction

This resource offers information to assist practitioners in determining their legal obligations to vulnerable adults. The law concerning the safeguarding of vulnerable adults is currently in a period of change as public policy moves towards offering them greater protection. The law on protecting vulnerable adults also varies between jurisdictions in the UK and may vary in its application across the different settings in which counselling professionals work. This resource primarily focuses on the law in England and Wales but also makes reference to the law in Scotland and Northern Ireland. Some resources are also provided in the reference section relevant for the legal system in Eire.

Throughout the British Isles, including the Isle of Man, an adult is defined as anyone aged 18 years or older. The legal definitions of 'vulnerable' are more variable but typically regard an adult as vulnerable who is:

- dependent on others for care or support in their everyday life
- at risk of or currently experiencing neglect or abuse
- unable to protect themselves from significant harm or exploitation.

Some or all of these elements are present in how the law identifies situations in which adults are regarded as vulnerable and therefore requiring additional protection.

Key practice issues for practitioners when working with adults who may appear to be vulnerable are to ask ourselves 'What does this mean for my practice, if:

- I am working with someone who seems unable to adequately protect themselves from abuse or exploitation?
- I am working with someone who appears to have difficulty in identifying or stating their needs or wishes, or in understanding their situation sufficiently to give their informed consent?

Significant practice issues may include consideration of the practitioner's responsibilities to their vulnerable client and/or the client's carers, and how confidentiality may be negotiated and agreed with them.

Statutory law varies in the countries to which it applies and may be restricted to specific types of services. The law considered in this resource primarily applies to England and Wales.

Law for Northern Ireland and Scotland are mentioned specifically where relevant. The Republic of Ireland (Eire) has its own legal system, which is not considered in detail here. Useful resources are suggested at the end of this resource to assist in navigating between different jurisdictions and to assist practitioners working in more than one jurisdiction, type of agency or setting. Key legislation concerning vulnerable adults includes the Mental Health Act 1983. For reference, key terms are defined in the glossary at the end of this resource.

The table below may help you to see quickly where to look for the law on specific practice issues.

Professional practice issues and the law

Professional practice issue:	Law, and where to look in this resource:
When can I rely on my client's consent?	1. Mental capacity
What ought I to do when a client appears to have difficulty knowing what they want or in giving their consent?	1. Mental capacity
How hard should I try to obtain my client's consent?	1. Mental capacity
How ought I to manage client confidentiality generally	2.1 Contractual agreements with vulnerable clients
Can I share information about clients?	2.2 Information sharing
Making referrals	3.1 Referrals and disclosures 11. Referral checklist
Responsibilities to clients receiving social care	4. Working with vulnerable clients in the context of social care
How can someone, including carers of vulnerable adults, check if a professional has not been excluded or barred from working with vulnerable clients?	5. Disclosure and barring service
How can someone, including carers of vulnerable adults, check if a professional meets the practice requirements for their particular role?	5.3 Professional regulation
How can someone check that a professional is registered?	5.3 Professional regulation
What protection or support is available for my clients who are appearing as witnesses in criminal cases?	6. Vulnerable witnesses in court (and eligibility for 'special measures') 8. Support for victims and witnesses

Professional practice issues and the law

Professional practice issue:	Law, and where to look in this resource:
What are my responsibilities for clients who are or are likely to be witnesses in a criminal case?	7.1 CPS guidance
How should I decide about how to respond to safeguarding issues?	9. Principle and ethical decision making in the context of safeguarding vulnerable adult clients 10. Disclosure checklist: vulnerable adults
Professional practice issue: what is new in the law to be implemented in April 2022?	See *Legal provisions of the Mental Capacity (Amendment) Act 2019 (to be implemented on 01 April 2022)* at 1.3

The applicable law works hierarchically. The Human Rights Act 1998 (applicable from 2000), which incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), sets out the rights applicable to all citizens in the UK. These rights are binding on all public authorities which include government departments, local authorities, courts and tribunals (s.22(4)).

1 Mental capacity, consent and legal orders in relation to vulnerable adults

1.1. Mental capacity and consent

The law has been developing to protect the rights of vulnerable adults to make decisions for themselves and has created responsibilities for professionals to help adults to overcome obstacles in making or communicating their wishes. The legal presumption has switched from making untested assumptions that someone is incapable of making decisions for themselves, instead the assumption has become that everyone is capable of making decisions for themselves unless there are strong grounds to indicate the opposite. This area of law concerns mental capacity.

The law regards mental capacity as a person's ability to make rational, informed decisions. There is no single, definitive test for mental capacity to consent; however, the assessment of it is based on a set of principles in which it is situation-specific and depends upon the ability of the person 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.

Protection of adults with mental incapacity is governed in England and Wales by the Court of Protection (the law relating to mental capacity issues is different in Northern Ireland and Scotland). Orders in England and Wales may all be commenced by application to the Court of Protection. They may be brought to an end by court order, variation or discharge and subject to additional provisions. For an excellent practical and readable book on details of the Mental Capacity Act legislation and guidance to practice in England and Wales, see the *Court of Protection Handbook: A Users Guide 3rd edition* (Ruck-Keene et al., 2019).

For Northern Ireland, see an excellent guidance and list of useful Northern Ireland resources from the Northern Ireland College of Nursing (2019): *Commitment to Care of People living with Dementia*, available at: www.rcn.org.uk/professional-development/publications/pub-007827.

Note: A person's mental capacity to make any particular decision may be affected temporarily or permanently by illness, ability, substance use or abuse, medications, and psychological response to stressful or traumatic life events. Care should be taken therefore in assessment, as someone with capacity one day may not have capacity the next (or vice versa).

For adults, law relating to mental capacity is now governed by the Mental Capacity Act 2005, the Mental Health Act 2007 and The Mental Capacity Act 2005 (Appropriate Body) (England) Regulations 2006 S.I. 2006 No. 2810. Relevant publications and websites are listed at the end of this resource.

1.2 Current legal orders in England and Wales in relation to vulnerable adults

Table A Court orders that may be made in England and Wales in relation to vulnerable adults:

Order: Declaration of mental capacity	**Statute:** s.15 Mental Capacity Act 2005
Order: Appointment of deputy to make decisions	**Statute:** s.16 Mental Capacity Act 2005
Order: Determinations re lasting power of attorney	**Statute:** s.20 Mental Capacity Act 2005
Order: Deprivation of Liberty Safeguards (DoLS)	**Statute:** s.21A and Schedule A1 Mental Capacity Act 2005

Capacity and consent are explored further in Mitchels and Bond (2021)

The assessment of mental capacity is also an important issue for decision making, for which the Mental Capacity Act 2005 applies in England and Wales.

The Bamford Review of Mental Health and Learning Disability recommended in 2007 that similar legislation be implemented in Northern Ireland (see www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability; and for the work of the Bamford Monitoring Group see www.patientclientcouncil.hscni.net/ bamford-monitoring-group). The Mental Capacity (2016 Act) (Commencement No. 1) (Amendment) Order (Northern Ireland) 2019, makes similar provisions.

1.3 Legal provisions of the Mental Capacity (Amendment) Act 2019 (to be implemented on 01 April 2022)

The Mental Capacity (Amendment) Act 2019, which was passed in 2019, is now scheduled to be implemented on 01 April 2022. It introduces new *Liberty Protection Safeguards* (LPS) for England and Wales to replace the bureaucratic and complicated current Deprivation of Liberty (DoLS) procedures.

The 2019 Act is accompanied by the *Mental Capacity (Amendment) Act 2019 Code of Practice*, to show how LPS should be put in place. See also the Mental Capacity (Amendment) Act 2019 and in Northern Ireland, the Mental Capacity (2016 Act) (Commencement No. 1) (Amendment) Order (Northern Ireland) 2019.

A briefing document *Implementing the Mental Capacity (Amendment) Act 2019*, setting out the provisions and implementation of the new legislation and code of practice can be downloaded from the House of Commons Library, at: https://commonslibrary.parliament.uk/research-briefings/cbp-9341.

Liberty Protection Safeguards (LPS)

The Deprivation of Liberty Safeguards (DoLS) were designed to ensure that someone is only deprived of their liberty when it is in their best interests and there is no other way to look after them. The DoLS framework does not apply to those under the age of 18 years.

The DoLS system has been criticised as overly complicated and poorly drafted, and the *Liberty Protection Safeguards* (LPS) will replace the DoLS system.

From 1 April 2022, the Mental Capacity Act will have a new section AA1, which will apply the LPS system to all over the age of 16, and in all settings, i.e. care homes, hospitals, supported living, family or own home, etc. The rules could apply to those who lack the relevant capacity to make decisions, including those with autism, dementia or learning difficulty, see the government factsheet at Liberty Protection Safeguards: overview of the process – GOV.UK (www.gov.uk).

To authorise a deprivation of liberty, the rules state that '...it must be clear that all the 'authorisation conditions' listed below are met:

- The person lacks the capacity to consent to the care arrangements;
- The person has a mental disorder, within the meaning of section 1(2) of the Mental Health Act 1983; and
- The arrangements are necessary to prevent harm to the cared-for person and proportionate to the likelihood and seriousness of that harm.

Three assessments will be required:

- The capacity assessment and determination; and
- The medical assessment and determination; and
- The necessary and proportionate assessment and determination.

The person concerned, and any others close to the person (i.e. family members, attorneys, court appointed deputies, or independent mental health advocates) should be consulted to ascertain the person's wishes and feelings. The evidence from the assessments and the consultations are then reviewed by the responsible body, and a decision made on authorisation of deprivation of liberty. An Independent Mental Capacity Advocate (IMCA) will be appointed in the person's best interests, to provide support to the cared-for person throughout the LPS process.

Deprivation of liberty means that a person is objectively 'not free to leave' and is 'under continuous supervision and control' (see P v Cheshire West and Cheshire Council and another; P & Q v Surrey County Council. 2014] UKSC 19). Throughout the authorisation of deprivation of liberty, the person will be entitled to 'an appropriate person' to secure their wishes and feelings and to support them, and if necessary to challenge the authorisation. This will usually be a family member or someone from the volunteer sector.

The Act, creates the role of an **Approved Mental Capacity Professional (AMCP)**, a 'new, specialist role providing enhanced oversight for those people who need it most'. Most AMCPs will be independent, trained, and registered professionals and will normally be employed by a local authority, NHS Trust, local health board or clinical commissioning group. AMCPs will be required to carry out the pre-authorisation review if the cared-for person is objecting to specified aspects of the proposed arrangements.

The **Independent Mental Care Advocate (IMCA)** is a new role, introduced to support patients who are unable to make decisions for themselves. IMCAs are trained and experienced to provide support to the cared-for person throughout the LPS process. The guidance states that '...there is a presumption that an IMCA will be appointed such patients, unless it is not in their best interests'. We will have to wait for implementation before we can really know how this presumption will be interpreted in practice.

In exceptional cases, it may be necessary to take steps which deprive a person of their liberty before a formal authorisation decision has been made by a responsible body or court. Exceptional circumstances are defined in the Act as those when it is necessary to carry out life-sustaining treatment or a 'vital act'. A vital act is where there is a reasonable belief that it is necessary to prevent a serious deterioration in the person's condition.

The authorisation must be reviewed regularly by the responsible body with access provided to an IMCA or appropriate person to represent and support the cared-for person throughout the authorisation period. The authorisation can be renewed, or it may be ended if any of these conditions are not met:

- the cared-for person has capacity, or has regained capacity, to consent to the arrangements; or
- the cared-for person no longer has a mental disorder; or
- the arrangements are no longer necessary and proportionate.

The new LPS authorisation process will be overseen by the Court of Protection which has jurisdiction over these matters to hear appeals and disputes. Where an LPS authorisation is in place, the cared-for person, their appropriate person or IMCA, or anyone else can apply to challenge the arrangements at the Court of Protection under section 21ZA of the MCA. The Court of Protection has power to uphold, vary or terminate the authorisation.

2 Confidentiality

Confidentiality is critically important in counselling, psychotherapy, coaching and pastoral care, where clients need to feel able to discuss sensitive thoughts and issues without worrying that their confidences might be communicated to others in ways that could harm them by damaging their reputation or upsetting others.

'To confide in someone is to put your trust in that person. The origins are Latin with con acting as an intensifier of *fidere* – meaning to trust or put one's faith in and is probably best translated as 'to strongly trust someone.' Confidentiality presupposes trust between two people within a community of at least three people. For example, confidentiality occurs when two people decide to restrict the communication of information, keeping it between themselves in order to prevent it being communicated to a third person or to more people. In a professional relationship, 'confidentiality' means protecting information that could only be disclosed at some cost to another's privacy in order to protect that privacy from being compromised any further. In her extended consideration of *The Law of Professional – Client Confidentiality*, Rosemary Pattenden observed that recent developments in the law have removed the need for a relationship of trust as a prior condition to create legally binding confidentiality. All that is necessary is that the professional was aware, or a reasonable person in her position would have been aware, that the information is private to the subject of that information' (Pattenden, 2003: 13; Mitchels and Bond 2021).

The law is developing to provide increasing protection for confidentiality, and this principle applies equally strongly to vulnerable adults. If the adult has mental capacity to enter into a contract, then confidentiality must form part of the contractual agreement made.

2.1 Contractual agreements with vulnerable adults

Contracts for counselling-related services need to make clear to the client the status of client records and the length of time that the counselling records will be kept.

It is vital to be clear with the client at the outset about the status of their records, because confidentiality law and data protection legislation may permit and/or require client access to client records, or sometimes third-party access in the case of vulnerable adults.

The law may allow access to medical or social care records by order of a court, or access may be required by those who have legal responsibility for the affairs or wellbeing of a vulnerable adult, for example under guardianship or powers of attorney.

A client who has the mental capacity to make their own decisions but is vulnerable for other reasons, for example, physical illness or victim status, may wish to have their confidentiality protected. In such cases, the client is entitled to know of any limitations on their right to confidentiality that may be imposed by the law, or by the context in which the therapy service is provided.

Typically, confidentiality forms an important element of the contract, which is governed by both statute and case law; see Chapter 4 in the third book of BACP's Legal Resource Series, *Essential Law for Counsellors and Psychotherapists* (Mitchels and Bond, 2008).

A contract is a legally enforceable agreement with terms that may be explicit or implied. It does not have to be in writing but it helps to have some written or otherwise recorded evidence of what is agreed, for clarity and as an *aide-memoire* if required.

The parties contracting will include the practitioner and the client. They may also include those holding responsibility for a vulnerable adult through guardianship or a power of attorney.

The organisation providing the counselling-related service might be included if the practitioner is an employee. Clients, carers and practitioners may have different expectations about confidentiality, and contract terms should clarify issues such as mutual expectations and limitations on confidentiality.

Some essential contract terms can be clarified by providing the client and/or their guardian, attorney or carer with a leaflet to read in advance, which sets out the basic terms of the therapy offered, or by careful discussion with new clients at their intake assessment or first session.

Be careful about reliance on verbal contracts reached at the first session: vulnerable clients might be anxious or not able to concentrate, so may be less able to reach a considered agreement with the practitioner or may fail to recall what was agreed.

A vulnerable adult client will need the mental and legal capacity to enter into a valid contract for counselling-related services (see the section on mental capacity earlier in this resource).

2.2 Information sharing

Inter-agency sharing of information is increasing to the extent that it has now become the norm. Practitioners working in the context of social care, healthcare, education and other services may need to share information for the protection of the public or the safety and welfare of a vulnerable client or others, and to enhance the quality of the service provided.

Information will usually be shared with the full explicit consent of the client. In other situations, in the absence of client consent, the public interest may require the practitioner to exercise their discretion in disclosing information, for example where there is an imminent risk of serious harm to the client or others. In these situations, the practitioner's discretion to disclose information in the public interest is protected by the courts, in that they will not enforce a client's right to confidentiality (i.e. the courts will not punish the practitioner for disclosure) in cases where the practitioner acted in good faith, and the public interest was protected by making the disclosure. See the case of *W v Edgell and others* [1990] 1 All ER 835.

For discussion of ways to approach decision making when faced with dilemmas about confidentiality and disclosure, and for a checklist of factors to consider, see the section on ethical dilemmas and decision making later in this resource. See also Department of Health (2015) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*

2.3 Data protection and case records

Personal information (data) should be protected (i.e. treated with respect and confidentiality) and the legal issues applicable to the holding of personal data are governed by the United Kingdom General Data Protection Regulation (UK-GDPR), the Data Protection Act 2018, the Freedom of Information Act 2000 and other relevant subsidiary legislation Practitioners will need to be familiar with their obligations under the current law. Further information can be found on the BACP website in GPiA 105 *the United Kingdom-General Data Protection Regulation (UK- GDPR) legal principles and practice notes for the counselling professions*. The UK-GDPR and data protection legislation apply to records containing personal data, and there are additional protections for sensitive personal data, whether the information is held electronically or in any other form. The processing of personal data, including sensitive personal data, is protected under this law. The operation of the law relating to data protection in England is administered by the Information Commissioner, and the Information Commissioner's Office (ICO) provides information, advice and support through telephone, email and postal contact with the office, publications and its website at https://ico.org.uk. To contact the ICO for Scotland, email: scotland@ico.org.uk; for Wales, email: wales@ico.org.uk; and for Northern Ireland, email: ni@ico.org.uk.

Practitioners working in the context of any government organisation are likely to be contractually bound to comply with the data protection legislation because of the content and the context of their work, irrespective of their own personal methods of data processing. The manner of processing has an impact on payment, as the ICO's registration fee applies to digital processing, but the data protection law applies to all forms of processing, including handwritten notes.

As a matter of interest, the ICO now seems to assume that most practitioners will use some form of digital processing for making appointments, keeping records and other communications with clients, colleagues and employers in the provision of their therapy services.

'Processing' is wider than clinical notes, so communications within a counselling-related service (in whatever context it takes place), particularly appointments or other data related to providing and receiving services, could constitute 'personal data and/or sensitive personal data'.

Failure to register when required to do so is an offence of strict liability, punishable with fines.

Practitioners deciding whether or not to register, should consult the ICO for assistance or answer the self-assessment questions on the website at www.ico.org.uk (see https://ico.org.uk/for_organisations/register/self-assessment).

Under data protection law, vulnerable adults with capacity to make their own decisions have a right to see their own records, subject to certain safeguards. If the client does not have the capacity to make their own decisions, then those with legal responsibility for them (e.g. legal guardians or those with powers of attorney for the finances or the health and welfare of the client) may have the right to make decisions relevant to the counselling-related service, and under data protection law may also have the right to see all or part of the client's counselling records (with certain exceptions to allow the practitioner to maintain confidentiality to safeguard the health or safety of the client or others, or to safeguard a police or other investigation in the context of legal protection).

3 Confidentiality, managing risk and the practitioner's duty of care

All clients take risks when seeking the help of any professional and do so in the hope that the benefits will outweigh any risks. Vulnerable adults are arguably exposed to heightened levels of risk because of their dependence on their practitioner. When a client confides in a practitioner the risk is that the confidence will be broken and confidential material communicated to others in ways that the client either does not want or has not agreed to. From the practitioner's point of view the responsibility to protect confidences may compete with other responsibilities to the client, for example a concern to protect them from preventable harm inflicted on themselves or by others. Practitioners working with vulnerable adults may experience these dilemmas more acutely because of the heightened vulnerability and dependence of their clients.

The practitioner's duty of care to vulnerable adults as clients includes a duty of confidentiality to the vulnerable adult client, both professionally and in the law of contract (see section 2.1, *Contractual agreements with vulnerable adults*) and in the law of tort. There is insufficient space here to discuss the law of tort in detail, but it is this area of law that governs our responsibility to others (e.g. professional negligence, health and safety issues, prevention of noise and other nuisances). The law of tort applies to the duty of care of a professional person to their clients, which includes both expertise and confidentiality. For a more detailed exploration of the law of tort in relation to counselling see Mitchels and Bond (2008: Chapter 3).

Confidentiality for a vulnerable adult client may be limited by legal safeguards, which may impose a duty of disclosure where the counsellor has a serious concern for the welfare and safety of their client or others. For further discussion, see Bond and Mitchels (2015) and also part 9 of this resource, *Principles and ethical decision making in the context of safeguarding vulnerable adult clients*.

3.1 Referrals and disclosures

Counsellors have an ethical responsibility to act within their particular range of qualifications and expertise.

This might require referral where we are asked to work with vulnerable adults but lack the expertise or experience to do so. When working with vulnerable adults we can find ourselves out of our depth unless we have been trained in this area of work.

In these cases, referral is ethically both appropriate and necessary. *The BACP's Ethical Framework for the Counselling Professions* (2018) makes this clear (see Good Practice, point 28).

We may be working with a vulnerable adult client who discloses abuse or another safeguarding need. In this situation we have to assess:

- the seriousness of the likely harm
- how imminent the risk is to the vulnerable adult or others
- the effectiveness and impact of disclosure
- whether we are referring with client consent or making a referral without consent in accordance with a legal responsibility (e.g. in obedience to statute or a court order), or a disclosure made to protect the client's vital interests or in the public interest.

Disclosures and referrals may be necessary in the interests of the vulnerable adult client, or for the protection of other vulnerable adults.

Where a disclosure has to be made in the public interest in the context of therapy, the mechanism is set out in *Information sharing – advice for safeguarding practitioners* (DfE 2015, updated 2018). Wherever possible, disclosures should be made with the consent and co-operation of the vulnerable adult concerned. However, if there is a serious risk to the client or others, or if the client is not competent to make their own decisions and the consent of those with legal responsibility for the client is required, there are some safeguarding situations where seeking prior consent from carers or others might put the client or others at greater risk of significant harm - or risk jeopardising a police investigation or social care enquiry (for example, where the client's carers are the alleged perpetrators of abuse of the client or present a risk of harm to the client or to another vulnerable person), and in these circumstances the counsellor should first seek advice from the appropriate legal advisor, the police or the social care legal advisor of the local authority.

4 Working with vulnerable adults in the context of social care

The term 'social care agencies' is used to mean inclusion of all those agencies working with, or providing community care for, or working with adult clients who are elderly or vulnerable, or who have special needs, mental illness or disability. This includes practitioners working with individuals who are vulnerable for any other reason and may include clients who are socially vulnerable, for example those who are refugees or homeless.

For specific contexts, see Mitchels and Bond (2008), in which Chapter 8 looks at therapeutic work with and for the police and the Home Office, including working with offenders, ex-offenders and probation services in liaison with social services.

Chapter 6 looks at therapeutic work in the context of healthcare and includes a perspective of therapy in the context of medical social work.

The Health and Social Care Acts 2001, 2008, and 2012, with the Health and Social Care (Reform) Act (Northern Ireland) 2009 along with their subsequent subsidiary legislation, address among other things, funding for health authorities and primary care trusts, local authority scrutiny of health services, public involvement, consultation and patient advisory groups. Since then, there have been further reforms, including a radical revision of healthcare funding, so look for additional changes to health and social care provision, funding, standards and inspections.

In Northern Ireland, on 1 April 2009, under the Health and Social Care Reform (Northern Ireland) Act 2009 the functions of the Mental Health Commission (MHC) transferred to the Regulation and Quality Improvement Authority (RQIA). See the RIQA website for details of the reports and guidance on safeguarding children and vulnerable adults in Northern Ireland, all available to download at www.rqia.org.uk.

In England, the General Social Care Council sets standards of conduct and practice for social care workers and their employers and is responsible for codes of practice, the Social Care Register and social work education and training (see www.scie.org.uk/workforce/files/CodesofPracticeforSocialCareWorkers.pdf?res=true).

The Care Quality Commission (CQC) is the health and social care regulator for England. The CQC has the power to require registration of health and social care professionals. Details are available on its website at www.cqc.org.uk, where guidance about registration and compliance can be found.

From April 2010, all NHS trusts have had to be registered with the CQC, and all health and adult social care providers are required by law to be registered with the CQC if they provide 'regulated activities' (as defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). From 1 October 2010, this has also applied to independent healthcare and adult social care providers and, from April 2012, to primary medical care services (including GP practices and out-of-hours services). Practitioners working for a registered provider in the context of health or social care may therefore find themselves subject to the new regulations. Guidance on standards, implementation and the registration process in adult social care can be found at www.cqc.org.uk.

The social care structure in Northern Ireland is slightly different. The Department of Health Social Services and Public Safety (DHSSPS) is responsible for creating policy and legislation for primary, secondary, community and social care. The Health and Personal Social Services Act (Northern Ireland) 2001 established the Northern Ireland Social Care Council (NISCC), whose duty is to provide high standards of conduct, practice and training among social workers. It is responsible for regulating and registering the social care workforce in Northern Ireland.

Registration with the NISCC demonstrates that a particular social worker is suitably trained, professional in their practice and accountable for the work they do. Registered workers must meet the agreed standards in their conduct and practice set out in the NISCC Code of Practice. The NISCC has also developed Registration Rules and Conduct Rules. All three documents are available at www.niscc.info.

In Scotland, the Care Inspectorate fulfils a similar function to the CQC in England. Further information can be found at www.careinspectorate.com.

All of the regulations are perhaps relevant in some way, but for England and Wales, Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 contains provisions that may be of particular interest to practitioners working in social care contexts:

Reg. 9: Care and welfare of service users
People experience effective, safe and appropriate care, treatment and support that meet their needs and protect their rights.

Reg. 10: Assessing and monitoring the quality of service provision
People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.

Reg. 11: Safeguarding people who use services from abuse
People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.

Reg. 18: Consent to care and treatment
People give consent to their care and treatment and understand and know how to change decisions about things that have been agreed previously.

Reg. 20: Records
People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.

Reg. 23: Supporting workers
People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.

In Northern Ireland, the law was reformed by the Health and Social Care (Northern Ireland) Act 2009. This Act dissolved the Health and Social Services Boards, the Mental Health Commission, the Central Services Agency and the Health and Social Services Council.

The Northern Ireland Health and Personal Social Services Regulation and Improvement Authority was renamed as the Health and Social Care Regulation and Quality Improvement Authority (RQIA) and took on the functions of the Mental Health Commission in addition to its existing functions. The Act also established the Regional Health and Social Care Board, the Regional Agency for Public Health and Social Well-Being, the Regional Business Services Organisation and the Patient and Client Council.

There are many issues for practitioners in the context of working with clients who have a diagnosed mental illness. Perhaps the most noticeable challenges are posed by the operation of the Mental Health Acts, in particular, in England and Wales the Mental Health Act 1983 (MHA 1983) containing provisions for compulsory detention for assessment or treatment, and compulsory treatment. Practitioners may also be involved with social care in the provision of patient after-care following discharge from hospital and in provision of client care in the community. For detailed up-to-date guidance see the Mental Health Act 1983 Code of Practice (DH 2015).

Under s.117 of the MHA 1983, the provision of after-care following discharge from compulsory detention in hospital is the duty of the local health board, the primary trust and local social services, whilst the person remains under supervision or until they are satisfied that the client is no longer in need of those services. In Northern Ireland, Article 7(1) of the Health Services (Northern Ireland) Order 1972 imposes a duty on local authorities to make arrangements, to such extent as the Department of Health and Social Services and Public Safety considers necessary, for the after-care of a person suffering from illness (the term illness includes mental disorder for the purposes of this order).

The law is complex with regard to the respective duties of health professionals and social care needs. Authorities may get into a 'who should do what and when' argument, particularly in cases where clients deteriorate over time (e.g. when they have dementia).

There is a clear and useful exposition of the relevant law in Chapter 7 of *Community Care Law and Local Authority Handbook 3rd edition* (Butler, 2015). The law in the area of community care is rapidly developing, partly due to the increasing numbers of the population to which it applies (i.e. generally older adults).

The case o*f R v Ealing District Health Authority, ex parte Fox* [1993] 3 All ER 170 established that health authorities and local authority social services must take reasonable steps to identify appropriate after-care facilities for a patient before discharge from hospital. Discussion should therefore take place before the Mental Health Review Tribunal hearing or hospital managers' meeting takes place. (For discussion of the law, see Butler and Fulwood 2015.)

'Soft law includes government guidance, some of which may be enforceable by the courts by statutory regulation', for example the Mental Health Act 1983 Code of Practice (DH 2015), issued by the Secretary of State in 2015, see: www.gov.uk/government/publications/code-of-practice-mental-health-act-1983.

Local authorities in England have a duty to plan, provide and publish information about community care services in their area. Assessment is mandatory where it appears to the local authority that community care services may be required for an individual. Assessment should be followed by evaluation for provision of services, within the principles of reasonableness. Any of the client groups with special needs, disability or mental illness may qualify for assessment, as may those who are elderly or otherwise vulnerable. The Community Care Assessment Directions 2004 add a requirement to consult the person being assessed, to give information about any payment required and to agree the services to be provided with the recipient. Where appropriate, this also applies to that person's carers.

In Northern Ireland, the Health and Personal Social Services (Northern Ireland) Order 1977 contains a duty for local authorities to 'make arrangements to such extent as the Department of Health, Social Services and Public Safety considers necessary for the presentation of the prevention of illness and the care and aftercare of a person suffering from an illness.'

Local authorities should carry out an assessment of anyone who appears to be in need of community care services, including residential care. The Disabled Persons (Northern Ireland) Act 1989 also places a duty on local authorities to make a care assessment of people who are defined as 'chronically ill or disabled'.

The Department of Health in England and Wales has issued guidance on the eligibility criteria for 'social care': see Care and Support statutory guidance (available at: www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#using-the-care-act-guidance). This guidance carries the force of law, being made under s.7(1) of the Social Services Act 1970, which makes it compulsory for local authorities and government departments to follow the guidance unless there are cogent reasons to depart from it. It is enforceable through local complaints procedures, and in the High Court by judicial review.

The implementation of the *National Service Framework: older people* was designed to provide a structure for improving the standards of care to all elderly people, offering integrated services that will allow elderly people to receive appropriate care at home, in residential or nursing homes and in hospitals. The aims are to end age discrimination in the provision of health and social care services, to promote healthy lifestyles and provide support so that elderly people can live independently, and overall to treat older people with respect by providing high-quality services.

For the elderly with dementia or mental health illnesses, the NHS and local councils are required to work with care homes in their areas to develop a range of services to meet the needs of older people with mental health problems, including specialist residential care places for older people with dementia. Within residential care, one would expect that therapy should be available to those who need it, but therapeutic interventions will only be requested if this need is identified as part of the assessment and formulation of a care plan for the individual. There is now a 'single assessment process' see: National service framework: older people (www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people (DH, 2007)).

In circumstances where an assessed need exists, a local authority considering the provision of services for an adult may take into account its available resources but it may not take decisions on the basis of resources alone, and may not unreasonably refuse to provide a necessary service.

The advent of the COVID-19 pandemic has resulted in the publication of lots of new government guidance on the care of vulnerable adults, which can be accessed via the Government website www.gov.uk/government/publications.

A breach of the duty of care by a practitioner working in the context of social care may lead to a formal complaint to the local authority and/or the practitioner's professional body, and/or a legal claim. The practitioner's own professional liability insurers should be notified of any complaint or legal action involving a practitioner (whatever their employment status). Claims may be covered by an employer's professional insurance. In situations where the practitioner has acted in the course of their work (e.g. in cases where the practitioner has complied with social care agency policies and government guidance), the agency (e.g. local authority, adoption agency) may be held vicariously liable for the actions of the practitioner (see Mitchels and Bond, 2010: Chapters 3 and 9). Therapeutic contracts with clients are regulated by the general law relating to the duty of care (Mitchels and Bond, 2010: Chapters 3 and 4) – the practitioner's professional code of conduct giving the client a right of complaint – and also by general contract law. Agency policies and procedures may place limits on the contractual arrangements between a practitioner and client working in social care (e.g. the place where the practitioner may see the clients, times of appointments, health and safety procedures, confidentiality in making, keeping and storage of records, and fees payable).

5 Disclosure and barring services

5.1 England and Wales

The Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) merged to become the Disclosure and Barring Service (DBS). The DBS runs lists of people who are barred from working with vulnerable adults by reason of their history and criminal convictions. A DBS certificate search is colloquially known as a 'DBS check'. There are three levels of check available: standard; enhanced; and enhanced with list checks. Employers or contracting organisations have a responsibility to run criminal records and other necessary security checks on practitioners working with vulnerable adults, as appropriate to the practitioner's level of contact with the vulnerable clients. Applications for a DBS check can only be made by post or online by an employer. For a full explanation of how the system works, please refer to the website www.gov.uk/disclosure-barring-service-check/arrangingchecks-as-an-employer. Employers do not have to pay for registration or searches, but they must be legally entitled to carry out the check and must also have the worker's permission. There is an annual registration fee (and registration is free for volunteers).

The DBS runs an updating service, see the website at www.gov.uk/government/publications/dbs-update-service-applicant-guide.

Once registered for the updating service, an ID number is issued, allowing the registered person to log on to the DBS service, see the certificate online, and 'take' the certificate from one employment to another. Employers may be given permission to check the certificate online and the registrant may see who has checked it. DBS addresses and contact details are provided at the end of this resource.

Self-employed practitioners wishing to obtain a personal DBS check for themselves may apply through DBS's Disclosure Scotland service, see: www.disclosurescotland.co.uk/apply/individuals.

5.2 Northern Ireland

AccessNI is a branch within the Department of Justice, established in April 2008. Its job is to supply certificates that show whether people who want to work in certain types of job (for example, with children and/or vulnerable adults) have a criminal record or if other important information is known about them. This enables employers to make safer recruitment decisions.

AccessNI operates within Part V of the Police Act 1997 and issues three types of disclosure: basic, standard and enhanced. Enhanced disclosure can include a check of those barred from working with children or adults.

If you are a Northern Ireland citizen and require an application form or other information about AccessNI, or you are (or work with) an organisation registered with AccessNI and need further information about the application process, please visit www.nidirect.gov.uk/accessni.

For information about how the disclosure and barring programme works in Northern Ireland, see www.dojni.gov.uk/accessni.

5.3 Professional registration

Clients may feel greater confidence in a practitioner who is registered with an appropriate professional body. Membership of a professional body provides the public with the knowledge that the practitioner adheres to a code of professional ethics and conduct, with redress in the form of complaints procedures and professional conduct and disciplinary procedures.

Registration provides a further level of confidence for clients, in confirming that the practitioner has also achieved a certain level of qualification and expertise. For example, BACP members registered with the Professional Standards Authority have achieved a certified level of professional competence.

6 Vulnerable witnesses in court (and eligibility for 'special measures')

The courts recognise that giving evidence in court may be stressful, particularly in criminal trials, and the rights of vulnerable or intimidated victims of criminal offences are therefore entitled to 'special measures' (see 8). These special entitlements do not yet exist in the civil courts.

The Youth Justice and Criminal Evidence Act 1999 (YJCEA 1999) (as amended by the Coroners and Justice Act 2009) makes all children under 18 years of age, appearing as defence or prosecution witnesses in criminal proceedings, eligible for special measures (see sections 16 to 33, YJCEA 1999) to assist them to give their evidence in court. Vulnerable witnesses are defined by s.16 of that Act. Children are defined as vulnerable by reason of their age under s.16(1).

In the Government publication *Vulnerable and Intimidated Witnesses: A Police Service Guide* (Ministry of Justice 2011b), there are prompts intended to assist service providers in recognising when an adult witness is vulnerable and see also the new Code of Practice for Victims of Crime, MoJ (2015).

In addition to children under the age of 18 at the time of the hearing, three other types of vulnerable witness are identified by s.16(2) of the Youth Justice and Criminal Evidence Act 1999. Briefly, these are vulnerable adults who have a mental disorder, learning disability or physical disorder or a disability that is likely to have an impact on the quality of their evidence, including:

- witnesses who have a mental disorder or any disability of the mind as defined by the Mental Health Act 1983 (as amended by the Mental Health Act 2007);
- witnesses significantly impaired in relation to intelligence and social functioning (witnesses who have a learning disability); and
- witnesses who have a physical disability.

Witnesses in this category (s. 16 [2]) are only eligible if the quality of evidence that is given by them is likely to be diminished by reason of the disorder or disability (s.16[1] [b]).

Wherever a reference is made in the legislation to the 'quality of a witness's evidence' for the purposes of defining a witness as vulnerable or intimidated, and in terms of access to special measures, it refers to the 'completeness, coherence and accuracy' of the evidence; 'coherence' refers to a witness's ability, when giving evidence, to give answers that address the questions put to them and can be understood both individually and collectively (s.16[5]).

The court must take account of the views of the witness in determining whether he or she may be regarded as vulnerable by virtue of a disorder or disability (s.16[4]). *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures* (Ministry of Justice, 2011a) was issued by the Crown Prosecution Service, Department for Education and Department of Health, along with the Welsh Assembly Government. It recognises mental disorder, but states that this may be the most difficult category to identify for support through special measures because of the fluctuating nature of many mental disorders. The provisions from the Mental Health Act 2007 may be relevant for consideration. A person with mental disorder may need special assistance only at times of crisis.

Note that a brief interview may not necessarily reveal mental disorder, but if clear evidence and/or a clear diagnosis becomes available that suggests the need for special measures, then these should take account of any emotional difficulties, so as to enable the witness to give evidence with the least possible distress. Currently, there is no accepted and consistent approach to the assessment of witness competence. It is likely that varying criteria may be used by experts called to make assessments. In addition, mental instability might be aggravated by alcohol, drugs and withdrawal from drugs. The effect may be temporary and the time elapsed before a witness is able to give clear evidence will vary, according to the type and severity of the intoxication, from a few hours to a few days.

Achieving Best Evidence also defines specific terms, but in places shows what some specialist practitioners may feel is a limited understanding or a generalisation of some aspects of the various conditions to which it refers.

However, it is a step towards a better understanding and improved arrangements for a wider range of witnesses - see, for example, the following extracts (Ministry of Justice, 2011a).

Significant impairment of intelligence and social functioning (learning disability):

2.67 Learning disability is not a description of one disability, but a collection of many different factors that might affect a person's ability in relation to learning and social functioning to greatly varying degrees.

While some 200 causes of learning disability have been identified, most diagnoses are still 'unspecified learning disabilities'. People with high support needs may be easily identified but people with mild or moderate learning disabilities may be more difficult to identify.

2.68 It is impossible to give a single description of competence in relation to any particular disability, because there is such a wide range of abilities within each in terms of degree of intellectual and social impairment. However, there are some indicators that may help identify a witness with a learning disability.

2.69 Though generalisations cannot be made, some characteristics may exist in relation to some syndromes. For example, witnesses with autistic spectrum disorder, which includes Kanner's syndrome and Asperger's syndrome, have a huge range of abilities/disabilities, but:

- They often have difficulty in making sense of the world and understanding relationships;
- They are likely to have little understanding of the emotional pain or problems of others; and
- They may display great knowledge of certain topics and have an excellent vocabulary but could be pedantic and literal and may have obsessional interests.

2.70 Some people with learning disabilities are reluctant to reveal that they have a disability, and may be quite articulate, so that it is not always immediately obvious that they do not understand the proceedings in whole or in part.

Physical disability (recognised in *Achieving Best Evidence* as potentially creating vulnerability):

2.71 Recognition of this type of disability is less likely to be a problem, although some disabilities may be hidden, but it is important to be aware of whether or how a physical disability may affect the person's ability to give a clear statement. Most witnesses will be able to give evidence with support.

2.72 Some physical disabilities may require support. Hearing or speech difficulties may require the attendance of a skilled interpreter and/or intermediary.

Witnesses with a mental disorder:

2.73 A mental disorder does not preclude the giving of reliable evidence. However, for many disorders there is a need to protect the witness from additional stress and provide support to enable them to give reliable evidence. The recall of traumatic events can cause significant distress, and recognition of the mental state of the witness and its effect on their behaviour is crucial. There is also the need to ensure that the type of behaviour is identified, as far as possible.

2.74 Witnesses with a mental disorder, such as schizophrenia or other delusional disorders, may give unreliable evidence through delusional memories or by reporting hallucinatory experiences, which are accurate as far as the witness is concerned but bear no relationship to reality (e.g. they might describe a non-existent crime). Challenges to these abnormal ideas may cause extreme reactions and/or distress. Interviewers should probe these accounts carefully, sensitively and in a non-judgmental way with a view to identifying which elements of the account may be delusional and which elements might have a firmer foundation in reality.

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The evidence given by depressed witnesses may be influenced by feelings of guilt, helplessness or hopelessness. Witnesses with antisocial or borderline traits may present with a range of behaviours such as deliberately giving false evidence.

These disorders cause the most difficulties and contention in diagnosis and require very careful assessment.

2.76 Witnesses, particularly some older witnesses, may also have dementia, which can cause cognitive impairment. A psychiatrist or clinical psychologist with experience of working with older people should be asked to assess their ability to give reliable evidence and the effect such a procedure might have on their health and mental welfare.

2.77 Witnesses with a mental disorder may show some of the behaviour seen in witnesses with a learning disability, such as confusion, memory loss and impaired reasoning. For this reason, many of the interview practices that are likely to help witnesses with a learning disability may also benefit witnesses with a mental disorder. Properly preparing the witness for the interview may help to identify and reduce confusion, emotional distress and anxiety.

Cognition may not be an immediate difficulty, but attention to the way a statement is given and how questions are posed must always be considered.

2.78 The witness may wish to please the person in authority. They may be suspicious of the person, aggressive, or wish to impress the interviewer. Interviewing teams should be aware of such possibilities. Consultation with people who know the witness well should give some indication of their likely behaviour and some suggestions as to how interviewers can best interact with the witness.

2.79 Confusion may be exacerbated by the use of drugs or alcohol or withdrawal from drugs. An assessment should include information as to how this is likely to affect the interview, and how long this effect is likely to last.

2.80 Preparation of the witness for the interview and a rapport stage prior to formal questioning during the interview are essential. This will allow the witness to have some familiarity with the personnel who will be involved in the interview, including the interviewer, interview monitor and intermediary (where used).

Witnesses with a significant impairment of intelligence and social functioning (learning disability):

2.81 Some witnesses with a learning disability may wish to please people in authority. Some may be suspicious of people, or aggressive, or may wish to impress the interviewer. Interviewing teams should be aware of such possibilities. Consultation with people who know the witness well should give some indication of their likely behaviour and some suggestions as to how interviewers can best interact with the witness.

2.82 Some witnesses with a learning disability may show confusion, memory loss and impaired reasoning. Properly preparing the witness for the interview may help to identify and reduce confusion, emotional distress and anxiety.

2.83 In some instances of mild and moderate learning disability, a difficulty with cognition may not be immediately apparent. The experience that many people with learning disabilities have of discrimination towards them in society is likely to act as an incentive to conceal or minimise their disability whenever possible. Where there are concerns that a witness has a learning disability, even if the extent of the disability is considered to be relatively mild, it is essential that a great deal of care is taken in framing questions and evaluating the witness's response to them.

2.84 Some witnesses with a learning disability communicate using a mixture of words and gestures (e.g. Makaton signs/symbols when used as an augmentative communication system).

While an intermediary should be considered in every case where a witness has a learning disability, the services of an intermediary are essential in circumstances where a witness communicates using a mixture of words and gestures.

2.85 Some witnesses with a learning disability do not use speech but communicate using alternative methods of communication. Such alternative methods include sign and symbol systems. Examples of sign systems include Makaton signing and Sign-a-long (these systems may be used either as an augmentative system with speech or as an alternative system without it). Examples of symbol systems include Rebus, Bliss and Makaton. The symbols may be printed on boards or cards or contained in booklets. They vary from being iconic and concrete to being more abstract in their composition. They may be personalised and can be composed of words, pictures and symbols.

While an intermediary should be considered in every case where a witness has a learning disability, the services of an intermediary are essential in circumstances where a witness uses an alternative method of communication instead of speech.

7 Pre-trial therapy with vulnerable adult witnesses in criminal trials

The courts understand that giving evidence is likely to be accompanied by a degree of stress. Nevertheless, cases continue to be reported in the press where vulnerable witnesses involved in the judicial process have been severely affected or re-traumatised by the police investigation and the court process. Some witnesses have been so affected by the judicial process that they have become ill, made attempts on their own life or carried out suicide following their giving of evidence in court. This has led to renewed concerns about the welfare of vulnerable witnesses, and a re-examination of the way in which they are treated and the support they receive during a police investigation and throughout the judicial process. There is cogent evidence to support the argument that support should continue after the court case has finished. As a result of these concerns, in criminal proceedings, vulnerable or intimidated adult witnesses are legally entitled to 'special measures' and other forms of support (see 8), including pre-trial therapy, (see 7.1-7.6). Practitioners working with vulnerable adults and children will need to have valid consent to enter into a therapeutic contract (see Mitchels and Bond , 2021) and if the client is involved in a court process, additional confidentiality issues are involved in the therapeutic process, because there is likely to be a need to share information between professionals.

7.1 CPS guidance

In line with this, the Crown Prosecution Service (CPS) has issued guidance for the police, the CPS and therapists on pre-trial therapy in criminal cases: *Provision of Therapy for Vulnerable or Intimidated Adult Witnesses prior to a Criminal Trial: Practice guidance* (Crown Prosecution Service, 2002a) and *Provision of Therapy for Child Witnesses prior to a Criminal Trial: Practice guidance* (Crown Prosecution Service, 2002b). These two early documents are still in force and available online from the CPS website at www.cps.gov.uk, together with other guidance and codes of practice documents.

Following a public consultation which ended on 30 October 2020, these two guidance documents will be republished in an updated amalgamated version, perhaps sometime in 2022. Please watch out for the new updated guidance which will be available on www.cps.gov.uk.

It is likely to also contain proformas for use by therapists in liaison with the CPS, police and the courts.

For more information on the current CPS guidance on pre-trial therapy for vulnerable witnesses in force at the moment, please see GPiA 070 (Adults) and GPiA 098 (Children).

8 Support for victims and witnesses

For the document *CPS Commitment to Support Victims and Witnesses*, see www.cps.gov.uk/legal-guidance/victims-and-witnesses-cps-commitments-support.

On the CPS website, www.cps.gov.uk, there are links to codes of practice relating to victims and witnesses:

- Care and treatment of victims and witnesses
- Code of practice for victims of crime
- Code of practice for victims of crime – Welsh
- Adult victims of crime code leaflet
- Children victims of crime code leaflet
- Pre-trial witness interviews: code of practice
- The witness charter
- The witness charter – Welsh.

There are also links to information and special help for victims and witnesses:

- Agreement on the arrangement for the attendance of interpreters in investigations and proceedings within the criminal justice system
- Interpreters
- Expenses and allowances
- Pre-trial witness interviews legal guidance
- Provision of therapy for vulnerable or intimidated witnesses prior to a criminal trial
- Special measures
- TV links for witnesses outside the UK
- Homicide cases – guidance on CPS services to bereaved families
- Witness protection and anonymity
- Director's guidance on witness anonymity.

A revision of the earlier Victims' Code has been criticised for reducing the level and availability of support for the victims of crime (see the response to the consultation produced by Victim Support at www.victimsupport.org.uk).

Although the Victims' Code does not have the force of law, it has some teeth. The Parliamentary Ombudsman currently has a statutory responsibility to consider complaints, referred by MPs, from those who complain that a body has not met its obligations under its provisions.

The obligations placed by the current Victims' Code on the agencies concerned include that:

- they provide victims, or their relatives, with information about the crime, including about arrests, prosecutions and court decisions
- they provide information about eligibility for compensation under the Criminal Injuries Compensation Scheme
- victims be told about Victim Support and either be referred on to them or offered their service
- bereaved relatives be assigned a family liaison police officer
- victims of an offender who receives a sentence of 12 months or more after being convicted of a sexual or violent offence have the opportunity to make representations about what licence conditions or supervision requirements the offender should be subject to on release from prison (see www.ombudsman.org.uk).

9 Principles and ethical decision making in the context of safeguarding vulnerable adult clients

Section 8 of the Mental Health Act 2007 adds to s.118(2) of the Mental Health Act 1983 Code of Practice the requirement that a statement of principles shall be included to inform the decisions made by relevant mental health professionals under the Mental Health Act 2007. These principles should address issues including:

a. respect for patients' past and present wishes and feelings

b. respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)

c. minimising restrictions on liberty

d. involvement of patients in planning, developing and delivering care and treatment appropriate to them

e. avoidance of unlawful discrimination

f. effectiveness of treatment

g. views of carers and other interested parties

h. patient wellbeing and safety

i. public safety.

This section also requires resources to be used efficiently and distributed equitably. It is appropriate that the issues included in the Code of Practice should also be considered when working therapeutically with clients with mental disorder, and, although not compulsory, it is suggested that they are relevant to all our client work with vulnerable adults.

There are many situations in safeguarding vulnerable adults that pose ethical dilemmas, including the appropriate management of risk in self-harm, addictions, vulnerable adults in need, and all forms of abuse of vulnerable adults.

Practitioners working with vulnerable adults in residential care or living with their families may be told of situations where their client is the victim of bullying or direct physical or other form of abuse. The client may be afraid of reprisals as a result of any disclosure, and so they may request the practitioner not to say anything to others about the situation.

The practitioner is then faced with the potential dilemma of whether to make a disclosure to protect the client from future harm and in the public interest, or to keep silent and maintain their duty of confidentiality to the client. This is a balance which requires careful reflection, perhaps in supervision or consultation with any other appropriate practitioners. A salient consideration is whether a disclosure would help to end or at least alleviate the risk to the client, or others, who is the best person to tell, and how can disclosure be best achieved for safeguarding? See GPiA 014 for more on disclosures and there are checklists for reflection at 10 and 11 in this resource. The practitioner's decision might be influenced by their employment contract, which is likely to require compliance with agency policies or procedures and/or compliance with government guidance. The limits of confidentiality should always be made clear to clients at the outset of counselling-related services as part of the therapeutic contract, and if the situation is regulated by the practitioner's agency, clients should be made aware of (and agree to) the terms of work.

Practitioners may find themselves aware of organisational or individual failures, for example failure to comply with the patient's contract of care or to fulfil the care plan of a person in residential care. Practitioners are then in the difficult position of having to disclose the failures of staff or work colleagues in the best interest of the client. No professional is likely to feel entirely happy about reporting the bad practice or professional misconduct of another person, especially a colleague with whom they work. However, in some situations, 'whistle-blowing' may be necessary to maintain good professional practice, and it may be permitted or even required within agency policy (contractually agreed by all the agency's employees) or required by law. There are other circumstances in which whistle-blowing may not be specifically required by law or agency policy but is left to the practitioner's discretion. These situations may include the discovery of criminal acts by a colleague (e.g. a practitioner taking illegal recreational drugs and potentially placing vulnerable clients at risk) or unethical practice by a colleague leading to the risk of potential harm to a vulnerable adult, where practitioners feel that preventive action is necessary and that therefore whistle-blowing is morally and ethically justified. The *Ethical Framework* (2018) contains specific guidance on maintaining professional practice in relation to the actions of colleagues, see the section on Good Practice, points 11 and 24.

An issue for the practitioner is not only whether whistle-blowing is ethically defensible but also whether it is legally defensible, for example, in the public interest (i.e. that the protection of the general public may justifiably outweigh personal or private rights).

The biggest problem for practitioners is how to think through these dilemmas, and how to balance law and needs – acting in the best interests of the client, in the context of the law, guidance and the public interest in safeguarding vulnerable adults, and according to the needs of this specific client.

It is not possible to address specific case studies here, but it may be helpful to have to hand the disclosure and referral checklists in sections 10 and 11 of this resource. These include issues to consider when thinking through an ethical dilemma. Wherever possible, consider the issues in confidence with the help of supervision, discussion with experienced colleagues, and/or taking legal advice. Help and advice in relation to safeguarding vulnerable adults can also be obtained from the NHS, Citizens Advice Bureaux, the Office of the Public Guardian and other specialist charities and organisations, for which there are contact details at the end of this resource.

In some situations, information may be shared with the full explicit consent of the client. In other situations, in the absence of client consent, the public interest may require the practitioner to exercise their discretion to disclose information, for example where there is an imminent risk of serious harm to the client or to others. In these situations, the practitioner's discretion to disclose information in the public interest is protected by the courts, in that they will not enforce a client's right to confidentiality (i.e. they will not punish the practitioner for disclosure) in cases where the practitioner acted in good faith and the public interest was protected by making the disclosure. See the case of *W v Edgell and others* [1990] 1 All ER 835.

Doctors have clear guidance about confidentiality and disclosures (General Medical Council, 2009), which is available online at www.gmc-uk.org. This is useful reading for practitioners, too. In relation to vulnerable adults, paragraphs 57–63 are particularly helpful.

Paragraph 63 relates to those who do not have capacity to consent to disclosure, and states:

> *63. If you believe that a patient may be a victim of neglect or physical, sexual oremotional abuse, and that they lack capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm...*

However, remember that disclosure may be discretionary if it is not required by law or by an order of a court. The client's consent may not be available, either because of refusal or incapacity. A therapist would be protected if a disclosure is made in the public interest, in good faith and on reasonable grounds (i.e. a reasonable belief that the grounds reported are accurate), where the disclosure is made in order to protect the client or others from an imminent risk of serious harm. The guidance goes on to advise doctors that:

> *If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision.*

The Department of Health also provides guidance on the type of situations where the definition of serious harm may apply:

> *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).

For a detailed exploration of confidentiality and disclosures in counselling and psychotherapy, see Mitchels and Bond (2021).

10 Disclosure checklist: vulnerable adults

When making decisions about disclosure and information sharing in relation to vulnerable adults, it may help to consider these points:

- Is this information regulated by the Data Protection Act 1998 (DPA) (or from May 2018, the General Data Protection (GDPR) and/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?)
- Has the information arisen in the context of working for a public body (e.g. in health, education or social care)?
- What are the relevant rights of the person concerned under the Human Rights Act 1998 (HRA)?
- Is there a legal requirement to share this information (e.g. a statutory duty or a court order)?
- What is the purpose of sharing the information?
- If the information concerns a vulnerable adult, is sharing it in their best interests?
- If the information concerns a vulnerable adult, is sharing it in the public interest?
- Is the information confidential? If so, do you have client or other appropriate consent to share it?
- If client or other appropriate consent is refused, or there are good reasons not to seek consent, does the public interest necessitate sharing the information?
- What is the most appropriate way to share this information?

Information in relation to vulnerable adults should be shared in accordance with the principles set out in *Information Sharing: Guidance for practitioners and managers* (DfE 2008).

11 Referral checklist: vulnerable adults

If sharing the information is necessary and appropriate, record:

- the date the information is provided
- 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, the reasons this decision was made.

Glossary of terms

Authority: The local authority of a geographical area, including county councils, district councils, unitary authorities in England and Wales, Welsh county councils and Welsh county borough councils.

Health: Includes mental and physical health.

Hospital: Any health service hospital, and accommodation provided by the local authority and used as a hospital. It does not include special hospitals, which are those for people detained under the Mental Health Act 1983, providing secure hospital accommodation, s.145 Mental Health Act 1983.

Learning disability: Under s.2 of the Mental Health Act 2007, 'learning disability' is defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'. (Also see mental disorder, below.) Achieving Best Evidence (Ministry of Justice, 2011a) also defines 'Significant Impairment of Intelligence and Social Functioning (Learning Disability)', stating that:

2.67 Learning disability is not a description of one disability, but a collection of many different factors that might affect a person's ability in relation to learning and social functioning to greatly varying degrees. While some 200 causes of learning disability have been identified, most diagnoses are still 'unspecified learning disabilities'. People with high support needs may be easily identified but people with mild or moderate learning disabilities may be more difficult to identify.

Local authority: Under s.182 Mental Health Act 2007 means the council of a county, the council of a district for which there is no county council, the council of a London borough, the Common Council of the City of London or the Council of the Isles of Scilly. In relation to Wales, 'local authority' means the council of a county or county borough; in Scotland, it means a local authority under Social Work (Scotland) Act 1968, s.12.

Mental disorder: Section 1 of the Mental Health Act 2007 defines 'mental disorder' as 'any disorder or disability of the mind', but the definition does not include drug or alcohol addiction.

Under s.2 of the Mental Health Act 2007, a person with a 'learning disability' (defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning') is not to be considered to be suffering from a mental disorder, or requiring treatment in hospital for mental disorder, unless there is abnormally aggressive or seriously irresponsible conduct on his or her part. Those working in therapy or research with clients with drug or alcohol addictions or learning disability therefore are not treated under this legislation as working with clients with mental disorder. Interestingly, food addictions are not included in the definition.

Safeguarding: By the use of the term 'safeguarding' in this resource, the intention is to include those actions that will operate to enhance a person's health, development and welfare and prevent the risk of harm, and in particular this is intended to apply to those adults who are vulnerable for any reason, in law or in practice.

Serious harm: The Department of Health, in 2003, provided guidance on the type of situations where the definition of serious harm may apply. This is still valid today:

> *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).

Voluntary organisation: A body (other than a public or local authority) whose activities are not carried out for profit.

Vulnerable or intimidated victim: Under the Code of Practice for Victims of Crime (Ministry of Justice, 2015: Part A), a person is eligible for enhanced entitlements as a vulnerable victim if:

a. you are under 18 years of age at the time of the offence, or

b. the quality of your evidence is likely to be affected because:

i. you suffer from mental disorder within the meaning of the Mental Health Act 1983;

ii. you otherwise have a significant impairment of intelligence and social functioning; or

iii. you have a physical disability or are suffering from a physical disorder.

About the author

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References and further reading

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GPiA 031 Legal Resource: *Safeguarding children and young people.* (Mitchels, B.), Lutterworth: BACP.

BACP GPiA 070 Legal Resource: *Pre-trial therapy with Vulnerable and Intimidated Adults as Witnesses.* (Mitchels, B.). Lutterworth: BACP.

BACP GPiA 098 Legal Resource: *Pre-trial therapy with Children as Witnesses.* (Mitchels, B.). Lutterworth: BACP.

BACP GPiA 105 Legal Resource: *the General Data Protection Regulation (GDPR) legal principles and practice notes for the counselling professions.* (Mitchels, B.). Lutterworth: BACP. BACP

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Access to Medical Reports Act 1988

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Data Protection Act 2018

Disabled Persons (Northern Ireland) Act 1989

Freedom of Information Act 2000

General Data Protection Regulation 2018 (European Regulation)

Health and Social Care Act 2001

Health and Social Care Act 2008

Health and Social Care Act 2012

Health and Social Care (Safety and Quality) Act 2015

Health and Social Care (National Data Guardian) Act 2018

Health and Personal Social Services Act (Northern Ireland) 2001

Health and Social Care Reform Act (Northern Ireland) 2009

Human Rights Act 1998

Local Authority Social Services Act 1970

Mental Capacity Act 2005

Mental Capacity (Amendment) Act 2019

Mental Health Act 1983

Mental Health Act 2007

Mental Health (Northern Ireland) Order 1986

National Assistance Act 1948.

Police and Criminal Evidence Act 1984

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Protection of Children Act 1999

Race Relations Act 1976

Rehabilitation of Offenders Act 1974

Serious Crimes Act 2007

Sexual Offences Act 1956

Sexual Offences Act 2003

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Data Protection (Subject Access Modification) Order 2000

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Government and Law Society publications

- The Ministry of Justice (www.justice.gov.uk) publishes policy regarding the courts in England and Wales.
- The Northern Ireland Government publications are available from the Department of Health, Social Services and Public Safety (www.dhsspsni.gov.uk).
- The UK Government publications available from the Stationery Office (TSO, www.tsoshop.co.uk).
- The Welsh Government (https://gov.wales/children-families) publishes policy regarding children's services in Wales.

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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/guidance). 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)
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- Justis (www.justis.com). Online resource
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Contacts

Care Quality Commission
www.cqc.org.uk

CPS
www.cps.gov.uk

General Social Care Council
www.scie.org.uk/workforce/files/CodesofPracticeforSocialCareWorkers.pdf?res=true

Information Commissioner's Office
https://ico.org.uk

Wales

Information Commissioner's Office, 2nd floor. Churchill House Churchill way. Cardiff CF10 2HH Tel:029 2067 8400. Fax: 0292 067 8399. Email: wales@ico.org. Website: www.ico.org.uk/global/contact-us

Scotland

Information Commissioner's Office, 45 Melville Street Edinburgh EH3 7HL Tel: 0131 244 9001. Email: scotland@ico.org.uk

Northern Ireland

Information Commissioner's Office, 3rd Floor 14 Cromac Place Belfast BT7 2JB Tel: 028 9027 8757 or 0303 123 1114. Email: ni@ico.org.uk

Regulation and Quality Improvement Authority (RQIA)
www.rqia.org.uk

Disclosure and Barring Service (DBS)

England and Wales

DBS customer services, PO Box 110, Liverpool, L69 3JD; Tel: 0870 90 90 811; Minicom: 0870 90 90 344; Welsh language line: 0870 90 90 223; Email: customerservices@dbs.gsi.gov.uk; Transgender applications: sensitive@dbs.gsi.gov.uk

Northern Ireland

Information on the application process: www.nidirect.gov.uk/accessni; information on the disclosure and barring programme in Northern Ireland: www.dojni.gov.uk/accessni.

Legal contacts

England

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

Northern Ireland

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

Republic of Ireland (Eire)

An Roinn Slainte: Republic of Ireland Department of Health, Hawkins House, Hawkins Street, Dublin 2, Ireland; main switchboard: 01 635 4000 (dial +353 1 635 4000 from outside Ireland).

Organisations and agencies

Age Concern Astral House, 1268 London Road, London SW16 4ER; Tel: 020 8765 7200; www.ageconcern.org.uk

Age UK St James' Walk, Clerkenwell Green, London EC1R 0BE; Free welfare rights advice line: 0808 800 6565; www.ageuk.org.uk

Alzheimer's Society Gordon House, 10 Green Coat Place, London SW1P 1PH; Helpline: 0845 300 0336; www.alzheimers.org.uk

British Association for Counselling and Psychotherapy BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB; Tel: 01455 883300; Email bacp@bacp.co.uk; www.bacp.co.uk

British Medical Association Tavistock Square, London WC1 9JP; Tel: 020 7383 6286; www.bma.org.uk

British Psychological Society St Andrews House, 48 Princess Road East, Leicester LE1 7DR; Tel: 0116 254 9568; Fax: 0116 227 1314; Email: enquiry@bps.org.uk; www.bps.org.uk

Carers UK Ruth Pitter House, 20–25 Glasshouse Yard, London EC1A 4JT; Carers Line Tel: 0808 808 7777, 020 7490 8824; www.carersonline.org.uk

Care Quality Commission (CQC) www.cqc.org.uk

Court of Protection see Public Guardianship Office below

Crown Prosecution Service (England and Wales) has headquarters in London and York, and operates under a structure of 42 areas in England and Wales. London Office: 7th Floor, 50 Ludgate Hill, London, EC4M 7EX; Tel: 020 7796 8000; Fax: 020 7710 3447

Dignity in Dying (formerly the Voluntary Euthanasia Society) 181 Oxford Street, London W1D 2JT; Tel: 0870 777 7868; Email: exit@euthanasia.cc; www.dignityindying.org.uk

Down's Syndrome Association 155 Mitcham Road, London SW17 9PG; Tel: 020 8682 4001; www.downs-syndrome.org.uk

Foundation for People with Learning Disabilities 7th Floor, 83 Victoria Street, London, SW1H 0HW; Tel: 020 7802 0300; www.learningdisabilities.org.uk

General Medical Council 178 Great Portland Street, London W1W 5JE; General Enquiries Desk: 020 7580 7642; www.gmc-uk.org

Headway (brain injury association) 4 King Edward Court, King Edward Street Nottingham NG1 1EW; Helpline: 0808 800 2244, 0115 924 0800, (Nottingham); 020 7841 0240 (London); www.headway.org.uk

Help the Hospices Hospice House, 34-44 Britannia Street, London WC1X 9JG; Helpline: 0879 903 3 903; www.hospiceinformation.info

HM Revenue and Customs www.hmrc.gov.uk/menus/contactus.shtml

Hourglass (Safer ageing, stopping abuse) Astral House, 1268 London Road, London SW16 4ER; Freephone helpline: 0880 8808 8042; www.wearehourglass.org

Manic Depression Fellowship Castle Works, 21 St George's Road, London, SE1 6ES; Tel: 020 7793 2600; www.mdf.org.uk

MedicAlert Foundation 1 Bridge Wharf, 156 Caledonian Road, London, N1 9UU; Tel: 0800 581 420; www.medicalert.org.uk

MENCAP 123 Golden Lane, London EC1Y 0RT; Helpline: 0808 808 1111; Tel: 020 7454 0454; www.mencap.org.uk

Mind (National Association for Mental Health) 15–19 Broadway, Stratford, London E15 4BQ; Tel: 020 8519 2122; Mind Infoline: 08457 660 163; www.mind.org.uk

Motor Neurone Disease Association PO Box 246, Northampton NN1 2P2; Tel: 01604 250505; Helpline: 08457 626262; www.mndassociation.org

National Assembly for Wales https://gov.wales

Official Solicitor 81 Chancery Lane, London, WC2A 1DD; Tel: 020 7911 7127; www.gov.uk/government/organisations/official-solicitor-and-public-trustee

Patients Association PO Box 935, Harrow, Middlesex, HA1 3YJ; Tel: 020 8423 9119; Helpline: 0845 608 4455

Patient Concern PO Box 23732, London SW5 9FY; Tel: 020 7373 0794

Patient Information Advisory Group (PIAG) www.legislation.gov.uk/uksi/2001/2836/made

Public Guardianship Office Archway Tower, 2 Junction Road, London N19 5SZ; Customer service helpline: 0845 330 2900; Enquiry Line: 0845 330 2900; www.gov.uk/government/organisations/office-of-the-public-guardian

Respond Third Floor, 24-32 Stephenson Way, London, NW1 2HD; Helpline: 0808 808 0700; www.respond.org.uk

Rethink (formerly National Schizophrenia Fellowship) 17 Oxford Street, Southampton, SO14 3DJ; General enquiries: 0845 456 0455; Advice Line: 020 8974 6814; www.rethink.org

SANE 1st Floor, Cityside House, 40 Alder Street, London E1 1EE; Helpline: 0845 767 8000; www.sane.org.uk

Scope 6 Market Road, London N7 9PW; Tel: 020 7619 7257; Cerebral Palsy Helpline: 0808 800 3333; www.scope.org.uk

Speakability 1 Royal Street, London SE1 7LL; Tel: 020 7261 9572; Helpline: 080 8808 9572; http://rva.org.uk/organisation/speakability

Solicitors for the Elderly PO Box 9, Peterborough PE4 7NN; Tel: 01733 326769; www.sfe.legal

Stroke Association Stroke House, 240 City Road, London, EC1V 2PR; Tel: 020 7566 0300; Helpline: 0845 30 33 100; www.stroke.org.uk.