

CR209

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# Good Psychiatric Practice

## Confidentiality and information sharing

Third edition

COLLEGE REPORT

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# Guiding principles

- (1) Patients have a right to the privacy and confidentiality of their health information. Patients and people with parental responsibility for children who have not yet attained competence have a right to:
  - (a) access in a timely manner their own health information or that of the person for whom they have responsibility;
  - (b) control the access and disclosure of their own health information or that of the person for whom they have responsibility through the giving or withholding of consent.
- (2) **When you can disclose personal information:** the General Medical Council's (GMC's) guidance on confidentiality states:

'Confidentiality is an important ethical and legal duty but it is not absolute. You may disclose personal information without breaching duties of confidentiality when any of the following circumstances applies.

  - a The patient consents, whether implicitly for the sake of their own care or for local audit, or explicitly for other purposes.
  - b The disclosure is of overall benefit to a patient who lacks the capacity to consent.
  - c The disclosure is required by law, or the disclosure is permitted or has been approved under a statutory process that sets aside the common law duty of confidentiality.
  - d The disclosure can be justified in the public interest' (General Medical Council, 2017a: para. 9).
- (3) Information sharing for the purpose of direct patient care – assisting assessment, treatment and the maintenance of safety – is encouraged. This includes sharing with family members or carers and other professionals providing care and treatment. You should advise patients of potential benefits of disclosure of confidential information in this context. Even if a patient has refused to give consent to disclosure to a family member or carer, there is nothing to prevent you from receiving information about the patient from such individuals, as this does not equate or lead to disclosure of information by you. Indeed, provided that the circumstances do not involve disclosure of confidential information, you may actively request information from a family member or carer without the patient's consent.
- (4) Patients may refuse to give consent to disclosure and, if they have mental capacity to refuse, then you must accept this unless there are compelling reasons not to do so.
- (5) For patients who lack capacity to consent to sharing information, discussions regarding its withholding and disclosure should take

place with the Caldicott guardian,<sup>1</sup> if possible. It is appropriate to share information with family members and carers if this enhances their understanding of the patient's condition and helps them to provide support and care: in this case, disclosure may be regarded as being in the patient's best interests. If the issue about which you are considering disclosure is not urgent, and the patient may be reasonably expected to regain capacity to consent, then you should defer the decision about disclosure until the patient regains capacity and can withhold or give consent.

- (6) The starting point is that you should not disclose confidential information in the face of a refusal or without consent and that you should always seek the patient's consent. However, there may be circumstances where disclosure is justified in the public interest. The public interest has been defined by the GMC as the interests of the community as a whole or of any group or individual members of the community (General Medical Council, 2017a: para. 22). If you decide to disclose without consent or in the face of a refusal, you must inform the patient unless to do so would increase the risk of harm or inhibit effective investigation of risk.
- (7) In balancing the patient's right to confidentiality against the public interest, you should consider: the extent of disclosure; the nature of the intended recipient; and the risks and benefits to the patient and the public of disclosure and non-disclosure. Disclosure in the public interest can include various considerations, such as:
- (a) the importance of information sharing between professionals;
  - (b) the protection of patients from harm;
  - (c) the protection of others from harm;
  - (d) trust in the medical profession.

**Even if an individual piece of information may not satisfy the test for suggesting that there is a risk of serious harm, it may still be appropriate to make the disclosure if the information to be disclosed might lead to that conclusion when combined with other information.**

- (8) Many issues relating to disclosure concern anxieties about assessed risk. It is important to take the necessary time to make complex decisions about disclosure in this context and to obtain advice (without using patient-identifiable information), for example from colleagues, your employing organisation's legal and information governance department (including the Caldicott guardian), the GMC and your medical defence organisation, if you belong to one. They must pay due regard to the set of diverse values operating in any particular situation.
- (9) In limited circumstances, disclosure may be required by statute or other legal obligation. For court proceedings, you do not have to disclose information in the absence of a court order unless you have consent or there are grounds to override refusal. If in doubt, consult your organisation's legal department and your

1. The Caldicott Committee's *Report on the Review of Patient-Identifiable Information* (Department of Health, 1997) recommended six principles for the protection of people's confidentiality, which became known as the Caldicott principles. They included a recommendation that organisations should appoint someone to take responsibility for ensuring the appropriate security of confidential information. The people undertaking these responsibilities became known as Caldicott guardians. The principles were revised in 2013 (Department of Health, 2013). See 'Security of patient information' (p. 14, paras 26–28), below.



medical defence organisation, if you belong to one. When making a disclosure to a regulatory body (e.g. the GMC or Nursing and Midwifery Council), consent should be obtained, but regulatory bodies do have the power to order disclosure if consent is refused.

- (10) You should document in the patient record all discussions about confidentiality, together with a clearly set out decision-making process, when considering withholding or disclosing confidential information. This is particularly important when making finely balanced decisions about withholding or disclosing when a patient lacks capacity or refuses consent to disclosure or when consent has not been sought (see principle (7) above).

For additional guiding principles specific to children and young people see pp. 61–62 (para. 225).

# Introduction

## Purpose of this guidance

- 1 This College Report is informed by and should be read in conjunction with the GMC guidance *Confidentiality: Good Practice in Handling Patient Information* (General Medical Council, 2017a) and supplementary guidance published on the GMC website ([www.gmc-uk.org/guidance/ethical\\_guidance/confidentiality.asp](http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp)). The GMC's supplementary guidance includes notes on:
  - a patients' fitness to drive and reporting concerns to the Driver and Vehicle Licensing Agency (DVLA) or the Driver and Vehicle Agency (DVA)
  - b reporting gunshot and knife wounds
  - c disclosing information about serious communicable diseases
  - d disclosing information for employment, insurance and similar purposes
  - e disclosing information for education and training purposes
  - f responding to criticism in the media.

Every practising psychiatrist should read and be familiar with the GMC guidance on confidentiality and disclosure of information.
- 2 The guidance in this report does not replace legal advice. It contains references to UK practice throughout, particularly regarding the law relating to England and Wales, but the guiding principles on pp. 5–7 are intended to apply more generally.
- 3 The central purpose of this document is to provide members of the Royal College of Psychiatrists with guidance on good practice in dealing with confidentiality. This includes advice on information sharing and on disclosure, including handling requests for disclosure. This guidance builds on that given in *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009). The focus is on practical guidance relevant to a variety of situations and problems that confront psychiatrists and other members of multidisciplinary teams throughout the National Health Service (NHS) and independent sector.
- 4 This guidance has been prepared by the Special Committee for Professional Practice and Ethics and the College Confidentiality e-Group.
- 5 Since the previous edition of these guidelines (Royal College of Psychiatrists, 2010) there have been changes in health service organisation, clinical practice and public expectations. Particular consideration has been given here to the special issues surrounding the sensitivity of mental health information,

the impact of changes in health service organisation, including the Health and Social Care Act 2012, developments in practice (e.g. a move towards open-plan working in some workplaces) and the impact of advancing technologies (e.g. the use of social networking websites).

- 6 Psychiatrists should recognise that a greater emphasis on public protection (e.g. multi-agency public protection arrangements (MAPPA) and safeguarding adults procedures) has tended to create a system in which there is an assumption that confidentiality should be breached rather than maintained. You should be ready to defend a patient's rights in this context. As always, you should make every effort to establish and respect a patient's wishes.
- 7 There is an extensive body of ethics, law, policy material and formal guidance relating to consent to disclosure and the common law duty of confidence, information governance and sharing, and access to health records and data protection.
- 8 This guidance cannot summarise the extensive legal position. You need to be aware that the law, policy material and formal guidance is subject to change: you should seek advice if you are unsure or wish to seek support for a course of action you propose to take. You should be aware that the law in different jurisdictions can vary considerably from that set out in this guidance.
- 9 In this guidance, the term 'patient record' describes the information collated by a healthcare provider in order to deliver care and treatment to a patient. It may also be known as the 'clinical record' or 'health record'.
- 10 'Confidential information' is that which a psychiatrist obtains as a result of a professional relationship they form with an individual, through an assessment or the provision of care and treatment, when the individual becomes their patient. The relationship between the psychiatrist and the patient is one of 'fidelity' or 'trust'. Within that relationship there exists a tacit understanding on the part of the patient that confidential information (i.e. identifiable personal information) will not be further used or disclosed without their awareness and consent.

## Disclosure in high-risk situations

- 11 These are situations where there is an immediate risk of serious harm to a person who may be identifiable or to people who may form a group or community who may or may not be identifiable. The risk may be heightened because the patient is distressed and agitated and may be refusing to consent to discussion of their case with others. There may also be concerns that alerting the patient may actually increase the risk to others; or that attempts to contact the patient or their representative may result in delay in warning others who may be at risk of serious harm.

- 12 In circumstances such as these, you may decide that it is in the public interest to disclose information, in the face of a refusal and even without the patient's knowledge. Since this is in breach of the duty of confidentiality, you need to have good justification for this decision and, if the circumstances permit, you should take advice from colleagues and relevant organisations before making the disclosure.
- 13 The risk of child abuse or neglect, assault, a traffic accident or the spread of an infectious disease are perhaps the most common situations that a psychiatrist may face. However, consideration of other forms of harm should also inform decisions about disclosure in relation to crime. Serious fraud or theft involving NHS resources would be likely to harm individuals waiting for treatment. A comparatively minor prescription fraud may actually be linked to serious harm if prescriptions for controlled drugs are being forged. It is also important to consider the impact of harm or neglect from the point of view of the victim(s) and to take account of psychological as well as physical harm.
- 14 See 'Disclosure in the public interest' (pp. 28–31), below.
- 15 The College recommends education and training in confidentiality at undergraduate, postgraduate and continuing professional development (CPD) levels. The use of case-based discussions in CPD may be especially helpful.

# Information protection, uses and disclosures: general considerations

## Protecting information

- 16 Patients have a right to expect that information about them in their patient record is stored and communicated securely, so that only professionals contributing to their care and treatment have access. This applies to patient records stored in any way (e.g. on paper or electronically) and communicated in any way (e.g. on paper, electronically or verbally).

## Telling patients how their information is used

- 17 Where a psychiatrist has clinical responsibility, this responsibility includes ensuring that relevant information is given to patients in a sensitive and timely fashion. You should respect and help patients to exercise their legal rights both to be informed about how their information will be used and to have access to copies of their health records.
- 18 To safeguard privacy, patients must be given control of the use of their records wherever possible. You should inform patients of the uses of their healthcare information for their direct care (primary uses) and for other healthcare purposes (secondary uses). This includes the primary use of information sharing within a healthcare team; if the patient objects to information sharing within a healthcare team, you should respect their objection unless there are compelling reasons not to do so (see the guiding principles on pp. 5–7).
- 19 Patients should be informed of the choices surrounding primary and secondary uses of their healthcare information and whether they can opt out. Information for patients should be available in a variety of forms, sensitive to cultural and religious diversity, hearing or visual impairment, and/or intellectual ability. If an interpreter is needed, you should bear in mind that a family member is not usually the best placed person to perform this role and should not be asked to do so, unless this is the patient's preference and it is clinically appropriate.

- 20 We recommend that organisations produce a leaflet for patients that provides information about procedures for information storage and communicating, and that gives them the opportunity to opt out of certain ways that information about them may be stored, for example by uplifting electronic information to the summary care record (SCR) (see ‘Electronic patient records’ (pp. 16–17)).

## Capacity, consent and refusal of consent to disclose information

- 21 In general, for confidential information to be disclosed, patients should have capacity to decide whether to consent to disclosure and should give their consent to it.
- 22 Decision-making capacity is assumed, but if there are doubts, then capacity should be assessed using the test set out in the Mental Capacity Act 2005. A person lacks decision-making capacity if all of the following requirements are satisfied:
- a the person has an impairment or disturbance in the functioning of the mind or brain;
  - b that disturbance or impairment causes the person to be unable to make a decision;
  - c the inability to make a decision is characterised by one or more of the following:
    - i an inability to understand information relevant to the decision;
    - ii an inability to retain information relevant to the decision for long enough to use it to make the decision;
    - iii an inability to use or weigh the information to arrive at a decision;
    - iv an inability to communicate their decision.
- 23 The Mental Capacity Act 2005, in particular sections 1–3, and its code of practice (Department for Constitutional Affairs, 2007) provide further guidance on the assessment of capacity. If a patient is reasonably expected to regain capacity, if possible no disclosure should take place, so that the patient can be consulted about the disclosure after they regain capacity.
- 24 Three conditions must be satisfied for consent to be valid:
- a the consent obtained must be informed consent; information provided to the patient that is relevant to the decision includes information about the reasonably foreseeable consequences of (a) deciding one way or another, and (b) failing to make a decision;
  - b the patient from whom consent is sought must be able to freely exercise their decision-making without being subjected to external pressure such as coercion, manipulation or undue influence; and

- c there must be an indication that the patient has given consent; this may be 'express' (explicit) or 'implied' (implicit).
- 25 Express (explicit) consent means consent that is given verbally or in writing, except where patients cannot write or speak, when other forms of communication may suffice. Implied (implicit) consent means consent that is inferred from a person's conduct in the light of facts and matters of which they are aware, or ought reasonably to be aware, including the option of refusing. For example, a patient visiting a general practitioner may be taken to imply consent to the general practitioner providing information about the patient's clinical condition when making a referral to a specialist health professional.

# Security of patient information

- 26 The need and requirement to safeguard the confidentiality of information that patients share with clinicians is, from a clinical practice perspective, as fundamental as the principle of consent. One challenge is balancing the requirement for information about patients in order to optimise the quality of care with patients' expectation that their information will be kept confidential. Such balancing requires the development of and adherence to explicit and transparent principles of good practice on all aspects of patient-identifiable information (Department of Health, 1997).
- 27 Given that psychiatrists have clinical responsibility to maintain confidentiality, you should seek assurances that appropriate policies and protocols are in place and operational in your hospital/unit and among commissioners of services. In the UK, all NHS organisations have Caldicott guardians (known as personal data guardians in Northern Ireland), who are responsible for safeguarding the confidentiality of patient information. As the NHS code of practice on confidentiality (Department of Health, 2003) indicates, confidentiality and security arrangements must be clearly balanced against the need to provide safe care, where missing information could be dangerous.

## The Caldicott principles

- 28 You should follow the Caldicott principles for protecting confidentiality and using, transferring and accessing personal confidential information (Department of Health, 2013: pp. 20–21). These are as follows.
- 1. Justify the purpose(s)**

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.
  - 2. Don't use personal confidential data unless it is absolutely necessary**

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).
  - 3. Use the minimum necessary personal confidential data**

Where use of personal confidential data is considered to be



essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

**4. Access to personal confidential data should be on a strict need-to-know basis**

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

**5. Everyone with access to personal confidential data should be aware of their responsibilities**

Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.

**6. Comply with the law**

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

**7. The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.<sup>7</sup>

- 29 At NHS trust, other organisational and health board level, therefore, there should be a local policy on security and confidentiality, together with guidelines that include local procedures and rules for security and security monitoring (Department of Health, 2003). The Care Standards Act 2000 requires similar provisions in the independent sector. Psychiatrists should be aware of control mechanisms governing access to patient information.
- 30 The Data Protection Act 1998 requires adequate organisational and technological measures to be in place to guard against unauthorised or unlawful processing of personal data. Threats to the security and integrity of patient information can be considered under several categories. One is accidental, owing to either human error or system failure (both software and hardware). A second relates to deliberate breaches of security from within the healthcare system or by external hackers. A third relates to acts of nature such as fire or flooding.
- 31 The principles developed for data protection apply to all data used in healthcare, whether held on paper, computer systems or other media. Although the situation with respect to electronically held information is not, in principle, different from that for paper-based information, new technologies and integration of information systems raise new challenges, including risks of

unauthorised remote access to large databases. Access controls and anonymisation can minimise security threats.

- 32 The two principal means of enhancing the security and integrity of clinical information are restriction of access and anonymisation of records.
- a Access: Good security practice includes strong physical access controls. In general, access to individual records should be granted only to persons with a direct clinical responsibility for a given patient. Every healthcare organisation should have protocols for authorising personalised access to information systems. Electronically maintained identity controls and passwords should be used. Additional or alternative access controls include smart cards and electronic fingerprinting. Monitoring is an important feature of security practice. This can be easier with electronically maintained information, for example auditing who has access and to what information.
  - b Anonymisation: Wherever possible, person-based information should be maintained in a non-identifiable form and, for the large NHS databases, reconciliation of such information with patient identifiers should be restricted to appropriate circumstances and designated individuals. Encryption is a method for anonymising electronically held patient information. It is the process by which patient information or data are converted into a sequence of alternative characters, by applying a set of rules (or key) that both generates the encrypted material and is capable of recreating the original information.

## Electronic patient records

- 33 The use of information technology as the basis for the patient's health record has potential benefits through improved information management and communication. Nevertheless, the development of the electronic record creates 'a new risk scenario, which calls for new, additional safeguards as counterbalance' (Article 29 Data Protection Working Party, 2007: p. 11). If you anticipate sharing information under your control with individuals or agencies outside the organisation for which you work, including any proposed uplift of information to the summary care record (SCR), you should seek patients' explicit consent. You should also advise patients that information may be uplifted unless they register an objection. The simplest way for this to be achieved would be a leaflet produced by the organisation for which you work.
- 34 As patients present to their general practitioner they will have the opportunity to check their SCR and to opt out of information being added to it: the NHS assumption is that consent to uplift of information is presumed unless the patient has chosen to opt out

([www.nhs.uk/scarerecords.nhs.uk/faqs](http://www.nhs.uk/scarerecords.nhs.uk/faqs)). This represents a departure from what some concerned health professionals have advised, which is that every patient's consent to opt in should be sought.

- 35 Healthcare providers may upload some parts of records to a central data warehouse, for example as mandated by the Department of Health for the Mental Health and Learning Disabilities Data Set (MHLDDS).<sup>2</sup> You should make patients aware of such arrangements. Again, the simplest way for this to be achieved would be in a leaflet produced by the organisation for which you work.
- 36 Any non-mandated proposed use of patient-identifiable information for secondary purposes requires the patient's explicit consent.

<sup>2</sup> The Mental Health and Learning Disabilities Data Set (MHLDDS) was formerly called the Mental Health Minimum Dataset (MHMDS). The MHMDS was renamed in September 2014 to reflect an expansion in its scope.

## Transfer of information between psychotherapy services and other services within an NHS trust

*Information on the provenance of this section can be found in Appendix 1.*

- 37 The Executive Committee of the Royal College of Psychiatrists' Faculty of Medical Psychotherapy fully supports the use of electronic patient records for the accurate recording of patients' records and the progress of psychotherapeutic interventions. This information needs to be available to all teams involved in the patient's care within a mental health trust in order to coordinate care, enhance understanding, manage risk, and provide effective care and treatment planning. For this purpose, information about the clinical presentation, interventions offered, risk or safeguarding concerns and other information about case management and future interventions planned should be available on the electronic record system. Correspondence about the case should also be available as part of the electronic record system to effectively inform about management and coordinate care. Thorough progress notes should be made after each clinical contact to record the contact, with details of attendance and all other material that other clinical services need to be aware of.
- 38 **Personally intimate information that emerges during sessions within the boundaries of a therapeutic relationship should not appear in any records that are available to other clinical services.** This applies to material usually addressed in a psychoanalytic psychotherapy and may include, for example, the detail of traumatic experiences, unconscious fantasies and impulses, dreams and repressed conflicts as they emerge during therapy. The confidentiality requirement for the detail of this material is in keeping with ethical and professional guidelines adhered to by most psychotherapy organisations.

- 39 Electronic patient record systems usually have confidential areas to which only psychotherapy staff have access. These vary with different systems and can be locally configured. We refer to them here as 'secure envelopes'.
- 40 Members of the Faculty of Medical Psychotherapy are strongly encouraged to participate in trust negotiations/consultations and to talk to Caldicott guardians about the local configuration of their trust's electronic record systems, particularly when systems are introduced or re-contracted. Experience from a number of trusts shows that it is becoming possible for record systems to be agreed with secure envelopes or restricted access for the confidential components of therapy notes.
- 41 In systems lacking such confidentiality measures, the Faculty recognises that its members are, at times, faced with a conflict between the requirements of their trusts to use electronic patient records as the sole medical record (e.g. in paper-free systems) and their need to work within the ethical guidelines of their professional bodies to protect the confidentiality of aspects of their work. In such cases, the electronic record systems do not provide the level of confidentiality required by the ethical guidelines produced by psychotherapists' registration bodies. This conflict can put therapists practising in the NHS in the position of either working outside the operational and legal requirements of their NHS trusts or breaking their ethical practice guidelines. Under these circumstances, therapists should keep separate paper records within the psychotherapy service containing detail of the therapeutic work until a suitable alternative can be found. We recommend transparency about the existence of these case records. Staff in psychotherapy services must still use their trusts' electronic record systems as required, and it is incumbent on the clinician to ensure that all information that it is appropriate and necessary to make available on the electronic system is entered.
- 42 The Executive Committee agrees that professionals who are developing their psychotherapeutic skills through supervision learn from discussion of details of their cases with their supervisors. This material can be brought as process notes and video or audio recordings of interactions between therapist and patient. Such information should always be anonymised and should be destroyed once it has served its purpose (British Psychoanalytic Council, 2005; see also 'Media, audio and video recording' on pp. 63–64 below). Such material is for learning and training purposes and does not form part of the medical record.
- 43 The electronic patient record remains the main means of recording and sharing information about the patient and their care and should be fully utilised by therapeutic services as the main medical record.
- 44 This section relates to NHS psychotherapy services: services offering other forms of psychological treatment (e.g.

cognitive-behavioural therapy and family therapy) may adhere to different principles.

- 45 Psychotherapists working outside the NHS will encounter similar situations and this guidance is also likely to be useful to their practice.

## Open-plan working

- 46 There is a trend in some healthcare organisations towards 'open-plan working' for reasons that may include integrated team working, modernisation, efficient use of estate, mobile working, hot-desking and multi-site working. Ideally, protecting confidentiality should be considered at the planning stage. You must ensure that confidential patient information is not disclosed, either verbally or visually, to anyone sharing an open-plan office. 'Verbally' includes conversations between staff in the office and telephone conversations. 'Visually' includes paperwork and information on a computer screen that can be seen from inside or outside the room.

# Confidentiality and disclosure in relation to direct patient care

## Disclosure for the benefit of a patient's care (primary uses of healthcare information)

- 47 Patients should be informed of the use and sharing of their information with your multidisciplinary clinical team, and of the choice they have in sharing and protecting their information. Provided that patients have been informed of this choice and have not objected, explicit consent is not required for information sharing needed to provide healthcare, and consent is implied. Similarly, if a patient is informed that a referral or other contact is to be made, for the purpose of their care, to a healthcare professional outside the healthcare team, consent to share their information is implied unless they object. If a patient lacks capacity to consent to their healthcare record being shared in this way, the healthcare team can share the information needed to provide the patient with care and treatment in their best interests.
- 48 The Mental Health Crisis Care Concordat is a national agreement in England between services and agencies involved in the care and support of people in crisis ([www.crisiscareconcordat.org.uk](http://www.crisiscareconcordat.org.uk)). In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector signed it. The concordat sets out how organisations should work together to help people in crisis and makes implicit reference to information sharing for direct patient care. It does not replace any part of the guidance in this report, but emphasises the benefits of disclosure of information for patients' care and safety.
- 49 On 7 November 2014, the Department of Health sent a letter to NHS trust and local authority chief executives setting out new guidance on sharing information for people's direct care and treatment (Poulter & Lamb, 2014). The letter noted that, although it is essential to protect the personal information of everyone in the health and care system, whether patients, people who receive care and support, staff or carers, this should not get in the way of sharing information where it is necessary for a person's direct

care and treatment. It continued, 'People should be involved in decisions about how their information is used, and all too often are disappointed that they have to repeat information that they thought would be shared with each person involved in their care'.

- 50 Psychiatrists should ensure that, within their organisation, there is a policy on confidentiality and the threshold for disclosure in different circumstances. You must be aware of the variable boundaries around the healthcare team, which for particular purposes (e.g. to discuss particular patients) may fluctuate to encompass temporary members, people from other agencies (e.g. education, housing and social services and third-sector organisations), students, managers or commissioners.
- 51 In in-patient settings, the psychiatrist usually represents ultimate clinical authority within the hospital service for patients in their care. Given their clinical responsibility, the psychiatrist has the final decision-making responsibility within the healthcare team regarding the withholding and disclosure of confidential information.
- 52 In community healthcare teams, the psychiatrist's responsibility for confidentiality will depend on their role in the team as well as on their professional relationship with the patient. Different disciplines within teams have their own codes of practice. There is therefore the potential for different thresholds for disclosure of information. Consequently, each member of the team must be aware of the practices of the others, of their shared duty to protect patient confidentiality and of the consequences of their decisions.

## Disclosure to other doctors involved in the patient's care

- 53 To provide appropriate care, psychiatrists pass on information about a patient to the patient's general practitioner and other doctors directly involved in the patient's care. If a patient wishes specific items of information to be withheld from their general practitioner or other doctors, you should respect their request. In this case, you should discuss with the patient what information they wish to be disclosed and what they wish to be withheld. However, if a patient is objecting to the disclosure of personal information that you are convinced is essential to provide safe care, you should explain that you cannot refer them or otherwise arrange for their treatment without also disclosing that information.

## Copying letters to patients

- 54 Provided that the patient wishes it, letters from one psychiatrist to another, or to another health professional, should be copied

to the patient to improve the patient's understanding of their mental health and the care they are receiving. A letter should not be copied if it contains information about a third party who has not given consent.

- 55 You should not copy letters if you feel that it may cause harm to the patient (e.g. where an abnormal test result has not yet been discussed with the patient) or another party, or if there are other compelling reasons not to do so (see the guiding principles on pp. 5–7). Patient care can often be improved by involving their family and carers in management decisions; where the patient gives explicit consent, copies of letters may also be sent to family and carers.
- 56 Appointment letters sent out to patients should be clearly marked 'Confidential' and 'To be opened by the addressee only'. Letters sent to patients should not be franked with any stamp identifying their origin. It may be helpful to include with the letter information about confidentiality arrangements and information sharing in relation to healthcare information, including patient records and letters written as a result of the appointment.
- 57 You should consult your employing organisation, or your email service provider, about the security of email and the security of email transmissions made to other professionals and organisations. Access to email should be password protected. nhs.net is recognised as being a secure email provider. Employing organisations should provide a list of secure email address suffixes to and from which emails can be sent and received securely. Do not transmit confidential information using an insecure email address at either end, including 'copied in' destinations. Email attachments should be encrypted and password protected.

## Sharing information with, and listening to, family or carers

- 58 Families and carers closely involved in the care of a patient have an understandable desire, and often a need, to know about the patient's diagnosis, treatment and care. Such knowledge may benefit the patient and the family and/or carers, for example promoting from the family/carers helpful responses to the patient's behaviour in general and helping them to understand the treatment plan and recognise a change in the patient's mental state, about which they can then notify the healthcare team.
- 59 The National Confidential Inquiry into Suicide and Homicide has emphasised that talking to family members and carers when preparing clinical and risk assessments can prevent patient suicide and homicide (Appleby *et al*, 2015). There is nothing to prevent you, or any other healthcare professional, from receiving information provided by any third party about the patient, as receiving information does not equate to disclosure.



Indeed, provided the circumstances do not involve disclosure of confidential information, a healthcare professional may actively request information without the patient's consent. This can be an important part of the risk assessment of a patient.

- 60 The GMC guidance on confidentiality provides further advice on listening to those close to the patient:

'In most cases, discussions with those close to the patient will take place with the patient's knowledge and consent. But if someone close to the patient wants to discuss their concerns about the patient's health without involving the patient, you should not refuse to listen to their views or concerns on the grounds of confidentiality. The information they give you might be helpful in your care of the patient.

You should, however, consider whether your patient would consider you listening to the views or concerns of others to be a breach of trust, particularly if they have asked you not to listen to specific people. You should also make clear that, while it is not a breach of confidentiality to listen to their concerns, you might need to tell the patient about information you have received from others – for example, if it has influenced your assessment and treatment of the patient. You should also take care not to disclose personal information unintentionally – for example, by confirming or denying the person's perceptions about the patient's health' (General Medical Council, 2017a: p. 25, paras 39 and 40).

- 61 A consensus statement by a number of professional bodies, including the Royal College of Psychiatrists, on information sharing and suicide prevention for adults in England states in its introduction:

'Information can be shared about a child or young person where it is in the public interest to do so. In practice, this means that practitioners should disclose information to an appropriate person or authority if this is necessary to protect the child or young person from risk of death or serious harm. A decision can be made to share such information with the family and friends, and normally would be' (Department of Health, 2014a: p. 4).

- 62 The consensus statement is as follows:

'We strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. We recognise however that some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk.

We want to emphasise to practitioners that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk, **they should use their professional judgement to determine what is in the person's best interest.**

It is important that the practitioner records their decision about sharing information on each occasion they do so and also the justification for this decision.

Even where a person wishes particular information not to be shared, this does not prevent practitioners from listening to the views of family members, or prevent them from providing general information such as how to access services in a crisis' (Department of Health, 2014a: p. 7).

- 63 You should discuss confidentiality and information sharing with the patient at an early stage. You must respect their wishes and clearly record them in their notes. You should ensure that the patient understands the benefits of sharing healthcare information with their family and/or carers, while at the same time supporting them in decisions not to share certain information, for example of a more personal nature. The fact that disclosure may be beneficial does not diminish the patient's right to confidentiality.
- 64 If the patient has the capacity to refuse disclosure to the family/carers and does refuse, you should respect this wish unless there are overriding reasons of public interest not to do so.
- 65 The Mental Capacity Act 2005 and its code of practice (Department for Constitutional Affairs, 2007) give the following guidance when considering best interests decisions for a patient who lacks capacity to make a decision:
  - a if the patient lacks capacity to consent to their healthcare information being shared with family or carers, it may be shared with family/carers if this is in the patient's best interests;
  - b best interests must be considered with reference to section 4 of the Mental Capacity Act 2005, which provides that all relevant circumstances must be considered and consultation undertaken where practicable and appropriate with family members, carers and others with an interest in the person's welfare;
  - c in determining what is in a person's best interests, the decision maker must approach the matter from the person's perspective, and have regard to any views the person expressed and any statements they made before their loss of capacity.
- 66 Individuals who lack capacity to make welfare decisions may have registered a lasting power of attorney (LPA), or may have a court-appointed deputy for welfare decisions. In either case, you must consult their attorney or deputy in respect of any best interests decision that is made.
- 67 Non-personal information that builds on the existing knowledge of the family/carers can be shared without consent. The leaflet *Carers and Confidentiality in Mental Health* (Royal College of Psychiatrists, 2004) may be helpful.

## Inter-agency working

- 68 The holding of multidisciplinary care programme approach (CPA) or care and treatment plan (CTP) review meetings to plan

and coordinate patient care is standard in England and Wales. Such meetings may be held under the auspices of the treating psychiatrist (the responsible clinician in the case of patients detained under the Mental Health Act 1983 for England and Wales), and may involve the participation of outside agencies, in particular social services. Those attending such meetings should do so on the understanding that psychiatrists have a duty of confidentiality which must be respected for sharing of information to take place.

- 69 Explicit consent is usually necessary before patient information can be shared outside the immediate healthcare team. However, professionals' meetings may be convened for children, young people and adults, without explicit consent, to facilitate fact-finding to decide whether a safeguarding issue exists.
- 70 Any disagreements between different agencies regarding the protocol for the release of information should be made explicit before the meeting, so that the psychiatrist may restrict attendance and the release of information at the meeting. Local agreements with participating agencies to this effect are to be encouraged.
- 71 You should seek the patient's consent, in broad terms, about the content of information to be disclosed and the mode of disclosure. Record the details of this discussion in the patient record. The extent of the disclosure should be limited and proportionate; this may be achieved, for example, by inviting an external agency only to the part of a CPA review meeting relevant to its involvement and providing only extracts from the minutes of the meeting that contain information relevant to its role. You should obtain reassurance from the external agency that the information will be stored securely and not shared with any other agency or for any purpose within the agency other than that for which the information is disclosed.
- 72 If a patient refuses disclosure, you should respect their refusal unless there are compelling reasons not to do so (see the guiding principles on pp. 5–7).
- 73 You may also wish to disclose information to a third party for reasons not directly related to delivering healthcare either within or outside the CPA review process, for example to a housing association to which the patient has been referred for accommodation. You should always attempt to obtain the patient's informed consent, emphasising the reason for the proposed disclosure and how it may be of benefit to them. If a patient refuses disclosure, or if they lack capacity to consent to their health records being shared, then the absence of consent should be respected and no disclosure made unless there are compelling reasons not to do so (see the guiding principles on pp. 5–7). An external agency may draw adverse inference from non-disclosure, especially if they have requested information; you should warn the patient of this possible consequence.

- 74 Local protocols for sharing information between agencies may be available in your area, but they do not remove your obligation to consider individual cases on their merits.

## Patients who are receiving treatment elsewhere

- 75 If clinicians from another healthcare provider request the record of a patient they are currently treating or who has been referred, explicit patient consent is not required for its disclosure, provided that the patient has been informed of the process at all stages and has not objected to disclosure. This represents implicit consent. All requests from another healthcare provider for a patient record should be considered by the patient's usual psychiatrist, in accordance with their organisation's policy of making information available.
- 76 Psychiatrists assessing a patient in another hospital or service for the purpose of direct care should be allowed access to the patient record, unless the patient objects. This includes assessments in prisons if the purpose is that of patient care (rather than preparing a medico-legal report).
- 77 This advice applies to the provision of healthcare in criminal justice settings, including police stations (e.g. forensic medical examiners and mental health liaison/diversion services), courts (e.g. mental health liaison/diversion services), prisons (e.g. primary and secondary mental health services). Information obtained from the provision of healthcare in criminal justice settings must not be disclosed to the criminal justice system, except where there is a dual obligation or if there are compelling reasons to do so (see the guiding principles on pp. 5–7 and 'Situations with dual obligations' on pp. 27–28).

## The Mental Health Act 1983 (England and Wales)

- 78 Detention under the Mental Health Act 1983 (as amended in 2007) brings with it statutory responsibilities to share information with members of other agencies, for example an approved mental health professional (AMHP), the nearest relative (NR), a hospital managers' hearing, a mental health tribunal and the Ministry of Justice Mental Health Casework Section.
- 79 You need to be aware that you cannot automatically rely on a patient's refusal of consent to share information with the nearest relative in the context of decisions about compulsory detention under the Mental Health Act 1983. It had previously been considered that, where a patient who was the subject of an application to be detained under the Act objected to their

nearest relative being consulted, such consultation was not reasonably practicable within the meaning of the Act, and the patient's rights under Article 8 of the Human Rights Act 1998 would prevail. However, in a case decided in 2014 (*TW v Enfield London Borough Council* [2014]), the Court of Appeal held that an approved mental health professional (AMHP) who was considering whether consultation with the nearest relative was reasonably practicable needed to balance both the patient's Article 8 rights to protect their private information against the Article 5 safeguards that the nearest relative provided. In each case, a decision would need to be made as to whether it was justified and proportionate to consult the nearest relative despite the patient's objection.

- 80 Chapter 10 of the current code of practice for the Mental Health Act 1983 (Department of Health, 2015) addresses confidentiality and information sharing within the context of the Act.

## Commissioning a patient's care

- 81 You should be mindful of the separation that exists between the commissioning and provision of healthcare. Your employing organisation should have a protocol on information sharing for commissioning purposes, and patients should be made aware of how information is shared.
- 82 If you propose to refer a patient for treatment to a service where specialist commissioning is needed, commissioners will request information in order to arrange funding and monitor the service provided. You must keep the patient informed and attempt to obtain their consent to providing commissioners with the information necessary to support the referral, unless to do so would be likely to risk serious harm. If a patient who has capacity refuses consent to share information with commissioners, you cannot disclose the information unless the referral is for their compulsory treatment because of the nature or degree of their mental disorder and the associated risk to themselves or other people. If the patient lacks capacity to consent for you to share information with commissioners, you may make a decision based on their best interests and other relevant factors, considering the guiding principles on pp. 5–7.

## Situations with dual obligations

- 83 Psychiatrists may work in situations where they have obligations to both their patient and a third party, which may at times come into conflict, for example psychiatrists making recommendations for care and treatment in a legal context. In such cases, it is important at the start of any consultation or assessment to explain to the patient on whose behalf you are seeing them and the purpose of the consultation or assessment. You should

also explain that you cannot guarantee confidentiality of the information that they provide, setting out exactly what you mean by this, in accordance with the guiding principles on pp. 5–7.

- 84 In such circumstances, you may have access to the patient's record, or you may possess information about the patient through previous professional contact with them. It is important that you ask the patient for consent to include such information in your report. If consent is refused, you should include the information only if there are compelling reasons to do so (see the guiding principles on pp. 5–7).
- 85 There are other situations where obligations to third parties may become apparent. Public safety may be a particular issue for forensic psychiatrists. Those working in child and adolescent mental health services need to consider obligations to siblings and to families as a whole. We encourage you to refer to the general guiding principles on pp. 5–7 and to attempt to obtain consent to disclosure, if possible, unless by doing so you would risk serious harm to yourself or others, hamper the prevention or detection of a serious crime or would not fulfil a statutory obligation.

## Online forums

- 86 Online forums should not be used to discuss a patient's care or treatment, and patient-identifiable information should not be posted. Online forums are discussed in more detail in the section 'Internet and social media' (pp. 38–39).

## Disclosure in the public interest

- 87 The starting point is that confidential information should not be disclosed in the face of a refusal or without consent, and that you should always seek the patient's consent. However, there may be circumstances where disclosure is justified in the public interest. The public interest has been defined by the GMC as the interests of the community as a whole or of any group or individual members of the community (General Medical Council, 2017a: para. 22). If you decide to disclose without consent or in the face of a refusal, you must inform the patient unless to do so would increase the risk of harm or inhibit effective investigation of risk.
- 88 In balancing the patient's right to confidentiality with the public interest, you should consider: the extent of disclosure; the nature of the intended recipient; and the risks and benefits to the patient and the public of disclosure and non-disclosure. Disclosure in the public interest can include various considerations, such as:
  - a the importance of information sharing between professionals;
  - b the protection of patients from harm;
  - c the protection of others from harm;
  - d trust in the medical profession.

- 89 Even if an individual piece of information may not satisfy the test for suggesting that there is a risk of serious harm, it may still be appropriate to make the disclosure if the information to be disclosed might lead to that conclusion when combined with other information.**
- 90 Each case that addresses the public interest must be considered on its merits; the test is whether the release of information to protect the public, including protecting individual members of the public, prevails over the duty of confidentiality to the patient, taking into consideration both necessity and proportionality.
- 91 GMC guidance on confidentiality is compatible with *Confidentiality: NHS Code of Practice* (Department of Health, 2003) and *Confidentiality: NHS Code of Practice. Supplementary Guidance: Public Interest Disclosures* (Department of Health, 2010). These documents assist NHS staff in making difficult decisions about when disclosure of confidential information may be justified in the public interest for the prevention, detection or prosecution of a serious crime, or in situations where disclosure is necessary to the defence of a case to ensure that there is no miscarriage of justice. The flowchart for making public interest judgements from the supplementary guidance is reproduced in Appendix 2.
- 92 The definition of serious crime is not entirely clear. Murder, manslaughter, rape, treason, kidnapping, child abuse or other situations where individuals have suffered serious harm all warrant breaching confidentiality if information is not disclosed by an alternative source. Serious harm to the security of the state or to public order and crimes that involve substantial financial gain or loss will also generally fall into this category. In contrast, theft, fraud or damage to property where the loss or damage is less substantial are unlikely to warrant breaching confidentiality.
- 93 Although the professional with clinical responsibility must make the decision, the correctness of such a decision is ultimately a matter for legal examination. There are legal precedents: for example, *W v Egdell* [1990] found that a psychiatrist may disclose information in the public interest without consent 'in certain circumstances such as, for example, investigation by the police of a grave or very serious crime' and, when there is a 'real risk of [...] danger to the public [the psychiatrist may] take such steps as are reasonable in all the circumstances to communicate the grounds of his [or her] concern to the responsible authorities'. *Palmer v Tees Health Authority* [1999] found that healthcare professionals have a duty of care to third parties (i.e. potential victims) if they are identifiable or identified. It would be sensible to obtain advice from colleagues and professional organisations as part of a decision-making process, provided that this does not result in undue delay. It is essential to keep a detailed written account of the decision-making process, using all of the information available.
- 94 Disclosure in high-risk situations has been discussed at the beginning of this guidance (pp. 9–10). The risk of child abuse or



neglect, assault, a traffic accident or the spread of an infectious disease are perhaps the most common situations that a psychiatrist may face.

- 95 Professional judgement whether or not to disclose information in the public interest without consent may be finely balanced. Such balancing needs to take into account the various legal responsibilities at stake, including your duty of confidentiality to the patient and the wider public interest in the health service maintaining confidentiality. You need to consider whether the harm that could result from disclosure (e.g. the possible harm to the relationship of trust or the likelihood of non-concordance with a programme of healthcare in the future) is likely to be outweighed by the possible benefits. The potential benefits of disclosure need to be soundly grounded on the expectation that disclosure would have the desired effect (e.g. a significant reduction in the risk of harm).
- 96 Whether a breach of confidentiality is justifiable in the public interest will depend in some measure on the extent of the disclosure. When considering whether to disclose, you should also consider how much information to disclose and to whom.
- 97 Factors that you should take into consideration when reaching a decision on whether to disclose, and to whom, include:
  - a whether the risk is real, immediate and serious;
  - b the risks of non-disclosure;
  - c the probability of consequences and their seriousness: in general, disclosure should only be considered if there is a significant risk of death or serious harm, including abuse; the assessment of the risk should include history, current situation and current mental state;
  - d the benefits of disclosure – the likelihood that disclosure will substantially reduce the risk;
  - e the existence of an identifiable potential victim;
  - f the sensitivity of the information in question;
  - g the amount of information that will be provided, which should be no greater than is necessary to reduce the risk;
  - h the harm of disclosure – the consequent damage to the public interest protected by the duty of confidentiality should be outweighed by the public interest in minimising the risk;
  - i the context and role in which you are working.
- 98 It is important to be able to show documentary evidence of the balancing exercise undertaken, so that if questioned you can justify your reasoning for disclosure and/or non-disclosure.
- 99 You must decide that the disclosure is in the public interest. Most situations in which decisions to disclose are reached require good communication with and support for patients about whom a disclosure is made, especially if they have refused consent.



- 100 If, in the public interest or because of statutory or other legal obligation, you decide to disclose confidential information about a patient who lacks capacity to consent to disclosure, or who has capacity and has refused consent, or for whom it has proved impossible to seek consent, you must disclose information only to the relevant authority (and individual, where there is an immediate risk of serious harm), the disclosure must be necessary (that is, not available from an alternative source), limited (to the purpose of the disclosure) and proportionate (so that only relevant information is disclosed). A disclosure made to prevent harm from occurring must be made with sufficient urgency and to the correct authority (and, where applicable, individual) for its purpose to be successful. If the information is available from another source, it may remove the need for the disclosure or limit the amount of information that needs be disclosed.
- 101 You should inform the patient that a disclosure will be made in the public interest even if you have not obtained their consent, unless to do so is impracticable, would put you or others at risk of serious harm or would prejudice the purpose of the disclosure (General Medical Council, 2017a).

## Police requests for information

- 102 There is sometimes a tension between the police's desire for information for public protection purposes and the medical duty of confidentiality. Requests for information from the police should be treated in a similar manner to those from other outside agencies. The fact that a request comes from the police does not in itself have any bearing on a decision whether or not to disclose. Police statutory powers to require disclosure are very limited. Disclosure must otherwise be justified in accordance with the guiding principles on pp. 5–7. You must be able to justify any decision to withhold or disclose information.

## Multi-agency public protection arrangements (MAPPA)

- 103 The duty placed on health services by the Criminal Justice Act 2003 to cooperate in the establishment of MAPPA does not extend to any statutory duty to disclose information to other agencies involved in these arrangements. The same medical duties of confidentiality apply with regard to MAPPA as apply in normal clinical practice, and the guiding principles on pp. 5–7 apply.
- 104 The policies of healthcare organisations should cover the role of psychiatrists and other members of the multidisciplinary clinical team in the MAPPA process, representation at MAPPA meetings,

withholding and disclosing information in accordance with good practice guidelines, conducting assessments at the request of a MAPPA meeting, and representation on a MAPPA strategic management board.

- 105 For further information and advice, see *Working with MAPPA: Guidance for Psychiatrists in England and Wales* (Taylor & Yakeley, 2013).

## Child and adult protection

- 106 Safeguarding adults boards (SABs) have a statutory power to obtain information relevant to the carrying out of their functions under section 45 of the Care Act 2014. SABs investigate cases where abuse or neglect may have occurred in respect of an adult (whether alive or deceased) with care and support needs.
- 107 Psychiatrists are sometimes invited by another agency to attend a case conference and/or submit a report about a patient. In such situations, you are strongly advised to read locally applicable guidance, even though the principles are broadly the same across the jurisdictions of the UK. Further guidance is available in chapter 14 of *Care and Support Statutory Guidance* (Department of Health, 2014b).
- 108 Psychiatrists responsible for the care of the parent of a child may be invited to a child protection case conference chaired by a representative from a social services department. You might be asked to give an opinion about the degree of risk your patient poses to the child. Before the meeting, you should ask the reason for your involvement and seek the explicit consent of the parent to disclose information, unless doing so might risk serious harm to the child or another third party. In all cases, it is important to clarify your role at the meeting and to ascertain the roles and responsibilities of the other participants. Again, the principle of consent applies, unless there are overriding considerations to the contrary, in which case the minimum necessary information should be provided. In child protection meetings, the best interests of the child are paramount. Although disclosure may often be the correct action, there may be occasions when non-disclosure is appropriate. You should document your decision-making process.
- 109 You should consider that information disclosed may not remain within the case conference and you may have no control over its distribution. You should be satisfied that the distribution and uses of the information are in line with locally agreed protocols. You should check the accuracy of your contribution as recorded in the minutes and correct it if necessary, ensuring that this is done within the time scale set by the chair of the meeting. If another professional makes a decision to disclose information with which you disagree, it should be made clear that this decision is the responsibility of the other professional.

## NHS Counter Fraud and Security Management Service

- 110 In England and Wales, the NHS Counter Fraud and Security Management Service (CFSMS) has powers in relation to the investigation of fraud and other unlawful activity, including assaults by patients.
- 111 Two legal provisions are relevant to requests by the CFSMS to psychiatrists for confidential information. First, there is a power under the National Health Service Act 2006 to request copies of existing documents – which could include medical records. Second, under directions of the Secretary of State for Health to the NHS, the CFSMS can also request the cooperation of NHS staff.
- 112 Directions can require healthcare providers or health boards to cooperate with reasonable requests, but it is unlikely that they would require an individual to prepare a report where this was felt to be inappropriate and not in the public interest.

## Fitness to drive

- 113 The Driver and Vehicle Licensing Agency (DVLA) (England, Scotland and Wales) and Driver and Vehicle Agency (DVA) (Northern Ireland) are legally responsible for deciding whether a person is medically unfit to drive. They need to know if a driving licence holder has a condition or is undergoing treatment that may affect their safety as a driver. The DVLA guidance *Assessing Fitness to Drive: A Guide for Medical Professionals* (2017) states that doctors and other healthcare professionals should:
- advise the individual on the impact of their medical condition for safe driving ability
  - advise the individual on their legal requirement to notify the DVLA of any relevant condition
  - treat, manage and monitor the individual's condition with ongoing consideration of their fitness to drive
  - notify the DVLA when fitness to drive requires notification but an individual cannot or will not notify the DVLA themselves.'
- 114 Chapter 4 and Appendix E of the DVLA guidance provide further information on fitness to drive and psychiatric conditions.

## Where the patient is a healthcare professional

- 115 The public interest applies if your patient is a healthcare professional and you have concerns over their fitness to practise;

the disclosure should be made to their organisation's responsible officer and the GMC.

## Firearms licence holders

116 The public interest justification also applies if you have concerns over a patient's fitness to hold a firearms licence; the disclosure should be made to the local police.

## Gunshot and knife wounds

117 The responsibility for reporting these wounds normally rests with the staff at the general hospital to which the patient is admitted and is covered in *Confidentiality: Reporting Gunshot and Knife Wounds* (General Medical Council, 2017b).

## Serious communicable diseases

118 Similarly, the responsibility for reporting these diseases normally rests with general hospital staff and is discussed in *Confidentiality: Disclosing Information about Serious Communicable Diseases* (General Medical Council, 2017c).

## Statutory and other legal obligations to waive the duty of confidentiality

119 Where there is a statutory or other legal obligation to disclose information, you must disclose it to the relevant authorities: failure to do so may lead to legal action. In addition, there are laws that afford various bodies the power to obtain disclosure of confidential information and that oblige psychiatrists to legally override any duty of confidentiality. If in doubt, seek advice if you believe there to be, or are informed that there is, a statutory obligation to disclose information.

## Procedure for the disclosure of information

120 We suggest that you use the following procedure – or similar – in considering disclosure, diverting from it as appropriate.

- a If you decide in principle to disclose confidential information, you must decide, in consultation with the healthcare team:
  - i what information to disclose (being the minimum necessary to fulfil the purpose of the disclosure);

- ii to which organisation and to whom in that organisation to make the disclosure in order that the purpose of the disclosure is fulfilled;
  - iii whether the information is available from another source, so removing the need for the disclosure or limiting the amount of information to be disclosed;
  - iv in what way the information should be disclosed, to enable a timely necessary response to the disclosure.
- b You should normally discuss the proposal to disclose information with the patient and, where appropriate (and where there is no statutory or other legal obligation to disclose), you must attempt to obtain the patient's consent in principle to the disclosure. You must always seek the patient's consent to the disclosure, unless doing so would increase the risk of harm or inhibit its effective investigation; you must document this in the clinical record.
- c For consent to be effective, it must be informed consent and the patient giving consent must have real choice. If the patient refuses consent, you must decide whether to override the duty of confidentiality (with reference to this guidance, particularly the guiding principles on pp. 5–7), documenting your decision and reasoning in the clinical record.
- d If the patient lacks capacity to consent to the disclosure, you may disclose relevant personal information if it is of overall benefit to the patient. Further guidance is given in the chapter 'Safeguarding and confidentiality for vulnerable patients and those who lack capacity' (pp. 53–55).
- e Regardless of whether consent has been given, you must tell the patient what information you intend to disclose, unless doing so would increase the risk of harm or inhibit its effective investigation. Section 29 of the Data Protection Act 1998 exempts data holders from notifying data subjects of such a disclosure under 'fair processing' if this would be likely to prejudice the prevention or detection of a crime.
- f The information will be disclosed to the designated individual and organisation on the understanding that its use will be restricted and that any proposal to share it with another party will be communicated to the clinical team and, unless there are exceptional circumstances, to the patient, so that any objections can be raised.
- g You must make a detailed entry in the clinical record of the process described above, the information that you have disclosed or withheld and your reasons for this.

# Healthcare purposes outside direct patient care (secondary uses)

- 121 'Secondary uses' of patient information are uses in healthcare that do not contribute directly to or support the healthcare that the patient receives. In common with all other areas of healthcare, patient information is increasingly required to inform a rational approach to service management and commissioning of services. Information is also required for long-term planning, both local and national.
- 122 You cannot assume that patients seeking healthcare are either aware of, or content with, the use of their information in these ways. Under the Data Protection Act 1998, patients must be informed about such secondary uses and have a right to object to the use or sharing of confidential information that identifies them. We recommend that organisations produce a leaflet for patients that provides information about secondary uses of their information and gives them the opportunity to opt out of secondary uses.
- 123 If it is planned to use patient-identifiable information, you must ensure that the patient is informed of the secondary use of their information and is aware of their right to object. If the patient objects to specific secondary uses, their refusal should be respected.
- 124 Given that psychiatrists have a clinical responsibility to maintain confidentiality, you should assure yourself that appropriate policies and protocols are in place and operational in services and among commissioners of services for secondary uses of patient-identifiable information.
- 125 Wherever possible, patient information for secondary uses should be anonymised. Anonymisation is not as simple as changing names or removing other identifiable details. Explicit consent may need to be obtained if there is the potential for the patient to be identified with some effort by third parties.
- 126 Further information about commissioning and confidentiality can be found in *Information: To Share or Not To Share? The Information Governance Review* (Department of Health, 2013).

## Clinical audit

- 127** Patients in general (and the wider public) have a clear interest in the NHS and other healthcare providers being subject to effective clinical audit. From an ethical perspective, a wide range of activities may be covered under the heading of audit. All doctors in clinical practice have obligations to participate in clinical audit. Clinical audit supports direct clinical care.
- 128** The Royal College of Psychiatrists endorses the advice of the Patient Information Advisory Group (now known as the Ethics and Confidentiality Committee) of the National Information Governance Board for Health and Social Care. Their advice is that implied consent is sufficient where patient-identifiable information is processed across organisational boundaries for clinical audit purposes, provided all of the following criteria are met:
- a** the data relate to a single episode of care, or the treatment of a particular disease or condition;
  - b** the data are being processed by staff employed by the NHS organisations that have provided that care or treatment;
  - c** the exercise has been approved by the medical director of the trust or health board involved and the use of patient information has been approved by the Caldicott guardian (Patient Information Advisory Group, 2004).
- 129** For all other forms of audit where it is proposed to use patient-identifiable information, patients' explicit consent must be sought and information should be anonymised or coded. When information is disclosed, it should be ensured that recipients are bound by a duty of confidentiality not to disclose it further.

## Research

- 130** People who participate in research have the same right to confidentiality as patients. Anonymity may be a key methodological feature of the research. Researchers who work with patient-identifiable information must, except in unique circumstances set out by a research ethics committee:
- a** obtain explicit consent from the participant to the use of information obtained during research;
  - b** provide information to the participant as to how research information will be stored so as to protect confidentiality.
- 131** It is good practice to provide research participants with feedback about the completed research in which they have participated.
- 132** As part of preserving confidentiality and anonymity of research data, researchers should ensure that they can abide by the appropriate national research governance guidelines and obligations under the Data Protection Act 1998.

- 133 There is provision for the use of anonymous and unidentifiable patient information without consent for the purposes of audit, service evaluation and some forms of epidemiological research. The onus is on the researcher or evaluator to check that their project falls within these remits. Advice should be sought from the organisation's research governance officer.

## Use of case histories

- 134 If case histories are being used for teaching or publication, then explicit consent must be obtained from the patient, as it is likely that identifiable material will be a part of any novel case history, although every step must be taken to anonymise the patient's information. If the patient lacks capacity to consent, it is good practice to consult relatives, although the patient's best interests are the primary concern.

## Education

- 135 GMC guidance states that, for most educational uses, anonymised information will be sufficient and should be used whenever practicable. This includes working notes, CPD notes and supervision notes. Anonymised information can be held on educational files. Any proposed use or creation of patient-identifiable information for such purposes should be with the patient's explicit consent and, if retained, should be held with the patient's clinical record (General Medical Council, 2017d).

## Internet and social media

- 136 It is difficult to completely separate the use of the internet for social purposes and for academic and teaching purposes. Psychiatrists who are involved in online forums should be very careful about the use of any patient-related material in discussion, because it is not safe to assume that only professionals will access these sites. Further, even in the case of professional forums, explicit consent may still be required from patients before their histories can be used for education and research purposes. Whatever the situation, all identifiable details must be removed; and it is good practice to get explicit consent. Given the insecurity of many internet websites, we would urge caution in the use of clinical case material and suggest that it is not used.
- 137 Use of a professional email address or NHS credentials as a user name is discouraged as it may jeopardise privacy and might be misinterpreted by others as a representation of a psychiatric service, hospital, organisation or profession.



- 138 As a matter of good practice, you should be mindful of the content of your online discussions and interactions, because if they are deemed inappropriate or in breach of a patient's confidentiality, this is likely to undermine the public trust in the psychiatric profession, your organisation (if identifiable) and your own professionalism.
- 139 You should bring any violations of privacy and confidentiality to attention of the forum moderator, asking them to delete the content immediately, thus preventing its further dissemination.
- 140 Further guidance can be found in *Doctors' Use of Social Media* (General Medical Council, 2013a).

# Requests for information and reports for non-healthcare purposes

## Reports on individuals evaluated in relation to legal proceedings

- 141 Psychiatrists are sometimes asked to produce assessment reports on individuals unknown to them, to be used in legal proceedings. Requests for such reports may relate to civil or criminal proceedings in the courts. The request may come directly from a civil court (county or High), from a criminal court (magistrates' or Crown) or from a coroner's court. Alternatively, such requests may come from social services or a 'children's guardian' (formerly a guardian *ad litem*) (in relation to civil proceedings), or from a prison, the probation service or the Crown Prosecution Service (in relation to criminal proceedings). Requests may be relayed by the legal representatives of the above agencies. Lawyers representing a claimant or defendant may also request a report on their client's behalf for use in court proceedings.
- 142 It is important to tell the individual in what capacity you are acting, who requested the report and the exact purpose of the request. You must explain that, once the report is sent to the solicitor or the court, it may be more widely distributed and therefore it will not be confidential. You must then obtain and record the individual's consent both to interview and to the preparation of the report. In doing so, you must consider their capacity to give consent.
- 143 If the individual refuses consent to be interviewed or wishes to consult a legal advisor first, you will be unable to proceed unless there are particular circumstances that justify disclosure of information without consent. In cases where you judge that certain disclosures need to be made to the court in the best interests of an individual lacking capacity, or in the wider public interest, you should provide only the minimum amount of information necessary to alert the court to the individual's mental state and to enable the court to take appropriate action. In cases before the criminal courts, if you consider that the individual has a mental disorder to an extent that warrants compulsory treatment or where their mental disorder may interfere with proceedings

in court (including fitness to plead), you should submit a report that makes this explicit, even in the face of a refusal of consent to make such a disclosure.

- 144 Any report about an individual prepared at the request of a solicitor should not be divulged to others without the consent of that individual or their legal representative. The only circumstance where this rule does not apply is in situations where disclosure may be necessary in the public interest.
- 145 Further guidance can be found in *Acting as a Witness in Legal Proceedings* (General Medical Council, 2013b).

## Court reports on patients known to the psychiatrist

- 146 You may be asked to provide written psychiatric reports for legal proceedings about patients you are treating or have treated in the past ('as a professional witness'). You should be clear about the purposes of the report and not take instruction unless you have appropriate qualifications, skills, experience and knowledge of the patient's circumstances.
- 147 You should explain your role to the patient and attempt to obtain their consent to prepare the report and discuss it with them. If the patient refuses or lacks capacity to consent, then you should consider the guiding principles on pp. 5–7 and 'Disclosure in the public interest' (pp. 28–31). A statutory or otherwise legally mandated report overrides a patient's refusal to consent.
- 148 The patient may have disclosed information to you as their psychiatrist that they would have withheld had they known it might be used in legal proceedings. This can pose an ethical dilemma if you judge that confidentiality should be breached to disclose that information. You should try to persuade the patient to allow disclosure, but if this is not possible, then refer to the guiding principles on pp. 5–7 and 'Disclosure in the public interest' (pp. 28–31) – and seek advice.

## Reports for coroners' courts

- 149 When a patient dies, the psychiatrist responsible for the patient's care may be asked to provide a report to the coroner detailing the care given. There is no specific law that orders compliance, but there are professional obligations on psychiatrists to cooperate with a coroner's inquiry. Furthermore, if you fail to provide a report to the coroner, the coroner may obtain a witness summons, which would compel you to attend court and give evidence. Failure to comply with the witness summons would amount to contempt of court. If you receive a witness summons in this way, but have continuing concerns about the disclosure, you are under an obligation to raise these concerns with the coroner.

## Court of Protection reports

- 150** Under sections 49 and 61 of the Mental Capacity Act 2005, the Court of Protection can appoint a 'Court of Protection visitor' to provide a report to the court in respect of a person whose capacity to make relevant decisions is under question. Court of Protection visitors can be medical practitioners (known as special visitors) or non-medical professionals (known as general visitors). Both types of visitor have the power, at all reasonable times, to examine and take copies of any health record that relates to the individual, and may interview the individual in private.
- 151** Under section 58 of the Mental Capacity Act, the public guardian may also direct that a report be obtained from a Court of Protection visitor, and has the power to examine and take copies of any health record that relates to the person whose capacity is in question. These powers may be implemented by the Office of the Public Guardian, whether or not legal proceedings are presently underway.
- 152** Under section 49 of the Mental Capacity Act, the Court of Protection has the power to call for a report from an NHS body. Such reports are not paid for by the court, and although they are most often sought from a treating clinician, there will be times when a new clinician is requested to provide information or an assessment of capacity.
- 153** Reports prepared for use in Court of Protection proceedings cannot be used for any other purpose unless the document has been read or referred to at a public hearing, or the court has given permission for further disclosure (The Court of Protection Rules 2007: rule 18).
- 154** Practitioners who produce reports for the Court of Protection should be aware that the court's permission will generally be required for further use of the report, and should consider requesting permission to place a copy of the report in the patient's health record.

## Who owns court reports?

- 155** Any report prepared for a legal process 'belongs' to the party that commissioned it and cannot be disclosed without their consent. For example, if you prepare a report for family court proceedings, this report cannot be disclosed without the court's consent, even if the subject of the report is happy for it to be disclosed to others. However, in general, the subjects of reports still 'own' the information about themselves in reports and may refuse to allow reports about themselves to be disclosed. If the subject of a legal report refuses to allow disclosure of information within it that you think may be clinically relevant (e.g. to a risk assessment), then it may be necessary to obtain legal advice about how to obtain disclosure.

156 When evaluating an individual for a court report, it is essential to advise them (and perhaps provide them with written advice) that the report will be read by others and that personal material about themselves will be seen by others. Some psychiatrists (and trusts) ask evaluatees to sign a form to show that they have understood the limitations of confidentiality in court reports.

## Where a court orders the disclosure of information

157 Generally, the courts have the legal power to order the disclosure of documents prior to and during proceedings and to order the giving of all material to an applicant and their legal, medical and professional advisors. Also, during any proceedings in court, the judge can order that medical records be disclosed, or that a psychiatrist answer any question even if this is a breach of confidentiality. In the absence of a court order, a request for disclosure made by a third party, for example a solicitor or officer of the court, is not sufficient justification for you to disclose information without a patient's consent (if in doubt, refer to the guiding principles on pp. 5–7).

158 Both the civil courts (magistrates', county and High) and the criminal courts (magistrates' and Crown) have wide-reaching legal powers to order disclosure of any documentation except where it is protected by evidential privilege, which includes legal professional privilege. Legal professional privilege means that any person is protected from having to disclose any communications passing between that person and their lawyers and *vice versa*, provided that the communications are directly connected with the litigation or pending/contemplated litigation. If uncertain about what and how much to disclose, you are advised to seek legal and professional advice before proceeding.

159 If required to produce a patient's clinical records under a court order, you should disclose only the documentation that comes under the terms of the order. If you are concerned about the disclosure, the material should be supplied to the judge or magistrate, with a written expression about the nature of your concern; that individual will then decide on the matter. Failure to comply with a court order would constitute contempt of court. If the patient's consultant psychiatrist is on leave or has left the service, another consultant psychiatrist should take on this responsibility. In modern psychiatric practice, most clinical records are multiprofessional and it is implicit that consent for disclosure relates to information collected by all members of the team. However, in situations where a patient has been referred by a general practitioner to one member of the healthcare team (e.g. a psychologist), that individual alone can give consent for disclosure. If that person is on leave or has left the service, then

the consent of the consultant psychiatrist or the healthcare team line manager is acceptable.

## Civil courts

- 160** In deciding whether to order public disclosure of information, the court will undertake a balancing exercise to determine whether disclosure is in the public interest. If you have concerns about the disclosure of information, you have an obligation to raise these with the judge. Objections will generally be on grounds of:
- a** inadmissibility – for example, where the information is covered by legal professional privilege or (in some instances) where it is hearsay evidence;
  - b** relevance – the relevance of the information to the proceedings will determine whether the duty of confidentiality should be waived; the less relevant the information, the less likely that the balance will tip in favour of disclosure;
  - c** proportionality – this is the balance between the harm caused by the disclosure and the benefit that would result from that disclosure;
  - d** public interest – the argument that disclosure would not be sufficiently in the public interest to be warranted.
- 161** It may be possible to release information to the judge alone, rather than in open court, in order that they can make a decision as to its wider disclosure on any of the grounds listed above.
- 162** The High Court has the power to order a potential party to an action to produce copies of documents they have in their possession before the proposed case commences (Senior Courts Act 1981: section 33). Furthermore, in certain situations, section 34 of the Act empowers the court to order the production of documents and other items held by persons who are not and will not be parties to the action.
- 163** Similar provisions exist in relation to the county courts. Part 31 of the Civil Procedure Rules 1998 deals with disclosure from a non-party to the action ([www.justice.gov.uk/courts/procedure-rules/civil/rules#part31](http://www.justice.gov.uk/courts/procedure-rules/civil/rules#part31)). Therefore, in instances where an individual seeks disclosure of confidential information, they can apply to the court under the above statutory powers and seek a court order for disclosure.

## Criminal courts

- 164** In a Crown Court, a party can seek disclosure of confidential information by applying for a court order under the Criminal Procedure (Attendance of Witnesses) Act 1965. Similar provisions exist in the magistrates' courts under section 97 of the Magistrates' Courts Act 1980. The procedure involves the issuing of a witness summons to compel the holder of the confidential information to

attend court or produce relevant documents. Failure to comply would amount to contempt of court and could result in a fine. However, if you have continuing concerns about a disclosure, you should raise them with the judge before the deadline given on the witness summons. It will then become a matter for the judge to decide whether disclosure should take place.

## Disclosure to tribunals

- 165 If a patient is detained under the Mental Health Act 1983, their consent is not required for reports for managers' hearings, mental health tribunals or for the Ministry of Justice's Mental Health Casework Section.
- 166 Many tribunals have powers similar to those of the civil and criminal courts in relation to ordering disclosure and/or attendance at a tribunal hearing. Tribunals that do not hold such powers in their own right have the option of applying for a witness summons ordering disclosure/attendance from the Queen's Bench Division of the civil court (as do coroners' courts).
- 167 Employment tribunals are governed by the Employment Tribunals (Constitution and Rules of Procedure) Regulations 2013 (SI 2013/1237). These provisions empower the chair of the tribunal to make any order (from the list contained within the statutory inquiries) which they consider to be appropriate. This includes the power to order that a party provide additional information and the power to order the attendance of any person in Great Britain, whether to give evidence or to produce relevant documents. An order requiring a person, other than a party to the proceedings, to grant disclosure or inspection of material may be made only where the disclosure sought is necessary in order to dispose of the matter fairly or to save expense. Failure to comply with an order of a tribunal could result in a fine.

## Disclosure to inquiries

- 168 There are two types of inquiry.
  - a Statutory inquiries (e.g. the Victoria Climbié Inquiry)

The Inquiries Act 2005 covers all public statutory inquiries commissioned by government ministers. The Act allows a minister to order an inquiry to be held in a case where it appears to them that particular events have caused, or are capable of causing, public concern or there is public concern that particular events may have occurred. The chair of any such inquiry can, by notice, require a person to attend to give evidence and produce documents in their possession. In making this decision, the chair must have regard to the public interest in the information being obtained and to the likely importance of the information.

- b Non-statutory inquiries (e.g. the BSE Inquiry and the Ayling Inquiry), which may be internal or external

The most common type of non-statutory inquiry that psychiatrists encounter are NHS homicide inquiries, which are set up to comply with HSG (94)27, on the discharge of mentally disordered people and their care in the community (Department of Health, 1994), but usually with no statutory powers to compel witnesses. Non-statutory inquiries have no coercive powers: they rely on the voluntary submission of evidence. Therefore, if disclosure of information is requested, you should obtain the patient's consent to disclose whenever possible. If there is no consent for the disclosure, information should be disclosed only if this is in the public interest (see guiding principle (7) on p. 6).

## Disclosure to regulatory bodies

- 169** Patient records/information may need to be disclosed to a statutory regulatory body investigating a healthcare professional's fitness to practise. If identifiable information is being disclosed, consent should be obtained wherever possible. Where it is not possible to seek consent or the patient refuses consent, the regulatory body will have the power under section 35a of the Medical Act 1983 to determine whether such disclosure is justified in the public interest. You can, and indeed you have an obligation to, raise any concerns over disclosure with the regulatory body, but where disclosure is required this must be complied with.
- 170** The GMC has a wide discretion under the Medical Act 1983 (section 35a) to obtain disclosure of otherwise confidential information for the purpose of the GMC or its committees. It has the power to require psychiatrists to supply any documentation or information that appears relevant to the discharge of its 'fitness to practise' functions, provided that the disclosure is not prohibited by any other legislation. Therefore, if the GMC makes a formal request for disclosure of confidential information under this Act, then the duty of confidentiality to the patient is overridden.
- 171** There are similar provisions with regard to other professional bodies, including the Nursing and Midwifery Council. The powers of the Nursing and Midwifery Council to order disclosure are governed by a statutory instrument (SI 2002/253, the Nursing and Midwifery Order 2001). At article 25, this states that: 'For the purpose of assisting them in carrying out functions in respect of fitness to practise, a person authorised by a Practice Committee may require any person (other than the person concerned) who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document', unless the disclosure is prohibited by, or under, any other enactment,



or the person could not be compelled to supply or produce the information in civil proceedings in any court to which an appeal would be referred.

## Ownership of reports prepared for regulatory bodies

- 172 A report provided for the purposes of a GMC investigation may include information on both a patient and a doctor's professional conduct. If the patient who is the subject of such a report requests disclosure, a balancing exercise must be conducted and the following principles apply:
- a the exercise involves a balance between the respective privacy rights of the data subjects;
  - b in the absence of consent, the rebuttable presumption is against disclosure; and
  - c if the main purpose of obtaining a document is for litigation, then the appropriate process is a court procedure, rather than the Data Protection Act 1998 (*DB v General Medical Council* [2016]).

## Regulation of healthcare providers

- 173 The Care Quality Commission, Healthcare Inspectorate Wales, Scottish Care Commission, and Regulation and Quality Improvement Authority have powers to enter healthcare providers' premises and inspect patient records.
- 174 The NHS Counter Fraud and Security Management Service has powers under the National Health Service Act 2006 and National Health Service (Wales) Act 2006 to require the production of documents to prevent, detect and prosecute fraud in the NHS.
- 175 The Parliamentary and Health Service Ombudsman, Northern Ireland Public Services Ombudsman, Public Service Ombudsman for Wales and the Scottish Public Services Ombudsman have statutory powers similar to those of the High Court or Court of Session to require the production of documents and the attendance and examination of witnesses for the purpose of investigation of the health bodies that fall within their remit.

## Medical reports for the DVLA or DVA

- 176 The role of the DVLA and DVA are described earlier in this report ('Fitness to drive', p. 33).

- 177 Where a medical report is requested by the DVLA, the patient's explicit consent to supply this report is normally obtained by the DVLA and a copy of this consent is provided by the DVLA when making the request.

## Disclosing information for insurance, employment and similar purposes (including benefits)

- 178 Doctors may be asked to provide reports on patients for insurers or employers or in relation to state benefits they may have applied for or be receiving. Although it might appear that the patient has consented to such disclosure, best practice dictates that you must ensure that the patient has been told about the purpose of the report and the fact that disclosure of the report is proposed, and must be warned that relevant information cannot be withheld. You must be satisfied that the patient has given informed consent and you must disclose only that which is required. The Access to Medical Reports Act 1988 entitles patients to be informed about their right under that Act to see the report before it is disclosed, and the patient's wishes in this regard should be sought prior to disclosure. The patient's written consent is required for reports prepared in relation to disability living allowance claims, insurance, employment and similar purposes.

- 179 Further guidance can be found in *Confidentiality: Disclosing Information for Employment, Insurance and Similar Purposes* (General Medical Council, 2017e).

## Disclosure of information after the death of a patient

- 180 An individual's death does not terminate the duty of confidentiality owed to that individual. The GMC advises that all doctors still have an obligation to keep information confidential after a patient dies (although see 'Reports for coroners' courts', p. 41). The Access to Health Records Act 1990 covers only applications for access made by the personal representatives of a patient who has died, or any person who may have a claim arising out of the patient's death. In other circumstances, as with a living patient, the question of disclosure after death must be resolved by considering whether the balance favours the public interest in disclosure or that of the deceased in maintaining confidentiality, for example where disclosure would protect another from serious harm.
- 181 If a patient has specifically stated that the information should remain confidential after death, this should be respected. But if you

think that disclosure may be necessary or you receive a request for disclosure and have no specific instructions, you should take the following into consideration when making a decision:

- a the purpose of the disclosure;
- b whether the information is already legitimately public knowledge and thus not confidential;
- c whether the information disclosed may cause distress to, or be of benefit to, the patient's partner or family;
- d whether the disclosure reveals confidential information about others;
- e whether the interests of the health of a living person outweigh those of the deceased;
- f whether the patient, when alive, made or did not make any mention of information sharing with those seeking confidential information;
- g whether the information can be anonymised, thus removing the problem of confidentiality.

**182** Where a decision to release information is made, the person sanctioning the release should be clear about the grounds on which they do so and be prepared to defend them if challenged.

**183** There are instances when information must be disclosed, for example on a death certificate (Births and Deaths Registration Act 1953, sections 15, 16 and 22). There is no statutory requirement for a psychiatrist to report a death to the coroner, although there is a common law duty to report a death in circumstances that might require an inquest.

## Requests for the disclosure of information by the patient or on the patient's behalf

### The Data Protection Act 1998

**184** The Data Protection Act 1998 is now the primary legislation under which patients can gain access to their health records. The Act affords patients the right to gain access to their records and the right to know what their personal data are used for. The Act also imposes a duty on the holder of the information (the psychiatrist or their employer) to process the data lawfully and fairly. The Act defines the term 'data' and confirms that a 'health record' is an accessible record (whether stored on paper or in electronic form) covered by the Act. Under the Act, patients have the right to have communicated to them in intelligible form the information constituting any personal data of which they are the subject and any information available to the data controller as to the sources of the data. The data should be provided to the patient in a permanent form, unless doing so is not possible or

would involve disproportionate effort, or they agree not to have a copy. Patients have the right to have any technical terms or abbreviations explained to them by a psychiatrist.

- 185 However, section 5 of the Data Protection (Subject Access Modification) (Health) Order 2000 (SI 2000/413) states that the right of access to personal data does not apply if disclosure 'would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person'. This decision can only be made by a health professional, and a health professional considering disclosure has a duty to consider whether this criterion is satisfied.

### **Independent mental health advocates**

- 186 Independent mental health advocates (IMHAs) are entitled to inspect medical records under section 130B of the Mental Health Act 1983, provided that the patient has consented. If the patient lacks capacity to consent, two criteria must be satisfied:
- a inspection would not conflict with a decision made by the patient's lasting power of attorney (LPA) or court-appointed deputy, and
  - b the person holding the records considers that they are relevant to the help to be provided by the IMHA and that inspection is appropriate.

### **Requests for disclosure of information from legal representatives for third parties**

- 187 Mainly in criminal cases, lawyers for the defence may seek disclosure of the medical records relating to a victim or complainant, where consent has not been obtained or has been refused. In such cases, the defence solicitors should obtain a witness summons (under the Criminal Procedure (Attendance of Witnesses) Act 1965, as amended by the Criminal Procedure and Investigations Act 1996) for the holder of the information. A hearing is then likely to take place and the judge will usually wish to consider the contents of the records before making any decision concerning disclosure.
- 188 The judge will rule against such a request for disclosure if they consider that any of the following apply:
- a the defence has not been specific enough in its request and is conducting a 'fishing exercise'; in such instances, the judge may order partial disclosure of material they consider to be relevant, or may refuse the request and discharge the witness summons;
  - b the information is inadmissible in court, possibly because it is hearsay evidence or there are questions concerning how the information was obtained or its relevance;
  - c the information is not sufficiently in the public interest to warrant disclosure in the absence of consent.

189 It is for the party seeking disclosure to persuade the judge that the records ought to be disclosed, and this will be decided by the judge, who will undertake a detailed review of those records.

## Disclosure by psychiatrists' employing organisations

190 If you become aware of a potential disclosure of patient information by your employing organisation, you should seek assurances that policies and protocols relating to disclosure comply with the guidance in this report.

## Responding to requests for information

191 We suggest that you use the following procedure in considering requests for the disclosure of information.

- a Ensure that the request is made in writing and that it specifies:
  - i the name and status of the individual and organisation making the request
  - ii the reason for the request
  - iii the information requested
  - iv how that information will be used
  - v the forum at which the information will be raised
  - vi with whom the information will be shared
  - vii how the information will be stored securely.
- b Discuss the request with the healthcare team and decide what response is necessary, balancing the duty of confidentiality and the public interest.
- c If you decide in principle to disclose confidential information, you must decide, in consultation with the healthcare team, what information to disclose (this being the minimum necessary to fulfil the purpose of the disclosure).
- d You should normally discuss the proposal to disclose information with the patient and, where appropriate (and where there is no statutory or other legal obligation to disclose), you must attempt to obtain the patient's consent in principle to the disclosure. You must always seek the patient's consent to the disclosure, unless doing so would increase the risk of harm or inhibit its effective investigation; you must document this in the clinical record.
- e For consent to be effective, it must be informed consent and the patient giving consent must have real choice. If the patient refuses consent, you must decide whether to override the duty of confidentiality (with reference to this guidance,

particularly the guiding principles on pp. 5–7), documenting your decision and reasoning in the clinical record.

- f If the patient lacks capacity to consent to their healthcare records being shared, the case should be treated as if consent has been refused. The only exception to this is when disclosure is not urgent, and the patient is likely to regain capacity to enable consent to be sought.
- g Regardless of whether consent has been given, you must tell the patient what information you intend to disclose, unless doing so would increase the risk of harm or inhibit its effective investigation. In the case of a court order (or other obligatory request) for disclosure of information, you should tell the patient about the order/request, unless to do so is impracticable, would result in undue risk or would undermine the purpose for which disclosure is sought. Section 29 of the Data Protection Act 1998 exempts data holders from notifying data subjects of such a disclosure under ‘fair processing’ if this would be likely to prejudice the prevention or detection of a crime.
- h The information will be disclosed to the designated individual and organisation on the understanding that its use will be restricted and that any proposal to share it with another party will be communicated to the clinical team and, unless there are exceptional circumstances, to the patient, so that any objections can be raised.
- i You must make a detailed entry in the clinical record of the process described above, the information that you have disclosed or withheld and your reasons for this. You should record details of all conversations, meetings and appointments involved in reaching your decision. Your decision may be legally challenged and you should be prepared to explain and justify it.
- j When you receive minutes of a meeting at which information has been disclosed, you will check them for the accuracy of the information disclosed and notify any corrections where appropriate.
- k There may be circumstances in which you decide to inform the authorities without following all of the above procedure. You should record your reasons for not following this procedure.

# Safeguarding and confidentiality for vulnerable patients and those who lack capacity

## Vulnerable adults

- 192 The Department of Health has issued guidance on safeguarding vulnerable adults, in particular chapter 14 of the *Care and Support Statutory Guidance* (Department of Health, 2014b). Vulnerable adults include not only individuals with impaired capacity, but also, for example, people with physical disabilities and those who misuse substances, are homeless or in abusive relationships. This chapter may be particularly relevant to psychiatrists working with older people and people who have an intellectual disability.
- 193 You need to be aware of the legal requirements in your own jurisdiction and of your duties to work within such frameworks and policies, but you should also be aware that, generally, individual rights and professional duties regarding confidentiality are not waived or changed in any statutory way by safeguarding procedures. Greater focus is required to make considered professional judgements of when the public interest may affect disclosure decisions.

## Disclosing information when a patient lacks capacity to consent

- 194 The GMC confidentiality guidance states:
- ‘You may disclose personal information if it is of overall benefit to a patient who lacks the capacity to consent. When making the decision about whether to disclose information about a patient who lacks capacity to consent, you must:
- make the care of your patient your first concern
  - respect the patient’s dignity and privacy
  - support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information’ (General Medical Council, 2017a: para. 44).

- 195 Patients who lack or have fluctuating capacity may not be able to give consent to disclosure of their personal information, even where it is in their best interests. When patients are expected to regain capacity, a decision about disclosure should (wherever possible) be delayed until capacity is regained and they can make the decision themselves. Emergency situations may make this impossible and, in these situations, you are expected to consider the patient's best interests and the wider public interest in accordance with the guiding principles on pp. 5–7.
- 196 An individual's response to being approached for consent to disclose information will be influenced by the authority, attitude and manner of your approach. Therefore you should be sensitive to this. Ensure that people are given any necessary specialised support to understand the complexities of confidentiality issues and to express their wishes. If linguistic or cultural difficulties arise, consider using an interpreter; confidentiality should be guaranteed by the interpreter organisation's code of practice.
- 197 Failure to take this approach, especially with an unduly compliant or dependent patient, can compromise that person's ability to give or withhold consent – consent should be adequate and appropriate, rather than tokenistic. In these circumstances, you should recognise that disclosure to families or carers can be a difficult matter, requiring careful judgement, especially when complicated by a patient's fluctuating levels of capacity or conflict-ridden relationships, whether between the patient and family members, or between family members themselves. Patients lacking capacity may refuse to give you permission to share information with key family members or other carers. If patients are unable to understand such information sharing or the potentially harmful consequences of their refusal to allow it, you should consider whether it is in their best interests to breach confidentiality; this also applies to sharing information with other agencies (e.g. social services).
- 198 A similar approach extends to copying letters about vulnerable patients and those who lack capacity, primarily intended for general practitioners and/or other professionals, to relatives and/or carers, or to the managers of residential/nursing homes. Only disclose limited and proportionate information.
- 199 Information sharing may be needed to enable assessment of the patient's best interests, but this does not mean that relatives, friends or carers have a general right of access to the patient's records or to irrelevant information. The meaning of 'best interests' is fully elucidated in the code of practice to the Mental Capacity Act 2005 (Department for Constitutional Affairs, 2007).
- 200 The GMC notes that if a doctor believes that a particular patient who lacks capacity to consent to disclosure may be the victim of neglect or physical, sexual or emotional abuse, the doctor must promptly inform an appropriate responsible person or authority if they believe disclosure to be in the patient's best interests or



necessary to protect others from a risk of serious harm (General Medical Council, 2017a). A provisional judgement that such a disclosure is not in the best interests in this situation should be informed by a discussion with an experienced colleague and other authorities.

- 201** In England and Wales, the Mental Capacity Act 2005 provides that a variety of people might determine capacity and make decisions on matters of confidentiality. It is important to note that, in England and Wales, the Mental Capacity Act requires those making decisions to carry out consultation, and now provides for adults with capacity to appoint another individual to make decisions for them after they have lost capacity (under a lasting power of attorney) or to set out their own wishes in a form that should be respected should they subsequently lose capacity (advance decisions). Although the advocacy system is helpful as an independent guide to the patient's wishes and is to be encouraged, it is not a substitute for the psychiatrist's responsibilities, which, where capacity to consent to information sharing is lacking, require you to act in the best interests of the patient, taking into account the nature of the material, the consequences of disclosure and the patient's wishes.
- 202** It is important to remember that in all situations where a patient lacks capacity to consent to their information being disclosed, and there is a need to share information with others in the patient's best interests – or, equally, where there is no need to share information – you should record the assessment, findings, discussion and decision to disclose/withhold information comprehensively in the patient's records. The assessment of mental capacity should also be carefully recorded.
- 203** None of the above prevents a clinician from receiving information from relatives or carers and, indeed, this is usually necessary to form a complete assessment of the patient.

# Children and young people

- 204 Since the Family Law Reform Act 1969, legally a child has been defined as a person below 18 years of age (the age of majority). However, the code of practice for the Mental Health Act 1983 uses the convention, which we follow here, that those under 16 years old are referred to as ‘children’ and those aged 16 and 17 as ‘young people’ (Department of Health, 2015). Laws differ between England and Wales, Scotland, and Northern Ireland as to the details of what children are able to do at different ages. Most of the legislation and guidance concerning confidentiality in general applies to children and young people as well as to adults. Here, we discuss additional considerations which may dictate that confidentiality is, in some situations, limited in scope for children and young people.
- 205 In England and Wales, capacity (defined in para. 22 above) is a term used for individuals aged 16 years and over; the equivalent concept for those aged 15 years and under is competence. The Mental Capacity Act 2005 applies to 16- and 17-year-olds as well as adults.
- 206 For convenience, we use the word ‘parent’ to mean an adult with legal parental responsibility for a child or young person.

## Key principles

- 207 Young people aged 16 and 17 are presumed to have capacity under the Mental Capacity Act 2005 and should be treated in the same way as adults. The Mental Capacity Act 2005 applies to everyone aged 16 and over in respect of capacity and best interests.
- 208 Children aged under 16 should be assessed for Gillick competence (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985]). A refusal by a Gillick-competent child should not be overridden by those with parental responsibility. This is confirmed in the Mental Health Act code of practice:
- ‘Although in the past the courts have found that a person with parental responsibility can override their child’s refusal, such decisions were made before the introduction of the Human Rights Act and since then court decisions concerning young people have given greater weight to their views’ (Department of Health, 2015: para. 19.39).

209 When assessing Gillick competence, you may find it helpful to consider the following questions:

- Does the child understand the information that is relevant to the decision that needs to be made?
- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for any other reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence' (Department of Health, 2015: paras 19.36 and 19.37).

## Withholding and disclosing information

210 The principles are the same for children and young people as for adults. Generally, if a child has Gillick competence or a young person has capacity to understand the implications and boundaries of confidentiality, their wishes on withholding and disclosing information should be respected. GMC guidance on the protection of children and young people states that, 'Information can be shared without consent if it is justified in the public interest or required by law' (General Medical Council, 2012: p. 21), in accordance with the public interest disclosure for adults.

211 The decision to breach confidentiality should be based on a judgement involving a balance between the stated wishes of the child or young person, whether they have competence or capacity, their level of understanding if they lack competence or capacity, any views of adults with parental responsibility (if known), and the best interests of the child or young person. If you have any doubt about breaching confidentiality, then you should seek advice. You should inform the child or young person if a breach of confidentiality occurs (unless to do so would increase the risk of harm) and record the decision and the considerations behind it in their healthcare record.

## Children's and young people's competence or capacity to decide about the use of their healthcare information

212 This is a complex area. A good starting point is the code of practice to the Mental Health Act 1983 (Department of Health,

2015), particularly chapter 19. When assessing a child's or a young person's capacity to consent to disclosure of information, you should consult the code of practice and record how you have assessed capacity.

- 213** This part of the guidance is informed by the publication *0–18 Years: Guidance for All Doctors* (General Medical Council, 2008). Department of Health guidance for England and Wales confirms that children and young people have a right to confidentiality:

'Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidentiality as adults. Children under the age of 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to make decisions about the use and disclosure of information they have provided in confidence (e.g. they may be receiving treatment or counselling about which they do not want their parents to know). However, where a competent young person or child is refusing treatment for a life threatening condition, the duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility for the child who might then be able to provide the necessary consent to the treatment' (Department of Health, 2003: pp. 30–31).

- 214** The Human Rights Act 1998 (Article 8) entitles individuals to a right to respect for private and family life, and this could be interpreted as a right of parents to be allowed access to the information necessary to exercise their parental responsibilities in caring for their children when there are medical problems. Case law in England and Wales, however, has clarified that, although parents clearly should be involved in their children's care in most cases, parents do not have an automatic right to healthcare information concerning their children; in the particular case, it was ruled that a parent does not have a right to be informed if a competent young person has had a termination of pregnancy (*R (on the application of Axon) v Secretary of State for Health* [2006]). The court has stated that 'the duty of confidence owed by a medical professional to a competent young person is a high one which should not be overridden except for a very powerful reason' (*R (B) v Crown Court at Stafford* [2007]).
- 215** The duty of confidentiality must, however, be balanced against the welfare of the child, which by law is paramount (Children Act 1989).
- 216** Concerns about confidentiality should not preclude a psychiatrist from involving parents in their child's psychiatric care. In the mental health setting, most children and young people require the help and support of their parents or other adults in the course of treatment, and their difficulties also have an impact on the wider family. Parents require access to information about, and advice concerning, their child's mental illness in order to be able to discharge their parental responsibilities properly and protect the best interests of their children. Parents, carers or others who are actively involved in the day-to-day care of a child or young

person need information and support from professionals involved in that individual's psychiatric treatment. It is good psychiatric practice to provide an assessment of the parents' or carers' needs. Keeping parents appropriately informed is particularly important when there are issues of risk, for example where a child or young person may be suicidal or at continuing risk of harm from others, such as when abuse has been disclosed.

## Access to healthcare records by children and young people and their parents

217 Children and young people have rights of access to their own records, as do their parents in some circumstances. In England and Wales, the Data Protection (Subject Access Modification) (Health) Order 2000 specifically provides that both Gillick-competent children and young people with capacity may prevent their records being disclosed to their parents, unless there are exceptional situations, for example in relation to life-threatening situations, when confidentiality may be overridden. In its guidance for doctors treating children and young people, the GMC advises that:

'Young people with capacity have the legal right to access their own health records and can allow or prevent access by others, including their parents. In Scotland, anyone aged 12 or over is legally presumed to have such capacity. A child might of course achieve capacity earlier or later. In any event you should usually let children access their own health records. But they should not be given access to information that would cause them serious harm or any information about another person without the other person's consent.

You should let parents access their child's medical records if the child or young person consents, or lacks capacity, and it does not go against the child's best interests. If the records contain information given by the child or young person in confidence you should not normally disclose the information without their consent.

Divorce or separation does not affect parental responsibility and you should allow both parents reasonable access to their children's health records' (General Medical Council, 2008: paras 53–55).

## Copying letters to children and young people and their parents

218 Letters to other professionals should be routinely copied to patients, unless there are specific concerns (e.g. if it might be detrimental to the patient to read the information contained). In general, children and young people, as well as their parents, should be consulted as to who should receive copies of correspondence; in most cases, children and young people have

no objection to their parents reading these letters. The wishes of Gillick-competent children and young people with capacity to consent to their information being shared or withheld should be followed, unless potential risks necessitate overriding them. Where parents are separated, there can be problems about who should receive information and copies of correspondence. If young people are reluctant to allow their parents to read correspondence concerning them, they may prefer to collect copies of their letters in person rather than having them posted to their homes.

## Sharing of healthcare information with third parties (primary and secondary uses)

- 219** The most relevant issue when dealing with children and young people will be suspected child abuse. See in particular the guiding principles on pp. 5–7 and ‘Disclosure in high-risk situations’ (pp. 9–10).
- 220** Professionals working with children and young people with complex mental health problems will generally be operating in a multi-agency context. This context will vary and might involve child and adolescent mental health services and youth offending teams, education staff, as well as social services, including social workers seconded to mental health teams. Any guidance about confidentiality, therefore, needs to be agreed and understood by professionals from a variety of disciplines. With regard to sharing information within healthcare teams for the purposes of direct patient care, and outside healthcare teams for non-healthcare purposes, the principles described thus far in this guidance apply.
- 221** The crucial role of communication between professionals of different agencies in the protection of children and young people has been highlighted following failures of child protection due to missed opportunities for sharing concerns about children at risk of abuse (e.g. Laming, 2003). There can be no better case for information sharing and emphasising the principle of the Children Act 1989 that the welfare of the child is paramount. Professionals working with children and also with vulnerable parents (e.g. patients of adult mental health services) must have the training to suspect or recognise child protection issues. If there is sufficient concern for referral, interagency information sharing is required from assessment onwards (that is, both before, and central to, determining that a child is actually at risk), with social services having the central coordinating role. Professionals’ meetings can be convened without the consent of a child or young person, or their parents, to facilitate fact-finding to decide whether a safeguarding issue exists.

222 An annual report of the Child Death Review Programme in Wales advances that young people who have attempted suicide need a coordinated service involving multidisciplinary and multi-agency discussions (Public Health Wales, 2013). A panel that carried out a related thematic review of probable deaths by suicide of children and young people in Wales between 2006 and 2012 likewise felt that there was a need for improved communication between services and coordination across agencies to help prevent some of these deaths (John *et al*, 2014). The panel concluded that the current child protection register system is not as effective as it could be in supporting communication, across nations and services or within local authority areas, about children who have been recognised as being at risk of significant harm.

223 The Academy of Medical Royal Colleges' report *Child Sexual Exploitation: Improving Recognition and Response in Health Settings* sets out how children and young people who are sexually exploited can present across a range of healthcare settings in a variety of ways: poor self-care; injuries; sexually transmitted infections; contraception; pregnancy; termination; drug and alcohol problems; medically unexplained symptoms; mental health problems; self-harm; problem behaviours; problems in relationships (Academy of Medical Royal Colleges, 2014). The report highlights the importance of information sharing when child sexual exploitation is suspected, stressing that local safeguarding procedures should be followed to protect the child from further exploitation and that the suspicion be reported to the police. The analysis of cases in the Independent Inquiry into Child Sexual Exploitation in Rotherham (1997–2013) demonstrated that addiction and other mental health problems were prevalent in a significant minority of the parents of the children who were sexually exploited (Jay, 2014).

224 A child's refusal of medical treatment in a life-threatening situation may require the breaching of confidentiality to involve adults with parental responsibility or professionals from other agencies. Psychiatric emergency treatment is likely to fall under the scope of a 'life-threatening situation'.

## Guiding principles specific to children and young people

225 In addition to the guiding principles on pp. 5–7, psychiatrists treating children and young people should keep in mind the following guidance.

- a Be aware that the welfare of the child is paramount, as set out in the Children Act 1989.
- b Understand the legal context and ethical principles concerning confidentiality for children and young people and have an agreed policy with regard to confidentiality within the

healthcare team that is understood and adopted by all and is in accordance with the employing organisation's policy.

- c Assess the child's or young person's competence or capacity to make decisions about treatment and about withholding or disclosing confidential information.
- d Establish which individuals have parental responsibility for the young patient; in complex situations, such as where a child or young person is in care, the parents are separated, there is parental conflict, or only one parent or no parent is attending services with their child, issues of confidentiality concerning all carers and adults with parental responsibility should be carefully discussed to avoid inadvertent breaching of confidentiality or later misunderstandings and conflict.
- e Be prepared to involve parents as necessary. Most children and young people will usually be happy for professionals to talk to their parents and others involved in their care.
- f In the initial stages of engagement with children and young people and their parents, explain the policy concerning confidentiality and the limited nature of guarantees of confidentiality, so that there are no misunderstandings or feelings of betrayal later.
- g Ask children and young people for their views on what should remain confidential and what can be shared with parents, and what to share with other agencies such as schools and social services.
- h Wherever possible, respect a young patient's request to keep information confidential. However, you may decide to override such a request from a Gillick-competent child or young person with capacity in limited circumstances, as set out in para. 211 above and in the guiding principles on pp. 5–7 and 'Disclosure in high-risk situations' (pp. 9–10). If a child is not Gillick-competent or a young person lacks capacity, disclosure would be justified in the public interest if it is in the overall best interests of the patient and it is impractical to obtain consent from someone with parental responsibility.
- i If unsure of the best course of action, discuss the situation with other healthcare team members, the local Caldicott guardian and colleagues experienced in child protection. Consider discussing the case anonymously with a medical defence organisation and/or seeking other legal advice. Make records of all such discussions and the reasons for and against breaching confidentiality, as well as the final decision.
- j Discuss with the child or young person and their parents to whom letters should be sent and what information should be contained in the letters; in most cases, joint letters to the parents and the young patient would be the best and preferred option. Assessment of a young patient's stage of development is also relevant in guiding these discussions.



# Media, audio and video recording

- 226 Public understanding and awareness of mental health problems can be greatly influenced by the media. General guidance on liaising with media representatives is given in the College's *Public Education Handbook* (Royal College of Psychiatrists, 2013). Although maintaining confidentiality of patient information is of fundamental importance, general comments on mental health problems and correcting factual inaccuracies about such problems in press reports does not breach confidentiality.
- 227 Hospital settings, patient groups and individual patients may be the subject of media interest. Direct patient interviews may be sought or the recording of visual images of people in clinical settings, and the GMC's *Good Medical Practice* gives comprehensive guidance on these matters in the section 'Recordings for use in public media' (General Medical Council, 2013c: paras 36–42). In relation to media requests, patient consent is essential and, where possible, should be obtained in writing. In addition, you should consider the patient's vulnerability to pressure and capacity to consent.
- 228 Vulnerable individuals should be protected from media pressures, for example requests to appear on a programme to discuss specific mental health problems. You should refuse any request for names and addresses of patients who might be approached by media representatives. There should be a locally agreed policy for media access to clinical facilities, particularly where patient exposure is likely. Any approach made to the patient to obtain their consent should, in the first instance, come from the clinician with whom they have a professional relationship.
- 229 The recording of patient interviews is common in psychiatric practice and fulfils several purposes. Such recordings are particularly common for training and supervision, including interview skills training and therapy supervision, and are also used extensively for research purposes. Recording may also be used for clinical purposes. Again, psychiatrists should refer to the GMC's detailed guidance (General Medical Council, 2011), paraphrased as follows:
- a seek the patient's permission to make the recording and seek consent for any use or disclosure;
  - b give the patient adequate information about the purpose of the recording when seeking their permission and consent;

- c ensure that the patient is under no pressure to give their permission for the recording to be made;
- d stop the recording if the patient asks you to or if it is having an adverse effect on the consultation or treatment;
- e do not participate in any recording made against a patient's wishes;
- f ensure that the recording does not compromise the patient's privacy and dignity;
- g do not use recordings for purposes outside the scope of the original consent without obtaining further consent for that use;
- h make appropriate secure arrangements for the storage of recordings.

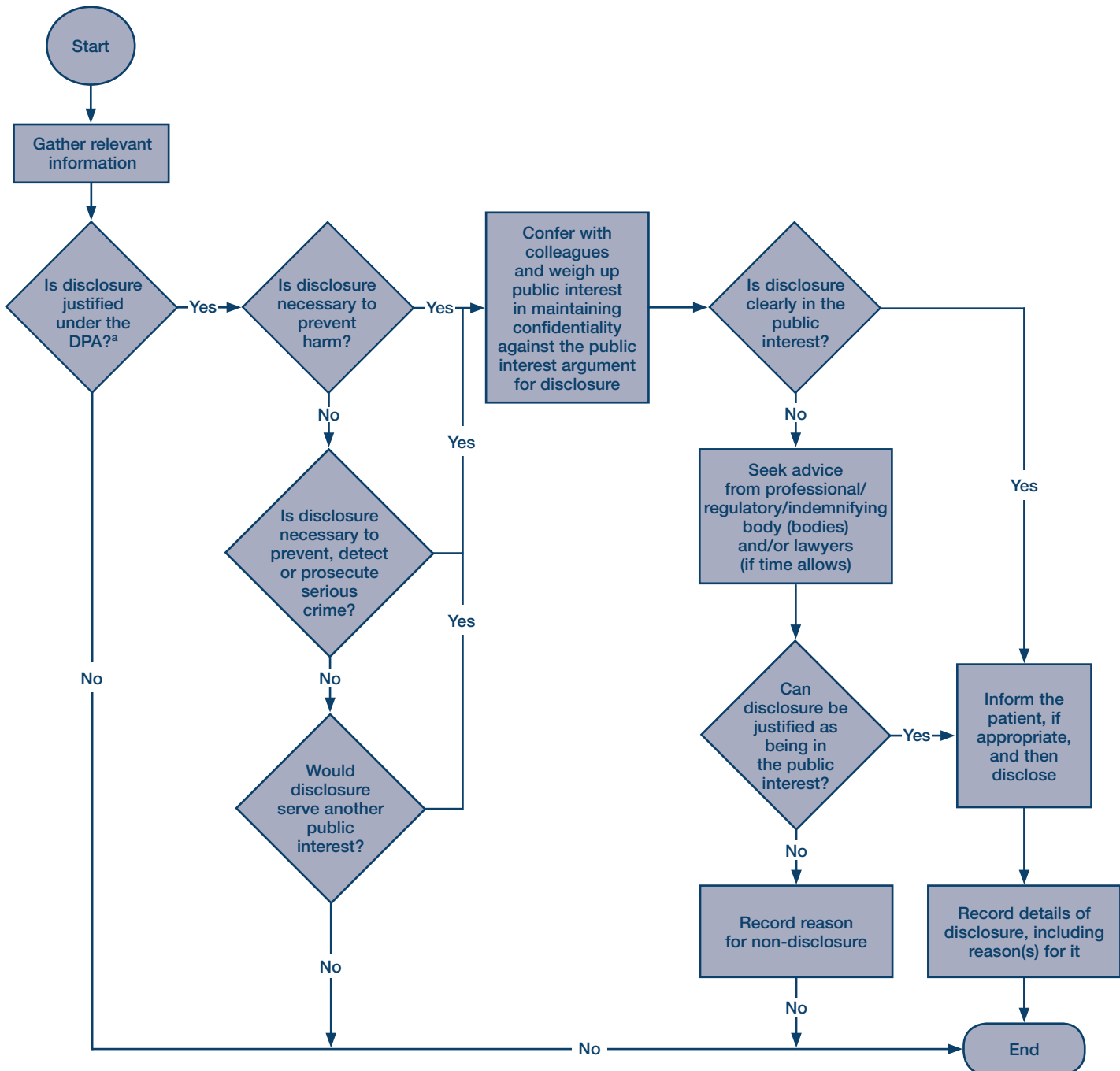
# Appendix 1: Faculty of Medical Psychotherapy's position on electronic patient records

The chapter 'Transfer of information between psychotherapy services and other services within an NHS trust' (paras 37–45 of this guidance) was prepared by the Electronic Records Working Group on behalf of the Royal College of Psychiatrists' Faculty of Medical Psychotherapy, Dr Jo O'Reilly, Dr Jo Stubley and Celeste Ingrams (service user representative). The chapter relates to medical psychotherapy records and provides additional recommendations and advice on the use of electronic records in psychoanalytic psychotherapy within NHS psychotherapy services.

The Executive Committee of the Faculty of Medical Psychotherapy has discussed and considered the introduction of electronic patient records in response to concerns raised by medical psychotherapists over recent years. A working group was set up to look at this with respect to the need to support high standards of clinical practice in finding a balance between the need to ensure confidentiality of sensitive information and the importance of managing risk and protecting patients and the public, which entails the considered sharing of risk-related information.

The working group included medical psychotherapy consultants and service user representatives. It was also informed by discussions of this matter at Executive Committee meetings and by a range of public policies, along with feedback from colleagues and service users who have experience of the introduction of electronic systems. Particular note has been taken of service user perspectives, which underlined the importance of developing a trusting therapeutic relationship in which service users can feel safe to share their experiences without censorship in a contained environment. This is accompanied by an understanding of the need also to share information, especially relating to risk and care planning, with colleagues in a range of services involved with the individual's care.

# Appendix 2: Public interest decisions flowchart



a. If confidential information is being disclosed for a purpose other than those identified as medical purposes in schedule 3 of the Data Protection Act 1998 (DPA), then another justification must be found for the disclosure. In practice, it will be very rare that such a justification will not be available, because 'functions of a public nature exercised in the public interest' is itself a schedule 3 justification, as are administration of justice and vital interests (matters of life and death).

Fig. A1 Flowchart to guide decision-making about protecting/disclosing confidential information in the public interest: decisions are shown in diamonds and actions in rectangles. (Department of Health, 2010: p. 5; contains public sector information licensed under the Open Government Licence v3.0.)

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