READING

Having confidence in therapeutic work with young people: constraints and challenges to confidentiality

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Confidentiality presents particular challenges to practitioners working with young people, on account of the latter’s vulnerability and emotional immaturity. Ethical codes place a key importance on confidentiality, from deontological and teleological perspectives. However, young clients may rely on a more pragmatic approach in deciding whether to disclose personal material to a counsellor. Surveys indicate that young people place high value on confidentiality in school and healthcare advice settings. Practitioners may perceive constraints and challenges to providing high levels of confidentiality to young people, in the form of assumed duties to report child abuse, under-age sexual activity, and the need to obtain prior parental consent for counselling. These apparent constraints are clarified in the light of recent statute and case law, which, in reality, provide robust support in law for counsellors providing high levels of confidentiality to young people.

Key words: autonomy; confidentiality; counselling; ethics; law; young people

Confidentiality is widely seen as being crucially important for the development of effective therapy, but, at the same time, as presenting particular problems and challenges in the area of work with children and adolescents. Confidentiality is routinely presented as a necessary condition for successful engagement of young people in therapeutic work, but also as needing to be hedged about with restrictions, due to the increased emotional and physical vulnerability of this client group. In addition, concerns about the respective rights of significant parties, not least of parents or of those with parental responsibility, and assumed duties to break confidentiality in order to report abuse may lead to a greater apparent fragility of the therapeutic frame than when working with adult clients or patients. While accepting the evident potential vulnerability of children and young people to harm and abuse, and the distinct set of legal or quasi-legal obligations imposed on practitioners working with this client group, this paper will explore key aspects of the provision of confidential, individual therapy for children and young people, its ethical justifications, current legal status and the consequent constraints and challenges to therapeutic work in this field.

Confidentiality is widely seen within the therapeutic community as an almost self-evidently desirable attribute of, or pre-condition for, effective therapy. Confidentiality, or the keeping of client secrets, enjoys a complex relationship to other...
over-arching ethical principles, as articulated in the influential *Ethical Framework*, produced by the British Association for Counselling and Psychotherapy (British Association for Counselling and Psychotherapy [BACP], 2007). While there is clearly a range of ethical models available to practitioners in this area, the BACP code will be used, given that it is representative of bio-medical principles enjoying broad currency and acceptance amongst the therapeutic professions. While the BACP framework does not define therapy as such, confidentiality is seen to hold a central place within therapeutic practice, as part of a linked and inter-dependent system of ethical obligations towards the client. Thus, ‘The practice of counselling and psychotherapy depends on gaining and honouring the trust of clients. Keeping trust requires...careful attention to client consent and confidentiality’ (BACP, 2007, p. 6). This perspective provides a primarily pragmatic justification, therefore, for confidentiality, in that any perceived limitations to, or undermining of, confidentiality will tend to adversely affect the quality of the therapy being provided. Furthermore, confidentiality in work with children and young people will also tend to raise certain additional problems, as noted above. In consequence, it is recognized that ‘Working with young people requires specific ethical awareness and competence’ (BACP, 2007, p. 7).

**Ethical principles in counselling young people**

Confidentiality, within this ethical code, is also directly linked to ethical principles, notably fidelity and autonomy, as part of a deontological or rule-following approach, derived largely from medical ethics (Beauchamp & Childress, 2008; Thompson, 1983). Practitioners who accept these principles are required to ‘regard confidentiality as an obligation arising from the client’s trust’ (BACP, 2007, p. 3). Within this framework, widely accepted in the broader field of health and social care, confidentiality holds an intrinsic and extrinsic value. It can be justified both by its essential contribution towards building the therapeutic relationship, and by its expression of practitioner commitment towards wider altruistic principles. As Eastman (1987, 49) comments, confidentiality thus rests upon two overlapping sets of ethical justifications. The first is pragmatic, utilitarian and teleological in its nature, in that confidentiality is valued precisely to the extent that it enables therapy to take place. The second justification is in terms of a deontological or rule-following approach, expressing commitment to wider ethical principles, widely held by health professionals, notably fidelity and autonomy.

The latter principle, i.e. the facilitation of client autonomy, is particularly relevant to any discussion of counselling for children and young people. While an offer of confidentiality may be necessary in order to engage a young person in therapy, their very age and vulnerability, as a non-adult, mean that their entitlement to unfettered respect for their right to autonomy, self-determination and independence is unlikely to be fully implemented, without at least some degree of qualification. The status of the young person as being potentially vulnerable to abuse or exploitation, or as partially dependent upon parental care and authority, or as being subject to overriding legal obligations to report harm or abuse, may mean that their right to autonomy will be rightly perceived as being conditional upon factors which reside outside the immediate therapeutic frame.
Young people and autonomy

From an ethico-legal perspective, this argument has been elegantly proposed in terms of the doctrine of ‘constrained parental autonomy’ (Ross, 1998, p. 3). From this perspective, the rights of the child or young person to make autonomous decisions in healthcare are constrained by the countervailing, if gradually diminishing, residual authority of parents. The young person’s right to consent to medical treatment, or to confidentiality, can thus be trumped by the rights of parents to retain effective control of significant decision-making affecting the young person in the process of transition towards full adult status. Applied to major medical procedures, this approach has some merit. However, it places therapists in an uncomfortable position with regard to confidentiality. If therapeutic confidentiality for young people can be penetrated by parents on demand, then this may effectively undermine the pragmatic utility and value of the service on offer. Or, as one commentator describes it, this reveals a continuing fault-line, namely the ‘inherent tension between a legal discourse and a clinical discourse’ in this area of practice (Trowell, 2001, p. 90).

The young person’s right to respect for autonomy is necessarily qualified by a number of factors, namely their increased vulnerability to harm, their emotional immaturity and their level of cognitive development. One medical authority therefore suggests making a useful distinction between children, who are not yet capable of making decisions for themselves, and young people, who have sufficient maturity to do so (British Medical Association Ethics Department [BMAED], 2004, p. 133). This distinction will be used in this paper on a provisional basis, reserving clarification of the criterion for making this judgement until a later point. In very loose terms, the term ‘child’ applies to those covered by primary school age, and ‘young person’ applies to secondary school age, but these are not rigid and fixed categories, and there is a clear need to allow for individual developmental differences in this respect. This paper will focus primarily on issues of confidentiality in the counselling of young people in a range of settings, including schools and healthcare advice agencies.

Confidentiality is a value, predisposition, or orientation on the part of the practitioner. It may also be perceived as a virtue, in Aristotelian terms (Lear, 2003, p. 17). It denotes a desirable trait, or set of behaviours, on the part of the person providing care, as part of a wider system of ethical requirements and sanctions applying to their profession. However, the therapeutic relationship is necessarily a reciprocal one between therapist and client, and the latter may well have a differing understanding or expectation of the role of confidentiality. At best, the client (and particularly a younger client) is perhaps unlikely to frame their expectations in terms of an obligatory ethical code, of which they may have very limited knowledge or experience. And yet, the younger client’s expectations of confidentiality may be crucial in relation to whether a counselling service is accessed, whether sensitive personal material is disclosed and the ways in which this material is actually expressed. Whatever the practitioner’s own ethical stance on confidentiality, it is likely that the young client’s expectations of confidentiality will, in reality, play a determining role in controlling the process of disclosing secrets to the adult counsellor.

Surveys of young people’s views on confidentiality

Surveying young people’s views on confidentiality tends to present formidable problems from a research perspective. The findings tend to be localised or, indeed,
often highly personalised, and to be based on limited-scale quantitative or small-scale qualitative surveys (Daniel, 1997; LeSurf & Lynch, 1999; Montgomery, 2003; Rayment, 1996). Despite these limitations, there are some useful indications about young people's perceptions of confidentiality which also can be drawn from other available material covering therapeutic services provided in school and healthcare settings.

**Counselling young people in schools**

Counselling in (largely secondary) schools has experienced a resurgence of interest in recent years, albeit in a decentralised, under-funded and unregulated manner, with varying levels of provision, management and evaluation. Almost three-quarters (71%) of secondary schools in England and Wales claim to provide ‘therapeutic individual counselling’ to pupils, as distinct from other forms of pastoral support, such as mentoring or anti-bullying programmes (Jenkins & Polat, 2006, p. 8). Counselling in schools, as described by BACP, carries a strong reference to confidentiality as a central, and even as a defining feature of the activity: ‘Counselling takes place when a counsellor sees a client in a private and confidential setting...’ (BACP, 2006, p. 5). However, information on how confidentiality is actually provided within secondary school settings is patchy. Baginsky comments, for instance, on the lack of comprehensive information about written policies on confidentiality on the part of schools and counselling providers (2004, p. 33).

Young people’s perceptions of therapeutic confidentiality are often accessed via evaluation or satisfaction surveys. Cooper’s influential survey of school-based counselling in Glasgow schools found the following:

> For many clients, the most helpful aspect of school-based counselling is having an opportunity to talk and be listened to. This is followed by confidentiality, getting things off one’s chest and experiencing advice and guidance from the counselor. (Cooper, 2006, p. 28)

Young people’s views of confidentiality tend to be pragmatic and outcome-based, given their role as actual or potential consumers of the counselling service. Mabey and Sorensen refer to unpublished research to the effect that concerns about confidentiality were a major factor with regard to counselling in educational establishments (1995; Feavour, 1992). However, confidentiality as a concept needs to be further unpicked in order to clarify the nature of these concerns. Thus, ‘an evaluation of a NSPCC counselling service in two comprehensive schools found that pupils were not at all concerned about peers knowing that they were using the service but were concerned about confidentiality in relation to the content of sessions’ (Baginsky, 2004, p. 36). Young people’s concerns about confidentiality are therefore quite complex and embrace a number of different dimensions. In one survey, young people valued the confidential nature of the school counselling service, but differentiated between potential disclosure to interested parties, such as peers and teaching staff: ‘...there was a general perception that friends and teachers might not keep things confidential’ (Fox & Butler, 2007, p. 105). Furthermore, ‘...there was a concern among many of the young people that the school counsellor might not keep things confidential (even though he/she is supposed to)’ (2007, p. 105).
Exploring anxieties about confidentiality is therefore an important aspect of appraising young people's perceptions of school counselling services. In one evaluation of a peer counselling service for bullying, '...a substantial proportion (30.8%) said that lack of confidentiality would deter them' (Boulton et al., 2007, p. 192). Even where young people do not cite concerns about confidentiality as such as a major inhibiting factor in accessing counselling in schools, closer examination of the data suggests that this is not necessarily unproblematic. Contextual factors which are closely related to confidentiality, such as issues of trust, potential embarrassment or anticipatory anxiety if personal material was disclosed to others without consent, can still figure strongly amongst the reasons given by young people for choosing not to see a school counsellor (Baginsky, 2003, p. 36).

**Parental oversight of counselling in schools**

The unresolved issue of parental oversight of school counselling presents a number of direct challenges to confidentiality in this setting. One national survey of school counselling in England and Wales found that a significant proportion of schools (41%) insisted on evidence of prior parental permission for a young person in order to access counselling (Jenkins & Polat, 2006, p. 8). In effect, this deference to the assumed right of parents to give or to withhold consent to school counselling constitutes nothing less than a parental right of veto. This unwarranted extension of parental authority into the school counselling arena represents a serious diminution of confidentiality and a potential denial of a therapeutic service to many young people. It also has somewhat dubious authority in law, as will be discussed later. With regard to the issue of limiting access, Baginsky (2004, p. 37) cites earlier findings by Dennison (1998) to the effect that 'some children were put off from counselling, where one of the schools required specific parental consent rather than where... parents were simply informed of the existence of the service and could opt out if they wished'. Anecdotal evidence suggests that this 'opting out' approach is fairly widespread among schools, as a way of attempting to calibrate school counselling provision with acknowledgement of parental wishes. However, it radically overstates the proper, lawful extent of parental authority in this field, and is therefore seriously flawed as an approach.

Issues about parental knowledge of, or involvement in, counselling provision for young people are potentially of crucial importance in determining the dimensions of confidentiality on offer, and therefore of young people's perceptions of its value to them as a service. The young client may, in reality, wish to see a counsellor because of a major perceived conflict of interest with parents, such as concerns about parental divorce, abuse or drug use; or differences in attitudes about lifestyle, regarding adolescent dress, sexual activity, or leisure pursuits; or, quite simply, differing experiences of family and peer relationships, including ways of coping with a reconstituted family, bereavement or bullying. Any of these issues can require a sufficiently private and safe place for disclosure, independent of parental knowledge or oversight. Young people will often tend to evaluate the counselling service on a pragmatic and outcome-based perspective, based on an anticipation of the consequences of further onward disclosure by the counsellor to other parties. At this point, according to McLaughlin, 'it is the fear of losing control over the process which concerns them, or having no say in the matter of disclosure' (1996a, p. 59). If young people are therefore prone to evaluating school counselling confidentiality on
a broadly pragmatic basis, they will presumably need reassurance in advance as to
the exact limits of confidentiality, and a negotiated, rather than prescriptive, style on
the part of the counsellor towards further disclosure of sensitive material to
interested parties, such as teaching staff, parents or welfare authorities.

School counselling is a major provider of counselling for young people, but the
 provision of confidentiality is currently hedged around with significant concessions
to parental authority in a substantial proportion of schools (Jenkins & Polat, 2006).
The young person's appreciation of confidentiality appears to be an important factor
in influencing their attitude towards the service, and potentially their usage of it
(Boulton et al., 2007; Fox & Butler, 2007). They appear to be aware that school
counselling is distinctive, in offering a higher level of confidentiality than would be
provided in talking to a teacher (Cooper, 2006). Contextual concerns about potential
breaches of confidentiality, such as embarrassment, and loss of trust seem also to be
important factors further influencing their view of the counselling on offer
(Baginsky, 2003, 2004). A requirement for prior parental permission may deter
some young people from accessing the services available (Dennison, 1998).

Counselling young people in healthcare advice services

Health services for young people operate within a different professional and ethical
culture to education and are more firmly based on a deontological tradition of
respect for autonomy and therefore of patient confidentiality (Beauchamp &
Childress, 2008). There is evidence that young people require assurance of high
levels of confidentiality in order to make use of sexual health services (Allen, 1991;
Donovan, Mellanby, & Jacobson, 1997; Thrall, McCloskey, & Etter, 2000). Thus,
'though 86% of adolescents would normally seek health care from the family
doctor, this fell to 57% if the problem was related to pregnancy, HIV or substance
misuse, and 25% would forego health care if they had concerns about confidentiality' (Carlisle, Shickle, Cork, & MacDonagh, 2006, p. 133). Offering patient confidentiali-
ity for young people therefore has a distinct value, in utilitarian terms, in improving
rates of access to key healthcare services. However, confidentiality within health and
therapeutic services may also have additional, unanticipated benefits which are
related to the development of the young person's sense of self. Although the keeping
of secrets, for example from parents, may be experienced as a negative trait, not least
by the parents themselves, this may have appreciable benefits to the young person,
according to one empirical study. Here, '...secrecy emerged as an important
predictor of adolescents' feelings of emotional autonomy' (Finkenauer, Engels, &
Meesas, 2002, p. 132). Thus young people who made use of confidential health
services, without seeking parental involvement or permission, were rated more highly
than peers with regard to their level of emotional differentiation from their parents.
Hence, 'certain features of secrecy can be assumed to promote important aspects of
autonomy, including separation from parents, self-control, personal choice, and
identity...' (ibid., p. 133).

This single piece of research suggests, intriguingly, that access to confidentiality
can therefore contribute positively to the development of the young person's
maturation and the growth of their emotional autonomy. This might suggest that
counselling confidentiality could both respect the young person's ethical entitlement
to autonomy and facilitate its further practical development. Of course, it needs to be
recognised that the development of autonomy is not a social benefit without
concurrent disadvantages. Finkenauer et al. point, for example, to the potential growth of adolescent emotional autonomy as possibly resulting in a loss of safety or security for the young person, or in a diminishing level of parental protection (2002, p. 133). These potential costs would have to be borne in mind, at a minimum, by the counsellor and young person concerned.

Legal constraints on confidentiality for young people: child abuse reporting

One of the distinctive features of counselling children and young people relates to the weight of legal obligations, given their greater vulnerability to harm, and the consequent system of welfare and protection set up for their protection. The legal principle of a duty of confidence finds expression via common law and, more recently, via statute, in the form of the Data Protection Act and Human Rights Act, both of 1998. From a legal perspective, 'confidentiality is about keeping information secure and controlling its disclosure', according to one authority (Pattenden, 2003, p. 12). However, there are major perceived constraints and challenges to the maintenance of confidentiality when working with children and young people, with regard to the law. The major challenges to confidentiality in this respect include assumed duties to report child abuse and under-age sexual activity, and the problematic concept of parental rights.

Confidentiality agreements within child counselling services often include reference to a duty to report child abuse to the authorities. In reality, there is no duty in law for counsellors to report child abuse in the UK. In fact, 'a recent worldwide survey found that relatively few countries have mandatory reporting on child abuse', with the exception of the United States (Stewart, 2004, p. 27). In the UK, the duty to investigate child abuse rests with the local authority, under s.47, Children Act 1989, and with corresponding similar legislation in Scotland. Counsellors working for statutory services, including health, education and children's services, will be required, under the terms of their conditions of employment, to follow child protection reporting policies, but this is an employment matter, rather than a legal obligation as such. A counsellor's failure to report abuse could therefore lead to disciplinary action, including dismissal, rather than to personal liability via the courts. This may be a somewhat fine distinction, but it does underline the essential point that the duty to report is a statutory duty applying to organisations, rather than to individuals.

Clearly, in many cases, reporting abuse will be the only appropriate action for the therapist to take, consonant with an ethical duty to avoid harm to the young client. However, difficulties can arise where a young person discloses abuse, or even significant self-harm, but refuses to give consent to disclosure to the authorities (Clarke, 2008). The result can take the form of an acute ethical dilemma for the counsellor involved, in deciding whether to follow deontological principles of autonomy and fidelity, as opposed to furthering beneficence and non-maleficence. Independent legal opinion has clarified, with respect to fidelity and autonomy, that the counsellor holds a fiduciary duty of trust, in other words a higher level of obligation to respect and maintain client confidentiality, than that applying to, for example, teachers and lecturers (Friel, 1998). The introduction of the Children Act 2004 has placed child protection on a clear statutory basis for the first time, and introduced complex arrangements for information-sharing between agencies, but has not legislated a wider duty to report for all practitioners working with children.
Counsellors working with children and young people need to be cautious before assuming that a notional mandatory duty to report child abuse necessarily precludes the operation of high levels of confidentiality for this client group.

**Reporting under-age sexual activity**

A similar issue relates to more recent pressures to introduce mandatory reporting of under-age sexual activity by children and young people, as evidence of potential harm, abuse or exploitation, under the Sexual Offences Act 2003. The Bichard Inquiry recommended that under-age sexual activity should be routinely reported to the authorities, as an indicator of potential harm to the young person concerned (Home Office, 2004, p. 55). While this move towards mandatory reporting and intervention has been welcomed by children's services and the police, it has caused deep concern to services providing sexual healthcare and advice to young people, particularly amongst family planning agencies and sexual advice services. As previously noted, young people require assurances of high levels of confidentiality in order to access such services. The prospect of mandatory reporting, even if carried out in their 'best interests' from a protective point of view, is likely to deter many of them from accessing this provision. The British Medical Association has issued a robust defence of the need for client confidentiality in this respect, and pressures for mandatory reporting have been lifted (Department of Health [DoH], 2004, p. 1).

**Parental rights as a challenge to confidentiality**

The third challenge to counselling confidentiality has already been touched upon, namely the assumed right of a parent to have knowledge of their child's access to counselling. This issue was decided via the Gillick case in 1985 (Gillick v West Norfolk Area Health Authority [1986]). Here, the House of Lords ruled that a young person under the age of 16 years, with 'sufficient understanding', could give valid consent to medical treatment, without parental knowledge. This carried major implications for counselling and psychotherapy, in that, according to one authority on medical ethics, ‘…any entitlement to consent carries with it a simultaneous entitlement to confidentiality…’ (Mason & Laurie, 2006, p. 273). The Gillick decision, often reduced in a simplistic manner to the 'Fraser guidelines', thus provides the crucial legal authorisation for therapeutic confidentiality for young people under the age of 16, where they possess sufficient understanding, as decided on a case by case basis. The law on this point in Scotland carries still greater authority as statute, in the form of the Age of Legal Capacity Act (Scotland) 1991.

It would appear that schools which provide counselling subject to parental approval do so in spite of the Gillick decision. This is sometimes done with reference to the concept of the school being 'in loco parentis', i.e. carrying out the parental duty of care. From a legal point of view, this is a tenuous argument, lacking in conviction. 'The Elton report, Discipline in Schools (Department for Education and Science [DES], 1989) commented on the lack of definition of terms such as “in loco parentis”’ (McLaughlin, 1996b, p. 3). According to Hyams, ‘…today, the phrase in loco parentis has no real meaning and is likely to be misleading’ (1997, p. 187). Rather than being 'in loco parentis', the school is under a legal obligation to take no less than 'reasonable care' of its pupils. This duty does not delegate to schools the required legal authority to deny pupils counselling, if they are judged to be eligible under the
Gillick principle. From a broader social perspective, parents’ rights as such have been significantly eroded since the Children Act 1989, which reframed such rights in much reduced terms, as ‘parental responsibility’. A parent has no inalienable right to authorise, or to veto, counselling for a young person possessing sufficient understanding, as this would breach the latter’s right to confidential treatment.

Young people’s legal rights to confidentiality

Gillick consists of two key elements, namely the right of the young person under 16 to give consent to medical treatment; and a corresponding right to confidentiality, if of sufficient understanding. However, the Gillick decision was recently challenged via judicial review in the Axon case, following a termination carried out for a 14-year-old girl, by a school-based health worker (Axon v Secretary of State for Health [2006]). This treatment was provided in the absence of the mother’s knowledge or agreement. Significantly, the challenge was to the principle of confidentiality and not to the issue of consent as such. This was on the basis that the parent had a right to know if a termination was being offered to a young person, in order to be able to provide the necessary support. However, the judge decided that the Gillick decision had been correctly argued and was still valid, as ‘good law’. Any encroachment on the young person’s right to confidentiality in deciding highly sensitive matters, such as a termination, would increase the likelihood of untoward pressure upon the young person by others, including parents. Confidentiality was therefore a necessary precursor to exercising valid consent. Perhaps more significantly, the judge endorsed the principle of confidentiality for young people seeking medical advice and treatment as an important public policy issue. The evidence cited in the judicial review indicated that, where young people were not assured of high levels of confidentiality, then rates of accessing the service, particularly by young people from ethnic minorities, were adversely affected. At a public policy level, the Axon case provides strong support for the principle of adolescent autonomy, as expressed by Judge Scarman in the original Gillick decision, and indicates the utilitarian value, to society as a whole, of providing confidential counselling services for young people.

From a legal perspective, confidentiality for young people finds strong endorsement through case law and statute. This is linked, once again, to the ethical principle of autonomy. ‘By allowing the client to decide, when, how, and to what extent “his” information is communicated to others, the professional encourages and upholds the client’s autonomy’ (Pattenden, 2003, p. 20). Counsellors working with children and young people may be bound by agency policy to report abuse, but this is not necessarily an individual legal obligation or liability. In any event, legal opinion suggests that counsellors also possess a countervailing fiduciary duty of trust to clients, in order to maintain high levels of confidentiality. Similarly, duties to report under-age sexual activity do not hold statutory authority, and are similarly in conflict with the need to offer confidential advice. Despite widespread practice in schools, parents do not have a right to give, or withhold, permission for counselling of young persons with sufficient understanding, and schools are not obliged to abide by this practice, given that the concept of schools being ‘in loco parentis’ is both unclear and misleading. Recent case law endorses the Gillick principle, on both grounds of respecting the young person’s right to autonomy, and, from a utilitarian perspective, of the broader social benefit of providing confidential health advice for young people.
Conclusion

In conclusion, confidentiality is of particular importance in counselling children and young people, given their greater vulnerability to harm. Confidentiality is a value of key structural significance with regard to ethical obligations for practitioners, as it holds justification from both deontological and teleological standpoints, in respecting the right to autonomy. Young people, perhaps lacking full appreciation of the nature of ethical codes, may themselves tend to evaluate counselling services much more from a pragmatic, or outcomes-led, perspective. From the limited survey material available, it appears that confidentiality is an important factor for young people in appraising counselling services, along the different dimensions of disclosure of private material to peers, teachers and to parents, respectively, within the school setting. Heightened assurances of confidentiality seem to be particularly important in the context of providing healthcare advice on sensitive issues to young people. Research suggests that keeping secrets from parents may, in fact, have certain positive effects for young people, in facilitating the development of their emotional autonomy.

Constraints and challenges to maintaining confidentiality in therapeutic work with children and young people are often framed, perhaps apprehensively, in terms of assumed legal obligations to report abuse, or under-age sexual activity. These duties may be more nuanced and negotiable than is perhaps widely understood by practitioners. Recent case law has provided decisive support to the principle of adolescent autonomy, to be found in the Gillick decision and in Scottish statute, on this issue. The practice of limiting confidentiality in school counselling services seems to be at variance with this key principle. These findings would suggest that counsellors can take heart and have confidence in their future therapeutic work with young people.

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