WORKING WITH CHILDREN EXPOSED TO DOMESTIC VIOLENCE

ISSUES OF CONSENT, CAPACITY AND CONFIDENTIALITY FOR COUNSELLORS

April 2016

A report prepared by
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For the Domestic Violence Action Centre

This report was researched and written by senior law students **Colin Craig** and **Milly Khan** under the supervision of **Monica Taylor** at the TC Beirne School of Law, University of Queensland. It was produced for and on behalf of the Domestic Violence Action Centre located in Ipswich, Queensland, following a research request from Ms Rebecca Shearman, Operations Manager. The work was conducted from January to April 2016 in broad alignment with New Year vacation period and commencement of the academic year. The students undertook this task on a *pro bono* basis, without any academic credit or reward, as part of their contribution to service as future members of the legal profession. The UQ Pro Bono Centre thanks the Domestic Violence Action Centre for allowing us to contribute to its work in this vital area.

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I INTRODUCTION & OVERVIEW

This report was prepared in response to a referral made by the Domestic Violence Action Centre (DVAC) to the UQ Pro Bono Centre, requesting assistance in conducting research into the legal obligations of domestic violence workers in providing counselling and support to young people exposed to domestic violence. The referral noted that, in the context of domestic violence counselling and support services, it is unclear when a young person can consent to receive such counselling and support without their parent's knowledge.

Uncertainty about legal obligations is undesirable for domestic violence workers for several reasons. Most obviously, it places domestic violence workers at a greater risk of failing to meet their obligations and thereby exposes domestic violence workers and DVAC to liability. An informed approach to working with young people is therefore necessary to ensure that DVAC can adequately manage its risk of liability. Uncertainty about legal obligations also affects the quality of counselling and support services that can be provided. If domestic violence workers do not understand the extent of their legal obligations, there may be a 'chilling effect' upon them, refraining from providing counselling and support services to some children for fear of liability. An informed understanding of legal obligations can therefore improve the services provided by domestic violence workers by giving them the confidence to act within the law to their full capacity. Furthermore, with a clear understanding of the law, domestic violence workers can inform their young clients of their rights to confidentiality and the limited circumstances in which confidential information may be disclosed to other people. This may have a beneficial effect in helping to develop the relationship of trust between counsellor and client.

This report aims to clarify the law surrounding the capacity of young people to consent to receive counselling and support services, obligations of confidentiality towards young clients, and circumstances in which confidential information can or must be disclosed to third parties. In doing so, the report aims to help improve DVAC's risk management policies and facilitate the effective provision of counselling and support services to young people.

This report begins with an examination of relevant Australian law. This is divided into two sections, one concerning the law related to consent and capacity, and another concerning the law related to confidentiality and disclosure. Following the discussion of Australian law, the rights of children under international law is considered. The codes of ethics of two peak Australian counselling and psychology bodies are also examined. Throughout each of the sections in this report, recommendations to DVAC are made. These recommendations are highlighted distinctly from the rest of the body text by the use of black text-boxes. A full list of these recommendations is included in the next section of the report, before the report's main text.

While the initial aim of project was to provide a comprehensive outline of the law as it may apply to the DVAC, we were unable to fully examine all potential legal issues due to the large number of issues identified and the time constraints for the delivery of the project. Priority was instead placed on the legal issues we deemed to be of particular importance. Where a topic has not been included in this report, or has been included in less depth, we have tried to make a note of this in the text of the report, either explaining why further consideration was not deemed necessary or noting the issue as a potential area for further research.

II SUMMARY OF RECOMMENDATIONS

The following recommendations are made to DVAC throughout the report. The order of this summary matches the order of the recommendations made in the body of the report.

Recommendation 1: that DVAC bear the 'sliding scale' approach in mind in assessing competence, and give greater attention to the issue of competence when the gravity of the contemplated counselling and supported services is greater.

Recommendation 2: that DVAC provide to clients information about the nature of the proposed services, their goals and consequences, risks of unintended effects, alternatives to the proposed services, and the skills and expertise claimed by the social workers working with the client.

Recommendation 3: that DVAC not attempt to force a child to receive counselling or support services at the behest of the child's parent, if DVAC believes the child has attained competency to consent to and refuse these services themselves.

Recommendation 4: that DVAC use medical studies on capacity of children at different ages as a guide to what can generally be expected of children at that age, but not rely on such studies as wholly determinative.

Recommendation 5: that DVAC use the factors identified by the NCYLC in developing a policy for social workers in assessing *Gillick* competence.

Recommendation 6: that DVAC develop a list of questions based on those identified by Grisso and Appelbaum to be given to social workers to guide them in their assessments of competence.

Recommendation 7: that DVAC consider adopting a rule that social workers will not work with children aged 10 or below without the consent of a parent.

Recommendation 8: that DVAC consider whether it is willing to bear the risks of allowing the rule in recommendation 8 to be rebutted in exceptional cases.

Recommendation 9: that DVAC consider adopting a more rigorous assessment of capacity for children aged 14 or below.

Recommendation 10: that DVAC consider adopting a less rigorous assessment of capacity for children aged 15 and above, unless the social worker has reason to believe the child may not in fact be competent.

Recommendation 11: that DVAC also assess a child's capacity to enter a confidential relationship, particularly where the child is assessed as incapable of consenting to receive counselling and support services but has already given person information to a social worker.

Recommendation 12: that DVAC generally defer to the wishes of parents when dealing with children who lack to the capacity to consent to undergo counselling and support services (subject to obligations of confidentiality arising from a possible relationship of confidence with the child).

Recommendation 13: that DVAC seek legal advice if it believes that a parent's refusal to allow a child lacking capacity to receive counselling and support will cause serious harm to the child.

Recommendation 14: that DVAC refrain from disclosing personal information to a parent where a child has been assessed as capable of entering a confidential relationship and has not consented to the disclosure of personal information to the parent, even if the child has been assessed as lacking capacity to receive counselling and support services.

Recommendation 15: that where a child is assessed as being incapable of entering a confidential relationship, DVAC disclose to a parent personal information given by the child to a social worker where DVAC believes that this would be in the best interests of the child.

Recommendation 16: that DVAC examine the extent to which its privacy policy and practices are compliant with the Australian Privacy Principles, including principles not quoted in this report.

Recommendation 17: if DVAC's privacy policy and practices are not compliant with the Australian Privacy Principles, then DVAC should either:
(a) change its privacy policy and practices to be compliant;
(b) seek legal advice as to whether it is in fact bound by these principles; or
(c) choose to accept the risk of liability, weighing up likelihood of being bound by the principles, the extent to which DVAC does not comply with the principles, and the consequences of breach.

Recommendation 18: that, subject to certain circumstances of public interest, DVAC only disclose confidential information to a third party with the consent of the client.

Recommendation 19: that the DVAC only disclose personal information given to it in confidence without the consent of the client if the information relates to the existence or real likelihood of the existence of a crime, civil wrong, or serious misdeed of public importance, and the disclosure is made to a party with a real and direct interest in redressing the crime, wrong or misdeed.

Recommendation 20: the DVAC investigate whether its current insurance policy covers liability for breach of confidence and, if not, enquire about the costs of including such cover.

Recommendation 21: that the DVAC take care when providing support services to children to ensure that the DVAC is assisting the child with making or carrying out his or her own decisions and not making significant legal decisions on behalf of the child.

Recommendation 22: that the DVAC consider disclosure in breach of confidence to relevant parties where there is a clear risk of serious bodily harm or death to an identifiable person or group of persons and the danger is imminent.

Recommendation 23: that the DVAC conduct further research on other potential areas of liability in negligence if this a concern to the organisation.

Recommendation 24: that the DVAC consider the possibility of conflicts with obligations of confidentiality to students before agreeing to any contracts with schools that require disclosure of personal information about students to the school administration.

Recommendation 25: that, as part of DVAC's risk assessment procedures, DVAC report the possibility of child abuse to the Department of Communities, Child Safety and Disability Services if it is of the opinion that this would be in the best of interests of the child and not be more harmful than to the child than some other strategy.

Recommendation 26: that domestic violence workers inform children of their rights to confidentiality and the limits to these rights as part of the process of obtaining informed consent, reminding children of these rights and limitations as necessary in the process of providing counselling and support services.

Recommendation 27: that DVAC take care in developing an approach to informing children about the limitations to confidentiality that balances the child's right to be informed about these limitations with the concern that a child may be dissuaded from using counselling services if they are worried about the disclosure of their personal information.

Recommendation 28: that DVAC allow children not yet capable of providing their own consent in matters affecting them to express their views and be taken into account in the decision-making process, so far as is possible.

Recommendation 29: that the policies of DVAC reflect the acknowledgement of respect for the rights of parents contained in Article 5 of the *Convention on the Rights of the Child*.

Recommendation 30: that DVAC consider the competing policy arguments for and against working with children without the consent of their parents in developing its approach towards working with children, including the reasons behind APACS' more restrictive approach.

Recommendation 31: that DVAC consider the provisions in Section A.3 of the APS Code of Ethics when developing its own approach to obtaining informed consent.

Recommendation 32: that DVAC develop a policy of record keeping by social workers, particularly in relation to the assessment of capacity to enter into a confidential relationship and consent to receive counselling and support services, and obtaining consent for disclosure of personal information to third parties.

III THE LEGAL POSITION IN AUSTRALIA

A *Consent and Capacity*

There are no statutory provisions in Australia which deem young people capable or incapable of consenting to receive counselling and support services at particular ages. Nor has the question of capacity to consent to these services received judicial consideration by Australian courts.[1] English and Australian courts have, however, considered and decided upon the capacity of young people to consent to receive medical treatment. In the absence of statutory provisions or judicial decisions specifically addressing capacity in the context of counselling and support services, this report first considers the legal position with respect to medical treatment as a starting point for how Australian courts might address the issue. The report then explains why and how a link can be drawn to counselling services. Some medical studies into the capacity of children are then noted, before some practical tips for social workers on assessing capacity are given. The final sub-section on capacity considers a related but different type of capacity, capacity to enter a confidential relationship. In these sections, the words 'capacity' and 'competence' are used interchangeably.

1 *Capacity to consent to medical treatment*

Excluding certain exceptional circumstances, the consent of a patient must be obtained before by a doctor or other healthcare professional performs a medical procedure upon them.[2]

In some Australian states and territories, the age at which a young person can consent to medical treatment is at least partially governed by statute.[3] In Australian jurisdictions without these legislative provisions, such as Queensland, capacity is determined solely at common law.[4] The leading case on the consent of young people to receive medical treatment in England and Australia is the House of Lords' decision in *Gillick v West Norfolk and Wisbech Area Health Authority* ('*Gillick*').[5]

(a) *The decision in Gillick*

Legislation in the UK provided that young people aged 16 or over were able to consent to medical treatment as if they were an adult.[6] However, the position with respect to people younger than 16 was unclear. In *Gillick*, the UK Department of Health and Social Security issued a memorandum of guidance to health authorities in the UK that said that family planning services and contraceptive advice should be available to people of all ages. The memorandum stated that the department hoped that attempts would be made to persuade children under the age of 16 who sought such services to involve their parent or guardian in the consultation, but that doctors had the discretion to prescribe contraception to children under 16 without the knowledge of their parents.

The plaintiff, Mrs Gillick, a mother of five girls under the age of 16, wrote to her local area health authority seeking from them an assurance that her daughters would not be given any contraceptive advice or treatment without her consent. The area health authority refused to give such an assurance. Mrs Gillick brought legal action seeking a declaration that the memorandum of guidance issued by the Department of Health and Social Security gave advice which was unlawful and which adversely affected the rights and duties of parents.

The case reached the House of Lords, the highest court in the UK. Among the issues for determination by the House of Lords were (1) whether, and in what circumstances, a person under the age of 16

[1] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 16.
[2] *Rogers v Whitaker* (1992) 175 CLR 479.
[3] See *Minors (Property and Contracts) Act 1970* (NSW) s 49; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 6, 12.
[4] The phrase 'common law' refers to judge-made law that comes from deciding legal disputes, and can be contrasted with 'legislation' (or 'statutes') that are made by Parliament.
[5] [1986] 1 AC 112.
[6] *Family Law Reform Act 1969* (UK) s 8.

could consent to medical treatment without their parent's consent; and (2) to what extent a parent had a right of control over their child's medical treatment.

The House of Lords held that a person under the age of 16 had the legal capacity to consent to medical examination and treatment if they have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment.[7] The House of Lords further held that a parent's rights of control over their minor child existed only in so far as it was required for the child's benefit and protection. A parent's right to determine whether their child should have medical treatment terminated when the child attained sufficient maturity and intelligence to understand the nature and implications of the proposed treatment and to make the decision themselves.[8]

(b) *Subsequent cases considering Gillick competence*

The High Court of Australia followed the House of Lord's decision in *Gillick* in *Marion's case*, and held that the decision in *Gillick* also represents the law of Australia.[9]

In *Marion's case* the High Court held that:

> A minor is … capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[10]

In the UK case of *Re R*, Lord Donaldson explained this requirement of understanding further:

> what is involved is not merely an ability to understand the nature of the proposed treatment … but a full understanding and appreciation of the consequences, both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of failure to treat.[11]

The law also seems to adopt a 'sliding scale' approach to level of scrutiny required in assessing capacity to consent to medical treatment.[12] This means that the degree to which a medical practitioner must be satisfied of a patient's capacity varies according to the contemplated treatment. In *Re T*, Lord Donaldson MR held that:

> What matters is that the doctors should consider whether at the time [the patient] had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious a decision, the greater the capacity required.[13]

Similarly, in *Marion's case*, Justice Deane held that:

> Pending attainment of full adulthood, legal capacity varies according to the gravity of the particular matter and the maturity and understanding of the particular person.[14]

Recommendation 1: that DVAC bear the 'sliding scale' approach in mind in assessing competence, and give greater attention to the issue of competence when the gravity of the contemplated counselling and supported services is greater.

(c) *Capacity to refuse treatment*

A related issue to capacity to consent to treatment is capacity to refuse treatment. On this point, Australian law seems to have diverged from English law since the decision in *Gillick*. In the UK case of *Re R (A Minor) (Wardship: Consent to Treatment)* it was held that parents retain an independent

[7] *Gillick* [1986] AC 112, 169, 186, 195.
[8] *Gillick* [1986] AC 112, 170–3, 184–6, 188–9, 195.
[9] *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 237–8, 311 ('*Marion's case'*).
[10] *Marion's case* (1992) 175 CLR 218, 237.
[11] *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592, 602.
[12] Paul Biegler and Cameron Stewart, 'A primer on the law of competence to refuse medical treatment' (2004) 78 *Australian Law Journal* 325, 333–4.
[13] *Re T (An Adult: Refusal of Medical Treatment)*[1993] Fam 95, 113.
[14] (1992) 175 CLR 218, 293.

right to consent to the medical treatment of their children until the child turns 18.[15] If a child's parents have consented to them receiving medical treatment, the child cannot refuse treatment even if they are competent to consent to treatment themselves.[16]

The English position was expressly criticised by Justice McHugh of the High Court of Australia:

> [T]he parent's authority is at an end when the child gains sufficient intellectual and emotional maturity to make an informed decision on the matter in question. In so far as *Re R (A Minor) (Wardship: Consent to Treatment)* … suggests the contrary, it is inconsistent with *Gillick*.[17]

As such, it appears to be the case in Australia that as soon as a child is capable of consenting to treatment, they are also capable of refusing treatment and overriding treatment decisions of parents.[18]

2 *Gillick competence and counselling services*

In the absence of any Australian court decisions specifically addressing the capacity of young people to consent to receive counselling and support services, the decision in *Gillick* is the best indication of how an Australian court would decide the issue – that is, that a young person can consent to receive counselling and support services if they have sufficient maturity and intelligence to understand the nature and implication of the proposed services.

The most basic of reasons to support this is that the common law develops by analogy. Where judges are presented with a novel case for determination, they will look to see if any similar cases have been decided previously and, in deciding the case before them, they may rely upon the reasoning in these earlier decisions to the extent that the cases are analogous. Secondly, if one takes the view that health includes mental well-being, some counselling and support services might fall directly within the concept of medical treatment as discussed in *Gillick*.[19] Thirdly, and perhaps most persuasively, it has been argued that the principle from *Gillick* is not limited to medical treatment. Rather, the principle enunciated by the House of Lords applies to the capacity of children to consent to any matter.[20]

As with medical treatment, capacity to consent to counselling would require the ability to understand the nature of the proposed services, their consequences, risks of unintended effects, and alternatives to the proposed treatment. Swain writes that in a social work context

> service users need to be advised not just about what services or forms of intervention are available from the agency or professional worker concerned. They also need information about any costs involved, the implications of refusal or agreement … and the alternatives if any available from both within the agency and elsewhere. In relation to involvement with a particular worker, the service user should be made aware of the particular skills or expertise claimed by the worker, and of the goals sought through the intervention proposed, and of the time period over which the intervention will be offered.[21]

Recommendation 2: that DVAC provide to clients information about the nature of the proposed services, their goals and consequences, risks of unintended effects, alternatives to the proposed services, and the skills and expertise claimed by the social workers working with the client.

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[15] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction*) [1993] Fam 64, 78, 86.
[16] See Queensland Law Reform Commission, *Consent to Medical Treatment of Young People*, Discussion Paper No 44 (1995) 68–77.
[17] *Marion's case* (1992) 175 CLR 218, 316–7.
[18] See Queensland Law Reform Commission, *Consent to Medical Treatment of Young People*, Discussion Paper No 44 (1995) 77–8.
[19] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 15.
[20] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 14–15.
[21] Phillip Swain, *In the Shadow of the Law: The Legal Context of Social Work Practice* (Federation Press, 2nd ed, 2002) 36.

Application of the 'sliding scale' approach from the law relating to medical treatment also has implications in the context of counselling services. It may be that the threshold to which social workers would need to be satisfied of a child's capacity to consent to receive counselling would be less than the threshold in most cases involving medical treatment.[22] Counselling is less invasive than medical treatment and might be seen to generally involve fewer risks. For these reasons it could be argued that the threshold of satisfaction for capacity to consent to counselling would generally be easier to meet. On the other hand, it has been noted that unlike medical services, counselling is an unregulated profession.[23] This poses different risks.

Recommendation 3: that DVAC not attempt to force a child to receive counselling or support services at the behest of the child's parent, if DVAC believes the child has attained competency to consent to and refuse these services themselves.

3 *Ability of children to consent to counselling*

While a detailed consideration of the medical studies into the capacity of children to make treatment decisions is beyond the scope of this report, it seems to be the case that most studies have found that by the age of 14, most children are as competent as adults in making treatment decisions for themselves.[24] For children between the ages of 11 and 14, there are varying levels of cognitive development and perceptions of social expectations, such that some children in this age group could be considered competent to consent to treatment, but others could not.[25] Below the age of 11, it is considered unlikely that a child would be capable of giving their informed consent to treatment.[26]

Recommendation 4: that DVAC use medical studies on capacity of children at different ages as a guide to what can generally be expected of children at that age, but not rely on such studies as wholly determinative.

4 *Assessing Gillick competence*

The National Children's and Youth Law Centre (NCYLC) identifies a number of factors which could be used to assess *Gillick* competence in the context of counselling:

(1) The child's ability to understand the current issues and circumstances;
(2) The child's maturity;
(3) The child's degree of autonomy;
(4) The type and sensitivity of the information involved;
(5) The amount of time spend reflecting on decisions to be made;
(6) Attentiveness and awareness regarding details of the problem situation; and
(7) The degree to which the child actively attempts to acquire information on decisions to be made[27]

Recommendation 5: that DVAC use the factors identified by the NCYLC in developing a policy for social workers in assessing *Gillick* competence.

Grisso and Appelbaum identify a number of helpful questions for practitioners in assessing the competence of children.[28] While these questions relate to consent to medical treatment, they may also

[22] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 45.
[23] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 16.
[24] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 17–19; David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 6.
[25] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 19.
[26] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 19.
[27] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 19.

be useful for social workers in assessing capacity to consent to receive counselling. Grisso and Appelbaum categorise these questions according to different aspects of decision-making capacity (understanding/comprehension, belief/appreciation, weighing/reasoning, and choosing).

Understanding/comprehension

- Ask patient to recall and paraphrase information related to proposed treatment including risks and benefits of treatment, alternative treatment and no treatment at all (retest later to check for stability).

Belief/appreciation

- "Tell me what you really believe is wrong with your health now."
- "Do you believe that you need some kind of treatment?"
- "What is the treatment likely to do for you? Why do you think it will have that effect?"
- "What do you believe will happen if you are not treated?"
- "Why do you think the doctor has recommended this treatment for you?"

Weighing/reasoning

- "Tell me how you reached the decision to accept (reject) treatment."
- "What things were important to you in reaching the decision?"
- "How do you balance those things?"

Choosing

- "Have you decided whether to go along with your doctor's suggestion for treatment?"
- "Can you tell me what your treatment decision is?" [29]

Similar versions of these questions related to the provision of counselling services could be asked of child clients to assess capacity.

Recommendation 6: that DVAC develop a list of questions based on those identified by Grisso and Appelbaum to be given to social workers to guide them in their assessments of competence.

The NCYLC recommends that children's capacity be assessed individually. There are two approaches that could be taken to this. One would be to make a formal individual assessment for every single child client. However, this could be overly time-consuming for social workers and unnecessary for all clients (for example, 17 year olds). Another approach could be to adopt some 'soft' presumptions in assessing the capacity of children.[30] For example, social workers could probably operate fairly safely on a presumption that, unless there is evidence to the contrary, children aged 15 or above have the requisite capacity. For children aged 15 or above, a social worker could forego a formal assessment of capacity unless the child gave the social worker reason to believe that he or she was not in fact competent. Social workers could also adopt a presumption that children aged 10 or below are not competent and not work with them without a parent's permission. In some exceptional cases, this too might be rebutted if there is evidence that the child's capacity is beyond his or her peers. Children between the ages of 11 and 14 would be assessed individually. Adopting presumptions of this kind could save social workers from having to conduct individual assessments in clear-cut cases.

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[28] Thomas Grisso and Paul S Appelbaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and other Health Professionals* (Oxford University Press, 1998) quoted in Paul Biegler and Cameron Stewart, 'A primer on the law of competence to refuse medical treatment' (2004) 78 *Australian Law Journal* 325, 342.

[29] Thomas Grisso and Paul S Appelbaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and other Health Professionals* (Oxford University Press, 1998) quoted in Paul Biegler and Cameron Stewart, 'A primer on the law of competence to refuse medical treatment' (2004) 78 *Australian Law Journal* 325, 342.

[30] See also Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2271–2, 2286–7.

Recommendation 7: that DVAC consider adopting a rule that social workers will not work with children aged 10 or below without the consent of a parent.

Recommendation 8: that DVAC consider whether it is willing to bear the risks of allowing the rule in recommendation 8 to be rebutted in exceptional cases.

Recommendation 9: that DVAC consider adopting a more rigorous assessment of capacity for children aged 14 or below.

Recommendation 10: that DVAC consider adopting a less rigorous assessment of capacity for children aged 15 and above, unless the social worker has reason to believe the child may not in fact be competent.

5 *Consent to enter a confidential relationship*

Some commentators have made a distinction between a child's capacity to consent to receive counselling and support services and a child's capacity to give information in confidence.[31] The distinction between the two is that counselling includes not only the receipt of confidential information, but also activities such as providing advice to the client and asking questions of the client to uncover more information. A relationship of confidence, on the other hand, involves only one party giving confidential information to the other.[32] This relationship does not necessarily involve the extra activities involved in the provision of counselling services. For example, a child could, without the solicitation of the adult, confide information in that adult. If the child has the capacity to enter into a confidential relationship, then that adult would be bound to keep that information in confidence irrespective of whether that adult is also acting as a counsellor for the child.

Bartholomew describes the capacity of a child to consent to a confidential relationship as follows:

> A non-competent child has this capacity when she or he is in a position to give rise to a confidential relationship (i.e. discloses information … in private) and is of sufficient understanding and intelligence to understand the nature of the relationship of confidence.[33]

The NCYLC also suggests that an understanding of the risks and benefits of a confidential relationship might be necessary for a child to be capable of entering into such a relationship. This could include an understanding of limitations to the relationship, such as when the recipient will or must breach confidence, and also an understanding of alternatives to confiding the information in the recipient.[34]

There is little research on capacity to enter a confidential relationship specifically. Research has, however, been conducted into children's understanding of secrets,[35] which is one aspect of a confidential relationship. This research suggests that children aged 9 to 12 are beginning to understand the 'contextual and conditional nature of secrets'.[36]

As with consent to receive medical treatment or counselling, capacity to enter into a confidential relationship will vary from child to child and no bright-line rule can be used. Nevertheless, it is useful to note that even though a social worker may ultimately deem a child to be incapable of providing his or her own consent to counselling, the social worker may still be obligated to keep confidential information already given by the child.

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[31] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 40–2, 47.
[32] The elements of a relationship of confidence and an action for breach of confidence are outlined below.
[33] Terence Bartholomew, *Minors, Competency and Confidentiality: A Guide for General Practitioners* (Young People and Informed Consent Project, 2001) 16.
[34] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 20.
[35] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 21–2.
[36] National Children's and Youth Law Centre, *Counsellors and Their Child Clients* (2004) 22.

Recommendation 11: that DVAC also assess a child's capacity to enter a confidential relationship, particularly where the child is assessed as incapable of consenting to receive counselling and support services but has already given person information to a social worker.

6 *Lack of capacity*

Where a child lacks the capacity to give informed consent, the law ordinarily regards the parent of the child as being the person in the best position to act in the best interests of the child.[37] However, in *Marion's case*, the High Court held that '[t]he overriding criterion of the child's best interests is itself a limit on parental power'.[38] What is in the best interests of the child is to be determined objectively, and may not necessarily coincide with the wishes of the parent. Where there is a dispute between a parent and another party about what is in the best interests of the child, it is possible for a court to side with the other party. This is particularly important in medical contexts where, for example, the parents of a child might refuse to consent to the child undergoing surgery to save their life. The possibility of a legal dispute over the refusal to allow a child to receive counselling and support services is more difficult to imagine because the consequences of failing to receive these services are likely to be less severe than the consequences of failure to undergo surgery.

Recommendation 12: that DVAC generally defer to the wishes of parents when dealing with children who lack to the capacity to consent to undergo counselling and support services (subject to obligations of confidentiality arising from a possible relationship of confidence with the child).

Recommendation 13: that DVAC seek legal advice if it believes that a parent's refusal to allow a child lacking capacity to receive counselling and support will cause serious harm to the child.

Recommendation 14: that DVAC refrain from disclosing personal information to a parent where a child has been assessed as capable of entering a confidential relationship and has not consented to the disclosure of personal information to the parent, even if the child has been assessed as lacking capacity to receive counselling and support services.

Recommendation 15: that where a child is assessed as being incapable of entering a confidential relationship, DVAC disclose to a parent personal information given by the child to a social worker where DVAC believes that this would be in the best interests of the child.

B *Confidentiality and Disclosure*

1 *Privacy legislation*

On 12 March 2014, a new regime of 'Australian Privacy Principles' came into effect, following the amendment of the *Privacy Act 1988* (Cth) ('*Privacy Act*').[39] This section of the report firstly examines whether organisations such as DVAC are bound by the Australian Privacy Principles. Secondly, the content of obligations for entities bound by these principles is discussed. Finally, the consequences for potential breach of these principles are noted.

(a) *Application of the Australian Privacy Principles*

According to section 15 of the *Privacy Act*, 'APP entities' must comply with the Australian Privacy Principles. Section 6 of the Act defines an 'APP entity' as an 'agency' or 'organisation'. 'Agency' is further defined in section 6 as one of a number of public bodies and public officers not relevant to private counsellors. More relevantly, 'organisation' is defined in section 6C(1) as meaning:

[37] See Queensland Law Reform Commission, *Consent to Medical Treatment of Young People*, Discussion Paper No 44 (1995) 34–5.
[38] (1992) 175 CLR 218, 240.
[39] Amended by the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth).

(a) an individual; or
(b) a body corporate; or
(c) a partnership; or
(d) any other unincorporated association; or
(e) a trust;

that is not a small business operator, a registered political party, an agency, a State or Territory authority or a prescribed instrumentality of a State or Territory.

The important part of this section in the present context is that the section provides that, subject to important exceptions outlined below, the general rule is that small business operators are exempt from the application of the Australian Privacy Principles.

Section 6D(3) of the *Privacy Act* then defines a 'small business operator' as:

an individual, body corporate, partnership, unincorporated association or trust that:

(a) carries on one or more small businesses; and
(b) does not carry on a business that is not a small business.

Section 6D(1) of the *Privacy Act* provides that:

A business is a ***small business*** at a time (the ***test time***) in a financial year (the ***current year***) if its annual turnover for the previous financial year is $3,000,000 or less.

Section 6D(4) then contains a number of exceptions to the general rule that small business operators are exempt from the Australian Privacy Principles by excluding certain parties from the definition of 'small business operator'. Importantly, section 6D(4)(b) provides that

an individual, body corporate, partnership, unincorporated association or trust is not a ***small business operator*** if he, she or it … provides a health service to another and holds any health information except in an employee record;

Section 6FB(1) provides that:

An activity performed in relation to an individual is a ***health service*** if the activity is intended or claimed (expressly or otherwise) by the individual or the person performing it:

(a) to assess, maintain or improve the individual's health; or
(b) where the individual's health cannot be maintained or improved—to manage the individual's health; or
(c) to diagnose the individual's illness, disability or injury; or
(d) to treat the individual's illness, disability or injury or suspected illness, disability or injury; or
(e) to record the individual's health for the purposes of assessing, maintaining, improving or managing the individual's health.

Section 6FB(3)(a) then provides that, 'to avoid doubt … a reference in this section to an individual's health includes the individual's physical or psychological health'.

Section 6FA provides that 'health information' includes:

(a) information or an opinion about:
  (i) the health, including an illness, disability or injury, (at any time) of an individual; or
  (ii) an individual's expressed wishes about the future provision of health services to the individual; or
  (iii) a health service provided, or to be provided, to an individual;

  that is also personal information;

(b) other information collected to provide, or in providing, a health service to an individual;

  […]

It is arguable, but far from clear, that some of the counselling services provided by DVAC might meet the definition of 'health service' in section 6FB. These services might be considered to be an activity intended to 'assess, maintain or improve' an individual's psychological health. The consequence of

this would be that organisations like DVAC would be bound by the Australian Privacy Principles, notwithstanding the fact that they may otherwise meet the definition of 'small business operator'.

The express reference to psychological health in section 6FB(3)(a) was included as part of changes to the definitions of 'health service' and 'health information' introduced by the *Health Legislation Amendment (eHealth) Act 2015* (Cth). The explanatory memorandum of this bill sheds some light upon the intention of the Commonwealth Parliament in making the changes to these definitions.[40] These changes were made in response to recommendations made by the Australian Law Reform Commission (ALRC) in 2008.[41] The ALRC identified a number of ambiguities in the previous definitions – principally ambiguities relating to the provision of palliative care and aged care services – and recommended changes be made to resolve these ambiguities. The ALRC did not expressly discuss ambiguities relating to the provision of counselling and other mental health services, but recommended that the definition of 'health service' be amended to include, among other services:

> (a) an activity performed in relation to an individual that is intended or claimed (expressly or otherwise) by the individual or the service provider to:
>
> (i) assess, predict, maintain or improve the individual's physical, mental or psychological health or status;
>
> […]

The ALRC's recommended definition differs from the new definition of 'health service' in section 6FB in two key respects. Firstly, the ALRC's recommended definition refers to an individual's 'physical, mental or psychological health', whereas section 6FB(3) states that 'health' includes an individual's 'physical or psychological health'. The omission of a reference to mental health in this definition may be significant. In its submission to the ALRC's inquiry, the New South Wales Department of Health argued that 'psychological health' was a narrower concept which was subsumed in the broader term 'mental health'.[42] The ALRC noted that:

> while there is overlap between the terms mental health and psychological health, there are also distinctions drawn between these two areas. For example, the Australian Psychological Society draws a distinction between the work of psychologists, who 'help mentally healthy people find ways of functioning better', and psychiatrists, who 'mainly treat people with mental illness, such as schizophrenia'. It is important, therefore, to include both mental and psychological health in the definition. The *Privacy Act* should be amended to make clear that 'health information' includes information in relation to physical, mental or psychological health. It is preferable to clarify the point by amendment, rather than wait for the issue to arise in the context of a complaint.[43]

The exact difference between the meanings of 'psychological health' and 'mental health' is unclear, but it could be the case that psychological health services do not embrace counselling services provided by social workers. On the other hand, the wording of section 6FB(3) is inclusive and does not necessarily preclude the meaning of 'health' in section 6FB from including mental health. The inclusion of a provision clarifying that the term 'health' includes physical, psychological and mental health was regarded as unnecessary by the Commonwealth Department of Health and Ageing because it regarded these concepts as plainly being included in the ordinary meaning of the word.[44] This was

[40] Explanatory Memorandum, Health Legislation Amendment (eHealth) Bill 2015 (Cth) 104–5. See also Amanda Biggs, Leah Ferris and Juli Tomaras, *Health Legislation Amendment (eHealth) Bill 2015*, No 41 of 2015–16, 9 November 2015, 25.

[41] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2058–69.

[42] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2061.

[43] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2062 (citations omitted).

[44] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2060.

also the view of the Office of the Privacy Commissioner.[45] Nevertheless, now that such a provision has been introduced into the legislation, the omission of a reference to mental health is conspicuous.

The second key difference between the ALRC's recommended definition and the new definition of 'health service' in section 6FB is that the ALRC's recommended definition referred to 'physical, mental or psychological *health or status*' whereas the definition in section 6FB refers only to 'health'. The decision to use a narrower definition in the *Privacy Act* may be indicative of a legislative intention to exclude counselling services from the definition of health services, but this is also far from clear.

Neither the explanatory memorandum to the amending legislation nor the official Commonwealth Government response to the ALRC's findings explain why the Commonwealth Parliament departed from the ALRC's wording on these points.[46] It remains unclear whether counselling services attract the application of the Australian Privacy Principles.

(b) *The Australian Privacy Principles*

In this section, some of the main obligations under the Australian Privacy Principles are briefly outlined. This section proceeds on the assumption that these principles do apply to organisations like DVAC, although this may not necessarily be the case, as explained above.

The Australian Privacy Principles are located in schedule 1 of the *Privacy Act.*[47] They are also reproduced on the website of the Office of the Australian Information Commissioner.[48]
Principle 1.3 provides that:

> An APP entity must have a clearly expressed and up to date policy (the ***APP privacy policy***) about the management of personal information by the entity.

Further information on the types of information that an APP privacy policy must contain are outlined in principle 1.4.

Under principle 5, an APP entity (in this case, DVAC) must take reasonable steps to notify an individual at or before the time of collection of personal information or, if this is not practicable, as soon as practicable afterward, of particular matters. These matters include the purposes for which the APP entity collects the information, the identity and contact details of the APP entity, any other APP entities to which this information is usually disclosed, that the APP entity's APP privacy policy contains information about how the individual may access and correct person information held by the entity, and that the APP privacy policy contains information about how the individual may complain about a breach of the Australian Privacy Principles and how such complaints will be dealt with.

Principle 6.1 provides that:

> If an APP entity holds personal information about an individual that was collected for a particular purpose (the primary purpose), the entity must not use or disclose the information for another purpose (the secondary purpose) unless:
>
> a. the individual has consented to the use or disclosure of the information; or
> b. the subclause 6.2 or 6.3 applies in relation to the use or disclosure of the information

[45] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2060.
[46] Explanatory Memorandum, Health Legislation Amendment (eHealth) Bill 2015 (Cth) 104–5; Australian Government, *Enhancing National Privacy Protection*, First Stage Response to the Australian Law Reform Commission Report No 108 (2009) 132.
[47] *Privacy Act 1988* (Cth), available at <http://www.austlii.edu.au/au/legis/cth/consol_act/pa1988108/sch1.html>.
[48] Office of the Australian Information Commissioner, *Privacy fact sheet 17: Australian Privacy Principles* (January 2014) <https://www.oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles>.

Further situations in which an APP entity can disclose personal information are outlined in principles 6.2 and 6.3. Notably, paragraph (e) of principle 6.2 provides that an APP entity can disclose personal information if:

> the APP entity reasonably believes that the use or disclosure of the information is reasonably necessary for one or more enforcement related activities conduct by, or on behalf of, an enforcement body.

Paragraph (c) incorporates a number of further situations in which personal information can be disclosed located in section 16A of the *Privacy Act*, including that personal information may be disclosed where the APP entity reasonably believes that this is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety, and in the circumstances it is unreasonable or impracticable to obtain the individual's consent to the disclosure of the information.

Individuals are provided with a general right to access personal information in principle 12.1:

> If an APP entity holds personal information about an individual, the entity must, on request by the individual, give the individual access to the information.

Some exceptions applicable to organisations are set out in principle 12.3. Principle 11.1 provides that:

> If an APP entity holds personal information, the entity must take such steps as are reasonable in the circumstances to protect the information:
>
> a. from misuse, interference and loss; and
> b. from unauthorised access, modification or disclosure.

Principle 11.2 outlines the circumstances where an APP entity must destroy or de-identify personal information:

> If:
>
> a. an APP entity holds personal information about an individual; and
> b. the entity no longer needs the information for any purpose for which the information may be used or disclosed by the entity under this Schedule; and
> c. the information is not contained in a Commonwealth record; and
> d. the entity is not required by or under an Australian law, or a court/tribunal order, to retain the information;
>
> the entity must take such steps as are reasonable in the circumstances to destroy the information or to ensure that the information is de-identified.

(c) *Consequences of breach of the Australian Privacy Principles*

If an APP entity is in breach of the Australian Privacy Principles, an individual can make a complaint to the Office of the Australian Information Commissioner (OAIC). The OAIC may then commence an investigation into the complaint. The OAIC also has the power to commence investigations on his or her own initiative.

The OAIC resolves the majority of complaints by conciliating an outcome between the parties.[49] Conciliated resolutions could include:

- taking steps to address the matter such as providing access to personal information or amending records;
- an apology;
- a change to the APP entity's practices or procedures
- staff training
- compensation for financial or non-financial loss[50]

[49] Office of the Australian Information Commissioner, *What happens to my complaint* <https://www.oaic.gov.au/individuals/what-happens-to-my-complaint>.
[50] Office of the Australian Information Commissioner, *What happens to my complaint* <https://www.oaic.gov.au/individuals/what-happens-to-my-complaint>.

The OAIC may also accept an undertaking from the APP entity to do, or stop doing, a particular thing so that they do not breach the *Privacy Act*. In serious cases, the OAIC may seek a civil penalty order (similar to a fine) against an APP entity for breach of the Australian Privacy Principles.

Recommendation 16: that DVAC examine the extent to which its privacy policy and practices are compliant with the Australian Privacy Principles, including principles not quoted in this report.

Recommendation 17: if DVAC's privacy policy and practices are not compliant with the Australian Privacy Principles, then DVAC should either:
(a) change its privacy policy and practices to be compliant;
(b) seek legal advice as to whether it is in fact bound by these principles; or
(c) choose to accept the risk of liability, weighing up likelihood of being bound by the principles, the extent to which DVAC does not comply with the principles, and the consequences of breach.

2 *Equitable duty of confidence*

(a) *Elements of an action for breach of confidence*

Obligations of confidentiality can also arise under what is known as the equitable duty of confidence. In *Coco v AN Clark (Engineers) Ltd*,[51] Justice Megarry held that there were two elements of this duty:

(1) The information imparted was confidential in nature
(2) The information was imparted in circumstances implying an obligation of confidence

There is no fixed list of categories of information that could be considered confidential in nature, however the main types of information that are usually considered confidential are commercial information, government information, and personal information. In the context of counselling, personal information is clearly the type of information that a counsellor might receive and be under an obligation to keep confidential. Examples of types of personal information which have successfully been relied upon in an action for breach of confidence include:

- Extracts from personal diaries (*Prince of Wales v Associated Newspapers*)[52]
- Private etchings made by Prince Albert and Queen Victoria (*Prince Albert v Strange*)[53]
- Details of group therapy for drug addiction (*Campbell v Mirror Group Newspapers*)[54]
- Details of sexual preference and activity (*Stephens v Avery*;[55] *Giller v Procopets*)[56]

These examples are provided as an indication only and it is not suggested that the concept of 'personal information' is limited to these particular types of personal information.

With respect to Justice Megarry's second element, information will be imparted in circumstances implying an obligation of confidence if the circumstances would lead a reasonable person to believe that the information was being communicated in confidence. In *Ansell Rubber Co v Allied Rubber Industries* Gowans J explained further that this obligation:

> may come into existence by reason of the terms of an agreement, or what is implicit in them, by reason of the nature of the relationship between persons or by reason of the subject-matter and the circumstances in which the subject-matter has come into the hands of the person charged with the breach.[57]

[51] [1969] RPC 41, 47. See also *Commonwealth v John Fairfax and Sons Ltd* (1980) 147 CLR 39, 51 where this test was approved by Mason J.
[52] [2008] Ch 57.
[53] (1849) 47 ER 1302.
[54] [2004] 2 AC 457.
[55] [1988] Ch 449.
[56] [2008] VSCA 236.
[57] *Ansell Rubber Co Pty Ltd v Allied Rubber Industries Pty Ltd* [1967] VR 37, 41.

The test of whether information is imparted in circumstances implying an obligation of confidence is an objective test in the sense that it does not depend on whether the recipient actually knew that the information was being communicated in confidence. Rather, it involves considering what a hypothetical 'reasonable person' would have thought in the position of the recipient.

Recommendation 18: that, subject to certain circumstances of public interest, DVAC only disclose confidential information to a third party with the consent of the client.

If these two elements are met, then the recipient of the information comes under a duty to keep the information confidential. For a successful lawsuit for breach of this duty, a plaintiff must also prove a third element:

(3) Unauthorised use or disclosure of the information

Use and disclosure of information obtained in confidence is limited to the purpose for which the information was provided (*Elliott v Ivey*).[58] If the information is used or disclosed for some other purpose, then there will be a breach of the duty.

Clearly, if the client has given their informed consent to the use or disclosure of information, then this will not be unauthorised. If the client's consent to disclose particular information is sufficiently broad, then it might also be the case that no duty of confidence applies at all. If the client made it clear that the information could be communicated to the world at large, then the information would not have been imparted in circumstances implying a duty of confidence (that is, element 2 would not be met).

(b) *Public interest defence*

The main defence which may be available in an action for breach of confidence is the defence of public interest. In the UK, a defendant can defeat a claim for breach of confidence by proving that disclosure of the information was in the public interest.[59] It appears, however, that the mere fact that there is some public interest in the disclosure of the information does not give a defendant a *carte blanche* to disclose the information as they please. The case of *Francome v Mirror Newspapers* is an example of this.[60] In this case the defendant sought to publish in its newspaper details of illegally-recorded phone conversations involving the plaintiff which implicated the plaintiff in a number of criminal offences. The Court of Appeal of England and Wales held that it was 'impossible to see what public interest would be served by publishing the contents of the tapes which would not equally be served by giving them to the police'.[61] Accordingly, it appears that when considering whether the defence ought to be available to a defendant, a court may consider whether the disclosure was to the appropriate person. For example, if a client disclosed in confidence information which led a counsellor to believe that the client might harm another person, the counsellor would likely have the protection of the public interest if they disclosed this information to the police but it would be more difficult to establish the defence if the counsellor disclosed the information to the media instead.

In any event, there is some doubt as to the status of the public interest defence in Australia. In *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)*, Justice Gummow took the view that there was no such 'defence' in Australia, but rather than information which relates to particular matters of public importance will lack the necessary quality of confidence to form the basis of an action for breach of confidence.[62] Justice Gummow held that, the principle:

> is no wider than one that information will lack the necessary attribute of confidence if the subject matter is the existence or real likelihood of the existence of an iniquity in the sense of a crime, civil

[58] [1998] NSWC 116 [9].
[59] *Lion Laboratories v Evans* [1984] 2 All ER 417. See also Queensland Law Reform Commission, *Consent to Medical Treatment of Young People*, Discussion Paper No 44 (1995) 44–5.
[60] [1984] 1 WLR 892.
[61] [1984] 1 WLR 892, 898.
[62] (1987) 14 FCR 434.

> wrong or serious misdeed of public importance, and the confidence is relied upon to prevent disclosure to a third party with a real and direct interest in redressing such crime, wrong or misdeed.[63]

On this view (which may or may not represent the law in Australia – it is unclear), a counsellor would not be liable for breach of confidence if they disclosed the existence or real likelihood of the existence of a crime, civil wrong or serious misdeed of public importance to a party with a real and direct interest in redressing the crime, wrong or misdeed. This category of parties would likely include, but may not be limited to, police and other government authorities.

Recommendation 19: that the DVAC only disclose personal information given to it in confidence without the consent of the client if the information relates to the existence or real likelihood of the existence of a crime, civil wrong, or serious misdeed of public importance, and the disclosure is made to a party with a real and direct interest in redressing the crime, wrong or misdeed.

(c) *Remedies for breach of confidence*

Upon a successful suit for breach of confidence, a plaintiff may obtain an injunction against the defendant to prevent further disclosure of the information. They may also obtain an order for money amounting to either the profit made by the defendant from the breach of disclosure (an 'account of profits') or the loss suffered by the plaintiff ('equitable compensation').

The remedy of an account of profits is likely to be of less relevance to organisations such as the DVAC because of the type of confidential information dealt with by the DVAC. Many of the cases in which an account of profits is sought by a plaintiff involve information of a commercial value that the plaintiff is seeking to prevent the defendant from profiting from. Many of the leading cases relating to the disclosure of personal information involve a celebrity as plaintiff seeking to prevent a tabloid newspaper from profiting from the publication of personal information about them. In contrast to these cases, it is difficult to envisage a situation in which the DVAC would receive a financial profit from the unauthorised use or disclosure of personal information about a client.

It is more likely that if the DVAC were to be sued for breach of confidence, it would involve a plaintiff seeking to obtain equitable compensation for harm that they have suffered as a result of the unauthorised use or disclosure of their personal information. This could be difficult to assess.[64] In an extreme case, this might involve a plaintiff seeking to recover damages for psychiatric harm brought about by the unauthorised use or disclosure. We were unable to find any cases dealing with equitable compensation for psychiatric harm in Australia. However, in two cases judges have assumed that such compensation is available to plaintiffs,[65] as is the position in the UK.[66] Financial losses caused by psychiatric harm could include medical expenses and loss of income consequent on the psychiatric harm. We do not intend to overstate the likelihood of such harm occurring to a client – clearly, in the majority of cases clients would not sustain serious psychiatric harm from the use or disclosure of confidential information – we mean only to highlight the possibility of liability for such harm in extreme cases.

In Australia, the law is not entirely clear on whether equitable compensation is available for emotional distress which falls short of the plaintiff suffering actual psychiatric harm.[67] In the case of *Giller v*

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[63] (1987) 14 FCR 434, 450.

[64] David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 2.

[65] *Giller v Procopets* (2008) 24 VR 1; *Wilson v Ferguson* [2015] WASC 15 (16 January 2015). In both of these cases judges consider whether equitable compensation is available for mental distress not amounting to psychiatric harm. It appears to be the assumption of these judges that the availability of equitable compensation for psychiatric harm is not controversial.

[66] *Wainright v Home Office* [2004] 2 AC 406.

[67] *Giller v Procopets* (2008) 24 VR 1, 99; Australian Law Reform Commission, *Serious Invasions of Privacy in the Digital Era*, Report No 123 (2014) 268.

Procopets,[68] the Victorian Court of Appeal unanimously allowed the plaintiff to obtain equitable compensation for emotional distress arising from a breach of confidence. In 2014 the Australian Law Reform Commission regarded the availability of equitable compensation for emotional distress as lacking sufficient clarity and recommended that the matter be clarified by legislation.[69] Since this report, however, the decision in *Giller v Procopets* has also been followed by Justice Mitchell of the Supreme Court of Western Australia in *Wilson v Ferguson*.[70]

The award of equitable compensation in *Giller v Procopets* was $40,000 but it is worth noting that the breach of confidence in this case was more extreme than would likely be involved in any case involving the DVAC. Ms Giller and Mr Procopets had been in a relationship together, and upon the termination of the relationship, Mr Procopets sent several videotapes depicting sexual activity between the parties to Ms Giller's family and friends. Similarly, in *Wilson v Ferguson* the plaintiff was awarded $35,000 for the defendant's intentional publication of sexual photographs and videos of the plaintiff to his Facebook profile. It is likely that, in any reasonably conceivable case of breach of confidence against the DVAC, the DVAC's liability for compensation would be much less than these figures for two reasons. Firstly, the nature of the personal information dealt with by the DVAC has less of a tendency to cause emotional distress than the material involved in these cases. Secondly, these cases involved breaches of confidence intended to cause emotional distress to the plaintiffs and the awards of equitable compensation were aggravated accordingly.

A recent publication by a law firm in Sydney recommends schools transfer the risk for breach of confidence by ensuring that it is covered in the school's insurance policy.[71]

Recommendation 20: the DVAC investigate whether its current insurance policy covers liability for breach of confidence and, if not, enquire about the costs of including such cover.

3 *Fiduciary duties*

Fiduciary duties are another potential source of legal obligations for social workers. Fiduciary duties are obligations of loyalty owed by one person (the fiduciary) to another (the principal). The classic fiduciary relationship is that of trustee and beneficiary, and the other relationships which have come to be recognised as fiduciary in nature bear some resemblance to the relationship of trustee and beneficiary.

In essence, a fiduciary is a person who, by reason of their power in their relationship with the principal, has the power to exercise discretions on behalf of the other party in a way that has the capacity to affect that other party's interests. Trustees have an obligation to act in the interests of the beneficiaries of a trust. Fiduciary duties exist to prevent trustees and other fiduciaries from acting in their own interests instead of the interests of the principal.

A relationship can be found by a court to be fiduciary in two ways. Some types of relationships are always fiduciary in nature ('presumed fiduciary relationships'). Trustee and beneficiary is the classic example of this, but solicitor and client is another common example. The other way is for the specific relationship between the two parties to be found to be fiduciary in nature ('actual fiduciary relationships').[72]

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[68] *Giller v Procopets* (2008) 24 VR 1.
[69] Australian Law Reform Commission, *Serious Invasions of Privacy in the Digital Era*, Report No 123 (2014) 269–270.
[70] [2015] WASC 15 (16 January 2015).
[71] David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 2.
[72] See *Hospital Products v United States Surgical Corporation* (1984) 156 CLR 41.

Social workers and clients are not a recognised category of presumed fiduciary relationships, but agent and principal are.[73] In the course of providing usual counselling and support services, social workers would not fall under fiduciary obligations. However, if a social worker stepped beyond their usual support services and started to make important decisions on behalf of the child as a quasi-agent, the relationship might become imbued with fiduciary obligations. It should be stressed that the actions made on behalf of the child would have to be quite significant for this fiduciary relationship to be recognised. Fiduciary obligations are very onerous and courts are reluctant to impose them. Fiduciary obligations would not arise from the usual activities of social workers. Because of the unlikelihood of these duties arising for social workers, the content of the duties is not further examined in this report.

Recommendation 21: that the DVAC take care when providing support services to children to ensure that the DVAC is assisting the child with making or carrying out his or her own decisions and not making significant legal decisions on behalf of the child.

4 *Negligence*

Negligence is a large area of law and a full examination of potential liabilities for negligence is beyond the scope of this report. Instead, this report will briefly consider one possible application of the law of negligence to counsellors: failure to disclose information about intended crimes. In one Californian case, a psychologist was successfully sued for failure to warn that the client planned to kill his girlfriend.[74] The psychologist reported this to the police but not to the woman or her parents. However, it has been widely doubted that Australian law would go so far as to impose a duty to warn in these circumstances.[75] Rather, it is argued that Australian law would follow the approaches taken in the UK and Canada, which permit disclosure in breach of confidentiality in these circumstances, not mandate it.[76] The position from these cases is that disclosure is permitted where:

(a) there is a clear risk to an identifiable person or group of persons;
(b) the risk is of serious bodily harm or death; and
(c) the danger is imminent.[77]

Recommendation 22: that the DVAC consider disclosure in breach of confidence to relevant parties where there is a clear risk of serious bodily harm or death to an identifiable person or group of persons and the danger is imminent.

Recommendation 23: that the DVAC conduct further research on other potential areas of liability in negligence if this a concern to the organisation.

5 *Contractual obligations*

The DVAC should be aware that obligations to disclose information received in the course of counselling may arise under contractual relationships that DVAC has entered into. Three potential sources of contractual obligations should be considered:

- Contracts between DVAC and schools
- Contracts between DVAC and donors
- Contracts between private schools and parents

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[73] *Hospital Products v United States Surgical Corporation* (1984) 156 CLR 41, 141.
[74] *Tarasoff v The Regent of the University of California* (1976) 131 Cal Rptr 14.
[75] See, eg, David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 10–11.
[76] See *W v Egdell*[1990] 1 All ER 835; *Smith v Jones* [1999] 1 SCR 455.
[77] David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 11.

Before each of these contracts is considered, a quick overview will be provided of the essential elements of a contract.

(a) *Elements of a contract*

A contract is a legally enforceable agreement between two parties. A contract involves the exchange of promises that, if breached, entitle the other party to a legal remedy. For there to be a legally binding contract there must be:

- Agreement between the parties (offer and acceptance)
- Intention to create legal relations
- Something of value given in return for the promise ('consideration')
- Certainty of essential terms

(b) *Contracts between DVAC and schools*

It is conceivable that a school may want to enter into a written agreement with the DVAC before the DVAC provides counselling and support services to students and that, as part of that agreement, the school requires the DVAC to disclose to the principal or school counsellors particular types of information received in the course of providing counselling services to students (e.g. information about domestic violence witnessed or self-harm). This would be problematic to the DVAC because it could place the DVAC's obligations of confidentiality to the student in conflict with its contractual obligations to the school.

It is suggested that the legal validity of such an agreement would largely depend upon whether there was valid 'consideration' for the contract. As mentioned above, for there to be a valid contract, something of value must be given in return for the 'promise' to which the contract relates. In this situation, the 'promise' of the DVAC would be for a social worker to attend the school and provide counselling and support services to students. However, if the school has not paid the DVAC for this service, then it is difficult to see what 'thing of value' the school is giving in exchange for these services. Consideration need not be monetary, and it need not represent the value of the services given (a payment of $1 or a Mars bar would be sufficient), but there must be *something* of value given or else the contract will not be valid.

It should be noted that just because an agreement is oral does not mean it cannot be an enforceable contract. However, oral agreements are generally more difficult to prove in court. The party alleging the contract would find it more difficult to prove that the parties had agreed upon the terms of the contract (in particular, any obligations of disclosure) and that the parties had intended to create legal relations with each other.

As such, if the DVAC continues to provide its counselling and support services to students in schools under no written agreement and in exchange for no money or other benefit from the school, then it is suggested that the DVAC will owe no contractual obligations to the school to disclose any information received in the course of counselling students.

Recommendation 24: that the DVAC consider the possibility of conflicts with obligations of confidentiality to students before agreeing to any contracts with schools that require disclosure of personal information about students to the school administration.

(c) *Contracts between DVAC and donors*

If there are any conditions attached to funding received by the DVAC which include obligations of disclosure then these too could come into conflict with obligations of confidentiality to clients. This conflict could arise if, for example, the DVAC received funding from a government body which required reporting of particular information about clients to that or another government body.

(d) *Contracts between private schools and parents*

In the context of private schools, contracts between parents and guardians of students and the school may affect the school's disclosure obligations. Parents may feel that under the terms of their contract with the school, they are entitled to information about their child's counselling.[78] However, any privacy policy contained in a contract between a private school and a parent must be consistent with the privacy principles contained in the *Privacy Act 1988* (Cth).[79] A contract with a parent cannot override the school's obligations of privacy and confidentiality to the student.[80]

With respect to the position of the DVAC, as the DVAC's social workers are not employees of the schools they provide counselling to, contracts between parents and the school cannot be enforced against them. Contracts are only binding against those who are party to the contract.

6 *Reporting of child abuse*

Under mandatory reporting legislation, certain classes of people come under obligations to report suspected cases of child abuse and neglect to government authorities. These obligations may require breach of a child's confidentiality to do so.[81] Queensland's provisions are contained in the *Child Protection Act 1999* (Qld). These provisions were amended in 2014 and many online resources outlining these obligations are out of date.

Social workers do not fall under the mandatory reporting regime. The effect of sections 13B and 13E of the *Child Protection Act 1999* (Qld) is that the only persons subject to mandatory reporting obligations are:

(a) a doctor;
(b) a registered nurse;
(c) a teacher
(d) a police officer who, under a direction given by the commissioner of the police service under the *Police Service Administration Act 1990*, is responsible for reporting under this section
(e) a person engaged to perform a child advocate function under the *Public Guardian Act 2014*.

While social workers are not under mandatory reporting obligations, they may still choose to report suspected child abuse or neglect to the Department of Communities, Child Safety and Disability Services.[82] Reporters of suspected child abuse are protected from civil and criminal liability for information given to the Department honestly and reasonably.[83] They are also protected from findings that they have breached any professional codes of conduct.[84]

Recommendation 25: that, as part of DVAC's risk assessment procedures, DVAC report the possibility of child abuse to the Department of Communities, Child Safety and Disability Services if it is of the opinion that this would be in the best of interests of the child and not be more harmful than to the child than some other strategy.

7 *Concluding remarks on confidentiality and disclosure*

An understanding of confidentiality and its limitations is an important aspect of obtaining informed consent from a child to enter into a confidential relationship and receive counselling and support

[78] See David Ford and Nathan Croot, *School Counsellors, Privacy and Confidentiality* (Emil Ford Lawyers, 8 October 2014) <http://www.emilford.com.au/imagesDB/wysiwyg/SchoolCounsellorsprivacyandconfidentiality2014_1.pdf> 13.
[79] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report No 108 (2008) 2308, 2315.
[80] Ibid.
[81] *Child Safety Act 1999* (Qld) s 197A(4).
[82] *Child Safety Act 1999* (Qld) s 13A.
[83] *Child Safety Act 1999* (Qld) s 13D, 197A.
[84] *Child Safety Act 1999* (Qld) s 13D, 197A.

services. As such, it important to provide information to children from the outset about circumstances where the social worker may or must breach confidentiality. The above sections have attempted to provide an overview of the main of the main exceptions to confidentiality and obligations of disclosure that social workers may come under.

Recommendation 26: that domestic violence workers inform children of their rights to confidentiality and the limits to these rights as part of the process of obtaining informed consent, reminding children of these rights and limitations as necessary in the process of providing counselling and support services.

Recommendation 27: that DVAC take care in developing an approach to informing children about the limitations to confidentiality that balances the child's right to be informed about these limitations with the concern that a child may be dissuaded from using counselling services if they are worried about the disclosure of their personal information.

IV RIGHTS OF CHILDREN UNDER INTERNATIONAL LAW

1 *Relevance of international law*

The rights of children are protected under international law because of children's vulnerability to exploitation and abuse. However, under the Australian legal system, international treaties are not automatically binding on Australian people or on federal or state and territory governments. International treaties must first be transposed into Australian domestic law before they take effect. The force of the legal rules then comes from the domestic laws transposing the international law, not the international law itself.

Nevertheless, international law is important because it shapes the interpretation of Australian laws. When there is ambiguity and judges are asked to interpret the law, judges will favour an interpretation that is consistent with international law over one that is not. Furthermore, international law on the rights of children is important for its aspirational value, outlining the rights of children which parties dealing with children should uphold. While international law is not binding on organisations such as DVAC, the rights enunciated in international treaties are helpful in guiding the development of policies towards working with children.

2 *The Convention on the Rights of the Child*

The main international treaty on children's rights is the *Convention on the Rights of the Child* (CRC).[85] Article 3 of the CRC sets out one of the convention's guiding principles:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

One of the key provisions of this treaty is Article 12, which provides that:

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

In keeping with this view, much of the available literature recommends involving young people in decision-making on matters such as healthcare and counselling even if the child is not yet capable of providing informed consent themselves.[86] Just because a child is not yet *Gillick* competent, this does not mean that their wishes should be ignored. In addition to respect for children's rights, involving

[85] Opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).
[86] See, eg, Queensland Law Reform Commission, *Consent to Medical Treatment of Young People*, Discussion Paper No 44 (1995) 60

young people in their health-care decisions has also been argued to be beneficial for their development.[87]

At the same time, the CRC recognises the role of parents in raising their children:

> States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.[88]

Another provision relevant in the context of counselling is Article 16 which provides that:

> No child shall be subject to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation … The child has the right to the protection of the law against such interference or attacks.

Recommendation 28: that DVAC allow children not yet capable of providing their own consent in matters affecting them to express their views and be taken into account in the decision-making process, so far as is possible.

Recommendation 29: that the policies of DVAC reflect the acknowledgement of respect for the rights of parents contained in Article 5 of the *Convention on the Rights of the Child*.

V BEST PRACTICE GUIDELINES

1 *APACS Code of Ethics*

The Australian Psychologists and Counsellors in Schools Association (APACS), formerly known as the Australian Guidance and Counselling Association (AGCA), has a code of ethics intended to guide counsellors working with children.[89] The introduction to this code notes that while the code is specifically for members of the association, 'it is hoped that it will serve to provide guidelines for the practice and conduct of all individuals employed in the fields of guidance and counselling, in education settings around Australia'.[90] It is also noted that '[t]he intent of this code is not to be restrictive, nor punitive, but to encourage members to reflect upon their practice and to strive for higher levels'.[91]

The code is divided into two sections, one on professional standards and one on professional practices. A number of excerpts from the code related to working with children are included in the following paragraphs and are organised by topic.

(a) *Guiding principles*

Section I(B)(1) of the division on professional practices states that:

> Members consider the welfare of the children and youth to be of primary importance.

[87] Lois Weithorn, 'Children's Capacities for Participation in Treatment Decision-Making' in Diane H Schetky and Elissa P Benedek, *Emerging Issues in Child Psychiatry and the Law* (Brunner & Mazel, 1985) 22, 27–8.
[88] *Convention on the Rights of the Child*, Article 5.
[89] APACS, *AGCA Code of Ethics* (1997) <http://www.agca.com.au/a_docs/AGCAcode.pdf>.
[90] APACS, *AGCA Code of Ethics* (1997) 1.
[91] APACS, *AGCA Code of Ethics* (1997) 1.

(b) *Informed consent*

Section I(B)(2) of the professional practices division seems to speak to the issue of informed consent of children:

> Members ensure that children and youth understand the nature and purpose of any assessment or intervention to the best of their abilities.

However, the code seems to regard the informed consent of parents, not the child, to be of paramount importance. Section I(G) of the division on professional standards contemplates counsellors generally refraining from working with children without parental consent:

> Members normally provide services to students with the informed consent of the parents or guardian, and preferably with the parent's or guardian's involvement. Exceptions to the need for parental consent prior to service may exist, particularly in a crisis situation (e.g. when the student may be a danger to his/herself or others).

In general, the code seems to place an emphasis on the inclusion of parents in the counselling process. This section is the clearest example of this. It may be arguable that the code takes an overly restrictive approach to working with children without a parent's consent.

Recommendation 30: that DVAC consider the competing policy arguments for and against working with children without the consent of their parents in developing its approach towards working with children, including the reasons behind APACS' more restrictive approach.

(c) *Confidentiality*

Section II(A) of the professional standards division states that:

> Members have an obligation to safeguard confidential client information that has been obtained in the course of their practice, teaching or research.

Section II(C) of the same division goes on to say that:

> Members obtain consent (preferably written) from parents before releasing confidential student information to professionals in other agencies. Under some circumstances they may obtain consent from students before releasing information to parents or professionals in other agencies. The need to obtain consent from students should take into account the age at which a person is legally defined as being independent as well as the level of the student's mental and moral development. An exception to this policy exists when the member believes clients are in immediate danger to themselves or to others.

(d) *Resolving conflicts of interest*

A number of provisions of the code address the priorities of counsellors when particular interests come into conflict with each other. Section I(C) of the professional standards division states that:

> When administrative codes and regulations conflict with ethical principles, good faith efforts are instituted to resolve problems and discrepancies. Should these efforts prove to be ineffective, ethical principles should take precedent.

Section I(F) of that division goes on to say:

> Members protect the welfare and act in the best interests of students, their parents, educators, colleagues and employers. Protecting the welfare of students, their parents, and educators is of utmost concern and takes precedence over self-serving actions by members. When conflicts of interest arise the member's first priority is to serve the best interests of students.

In the professional practices division, section I(A)(4) talks about prioritising service to students even when this may involve conflicts with other interested parties:

> Members attempt to discuss with children and youth, teachers and parents/guardians, their plans for assisting in the student's development, including various alternatives. Conflicts should not be avoided when their avoidance may result in a lowering of service to students.

Section I(C)(1) acknowledges the position of counsellors within the broader school community:

> Members strive to develop harmonious and cooperative working relationships with colleagues and school staffs. They recognise the need to function as a member of a team within schools, other institutions and communities.

However, section I(C)(2) again prioritises service to students:

> Attempts to develop harmonious and cooperative relationships should not result in the lowering of standards for services provided to students.

2 *APS Code of Ethics*

The Australian Psychological Society (APS) has a general code of ethics that applies to Australian psychologists.[92] While it is not strictly applicable to social workers not practising as psychologists, it does provide further guidance on best practice in obtaining informed consent and maintaining confidentiality. The APS Code of Ethics is not concerned with children specifically, but several relevant provisions are set out in the following paragraphs.

(a) *Informed consent*

Section A.3.1 provides that:

> Psychologists fully inform clients regarding the psychological services they intend to provide, unless an explicit exception has been agreed upon in advance, or it is not reasonably possible to obtain informed consent.

Section A.3.2 further states that psychologists should 'provide information using plain language'. Guidance is then given on what is necessary for informed consent in A.3.3:

> Psychologists ensure consent is informed by:
> (a) explaining the nature and purpose of the procedures they intend using;
> (b) clarifying the reasonably foreseeable risks, adverse effects, and possible disadvantages of the procedures they intend using;
> (c) explaining how information will be collected and recorded;
> (d) explaining how, where, and for how long, information will be stored, and who will have access to the stored information;
> (e) advising clients that they may participate, may decline to participate, or may withdraw from methods or procedures proposed to them;
> (f) explaining to clients what the reasonably foreseeable consequences would be if they decline to participate or withdraw from the proposed procedures;
> (g) clarifying the frequency, expected duration, financial and administrative basis of any psychological services that will be provided;
> (h) explaining confidentiality and limits to confidentiality (see standard A.5.);
> (i) making clear, where necessary, the conditions under which the psychological services may be terminated; and
> (j) providing any other relevant information.

Section A.3.6 deals with obtaining consent in relation to clients incapable of giving it themselves:

> Psychologists who work with clients whose capacity to give consent is, or may be, impaired or limited, obtain the consent of people with legal authority to act on behalf of the client, and attempt to obtain the client's consent as far as practically possible.

Recommendation 31: that DVAC consider the provisions in Section A.3 of the APS Code of Ethics when developing its own approach to obtaining informed consent.

(b) *Confidentiality*

The APS Code of Ethics contains several principles related to confidentiality. Section A.5.3 provides:

[92] APS, *APS Code of Ethics* (2007) <https://www.psychology.org.au/Assets/Files/APS-Code-of-Ethics.pdf>.

> Psychologists inform clients at the outset of the professional relationship, and as regularly thereafter as is reasonably necessary, of the:
>
> (a) limits to confidentiality; and
> (b) foreseeable uses of the information generated in the course of the relationship.

Section A.5.2 addresses permitted disclosure of confidential information:

> Psychologists disclose confidential information obtained in the course of their provision of psychological services only under any one or more of the following circumstances:
>
> (a) with the consent of the relevant client or a person with legal authority to act on behalf of the client;
> (b) where there is a legal obligation to do so;
> (c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information; or
> (d) when consulting colleagues, or in the course of supervision or professional training, provided the psychologist:
> (i) conceals the identity of clients and associated parties involved; or
> (ii) obtains the client's consent, and gives prior notice to the recipients of the information that they are required to preserve the client's privacy, and obtains an undertaking from the recipients of the information that they will preserve the client's privacy.

(c) *Record keeping*

The APS Code of Ethics also provides for minimum standards of record keeping for psychologists. Section B.2.1 required psychologists to 'make and keep adequate records'. Section B2.2.2 then provides that:

> Psychologists keep records for a minimum of seven years since last client contact unless legal or their organisational requirements specify otherwise.

Under section B.2.3, the requirement in relation to child clients is slightly longer:

> In the case of records collected while the client was less than 18 years old, psychologists retain the records at least until the client attains the age of 25 years.

Recommendation 32: that DVAC develop a policy of record keeping by social workers, particularly in relation to the assessment of capacity to enter into a confidential relationship and consent to receive counselling and support services, and obtaining consent for disclosure of personal information to third parties.

VI CONCLUSION

We hope that this report has met the goals of DVAC's referral to the UQ Pro Bono Centre in explaining the law surrounding consent, capacity, confidentiality and disclosure. The law related to these issues has numerous aspects, many of which unfortunately lack clarity. In this report, we have tried to resolve apparent uncertainties to the best of our abilities within the timeframe for the delivery of the project, while also being careful to acknowledge genuine uncertainties in the law instead of simply looking for convenient conclusions.

We hope that the DVAC finds the analysis and recommendations made in this report to be helpful in developing its policies and practices towards working with children, and that this report can contribute in some way to the continuing improvement of counselling and support services available to children exposed to domestic violence.