

# THE BRITISH ASSOCIATION OF ART THERAPISTS

## GUIDELINES FOR MEMBERS

### 1. Autonomous practice

As registered health professionals Members are expected to practise autonomously and, if they are the subject of fitness to practise proceedings brought by the Health Professions Council (“HPC”), will be held accountable on that basis.

Generally, Members are not accountable for the clinical decisions of other health professionals but do have an obligation to take appropriate action if another health professional deviates from accepted standards of professional practice.

That obligation will apply not only in relation to other Members but also where Members are working in a multidisciplinary setting, and whether or not they have any formal authority over practitioners from other disciplines.

Autonomy is not infinite. Clinical autonomy is exercised within the policies and priority constraints set by a manager or other policy setter. Practice autonomy operates within the resource and policy constraints of a manager, the management team or health authority.

Clinical autonomy for Members is the freedom to exercise discretion in art therapy casework with individual clients, within available resources and other limits, and without that discretion being overridden by a higher authority unless negligence or some other improper act is suspected.

Practice autonomy is the freedom to exercise discretion in the immediate management and running of a practice, department or specialty, within defined limits and available resources and without that discretion being overridden by a higher authority unless negligence or some other improper act is suspected.

Where conflicts of interest arise between the therapeutic role and other roles, Members should seek to ensure that the integrity of the therapeutic role is maintained within the available resources and any other limitations.

### 2. Consent

Members should ensure that a client’s consent to treatment is informed consent. Obtaining a client’s signature on a consent form is not necessarily evidence of informed consent if the client has been pressed into signing the form on the basis of limited information.

Where a client is physically unable to sign a consent form that is not a bar to

treatment if the client is capable of and has given consent orally. In such circumstances Members must ensure that they properly record how consent was given.

Consent is a continuing process and Members must remember that a client may withdraw consent at any time. Members should keep completed consent form with the client's notes and any changes made to a form should be initialled and dated by both the client and the Member.

Members can only obtain consent for care that they are capable of providing. A Member who acts outside of their scope of practice will not be protected because they have the purported consent of the client. If a Member believes that a task is beyond their own scope of practice then they must refer the client to an appropriately qualified practitioner. In accepting referrals from other health or social-care professionals, a Member must ensure that they fully understand the nature of the referral and that it is within their scope of practice.

### ***Consent and the Mental Health Act***

The Mental Health Act 1983 provides for certain treatment, such as electro-convulsive therapy, to be carried out with a client's consent where:

- (a) a registered medical practitioner (not being the responsible clinician (if there is one) or the person in charge of the treatment in question) and two other persons (not being registered medical practitioners) have certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it; and
- (b) the registered medical practitioner referred to in paragraph (a) above has certified in writing that it is appropriate for the treatment to be given.

Before giving such a certificate, the registered medical practitioner shall consult two other persons who have been professionally concerned with the patient's medical treatment but, of those persons:

- (a) one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner; and
- (b) neither shall be the responsible clinician (if there is one) or the person in charge of the treatment in question.

Where Members are asked to provide second opinions for the purposes of the Mental Health Act, they must ensure that they are not pressurised into doing so because of the limited number of appropriately qualified health professionals available, but act on their own judgement and within the limits of their knowledge, skills and experience.

### ***Consent when clients lack capacity***

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. Members should

seek to involve appropriately qualified colleagues in making assessments of incapacity and, if at all possible, the client should be assisted to make and communicate their decision, for example by providing information in non-verbal ways where appropriate.

Where an adult client does not have the capacity to give or withhold consent this fact should be recorded in the client's notes together with an assessment of the client's capacity, why the Member believes that art therapy is in the client's best interests and the involvement of those close to the client who have given consent.

### ***Consent when working with children***

If a child (i.e. someone under 18) is not competent to give consent, Members should seek consent from a person who has 'parental responsibility for that child according to the Children Act 1989 (the "Children Act")'. Although only one person with parental responsibility needs to consent, it is good practice to involve all those who are responsible for the child in the decision-making process.

The Children Act defines "parental responsibility" as all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property. It will often but not always be a child's natural parents that give consent but those with parental responsibility include:

- each of the child's parents, if they were married to each other at the time of their child's conception or birth;
- Where a child's father and mother were not married to each other at the time of his birth —
  - (a) the mother shall have parental responsibility for the child;
  - (b) the father shall have parental responsibility for the child if he has acquired it (and has not ceased to have it) in accordance with the provisions of the Children Act;
- the child's legally appointed guardian;
- a special guardian appointed by court order;
- a person in whose favour a court has made a residence order concerning the child;
- a local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the Children Act, also known as being 'accommodated' or in 'voluntary care'; and
- A local authority or other authorised person who holds an emergency protection order in respect of the child.

Foster parents, stepparents and grandparents do not automatically have parental

responsibility.

Members must also take into account the following provisions under the Children Act:

- References in this Act to a child whose father and mother were, or (as the case may be) were not, married to each other at the time of his birth must be read with section 1 of the Family Law Reform Act 1987 (which extends their meaning).
- The rule of law that a father is the natural guardian of his legitimate child is abolished;
- More than one person may have parental responsibility for the same child at the same time;
- A person who has parental responsibility for a child at any time shall not cease to have that responsibility solely because some other person subsequently acquires parental responsibility for the child;
- Where more than one person has parental responsibility for a child, each of them may act alone and without the other (or others) in meeting that responsibility, unless any legislative enactment requires the consent of more than one person in a matter affecting the child;
- The fact that a person has parental responsibility for a child shall not entitle him to act in any way that would be incompatible with any order made with respect to the child under the Children Act;
- A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf;
- The person with whom any such arrangement is made may himself be a person who already has parental responsibility for the child concerned;
- The making of any such arrangement shall not affect any liability of the person making it, which may arise from any failure to meet any part of his parental responsibility for the child concerned;
- A person who does not have parental responsibility for a particular child but has care of the child may (subject to the provisions of Children Act) do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare.

If children are competent to give consent for themselves, Members should seek consent directly from them. Even if a child is not competent to take a particular

decision, the child should still be involved as much as possible.

It is for Members to judge whether a child is competent to give consent and the test (so-called 'Gillick competence', from the decision in *Gillick v West Norfolk and Wisbech Area Health Authority*) is, in essence, whether the child has sufficient understanding and intelligence to be able to understand fully what is proposed, that being a question of fact in each case.

If a Member decides that a child is competent to give consent then parental consent to treatment is not required and the Member must respect any request from the child not to disclose details of treatment to those with parental responsibility for that child.

Even if a child is competent to give consent, it is still good practice to encourage competent children to involve their families in the decision-making process.

### ***Children with Disabilities***

Members should not assume that a child with learning disabilities is not competent to give consent. Many children will be competent to do so if information is presented in an appropriate way and they are supported through the decision-making process.

Where a child has a disability, Members should take particular care to ensure that information is provided in a suitable form involving, for example, interpreters for hearing impaired children or appropriate materials for those with learning disabilities. Specialist colleagues may be able to act as facilitators where children have particular needs.

### ***Consent when Working with Older People***

Seeking consent is part of a respectful relationship with an older person. Members should never assume that older people cannot take any decisions for themselves, just because they have been unable to take a particular decision in the past.

Some older people may have capacity to consent to some interventions but not to others. People suffering from the early stages of dementia, for example, may have capacity to make straightforward decisions about their own care, but might lack capacity to take complex decisions.

Older people may also be able to make a particular decision one day even if they were not able to take it the day before. Where the client's capacity is fluctuating Members should, if possible and appropriate, delay treatment decisions until a point when the client has the capacity to make their own decision.

People close to the client may sometimes be able to assist in choosing an appropriate time to discuss the client's healthcare wishes. It is important that any

person helping to 'translate' an older person's wishes realises that it is the older person's views and wishes that are important, not what they think is best for the older person.

Members may find it helpful, in assessing an older person's comprehension and ability to make choices, to explore:

- the client's ability to paraphrase what has been said (repeating and rewording explanations as necessary);
- whether the client applies information they have been given to their own case; and
- whether the client is able to compare alternatives, or to express any thoughts on possible consequences other than those which you have disclosed.

### ***Consent when working with People in Prisons***

Prisoners have the same rights as others to withhold consent to treatment and it is important to ensure that a prisoner's decision is truly their own. Members must not participate in attempts to coerce a person in prison to provide consent, for example, by implying that a decision to give or withhold consent could affect their privileges or remission of sentence.

Where a prisoner has a serious mental disorder that warrants detention and care under the Mental Health Act 1983, Members are reminded that the powers provided by the Act can only be used where a prisoner is detained in hospital. Prison health care centres are not hospitals for this purpose and treatment can therefore only be provided after the prisoner has been transferred to an appropriate hospital.

### ***Recorded images***

Photographic, video and other images recorded for clinical purposes form part of a client's health record and must not be used for any other purpose without consent.

Members should always ensure that they make clear, at the start of any therapy, whether photographic or video recordings will result from therapy and seek permission for the inclusion of such images in the client's notes.

Members who wish to use such recordings for education, publication or research purposes must seek the client's written consent, ensuring that the client (or any other person giving consent on the client's behalf as outlined in this section) is fully aware of the possible uses of the material and, in particular, that the member may not be able to control future use of the material once it has been

placed in the public domain.

Members who wish to make recording specifically for education, publication or research purposes must obtain both the client's consent to make the recording and to use it. Where a client consents to a recording being made for this purpose they must be told that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the client does not consent to the recording being used, it must be destroyed. As with recordings made with therapeutic intent, Members must inform clients about the possible future use of the recording, including the fact that it may not be possible to control future use of the material once it is in the public domain.

### **3. Confidentiality**

Clients have a right to expect that information about them which they entrust to Members will be held in confidence and not shared with other people without the client's consent. In addition to obligations under the Data Protection Act 1998 ("DPA"), the duty of confidentiality derives from the common law and is based upon the mutual obligations created when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence.

The obligation to respect client confidentiality is an essential part of health care practice and helps to ensure that clients provide all of the information they need in order to provide effective care.

Whilst clients' rights to privacy are important they are not absolute and situations may arise in which a Member is faced with conflicting legal duties and may have to act in a way which would otherwise be a breach of their duty of confidentiality.

Members may disclose information without the client's consent where it is in the public interest to do so, for example, where failure to do so may expose the patient or others to risk of death or serious harm, where a disclosure may assist in the prevention, detection or prosecution of a serious crime, or where disclosure is necessary to protect a child or vulnerable person from being abused.

#### ***Compelled disclosure***

Client information may properly be disclosed where a Member is compelled to do so in response to a demand made by a court or by other authorities, such as the HPC, exercising specific statutory powers. Other than in exceptional circumstances, for example in relation to the prevention of terrorism, the police do not have the power to compel disclosure of confidential health records.

If Members have any doubt about whether disclosure is a statutory obligation, they should ask the person or body seeking the information to specify, preferably in writing, the legislation under which the information is sought.

The courts and certain tribunals have the power to require the disclosure of information that may be relevant to matters within their jurisdiction. Where a court or tribunal so orders and the client has not given consent for the disclosure Members must make the disclosure strictly within the terms of the order. For example, if the order requires disclosure to the court, then the information should be handed to the court only.

Members may experience a conflict of duties if a court demands the disclosure of information which the Member feels, on ethical grounds, should not be disclosed. In such cases Members should make their ethical objections known to the judge or presiding officer but, if the court nonetheless decides that the information must be released, Members risk being found in contempt of court or, in the case of certain tribunal proceedings of committing an offence, if they refuse to comply.

### ***Disclosure in criminal cases***

If a Member refuses to release health records for use in criminal proceedings the person seeking the information may apply to the court for a witness summons to be issued requiring the Member to produce the information. The court rules place the burden on the person seeking disclosure to justify the issuing of a witness summons, requiring them to state specifically what information they require, why they believe the Member concerned holds the information and why it is material to the case. Before issuing a summons the court will allow the Member an opportunity to make representations as to why the information should not be disclosed. If a summons is issued the information must be provided or the Member risks being found in contempt of court.

### ***Search and seizure***

Health records are 'excluded material' for the purposes of the Police and Criminal Evidence Act 1984 and therefore cannot be the subject of an ordinary search warrant issued by a Magistrate. If the police wish to search for and seize excluded material they must seek an order for its production or a special warrant to search for and seize it from a circuit judge.

### ***Court reports***

Members who are asked to prepare reports for use in court proceedings need to ensure that they:

- have any consent necessary to do so; and
- clearly understand whether they are being asked to provide factual

evidence or expert opinion.

There is a crucial distinction between providing what amounts to a witness statement – a report describing facts directly observed by the member - and attempting to offer a professional opinion or recommendation to the court.

Members should only act as expert witnesses where they are competent to do so. Members should only provide expert opinion evidence on matters within their scope of practice and should ensure that they understand relevant court procedures and the obligations imposed on expert witnesses, including the overriding duty which they owe to the court, before agreeing to act as an expert. Members who fail to do so may find their expertise seriously challenged in court.

Members, in preparing court reports, need to recognise that they may become involved in progressively greater levels of disclosure as the case proceeds and, on the basis of their report, required to grant access to the original notes, therapy records, artwork and images. Members should take account of the risks associated with such disclosure and discuss them with the client.

### ***Retention of artwork***

If artwork is retained by Members whilst a client is undergoing therapy it will in most cases form part of the client's health records and therefore should be subject to the same sort of security arrangements as other confidential client information. Members should ensure that, so far as possible, such artwork is kept in locked storage in an individual folder clearly marked with the clients' name or initials, the Member's name, and the dates of therapy. These arrangements need to be continued even after therapy ends.

If, once therapy ends, the client is given the option of taking their artwork and does so, it will cease to be part of the client's health records.

## **4. Clients Records**

Health records are a specifically defined category of data to which the DPA applies. The DPA defines a health record as a record consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a registered health professional in connection with the care that individual.

Such records include any information or material made by or on behalf of a Member in connection with the care of a client. Members must ensure that they comply with their obligations under the DPA including the data protection principles that personal data must be lawfully processed, accurate, not excessive, retained for no longer than necessary, and kept under secure conditions (see Appendices C-E to these guidelines).

Clients have a right of access to their health records under the DPA but, except where Members are independent practitioners, those records will ultimately be the responsibility of their employing hospital or NHS Trust. A client who wishes to gain access to their records should therefore be advised to apply to that body, using the established DPA procedures. Clients can be denied access to all or part of their records where a clinician is able to show that allowing access may be damaging to the patient.

Members should comply with their employer's policies and procedures for the recording, storage, disposal and destruction of clinical records and other confidential material. For example, many organisations have adopted the practice of prohibiting clinicians from storing client information on the hard drive of computers, but requiring it to be recorded on a floppy disc or other portable media and stored in a locked place with the client's paper records. This procedure should be followed by Members where it is in place.

### ***Clients records in private practice***

Members working in private practice are responsible for their own DPA registration and compliance, and for how their records are kept and stored. Members in private practice who are sole practitioners should give consideration to what will happen to their records after their death and are recommended to make appropriate provision in their will for the storage or destruction of those records.

### ***Manual records***

Records should contain a 'top sheet', which sets out key information including the client's name, address, telephone number and date of birth; their gender, religion and ethnic origin and the names and contact details for their general practitioner and other key professionals and contacts.

Clinical notes should contain a description of the noteworthy aspects of the session in a style that is more objective than subjective, for example, a brief account of what took place and what was said written in a clear and unambiguous style which avoids judgmental comments. This may be followed by a brief indication of any speculative comments or opinions as long as they are identified as such.

Certain factual information should be regularly recorded including:

- the client's attendance and non attendance;
- details of any relevant interventions such as telephone calls, case reviews and other inter-professional correspondence or discussions;

- notes of any telephone calls with the client, their family, carers or other health professionals, including the date and time of each call, the content of the conversation and any advice given or action taken;
- any action taken in relation to suicidal or homicidal intents or ideas communicated by the client; and
- any difficulties arising during therapy between the Member and the client, including any threats made by the client or any dispute arising from the termination of therapy.

When making handwritten records Members should:

- use black ink;
- ensure there are no gaps in the notes and if accidental gaps occur, cross them through;
- include details of any unwritten consent to therapy provide by the client or any other person on their behalf;
- sign all entries, showing their title and profession, the date and time of each entry and countersign any notes written by students;
- clearly record all clinical judgments as such, for example “In my opinion...” or “In my view...” but not record judgmental opinions;
- if using loose-leaf pages ensure that the client’s name and identification number are shown on each page, and any gaps are crossed through;
- not use abbreviations unless they are widely understood;
- If an entry has been made in the wrong case notes, strike it through with a single diagonal line and endorse the entry to show that it was wrongly made;
- not use correction fluid or totally obliterate anything that has been written, but initial and cross out errors with a single line so that what has been written first remains legible; and
- clearly indicate if notes have not been written contemporaneously, for example “yesterday I saw...” or “I forgot to write on [date]....” or, if adding to case notes by showing the date on which the addition was made.

## **Appendix A**

### **Specifications for a Purpose Built Art Therapy Department**

The following is appropriate for a department with two full time staff or three part time staff providing a service to an acute mental health unit, containing 65-70 beds.

As the pottery and art room will be used for one-to-one sessions, group work and open studio sessions, confidentiality needs must be considered and soundproofing incorporated where necessary.

#### Office

- 15 sq. metres with desk space for three people;
- storage for paperwork and storage of confidential files etc;
- storage space for photocopy paper, and other stationary items;
- shelving for books, box files, policy folders, telephone directories equipment catalogues etc;
- computer and printer; and
- notice boards.

#### Pottery room

- 40 sq. metres with good lighting;
- large shallow sink;
- kiln and extractor fan;
- pugmill to reclaim clay and prevent clay wastage;
- tables and chairs;
- potter's wheel, kickwheel or electric;
- storage for moulds;
- clay bins;
- shelving for clay, glazes etc; and
- shelves for safe storage of people's work.

#### Art room

- 40 sq. metres with good lighting;
- floor with non-slip surface. no carpet except in social area;
- tables and chairs;
- shelving for paper, card, paints and other materials;
- shelving for books;
- cupboard – metal and lockable for storage of materials, including white spirit and methylated spirit;
- sink;
- kettle;
- shelving for cups, tea, coffee etc;

- easy chairs for small social area to enable time out from art making; and
- plan chests for safe storage of people's artwork.

## **Appendix B**

### **Consent to student's use of client information**

#### **1 Student Placement Consent Letter**

Dear .....

I am a student in Art Psychotherapy at the University of ... and part of my placement experience is at...

In order to finish the course I have to complete certain pieces of written work. One of these is a case study, which involves writing about the background of the clients and about the Art Psychotherapy sessions. This includes taking photographs of any work the client makes.

I would be grateful if you would sign and give your permission for me to refer to case notes, record sessions, take photographs and write a case study.

If you have any questions about this please do not hesitate to contact me ..... and my placement supervisor..... at .....on.....

I enclose a consent form for you to sign.

Yours sincerely

Art Psychotherapy Trainee

#### **2. Response letter from client**

I give permission for student .....to write a case study of my art therapy sessions.

I have read the accompanying letter and I understand its content.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix C

The following are principles under the Data Protection Act 1998 (“DPA”), which may alter from time to time, depending on amendment to the Act:

- 1) Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:
  - (a) at least one of the conditions in Appendix D is met, and
  - (b) in the case of sensitive personal data, at least one of the conditions in Appendix E is also met.
- 2) Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
- 3) Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- 4) Personal data shall be accurate and, where necessary, kept up to date.
- 5) Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
- 6) Personal data shall be processed in accordance with the rights of data subjects under the DPA.
- 7) Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
- 8) Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

## Appendix D

### Conditions Relevant for Purposes of the First Principle: Processing of any Personal Data

- 1 The data subject has given his consent to the processing.
- 2 The processing is necessary:
  - (a) for the performance of a contract to which the data subject is a party, or
  - (b) for the taking of steps at the request of the data subject with a view to entering into a contract.
- 3 The processing is necessary for compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract.
- 4 The processing is necessary in order to protect the vital interests of the data subject.
- 5 The processing is necessary:
  - (a) for the administration of justice,
  - (aa) for the exercise of any functions of either House of Parliament,
  - (b) for the exercise of any functions conferred on any person by or under any legislative enactment,
  - (c) for the exercise of any functions of the Crown, a Minister of the Crown or a government department, or
  - (d) for the exercise of any other functions of a public nature exercised in the public interest by any person.
- 6 (1) The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.  
  
(2) The Secretary of State may by order specify particular circumstances in which this condition is, or is not, to be taken to be satisfied.

## Appendix E

### Conditions Relevant for Purposes of the First Principle: Processing of Sensitive Personal Data

- 1 The data subject has given his explicit consent to the processing of the personal data.
- 2 (1) The processing is necessary for the purposes of exercising or performing any right or obligation which is conferred or imposed by law on the data controller in connection with employment.  
  
(2) The Secretary of State may by order:
  - (a) exclude the application of sub-paragraph (1) in such cases as may be specified, or
  - (b) provide that, in such cases as may be specified, the condition in subparagraph (1) is not to be regarded as satisfied unless such further conditions as may be specified in the order are also satisfied.
- 3 The processing is necessary:
  - (a) in order to protect the vital interests of the data subject or another person, in a case where:
    - (i) consent cannot be given by or on behalf of the data subject, or
    - (ii) the data controller cannot reasonably be expected to obtain the consent of the data subject, or
  - (b) in order to protect the vital interests of another person, in a case where consent by or on behalf of the data subject has been unreasonably withheld.
- 4 The processing:
  - (a) is carried out in the course of its legitimate activities by any body or association which:
    - (i) is not established or conducted for profit, and
    - (ii) exists for political, philosophical religious or trade-union purposes,
  - (b) is carried out with appropriate safeguards for the rights and freedoms of data subjects,

- (c) relates only to individuals who either are members of the body or association or have regular contact with it in connection with its purposes, and
  - (d) does not involve disclosure of the personal data to a third party without the consent of the data subject.
- 5 The information contained in the personal data has been made public as a result of steps deliberately taken by the data subject.
- 6 The processing:
- (a) is necessary for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings),
  - (b) is necessary for the purpose of obtaining legal advice, or
  - (c) is otherwise necessary for the purposes of establishing, exercising or defending legal rights.
- 7 (1) The processing is necessary for:
- (a) the administration of justice,
  - (aa) the exercise of any functions of either House of Parliament,]
  - (b) the exercise of any functions conferred on any person by or under an enactment, or
  - (c) the exercise of any functions of the Crown, a Minister of the Crown or a government department.
- (2) The Secretary of State may by order—
- (a) exclude the application of sub-paragraph (1) in such cases as may be specified, or
  - (b) provide that, in such cases as may be specified, the condition in subparagraph (1) is not to be regarded as satisfied unless such further conditions as may be specified in the order are also satisfied.

## 7A

- (1) The processing:
- (a) is either:
    - (i) the disclosure of sensitive personal data by a person as a member of an anti-fraud organisation or otherwise in accordance with any

arrangements made by such an organisation; or

(ii) any other processing by that person or another person of sensitive personal data so disclosed; and

(b) is necessary for the purposes of preventing fraud or a particular kind of fraud.

(2) In this paragraph “an anti-fraud organisation” means any unincorporated association, body corporate or other person which enables or facilitates any sharing of information to prevent fraud or a particular kind of fraud or which has any of these functions as its purpose or one of its purposes.

8 (1) The processing is necessary for medical purposes and is undertaken by:

(a) a health professional, or

(b) a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

(2) In this paragraph “medical purposes” includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.

9 (1) The processing:

(a) is of sensitive personal data consisting of information as to racial or ethnic origin,

(b) is necessary for the purpose of identifying or keeping under review the existence or absence of equality of opportunity or treatment between persons of different racial or ethnic origins, with a view to enabling such equality to be promoted or maintained, and

(c) is carried out with appropriate safeguards for the rights and freedoms of data subjects.

(2) The Secretary of State may by order specify circumstances in which processing falling within sub-paragraph (1)(a) and (b) is, or is not, to be taken for the purposes of sub-paragraph (1)(c) to be carried out with appropriate safeguards for the rights and freedoms of data subjects.

10 The personal data are processed in circumstances specified in an order made by the Secretary of State for the purposes of this paragraph.