NSPCC

Cruelty to children must stop. FULL STOP.

ChildLine 0800 1111

ChildLine is the free 24 hour helpline and on-line service fpr any child with any problem. Volunteer counsellors work with individual children and young people on the teleohone and oh-line, offering them support, advice and protection. ChildLine assists children in escaping from immediate danger and facilitates them in looking to longer-term solutions to their problems. ChildLine links callers to other agencies, including social services and mental health services, and will work alongside other professionals in continuing to support a caller through often difficult processes of investigations, treatment or court hearings. ChildLine in Scotland is currently operated by CHILDREN 1ST on behalf of the NSPCC.

ChildLine hears from children with a wide range of problems and queries, many of which are directly related to mental health such as depression, eating problems, self-harming, and suicide. Children also call us about a range of other issues that can have a direct, and sometimes long term, impact on their mental health, for example all forms of abuse, bullying and harmful parental drinking.

One of the fundamental aims of ChildLine's seryices is to make sure that children's voices are heard in society, in policy-making and in practice, and our comments relate only to those areas of the strategy that are relevant to the population under the age of 18. The ChildLine response is confined to questions 2 to 7 and 9 tp 11 (inclusive).

ChildLine greatly welcomes the Scottish Government's intention to take forward Scotland's mental health policy in a more joined up and systematic way. As the introduction makes clear, mental health improvement, illness prevention and service improvement are mutually supportive areas and any strategy to improve the mental health of the Scotland's population must address priorities in each of these areas. We appreciate that everything cannot be done at once and recognise the vital importance of outlining a programme of work based on clear priorities and outcomes, which can be evaluated to review progress and understand what still needs to be done. However, we consider the current strategy to be limited in the extent to which it is addressing young people's mental health and believe that if it is to take forward Scotland's mental health policy in a more joined up and systematic way, it must acknowledge and stress the continuing importance of *The Mental Health of Young People: A framework for Promotion, Prevention and Care*, the elements of which were expected to exist within local services by 2015. This framework was based on the Scottish Needs Assessment Programme (SNAP) Report in Child and Adolescent Mental Health, a meticulous review process, which involved those working in the field of children and young people's mental health and wider children's services in the development of recommendations, and most importantly the views of children and young people themselves shaped the document.

ChildLine would recommend an audit of progress on implementation of the recommendations contained within that framework.

Contacts to ChildLine about mental health problems generally have increased over the last 5 years, and we are concerned that improving mental health services for children and young people is not specifically included in the four areas identified among the key issues that if addressed will have a significant impact on better outcomes across the whole pathway of care.

51% of contacts to ChildLine in 2010-11 were aged between 12 and 15 and 29% were between 16 and 18.[1] Whilst concerns around depression / mental health issues, suicide and self harm together represented 12% of total contacts across all age groups, in the 16-18 age group these concerns represented 17% of contacts. The information ChildLine receives on a daily basis from contacts across all age groups, but particularly those aged between 12 and 18, leaves us in no doubt that there is an urgent need to improve access to and delivery of CAHMS if progress is to be made in improving the mental wellbeing of children in Scotland, and particularly to tackle the unacceptably high rate of suicide in the adolescent population. ChildLine also are of the view that provision of preventative care is crucial to this issue. Prevention and early intervention in child mental health problems is not only crucial to child health and welfare, but also can obviate the need for treatment later on in life.

Over 3300 children and young people were supported by CHiLDREN 1ST in 2011-12 and mental health concerns were an impact factor in 7% of the children and young people supported by our local services and indeed, in 12% of the children, young people and families accessing CHiLDREN 1ST family support services in Aberdeenshire, Moray, Highland, Dundee, Midlothian, East Lothian, Edinburgh and Ayr. CHiLDREN 1ST also operates ParentLine Scotland, the national helpline for anyone with a concern about a child. Parents and other carers are the predominant users of the service. in 2009/10 17% of calls received were about stress/anxiety – sometimes the caller's but also often about a child or young person's stress and 10.4% of calls were about mental health concerns. Nearly 5% of calls were about post natal depression and nearly 3% were about self harm. Calls were also received about a whole range of issues that potentially impact adversely on mental health, including bullying, family relationships, substance abuse, isolation, bereavement and loss and emotional abuse.

RESPONDENT INFORMATION FORM

Please Note this form must be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

ChiidLine in Scotland

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ ***Please tick as appropriate***

Surname

[1] based on when the child or young person provided their age to the Counsellor. In 2010-11, 58% of counselling interactions provided an age at the time of being counselled.

Forename

2. Postal Address

Tara House, 46 Bath Street, Glasgow		
Postcode G2 1HG	Phone 02076506763/4	Email fiona.robertson@children1st.org.uk awales@children1st.org.uk

3. Permissions - I am responding as...

Individual ☐ / **Group/Organisation** ☑

Please tick as appropriate

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☑ Yes ☐ No

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☑

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation *will be* made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your *response* to be made available?

Please tick as appropriate ☑ Yes ☐ No

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☑ Yes ☐ No

CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but we want to consult on:

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

Comments

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

Comments

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

Comments

Whilst ChildLine increasingly hears from children already experiencing mental health problems, it is vital also to call attention to the thousands of children who contact the helpline because of other issues closely correlated with mental health problems in later life. For example, there is overwhelming evidence that physical or sexual abuse in childhood is a key cause of mental ill-health in adulthood, and probably a more significant factor than genetic inheritance in most cases. Since it opened in 1990, physical and sexual abuse have consistently been amongst the top 5 primary concerns[2] about which children and young people contact ChildLine. Last year these concerns accounted for 13% of all contacts. Given the very clear relationship between sexual abuse and mental health problems in later life, trauma recovery services for children who have experienced abuse are also a clear priority, and should be provided where and when children need them as to delay access causes a further injustice. The Children's Services Bill to be introduced in 2013 will provide the opportunity to translate this and other provisions into specific powers or duties on either Ministers or public bodies to provide trauma recovery services.

ChildLine hears from many children already experiencing mental health problems and has a clear role in providing support, not least in accessing appropriate services, however the most crucial aspect of the service in relation to children's mental health is, undoubtedly, in preventative work. Everything ChildLine does is about promoting emotional and mental wellbeing: encouraging and enabling children to express their feelings about their problems, supporting and empowering children to start dealing with their problems in a way that makes sense in the context of their own lives.

Not all children are resilient. Information from our databases tells us that many young people need additional emotional support at times of change, disruption or pressure at home or at school. It also tells us, however, that children can find it very difficuh to talk about their problems to adults and to seek help when they need it. In many cases of children contacting ChildLine for help, friends are their sole confidants. Indeed children's concerns are all too often hidden problems – shared only amongst other children. It is important to stress that investment in early years intervention, whilst crucial as a preventative, and in the longer term, cost effective measure, should be made as well as, and not at the expense of, services for older children.

[2] Every time a trained volunteer responds to a contact by a child, they note the main problem presented by the child (primary concern), any additional concerns raised, any details revealed on family and the living circumstances of the child, and a narrative of the discussion

ChildLine consider interventions that raise awareness of mental wellbeing and encourage and enable children to express how they feel and to seek support themselves with ANY problem are of key importance, as well as the provision of universal, self referral psychological support services that children will access (see comments on barriers to children and young people accessing services at Q10). Therefore as well as promoting access to ChildLine for all children and young people to discuss their problems and act as a first point of contact, we would also strongly urge developments in the following key areas:

- Universal school counselling services based on the model recently piloted in Wales. An independent evaluation by the British Association for Counselling and Psychotherapy (BACP) of School-based counselling in Wales, found that 85% of young people using the service in Wales felt more positive about going to school and more able to cope with problems after receiving counselling. In June 2011, BACP called for the Scottish government to follow the example of Wales and Northern Ireland and provide funding for school-based counselling in every school, which they believe will also help to cut truancy rates, crime, teenage pregnancy and suicides[3]. It is ChildLine's understanding that at present only 4 local authorities in Scotland have provided counsellors in schools. ChildLine would enormously welcome the expansion of counselling services such as those provided by The Place2Be[4] in Edinburgh, East Lothian and in Glasgow to all local authority areas
- expansion of informal drop-in services (such as the CHILDREN 1ST service, Chill Out Zone, Bathgate)
- wide spread peer support programmes in schools and in the wider community based on models such as Voices Against Violence[5]
- the establishment (and funding) in Scotland of initiatives working with children and young people without the need for referrals or waiting periods

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments

It is essential that any actions to reduce self harm and suicide rates in young people must involve not only designing interventions specifically aimed at them, but also, as previously stated, the provision of self-referral services aimed at tackling underlying problems that can lead to self harming behaviour and suicidal ideation. ChildLine has repeatedly called for better resourced, accessible self-referral services for children and young people in order

[3] http://www.bbc.co.uk/news/uk-scotland-13891366

[4] The Place2Be is a charity working inside schools to improve the emotional well-being of children, their families and the whole school community.

[5] Voice Against Violence is a group of eight young experts who have first hand experience of domestic abuse and different services

that they can access support before their problems escalate or reach crisis point. We would reiterate the recommendations from ChildLine response to the consultation on self harm[6]. Whilst we note and welcome the commitment to deliver the actions that have been agreed in the final report on self harm, we remain of the view that that any national response to self harm must include policy objectives relating specifically to young people, and that robust research into the incidence of self harm in the population is required. Other key recommendations are:

- Specific 'positive intervention' training for professionals around self harm should be informed by a prioritisation exercise, based on which professionals young people are most likely to approach / be in contact with
- The delivery of national and local objectives should be informed by a pilot project or 'health demonstration project', using the evidence around young people's self harming behaviour and their needs to inform service design
- The development of peer support programmes in schools and other youth settings is a crucial aspect of responding to self harm in young people
- and perhaps most crucially, preventative spending must underpin the National Response to Self Harm.

Research by ChildLine in Scotland and Scottish Health Action on Alcohol Problems (SHAAP)[7] in 2009 found that many children and young people who talked to the helpline about harmful parental drinking also talked about self harm and suicidal thoughts. The research report *Untold Damage* highlighted that many callers were endeavouring to cope with parental harmful drinking against a background of family separation and loss, including bereavement, with multiple negative impacts on long term mental health and emotional stability. Many of these young people talked about having little or no support. This highlights the need for more support for families in times of crisis, as well as self-referral services for young people to help them cope with underlying problems, including issues that may not necessarily invoke a CAMHS referral.

ChildLine welcomes the progress made in reducing suicide rates since the introduction of Choose Life, but are concerned that this strategy ends in 2013. The strategy should continue suicide prevention work beyond 2013, and in particular to providing suicide intervention training outwith the NHS, as most people who complete suicide are not known to the mental health system[8]. The number of children telling ChildLine that feeling suicidal is their main reason[9] for calling has been increasing over the last five years. In addition, many more were counselled about another problem, but also said that they felt suicidal during the course of the contact. The most common additional problems mentioned by children and young people who called ChildLine about feeling suicidal were family relationship problems, depression/mental health and self-harm[10].

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[6] RESPONDING TO SELF HARM IN SCOTLAND ChildLine in Scotland (2010)

[7] *UNTOLD DAMAGE: children's accounts of living with harmful parental drinking* ChildLine in Scotland / SHAAP (2009)

[8] National Confidential Inquiry into Suicide and Homicide by People with a Mental Health Problem, Lessons for mental health care in Scotland, (2008)

[9] Every time a trained volunteer responds to a contact by a child, they note the main problem presented by the child (primary concern), any additional concerns raised, any details revealed on family and the living circumstances of the child, and a narrative of the discussion

[10] ChildLine casenote: Children talking to ChildLine about suicide 2009

Children and young people have often told ChildLine that they felt their concerns were not taken seriously by parents or by health professionals: that they do not feel that they are understood and listened to when they need help. Many feel that there is no one to turn to for help[11]. Children and young people can feel that health professionals do not understand their needs and often do not communicate with them at their level. Children and young people also worry about their confidentiality being breached. ChildLine has over two decades experience in listening to children and young people's concerns about suicidal feelings, and mental health issues in general. In our view it is vital that there is a need for detailed research to understand suicide ideation in children and young people. Based on what we hear on the helpline we would recommend:

- Counselling services should be provided confidentially. Confidential services give children and young people an opportunity to talk to someone before problems escalate and counsellors can support children in developing the tools to help themselves and build their resilience.

- Parents need help to identify the danger signs. Parents and carers should be provided with guidance on ways to identify the warning signs that a child is feeling suicidal, and possibly planning suicide. Such advice should be provided by primary health care professionals and parenting organisations
- Information about help and support should be widely available to all children and young people in an accessible and age appropriate form. Information about ChildLine should be available, particularly on school premises, but also in a wide cross-section of public spaces including those related to information and communications technology

- Boys and young men are significantly more likely to commit suicide than girls and young women. It is imperative that national, regional and local agencies develop information that is more accessible and acceptable to boys and young men, and/or inform the provision of gender-specific information

- Training in suicide awareness and prevention should form part of the competencies of all professionals who deal with or work with children and young people. Suicide is a particular risk for children and young people in transition, especially where neglect or abuse have been a feature of their lives, while experiences of bullying or being bullied are strongly associated with attempted and completed suicides (Brandon et al, 2008). In addition, research has shown that children in Scotland aged 5 to 10 who were looked after at home or accommodated are six times more likely to have a mental disorder than those children living with families in the community (52% compared with 8%)[12]. Training on suicide awareness and prevention, including identification of early risk and high risk groups, should be part of the competencies of all key professionals, including teachers, school nurses, counsellors and general practitioners, and should ideally include input on suicide prevention to all professional training and continuing professional development courses.

[11] ChildLine casenote: Children talking to ChildLine about suicide 2009

[12] Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004) The mental health of young people looked after by local authorities in Scotland. Edinburgh: The Stationery Office

- All internet services geared toward children should have clear links to sources of help and support. It is important to ensure that there is information about readily available sources of support, such as ChildLine, on all the major social networking sites and other online services that children use. We also recommend that internet services have clear policies on content, which include review and removal of content where appropriate, as well as proactively offering support to users who have shown an interest in seemingly harmful suicidal content

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health ahd to reduce discrimination?

Comments

ChildLine would acknowledge the substantial progress there has been in reducing stigma and discrimination and strongly support initiatives which raise awareness of mental health issues with people of all ages. Campaigns such as *See me* and current.UK campaign *It's Time To Talk – let's end mental health discrimination have* done much to break down barriers. We welcome the imminent young people's campaign 'What's on your mind?' to educate 13 -15 year olds about the stigma of mental ill-health. Contacts to ChildLine on issues such as depression and mental health as well as suicide and self harm have increased in the last 5 years, and problems encompass a wide range of issues such as feeling depressed, suffering delusions, hearing voices, suffering anxiety attacks, phobias, schizophrenia. Many young people who contact ChildLine use the language of clinicians – whether it is as a result of having been referred to a professional, or due to high profile sufferers talking publicly about their problems, or story lines in soaps etc , it is clear that terms such bi- polar, paranoia and schizophrenia have entered the lexicon of young people. It is possible that young people have become more willing to open up about such problems where previously there was stigma and have the terminology to express their concerns leading to the increase in contacts, or possibly mental health problems have become more prevalent in society. Either way, it is vital that the impetus of *See Me* and other campaigns is sustained. ChildLine consider it never too early to encourage children to think about and talk about and share their feelings in nurture groups and at "circle time" at primary school.

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

Comments

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

Comments

The Mental Health of Children and Young People provides a framework for mainstreaming young people's mental health promotion into universal services. An audit of progress in this area would provide a baseline from which to develop priorities and measure progress. More specifically, the framework identified the vital role that schools have to play in promoting mental health amongst children and young people, highlighting the importance of a whole school approach. The importance of such an approach has long since been recognised in Scottish policy and practice development, not least through the New Community Schools and Health Promoting Schools initiatives and most recently, the development of the Curriculum for Excellence which includes a health and wellbeing focus and is underpinned by a whole school approach. Clearly, the introduction of emotional and mental wellbeing into the curriculum represents a universal opportunity to help children and young people think about, discuss and reflect on issues surrounding their emotional and mental health and is a significant step towards universal mental health promotion. Nevertheless, ChildLine is concerned that there is no clear evidence that teachers will feel equipped to deliver this aspect of the curriculum in a meaningful way. Research on teacher training needs following the introduction of the sexual health and relationships curriculum in Scotland, for example, (Wight and Buston, 2002) clearly indicated the need for programmes of teacher training to support successful delivery of the curriculum. As well as topic based training, the research strongly indicated the need for training to help teachers develop 'non-traditional' teaching methods, such as open discussion and debate and life skill development. ChildLine consultations with young people over the last decade have consistently identified significant problems with the personal, social and health education curriculums not least failure to address issues of importance for young people or support development of life skills[13]. The SNAP *Report on Child and Adolescent Mental Health* identified a need for mental health awareness training for teachers and activities to ensure support and training for all school staff were subsequently laid out in the Framework. An audit of education authorities/ schools to establish progress in this area as well as identifying on-going training needs is essential. ChildLine also strongly endorse SAMH

[13] ChildLine in Scotland have a series of reports, papers and other resources outlining young people's views and recommendations about the Personal, Social and Health curricula in Scotland, which are derived from consultation with young people. For further information please see contact details

and Bamardo's call to include mental wellbeing in initial teacher training and continued professional development.

The research report *UNTOLD DAMAGE*[14] highlighted that many young people who contacted the service were endeavouring to cope with parental harmful drinking against a background of family separation and loss, including bereavement, with multiple negative impacts on long term mental health and emotional stability. Many of these young people talked about having little or no support. This highlights the need for: -

- more locally available support for families in times of crises
- therapists working in the community in all local authority areas to ensure improved access for children experiencing difficulties without the need for formal referral by a GP or other health professionals
- more drop-in and other self– referral services for older children and young people in locally accessible and non-stigmatising settings

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

Comments

ChildLine would agree that action should be focused on early years and childhood (we would define "childhood" as including anyone up to the age of 18 and in some circumstances this should be extended beyond 18). ChildLine welcomes the target of delivering access to specialist CAMHS within 26 weeks by March 2013, and the introduction of a HEAT target for access to mental health services for all age groups within 18 weeks by December 2014. Whilst any improvement in waiting times is to be welcomed, it should be recognized that an 18 week wait for a child with mental health problems is still relatively long.

ChildLine work with children and young people with a wide range of mental health needs and is acutely aware of the pressure on children's services in this area. It would appear that sadly it is often the case that by the time a child or young person reaches the stage of a CAMHS referral they are already damaged to the extent that they find it all the more difficult to engage with formal services, and may have come to the attention of CAMHS by virtue of a referral on offence grounds to the Children's Hearing System (CHS). It is important to ensure that CHS is not the gatekeeper of access to services for children and

[14] *UNTOLD DAMAGE: Children's accounts of living with harmful parental drinking* ChildLine in Scotland / Scottish Health Action on Alcohol Problems (2009)

young people: instead, there should be a standard set of child friendly, children's services locally available which are the responsibility of community health partnerships to deliver. ChildLine understands that GPs are the most common source of referrals to CAMHS, yet we hear from many contacts to the helpline that young people can be reluctant to access GPs in respect of mental health issues for a number of reasons, not least, fears around confidentiality. Very often these fears can be something as basic as being embarrassed by a casual inquiry from someone they know in the waiting room as to the reason for the young person visiting the surgery. This can be a disincentive for adults never mind younger people to seek help with depression etc and it is to be hoped that this kind of embarrassment and stigma is gradually being broken down, but it is important to consider alternative routes to CAMHS in the same way that young people can access some sexual health services without having to go through their GP.

ChildLine would also highlight that the voluntary sector in Scotland has a high level of expertise in working with young people and at times a more flexible approach than statutory services can provide. Voluntary sector services can often respond more quickly to the individual requirements of young people, and change the configuration of their services to respond to particular needs. Vitally, voluntary sector services are perceived as more 'neutral' and are able to build up good relationships with clients because they are trusted.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Comments

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

Comments

It is important to recognise that children and young people largely do not have the same control over their lives and access to resources that most adults do, and accordingly are not always in a position to "take action themselves to maintain and improve their mental health". The single most important message for children and young people who have mental health issues, or are experiencing problems that can lead to them developing such issues, is to talk to someone they trust. It is also incumbent on school and other institutions, health services, and other types of organisation with which children and young people have contact, to publicise available helphnes and other sources of advice and support which may be of use for any child or young person who has a problem.

Children tell ChildLine that the most common causes for suicidal feelings are family upheaval, relationship breakdowns, abuse, bullying, exam stress and mental health problems in themselves and in members of their families[15], and *UNTOLD DAMAGE* highlighted the extent to which family conflict and loss can impact on the mental health of children and young people. It is crucial that parents and carers know where to get help and support through times of stress and crisis, and that information on services such as Relationship Scotland and Parentline Scotland is more widely publicised.

Question 10: What approaches do we need to encourage people to seek help when they need to?

Comments

Successfully encouraging children and young people to seek help when they need to will depend on a wide range of approaches, given the plethora of evidence around young people's help seeking behaviour and the significant barriers that can prevent them from seeking help or support with issues such as mental health problems, including the following:

Family issues

Research from developed countries indicates that young people contact primary care health services mostly for respiratory or dermatological reasons, however for mental health problems they overwhelmingly seek help from friends and families rather than health services (Lancet, 2007). However, for many young people, family support is not available for a range of reasons, not least because family problems such as abuse and neglect mean families can be the main source of the problem for some young people. Furthermore,

[15] ChildLine casenote: Children talking to ChildLine about Suicide (2009)

children often tell ChildLine that they are reluctant to talk to their family or other carers about the emotional, mental health problems they are experiencing as they don't want to be a burden. Often, if parents are struggling with complex problems such as alcohol dependency, family breakdown, bereavement, unemployment etc, children can display a profound understanding of the pressures facing them and can be reluctant to 'add to' family difficulties, so striving to keep their own problems hidden.
This is backed up by CHILDREN 1ST experience in supporting families who are often referred to their services for more immediate concems such as family breakdown or substance misuse, but work with children, young people and parents often uncovers significant mental health concerns also having an impact on the family and in particular children and young people in the family.

Self referral services
Research indicates that children and young people frequently require an adult to be aware of a (mental health) difficulty to be able to access any specialised help. There are very few services that children and young people can access directly and without adult consent, therefore accessing formal support requires recognition of a problem and action by (supportive) adults. This raises very clear problems both for children who are experiencing significant family problems – as well as for children with emotional or conduct disorders, for example, who may be struggling significantly with relationships at school or who indeed may be excluded from school and may be much less likely to have contact with supportive teachers.

ChildLine consider access to self-referral services for children and young people to be crucial in order that all children, not just those with supportive relationships with adults, can access help before problems escalate. In addition, having to be referred to support services via a professional, can result in either a wait for the service they need, or not receiving the service as they do not fit the threshold. Self referral allows children and young people to recognise when they have a problem, and to seek support at a pace and time that is appropriate to them.
Peer support
Friends are cited as young people's most common confidantes across most problem categories for children and young people contacting ChildLine, indicating the central place of peer support programmes in young people's mental health promotion and prevention. The group work with children and young people carried out by organizations like CHILDREN 1ST as part of family suppprt programmes is valued by participants as a way of building resilience and valuable peer support.

Gender issues
More girls contact ChildLine than boys about all mental health issues, although the difference is far more pronounced in some areas. For example in calls about eating disorders in recent years the ratio of girls to boys was 18:1 and in self-harm 8:1 whilst in calls about suicide it was 3:1. This fits the general pattern of what ChildLine know about males contacting the service. Boys use the service less in general across all problems, for a range of cultural reasons, including difficulty in admitting to problems they can't deal with themselves. Subsequently, boys often wait longer before seeking help, and are more likely to have reached 'crisis point' when they call ChildLine. This is reflected in the kinds of concerns that boys can be expected to make contact about more often: physical abuse, sexual abuse, suicide. ChildLine works in a variety of ways to tackle gender differences in service use. Training ('*Working with Boys*') helps volunteer counsellors develop a different

counselling style when working with boys on the helpline (more direct, helping boys name their emotions etc.). The service has also worked with groups of boys to identify key barriers to their service use and involve them in developing potential 'solutions'. ChildLine is in no doubt that tackling long recognised gender differences in help seeking behaviour, and encouraging boys to talk about problems are crucial aspects of preventing mental health problems in boys and young men.

Fears about confidentiality

Confidentiality is a key reason that children and young people use the ChildLine service and it is clear from what many young people tell us that perceived lack of confidentiality remains one of the main barriers to young people accessing help from GPs and other statutory services when they need it, for a range of problems, but particularly in respect of mental health concerns. The new online channels introduced by ChildLine in 2009 are accounting for much of the increase in contacts about mental health issues, and it is clear that children and young people are finding it easier to explore their feelings around issues such as suicide and self harm online, via 1-2-1 chats, Personal Inbox Messaging (e-mail), Message Boards (peer support), and can access a huge variety of information and advice on the web site. ChildLine's confidential helpline service overcomes a range of access barriers for children and young people. The helpline service with its range of contact channels represents a 'safe space' where children can explore a range of feelings at their own pace, without feeling pressured, and without fear of automatic breach of confidentiality. It is often a first step in the difficult process of children accessing the help they need.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

As indicated previously, the *Mental Health of Children and Young People* provides a framework for mainstreaming young people's mental health across universal and community settings. ChildLine contact data is a valuable source for understanding the barriers to young people accessing health services. Confidentiality is a major issue. Many callers are reluctant to access health services, such as CPs about sensitive issues because of fears about parents finding out, or things being taken out of their control. Even where

efforts have been made to make services more available and accessible, young people may not access them because of fears about confidentiality[16].

Confidentiality is one of the key reasons that children and young people use the ChildLine service. This means we are often the first point of contact for young people who have identified, or are in the process of identifying, that they need some form of help or support in relation to their mental wellbeing. The sheer volume of young people who call each year about mental health related issues underlines the importance of confidential services for young people. Many of these cases would not necessarily warrant a CAMHS response, reinforcing the importance of confidential services for early intervention and prevention. ChildLine and the Centre for UK Learning in Child Protection have jointly been investigating children's right to confidentiality. A report of this work will be available shortly, outlining practitioners' views of the tensions inherent in affording young people confidentiality in mainstream seryices and outlining some potential solutions[17]. ChildLine believes that statutory services need to be more creative in how they engage children and young people. It is clear that a 'one size fits all' approach is not sufficient. We think that making available a range of options, including drop-in services in a range of settings, online advice and support, and therapeutic interventions will help to encourage young people to seek help at the earliest opportunity. We also need to eliminate the 'hoops' young people need to jump through to access services.

We think the ChildLine service could be more actively promoted by other agencies as a first point of contact for children and young people in relation to mental health services. Initiatives such as *Choose Life* and *See Me* already do this, but young people could benefit if this was implemented more widely by other service providers.

We also think that GP practices, health clinics, social service departments, schools etc. could be better informed about the benefits of helpline services as a first point of contact and a source of support to young people.

ChildLine strongly recommends further exploration of the potential of telephone and on-line counselling for young people as an integral aspect of young people's mental health improvement and ChildLine in Scotland would be happy to collaborate in any research project.

[16] WHO. Global consultation on adolescent health services - a consensus statement. Geneva: Department of Child and Adolescent Health and Development, World Health Organisation, 2001

[17] Roundtable Report ***Finding the balance: Children's right to confidentidlity in an age of information sharing*** (please contact ChildLine for a copy)

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Comments

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

Comments

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

Comments

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

Comments

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Comments

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

Comments

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

Comments

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Comments

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

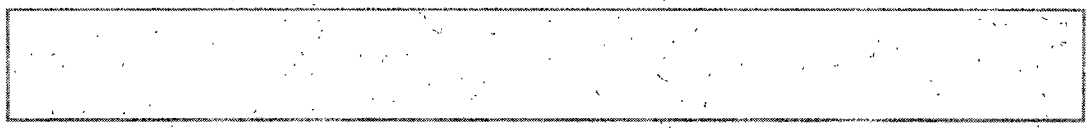
Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

Comments

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments



Question 23: How do we disseminate learning about what is important to make services accessible?

Comments

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Comments

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

Comments

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

Comments

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a routine aspect of care delivery?

Comments

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

Comments

Question 34: What specifically needs to happen nationally and locally to ensure we effeetively integrate the range of improvement work in mental health?

Comments

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

Comments

ChildLine would be happy to provide case studies, and work with the Scottish Government in looking more closely at information on mental health issues over a set period from the ChildLine contact database (particularly from online contacts), to help inform the design of services for children and young people.

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Roundtoble Report

Finding the balance: Children's right to confidentiality in an age of information sharing

Friday 30th September 2011, NSPCC/ChildLine Offices, Glasgow.

Louise Hill, Centre for Learning in Child Protection.
Alison Wales, ChiidLine in Scotland

Key summary

In September 2011, a Roundtable event was organised by ChildLine Scotland and the Centre for Learning in Child Protection at the University of Edinburgh to critically explore children's right to confidentiality and the need to share appropriate information with on explicit aim of safeguarding children.

There is a clear tension in children's right to confidentiality and the increasing policy directives on sharing information amongst professiondls to effectively safeguard children (Munro and Parton, 2007). The decision to breach confidentiality will be informed by professional judgement and practice. The sharing of 'appropriate' information will be open to interpretation. Children and young people's key concerns are around confidentiality and their ability to control what is known about them by others. This is a difficult area where there will be divergent and strongly held views informed by professional practice. We welcomed the opportunity to share our ideas and have an opportunity to debate.

The event involved thirty participants with specific expertise and insights into confidentiality across health, education, social work, children's hearings and third sector organisations. Discussions were informed by presentations that highlighted the key issues from legal, policy and practice perspectives. Children and young people's views were also shared via a presentation. The event used 'Chatham House Rule' to allow space for free discussion without affiliation to specific organisations or individuals. This event was funded by the University of Edinburgh Moray House Seed corn fund.

The key issues raised were:

- Professional confidence and sound professional judgement are the cornerstone of a good child protection system
- Various factors are undermining professional confidence including lack of support and a proliferation of complex guidance
- Confidentiality is of fundamental importance to children and young people when accessing support from services or professionals
- 'Confidentiality' and 'information sharing' are not well understood in practise
- Professional guidance and practice differs with regards to children's right to confidentiality; this presents specific challenges when multi agency working and may lepd to unnecessary breaches of confidentiality
- There is an inherent tehsion in respecting children's right to confidentiality in a process driven child protection system
- There is a clear need for societal debate about the child's right to confidentiality and the professional response to child protection

Conclusion

Findings from the discussion forum suggest that decisions about information sharing and breaching children's confidentiality ore often not being driven by consideration of the best interests of the child. This is a complex and vital issue that urgently requires greater discussion and widespread debate. A range of actions associated with key concerns practitioners raised are outlined at the end of the report and may usefully inform wider discussion.

Main report

The debates surrounding children's right to confidentiality are not new. ChildLine was set up specifically to provide children with a confidential space, after the 1986 child-watch study uncovered the extent of abuse in the UK and the sheer numbers of children who suffered in silence, unable to tell adults or seek help (ref). Yet when ChildLine was established, many professiondls queried how a service could operate when children report abuse and statutory authorities were not informed. In our Roundtable event, we were all reminded of these challenges in an opening address.

> 'In the early days we had many battles to win. Social workers would ask me "how can a child report abuse and you do nothing?" I replied, "When a child chooses tp call ChildLine to talk about abuse, we never 'do nothing' – we listen to the child and this is the first step." (check)

ChildLine has not lost sight of what matters. Children choose to contoct ChildLine services, they communicate at their own pace and they retain control of what happens in the vast majority of cases. Over the years, physical abuse and sexudi abuse have consistently been reported in the top five reasons for why children have contacted ChildLine. In 2009/10, 508,943 children across the UK contacted ChildLine directly asking for help, advice and protection (NSPCC, 2010). These figures alone highlight the importance children and young people themselves place on having access to a confidential support service.

This report is divided into three sections. In the first section, the legal, policy and practice framework in Scotland is outlined. In the second section, the findings from discussions generated in the roundtable event and in three small group discussions with young people ore presented. In the final section, a series of action areas ore identified to develop this work.

1 Context

1.1 Legal

There are several legislative frameworks that cover confidentiality and information sharing. Key statutes include The Human Rights Act 1998 which incorporates the European Convention on Human Rights (ECHR) into domestic law and the Data Protection Act 1998. In 199.1, the UK Government ratified the United Nations Convention on the Rights of the Child (UNCRC) 1989. The following Articles are particulorly pertinent when considering confidentiality and information sharing:

UNCRC Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right fo 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.'

UNCRC Article 16

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

Under the Children (Scotland) Act 1995, children's views should be sought taking into account the age and maturity of the child. This Act established discretion for a degree of confidentiality for children participating in the Scottish Children's Hearings System. For example, Section 46 states panel members have the right to clear the room to speak privately with a child at a Hearing. However, this is rarely used and the substance of what the child has said must be disclosed, although Griffiths and Kondel (2006) found panel members displayed a flexible interpretation of what 'substance' may entail.[1]

If a child is deemed to have sufficient capacity, they have the same legal rights as an adult; for example, they can consent to medical treatment and instruct a solicitor. Professional codes of conduct and guidance may invoke a legal duty. For example, a duty of confidentiality exists between a doctor and a patient. A breach of confidentiality could lead to a criminal investigation and professional disciplinary action. However, there are statutes that would override a duty of confidentiality; for example, information may be shared without consent if it is: in the public interest, in the best interests of the child or is required by law (GMC, 2007). The UK does not have a mandatory reporting system for children who are abused; however, professional guidance may indicate a duty to share information when a child is 'at risk of significant harm' (ref). Dowty (ref) suggests that professional cultures may imply mandatory reporting.

1.2 Policy

Sharing appropriate information about children who are in need of support, or 'at risk' of harm, is a central component in the Scottish Government's programme, Getting it Right for Every Child (GIRFEC). Professionals across agencies are encouraged to share appropriate information with an explicit aim to safeguard children. The UNCRC highlights the need for a proportionate response when acting to protect a child where action 'must avoid causing the child undue distress or adding unnecessarily to any harm already suffered' (ref). As part of the national child protection reform programme, a consultation with children and young people produced: *Protecting children and young people: The Charter* (Scottish Executive, 2004). The Charter included key messages of 'respect our privacy' and 'think carefully about how you use information about us'.

[1] The Children's Hearings (Scotland) Act 2011 is planned to be fully implemented by September 2012 (until then the Scottish Children's Hearing system will continue to operate using the Children's (Scotland) Act 1995).

The National Child Protection Guidance 2010 clearly states there are limits to confidentiality. In the Guidance, paragraph 93 states: If a child is considered to be dt risk of harm, relevant information must always be shared. However, the Guidance also reflects on the challenges in applying this principle when children and young people access services because they provide confidentiality. As the Guidance recognises,

> Many young people need the time and space that such confidential services can offer to talk about their problems with someone who can listen and advise without necessarily having to refer (Scottish Government, 2010:28)

The Guidance also states that 'service providers have a responsibility to act to moke sure that a child whose safety or welfare is at risk is protected from harm' and service users should be made aware of the heed to breach confidentiality when initially in contact with the service (Scottish Government 2010:138). One of the challenges in the interpretation of national guidance may be in ensuring a balance in recognising young people's need for time and space whilst responding to the outlined 'responsibility to act'.

1.3 Practice

A literature review of fifty-four papers on adolescents' views of helping professionals found 'what I tell them is confidential' and 'they explain things and give me information and advice' were ranked as most important (Freake et al., 2007). Yet, many children and young people are often unaware of their right to confidential services (Freake et al., 2007). There are various sources of support where children and young people may have a degree of confidentiality when accessing a universal or specialist service. One area of provision that may have particular expertise in this regard is the work of sexual health services. If a child is considered to hove the capacity to make an informed decision, they hove the right to access services independently (i.e. without the need for parental or *locus parentis* permission). As discussed in Section X, professionals have a wide range of experiences across disciplines of different approaches to principles of confidentiality. This section considers two specific examples in Scotland of services that provide higher thresholds of confidentiality for children and young people.

The ChildLine service was set up specifically to provide children with a confidential space after the 1986 child-watch study uncovered the extent of abuse in the UK and the sheer numbers of children who suffered in silence, unable to tell adults about their problems or seek help.

Children and young people choose to talk to ChildLine because they know they will receive a confidential service and that what they say will not go further unless they wish. On occasions, this contract of confidentiality can be broken if the information a child gives concerns life threatening situations, risk to other children, adult abusers and abuse by an adult in authority (see ChildLine's confidentiality policy, Appendix one). Confidentiality is crucial for many children who contact the service for a variety of reasons: children and

young people can greatly fear the consequences of particular people finding out about their problem; they are often deeply worried that disclosure will initiate a sequence of events over which they will have no control, or that it may harm people they love or result in a worse set of circumstances than they ore already living with. Many young people need the time and confidential space that ChildLine offers to talk about their problems with someone who can listen and advise whilst not necessarily having to refer. In ChildLine's experience, automatic referral before a child or young person is ready to talk about what is happening to them can lead to retraction. (see appended cases study)

The confidential aspect of the service means ChildLine hears from many 'hidden' children and young people, who are currently outwith the child protection system and who may only enter it with the kind of support and encouragement that a confidential listening service can offer. Notwithstanding that telephone callers con opt for anonymity and therefore in most cases ChildLine would require the consent of the child before referring to a statutory service, risk assessment is at all times and with every child an ongoing aspect of handling the coll or other form of contact. As well as listening and providing a non-judgementdl ear to any problem thdt a caller presents with, ChildLine works with the child, at the child's own pace, to help them understand what is going in their lives, and support the child to moke an informed decision as to what should happen.

Children con contact ChildLine through a free telephone Line, email and text services. The ChildLine interactive website also provides opportunities to seek information, read and contribute to user generdted threads on moderoted message boards, as well as ploy games.

Established in 1994, the Eighteen and Under service in Dundee provides free and confidential support to young people who have experienced any kind of abuse. The service is open to all and is led by the young person (for example, they do not have to share their name or date of birth). The service has evolved and developed to meet the needs of the young people accessing the service through twice yearly consultations. The service does not offer absolute cbnfidentiality as it recognises that there are occasions where, in discussion with a young person, it is recognised that others may need to be involved. With many years of experience, the service highlights the strengths of the service:

> 'If we listen to them, we build trust and confidence and when they are ready to go forward, they never retract. Most young people tell, and then pull bock. We tell them the truth – we tell them it's unlikely to get a cbnviction, families fall out and take sides, court will be a nightmare and might dp nothing – we tell them this. This is our experience.'

The service strongly advocates the provision of confidential spaces for young people. The inequality of age in accessing services was recognised where young people may wait until they ore aged sixteen years old before they access a service due to concerns about confidentiality. The service emphasises the importance of each individual young person and the focus

on sharing information should be informed by the benefit to the young person.

2 Sharing expertise at the Roundtable event

2.1 Key learning from children and young people

ChildLine in Scotland conducted three discussion groups involving 29 children and young people aged 15 - 21 on the topic of confidentiality to inform the Roundtable event. The young people involved in the discussion groups were drawn from two ChildLine in Scotland Young People's Advisory Groups in Glasgow and Aberdeen, and from an LGBT youth group in Glasgow. Young people were asked to work together to agree definitions of confidentiality (in relation to concepts like 'secret' and 'private') and also to discuss case studies illustrating issues around young people's confidentiality.

Young people shared some clear understandings of confidentiality which they defined using concepts like 'serious' and 'professional'. A spectrum of seriousness emerged in all discussions and definitions, with 'confidential' at the serious end of the spectrum, 'private' somewhere in the middle and 'secret' the least serious. 'Seriousness' related both to the level of confidentiality young people would expect and also to the kind of issues that young people would be seeking help with.

All groups considered confidentiality to be something that young people would expect from professionals, in contrast to 'secrets' which would be told to friends and which would almost inevitably at times be given away.

Confidentiality was clearly understood as a legal entitlement, backed up by 'law', 'duty' or 'policy' which professionals must adhere to. Whilst decisions to 'risk' telling friends secrets would be 'weighed up' based on personal knowledge of friends and their perceived trustworthiness, the 'official promise' of confidentiality was considered to be in port where young people's trust in professionals or services is derived from, when sharing personal information. However whilst young people clearly understood confidentiality as an important right, they were much less clear about what this meant in practise. For example, only one discussion group (5 young people) were aware that they had a right to see a GP confidentially.

Confidentiality was not considered to be absolute and all groups included the concept of some kind of 'line' in their definitions, beyond which confidentiality could not and would not be expected by young people, as follows:

> '[Confidentiality is upheld] unless you ore in danger – there's always circumstances where things would not be kept confidential'.

There were a series of discussions about situations where confidentiality would not be upheld, for example 'if it is life threatening' and 'when it's a really big thing – a serious thing like abuse', in the case of two groups.

There were also a series of discussions about cose studies involving situations where a young people had disclosed information to a professional which indicated that they may be at risk of harm. In all groups, the level of cohfidentiolity that young people felt should be offered shifted towards being determined by the individual circumstances of the child and what would be in their best interests, rather than by a predetermined threshold, as the following extract illustrates.

ChildLine Composite Case Study*

Rachel is 14. Her step-dad has a terrible temper and is otten violent. He bullies her mum and sometlmes batters her when he gets angry. Rachel tries to protect her mum and sometimes gets hit too. Rachel and her mum have never told anyone what goes on. They are very scared ot what Rachel's step dad mlght do it they told anyone.

One evening Rachel got a black eye when she got between her mum and her step-dad. The next day in school the teacher asked to speak to her privately and osked her very kindly about her blacк eye. Rachel got upset and told the teacher what was happening at home. The teacher was supportive and understanding but said she had to tell the Head Teacher - and also that they would need to contact social work and possibly the police. Rachel was very upset and scared. She said she needed time to warn her mum that she had told the school and also needed time for her and her mum to think about what might be the best thing for them to do. But the school said they had to contact social work immediately. Rachel was extremely upset and ran out of the building. ... ...

21 young people were asked to consider this case study in small groups and discuss their thoughts about what happened.

There was some feeling in one group that it was 'good the school had taken over as bad situations can just go on and on unless someone steps in'. Nevertheless the group concluded that Rachel should have been given more time and support to think through her options before her confidentiality was breached.

One group felt it was possible that immediate breach could have escalated the situation and made things worse for Rachel and her mum.

All groups thought Rachel should have had time to talk things over with her mum, for example although some young people felt it was important that this happen immediately, with Rachel's mum invited in to the school for joint discussion.

One group felt that because Rachel had opened up to a teacher she trusted, the school was now in an ideal position to work with her, building up a better understanding of what was going on in her life. They thought the situation could have been monitored over time, with social services becoming involved it it did not improve.

Overall, young people were unanimous in concluding that Rachel's confidentialify should not have been breached immediately. Whilst they understood that she was in an abusive situation and potentially at risk of harm, they felt she should have been given more time, with support, to think about what should happen and more agency in making decisions about her own life because, for example;

'She's 14 and it's her life, her situation'.

All young people considered it imperative that the school stay closely involved in Rachel's situation.

*This cases study draws on what children tell ChildLine, but it does not describe a specific case

A third of children phoning ChildLine, who were worried about confidentiality, expressed a specific concern about the confidentiality of potential support services, including doctors (ChildLine Scotland, 2006). More recent anecdotal evidence from ChildLine counselling supervisors highlighted that confidentiality was a significant concern for children and young people when contacting the ChildLine service. Current recording procedures only allow a limited insight where concern about ChildLine's confidentiality is recorded. In 2010/11, 1 500 children explicitly wanted to discuss ChildLine's confidentiality; counselling supervisors highlighted that this was a considerable underestimation. Furthermore, confidentiality was considered to be a greater concern for children and young people where there was a greater risk of harm.

In a study of children's calls to ChildLine over a one year period who had experienced abuse, just over half discussed with the counsellor whether or not they had talked to anybody else and 69% (1649 out of 2404) told the counsellor they had spoken to somebody else (Vincent and Daniel 2004:162). The majority of these children chose to speak to a friend (44%), followed by a parent (22%) or a professional (9%). This suggests that there ore many children and young people who ore experiencing significant harm who professional adults hove only a limited awareness.

2.2 Key learning from discussion groups

Importance of the principles of confidentiality

> "Not enough thought is given to the issue of when to breach confidentiality because we have lost sight of the best interests of the child and confidentiality as fundamental principles."

There was a broad recognition of the vital role of confidential services and relationships which allow space for children and ypung people to talk about abuse and other serious issues, articluating their feelings and building trust in the person/ service they hove made a choice to talk to. Across the groups confidentiality was considered to be a fundamental principle; however, there was concern thdt decisions to breach cohfidentiolity were freauently not being informed by considering what was in the 'best interests' of the individual child. This was raised on a specific point where there was a concern that the 'best interests' of the child were being overlooked in sharing informdtion.

There was concern that the issue of confidentiality was not widely understood or felt by professionals to be fundamentally about respect for young people. Practitioners emphasized the privilege of being trusted by a young person enough in order for them to feel able to tell something.

Different 'thresholds' of confidentiality in different organizations were also regarded as confusing for both for children dnd young people and for professionals to negotiate. Practitioners pointed to the need for both to understand what 'confidentiality' and 'information shoring' mean in practice.

For example, teachers pointed out that 'sharing information' need not mean 'telling your parents' - a key fear for children in many coses. Nevertheless, there were seen to be clear cultural differences in the emphasis given within different services to parental rights and the child's right to autonomy.

Respecting every individual child

Every child is unique and 'a total individual'. This was also shared from a legal perspective in recognising that decisions about the capacity of a child hod to be based on the individual. Practitioners acknowledged the solid child centred principles underpinning Getting it Right for Every Child, however there was a concern that guidance over simplified the diversity of children and the subtle, complex and difficult circumstances in individual children's lives. This was highlighted in respecting the knowledge that children and young people hove about their own lives:

> "It's the child's life after all so they know more about it thdn anyone else. We underestimate children – even 4,5,6 year olds."

However, it was recognised that this was more challenging when a relationship did not exist and an ongoing relationship was not part of the service offered. In these circumstances it was suggested there was o much lower threshold for confidentiality due to a concern about not taking action.

There was a reflection that current guidqnce does hot acknowledge the agency of children and young people. This was raised specifically with regard to older children, many of whom may be judged to hove legal capacity to moke complex decisions about their own lives.

Professional judgements

> 'We need the culture of organisations to build the confidence of the professionals responsible for decision-making: must be non-judgemental, accept that mistakes will be mode sometimes, but it's about how those mistakes ore handled'.

> "There has been such an emphasis on sharing information that people think they are under obligations to shore, with professional judgment taking second place."

Practitioner confidence was considered to be the 'cornerstone of a proportionate child protection system'. However it was understood as being diminished or undermined by key factors including lock of on-going professiondl training; lack of support in decision making and for decisions mode, lack of solid practical advice in guidance (cose studies, prqctice examples) and ironically, the sheer volume of complex guidance, which was understood by some practitioners as 'poralysihg' professionals and making them feel less safe in their own judgement.

> "Complex guidance can de-skill people, create fears that professional judgement is inadequate."

There wos an emphasis on the importance of professional judgements when deciding whether or not to breach confidentiality. There was a concern that some professionals may not feel fully supported to make these judgements, including lack of time and space within professional line management arrangements to reflect on cases and make measured responses to children - which can lead to unnecessary sharing of information. It was recognised that complex decisions may be mode with the support pf line management.

There may be cultural expectation of sharing information about children and young people that may overlook the nuances of how, why and when information is shared;

> "We heed to remember that sharing information does not mean sharing ALL information. We must not lose the subtlety in these judgements."

Specific concerns were raised about the anxiety for teachers when children disclosed abuse with one participant commenting that teachers may lack confidence in dealing with disclosure, leading to unnecessary shoring, and that that the necessity of sharing information had been 'drummed ihto' teachers in guidance. Two participants shared their practice experience where teachers were not encouraging children to 'speak out' because of the traumatic process for the child in beginning child protection procedures.

Information Sharing

> "Information sharing is about protecting the bock of the worker, about following guidance. We need to stop and ask why we're sharing, what is the purpose of it?"

The underpinning principle of 'getting it right for every child' is understood as being fundamentally a good one. However there was concern that children's basic right tb confidentiality is subsumed by the process of GIRFEC: the procedural drive to gather and shore substantial volumes of information about children and young people without sufficient consideration given to how it will be used, and whose interests it is serving. The 'procedural drive' towards information sharing, con be and is interpreted by professionals as a compulsion to share. Subsequently, decisions about breaching individual young people's confidentiality ore considered to be in sorne cases driven by 'the process', rather than by the drive to get it right for each individual child. According to one practitioner, the key questions that should be asked are;. 'what is the purpose of sharing? 'how will it benefit this child? what is appropriate to shore and with whom?

> 'Papers ore filled in – procedures are in place and people just follow these. The child is rapidly lost. People don't make any active decision about confidentiality'

There was perceived to be a widespread lock of understanding of what information sharing means in practice and a dearth of cases studies and examples from practice in guidance, which could helpfully illuminate this area. Furthermore there was widespread concern that children and young people are not currently meaningfully involved in decisions to share and may hdve no clear understanding of what is going on. Prdctitioners gave examples of how giving clear information can be empowering, for example there is a world of difference to a young person between sharing information with people discretely in the some organization and 'telling your parents'.

The control of information

It was discussed that 'information is power'. Children are often in positions where they become powerless because they do not know what others know about them. One of the strengths of ChildLine and 18 and Under is the ability for children to control what information is shared; this can be a way of retaining some control. One of the concerns of sharing information about children and young people is their lack of control in this process and the consequence that they may choose not to share any information about their lives.

Questions were raised about children and young people's abilities to redress information shared about them. There were some shared experiences of information being inaccurdte and biased. There were significant concerns about the incorporation of children and young people's perspectives. This concern may be heightened for younger children, children with disabilities, children whose first language is not English.

Children and young people's experiences of disclosure/ child protection processes

> 'Young people consistently tell us that it (the disclosure process) con be traumatic. Stories of information sharing from young people are scary! Child protection in some coses has become the opposite from what you intend'

There was widespread concerh thot children's experiences of the child protection process were in and of themselves traumatic and that 'what happens after [children] have disclosed abuse con feel more abusive than the abuse'. Practitioners described situations where information sharing was not done 'as sensitively' as children would like, with one describing a risk of forgetting how traumatic information sharing can be for children;

"It's like ripping off a layer of skin"

A front line worker also described practitioner anxiety about communicating openly with children who hod disclosed abuse, for fear of contaminating evidence that may be used later in court proceedings. There was also concern raised about children being denied access to confidential,

therapeutic support prior to any legal case. This was framed as a court perception of evidence becoming contaminated.

3 Action

Legal

- Clear statement in guidance about children and young people's right to therapeutic support, at any stage of the disclosure or legal process, as advocated by Justice for Children.

Policy and guidance

- Wide recognition across policy and guidance of the importance of confidential spaces and relationships to the child protection system.
- Clear exdmples in guidance of how confidential spaces help to keep children and young people safe
- Overarching principles and values around confidentiality and information sharing to be agreed
- Strong position statement in GIRFEC on the importance of respecting children's confidentiality as o fundamentol principle and the parameters on information sharing. One suggestion is for confidentiality to be framed as the 'default position' within guidance; only where there is assessed to be need to share information should sharing happen.
- Consolidation of the same coherent message with regards to confidentiality across all relevant guidance.
- Discrete section on information sharing within GIRFEC.
- Urgent need for a critical discussion about how the child protection process is working fpr children and young people in practise, informed by children's actual experiences.

Practice

- Meaningful involvement of children and young people in decisions around information sharing.
- Multi agency child protection training for professionals with a clear emphasis on confidentiality and information sharing to increase practitioner confidence and support professional judgement. Training should involve practical cose examples and case studies to 'make it real' and move it out of the realms of policy rhetoric.
- Practice guidance on confidentiality and information sharing underpinned with cose studies and examples from practise. Crucially, practise guidance must include real exdmples of how holding a child's confidentiality can be in their best interests, helping to protect them.
- Time and space within the professional line management structure for practitioners to reflect on coses and moke measured responses to children and young people.
- Development and piloting of alternative models of providing 'safe spaces' for children and young people. One option forwarded is to pilot a joint voluntary/ statutory project offering a higher threshold of confidentiality, in one local authority area.

Conclusion

Findings from the discussion forum suggest that decisions about information sharing and breaching children's confidentiality are often not being driven by consideration of the best interests of the child. This is a complex and vital issue that urgently requires greater discussion and widespread debate. Key issues and action points outlined in this report may usefully inform wider discussion.

Appendix one

Composite cose study, ChildLine in Scotland

Pauline (16) called ChildLine because she was being sexually abused by her father. It has been going on for two years. She hod a younger brother but was certain he was not being abused. Pauline had not told anyone about the abuse as she thought no one would believe her. She said 'dad's so well thought of and he's got a good job'.

Not long after Pauline began calling ChildLine her father moved out of the family home but she remained terrified of him. She believed that the abuse had been her fault and she also felt 'it was meant to happen'.

Pauline wanted to talk to ChildLine but also said she didn't want to as it was so frightening and upsetting for her to talk about what had happened. She spoke about hdving 'different personalities' as a way of not thinking about the abuse.

In Liz's opinion (Pauline's counsellor at ChildLine) when Pauline called ChildLine she was incapable of trusting anyone, especially moles. Nevertheless, after speaking to ChildLine for several months she decided to speak to a face to face counsellor. After Pauline told her story, and without her knowledge or permission, the counsellor went to the police, destroying her faith in the counsellor and her confidence in being able to proceed at her own pace. When social services visited, she refused to speak to them'.

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