

CONFIDENTIALITY POLICY FOR THOSE WORKING WITH YOUNG PEOPLE.

WHEN IS INFORMATION CONFIDENTIAL?

The Children's Legal Centre document says 'it is generally accepted that a duty of confidence arises where confidential information comes to the knowledge of a person (the confidant), in circumstances where that person has notice, or has agreed, that the information is confidential'.

In a youth work setting circumstances should include if the young person makes any attempt to restrict the environment or the audience. For example, asks to talk in private, moves you away from others before talking, talks in a whisper, and watches the whereabouts of others.

A confidence may even seem trivial, but it does not mean it should be treated with any less discretion. It is not for youth workers to judge what personal information is.

HOW DO I KNOW IF INFORMATION SHOULD BE TREATED AS CONFIDENTIAL?

There are three principles to be applied in assessing whether information given is to be treated as confidential;

- a) The information must be confidential. Once the information is in the public domain and is generally accessible to others, it is no longer confidential.
- b) The information must not be useless or trivial.
- c) The information must have been given in circumstances where the confidant must reasonably have understood that what was said was confidential'.

WHAT ARE THE LEGAL ASPECTS?

The concept of a 'confidential relationship' is recognised by law. Certain professions have an obligation of confidentiality, by the nature of the relationship that exists between the worker and the client. There can be little doubt that the youth worker is included in this group. A young person therefore has the right to have their confidence respected, and the youth worker has an obligation to maintain and respect that right.

There exist exceptional circumstances where confidentiality cannot be maintained, and a young person's wishes must be overridden, defined as being where:

- The young person is in a life threatening situation (including self harm)
- Inaction might place them or someone else in a life threatening situation
- If a young person is threatened by an abuser
- Where the rights of other young people who have not been consulted would be infringed
- Where someone else could be harmed

However, they do not include disclosure about a young person's

- Drug use
- Illegal activity
- Sexual activity

WHAT SHOULD I DO IF I HAVE TO DISCLOSE CONFIDENTIAL INFORMATION?

When a decision is taken to disclose confidential information the following procedure must be followed:

Inform Senior Leader (eg Line Manager, Parish Priest, Diocesan Child Protection Officer). This can be done directly or the youth worker can inform their immediate line manager, who will then pass the information on. Speed is of essence, especially in cases where exceptional circumstances apply. There is an emergency call out system, this should be used.

An action plan following guidelines and attached flow chat will be agreed with the Senior Leader which could include an agreement as to who informs Social Services. In these circumstances Youth workers have a statutory duty to inform Social Services of 'suspected or identified abuse', whether sexual or physical, which would include information disclosed about another young person.

Whenever possible this should be done with permission of the young person, who may need a lot of in depth support from the youth worker to be able to make this decision. However, with or without the permission of the young person involved, the information must be passed on to Social Services.

Confidential 'file notes' need to record all actions taken.

CONFIDENTIALITY POLICY WORKING GUIDELINES AND FLOWCHART

This paper refers to all situations where personal or private information is shared, including those which may arise in a befriending relationship, prayer support, or in initial telephone calls/emails seeking advice. It also offers advice to those working in situations where issues of confidentiality relating to eating disorders or self harm may arise.

What does the law say about confidentiality?

Whatever your role, it is important that you know what your position is legally regarding issues of confidentiality – and this is any time when ‘confidential information comes to the knowledge of a person (the confidant) in circumstances where has notice or is held to have agreed that the information is confidential’. What this means is any time you *agree* to keep something confidential, or it might be *assumed* that you would (for example if someone asks to speak to you in private). Relationships such as that between a counsellor/pastoral carer and a client would certainly be covered by the constraints of confidentiality, and would any where you are undertaking one to one support of a young person or child. Greyer areas might be if someone talks to you about something private in an environment where theoretically other people could hear – perhaps at the end of a meeting, or if you are told information that is well known to friends of the person in question, say, but not to their parents.

Legally, confidentiality can be broken on certain grounds – if for example it involves a serious crime. One unusual situation is also if someone is to be forced to receive treatment under the mental health act (for example in-patient treatment for anorexia, or suicidal attempts) – where the Mental Health Act (1983) states that their nearest relative must be consulted. However, situations such as they are very rare.

No information, be that addresses, phone numbers, emails etc or personal details such as those relating to the individual’s mental or physical health, will be passed on to any external parties (ie those not within the main committee) without the permission of the person in question except in the following circumstances:

- If a child or minor may be at risk.
- If the individual in question may be themselves at risk of death or serious injury.
- If the individual is not able to give consent themselves.

In occasions where a request is made for prayer for further support, where possible this shall be achieved preserving the anonymity of the individual. Please note that even using initials may breach this requirement if it makes the individual potentially identifiable. Individuals who receive copies of prayer lists, or requests for prayer should be clearly informed that this information is strictly confidential.

Children, young people and confidentiality

In situations where confidentiality issues concern children and young people, further guidance is required. Working with this age-group, who are by definition at increased risk of both eating disorders and self-harm, may present situations where legal or ethical judgments regarding confidentiality are required. An example of this would be the question of whether or not it is right or acceptable to inform a child or young person's parent/guardian if the child is struggling with one of these issues.

At what ages does a child become considered an adult?

A document released in 2003 to the NHS offers some up to date guidelines which answer this question¹. It states that young people aged 16, 17 or above are assumed to be as able as adults to consent to treatment – and therefore are entitled to the same confidentiality as adults. Children under the age of 16, however, can also be given the same rights as adults, as long as they can be demonstrated to what is called 'Gillick competent'. This term dates back to a case in 1985 where a judge ruled that a young person under 16 had the legal capacity to consent for medical treatment (in this case contraception) without his/her parent's knowledge if they met certain criteria. These are that they were able to understand the advice they were being given, and its implications to their health, both long and short term as well as the other choices they had. Children who meet these criteria, according to the NHS guidelines, are also able to make decisions about the disclosure of information they have given in counselling (or similar) situations, when they do not want their parents to know. So basically, if the child or young person has the intelligence and understanding to appreciate the long and short term implications for their health, and what their options are, they can request that their parents are not informed.

So if I think they are able to think like an adult I can treat them as one?

In essence this is the case. However, two important other things **MUST** be considered.

The first is that it is expected that you will do all you can to try to persuade or enable the child to share the information with his/her parents. This is particularly important in situations such as self harm or eating disorders, where it is difficult to be sure just how much the child/young person is or is not aware of the risk to their health, and may also simply be too afraid of what will happen if their parents find out. It may well be that you are able to assist them in speaking with their parents, and also in what happens next.

The second vitally important point is that whilst the law does protect the child/young person's right to confidentiality, it does not protect them if they are refusing treatment for a condition which might be life threatening. In this situation what is called your 'duty of care' would require you to break confidentiality to make sure that those with parental responsibility (parent/guardian) were able to seek treatment. In this situation, if the child is under 16, the parents can then consent to treatment on their

behalf, even in situations where normally the child would be judged as able to consent.

Whatever the situation, you need to be aware that potentially you could be asked to justify the actions you took. Therefore it is essential that you do consider very carefully what action to take.

So what if I do think the parents should be told? How can be sure it is ok (or right) to overrule this and break confidentiality?

Obviously there are two main challenges to anyone working with children or young people presented here. The first is how to determine whether or not a child is or is not 'Gillick competent'. Ultimately, proving Gillick competence can be very complex and could require professional intervention including a psychological assessment which measured the child's cognitive and emotional development as well as identifying any mental disorder which might affect his/her ability to make decisions. Obviously someone suffering from an eating disorder, or in extreme circumstances self harm, may be unable to appreciate the risks they are taking with their health – for example in continuing to try to lose weight even though they are already very thin, or in persisting with risky behaviours such as abusing laxatives. If this were the case then it could be argued that they were not competent to make decisions regarding their treatment. Again, it is vital to realise that if they are refusing to seek treatment, and are risking their long term health or even life, then you have a duty of care to ensure that their parent or guardian is informed.

An aside on the case of child protection

It should always be noted that it is unwise to ever promise a child or young person that you will keep information confidential before they have revealed it to you. In the case of abuse or child protection concerns you may well be obligated to inform the relevant authorities, particularly if children are currently at risk. Situations such as this should be covered by your church or organisations child protection policy. If no such policy exists, it is recommended that the leadership immediately contact the Diocesan Child Protection Officer in order to draw up a child protection policy as such guidelines are an essential backup for anyone working with children or young people.

If you do feel it is necessary to break confidentiality and inform a parent/guardian:

In this situation it is important to be aware of the risk that the child/young person may feel betrayed and an overwhelming sense of loss of control. It is important that this is minimised, and for this reason it is important to take the time to explain to them calmly and clearly why you will be forced to inform their parent/guardian. It may be that once they understand the position you are in, they may be more willing to seek treatment, or to try to inform their parents themselves or with your help.

It is always our advice that if you share a confidence with a child/young person, you make clear to them that there may be circumstances where you are unable to keep information completely confidential but might have to tell someone else. Do reassure them that if this is ever the case you will tell them before you take any further action. This helps them to understand when they can and cannot be sure that information will remain confidential, and removes any fear that they have that you may inform someone else without their knowing. It sets out clearly what the position of trust between you is, and also emphasises that you have their best interests at heart.

What about sharing within a leadership team?

If you are working or volunteering for an organisation such as a church or youth group, it is suggested that the leadership of your organisation agree a clear policy on whether or not information regarding potentially risky behaviours (eg eating disorders, self harm, etc) should be shared with any other members of the leadership team. It is inadvisable for one person to make decisions regarding confidentiality issues in such a potentially serious context on their own and for this reason we would advise that at least one member of the senior leadership is always informed if such issues are divulged to any leader. If a decision is made to break confidentiality and contact a parent or guardian this decision should *always* be made at a leadership level and *never* by an individual acting alone. In this situation it should be made clear to the child/young person that the information will be shared with that person, but that it will remain confidential beyond this point unless there is a need to inform anyone else. Decisions regarding any action that may or may not need to be taken should then be agreed between all those who are aware of the ongoing situation.

THE RIGHT 'NOT TO KNOW'

You need to recognise your own limits when it comes to keeping confidences. You should not feel that it is a strict requirement of the job to accept any and every confidence offered to you.

You may feel yourself to be:

- Insufficiently skilled or experienced.
- Worried that your own beliefs or experiences may interfere with your ability to keep a confidence.
- Unable to give the commitment to a young person that the disclosure might lead to.

You need to decide your limits in advance of a confidence being made, in order to avoid putting yourself in a difficult position, breaking the trust of the young person or letting them down. It is important that you seek to inform the young person of these limits before the confidence takes place.

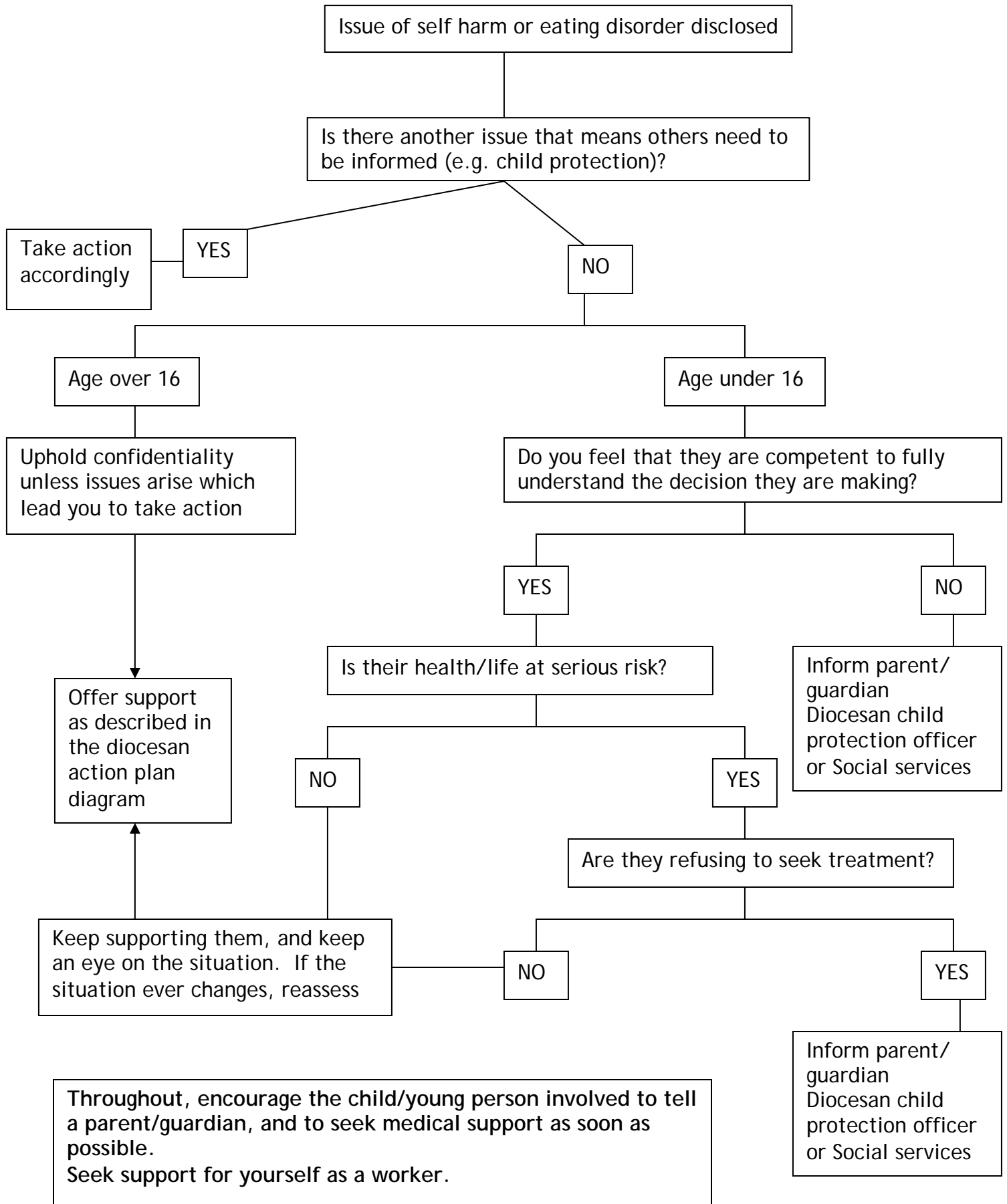
FINAL WORD

As can be seen from the document you have just read, issues of confidentiality are often complex and workers may find it difficult to decide on the best course of action. It is important that staff use the many policy and guideline documents provided for their 'support' and that they do not try to handle the issues alone.

1 Confidentiality: NHS code of practice, Dept of Health 2003

AT A GLANCE - CONFIDENTIALITY & EATING DISORDERS/SELF HARM

- issues of confidentiality regarding children/young people and eating disorders/self-harm



SELF HARM

BACKGROUND PAPER

Introduction

The self harm is the act of deliberately of injuring yourself physically. It can be unnoticed harm, hitting or punching themselves, or taking small doses of poisonous or reactive substances. It can also include acts of visible damage, such as cutting or burning.

At the present time the UK has the highest rate of self harm in Europe, and self harm leads to around 15,000 A & E attendances each year. About 1 in 10 teenagers say that they deliberately self harm.

It generally starts in adolescences, average age is 13. Peaks in early and mid 20s if no help is sought. It is not just a problem for girls, although more girls than boys seek help. It is strongly linked with problems of low esteem and confidence.

How can we help

- Do talk about what is going on.
- Do help them see that you understand – and help them to understand.
- To ensure their safety in episodes of self harm.
- To encourage them to get some help.
- Get some support yourself.

One of those difficult and frustrating issues about self harm is that it can easily be manipulated. Suffers feel that the only way that they will get love, care and attention is if they force you to show it, and they can do this by self harming. Such manipulative behaviour includes threatening to harm themselves if you don't call round, making sure you see scars or evidence of harm, reluctance to improve, and easy on relapse following any step forward. This means:

- Always needs to keep very clear boundaries.
- Try and not to react to manipulation.
- Try not to confront it when you experience it.
- Do not handle the situation alone.

Practical Suggestions

Discuss why people self harm.

- Teach or trying different ways of dealing with negative emotions.
- Teach the whole youth group.
- Be willing to share how you deal with emotions, being aware of your own strategies.

Note:

1. Self harm can be catching, if one person begins to self harm it is possible that others in the group will want to do the same.
2. Self harm is not the same as attempted suicide ('self harm is an attempt to feel better, not to die. Suicide, in contrast, stems from the desire not to feel at all any more')

EATING DISORDERS

BACKGROUND PAPER

Introduction

This is generally thought to affect up to 2% of the female population. However some studies suggest much higher rates than this. The EDA estimates that around £1.15m people in the UK are suffering from eating disorders. Only 60,000 on average are receiving treatment.

There are a number of different types of eating disorders, for example, the two most common are anorexia nervosa, bulimia nervosa.

The potential medical consequences can be very serious.

There are many causes for eating disorders, there is evidence, and they may be initial diet, concern about body image, family dysfunction, relationship difficulties. There are also more serious causes, low confidence and self esteem, perceived responsibility of other people's happiness, revulsion of life, abuse etc. In all these cases action needs to be taken.

Action

If you are concerned about someone:

- whatever you do do something.
- early identification is important
- be aware – particularly if you are working with young people who are high risk.
- cover background issue with everyone if you can – e.g. self esteem – discuss weight issues.
- if you find out there is a problem – don't panic, think am I the best person to tackle this.
- do talk to them – but try to avoid focusing on food or weight.
- Be on their side and engage.
- bring hope, and support as they start to seek help.
- don't go it alone – get support yourself.