FMC
Mediation and Counselling Victoria

Young Children, Confidentiality and Consent:

Educating Young Clients to Improve Child Safety

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FMC Overview

FMC established in 1983

Receives majority of funding from Commonwealth Government

Provides services across 21 locations across Victoria

Over 7500 clients per annum

- Relationship Counselling
- Individual, Children and Young People's Counselling
- Family Dispute Resolution
- Legally assisted FDR
- Family Mental Health Support
- Parenting after Separation groups
- Bulk billed psychological services in schools and clinics
- Financial Counselling & Financial Capability development
- Respecting Elders service
- Training services

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Overview

Current context

Informed consent

The FMC model

Parental styles and child development

Child safety standards

Case studies

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Current context of consent in child therapy

Consent in child therapy is focussed on ensuring that carer's are informed on the child's behalf

The introduction of the Child Safety Standards includes a shift towards empowering and inviting children to directly communicate risk and abuse

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Informed consent

Our legal and ethical frameworks have focussed on when a client can be considered capable of informed consent

A child of 16 or over can provide consent unless shown to be incapable. A child under 16 is assumed not to be capable of providing informed consent unless shown to be capable.

Without informed consent important therapeutic decisions must be made with the input of a legal guardian

Such a structure can highlight the power differential between the clinician and the child client. Also between the child client and their guardian

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Successful therapy

Strength of the therapeutic relationship

Sense of trust

Sense of credibility

Barkley, R. A. (2013). *Defiant Children: A Clinician's Manual for Assessment and Parent Training.* New York: The Guilford Press.

General Medical Council. (2000). *Confidentiality: Protecting and providing information.* London: GMC.

Sue, D. W. (1981). Evaluation process variables in cross-cultural counselling and psychotherapy. In A. J. Marsella, & P. B. Pedersen, *Cross-Cultural Counseling and Psychotherapy* (pp. 102-125). New York: Pergamon Press.

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Communication in child therapy at FMC

Clear discussion on confidentiality with both child and guardian

Highlight what is negotiable and what is not
E.G. Reporting of abuse/neglect to authorities is mandatory. FMC practice is that reporting of risk to parents is mandatory

Supporting the child to communicate with the carer

Encouraging the carer in their communication with the child

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Working with carer's

Carer is not the client but parental wellbeing has a large impact on child wellbeing
E.G. Carer is highly anxious following breakdown of relationship with other parent.

Boundaried support can be provided directly to the carer
E.G. Provide treatment plan and referral to assist with implementation

Boundaried support around family functioning can be provided as family conflict is a predictor of child
E.G. Encourage parents to process conflict without the involvement of the child and refer with aim of reducing acrimony

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Styles of Parenting

Passive

Passive parenting can be typified by trouble setting boundaries and expectations. There may not be a reaction to problematic behaviour.

Children can feel superficially free and rewarded but also uncontained and unsafe.

Authoritarian

Aggressive communicators using direction without justification, criticism and domination.

Children can feel unheard and that situations are unjust.

Authoritative

Assertive communicators value and allow the opinions of others without letting it encroach on their expectations and boundaries. They display respect for their children, hearing their perspectives and explaining their parenting decisions.

Children can find boundaries superficially frustrating but containing.

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Communication and child safety

Child Safety Standard 7: Promotion of the participation and empowerment of children

Isolation can be an element of grooming for abuse

We believe that creating a culture of openness and empowerment for staff and all clients will reduce the risk of isolation and increase a child's belief that they can disclose

Owton and Sparkes, Sexual abuse and the grooming process in sport: Learning from Bella's story, Sport, Education and Society, http://dx.doi.org/10.1080/13573322.2015.1063484

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Developmental Stages

Age	Characteristics	Signs of Distress	Suggestions
5-8 years	Developing peer relationships Moral development progresses	Overt signs of grief e.g. sadness, anger. Feelings of abandonment & rejection. Changes in eating & sleeping. Behavioural problems Loyalty conflicts May try to take on role of any departing carer.	Opportunities to express feelings, learn coping strategies Reassurance that they are not responsible for separation. Permission to love all carers. Participation in extracurricular activities to detach from parental problems. Benefit from spending as much time as possible with each carer.
9-12 years	Increased awareness of self Trying to fit in with peers	Intense anger Physical complaints Overactive to avoid thinking about issues. Feel different from other children. More likely to ally with a carer or be alienated.	Opportunities to express feelings Learn skills to cope Reassurance they are not responsible for parental alliance. Permission to love all carers. Participation in extracurricular activities to detach from parental problems. Benefit from spending as much time as possible with all carers.
13-18 years	Solidifying identity & establishing self in relation to rules & regulations of society.	Withdrawal from family Difficulty concentrating Engaging in high-risk behaviours (sexual promiscuity, drug & alcohol use). Worry about own future relationships.	Consistent limits balanced with more freedom & choices. Have input about carer contact but not burdened by having to decide custody & access schedule.

Adapted from Johnston & Roseby, 1997; Solomon, 2005

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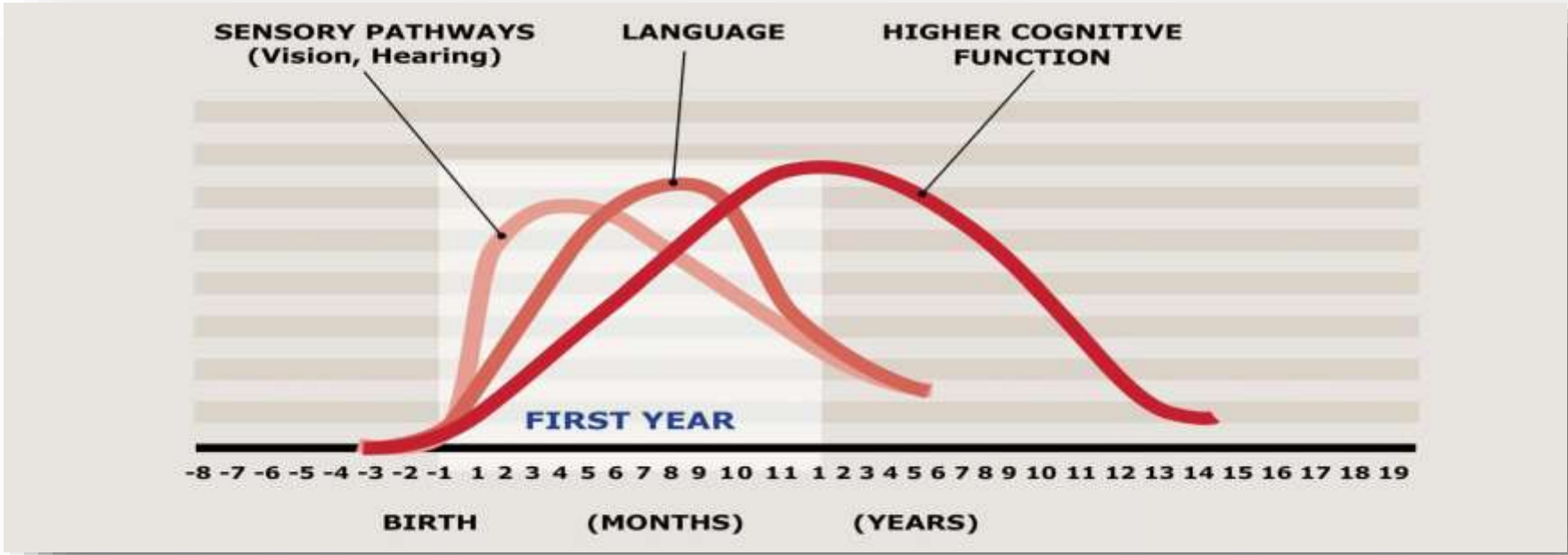
Development



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FMC's organisation change

All of the changes discussed are based on analogous qualitative research and therapy theory

Next step is to assess, measure and review

We are currently finalising a review of out child therapy program logic (organisational processes and outcomes) to ensure we are working towards child empowerment and comfort.

We are also currently in the process of finalising a review of our child therapy outcome measures to include issues of child empowerment and comfort.

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Case study

Academically high functioning 8 year old with very high anxiety and perfectionistic traits

Mother is present at the start of first session and is always present at the end for debrief lead by child client

Father has no contact due to intervention order, long history or domestic violence against mum, witnessed by child.

Mum and child both report that child was never a direct victim of violence

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Case study

13 year old living with dad, every second weekend with mum. The child presents with behavioural problems

Ongoing conflict between mum and dad where the child is placed in the role of messenger

Dad presents as very restricted and minimal in his communication with the clinician and the child. Mum does not engage in the therapeutic process

Child raises her interest in starting a sexual relationship with a boy 1.5 years older who has shown interest. Child reports that the boy has similar behavioural
problems

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Summary

Gaining the informed consent of carer's can conflict with effective therapy

There is an expectation from government that organisations providing child therapy do everything they can to create an environment which empowers and encourages children to discuss and disclose risk

FMC believes that this is an organisation wide issue with specific implications for child therapy practice

Our next steps are to move from the theoretical and qualitative to measurable and quantitative

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QUESTIONS

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Further Questions

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