Confidentiality in a preventive child welfare system

Abstract

Emerging child welfare policies promoting preventive and early intervention services

present a challenge to professional ethics, raising questions about how to balance respect

for service users with concern for social justice. This article explains how the UK policy

involves shifting the balance of power away from families towards State and professional

decision-making. The policy is predicated on sharing information between professionals

to inform risk and need assessment and so poses a problem for the ethic of confidentiality

in a helping relationship. This article examines the arguments for information sharing and

questions whether the predicted benefits for children outweigh the cost of eroding family

privacy and changing the nature of professional relationships with service users.

Key words:

Confidentiality in a preventive child welfare system

Introduction

At first sight, a policy of prevention and early intervention in child welfare looks beguilingly altruistic. It has many persuasive attractions: it could reduce the amount of distress or harm experienced by the child; problems may be easier to tackle while they are still at a low level; if effective, the policy might reduce the cost to society of responding later to severely problematic older children and adults.

Prevention and early intervention services also seem more appealing than the current state of child welfare systems in many developed countries. They have become dominated by reactive services for serious problems, especially problems of child abuse and neglect (Audit Commission, 1994; Dept. of Health, 1995; Waldfogel, 1998). Many find this frustrating and irrational: so often, the families presenting with severe and complex abuse problems were clearly showing low level signs of difficulty for years beforehand but had been unable to obtain services because the threshold for access had become so high. Practitioners now faced with intransigent difficulties wish that help had been offered earlier to prevent the situation deteriorating. Not only would the problems have been easier to solve but also the children would have endured less adversity and harm.

But such a change in policy raises a set of questions about the power balance involved in implementing it. Who needs preventive help and what type of help do they need? Who

decides what is in the child's best interests? Should help be universally available or targeted on specific groups? Should it be available on a voluntary basis for those families who want to take up a service or should the need for a service be determined by professional assessment followed by encouraging, or even coercing, the family to accept the service?

These are the questions that the UK government has faced as it has drawn up ambitious plans to tackle problems of social exclusion, criminality, and child abuse in England[1]. The conclusions it has reached lead to policies that, when fully implemented over the next two years, will change the relationship between the family and the State and the relationships between the family and professionals in the helping professions. In its concern to tackle the social injustice experienced by children born into disadvantage, the government is placing a greater onus on the professional network to take responsibility for children's outcomes and for judging needs. The policy therefore includes an emphasis on sharing information between professionals to monitor children's development and improve risk and need assessment. This article will explain why information sharing has taken such a prominent role in the new policy and discuss the implications for professional practice and, in particular, for the professional ethic of confidentiality that has been so fundamental to practice in the caring professions.

The new children's policy in England

The new approach to children's policy, embodied in the Green Paper: *Every Child*

Matters: Change for Children (The Treasury, 2003) (hereafter referred to as ECM) aims

to develop preventive and supportive services for all children. In the Introduction to the

Paper, the Prime Minister begins by saying that it is being published as the government's

response to the inquiry into the death of Victoria Climbie who suffered severe abuse at

the hands of her carers before being murdered by them (Laming, 2003).   The goal of the

ECM policy, however, is far more ambitious than just reducing the incidence of abuse

and neglect. In its broadest formulation, it is to help all children fulfil their potential.

The UK Prime Minister, Tony Blair, summed up the political aim in his introduction to

the Green Paper:

> This country is still one where life chances are unequal. This damages not only
>
> those children born into disadvantages, but our society as a whole. We all stand
>
> to share the benefits of an economy and society with less educational failure,
>
> higher skills, less crime, and better health. We all share a duty to do everything
>
> we can to ensure every child has the chance to fulfil their potential.

A key element of the new policy is to move from a reactive service for a few to a

preventive service for the many:

> We need to shift away from associating parent support with crisis interventions to
>
> a more consistent offer of parenting support throughout a child and young
>
> person's life. We will work towards a mix of universal and targeted parenting

approaches, including advice and information, home visiting and parenting classes

(The Treasury, 2003, para. 3.6).

Within this all-embracing agenda, however, certain groups are identified as key priorities: The policy: 'aims to reduce the numbers of children who experience educational failure, engage in offending or anti-social behaviour, suffer from ill health, or become teenage parents' (The Treasury, 2003, p.5). The social exclusion action plan (HM Government, 2006a) gives more detail of the priority groups and the reasons for selecting them. A 'cycle of disadvantage' is identified, in which 'deprivation in one generation is likely to pass down to the next. For example, the daughter of a teenage mother is twice as likely as the daughter of an older mother to become pregnant in her teen years' HM Government, 2006a, para.1.4). The aim of the action plan is to 'mitigate the lifelong effects of social exclusion and prevent them being passed down to future generations' (para. 1.5). The size of the problem is estimated as 'about 2.5% of every generation seem to be stuck in a life-time of disadvantage' (Blair, 2006b).

Historically, concerns about problem families have been fired by a mixture of concern for the injustice experienced by the underprivileged and concern for the negative impact of their problematic behaviour on society (Parton, 2006). This combination is apparent in the current policy. There is a condemnation of the social injustice of being born to a position in society where children lack the same opportunities as their more privileged peers. But there is also a strong concern that these children may become a problem for society: they may become criminals or make little economic contribution. A new term

has been coined to describe the problems they present: high cost/high harm adult

outcomes (Feinstein and Sabates, 2006, p.1).

Who needs help?

Deciding who needs help is a complex problem. The first issue to address is whether the

answer should be based on a rights or a needs approach.

Since the UK has ratified the UN Convention on the Rights of the Child, it has committed

itself to respecting the rights of children. This Convention has an impressive

international endorsement. It has been ratified by all countries in the world, except for

the USA and Somalia who have indicated their intention to ratify by taking the initial step

of signing it. In listing children's rights, the Convention provides a checklist of their

needs – e.g. for family life, health care, education, protection from abuse etc. The

Convention, however, has limited practical value in that it is phrased in such general

terms that further definition is required to apply it to specific contexts. This, in fact, was

essential as a means of reaching some area of agreement between the diverse range of

cultures in the world.

In practice, the UK government have not drawn on the Convention framework in their

policy, preferring instead to take a needs approach. In Parliamentary debates on the

Children Bill, it was made clear by the Minister for Children that a rights approach was

not the basis for its policy when rejecting amendments from the House of Lords that

anchored the legislation in the rights framework (Hansard debates for 13 Sept. 2004).

This has the significant effect of changing the basis for receiving a service from being a

right to being assessed by someone else as having a need and allows the government to

set its own priorities about which needs to tackle. Instead of using the Convention on the

Rights of the Child, the government has chosen to define needs in relation to five overall

targets or preferred outcomes: be healthy, stay safe, enjoy and achieve, make a positive

contribution, and achieve economic well-being.   Even when the meaning of these targets

is expanded by the set of performance indicators (DfES, 2004), there is, as with the

Convention, further work needed to apply them in particular instances.

Who should do this further work? Should need be defined by family members

themselves, in accordance with their values and beliefs, and their judgments about what is

in a particular child's best interests? Should it be defined by experts, in the light of their

specialist knowledge of child development? Or should it be defined by the government,

the paymaster of the helping services, taking account also of what is in the best interests

of the country?

In practice, definitions of need tend to result from some combination of all three points of

view, with no one voice being supreme. However, the balance of power between them

becomes significant when we move on to the next question of how to identify children in

need of help. The three main strategies mentioned in government documents echo these

three points of view. They are:

(1) family members themselves seeking help;

(2) professionals in contact with the family judging that the child is developing, or is at risk of developing, problematic behaviour and making a referral to the appropriate service;

(3) screening all families for the presence of risk factors, identifying a sub-group as 'high risk' for outcomes of major political concern , and then targeting services on them.

Service provision (1) families seeking help

The option of families identifying a need and seeking help is a familiar one and it accords well with a liberal society such as England where parents have, traditionally, been given the primary responsibility for their children's upbringing. Their responsibility has involved not only duties, such as ensuring children receive an education, but also powers, such as deciding what religion they should be taught, or what medical care they should receive. This option accords well with the political rhetoric about the autonomy of the family, the expertise of the parents in knowing what is in their child's best interests, and the State's reluctance to intervene.

The rights of parents are set out in the Children Act 1989, section3(1). The primary role of the family is endorsed by the United Nations Convention on the Rights of the Child. Article 5 sets out parents' powers and duties that States should respect:

The responsibilities, rights and duties of parents or, where applicable, the

members of the extended family or community as provided for by local custom,

legal guardians or other persons legally responsible for the child, to provide, in a

manner consistent with the evolving capacities of the child, appropriate direction

and guidance in the exercise by the child of the rights recognized in the present

Convention.

It is important not to overstate the autonomy of the family. Parents are subject to

extensive rules and forceful guidance on the proper way to bring up their children (King

and Piper, 1995, p. 2).

The option of families seeking help does not imply a passive role for the helping

professions or for the State. Services may advertise their availability and seek to advise

families on how to recognise when help might be useful. The health visiting service is a

good example of a well-known support service that is universally available but taken up

on a voluntary basis. Professionals who are already in contact with the family may

identify additional need and suggest seeking help. At the level of the State, public health

education seeks to inform families of healthier options, e.g. of what is a nutritious diet

and how to minimise the risk of obesity.

From families' point of view, the main problem they have experienced is that, in practice,

there are inadequate services available so that families with low level problems are often

turned away without receiving the help they seek. Increasing resources would alleviate

this problem but governments are, understandably, concerned about keeping control of public spending and, if services were more readily available, it is difficult to predict what the level of unmet need might be. In addition, families who currently find the help and support they need from informal sources might start using public services instead, fuelling the level of demand even further. Economic factors place a restriction on how much the State can respond to families' requests for help.

When the family is the key decision maker, it is easier to implement the professional ethics about respecting users, supporting their right to control their lives, and respecting diversity. However, leaving authority with the family does lead to concerns about social justice.   What about the families who do not seek help despite their children having unmet needs? What duty does the State have to protect children from inadequate care? How strenuous should official efforts be to ensure all children have the opportunity to fulfil their potential, even when their parents do not share the State's concerns or beliefs about what is in the child's best interests?

Historically, the State has intervened forcibly in English family life very little so that the threshold for invading the private family space has been set relatively high at the level of significant harm. When the inadequate care amounts to serious child abuse or neglect, then coercive measures may be taken and the professional ethic of confidentiality will be breached to ensure accurate assessment of the risks to the child.

The key relevant aspect of abuse and neglect is that abusive and neglectful parents often go to great lengths to conceal their actions; we are essentially trying to expose a crime. In these circumstances, it would be unrealistic to rely on parents giving consent to the sharing of information that would incriminate them. The importance of sharing information has been repeatedly demonstrated in inquiries into child deaths. For the UK, the landmark illustration of this was the case of Maria Colwell whose death in 1973 led to a major public inquiry into child protection services (DHSS, 1974). The inquiry revealed how a number of agencies had had partial pictures of Maria's life which, taken independently, only produced moderate concern in practitioners but, once put together, showed that she was suffering extreme abuse and neglect for many months before her death. As a result of cases like this, it has become well established that a family's right to privacy is limited when there are child protection concerns. This principle is recognised, in law, in the Human Rights Act 1998 and the Data Protection Act 1998 and, in professional practice, by the ethical guidance on confidentiality (e.g. General Medical Council, 2004, para.29).

With other child welfare concerns, parents are not generally trying to hide their problems in such nefarious ways but they may have any of a number of reasons for not wanting to engage with formal services. Some may prefer to handle the problems on their own or by relying on support from families and communities. Some may feel it is a waste of time to ask for help because they know how limited resources are or they had a bad experience in previous contact with the service. To some degree, parents' willingness to accept help depends on how it is made available. It can be argued that there would be a greater take

up of services on a voluntary basis if they were offered in a more accessible and user-friendly way, drawing on the research findings on service users' views (e.g. Quinton, 2004).

However, there is one further group of parents who refuse to engage with services: those who do not use services but who are living in circumstances that the government deems to make them socially excluded. They are described as groups 'that have generally failed to fulfil their potential and accept the opportunities that most of us take for granted' (HM Government, 2006a, para. 1.16). This group seems to be a particular concern to the government who see them as being too unreliable and untrustworthy to be left in charge of decision-making about their children. It is this group that leads to political rhetoric with an authoritarian ring: 'there is not going to be a solution unless we are sufficiently hard-headed to say that from a very early age we need a system of intervention' (Blair, 2006a); 'social inclusion means tough policies' (Armstrong, 2006).

The group are referred to as 'hard to reach' but there is an ambiguity in the meaning of this phrase. It does not appear to mean hard to find since one of the complicating factors in helping them is considered to be the number of agencies involved with them (HM Government, 2006a, para. 1.21). Blair uses the phrase 'hard to reach' to refer both to those who are hard to engage in a helping relationship and those who are hard to help effectively (Blair, 2006b).   If they are already in contact with several agencies and so engaged in some form of relationship, it is unclear how much professional lack of resources or skill contributes to the failure to help them effectively.

Concern about this group of 'hard to reach families' seems to be a major factor in inspiring the emphasis on information sharing as central to the ECM policy because, like abusive parents, they are less likely to co-operate and agree with professional judgments about their children.

Service provision (2 and 3) professional need assessment and screening

In developing preventive services, one decision to make is between primary and secondary prevention (Farrington, 2006). Primary prevention involves offering a service to all families. This can be at a national level, such the English health visiting service, or in specified areas – the early SureStart schemes were located in areas of deprivation but were then universally available to all who lived there. In a secondary prevention policy, screening and risk assessments are carried out to identify 'high risk' families and then services are targeted on them.

With the ECM policy for England, the government have decided to opt primarily for secondary prevention, targeting services on those deemed most at risk. Consequently, monitoring and assessing parental factors as well as children's development becomes a central concern. The concept of children 'at risk' has now been extended from its familiar meaning of children at risk of abuse to include a number of other outcomes that

the Government wishes to change, in particular children at risk of social exclusion and at risk of anti-social and delinquent behaviour.

The government draws on research about children's development and outcomes to conclude that it is possible to assess risk accurately: 'There is now a wealth of empirical data to analyse. The purport of it is clear. You can detect and predict the children and families likely to go wrong' (Blair, 2006b). The two main sets of research that they consult are studies on crime and anti-social behaviour (summarised by Farrington, 2006) and on the prediction of which children will be high cost/high harm in adult life (summarised by Feinstein and Sabates, 2006). The literature on predicting child abuse and neglect is not mentioned in policy discussions of social exclusion.

The importance of monitoring and the dominance of professional judgment and decision making over the families' own views are illustrated in the central importance ascribed to inter-professional sharing of information:

> A positive commitment to information sharing between professionals and agencies, taking full advantage of the opportunities set out under statute, is the only way to ensure that all children and young people are provided with the most appropriate support as and when they need it. (The Treasury, 2003, p.2).

And

Good information sharing is the key to successful collaborative working and early intervention to help children and young people at risk of poor outcomes' (DfES, 2005b, p.1).

To improve information sharing, the government committed itself to removing the legal and technical barriers: 'the Government will remove the legislative barriers to better information sharing, and the technical barriers to electronic information sharing through developing a single unique identity number, and common data standards on the recording of information (The Treasury, 2003, p.8).

The groundwork for removing the legal obstacles to sharing information has been set out in the Children Act 2004. Section 10 of the Act places a duty on each children's services authority to make arrangements to 'promote cooperation' between itself and relevant partner agencies to improve the well-being of children in their area in relation to: physical and mental health, and emotional well-being; protection from harm and neglect; education, training and recreation; the contribution made by them to society; and social and economic well-being. Section 12 requires children's services authorities to establish information sharing and assessment databases covering ALL children living in the area served by the authority. The government intends these databases to be tools to assist a wide range of practitioners in achieving the five outcomes for all children and young people identified in the legislation. The databases are not intended to be narrowly focused on child protection or child abuse, but aim to improve the sharing of information between professionals in order to improve the well-being of all children.

The technical obstacles to sharing information are tackled by two key strategies: providing standardised forms for recording data about families for use by all professional groups, and developing an ICT system so that data is electronically recorded in a way that is readily accessible to the various agencies and practitioners involved with families (Anderson et al, 2006).

The key data collection systems will be:

The information sharing index (IS Index). This will contain basic details of all children in England, including all professionals in contact with them and their contact details. Professionals will enter an 'indication' (formerly called a 'flag of concern') to show that they have important information to share, have made an assessment, or are taking action. The index will contain no sensitive case information, such as the child being on the child protection register.

The common assessment framework (CAF). This is a 'nationally standardised approach to conducting an assessment of the needs of a child or young person and deciding how those needs should be met' (downloaded from www.everychildmatters.gov.uk 21 February 2006). It should be completed by any professional when they consider that a child has additional needs that require the involvement of more than one service. The idea is to save time by doing one assessment that can be used thereafter by any other agency offering a service to the child. It includes a wide-ranging set of data covering

every aspect of a child's health and development, including details about the parents and siblings.

The Integrated Children's System (ICS).   This is an electronic case management system for children's social services that will include the case records of all children known to social workers. The ICS contains a set of 27 forms, 9 for each of three categories: children in need, children in need of protection, and children looked after.

In addition, there are databases in health, education and criminal justice but the extent to which they will be linked is not yet clear.

Evaluating a screening programme

The purpose of collecting and sharing so much information about families is to permit screening for high risk families. The strategy of screening populations for problems is well-established in medicine, though rarer in relation to social problems. It may involve identifying those with early signs of a disease and offering treatment (e.g. cervical cancer screening) or those who have the risk factors that make them at higher than average risk of developing a disease and therefore merit monitoring for signs of emerging disease or being given advice on how to reduce the risk factors (e.g. screening for high blood pressure).

While there is an obvious attraction to the idea that we are able to predict, intervene, and so prevent serious social problems, the introduction of a screening programme for a social problem needs to be measured against the same scientific criteria as screening for medical problems, such as screening for cervical cancer. There are three key criteria to judge a screening programme against: predictive accuracy, treatability, and the level of damaging effects.

Predictability: Does the screening process result in risk assessments with an acceptably high rate of accuracy? In predicting risk of child abuse and neglect, existing risk instruments lead to an unacceptably high level of false positives (families inaccurately deemed to be high risk) and high level of false negatives (dangerous families wrongly judged safe) (Munro, 2004; Peters and Barlow, 2003). With respect to predicting criminality and social exclusion, the reports are mixed:

> Any notion that better screening can enable policy makers to identify young children destined to join the 5 per cent of offenders responsible for 50-60 per cent of crime is fanciful. Even if there were no ethical objections to putting "potential delinquent" labels round the necks of young children, there would continue to be statistical barriers. Research into the continuity of anti-social behaviour shows substantial flows out of – as well as in to – the pool of children who develop chronic conduct problems. This demonstrates the dangers of assuming that anti-social five-year-olds are the criminals or drug abusers of tomorrow (Sutton, Utting and Farrington, 2005).

Farrington (2006), whose review of the criminology literature is cited by the government, concludes that predictive accuracy is insufficient and comes down in favour of primary not secondary prevention (i.e. *not* trying to screen and target high risk families). Feinstein and Sabates (2006) however come to the opposite conclusion in respect to the literature on high risk/high harm families. The discrepancy is partly explained by the fact that Farrington is looking at predicting serious criminality which is relatively rare whereas Feinstein and Sabates consider a wide range of poor adult outcomes that are more common. Their optimistic judgment on predictability is also qualified. They warn that:

> Children move in and out of risk in terms of their own development and their levels of contextual risk. Therefore, it is important that the policy mechanisms allocating interventions and support to children and families are flexible and able to track and monitor levels of risk, not always intervening at the first sign of risk but equally able to provide early interventions that may reduce the need for more substantive and costly later interventions. This requires a considerable degree of local practitioner skill (2006, p.35).

In the final analysis, judgments about 'acceptable' levels of accuracy come down to a moral judgment: how many innocent children is it acceptable to wrongly label 'a future menace to society' (Blair, 2006a) in order to catch a high number of accurate predictions?

Treatability: can the condition predicted by screening be usefully treated? Can we confidently say that we know how to tackle effectively the diverse range of factors predictive of poor adult outcomes? It is impossible to give a simple answer to such a complex question. There are undoubtedly some grounds for optimism in judging our ability to offer effective help that improves children's outcomes but success, while significant, is modest. In a review of interventions for reducing criminality for example, McLaren (2000) offers the remarkably wide estimate of between five and 50 percent success rate. To judge whether these were worth providing, we would also need to know the cost per child treated and to consider how else that money might have been spent.

The level of damaging effects: this applies to both the screening process itself and to the subsequent interventions used to alter the condition.   The proposed screening system for England requires a major change in the balance of power between families and professionals and its repercussions are as yet unknown. If midwives take on the task prescribed by the Prime Minister of judging 'which parents will be dysfunctional and which children will grow up to be a menace to society' (Blair, 2006a), it might have a harmful effect on parents' willingness to confide in them.

The impact of professionals being able to offer less confidentiality is also potentially serious. Since the preventive policy is premised on the free flow of information between practitioners in order to identify and track children at risk of some problem, it is perhaps inevitable that government guidance only mentions confidentiality and privacy in a negative light. They are repeatedly referred to as 'obstacles' to the efficient functioning

of the integrated management system being developed for children's services. However, privacy and confidentiality are rights and therefore not to be lightly disregarded. Moreover, they have practical value: there is a substantial body of research that shows that people value a confidential helping relationship and will withhold information if they are not sure that it will be treated in confidence (Wattam, 1999; Hallett et al, 2003; . Recent studies of children's views of the new information sharing proposals have produced a consistent message from children that, while they appreciate the need to breach confidentiality sometimes when there is a risk of significant harm, breaching it for other problems will deter young people from asking adults for help and advice (CRAE, 2006; Hilton and Mills, 2006).

We also need to consider whether the interventions provided have any harmful effects. The government rightly stresses the need to evaluate the new services (HM Government, 2006a) but evaluative studies need to look for harm as well as success and they need to be rigorously conducted to maximise the reliability of the findings. Rutter (2006) is highly critical of the government's standard of evaluation of SureStart schemes, arguing that political considerations led them to ignore advisers and create an initiative that was impossible to evaluate because that could 'carry the danger of showing that a key policy was a mistake'. It would have been feasible and highly desirable to have conducted a random controlled trial which would have led to a more reliable judgment about whether large sums of public money were being put to the best use.

Overall, the case for a screening programme is not compellingly made. It carries uncertain benefits and certain losses in that it erodes people's privacy and right to confidentiality. Neither primary nor secondary policies have been tested adequately at this stage but there is a case for trying the less intrusive option first and seeing what progress can be made on a voluntary basis – finding out whether adequate resources can be provided and testing the effectiveness of the interventions offered.

Consent

The negative consequences of sharing information about families might be less if it were only done with families' consent. Government guidance endorses obtaining consent as necessary in some cases and good practice in others (HM Government, 2006b). However, this respect for the user's choice is diluted by the clear assertion, within the guidance, that giving consent is essential for providing effective help and so it is presented as the rational thing to do:

> Sharing information is vital for early intervention to ensure that children and young people with additional needs get the services they require. It is also essential to protect children and young people from suffering harm from abuse or neglect and to prevent them from offending. (DfES, 2006)

The belief that giving consent is the sensible thing to do is also illustrated by the requirement that practitioners need to 'understand how to present genuine choices to young people and how to obtain consent to sharing information' (DfESa, 2005, p.8).

This biased view of the rationality of giving consent colours the way that consent may be sought and carries with it the implication that anyone who withholds consent is in some way questionable.   Indeed, in one illustrative vignette, it is suggested that it is acceptable to seek consent from a parent with the warning that if it is withheld, it will be interpreted as grounds for suspecting the parent of being abusive or neglectful (DfES, 2005b).

To be legally valid, consent needs to be free and informed which the Information Commissioner clarifies as:

> *Consent should always be freely given, thus any document prepared by the data controller to obtain consent should not contain any coercive element, and lack of consent should not generally cause any detriment to the individual, particularly in respect of any statutory rights that individual has.* (Information Commissioner, 2006).

Evidence from trials of the databases gives cause for concern about the way that the issue of obtaining consent is being handled. In trials of the Common Assessment Framework, it was found that professionals did not seek the necessary consent from the family in 20%

of cases (Brandon et al, 2006).   There is anecdotal evidence from other pilots that consent is being required as a condition for receiving a service.

For professionals used to offering a confidential service, current developments present problems. Besides its therapeutic value, confidentiality is an important ethical principle in showing respect for individuals, supporting their right to control their lives, and respecting diversity. However, professionals will need to reach a clear understanding of when and with whom they may be required to share information so that their clients know the limits of confidentiality before giving them sensitive and personal information. In order to obtain informed consent, they will also need to understand the way that shared information will be used and may be accessed by other agencies.

Conclusion

The UK policy on prevention in child welfare includes a praiseworthy commitment to tackling the social injustice experienced by those children born into adverse circumstances that restrict their opportunities for achieving their potential in life. However, by opting for secondary instead of primary prevention, it rests on a number of risky assumptions: that professionals can accurately predict which children will be problematic, that they can intervene effectively, using coercion if necessary, to change the course of children's development, and that there will be adequate resources to meet the needs identified through screening. It fails to consider what harm may be caused by the process of surveillance of families and by labelling children as future problems.

Rejecting the rights approach to defining children's needs that is embodied in the UN Convention on the Rights of the Child, the government has opted for its own set of targets and performance indicators. These can be criticised for placing too much value on the needs of society (for well-educated, healthy, law-abiding citizens) compared with the needs of the individual child. This imbalance is evidenced in the failure in policy documents to discuss children with special needs – those with physical disabilities and learning difficulties – whose need for support is immense but who are low risk for being high cost/high harm adults. Recent research has shown that most local authorities are ignoring disabled children in their children and young people's plans (EDCM, 2006).

In policy debates, there seems to be an assumption that there is some objective measure of what is in a child's best interests and some objective standards of good parenting applicable in all social circumstances. The possibility of rational disagreement between a parent and a professional on what is in the child's best interests at a particular point in their lives is not addressed. As a French critic has commented, such an assumption of objectivity is unfounded and conceals the power struggle involved in reaching decisions about what is in a child's best interests:

> Which social classes, which sub-cultures, which professions or institutions, or which combination of these are going effectively to insert their social, moral and psychological values into the process of determining the child's best interests? (Stender, 1979).

This failure to recognise the potential for conflict illustrates what is possibly the most serious problem with the UK policy. 'Power corrupts' is a well-known truism but there is no acknowledgment of the possible danger of increasing State power over families. There is no recognition of the fact that liberal societies have placed a high value on privacy and confidentiality precisely because they present an obstacle to the State. While the State sees this in a negative light, the individual values it as a protection of their freedom. The professional ethic of confidentiality is seen by the government as an *obstructive* barrier to be removed in implementing their monitoring and assessment programme but this should remind us that the ethical principle is playing its rightful part as a *protective* barrier, defending the individual against excessive intrusion by the State.

Footnote [1]: this article refers to the UK government making children's policy specifically for England not for the UK. Responsibility for children's services in the other three countries of the UK is devolved to the Northern Ireland Assembly, the Scottish Assembly, and, partially, to the National Assembly for Wales.

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