The interface between medicine and social work in working with looked after children

On the basis of her long career in social work with children and their families, Daphne Batty reviews the interface between doctors and social workers, its nature, how it has developed and attitudes to it displayed by both professions.

Key words: children, social worker, doctor, health assessment, role, responsibility, trust

Introduction

Constrained as we feel these days by limited resources, we sometimes forget the distance that childcare practice has come since my career began shortly after the Second World War. There is a paradox here – doctors and social workers at that time were usually considered to be angels of mercy, whereas now they are sometimes depicted as agents of the devil. In contrast, however, the improvements in practice are remarkable. Especially notable developments are the involvement of the people using the services and the acceptance of full co-operation between services.

As I write in the spring of 2002 we are waiting in the anteroom of change. The Adoption and Children Bill has not yet been implemented and the long-awaited Department of Health document on securing health for looked after children has still not been released. We are also waiting for the report from the Climbie Inquiry and its subsequent recommendations. All of these are likely to affect both the medical and social work professions and will almost certainly call for increased co-operation between them, possibly at a statutory level. I suggest that the time has come for us to examine more closely how our two professions work together.

Writing from the point of view of a social worker, I want first to consider how this relationship has progressed, where it is now with regard to the roles played by the participants and what might be the way forward.

How the relationship has developed

In my first two years as a childcare officer I cannot remember once consulting a doctor about a child. Medical contact with children in the care system was little more than freedom-from-infection examinations. Medical examinations of adoptive applicants were perfunctory if they were held at all. What is now the BAAF Medical Group put a stop to this when it was launched in 1964 by an outstanding group of paediatricians who wanted to extend the benefits of adoption to more children than those who were both healthy and very young. However, officially named medical advisers did not feature in adoption until the Adoption Agencies Regulations 1983.

Since then the government has become increasingly concerned with the health of looked after children (House of Commons Health Committee Report, 1998) and doctors have become involved with these children in addition to those for whom adoption is the plan. It is likely that the newly constituted primary care trusts will appoint named doctors with responsibility for the health of looked after children,
their work to be co-ordinated by designated doctors from the relevant strategic health authorities. Some trusts are appointing members of the child and adolescent mental health services (CAMHS) teams to act as consultants to social services. Because of concern highlighted in local surveys regarding statutory annual health assessments (Butler and Payne 1997; Mather et al, 1997), some trusts are seconding nurses to work with social services teams, with specific responsibility for these assessments. As a result, more and more often doctors and social workers, together with representatives of other disciplines, find themselves sitting around a table talking about looked after children.

Attitudes to the interface
When I worked in a local authority adoption and fostering section some years ago I did not think in terms of an interface between medicine and social work. Despite the implications of the Children Act 1975, doctors, it seemed to me, operated quite separately from social workers. They examined children, alerted us to any problems presented and spoke to their reports at adoption and fostering panels, and then disappeared until the next time. I do not believe that I was alone among social workers with this attitude and it still persists in some agencies.

Very soon after I began work with the Medical Group I thought differently. The holistic approach that community paediatricians bring to their task became clear both from the Medical Group Advisory Committee discussions and also from the telephone conversations that I had with medical advisers who raised queries. Overall I began to think in terms of developmental health assessments being an integral part of planning for children, acknowledging as well as children’s physical development their emotional, social and cognitive development, in which the lifestyle of birth families was of great importance.

At the same time many of the doctors with whom I worked seemed to feel themselves as distanced from social workers as I had earlier felt from them. Many of them felt a sense of isolation as they were often the only doctor within a circle of social work oriented decision-makers. Their attitude manifested itself as general dissatisfaction with social work practice. Common complaints were social workers’ failure to produce reports on children’s family histories in time for health assessments, failure to attend assessments with a carer and (less frequently) failure to follow through on recommendations. Overall, they felt, there was a failure to understand the importance of holistic assessments. These complaints may have been justifiable in themselves, but they seemed to me to be used to denigrate social work practice in general, so that, although doctors did not hesitate to praise what they saw as good practice in individual cases, their trust in the profession was low.

Where the interface lies
The interface between medicine and social work exists at two levels, organisational and individual, each of them involving both managers and practitioners. The many reciprocally-funded projects and procedures linking health and social services staff, including fostering and adoption procedures, represent one level, while planning for hundreds of individual children in need, whether or not they are looked after, represents the other. Specific statutory requirements exist at both levels.

Within this framework three main functions link medicine and social work: assessment, decision-making and direct therapeutic work.

The statutory developmental assessment of children early in their career in the care system has long had a fundamental impact on long-term planning. These assessments are usually carried out by a community paediatrician. It is of great value for a child’s social worker as well as carer to attend the actual appointment, not only to gain a holistic view of the child at an early stage, but also to understand for future reference the significance of a developmental assessment as distinct from a medical examination. The implication of the Department of Health’s Framework for the Assessment of
Children in Need (2000) whereby six dimensions of a child’s life are considered (Department of Health, 2000) is another area of interface, not only with paediatricians but also often with psychiatrists. Doctors involved may know the child and family already, but in other cases they cannot fully complete an assessment of a child’s health without the family history. These assessments therefore represent an essential co-operative effort by both doctor and social worker.

Health assessments of applicants to foster or adopt are usually carried out by general practitioners (GPs) and submitted to statutory medical advisers for comment and any subsequent discussion. Agencies are advised to emphasise this procedure in their approach to GPs. The intermediary role of the adviser certainly encourages GPs to be more open in their reports, but it also distances social workers from contact with them. Later in the article I describe some social workers’ views on their relationship with GPs.

With regard to decision-making, an adoption agency’s medical adviser is required to sit on its adoption panel, and in 1997 a local authority circular encouraged advisers to play a full part in panel discussions, not confining themselves only to medical issues (Department of Health, 1997). Thus they are empowered to share in the important recommendations made. The fact that many medical advisers are now also members of fostering or dual functioning panels is a most welcome development. In child protection procedures the doctor most concerned with the abuse will invariably have a key role and, even when peripherally involved, government guidance (Department of Health, 1999) encourages doctors and psychiatrists concerned with a looked after child to attend case conferences.

Direct work with a child will require one-to-one contact between social worker and doctor, whether medical adviser, hospital specialist, psychiatrist or GP. In the case of a child with a disability or serious medical condition, a medical adviser could work directly with a carer at least for a time and clarity of roles between the two disciplines would be essential, especially for a child to be placed away from the home area.

**Medical and social work roles in child care**

A good deal has been written about the role of statutory medical advisers to adoption agencies, most recently in the BAAF publication *Doctors for Children in Public Care* (Mather and Batty, 2000). This accepts the view that equal standards should be met in all work concerning the health of looked after children, not only those for whom adoption is the plan. The required knowledge for doctors and social workers working with looked after children is strikingly similar, apart from the former’s in-depth and comprehensive knowledge of child health and development and the genetic implications of family illness. Both must understand the long-term effects of abuse and neglect and be able to support carers in dealing with these. They must be capable of direct work with children, carers and birth families and they must be able to play their part in an interdisciplinary team. They must also have wide knowledge of the support services available in the area in which the child will live – often, significantly, not that in which the doctor and social worker are based.

Social workers, with their managers, have additional requirements. They make the final decision regarding whether or not children are eligible for what are likely today to be scarce resources. Although they have the benefit of the advice of a named legal adviser, they must have a thorough basic knowledge of childcare law in order to prepare for care proceedings and of adoption law in order to support birth parents and adopters in steering a path through its complexities. I consider these two requirements further below.

What kind of training qualifies doctors and social workers to fulfil their roles? A doctor’s general training includes three years’ academic study, three years’ clinical study, at least two years in practice and a qualification in paediatrics, which involves both hospital and community experience. Moreover, most medical advisers to social services are senior
practitioners, often consultants. In contrast, although many social workers are graduates before embarking on a professional training, until recently the training for qualification was only two years in duration, so that a more thoroughly prepared group of workers is not yet in the system. It needed heavy lobbying by the profession over many years before the present government agreed to the extension to a three-year degree course.

In comparing training for the two professions I am not decrying the value for a social worker of experience in practice. On the contrary, I believe a well-trained, well-supervised and experienced social worker to be the equivalent of a medical consultant in the field of planning for children. But in the past 100 years or so the status of doctors has increased significantly, both professionally and socially, and this, together with a thorough training, breeds confidence in a practitioner. It must be borne in mind that in many social services departments today a social worker with responsibility for a looked after child may well be very young and recently trained, a stop-gap agency worker or one who has trained and worked in another country. Attending a case conference can be extremely daunting for such workers and could lead to their unwitting collusion in a mistaken decision with unhappy consequences for a child.

A former colleague recently gave me an interesting example of this phenomenon. She was a social services area manager and had been asked to chair an informal meeting because a social worker was concerned about why a foster carer had taken a child to the hospital Accident and Emergency department. Attending the meeting with the carer were the paediatric registrar who had examined the child, the social worker, the health visitor, a nursery nurse and also a psychiatric consultant to the social services department. After the social worker’s introduction the paediatrician said that the injury was minor and he thought the carer’s explanation was perfectly acceptable. He did not think that the child was at risk. There was little further comment and a murmur of agreement when the chair suggested that the current level of supervision at the day nursery should continue. The next day the social worker received two independent calls from the health visitor and the nursery nurse, both of them expressing serious concern about the recent behaviour of the child and querying the placement. When the chair asked them individually why they had not spoken up at the meeting they both replied that the psychiatrist had accepted the paediatrician’s opinion and so they felt they could not disagree. The psychiatrist, asked in turn, said that as she did not know the child personally she felt she was not qualified to voice an opinion. My colleague, who at the time was new to her job, learned a lesson she never forgot about the influence of status and confidence. The two workers concerned in this instance were not social workers, but in other circumstances they could well have been so.

Both the experienced medical advisers I spoke with recently said that social workers must learn to challenge doctors, or must at least be helped by their managers and conference chairs to do so.

**Implications of the social worker’s role**

We can see from the above analysis of a social worker’s role that there are three quite separate elements in it.

First, social workers work directly with children and families, for the most part in the home environment. They observe relationships between members of families and from this point of view they assess children’s needs.

Second, they must be aware of what resources are available to meet children’s needs, whether within social services or other agencies. It is then their responsibility to decide or recommend which resources should, and in reality can, be allocated to individual children.

Third, the ultimate responsibility regarding whether or not an application should be made to a court for a care or supervision order in respect of a child rests with social workers and their managers. They also carry responsibility for the most serious decision that can be made on behalf of a child: whether or not...
he or she should be placed with an adoptive family. These serious decisions are usually based on recommendations from placement panels or case conferences, but ultimate responsibility lies with social services.

Doctors carry out the equivalent of the first role outlined above in making health assessments of children. They contribute to the decisions made in the second and often also in the third, but as far as looked after children are concerned, responsibility not only for the decisions themselves but also for the multitude of administrative tasks involved, lies with social services.

Most people considering a career in social work think in terms of direct work with children and families. They soon learn that the other two elements in the role described above take up a significant proportion of their time. Some social workers I talked with recently seemed to me to underestimate their expertise in working with families and the expert knowledge that they have of the child in the home environment. The consultant psychiatrist with whom I spoke is a member of a team which assesses and plans for children with both learning and severe behavioural difficulties. The team also includes two community psychiatric nurses and two social workers from the local area team. The psychiatrist felt that the social workers’ approach was resources led rather than needs led, and that this introduced a negative element into the team’s thinking. Resources, she thought, should be considered only after the team had decided what steps would best meet needs. In the extreme, preoccupation with negative elements such as resource scarcity could lead to denial of the existence of a child’s problem. This might be the cause of some of the extraordinary instances of lack of perception identified by recent enquiries into deaths of children.

The psychologist I consulted, who worked with young people, also told me that she had come across situations where lack of resources had dominated social work thinking. She felt that this difficulty could be dealt with only by acknowledgment. She suggested that initial planning, called Plan A, should be based consciously on needs, then if a resources problem intervened time must be allowed to discuss how to deal with it creatively, even if there was no immediate solution – for instance, by drafting a paper or drawing up a research plan or a petition to management. Only then, she felt, could workers be freed to bring creative thinking to the inevitable Plan B. An ideal solution, perhaps, but the support of other disciplines, involved but more distanced from the details of planning for children and therefore able to think more objectively, would be of great help in such situations. The recent publication Working in Teams (British Psychological Society, 2001) analyses interdisciplinary team work in its second section. It suggests that the more experienced workers:

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\ldots\text{can be proactive in educating teams} \ldots\text{and can support team members and their line managers in achieving improved team operations in line with the needs of clients. } (p\ 56)
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Both social workers and doctors must balance their commitment to a child with the professional detachment that enables them to think clearly. I suggest that this requirement is more acute for social workers who may work with a family in their home over a long period. Also, if they are to understand a family’s functioning they must attempt to get alongside the family and see events from their viewpoint, while guarding against overidentifying with the adults involved. This makes detachment yet more difficult. When their plans for a child are frustrated by lack of resources the resulting stress is often acute and can sometimes distort perception.

The third element in the social worker role gives them the authority to plan for fundamental changes in the lives of children and families. Preparing for court is certainly time consuming, but its effect on social work practice is more fundamental than that. It means that social workers’ primary task, that of working closely with a family to help them effect change, can in the perception of some families be permeated with the power to
remove children. This can discourage some from requesting the help they need for fear of losing their children. The press sometimes gives the impression that social workers are similar to police in the power they wield. A team of French social worker child protection specialists, taking part in a joint English/French research project (Hetherington, 1996), were astounded that their English colleagues were obliged to carry what they saw as two contradictory roles. In France the authority rests with a magistrate from the day that the question of abuse is first mooted, freeing the social worker to work therapeutically with the family. Our system can be a serious handicap which can carry over from child protection to other areas of child care and in some instances the stress caused can affect practice.

That the burden of responsibility for vital childcare decisions is heavy is borne out by the fact some doctors also find it so. When I worked for the Medical Group I received a significant number of telephone calls from doctors regarding medical conditions that might affect decisions – usually regarding prospective adopters but sometimes regarding children. They were fearful that their report might be the reason for a negative decision, and had to be reassured that although it might sway the balance, the panel’s recommendation was a corporate one.

I was also told an interesting anecdote by a social services manager. A child protection conference was held in a hospital with several disciplines represented. After a long and amicable discussion, with contributions from everyone present, a united decision was reached that a care order should be sought. The minutes, written by a member of the hospital staff, read as ‘on the advice of social services, a decision was made . . .’ (It was later amended.) The weight of responsibility in making decisions affecting children’s lives should never be underestimated.

These pressures tend to divert social workers from what many of us see as their main function – direct work with families. In fact, the psychologist quoted above remarked that the specialised knowledge of child care that she had experienced in social workers in the past was no longer apparent. Yet one of the consultant community paediatricians with whom I talked said that her main need from social work was a thorough family history, including family lifestyle and the general health of the extended family. This information, she said, is vital for a child approaching adulthood and therefore is of prime importance. She also emphasised that, through direct observation in the home, social workers can assess the long-term dangers of child abuse, which are the results of what she described as ‘a low warmth and high criticism environment’ in a family.

**What the social workers were saying**

All the social work agencies I visited found their medical advisers helpful and easily accessible. However, the quality of the relationship differed. One of the local authority teams had severe staffing difficulties. Two of the small groups I saw had only been in post for a few months and I was told that there was a high proportion of agency workers. This meant that their well-respected manager spent a disproportionate amount of time interviewing staff. Some of them did not know the name of the adviser who, although always ready to give advice, did not meet the team members face to face other than when they attended panel meetings.

All the advisers to the three teams I saw were community paediatricians, and in the second local authority the adviser, a part-timer, gave almost all her time to the childcare team. This authority had relatively little difficulty in recruiting social workers, who were organised in specialist groups and appeared to me to benefit from the stability of the work force. Their frequent contact with their adviser seemed to give them confidence in work with other doctors without any misplaced sense of status.

The same could be said for the voluntary agency I visited, where social workers had even more frequent contact with their adviser. From time to time he arranged for other doctors or health workers to talk to the team about medical
conditions they might encounter. They were an experienced group who had worked together for some time, within a congenial working environment. My impression after visiting these agencies was that frequent contact with the named adviser led to greater acceptance of the importance of health issues in caring and planning for children.

Both the local authority departments I visited employed nurses and in one they had responsibility for all annual health assessments. This is strongly supported by the BAAF Medical Group, which now counts two nurse practitioners on its Advisory Committee. My impression was that they made a valuable contribution to the childcare teams, not only in dealing with an often neglected area of care, but also for individual consultation and providing a link to the health services. However, it seems that careful thought should be given to induction plans for nurses. A former colleague told me of a nursing team whose arrival without proper preparation had caused resentment among some social workers.

All the local authority social workers seemed to experience difficulties in gaining the co-operation of their local CAMHS. There was considerable resentment in one of the agencies because of a seeming unwillingness to join with social services in planning for children at crucial periods in their lives in spite of the Department of Health guidance referred to above. I was left with the impression that this was the policy of a particular school of psychiatry which, for reasons of confidentiality, may not share its thinking even with a parent. If this is so, at least an explanation of policy is owed to social workers who are involved in complex planning for children.

All three agencies found that relationships with GPs varied from doctor to doctor, depending more on that individual’s personality than on age or experience. Two social workers who had worked in areas where training had been offered to GPs said that co-operation afterwards had improved greatly. One GP had remarked: ‘Now I know what you are trying to do it makes sense.’ This experience is borne out by the community consultant paediatrician who told me that, following a joint course with social services on child protection, her colleagues had said that, although they hadn’t learnt much new about child protection, they had gained very useful information about the roles of other disciplines involved. BAAF has had similar experiences with its courses on adoption panels. It is to be hoped that in time medical advisers and social workers will have easier access to GPs through primary care trusts and will co-operate in offering training.

In talking with the social workers I found that some of them, although clearly able, seemed to have lost confidence in their role and did not seem to recognise that their knowledge of families and skill in working with them is a unique attribute and a vital ingredient in planning for children. In many cases, I was told, the court prefers the evidence of an ‘expert witness’ who may hardly know a child to that of the child’s social worker. In recent years has pressure on public services brought too much emphasis on resources and not enough on what is actually happening to the child? Are social workers overwhelmed by the inevitable need to judge each child’s eligibility for resources that are all too scarce?

**Building trust**

We say too readily that good teamwork implies trust, but how do we build trust? An important ingredient must be good communication. One of the consultant paediatricians with whom I spoke told me that she recently co-operated with a social worker over a complex case and their communication was entirely via emails and voice-boxes. They eventually met outside the court. ‘How,’ she said, ‘can you build trust by electronic proxy?’ Part of the commitment to the child of workers in partnership must be at least one face-to-face meeting or, if distance makes this totally impracticable, an uninterrupted telephone conversation. Time given to the early stages of a partnership in order to build trust must save time in the future.

It was evident from my talks with social workers that frequent contact between doctor and social worker promoted trust between the two. This can
only be brought about by social services and their management enabling face-to-face consultation and doctors being willing to give of their time. The evidence is strong that joint training promotes understanding, which is a close relative of trust. This requires a subject compelling enough to tempt members of both professions and the coming months should offer plenty of topics that will lend themselves to joint training. The concept of each discipline discussing the Department of Health’s views on looked after children separately simply does not make sense.

Sharing a conference table with other disciplines will always present difficulty for some workers unless more informal contact exists in advance, but much can be achieved by the chair clarifying roles from the start and particularly by everyone recognising that the contribution of each member is potentially of equal value to the child concerned. It is not always easy for senior staff to deflate their status for the sake of encouraging a less experienced but vital member of the childcare team, but it has to be done if the group is to function in the child’s interest. A case conference where each member contributes with confidence is a powerful element in promoting interdisciplinary trust.

With regard to interdisciplinary team work, the consultant paediatrician I mentioned above thought that all those involved in planning for children tended to be too compartmentalised. This could be dangerous for children, in particular in child protection. Workers are either too defensive about their own roles, fearing that someone from another discipline might beat them at their own game, or nervous lest a colleague should think that they were trying to take over their role. She felt that all workers had a right to contact another member of an interdisciplinary team to confirm that a task affecting a child had been carried out, for example, a social worker confirming whether a paediatrician had been able to arrange an appointment for a child’s mother, or a paediatrician enquiring about how a child was progressing at home. Too often this kind of query was seen as interference.

A simple example of this emerged in one of my conversations with social workers. One of the workers happened to know through her assessment that an applicant to adopt had had a mental illness, but the GP had not mentioned this in his report. She sent a note to this effect to the medical adviser with the GP’s report. The adoption panel was imminent but she had not confirmed with the adviser as to whether the GP had been contacted because she did not like to interfere. There was no reason to believe that the adviser would not follow this through, but if for any reason she had not done so the social worker would be obliged to confront her at the panel and probably delay the application until the next meeting. How often have all of us let something like this slip by? But timely communication should be seen as teamwork not interference.

I return to my impression that doctors working with looked after children lack trust in social services practice in general. This is partly because few social workers have adequate opportunity to create a relationship with the doctors concerned with ‘their’ children and some of them still tend to consider the medical service as there for use from time to time, but not an integral part of the childcare scene. A social worker myself, I have emphasised the role of social workers and the particular difficulties that they face today as I think it is essential that doctors understand the various aspects of this role if they are to work together creatively. I also think it important that social workers should understand the significance of the changes in community health services and the implications these have for their medical colleagues. Only thus can we learn to respect each other, and this is essential if we are to build trust and work together for children.

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