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Multi disciplinary work — where next?

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The focus of this paper is on co-operation in the prevention, assessment and treatment of child abuse. It involves consideration of both interprofessional and interagency relationships. The fundamental question addressed is: 'Why has it been so difficult to achieve the co-operation necessary to protect children at risk?'

The need for co-operation has been widely recognised in official literature, from DHSS circulars to numerous inquiry reports. Indeed, what may be described as a literature of exhortation is now well established, illustrated most recently in the draft guide — 'Child Abuse, working together'. (DHSS 1986). However, to be fair, it is also officially recognised that exhortation alone will not suffice and various initiatives are under way to improve matters, including a project funded by DHSS in my own university to develop materials which can be used in interprofessional and interagency training. Before one can do so, however, the urgent need is to understand more of the barriers that exist against effective co-operation; to dismantle or lower the barriers must be one objective of this exercise.

Such an analysis has to be about occupational roles — the effect on individuals of the way they have been socialised into prescribed roles, doctor, nurse, social worker or teacher. The way in which they see their work has a profound effect on how they see each other and on the nature of their interactions. But it is also essential to examine the ways in which the objectives and structure of the different agencies involved affects co-operation. These two elements, of course, interact. The task of this paper is to unpick some of the complex issues which arise in these matters and to ask how we may best move forward.

Some 25 years ago not long after central government had issued a circular on the need for co-operation in work with families at risk, I wrote a paper — 'Co-ordination Reviewed' (1963) in which the effect of different roles on the way in which professionals conducted themselves at a case conference was analysed. It received relatively little professional attention; indeed, outside the hospital context, in which issues concerning interdisciplinary team work have been a steady focus of attention, there was little consideration in the literature of these matters until 1974, when the Maria Colwell inquiry report (DHSS 1974) sharply raised professional and academic awareness. Although my minority report in that inquiry created some attention at the time, the agreed section on interprofessional and interagency co-operation, which in my view was of more importance, received little. In that section we

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These reflections on the past raise two important points. First, early circulars were not about child abuse; they were about 'problem families' as we somewhat tendentially called them. Problems of co-operation arise in all areas of work in which a person or family in trouble has to relate to a variety of professionals or agencies. Such issues are critical, for example, to effective work for frail elderly people in the community and raise many similar questions. Of course, there are distinctive elements; in child abuse, the tragic consequences of failure to co-operate effectively are more starkly evident and give impetus for its improvement. But it is important to acknowledge that, in developed societies, the fragmentation and proliferation of individual and agency roles is a general phenomenon. As we become more 'expert', more sophisticated, we split up services to people in need and then spend a good deal of time getting them back together again. Holistic medicine is a familiar example of such a process, 'Getting it together again' is a legitimate and essential part of service to patients or clients. Too often, time spent in talking to others about the patient/client is felt to be time wasted. The 'real' work is felt to be direct work. This is unsound and leads to neglect of an important area of practice.

Secondly, those recollections remind us just how intractable these difficulties appear to be. The comments in the Beckford Inquiry (1986), 12 years after Colwell, bear a striking resemblance to that earlier report, particularly in matters surrounding co-operation. It is very urgent that the problems are consistently and rigorously addressed.

Such work as has been done suggests a number of dimensions on which an exploration might be conducted. In what follows, seven broad areas are identified, all of which merit much fuller attention and are simply 'flagged' here for further discussion.

Differing attitudes towards, and values concerning child abuse and the family

Attitudes and values are a combination of the personal and the professional. They may be explicitly formulated or 'taken for granted', that is, not conceptualised unless challenged, or they may be powerful but unconscious. They play a highly significant part in decision making. Yet, characteristically, in discussion, the differences between individuals on such matters remain largely unexplored, a huge partially hidden agenda, an iceberg with the tip only showing. The good ship co-operation may sink when it encounters the submerged part.

Let us take as an example the question of 'cultural relativism'. This involves a formulation that 'all cultures are equally valid ways of formulating relationships between human beings and between human beings and the material world'. One can move from that to say that 'members of one culture have no right to criticise members of another by imparting their own standards of judgement'. (Dingwall 1984:82). Thus, although 'moral character is . . . central to decision making in child abuse and neglect, as in any other type of deviance' (Dingwall 1984:80) it is to people in need and then spend a good deal of time getting them back together again. Holistic medicine is a familiar example of such a process, 'Getting it together again' is a legitimate and essential part of service to patients or clients. Too often, time spent in talking to others about the patient/client is felt to be time wasted. The 'real' work is felt to be direct work. This is unsound and leads to neglect of an important area of practice.

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Such work as has been done suggests a number of dimensions

Conflict between professionals may arise in three ways. First, participants vary in their awareness of the significance of cultural differences. Such awareness is borne either of good sociological education, or well used and tested experience (or both). Those whose background, training and professional focus has been on what one might describe as 'clinical' rather than 'social' facts may give less weight to such matters.

Secondly, the participants may differ in their views as to the extent to which certain behaviour is normal in the cultural group under consideration. There are pitfalls here, bound up with stereotypical views of those whom we view 'from outside', at a distance, notably in relation to ethnic groupings. The statement 'Afro-Caribbean parents physically chastise their children more severely than do white parents' is an example of one such unhelpful stereotype. Such superficial observations may lead us to underplay the psychological, even pathological, factors in certain pieces of behaviour. It is a kind of phoney sociology with racist undertones.

Thirdly, what weight is to be given to cultural variations? It does not let us off the moral hook, which is to decide how far such variations can be accepted without action being taken to protect children.

However, conflict does not usually arise in relation to the actual incidents of child abuse. It is only rarely that the child rearing practices of a particular group offends fundamentally against the prevailing norms and values of our society to a point when someone believes a child's well being is seriously endangered. If such situations exist, then it can reasonably be argued that cultural relativism is not an acceptable justification. What is quite common, however, is that aspects of the family functioning, which may be felt to bear on child abuse but are not a direct cause of it, may be unacceptable to some of the participants discussing the case. A frequent example concerns marital roles; in various cultural groups in the country, white or black, there are traditions of female subservience which some regard as oppressive. The extent to which that situation is accepted or to which intervention is designed to change it becomes, therefore, problematic. These related issues may influence the attitudes of professionals in reaching a judgement about the future; for example whether to remove children from the parents or to return them.

This issue of cultural relativism is only one of many arising from a consideration of attitudes to family functioning. But it is very important in everyday discussion between professionals of different backgrounds. There are two main hazards. One is that underlying conflict is not recognised and dealt with, that we talk past each other. The other, more serious, is that we collude in pseudo-sociological assessments, accepting explanations which in some way allow us to opt out of effective intervention.

The use of research in child abuse

This critical area is exemplified in the statement 'Afro-Caribbean parents physically chastise their children more severely than do white parents' is an example of one such unhelpful stereotype. Such superficial observations may lead us to underplay the psychological, even pathological, factors in certain pieces of behaviour. It is a kind of phoney sociology with racist undertones.

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shown so well, some research in this area has been badly flawed methodologically. A related but different example from the work of Rutter helps to expose a central weakness in so much research which seeks to link past experience with present behaviour.

Rutter (1979/80) studied a group of women whose children were in care and found that a high proportion had been in care themselves or in similarly vulnerable circumstances. Such a study may lead one to infer, incorrectly, that the children of women who had been in care were more likely to be in care, i.e. that the parenting capacity of the women had been affected. But of course to establish that, one has to find an unbiased sample of such women whose children were not already in care. Rutter found such a sample and showed that many such women who had been in care were bringing up their children in normal and relatively stable circumstances.

The history of child abuse is littered with such problems. To find that a substantial proportion of those who abuse their children have themselves been abused tells you nothing about all those who, having been abused, do not abuse their children and do not come to professional attention. Similarly the social deprivation, poor housing, poverty, unemployment and so on, endured by so many abusing families, is part and parcel of the lives of many who do not thus abuse.

To utilise research for practice effectively and responsibly requires quite a high degree of expertise and sophistication which is not always present in interprofessional discussion. Such encounters may wrongly take some research evidence as carrying more weight than it can bear, above all, in relation to prediction. The anxiety which uncertainty generates is intense and there is a temptation to look for 'hard' research evidence where none may exist. The real need is for sound professional judgement, even wisdom, an elusive but precious commodity, informed, but not dominated, by research. In the meanwhile, knowledge is power. As we shall later discuss, relative power and status significantly affects processes of co-operation. Those less knowledgeable in the complex and technical area of child abuse research may be unduly impressed by apparent expertise.

The extent to which co-operation is perceived to be mutually beneficial and in what ways.

An essential question in any discussion of co-operation has to be 'what's in it for me?' If one is committed to the protection of children from abuse, that motivation is a powerful factor in the way one behaves; if interprofessional co-operation is perceived to be relevant to such a goal, the psychological motive for so doing is powerful. However, the perceived benefits of co-operation for the wide variety of individuals concerned vary considerably. We need to sharpen our understanding of the factors involved, of which four seem particularly important.

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Whilst it would be unduly sceptical to minimise the importance of this motive in good co-operation, one notes also that co-operation is affected by what individuals believe to be acceptable behaviour, likely to lead to their own advancement. Thus, an agency which makes known at senior levels its approval of co-operative behaviour encourages it amongst employees. (The converse must also apply).

The points above are merely illustrative. What is needed is a systematic analysis of the perceived rewards for the various actors, in terms of their professional or occupational image, esteem and advancement and of the ways these are fostered by the employing agency.

Relative status and perceived power of the parties

The research into conferences which Christine Hallett and I undertook (Hallett and Stevenson 1980), suggested that matters of status and power were critical to the co-operative process. Indeed, amongst relatively sophisticated professionals, this is widely accepted. However, there are three particular dimensions which have received less attention than others.

The first concerns the weight which is given to people's observations according to their status and the problems which this may create in making sound assessments. Louis Blom Cooper in the Beckford report remarks cautiously of a Health Visitor's contribution that:

'We hesitate to conclude that the reason for such dismissal of Miss Knowles information was the inferior status accorded to health visitors by the doctor.'

He continues:

'Where physicians are trained in a psycho social context, medical people are more likely to perceive themselves as equals and colleagues of nurses, health visitors, social workers and occupational therapists, rather than being top dogs.' (p82)

What Blom Cooper does not refer to is the issue of gender in relation to occupation. One has only to observe the difficulty many women have in breaking into a formal conversation, even in relation to strength of voice, to see how unhelpful the interaction of gender with occupation may be. Yet, hearing the quiet, even uncertain, voice in a case conference may be critical.

A second matter to note is that there may be a distinction between the ascribed status of individuals and their perceived power, which can lead to some very interesting dynamics! In particular, the central position of social service departments which carry responsibility for so many of the actions and which therefore have considerable power may come as an unpleasant shock (or as a relief) to those accustomed within their own domain to exercising authority. Central government seems less equivocal these days about the role of social service departments; for example, DHSS insistence that case conferences recommend and do not decide and on the need for the key worker to be within the social service department or

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infrequently and are uncertain of the way this particular game is played. Finding ways of ensuring that their contribution is made effectively heard is an important element in co-operative activity, the more so if they are insecure about their status.

Professional and organisational priorities

Reference was earlier made to the relevance of professional and organisational priorities to co-operation. Those required to co-operate vary greatly in the frequency with which they encounter child abuse. Agencies are on a continuum from specialist, like the NSPCC, to the supposedly generic, like social service departments, to hospitals and schools in which child abuse represents a tiny fraction of their work.

Professionals and agencies, therefore, necessarily and properly differ in the extent to which child abuse is 'centre stage'. Yet this is sometimes given as a reason for not according a particular case or instance the attention which it requires, for example when a general practitioner has not time to attend a case conference, or for not devising adequate systems for internal communication, as in some schools. This seems like saying of the Herald of Free Enterprise disaster — 'well, the staff had a lot of other things to attend to beside the bow doors'. And yet nothing could be more important than ensuring those doors were closed. Similarly, surely all the human service occupations would place protecting a child from serious danger at the top of their list of priorities. If a GP says (as they do) that they only encounter a handful of such cases over some years, that does not lessen the importance of their co-operation when one occurs. Thus, the problem must be re-formulated to ask: what is the proper professional and organisational response to child abuse amongst those who encounter it rarely, who have a range of other activities more central to their daily work? It seems likely that the situation may be managed more securely if one has a designated person or persons who take some responsibility for critical assessment and who understand local procedures. This, of course, remains problematic where general practitioners are single handed or do not operate as an 'agency' in any meaningful way. There is, however, considerable potential scope for such arrangements in modern health centre developments.

The dynamics of small task focussed groups, such as case conferences

Much of the discussion concerning 'team work' has limited applicability in interprofessional child abuse work. Most people required to co-operate do not work together routinely. They come together for a few hours, undertake to keep in touch for various purposes and go back to their original occupational groupings. This complicates an analysis of their interactions. It is interesting to reflect on how rarely groups of people so loosely connected are given responsibility for life and death situations; contrast it with an intensive care team in hospital, army officers planning a military exercise or firemen attending an emergency. Such examples serve to remind us what a strange burden we place on these assorted persons, whose deliberations and decisions are not infrequently exposed to public scrutiny in inquiries. Under the spotlight ones the interaction of, say, the is sometimes given as a reason for not according a particular case or instance the attention which it requires, for example when a general practitioner has not time to attend a case conference, or for not devising adequate systems for internal communication, as in some schools. This seems like saying of the Herald of Free Enterprise disaster — 'well, the staff had a lot of other things to attend to beside the bow doors'. And yet nothing could be more important than ensuring those doors were closed. Similarly, surely all the human service occupations would place protecting a child from serious danger at the top of their list of priorities. If a GP says (as they do) that they only encounter a handful of such cases over some years, that does not lessen the importance of their co-operation when one occurs. Thus, the problem must be re-formulated to ask: what is the proper professional and organisational response to child abuse amongst those who encounter it rarely, who have a range of other activities more central to their daily work? It seems

of the group over individuals in giving correct answers, for example to the Highway Code. (Of course, all kinds of other factors are variables — the size of a particular group, the relative status of its members and so on). Another critical factor concerns the nature of the judgements required. Right or wrong answers to the Highway Code are clearly a far cry from a 'correct' decision concerning a child. The latter is infinitely more complex and much more difficult to evaluate since the actual definition of 'correctness' is itself contentious. None the less, much of the guidance and comment which has been made on child abuse rests on the proposition that several heads are better than one and that *collective deliberation* is a valuable exercise. It would be perverse to deny this but, equally, it is dangerous to idealise the process. The phrase 'group think' is used to describe a kind of false consensus when it becomes increasingly difficult to differ without being labelled as awkward, out of step etc. Such dissension requires considerable courage, which is affected by what Dingwall describes as the 'rule of optimism' about families, a reluctance to acknowledge negative factors. As some inquiries (Beckford 1986; Spencer 1978) have shown, this can be particularly difficult when a rehabilitative process is in train, in which some have a strong investment and which others are understandably reluctant to challenge or doubt.

Administrative arrangements and systems

Thus far, six issues fundamentally affecting co-operation have been briefly outlined. A seventh, widely acknowledged to be of vital importance, concerns the arrangements which agencies make for the recording and transmitting of information within the organisation and for communicating with those outside. Numerous inquiries have pinpointed administrative failures in agency liaison, sometime, as in the Darryn Clarke case (1979) with tragic consequences. These problems, although complex, are susceptible to rational, practical solutions, provided (and the proviso is huge) that resourcing is adequate. Social service departments, for example, have in general been starved of the basic secretarial and clerical services which are integral to efficient functioning. Whatever developments (and they are welcome) there may be in the use of computers, the need for skilled human resources, for example, for people who take good messages and minutes, remains at the heart of administrative requirements for co-operative efficiency. Such provision, therefore, is a necessary condition for interagency co-operation to be successful. It is not, however, a *sufficient* condition, for the best systems will not ensure effective co-operation unless we pay attention also to the motivation, dynamics and processes underlying co-operative activity.

So what is to be done? Concern about child abuse shows no sign of abating. Yet another inquiry is sitting; sexual abuse opens up new problems in collaborative work; practitioners are more harassed than ever in the face of their increasing work load and of continuing public criticism.

We have learnt a great deal since the Colwell inquiry about the facts which contribute to frustration on being labelled as awkward, out of step etc. Such dissension requires considerable courage, which is affected by what Dingwall describes as the 'rule of optimism' about families, a reluctance to acknowledge negative factors. As some inquiries (Beckford 1986; Spencer 1978) have shown, this can be particularly difficult when a rehabilitative process is in train, in which some have a strong investment and which others are understandably reluctant to challenge or doubt.

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reflects a commitment to interprofessional activity, later programmes have not only to complement basic training, they may have to challenge, even 'undo', the assumptions inculcated in earlier years.

So far as basic training is concerned, changes and innovation present formidable difficulties. Professions rightly guard their autonomy in such matters and should not be controlled by the ebb and flow of political preoccupations and by expediency. However, some political initiatives, for example, a request to the parties to examine the curriculum content of the various courses and make recommendations concerning interprofessional work, would be welcome.

Meanwhile, and more immediately, a wide range of strategies and initiatives at the post qualifying level are urgently required. Every JCAC (or ARC) should now be making systematic plans for locally based workshops for those who currently work together, (the inner circle), with related but separate provision for those whose interest and concern we need to mobilise but who are not systematically engaged in it (the outer circle). These should not be mass events in which halls full of anxious practitioners, (with some of those we most need absent), gather to hear experts discourse. Small, very local, groups with an external facilitator whose task would be to explore some of the issues and problems of particular significance to the members, are likely to achieve much more. Those groups, 'the inner circle', would consider the best ways of involving 'the outer circle' to the extent that is realistic and appropriate.

These working groups should have two explicit goals. The first would be to explore aspects of child abuse, for example, research findings. However, the exploration should take place in a multi disciplinary forum and the second goal should be to examine issues concerning co-operation. Hearing and learning the same things should, of itself, enhance co-operation but some sensitive consideration of group process would also be desirable. Realistically, this will not always be possible. However, the development of professional insight has a different focus from personal therapy. The interaction between the professional and the personal is complex but in the hands of a skilled facilitator, the participants should feel safe. Indeed given the anxiety which those working in child abuse experience, such working groups might prove supportive rather than threatening.

In short, what is proposed is an unequivocal commitment by those who formulate policy at local level to programmes of training which place interprofessional work 'centre stage', which affirm that examination of the processes involved are an essential component of effective work in child abuse. Such an examination will involve people in attempts to understand other people's working situations, in particular, (an area much neglected by inquiries so far), the overall context of stress and working priorities with which workers have to cope. We cannot take in each others emotional washing but a more sensitive and realistic understanding of other people's situations may alter the way we seek to use or to help them. Members of a conventional

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However, both quantitatively and qualitatively provision is still quite inadequate. Case conferences remain a focal point for improving co-operation and one from which it is possible to fan out. Much more remains to be done in the development of chairing skills.

Training initiatives of this kind require resourcing. Yet, without such improvements, increases in man or woman power, desirable as they may be, will be much less effective. Even the hard nosed Audit Commission, commenting on the implication of community care policies, remarked on the importance, and relative dearth, of training for the staff involved. (HMSO 1986). What holders of purse strings, and those who influence purse holders, must now realise is that advice and encouragement is simply not enough. The nature of the activity, of effective interprofessional work, must be better understood by those involved in it.

Professor Stevenson gave this paper at the Alfred White Franklin Memorial Day in London in May 1987.

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