Working with Children Individually Issues for Good Professional Practice

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This document was drawn up on the initiative of the joint ACP/ Royal College of Psychiatrists Liaison group. The working party hope that teams and departments will set aside time to discuss the issues in relation to their own practice.

Miranda Feuchtwang

This document has been written in response to concern expressed by professionals in a range of disciplines. It is presented in order to suggest the areas that need consideration and discussion by professionals and agencies whenever a professional is working with a child or young person individually.

Working Party:

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This paper has been drawn up in order to promote good clinical practice and stimulate discussion in the public service and the private sector in the light of recent developments.

These include:

1. Increasing recognition of child sexual abuse and the implications of this for Individual work with children;
2. The need for protection of children and families from malpractice:
3. The protection of professionals from false allegations, injuries and undue stress.

The various professional groups whose members are likely to be involved in individual therapeutic work with children, each have their own disciplinary and procedural codes of practice, including dealing with the issue of confidentiality. There is no mandatory reporting law about suspicions of child abuse in this country. Nevertheless, in the context of the Children Act, and "Working Together" and recent public enquires (e. g. the Pindown Report and the Kirkwood Report), there is an expectation of professionals' awareness and recognition of symptoms and signs suggestive of child abuse. There is also the possibility that children might, in the course of therapeutic work, divulge actual abusive experiences, either current or previous. Professionals who suspect or have knowledge of abuse are expected to share information with colleagues and, if necessary, to inform the Local Authority, Police and NSPCC (Working Together DOH 1991). Locally agreed procedures monitored by Area Child Protection Committees (ACPC) form the basis for professionals' response to such situations.

It has been thought helpful to highlight issues of potential' difficulty as follows:

1. Communications with Parents/Carers

Informed consent is important. Thought must be given to what parents/ carers need to know, and also the question of who can appropriately give consent. Informed consent involves discussion of the child‘s treatment needs and how these will be approached, particularly in relation to sensitive issues like adoption, terminal illness, etc. There will be an expectation that parental involvement will continue until the age of 16, although full consideration needs to be given to the rights of the child under the provisions of the Children Act and the Gillick ruling.

Parents / Carers need to know:

1.1. The boundaries of confidentiality within which the professional works and which are only breached by the professional when there are serious concerns about child protection. Any breach would be fully explained to the child.

1.2. The profession of the worker who is the responsible case manager.

1.3. The fact that the worker may address all aspects of the child's life, as appropriate, including sexuality.

1.4. The arrangements and expectations regarding the beginning and ending of sessions, breaks, parents’ and carers' communications with professionals and a specific understanding about any payment involved.

1.5. That they will be offered opportunities to review the child's progress.

1.6. That practical management and safety issues may arise during the session, and that agencies will have developed policies with regard to informing carers when verbal or physical restraint has been used or when the child has suffered any injury. Parents/carers should be

informed of any injury to the child as soon as possible.

2. Direct Contact between Professionals and Child or Adolescent

Consideration needs to be given to the following issues:

2.1. Consent

The need for, and limitations of, a child's informed consent to treatment. Special consideration needs to be given to children of different ages, children with disability and children who change their minds with regard to their willingness to continue with the work.

2.2. Confidentiality

The need for explanation of the boundaries of confidentiality and particular explanation about when this may need to be breached.

2.3. Verbal Behaviour

Awareness and sensitivity to a particular child or young person's use of language, especially relating to anatomy, bodily functions and sexual matters. Where there may be concern that use of language during the session may be misconstrued, this should be recorded.

2.4. Physical Behaviour

There is a need for agencies to raise awareness and establish good practice in' the following areas:

2.5.

a. Restraint for the child’s protection
b. Restraint for the professionals protection
c. The issue of the appropriateness of physical comforting
d. Differentiation between affectionate, sexual and aggressive approaches by the Child.
e. The meaning to the child of particular forms of touching
f. Response to touching initiated by the child.

g. The possible need for the premature termination of the session

3. Guidelines for the Induvial Professions, Supervisors, Clinical Managers and Colleagues

3.1. Individual Professionals

3.1.1. All professionals need to insist on adequate training and ongoing supervision for themselves, and, where appropriate, to request joint supervision.

3.1.2. Uncertainties and concerns need to be appropriately discussed in supervision - such as worrying emotional responses from the child and doubts about physical contact between the professional and the child.

3.1.3. In addition to routine clinical notes, it is advisable that a record be kept of:

a. any discussion with parents/carers occurring before or during treatment
b. any incident of verbal or physical restraint of the child and/or injury to the child.
c. any physical injury to the professional

3.1.4. Professionals need constantly to be sensitive to issues of race, culture, class and gender. (Anti-oppressive practice).

3.1.5. Professionals need to be aware of the extent and limitations of their training and draw the attention of their fine managers to their own training, supervision and consultation needs.

3.2. Supervisors

3.2.1. Supervisors must hold the possibility of child abuse in mind so that clinical material emerging can be added to other information which in itself may be insufficient to raise justifiable suspicions. Disclosure of abuse or indication of abuse may emerge at any, time during clinical interventions. There may be times when supervisors need to try and clarify what is fantasy and reality in the material

3.2.2. Supervisors need to help professionals decide when the concerns about a child are sufficient to merit discussion with the clinical manager. This may involve a shift from a therapeutic to a child protection stance, and the supervisor's role is crucial as this transition is difficult for the therapist. Discussing the therapeutic stance when child protection issues are involved requires delicate and skilled supervision.

3.2.3. Supervisors need carefully to distinguish what is part of the clinical work and what belongs with the professional who may need to be advised to seek a consultation, counselling or personal therapy.

3.2.4. Where supervisors have concerns about the professional's behaviour, capacity to hold and respect professional boundaries or mental health, they need to discuss this with the professional and, if necessary, with the professional's clinical manager.

3.3. **Clinical Managers**

3.3.1 Clinical managers should pay attention to the levels of stress generated by the case load carried by professionals at any one the

3.3.2 Clinical managers should be clear about the overall professional context within which the individual work is taking place and who are the persons responsible for decision making. Clinical managers should also ensure that the individual professionals are familiar with these lines of responsibility.

3.3.3 Clinical managers are advised to ensure that adequate supervision and consultation are available to professionals and that adequate arrangements are made during annual leave and in the event of sickness.

3.3.4 All line managers need to be familiar with agency and disciplinary procedures and to act within the relevant guidelines.

3.4. **Colleagues**

3.4.1 All professionals need to take some responsibility for the mental health of their colleagues. In case of concern, the supporting line manager needs to be informed.

4. Allegations about Professionals by Children, Adolescents and Adults

It is advisable that agencies have a procedure for dealing with allegations. It is suggested that such procedures take into account the following:

4.1. All allegations need to be taken seriously. There needs to be a sensitive, careful and thoughtful response.

4.2. There needs to be discussion with everyone involved and an explanation of what steps are to be taken.

4.3 Where there have been allegations of professional misconduct with an individual child, it is suggested that the professional involved stop seeing children individually pending clarification of the allegation. In the light of a particular allegation, consideration will also need to be given to suspension from any of the following activities: work with families, co-working, consulting and teaching.

4.4 The appointment of an independent mental health professional to interview

all parties and prepare a report is suggested, in preference to internal inquires.

4.5 It is highly desirable that any investigation is completed as rapidly as possible to protect the best interests of the child and the professional.

The Disciplinary procedure

The Association, in line with other professional bodies has formally adopted a Disciplinary procedure. The document was drawn up by a lawyer in consultation with the Ethics Committee. It was presented to the Executive Committee In draft form in January and formally adopted at the February Executive meeting. It has been sent to our Union, MSF, for their information, and is available on request from Angela Lee-Lazone.

It consists of:

1. The remit for and constitution of the Ethics Committee
2. The procedures the Committee will adopt upon receipt of a complaint
3. It specifies the stages of investigation that may lead to a Disciplinary Hearing and the Sanctions that a Disciplinary Committee may Impose.

It specifies the procedure for an appeal.

There are two associates rule changes which the Executive will bring before the membership at the AGM in July.