
THE CHILD, THE FAMILY AND THE GP : TENSIONS AND CONFLICTS OF INTEREST IN SAFEGUARDING CHILDREN

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Introduction

The role of GPs in safeguarding children has long been seen as vital to inter-agency collaboration in child protection processes and to promoting early intervention in families. It has often been characterized as problematic to engage GPs and recognized that potential conflicts of interest may constrain their engagement. The project team was commissioned by the Department for Children, Schools and Families and the Department of Health as part of the Safeguarding Children Research Initiative to explore the tensions and conflicts of interest when children, about whom there are welfare concerns, and their parents are both patients, and to suggest ways of resolving these conflicts of interest. The study focus was broadened to explore the complexity of relationships between GPs, parents and children, and other professionals, in response to initial feedback from the piloting of research tools.

Key Findings

- Expectations of GPs as set out in Government policy documents are not fully shared by GPs themselves and other stakeholders. GPs interviewed saw their role in most cases as referring patients / families on where concerns were raised, while key stakeholders expected fuller engagement in all stages of child protection processes.
- GPs see supporting parents as the best way to support children and families; all study participants agreed that where harm or its likelihood was evident, the child's interests must come first, but keeping the focus on the child was more difficult.
- Although GPs are clear about 'what to do' when the situation is clear cut for child protection referrals to children's social care services, if it is more complicated they would seek advice and support from a paediatrician or a health visitor first.
- GPs' lack of confidence in responses from child protection services was cited as a reason for this reluctance; not being able to speak directly to social workers in children's services, over or under response to concerns, lack of feedback from children's social care services when referrals were made, and potential impact on families of intervention were cited as reasons for hesitance in referral and dilemmas in confidentiality.
- An unexpected finding of this study was the lack of reference by most of the GPs (and Key Stakeholders) to the views and wishes of children, suggesting more work is needed to improve communication and children's involvement in decisions.

- The important role of the health visitor in safeguarding children, both for parents and as a key fellow professional for the GP to refer to, was confirmed in this study. Future policy guidance might consider strengthening health visitor safeguarding responsibilities in the light of any location changes away from GP practices for health visitors (e.g. to children's centres) since this study was completed.

- GPs' in the study had the perception that child protection work is not as valued as other activities which are rewarded under the Quality and Outcomes Framework. It is suggested that policy makers could explore ways of raising the profile of safeguarding work amongst GPs.

- GPs in the study reported low attendance at child protection conferences though provision of reports to conferences was higher than expected. Some suggested that conferences may be better informed by other / health professionals who may hold more relevant information.

Background

Following the Victoria Climbié Inquiry (2003) and the development of the government's Every Child Matters policy, subsequent legislation and policy guidance has marked a rebalancing of emphasis from protection to prevention in safeguarding children and the promotion of better outcomes for all children. The GP role in safeguarding children is defined primarily to identify children felt to be at risk of harm and refer them for appropriate assessment and services, but also includes possible involvement in subsequent intervention. Their role is largely described within primary health care team duties and responsibilities. There is also considerable profession specific advice to support GPs in their safeguarding roles with children, especially concerning confidentiality and their duties as a GP and doctor, from the regulatory and professional bodies and Royal Colleges (e.g. GMC, RCGP, RCPCH, BMA).

Several commentators have drawn attention to the 'unique' contribution GPs can make to preventive approaches to safeguarding and family work, based on their longstanding knowledge of families, professional stability, open access offered by self referral, and generally high regard from parents. Research, however, has tended to focus more on limited GP participation in multi disciplinary activities (such as child protection conferences) and discrepancies in perception of causes for concern.

While the RCGP have been seeking to integrate child abuse and neglect into the GP core curriculum and responsibilities, there remains a challenge as to how the prioritization of safeguarding children is promoted for GPs and evidence gathered about the effectiveness of their intervention.

Aims

The study had three specific aims:

1. to explore the nature and consequences of tensions and conflicts of interest for GPs in safeguarding children taking account of key factors;
2. to evaluate how these tensions and conflicts are seen and responded to from a range of professional, parent and child perspectives;
3. to consider ways of managing these tensions and conflicts to promote best practice.

Methodology

This was an exploratory mixed methods study, focusing particularly on GPs in two contrasting Primary Care Trusts (PCTs) and groups of GPs accessed through training events. It also included interviews with Local Safeguarding Children Board (LSCB) key stakeholders and drew on a Delphi panel of 25 independent experts and three focus groups of parents, young people and a minority ethnic group. It was supported by a literature and policy review and demographic and child protection statistics in the PCTs. Data collection was conducted from May 2006 to June 2007.

540 questionnaires were distributed to GPs, electronically and on paper. Despite a variety of strategies used to enhance completion rates and numbers of respondents, 96 were returned, a response rate averaging 18% over the three access areas. 14 GPs (a subset of the questionnaire GPs) agreed to be interviewed, many by telephone.

The range of professional perspectives explored through the different methods and the inclusion of parents, young people and a minority ethnic group allowed the juxtaposition of different viewpoints on a complex set of issues. However caution must be exercised in relation to representativeness and generalisability beyond this study, due to the restricted numbers of case study sites and responding GPs, the likelihood that the GP responder may have an interest in safeguarding children, and the context of considerable change in policy and service structures at the time of the study.

Findings

Understanding of interests, conflicts of interests and their incidence

'Interests' cover a range of concepts such as needs, wants, and rights, in various combinations, and findings from all parts of the study suggested that there are many ways that potential conflicts of interest may arise for those involved (the GP, a child, a parent or carer). GPs are balancing these regularly, alongside other competing tensions that affect individual GP decisions or assessment, such as the time pressure of consultation arrangements, their own experience or knowledge of safeguarding issues, or variability in support from or confidence in other professionals. GPs recognized the existence of conflicts of interest even if they reported small numbers of problem cases. A paediatrician (Key Stakeholder) challenged the notion of limited incidence, suggesting GPs will see risk indicators of child abuse or neglect in every surgery.

GPs in the study provided strong evidence that where issues are clear cut, the framework for safeguarding children is well understood and can provide appropriate guidance to act when necessary.

The Doctor / Patient Relationship: adult, child or family focus?

Maintaining a positive continuing relationship with parents was identified by almost all the GPs in questionnaires as an important means to supporting children and families through supporting parents, though a third considered addressing concerns about children's welfare with parents difficult. Managing the priority to protect and consider children while managing relationships with all family members, when the *doctor / parent* relationship was the usual focus of consultation, was the GPs' most frequently cited conflict of interest. GPs rated their knowledge of families beyond individual patient medical information as limited, but valued the relationship with the patient as important.

Both Key Stakeholders and the Delphi panel acknowledged the importance of the doctor / patient relationship but expressed concerns that over-confidence in 'knowing' the parent or carer, might lead to misjudgment, over-identification with parents or GPs not seeing concerns about children.

Most Focus Group members experienced the GP consultation as a service not as a relationship; they expressed disappointment when their high expectations of the GP were not always met, especially in terms of relationships rather than roles. They emphasized pragmatic difficulties relating to access (to the same GP, and time availability) and in contrast, rated health visitors very highly in terms of their child care expertise, accessibility, knowledge of families and support they gave to parents and children.

Key Stakeholders acknowledged the difficulty in separating out the interests of the child from the parent / family.

Where significant harm or the likelihood of significant harm to the child is evident, then all participants in the study agreed that the child's interests must come first.

Expectations of the GP role

In relation to safeguarding, GPs in the study emphasized their continuity role with families, a specific and preferred role in early identification of concerns and referral on, and a limited contribution in multi-agency interventions to protect children at later stages. These perceptions were not shared by other professionals or consistent with how policy guidelines for GPs on participation in all stages of safeguarding children were interpreted by others. Key Stakeholders and Delphi panel members expected GPs to play a significant, ongoing role in all aspects of safeguarding children, and even to take on a more central role in particular individual cases.

Drawing on data from the study, the researchers developed a set of descriptors for separated roles in safeguarding ('Case holder', 'Sentinel', 'Gatekeeper / Gateway' and 'Multi-agency Team Player'), as a means of distinguishing where expectations of GPs and stakeholders diverged most - which was greatest in relation to multi-agency involvement activities.

Key Stakeholders rated the GP's understanding of families' situations as important and potentially highly significant in neglect cases, where neglect was a process not a single event. Focus Group members and some Key Stakeholders were however unsure of some GPs' abilities to identify that a child was at risk of harm, compared to health visitors.

Most Key Stakeholders had definite expectations that GPs would attend child protection conferences, which were seldom realized. GPs cited reasons of time, inconvenience and distance, as reasons for their non-attendance, but also questioned whether their contribution was different from that of others, suggesting that other health professionals might be more informed at conferences or writing reports. Only nine of the 44 GPs invited to child protection conferences attended, with six of these writing a report as well, while two thirds of the non-attenders sent reports.

GP confidence in the child protection process and other professionals

All GPs completing questionnaires were aware of the child protection procedures and need to refer to children's social care services. Where GPs interviewed identified a child was at risk of harm and the situation and evidence were clear cut, all expressed no difficulty in coming to a decision to make a child protection referral. Most GPs rated children's social care services highest as the professionals they would consult on child protection concerns, reflecting legal requirements and responsibilities, and two thirds reported they had not experienced inadequacies in child protection procedures.

With reference to parental and child concerns that would worry them, GPs in the questionnaires identified situations that they would deal with themselves (e.g. 'mental health difficulties in the parent), concerns that they would refer to a health or practice colleague (e.g. parental 'learning disability', child 'failure to thrive'), and concerns that would trigger referral to children's social care services: for example, 'domestic violence' was the most concerning parental difficulty, followed by 'alcohol and drug abuse' as the next most significant factor for parents. In relation to child presentation, most concerning was evidence of 'injury' and 'neglect'. Half the GPs expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care services. Two thirds of GPs rated the health visitor as highly significant to refer to, where there was concern for a child. GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation before 'raising concerns'.

Many GPs sought local solutions with the family, and would be more likely to delay referral for concerns to children's social care services, where response levels were unpredictable, or seemed inappropriate (child protection procedures invoked with "*all guns blazing*" or 'no action').

After the doctor / patient relationship, the second most important concern for some GPs was dissatisfaction with referral processes to children's social care services (especially through contact centres) and lack of feedback from referrals. Loss of control of the process and potential loss of contact with families affected negatively by intervention were fears expressed by GPs about investigative intervention.

Information sharing and confidentiality

GPs routinely manage patient assessment and confidentiality and experienced minimal confidentiality issues sharing information with health colleagues, where the need for explicit parental consent was avoided. Half the GPs in the questionnaires indicated that confidentiality and seeking consent were constraints when dealing with a child at risk. A quarter of GPs accepted the need to share information to safeguard a child within their professional guidelines, if it was 'proportionate' to the issue and on a 'need to know' basis. Parents' and young people's Focus Groups preferred GPs to contact health visitors first, fearing consequences and stigma from children's social care services' intervention, thus constraining potential GP information sharing if GPs respect these views.

Incentives for GP safeguarding work and training

Keeping up to date with safeguarding children arrangements and expectations along with all the other areas of GP practice 'business' is problematic. Time factors constrain attendance at training or case conferences as well as consultation time for addressing difficult issues. Less than half of GPs in questionnaires had participated in child protection training since 2003 (the newly qualified forming the highest proportion), and only a quarter of these in multiagency events. GPs in the study commented that indicators for safeguarding children in the GP contract and the Quality and Outcomes Framework (QOF) appear less than for other areas of GP practice, suggesting a (possibly unintended) lower prioritization by government. Some GPs made specific suggestions about making child protection training and templates for significant event analysis linked to Quality and Outcomes Framework indicators.

Forgotten or Invisible Children

An unexpected finding of this study was the lack of reference by most of the GPs (and key stakeholders) to the views and wishes of children, suggesting more work is needed to improve communication and their involvement in decisions. Issues concerning the needs of children with a disability and/or from black and minority ethnic families were seldom identified.

Conclusions

The study highlighted the complex web of professional issues and tensions for GPs in safeguarding a child's welfare, which go beyond conflicting interests and competing priorities for the child, their parent and the family. The study findings are consistent with much of previous literature and research on multi-professional relationships and the GP contribution to identification of children at risk of harm or neglected. The GP role may need disaggregation, to clarify and manage expectations of GP participation in early assessment, intervention and multi-professional support for families. While there is much evidence of the commitment of individual GPs to the welfare of their families and to managing tensions and conflicts that can arise, the study also reiterated the need to see the child behind the parent, and to 'Think child, think family,... think child'. A focus on seeing and communicating with children, and engaging their wishes and feelings in decisions about them would improve the basis for professional decisions, but may require more training or specialist roles.

Changing policies, structures and guidance emerging since this study was initiated will provide a new framework in which these tensions can be addressed, in collaboration with GPs themselves and the RCGP, to bring about more effective interagency collaboration in safeguarding children and better outcomes for children.

Though restricted in scope and given the exploratory and descriptive nature of the findings, the study has generated messages relevant to policy makers, practitioners and organizations, and identified further areas for research and some examples and suggestions for best practice in managing tensions and conflicts.

Key Messages for Policy include

1. Policy makers could explore ways of raising the profile of safeguarding work amongst GPs through initiatives that would help GPs prioritize this work.
2. Future policy guidance might consider strengthening health visitor safeguarding responsibilities in the light of any location changes away from GP surgeries (e.g. to children's centres) since this study was completed.

Key Messages for Research include

1. Greater clarification of expectations and differentiation of roles expected of GPs might allow exploration of the impact on multi-disciplinary relations, the appropriateness of different professionals' involvement in child protection conferences, and the particular role GPs can play in neglect cases.
2. The RCGP strategy (2005) noted the lack of an evidence base for positive outcomes from intervention by GPs in safeguarding children cases. Changes in GP templates for child protection conference reports could contribute significantly to establishing an appropriate evidence base of cases and more detailed sets of indicators for identifying concern more confidently (e.g. where linked to parental factors or child development).
3. Further research is needed to evaluate outcomes for children who were involved by GPs in decisions about them.
4. The needs of children with a disability and / or from black and / or minority ethnic families would benefit from a focused study to include professionals and families from these minority groups.

Examples and Suggestions from some Research Participants for Managing Tensions and Conflicts include

1. For GPs: talking and listening to parents and to children about concerns, and involving them in decisions, even where difficult; forewarning parents early of limits to confidentiality; allocating separate GPs to parent / child where there are conflicts; recording decisions and justifications carefully, and ensuring any data generated by assessment relevant to the family on *all* family member records; development of the consultative, reflective space prior to referral for GPs, utilizing skills of named / designated professionals and paediatricians, and training and case discussion in the practice.
2. For LSCBs: agreeing common goals; regular face to face contact; finding ways to involve GPs in locally negotiated and shared discussion, protocols and guidance.
3. For children's social care services: Improvements in feedback following GP referrals could positively encourage recording of concerns and referral rates from GPs.

Additional Information

A more detailed executive summary (DCSF-RBX-09-05-ES) can be accessed at www.dcsf.gov.uk/research/

Further information about this research can be obtained from Isabella Craig, 4FL-ARD, DCSF, Sanctuary Buildings, Great Smith Street, London SW1P 3BT

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.