Reflections on Working for Children's Social Services in the United Kingdom

By Alexandra Eliot, PhD, LICSW

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Abstract

This paper comments on my experience as an American clinical social worker who worked for a year as a consultant to the Fostering Support Team and a group of foster parents in Ealing, a densely populated and culturally diverse borough of London. Over time, it became apparent that the strengths and weaknesses of both systems had much in common; my reflections in this article are more descriptive than comparative. There is discussion of the dearth of psychotherapists available to treat children who are in care in Ealing. Also, facts about the emergence of social services in the wake of the Industrial Revolution are put into historical context. Additionally, the efforts to establish and implement goals that have been outlined by the government and adopted by Ealing's fostering and social services are discussed.

The British savor ways in which their social customs, national policies, and service delivery systems differ from those of their American cousins, and vice versa. The most obvious, some would say egregious, example of difference between the two countries is the absence of a national health plan in the United States that, by stark contrast, has been in place in the United Kingdom since 1958. Virtually every person living within the United Kingdom, either permanently or temporarily, has access to basic health care and social welfare services via a general practitioner from the National Health Service. It is true that since the 1960s the U.S. federal government has taken considerable responsibility for the basic welfare of children, whose care is now largely under the auspices of the Department of Health and Human Services. However, these services are confined to the needs of the extremely poor rather than to the needs of all, and there is great variation in the provision of care to children among the 50 individual states. With that said, a review of my experience working for the British Children's services in 2003–2004 assumes a fundamental, if uneven, commitment by both nations to deliver good care to children who cannot be adequately maintained within their own families without some kind of supplementary support.

The population of the United Kingdom is approximately 60 million; that of the United States was about 282 million as of 2000 (of whom 45 million were uninsured), making enactment of any universal legislation in the United States ultimately essential but challenging on a larger scale. The British health care system is nationalized, highly centralized, and bureaucratic. In contrast, for children in the United States there are varied criteria for access to medical insurance and social services, and there are differing training and licensure requirements.

The majestically sprawling city of London is divided into 32 boroughs. Each is responsible for providing its own social services, education, and public housing. Although the central authority of Parliament ultimately guides services, there are considerable differences among the various boroughs emanating from population diversity, economics, and kinds and quality of services. Ealing, the fourth largest, is a densely populated borough of approximately 300,000 people from widely diverse

ethnic backgrounds. Over 100 languages and 400 dialects are spoken here. Half of the children are part of African, Caribbean, Indian, and Asian communities. Because of its proximity to Heathrow International Airport, Ealing is also the recipient of a significant number of refugees and others who are seeking asylum (Ealing Children's Services, 2003).

With this complicated mix of people from all rungs of the ethnic, economic, and social ladder, Ealing struggles to provide supplemental services to 2,000 children and young people (out of a national total of approximately 58,000 children); 450 of these children are under the compulsory and full-time care of the local authority. Others of these 2,000 include "looked after" children whose accommodations are provided on a voluntary or compulsory basis (Children Act, 1989, p. iv) as well as children in residential placement, kinship, or foster care. Young people age 18 or older who are "leaving care" are provided with services until age 21 and until age 24 if enrolled in full-time educational programs.

Priority work areas for social workers are 1) investigation and assessment of child protection referrals and children in need; 2) supervision of children in short- and long-term kinship, transitional, and respite placements; 3) training and support for approved foster carers; and 4) preparation of children over 16 who will be leaving care (Ealing Children's Services, 2003). Workers have an average caseload of 14–16 individuals or foster families; these numbers often do not adequately reflect the difficulty and stress of the work when crises and dangerous situations occur. It was noteworthy that there was no area of concentration that focused on referrals for psychological assessment of these children. Similarly, of the nine objectives outlined for the fostering service at an orientation meeting in October 2003, there was no inclusion of the necessity for evaluation of emotional problems. Rather, the targets articulated such aspects as annually inspecting the foster home, protecting the children from abuse and neglect, promoting health and education, and preparing the children for adulthood—all worthy but somewhat vague goals. In my interim report of February 1, 2004, I mentioned what I perceived to be an urgent need for access to psychological services, my willingness to assist in providing them, and the fact that I had discussed this with a clinical consultant.

However, some statistics illustrate the challenges to both managers and line workers that may determine priorities. There is a national shortage of 8,000 foster parents (carers), despite the 32,000 who are approved. Of the more than 58,000 children in care across the country, 11% live with their parents with the aid of supplementary social services, 11% are with other family members, 54% are in foster care, and 13% are in residential placements. Even though substantial, these numbers pale in comparison to some that were recently published on the number of children in public care in New York City. In 1991 the foster care population in that city alone reached a high of 49,100 (Santos, 2005).

Historical Context of Social Services

Social work as a profession began in the late 1800s as a delayed response to the upheaval of the Industrial Revolution, which gained momentum during the previous century and resulted in massive relocation to the cities and concomitant problems of poverty, neglect, and overcrowding. In fact, one of the first social service agencies was founded in London in 1869, with its counselors known as "friendly visitors" and later designated as caseworkers (Hartman, 2003). The first school to offer full-time study in social work in the United States was located in Boston. It opened in 1904 and continues as the Simmons College School of Social Work.

Casework remained as one of the three basic approaches to social service delivery, along with group work and community organization. Social caseworkers dealt with individuals and families in an effort to alleviate their adverse social and economic conditions and prevent social breakdown and the loss of personal control (Funk and Wagnalls, 1972). During this period, specialization in areas of medical and psychiatric casework proliferated within this group. In the past 3 or 4 decades, social work methodology and clinical application have become increasingly generic and the various branches more integrated.

For professional social workers in the United States, knowledge of their British counterparts was gleaned primarily from private agencies in the United Kingdom (most famously the Tavistock Clinic in London) that were staffed with highly trained caseworkers. Similarly, fully qualified social workers in this country were, and still are, widely required to complete 2 years of postgraduate academic training along with supervised fieldwork. However, in England in 1956, the Scottish psychiatrist R. D. Laing joined Tavistock and left a strong imprint with his social theory of mental illness (Hartman, 2003), as detailed in one of his books, *The Politics of the Family and Other Essays* (1971). The sociological approach to problems arising in the transformation from communities to mass industrial societies focused on the interrelationship among larger groups, rather than on individuals. This resulted in a shift away from the emphasis on psychological training as a prerequisite for individually oriented social casework by qualified professionals to a "larger systems" and less personalized approach.

It was in this environment that, by the 1980s, problems in the adequate delivery of services to children in need began to demand attention and remediation. Another factor was the gradual privatization of services through Foundation Trusts, which essentially created competitive forces in the social service marketplace and drew workers away from the public system, resulting in a kind of brain drain.

In recognition of the fact that laws regarding the protection of children were "inconsistent and fragmented across the face of the statute book," the Children Act of 1989 was "the most comprehensive piece of legislation which Parliament has ever enacted" (Children Act, 1989, pp. iii and 1). Its broad aim was to strike a new balance between the protection of children and family responsibility and autonomy. In turn, it emphasized the responsibility of local authorities to respond to the problems facing children in need in order to reduce their need to be brought into care. These goals reflected the perennial debate on both sides of the Atlantic as to whether priority should be given to family preservation or to child protection. In 2000 the Children Act was augmented by the Children Leaving Care Act, as well as by recent specialized programs (such as Quality Protects and Choice Protects) that are designed to give improved child and carer support and prevent placement breakdown and "foster drift." Foster drift in both

the United Kingdom and the United States is usually cited in the literature as having the primary negative impact on children in care. In the United Kingdom, 1 in 6 foster children move three or more times during the course of a single year, and 1 in 10 have more than 10 moves while in the foster care system. Present efforts are now focused on the Green Paper, called Every Child Matters, which in its final form will determine policy for the next several years (McCafferty, 2004).

Tragic social care scandals are no stranger to the United Kingdom, and they frequently become flashpoints for sudden, if not impulsive, policy and procedural changes and rules of behavior, just as they do in the United States. The shock of the Victoria Climbié death in 2000 undoubtedly added impetus to the demand that officials scrutinize services for children at risk in England. Victoria, a West African youngster, was moved from borough-to-borough by her aunt and her aunt's boyfriend, thus eluding the sustained attention of authorities. Despite being hospitalized with scabies and being in terrible condition, she was discharged to her aunt without a referral for assessment. Victoria was later starved, beaten, and murdered; her body was found in a black sack in a bathtub. Allegations, not only of untenable oversight of abuse but of institutional racism and cultural ignorance, were widely publicized.

Similar incidents have occurred in the United States. In New York City, 6-year-old Lisa Steinberg was murdered by her adoptive father in 1987 after years of being brutalized by him (Russo, 1997.) Most recently, a mother with known schizophrenia is alleged to have thrown her three young children into the San Francisco Bay (CNN, October 22, 2005). And in Boston, a 2-year-old, one of 7,800 foster children in Massachusetts, was beaten to death by his foster mother. Publicity surrounding this event focused on the large numbers of unlicensed foster homes and the paucity of criminal background checks being performed, despite the fact that in the 1990s scores of people identified as convicted criminals had been approved as foster parents by the Department of Social Services (Greenberger, 2005). Readers will surely be able to cite many other examples that arise from complex and tragic circumstances as well as from attitudinal ambivalence, inadequate training, and a lack of vigilance.

Recruitment Process

In the 15 years following enactment of the Children Act, it became apparent that professionally trained individuals, within both the clinical and management spheres, were essential ingredients for achieving the goals of the proposed new programs. Vacancy rates in many London boroughs were as high as 20%–30%. The dearth of suitably qualified social workers, exacerbated by the high cost of living in southeast England, the nature of the work, and general lack of experience and education, painted a bleak picture (Gilbert, 2004). As part of an effort to address this growing problem, local councils began to actively recruit from overseas. Australia initially proved to be the most attractive source of staff, followed by South Africa, Canada, Zimbabwe, and India (Gilbert). As part of this initiative, 15 new graduates from master's programs in the Boston area were recruited for referral and assessment work in Ealing. Along with this stimulating influx of foreign social workers, the United Kingdom has recently instituted new requirements for the profession, including a 3-year degree course (the equivalent of a bachelor's degree in social work), for inclusion in a National Registry, which establishes uniform standards for eligibility. Additionally, an American social worker with experience in the Massachusetts Department of Social Services was hired to head a substance abuse educational and clinical program, and I was hired in 2003 as the consultant to Ealing's Fostering Support Team. The recruitment campaign continues to be streamlined and has been quite successful. British social workers are benefiting from their more robustly trained overseas counterparts, and foreign workers are benefiting from the heterogeneous and culturally rich environment of England. In 2004 a 28-minute film *Making a Difference* by documentary filmmaker John Marshall was completed and is shown as part of the recruitment and orientation program.

My post as consultation officer had never existed before in Ealing, although it had been established 5 years earlier in the borough of Hounslow. This team of approximately 10 people was mandated to supervise and support the foster parents ("carers") who look after the 450 children who are in care under the auspices of the Children's Placement Services. Recently renamed supervising social workers, they were previously known as "link" workers and, in fact, attempted to function as the link among the foster parents, the biological parents, the agency, and the child's social worker. The reality, however, was that they were frequently caught in the middle of these conflicting factions and felt like "poor relations" with a negative self-image and little authority. During the Fostering Support Team Retreat meeting on October 13, 2003, the supervising social workers stated that their efforts on behalf of the foster families consisted of behind-the-scenes activities that were not as transparent or appreciated as those of workers doing referrals, assessments, and court appearances. One explanation for this might have been that their mandate was prevention instead of intervention and, therefore, their efforts had less dramatic visibility. The overall goal and responsibility of the Fostering Support Team was to prevent placement disruption and breakdown. During my tenure in Ealing there were two such breakdowns, representing a modest improvement over previous years.

Initial impressions were influenced by a plethora of difficulties settling-in in almost every aspect of normal daily living, a dramatic reminder of the densely bureaucratic environment in England. There were also striking dissimilarities in the work environment: physical, intellectual, and psychological differences from those to which I was accustomed after 35 years as a clinical social worker and administrator. The workspace was a vast, rather airless space holding approximately 60 workers from various job descriptions within Children's Services who were housed in a so-called "sick building" that was erected in the postwar building boom and scheduled to be demolished in 2006. With good humor and patience, the staff tolerated working in cramped spaces that were often distracting and always lacked privacy, quiet, and a place to speak with clients or fellow staff members (Eliot, 2004).

Within this framework it was necessary for me to create my own job description, as unfamiliar to the team as it was to me. Initially, I felt underutilized and overqualified. Eventually, however, my role centered

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around direct contact with the foster carers. Although I thought my days of home-visiting were long since past, this method of intervention was a familiar one, and I was able to use it as a fulcrum of my advisory role to the team workers and as a liaison to those involved with the young people themselves. As my assimilation became more integrated and less stressful, my impressions of the differences between problems encountered within the social services of both countries diminished. The present reflections, therefore, are based on descriptive rather than comparative data that allow the reader to note differences between the American and British systems based on individual observations and experience.

Problem Areas

My foremost concern, which worsened during the course of the year, was the dearth of qualified mental health professionals who were available and willing to evaluate and treat young people in care. I had arranged to meet with the head psychologist at Ealing's primary mental health facility for clinical consultations, but even when I presented situations that I felt required urgent attention, she was unable to facilitate rapid referral. The waiting list for a diagnostic evaluation was always 3 or more months and many months more for actual treatment of behavioral, emotional, or family problems. Recommendation for medication required a separate evaluation subsequent to the initial diagnostic, by which time the child had either settled into a despairing state of chronic disability or threatening placement breakdown, or he or she had to be hospitalized. The following case example illustrates this point.

> B., a 6-year-old boy of Kurdish extraction, had been in foster care for 6 months. Problems surfaced as the child became more trusting of the placement. He began to divulge a history of sexual abuse by his father. Father stalked the child at his school, watching him through the play yard fence. Contrary to agency policy, the father also knew the location of the foster family's house and had been there. Although parental contact was supervised, the chaperone did not speak Kurdish and, therefore, did not know what B. and his father talked about. The child's behavior deteriorated in that he became physically violent toward the foster mother, used foul and sexualized language, and described in explicit detail the alleged sexual abuse. The foster mother made repeated requests for B. to be in psychotherapy, but thus far the extent of this had been a half hour of drawing with a school counselor. He is a bright and engaging child who is obviously very troubled and needs ongoing therapy. At this point the placement had broken down and foster mother wanted him removed from her house because she could no longer handle his behavior and was afraid of biological father (Eliot, 2004.)

In such a situation, any delay in appropriate response represents an eternity for a youth in trouble or distress. The long-term consequences of such delays are far more costly than hiring more staff who are able to respond in a timely fashion. As a psychotherapist, I was anxious to take on this role but was prevented from doing so. A contract existed between Children's Services and the mental health clinic and, under this agreement, referrals and treatment services were exclusively the domain of that clinic, and my involvement carried potential liability problems. There was no designated place to see young people except in their homes, which was not appealing to them. I negotiated occasional informal sessions in local restaurants and parks, but the usefulness or authority of my recommendations or opinions was diluted or ignored. Children in care deserve priority rather than deferment, because they are the most severely damaged and vulnerable members of society. This reality speaks to some inequities in the British system, despite the fact that, on paper, everyone has access to health care. It was additionally discomfiting that I often heard from foster parents who had finally accompanied a child to an appointment that the experience was negative and irrelevant rather than helpful.

Broad bureaucratic structuring, the mandate for political correctness, and risk avoidance seemed at times to take precedence over independent and self-directed decision-making, that is, a sense of responsible autonomy; it is realistic and appropriate to assume that there is a distance from the idealism of White Papers debated in the House of Lords to delivery of services on the ground by local authorities. One size does not fit all. Policy demands modification and flexibility as it cascades down to individual human circumstances. But policy should not take precedence over adherence to the best interests of the child or to judgments based on experience and competence, even when such actions are unpopular and personally difficult.

The procedure process, regulations, and documentation that was necessary for every action sometimes resulted in a preoccupation with administrative detail and paperwork and a desire to do things by the book. Because authorization is required for almost all actions, such as case planning, change in circumstances, and emergency arrangements, these were delayed when management was not available (and management absenteeism was a chronic problem). Thus, the services delivered within the fostering team had the potential for quickly becoming unwieldy and inefficient. For example, when a placement was obviously successful from the point of view of all concerned and the child had settled in well and wished to remain, procedure nonetheless required that other foster families be interviewed and assessed as potential candidates. By the same token, contact between foster children in short-term placement and their birth parents could be as frequent as 5 times a week. Although the theoretical importance of maintaining close ties between the child and his or her birth family is understandable, it is damaging, even dangerous, when the reason for placement includes a history of trauma or abuse, even if contact is chaperoned. Such interruptions make it almost impossible for the carers to stabilize a routine in the placement that ensures consistency in the environment and promotes psychological healing and growth.

The clause in the Children Act emphasizing the best interests of the child seemed at times to be translated into the interests of the birth parents or even the system itself. Not taking at-risk children into care because there is no concrete evidence of abuse is a poor policy that poses an obvious obstacle to keeping them safe. Their wishes and needs are neither listened to nor heeded. It is to be applauded that some of the aforementioned recent programs are now beginning to address these issues in a sensitive manner.

During my contact with foster parents, a continuing issue arose around their lack of authorization to set boundaries and exercise any kind of reasonable discipline for their foster adolescents. The teens were acutely aware that there was little or nothing that could be done when house rules were broken or when their behaviors were unacceptable. They exploited this and made their carers feel helpless and less able to be effective mentors and adult role models. Out of this arrangement grew discrepancies between the treatment of birth children and foster children, which was disruptive and lent an atmosphere of tension and inequality in the household. My attempts to use an article in *The Spectator* (Liddle, 2004) as a basis for discussion were unsuccessful, as were recommendations for dissemination of a book called *Smart Discipline* (Koenig, 2002).

Prospective foster parents complained that they received little, if any, background information on the young people who were to be placed in their care. Facts that were vital for interaction with and treatment of a traumatized and frightened child needed to precede or at least accompany the placement event. Another source of fragmentation and communication breakdown was the policy of having separate workers for the child and the foster parents. This, compounded by a reluctance to get involved and a tendency to closely guard one's own turf and not tread on someone else's, caused problems with coordination and expedient action. Workers who represented the children and others who advocated for the foster and/or biological parents sometimes performed as if they were adversaries rather than collaborators (Eliot, 2004).

The issue of management expertise is also pertinent to the streamlining of services to the young people of Ealing. Policies regarding promotion of managers can depend on seniority more than on qualifications. In fact, for the country as a whole, the idea of "care managers" came into vogue in the late 1980s and began to take precedence over the individual worker, team expertise, and getting the job done in an effective, safe manner (Burton, 2004). One particular cornerstone of the Children Act, which rested on the belief that reunification with birth parents should occur as soon as possible (however unstable or disturbed the parents are), was risky when placed in the hands of less-than-competently-trained managers. Although lip service was paid to the promotion of a free exchange of ideas and problems among workers, most of them did not do so and felt that the environment was too charged for them to feel a sense of mutual trust. There were incidents that demonstrated a considerable lack of judgment, professionalism, or civility, and certainly did nothing to promote team pride and performance excellence.

Social workers are often asked to address problems that no one else in society wants to deal with, and both they and the children need all the specialized help possible. Hence, after 1 year (I was invited to extend my stay but was unable to do so) with these hard working, dedicated providers, my greatest sense of accomplishment was to succeed in persuading Children's Placement Services to hire a qualified clinician to succeed me and to provide comprehensive psychotherapeutic services to the children of Ealing. Important support was contributed by one of the new programs started in 2002 called Choice Protects, whose administrators actively emphasized the advisory and consultative role for supervising social workers and foster families.

These endeavors seem to have secured a solid footing, and despite perennial fiscal and bureaucratic constraints, they appear to have a good chance of surviving. A recent inspection of Ealing social services by an independent commission reinforced these ideas through strong sponsorship and approximately $400,000 for fiscal 2003–2004 to create six new posts in the fostering area under the banner of "Fostering for the Future." The government's stated aims were straightforward and unambiguous: to help local councils commission and deliver effective services for their looked-after children, with specific emphasis on fostering services. These goals, mandated to be high quality, family oriented, and child focused, are objectives that are surely worthy of pursuit on both sides of the Atlantic.

Anyone interested in learning more about working with Ealing Children's Services should contact Marcella Phelan, Manager, "Quality Protects," at www.ealing.gov.uk

References

Burton, J. (2004, February 19). No more managers? *Communitycare.* Retrieved from www.communitycare.co.uk

Cable News Network (CNN). News broadcast. October 22, 2005.

Children Act. (1989). United Kingdom. c.41.

Ealing Children's Services (2003). *Work Opportunities in the U.K.*

Eliot, A. (2004, September). Final report submitted to Ealing Children's Services.

Funk and Wagnalls new encyclopedia. (1972). (Vol. 21, pp. 455–456). New York: Funk and Wagnalls Inc.

Gilbert, H. (2004, January). Ever increasing circles. *Care and Health Magazine,* 7–20, 25–26.

Greenberger, S. (2005, April 15). Audit hits DSS on foster homes. *The Boston Globe,* pp. A1, A7.

Hartman, A. (2003). Smith college school of social work. In *World Book Multimedia Encyclopedia* [CD-ROM]. Chicago: World Book Inc.

Koenig, Larry J. (2002). *Smart discipline: Fast, lasting solutions for your peace of mind and your child's self-esteem.* New York: HarperCollins Publishers Inc.

Laing, R. (1971). *The politics of the family and other essays.* New York: Pantheon, Inc.

Liddle, R. (2004, February 7). *The Spectator.*

McCafferty, H. (2004). Vulnerable children's service planning meeting.

Russo, F. (1997, March 10). The faces of Hedda Nussbaum. *New York Times Magazine,* pp. 26–29.

Santos, F. (2005, October 23). Number of New York City children in foster care is at its lowest since the mid-80's. *New York Times New York Report,* p. 24.

About the Author

Alexandra Eliot, PhD, LICSW, was the chief social worker of Adolescent/Young Adult Medicine at Boston Children's Hospital from 1972 to 1996 and an instructor in psychiatry at the Harvard Medical School from 1988 to 1997. In 1979, Dr. Eliot co-founded and co-directed the outpatient clinic for eating-disordered adolescents at Children's Hospital. This was a collaborative effort between the Division of Adolescent/Young Adult Medicine and the department of psychiatry. In 2003–2004 she served as the first consultation officer to the Children's Placement Services in the westernmost borough of London, England.

She received her bachelor's degree from McGill University in Montreal, Canada, and her master's and doctoral degrees from the Simmons School of Social Work in Boston, where she is currently an academic advisor and instructor. She teaches a course in advanced clinical practice on adolescence, "Lives in Progress," and has a private practice in Belmont, Massachusetts.

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