**Point of View**

**Case conferences—for child abuse**

A cardinal recommendation of the Tunbridge Wells Study Group,¹ and now a pivotal part of widely followed procedures, is the holding of case conferences. These are immensely wasteful of professional time, and their only significant function can be to allay the anxieties of professional workers (and their realistic fear of being scapegoated), and there are better ways of doing this. Encouraging signs that a more critical attitude was beginning to be shown at one time towards case conferences and cognate activities by directors of social services departments ² now seem to have lapsed. We agree with Geach³ that case conferences are 'one of the most pernicious aspects of the procedures', and we strongly urge their abolition for the following reasons:

(i) Case conferences are dangerously irresponsible because they have no continued existence, and no one can be held personally accountable for their decisions.

(ii) Case conferences entail a gross breach of professional confidence; for it is naive in the extreme to accept the cosy assurances so readily offered that members of such an ad hoc gathering can trust each other. Caseworkers and clinicians are in any case not entitled to entrust to strangers the information they possess about their clients; and it is not part of a policeman's job to trust anyone, or to promise to respect confidences. ‘Character assassination’ may proceed without even the safeguards of a court of law; and the subsequent circulation of the minutes ensures an unrestricted and irrevocable dissemination of defamatory allegations. ³ ⁴

(iii) Case conferences are inherently ineffectual, because:

(a) The crucial decision whether, and when, it is safe to allow the child to return to its parents is a technical decision requiring the highest degree of professional competence. It is as absurd to expect a case conference to judge the fitness of a parent to have a particular child as it would be for a physician to ask a committee of nurses, pharmacists, laboratory technicians and ambulance men to tell him how to treat a complicated case of diabetes.

(b) Even if some of the individual participants should happen to be adequately equipped to make such a decision, it would be quite unrealistic to expect them to do so in such circumstances. The nature and degree of a parent’s emotional problems and their probable response to treatment can be assessed only in the course of a personal diagnostic-therapeutic interview,⁵ and not by any kind of debate, and still less by a debate arising out of differences of opinion that are inevitably based largely on emotional prejudices.

(c) Decisions on the feasibility of treating parents’ problems must also depend on the supervisor’s knowledge of the treatment facilities available—including the abilities of the particular caseworkers willing to undertake the treatment, which it is obviously not proper to discuss in a case conference.

(d) The decision cannot be made once for all. The supervisor must keep it continually under review.

**References**


⁵ Woodmansey AC. What should we teach the students? British Journal of Clinical and Social Psychiatry; 1:51-5.

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