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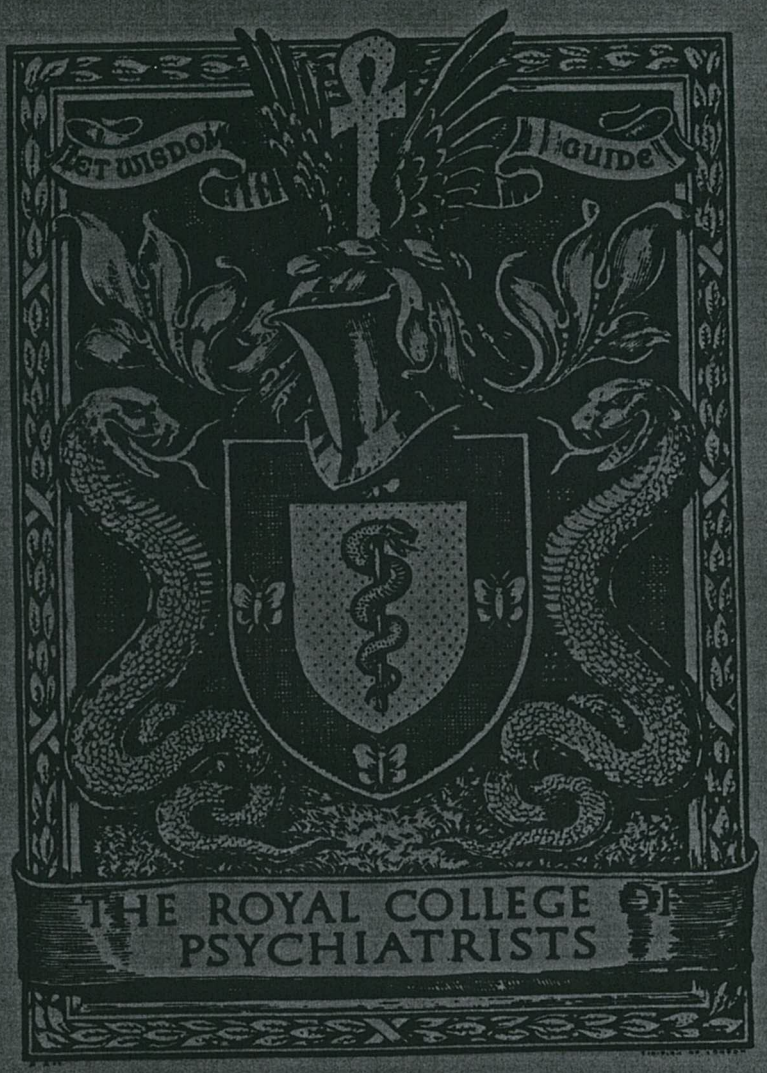

Child Psychiatry and Child Sexual Abuse

Council Report CR24

June 1993

Membership of the working group

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Contents

1 Introduction

This document has been prepared in the light of major changes in the law, developments in clinical practice and new research findings since the publication of the previous position statement about child sexual abuse in 1988 (Royal College of Psychiatrists). This paper will briefly outline these developments, then describe the current context within which child psychiatrists work, before reviewing the various types of child sexual abuse referrals and varieties of work with which the contemporary child psychiatrist is likely to be involved, concluding with some practical issues which face us in the 1990s.

2 Changes leading to new contexts

1. The Children Act 1989

The Children Act 1989 became law on 14th October 1991. All the legislation concerning children has been brought together under this Act. The Act emphasises the necessity for partnership between professionals and families, and the paramountcy of the welfare of the child as the guiding principle to inform all decisions concerning children. The child's wishes, views and feelings are specifically referred to within the legislation so that these will not be lost in the preoccupations of adults, be they parents or professionals. Delay is singled out for special mention as potentially deleterious to children's welfare and various procedures are incorporated into the Act to reduce unnecessary delay. The needs of children with disabilities is accorded special attention. There have been important changes to the laws of evidence, removing hearsay restrictions, which means that records of what children say during clinical work are specifically permissable and may well be required by the Courts. An increase in work for child psychiatrists has been anticipated (Royal College of Psychiatrists, 1991).

A degree of internal tension has also been introduced into the Act. On the one hand, it is based upon the principle that children are best looked after by their natural parents at home whenever possible. State intervention is discouraged unless absolutely required and the basis for actual intervention has been tightened up. The wide 'menu' of orders now available, offers a spectrum of interventions into family life, which may well fall short of removal of the child.

On the other hand, the public law component of the Children Act rests on the notion that children must be protected. However, state intervention in family life, in the form of care or supervision orders, can only be made if certain threshold criteria have been met. The Court must be satisfied that

(a) the child is suffering, or likely to suffer significant harm attributable to the care given to the child now or in the future (White & Adcock, 1991). Harm can be defined EITHER in terms of acts of ill-treatment (omission or commission) towards the child OR as the impairment of health or development. 'Ill treatment' now includes sexual and not-physical (psychological), as well as physical forms. 'Development' includes physical, intellectual, emotional, social or behavioural and 'health' includes both physical and mental. The Act falls short of defining precise cut-off points of 'significant' harm, and it is here that the contribution of child psychiatrist becomes very important.

(b) without an order, the care given to the child would be inadequate.

Past harm to the child is only relevant to the extent to which it results in current harm or the future likelihood of such harm. This is a change from the previous legislation.

2. "Working Together"

A new edition of "Working Together Under the Children Act 1989" elaborates on the need for professionals to work in partnership with families, from the outset and throughout all stages of child protection work. There will be a new guidance document entitled "Towards Partnership with Families in Child Protection Work" which refers specifically to the role of doctors. In the context of partnership with young people, the acceptance of the 'Gillick Principle' implies that young people who are of sufficient age and understanding can now be regarded as able to consent to or refuse both investigation and treatment; that their parents' consent need not be sought if the young person opposes this; and that the young person's wish may prevail over the parents' wishes. However, recent case law has cast doubts on this interpretation leading to uncertainty when the young person's and their parents' position on consent are at variance (Devereaux et al, 1993).

"Working Together" identifies the Area Child Protection Committees (ACPCs) as the appropriate fora for developing, monitoring and reviewing local child protection procedures. The Health Service was specifically asked to review its policies for handling child protection, actively contribute to the local ACPC and ensure that child protection is included in the contracts set up between purchasers and providers within the new NHS reforms.

The document also emphasises the section of the Children Act 1989 wherein local authorities can request the help of Health Authorities in providing services for children 'in need' and their families.

3. Investigation and the Criminal Justice Act 1991

Since our first position statement, there have been major changes in the process of investigation of suspicions and allegations of sexual abuse. Investigation is now primarily carried out collaboratively by police child protection teams and Social Services departments whose workers jointly interview the majority of children. (See also section E.6.). The actual investigation is preceded by a strategy discussion involving people holding relevant information. It has been recognised that investigation must extend beyond the interview with the child to include medical examination, a preliminary assessment of the family and interviewing the alleged abuser, since the investigation needs to satisfy both child protective and criminal justice purposes.

The Criminal Justice Act 1991 became law in October 1992. The recommendations of the Pigot Committee which preceded the Criminal Justice Act, were far-reaching and designed to lessen the potential for trauma to children

during their involvement with the Criminal Justice System. Unfortunately, only a few of the recommendations were incorporated into the new Act and it remains to be seen whether the desired dual effect of reducing children's distress and improving quality of justice will be achievable. Under the new Act, children's video-taped interviews are admissible as evidence in chief in criminal trials, but children will still be cross examined on their video evidence by the defence. The Act is expected to lead to more children coming within the criminal justice system, and because there may well be an additional stress upon them, this will increase the rate of psychiatric referrals following child sexual abuse.

The Memorandum of Good Practice on Interviewing Children (1992) sets out clear principles with regard to formal interviewing for the purposes of criminal justice, and these are likely to be extended to civil proceedings. A training pack prepared by the Open University (1993) to accompany the Memorandum will prove a useful guide on the all important issue of the interface between interviews conducted for civil and criminal purposes.

4. Pre- and post-protection work - purchaser/provider splits

There has been an increasingly clear division between the investigation of suspicions and allegations of abuse and subsequent immediate protection of the child from further abuse on the one hand, and treatment (or post protection work) for sexually abused children and their families on the other. A significant proportion of the latter is now being referred to the Voluntary Sector and child mental health services (while in many areas social workers are being concurrently withdrawn from these services).

In the context of purchaser/provider splits, treatment may be requested by children's general practitioners, commissioning health authorities and by Joint Commissioning between Health and Social Services. Requirements for costing of such treatment may lead to 'packages' of treatment being offered and evaluated. It remains to be seen to what extent these will fulfil the needs of individual children, particularly as requests for treatment often re-arise at different developmental (e.g. psychosexual and emotional) stages.

3 Recent research findings

There is now a vast literature on child sexual abuse which could not be comprehensively reviewed here, but some areas of research and analysis are of particular relevance. Selected aspects are listed here, together with their respective references:-

1. Children's memory and suggestibility (Steward et al, 1993; Goodman and Clarke-Stewart, 1990; Spencer and Flin, 1990; Dent and Flin, 1992).
2. Interviewing children (Jones, 1992; Vizard, 1991; Memorandum of Good Practice, 1992).
3. Physical examination (Royal College of Physicians, 1991; Emans, 1992; Bays and Chadwick, 1993).
4. Sexually transmitted diseases and child sexual abuse (Ingram et al, 1992;)
5. False allegations and validation (Jones and McGraw, 1987; Thoennes and Tjaden, 1990; Heiman, 1992; Berliner and Conte 1992).
6. Legal aspects (Spencer and Flin, 1990; Myers, 1992; Dent and Flin, 1992).
7. Impact of court appearance (Goodman et al, 1992; Runyan et al, 1991).
8. Effects of child sexual abuse during childhood (Kendall-Tackett et al, 1993; Friedrich, 1993; Beitchman et al, 1991).
9. Effects of child sexual abuse in adult-life (Beitchman et al. 1992; Mullen, 1993; Bagley, 1991).
10. Abusers (Marshall et al, 1991; Becker and Hunter, 1992; Marshall and Eccles, 1991).
11. Treatment issues (Friedrich et al, 1992; Gomes-Schwartz, 1990; Kendall-Tackett, 1993).

4 Increased recognition of various issues

1. Issues of culture and ethnicity

The victims in recent publicised cases including the Cleveland and Orkney Inquiries, and the evidence of institutional and ritualised abuse have, almost exclusively, been white British children. This may give a distorted impression both to professionals and to ethnic minority groups that child sexual abuse does not occur amongst these groups. The available literature, sparse as it is , and the slow trickle of reported cases suggests evidence to the contrary (Finkelhor & Korbin, 1988; Korbin, 1987).

Ethnic minority groups in Britain preserve their racial and cultural identity by providing mutual support through their extended families, kinship network or their religious communities. Outside interference can be seen as a threat to their stability and their very existence, especially when they are already subject to racism . However, they too must live within the legal framework of the nation.

Child psychiatrists need to be aware of important cultural differences in order to facilitate assessment, treatment and management. For instance, in some cultures, virginity amongst girls is highly valued and desired; the loss of it before marriage carries a strong stigma for the girls. The 'shame' (Nathason, 1989) that sexually abused children feel in such families is not theirs alone, but extends to all members of the family, due to potentially catastrophic punitive responses from the community. Not only the victim, but other children in the family can instantly become 'unmarriageable' if the abuse is intrafamilial and becomes public. There may be considerable pressure on the child not to disclose or to retract. There may also be a tendency to play down the abuse, if, on examination the hymen is intact. The abuse may go unreported in cultures where homosexuality amongst adults is not openly acknowledged, silence therefore being maintained over sexually abused boys. There is some evidence that Asian children are less likely to report the abuse to their mothers who may be unsupportive (e.g. Rao et al, 1992).

Care must be taken that intervention does not further isolate the victim or put her/him at further risk of sexual or other forms of abuse or retractions. Anonymous discussions with community leaders or religious figures may facilitate in engaging a family in treatment, but vested interests should not be allowed to interfere with child protection and treatment plans. Wherever possible, sexually abused children should be placed within the family - this applying equally to all cultures as enshrined in the Children Act. If placement is outside the family, then strong community ties, which act as a protective factor may work against

the child in some cases in not offering anonymity or privacy and making therapeutic work difficult.

2. Vulnerability and needs of children with disabilities - children with learning difficulties, physical disabilities and sensory deficits

There is increasing awareness of the vulnerability to sexual abuse, of children with disability. Children with learning difficulties, physical disability and sensory deficits have been particularly targeted by some abusers. In some cases parents are less vigilant in their protection of the disabled child, and are also grateful for offers of substitute care. Disabled children in institutional care are very much at risk of abuse.

Children with disability are at risk because:-

(a) they are perceived as unreliable reporters, or unable to communicate facts in detail, particularly those children with learning difficulties, deaf children and children with communication disorders (Kennedy, 1992);

(b) they may be more socially isolated and have fewer persons in whom they can confide;

(c) Symptoms and signs of abuse may be masked because
  (i) the child engages in self abusive behaviours;
  (ii) the child may be accident prone;
  (iii) the child may be sexually disinhibited;

(d) more physical contact may be required to assist the child, making accidental touching inevitable and exploitative touching difficult to identify;

(e) children may be more vulnerable to bribes due to cognitive impairment and emotional deprivation;

(f) children may be less likely to receive education and prevention training and may therefore be ignorant of the problem.

Frequently in children with disability, the signs and symptoms of abuse are attributed to the disability. Investigation, including interviewing, and the assessment of suspected abuse therefore requires particular skills. Children with learning difficulties may require help in finding appropriate words and also to become aware that their body cannot be used by others; issues of consent pose major problems. For fuller discussion of several of these issues see Kennedy & Kelly, 1992; Sinason, 1993; Westcott, 1993.

3. Abuse of boys

Whereas initially, reports of sexual abuse and its management were primarily concerned with girls, the fact that upwards of 30% of sexually abused children are boys is now recognised. The notion of males as victims and the high likelihood of homosexual activity have contributed to reluctance in disclosure (Watkins &

Bentovim, 1992). Less is therefore known about long term outcome.

4. Transition from victim to abuser

Possible future abusive behaviour by child and adolescent victims of sexual abuse is a sensitive issue. Reliable prediction is difficult, but there are some indicators (Ryan G, 1989 ; Watkins & Bentovim, 1992). Awareness of its possibility needs to be incorporated in therapy of children and young persons who have been abused.

5. Abuse by adolescents

Sexual abuse of younger children by adolescents is now recognised as more than a passing phase or an aspect of normal sexual experimentation. Adolescents represent a significant percentage of abusers. Some of these young persons, mostly boys, have themselves been abused and many lack social skills and are socially isolated. They require skilled treatment, possibly under a criminal legal mandate or, if themselves abused, under the Children Act. Therapy, mostly in group settings, needs to address issues of responsibility, victim awareness, non abusive sexual contact and sex education as well as any of their own victimisation experiences and social skills. Parallel work with the carers, and family work when the adolescent continues to live in the family where the abuse occurred, is also necessary (National Childrens Homes, 1992). The issue of future risk or dangerousness is an important one.

6. Inappropriate or coercive sexual involvement of children by prepubescent children

There is considerable concern about both the causes and management of this behaviour by younger children, most of whom are likely to have been inappropriately exposed to sexual experiences or actually abused. The problem is compounded by insufficient knowledge and consensus about norms of behaviour (National Childrens Homes, 1992).

7. Sexual abuse by women

Society's view of women (Welldon, 1988), difficulties in defining sexually abusive relationships between women and children and the fact that only a minority of abusers are women and adolescent girls, are some of the reasons for the belated recognition of this problem (Hanks & Saradjian, 1991) . Female abusers are more often past victims of sexual abuse than are male abusers. Children cared for solely by female abusers face particular confusions and dilemmas.

8. Abuse within institutions and by alternative carers

This worrying phenomenon is of particular concern for many reasons. Children who are living outside their families are particularly vulnerable to sexual abuse (Choosing with care, 1992); a significant proportion are already victims of past sexual abuse; the suspicion of sexual abuse by alternative carers is more difficult to investigate; and the allegations by children who have been previously abused are often thought less credible. Investigation by one agency and discipline in isolation may lead to a masking rather than an exposure of the abuse. Child psychiatrists can make an important contribution here.

9. Organised abuse

This not infrequent form of abuse involves several children and more than one adult (Wild & Wynne, 1986). It poses a particularly heavy burden of guilt on those children who are induced to recruit peers, and may also assume a mantle of normality due to the involvement of a peer group. The investigation of abuse 'rings' calls for a very carefully coordinated approach by police, social services and child psychiatrists experienced in this field. Due to the numbers of children involved, and the complexities of prosecution, the treatment needs of the child victims may be fragmented and, indeed, at times overlooked.

10. Sexual abuse within ritualised religious practice

This phenomenon has attracted much attention, doubt and concern, including the question of its very existence (Child Abuse and Neglect, 1991; Kelley, 1993). As well as sharing many aspects of organised abuse, children who suffer these experiences are likely to be additionally traumatised, when their carers are involved in such abuse.

11. Abuse by the professional intervention

Considerable concern has been expressed about the possibility that, on occasion, the mode of intervention may be more harmful than the abuse. This has led to a reluctance to report, or become involved in the management of children who are suspected or believed to have been abused. Sources such as Childline suggest that children do want the abuse to cease but wish for a therapeutic rather than a punitive or statutory response. Recent research shows that most children and parents appreciate the need for intervention despite the distress caused, but many feel abandoned thereafter. In a minority, measurable ill-effects of the intervention itself have been recorded (Jones et al, 1993 a).

5 Child sexual abuse and routine clinical work

Potentially, any mental health and family problems that bring children, young people and their families to child mental health services may have sexual abuse as an underlying cause even when this is not initially suspected. Furthermore, during ongoing clinical work, child sexual abuse may emerge. When there are reasonable grounds for suspicion or a disclosure occurs, the case manager who may well be a child psychiatrist, needs to initiate a strategy discussion with social services and the police, in line with the policy and procedures of their own organisation, local ACPC procedures and if medical, GMC guidelines. It is important that the case manager consider carefully with the workers how this breach of confidentiality is explained to the child/ren and the carers and when this is done. It is suggested that plans are made for this eventuality before it arises.

6 Types of work

A District child psychiatric service is in a key position to contribute to the overall professional response to, and management of child sexual abuse. This includes policy and service planning (with membership of the ACPC), training, service development and service provision.

1. Offering a child mental health perspective

This encompasses several aspects including

(a) a *developmental* perspective which takes into account the child's chronological age, as well as the emotional and cognitive stage at which the child is functioning. A view of the nature of the child's *attachments* is also of considerable importance.

(b) the assessment of any *psychiatric dysfunction* including anxiety, depression, post-traumatic phenomena, deliberate self-harm, eating disorders and somatisation.

(c) placing the abuse in the *context of the family history* and current family context.

2. Assessment of treatment needs

This is a most important role for child psychiatrists whether directly providing treatment or consulting to other providers of therapy. Assessment includes opinions about the suitability of particular *modes* of therapy - whether individual, group, or family; to *whom* therapy and support should be offered; and which therapy *settings* including out-patient, in-patient or psychotherapeutic residential are most suitable. The therapy needs of sexually-abused children already in residential settings are of particular importance and are sometimes overlooked.

3. Contribution to overall case management

In addition to statutory, child protective and Children in Need requirements which are the responsibility of Social Services, there is an important role for child psychiatrists to monitor the progress and fulfilment of the overall treatment needs of the child and the carers, which may include decisions about the most appropriate placement for the child. Questions also arise about the appropriateness of rehabilitating the child with the natural family. In addition, there is often a need to coordinate the efforts of the very complex network of professionals in order to minimise duplication, rivalry, mirroring of family conflicts and to promote cooperation, mutual understanding and support (Furniss, 1991).

(b) guardians-ad-litem, (including the Official Solicitor) often work in isolation, and are required to gather and integrate a considerable amount of information, in determining the best interests of a child. A child psychiatric consultation may obviate the need for a full psychiatric involvement as well as being of help to the guardian. Other professionals seeking consultation include *social workers* and, particularly at the stage of suspicion, *general practitioners, paediatricians and teachers.* It is important to ensure that this consultative work does not conflict with statutory aspects of the case.

(c) *professional networks* including residential units, special schools, social services and other treating teams often request consultation in order to enhance their processes, help to focus their activities and promote conflict resolution.

6. Special investigative or assessment interviews

Children with learning difficulties or other specific disabilities, children with serious psychological disturbance and very young children may, more appropriately, be interviewed by experienced child psychiatrists, who may then be called as witnesses.

There is also a definite place for assessment interviews, conducted by child psychiatrists (Re M, 1993). These interviews form part of a diagnostic assessment of the child and her mental state, one of the aetiological factors possibly being sexual abuse. Such assessment interviews could be conducted in conjunction with or independently of a formal investigation, unless abuse is disclosed. They may be video recorded.

It is important to be clear about the task of such an assessment interview, what method of recording (including video-recording) is to be used and the format and type of questions to be used. This specific assessment should not be confused with a joint police/social services investigative interview.

7. Second opinions

A very important contribution of the child psychiatrist, with their basic medical training in problem solving skills and in clinical assessment and diagnosis, is to provide a second opinion by evaluating the basis of suspicion and all other relevant issues. Insufficient weight may have been given to aspects of the evidence, despite a strong basis for suspicion; or there may not have been an adequate review of the mode of presentation, sources of information, and questioning about the quality and objectivity of the previous assessment.

A second opinion may be requested by parents, or social services. Comments about the process of the investigation and the conclusions reached should be based on all the available information from the initial enquiry in order to avoid unnecessary replications. Children should not be subjected to repeated indiscriminate re-interviewing by all parties.

4. Treatment

Whilst a therapeutic approach is required from the initial investigation onwards, child psychiatric services can fulfil at least some aspects of the post-protection treatment needs. There are no tailor-made approaches to treatment. Group, individual, dyadic (e.g. mother and child) and family work are all at times indicated, some running concurrently and utilising various therapeutic modalities. The work includes children who have been abused, their primary carers and often their siblings. Specific attention is required to the needs of children and adolescents who have abused younger children. Psychiatrists may well require additional training in the treatment of these young people. The individual or group treatment of adult abusers falls outside the remit of child psychiatric services, belonging rather in the field of general or forensic psychiatrists. Child psychiatrists may have a consultative role, and when the abuser is a family member, this vital treatment has to be integrated into the overall treatment plan for the child and family (Glaser, 1991). If rehabilitation of the abuser within the family is contemplated, child psychiatric services will have an important role to play.

Child sexual abuse treatment work may be undertaken by a designated team within the child mental health service, or included as an integral aspect of the overall clinical responsibility of the service. Specialist teams develop their own expertise and support and offer an important consultative source to colleagues. Their existence cannot, however, be assumed to meet the needs of all children who have been sexually abused and are being treated.

With no allocated social worker, the nature of the continuing involvement by social services in cases referred for treatment has given rise to great concerns, and there is considerable disquiet and debate about the acceptance of such referrals. In the light of social services' resource constraints (both qualitative and quantitative) and the increased role of health professionals described in Working Together, regular meetings with Team Leaders at referral to review and discuss progress and specific protective or statutory issues, may offer a compromise.

5. Consultation roles of child psychiatrists

Consultation may be offered at specific stages of the intervention process, to various individuals and to network teams.

(a) At the *investigative stage*, child psychiatrists may well be able to contribute to strategy discussions when the nature of an investigation is being planned. This is particularly so when the abuse is suspected, rather than already verbally described, when it involves very young or very troubled children, children with particular disabilities or in the investigation of organised or other complex abuse. Indeed, the consultation may lead to a preliminary assessment by the child psychiatrist who may become a member of the investigative team (Jones et al, 1993b).

The fallacy of the spurious external criterion in which one expert may base his presumption about abuse or its absence on another expert's evidence, needs to be guarded against. Second opinions from a psychiatrist working in the same unit is likely to be seen as a 'clone' opinion and therefore unacceptable.

8. Forensic work

Civil proceedings

Child psychiatrists may act as expert witnesses for the local authority, a guardian-ad-litem or by one or both parents, on the assumption that their expertise lies in first hand experience of the particular issues in question (King and Trowell, 1992). Irrespective of who has requested the psychiatric report, the guiding principle must be the paramountcy of the child's interests and the least detrimental alternative for the particular child in question. It should be specified that reports are expected to be seen by all parties. This is particularly important in view of a recent judgement which pointed out that proceedings under the Children Act are adversarial in nature and there may be no power to enforce disclosure of a medical report on which a party did not intend to rely (Times Law Report, 1993). Where more than one psychiatrist becomes involved, the judiciary are very encouraging of maximal common ground being agreed between the experts prior to the Hearing. In order to respond to adversarially motivated questions, and with the child's interests as paramount, the psychiatrist must be able to offer a coherent argument in which observations and facts are clearly separated from inferences and interpretations. The role of the expert is to guide the Bench, by bringing clinical expertise and sound research findings.

Child psychiatrists are called to give expert opinions on

(a) the likelihood of past sexual abuse having taken place;

(b) the risks of future sexual abuse of the child, taking into account both the offender risks and the nonabusing carer(s)' capacity to protect the child without blame;

(c) the risks of further abuse by, particularly, adolescent abusers. Where the question involves adults, this opinion may well be given in conjunction with a forensic psychiatrist;

(d) a child and family's treatment needs. Under the terms of a supervision order (Schedule 3 para. 5), it is possible for a court to include a requirement of treatment of the child by, or under the direction of a named psychiatrist, following the recommendation of a (s.12 Mental Health Act approved) psychiatrist, provided the child, if of sufficient understanding, agrees.

(e) the likelihood of Significant Harm occurring or being likely to occur.

Criminal proceedings

In criminal proceedings, it is the alleged abuser, not the child, whose rights have to be safeguarded. The child psychiatrist may be requested to comment on the credibility of the child's evidence, and on the child's or young person's mental health or illness, the defence using the latter as a means of discrediting the child's evidence. It is important to note that, unlike in civil proceedings, in criminal proceedings only the prosecution is obliged to disclose all its evidence to the defence prior to the trial. Child psychiatrists may also be expected to comment on the treatability of an adolescent abuser.

Child psychiatrists may also be called as professional witnesses, if they have conducted investigative interviews with a child .

9. Criminal Injuries Compensation Board reports and damage claims

Victims are eligible for compensation for acts which are deemed criminal, even when the offender has not been found guilty by a court. When completing reports in support of such claims, psychiatrists are requested to describe

- the nature and degree of abuse and harm referable to the abuse,
- the nature and duration of any treatment received,
- the nature and cost of further treatment likely to be required,
- the prognosis for future functioning, in the light of the abuse suffered.

Since young persons are entitled to see the reports, the phrasing of the prognosis is a very delicate issue. It is also important to remind the young person that, for financial reasons, the report is only addressing one aspect of their personality.

Occasionally, there may be claims or actions for damages against specific individuals, institutions or Public Bodies.

Compensation for a child is paid into a trust.

10. Teaching and training

There is a continuing and considerable demand for teaching and training in the field of child sexual abuse both to medical and non-medical professionals. Teaching the latter offers one means of ensuring the necessary continuation of multi-disciplinary and multi-agency cooperation in this field. Training is required at the various levels of professional intervention in child sexual abuse. Some settings are particularly relevant for child psychiatrists. They include:-

- Multi-agency training initiated by ACPC's.
- Training for trainee General Practitioners and for FHSA's.
- Teaching medical students.
- Continuing education for child mental health teams.

11. Audit of clinical practice

Auditing child psychiatric work in relation to child sexual abuse requires recognition of the complexity of the tasks and of the considerable time spent beyond direct clinical contact with the child and family. Light and Bailey (1993) have pointed out that a well functioning psychiatric service results in a considerable saving of overall resources.

12. Research and evaluation

Considerable empirical data are now available concerning the long term effects of untreated child sexual abuse. However, due to the relatively recent advent of intervention in childhood and nearer the period of the abuse, there is as yet little evaluation of the outcome of intervention, protection and treatment (e.g. Monck et al, Gomes-Schwartz et al, 1991). One aspect of longer term research will be to study the well-being of the future children of currently treated sexually abused children. Child psychiatrists also need to study the relationship of child sexual abuse to other disorders presenting to child mental health services.

7 Issues of practice

1. Professional responsibility and confidentiality

Some child psychiatrists receive requests for consultation by other professionals, especially medical colleagues such as general practitioners, paediatricians and community paediatricians and gynaecologists. The offer, by the child psychiatrist, of an *anonymous consultation* allows the legal and ethical responsibility, duty to parents and responsibility for child protection to remain with the "referring" professional. The child psychiatrist can therefore explore the clinical, legal and confidentiality issues at a hypothetical level, helping the referrer to clarify his/her concerns, evaluate the importance of the child's needs in relation to parental needs, discuss the options open to the consultee and outline their responsibilities. With this opportunity for an informed dialogue, many of these consultations eventually become formally referred to an appropriate agency.

Anonymous consultations are of particular use to those General Practitioners who are in possession of information about adults concerning past events, sexual deviancy or even paedophiliac activities which had occurred a long time previously. The public interest in maintaining confidentiality is being weighed against that of protecting children at risk from serious harm (Family Law, 1991). Doctors may be reluctant to report their privileged, confidentially received information to non-medical agencies; or they may consider that the previous sexual behaviour does not currently constitute a risk, while divulging this information could create serious problems for their patient. There is no mandatory reporting law in the UK but failure to report and initiate an investigation may be deemed as unprofessional practice. As well as consulting a child psychiatrist, and before making a decision, it is essential that the General Practitioner also seeks good legal advice or consults their medical defence society. It is important that both consultant and consultee keep a written record of such discussions and the reasons underlying any decisions reached.

In the field of child sexual abuse, child psychiatrists themselves sometimes encounter difficulties relating to the divulgence of confidential information. This may arise particularly, but not exclusively, when attending child protection conferences. Parents, and sometimes young persons are now invited to attend these conferences and if psychiatrists consider full attendance not to be in the interests of child or family member, it is important to discuss this with the chairperson of the conference in advance, if necessary requesting a prior professionals' meeting. Before sharing information about the child or family with other professionals, it is important to explain the need for this to the patients and gain their consent. Young children may not be in a position to give informed

consent but are usually able to understand to whom, why and what will be told. Where any family member objects, exploration of their misgivings often leads to resolution. The ultimate decision, based on the child's best interests, rests with the psychiatrist, who has the support of the revised GMC guidelines (1991).

2. Clinical records - written and video-recorded

Records may take the form of written clinical notes only, or also include videotaped recordings. Where possible, written notes should be made concurrently and records completed immediately after the interview. All records, including video tapes, need to be retained safely.

ACCESS by patients to written records and video tapes is subsumed under the Access to Health Records Act 1990, which is not retrospective. If a clinician considers that serious harm to the patient may ensue from seeing the record, this can be challenged by the patient in court.

Increasingly, the defence in criminal cases and other agencies are requesting the release of all case records including clinical notes and videotapes. The purpose of such requests which could be akin to a 'legal trawl' is frequently to challenge the reliability of a child or other witness. Compliance with these requests implies the release of highly confidential psychiatric, family or psychotherapy information, and may be very prejudicial to the further treatment of the child. Furthermore, written records and video tapes may include information about other children or family members which is not relevant to this case, and this would constitute a serious breach of confidentiality. It should therefore, in the first instance, be refused. In these circumstances, legal representation by the Health Authority can lead to the acceptance of a report or letter which extracts those issues considered to be salient, or alternately seek for the Judge to examine the records and determine what is relevant to the case and whether it would be appropriate to release any of the record (Times Law Report, 1992). Ultimately all records can be subpoenaed by the Court.

The Memorandum of Good Practice states that the Criminal Justice Act 1991 allows the copying of video recordings to facilitate the work of the police and lawyers. It is therefore suggested that investigative interviews carried out by child psychiatrists are recorded on police video tapes and, when appropriate, at the specially designated interviewing location rather than in the agency of the psychiatrist. If interviews are carried out by a child psychiatrist at his own agency and on Health Service tapes, copies should not be made. However, in civil proceedings, legal representatives are often invited to view the tapes at the Child Mental Health setting. The question of parents seeing the tapes rests on the individual case.

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