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Performance indicators and child sexual abuse

S. E. WRESSELL, Senior Registrar; C. A. KAPLAN, Senior Lecturer; and I. KOLVIN, Professor, Fleming Nuffield Unit, Newcastle upon Tyne NE2 3AE

Child sexual abuse has appeared as an epidemic of the 1980s. In our child psychiatry department we are acutely aware of the increased workload generated by referrals of complex and time-consuming cases. In this article we aim to look at the resource implications for a child psychiatry department which has teaching and regional commitments, as well as serving a district health authority.

The study

In Spring 1987, when the issues leading to the Cleveland Inquiry meant an increased number of second opinions were being requested of our University child psychiatry department, all staff of the department were asked to record the number of children they had seen in whom child sexual abuse was suspected or validated. Staff were asked to distinguish between new and old cases. New cases were children coming to our department for the first time within the period studied where a suspicion of child sexual abuse was being investigated. Old cases were children attending for ongoing therapy following investigation of suspected sexual abuse, or cases where the possibility of sexual abuse was picked up coincidentally during treatment of other conditions. On an independent dimension, a distinction was made between cases where sexual abuse was *suspected* and those where suspicions were considered to be *validated* after assessment based on a review of all available information. ("Validation involves assessing as many of the . . . features [the child's statement, supporting features, physical and physiological evidence] as possible, in any single case, weighting the relative weight of the individual elements". Jones & McQuiston, 1988).

The evaluative psychiatric assessment followed recommended guidelines and is a detailed and time-consuming exercise (Kolvin *et al*, 1988). Staff were asked to estimate the time spent seeing such cases within any four working weeks in a ten week period.

Findings

Over this period the total number of child sexual abuse cases was 66, of which 30 children were new cases. We would suspect that this represented a minimum number of cases seen over the full ten week

period in whom there were suspicions of child sexual abuse.

This child psychiatry department has a district catchment area as well as regional commitments. Table I indicates that only 24 (36%) of the children came from outside Newcastle but the percentages differed according to whether they were old or new cases, i.e. the majority of old cases (80%) came from Newcastle and the majority of new cases (57%) were from outside the Newcastle district. The number of validated cases of sexual abuse from Newcastle seen in the study period is deceptively high because it includes children with long-standing difficulties who continued to attend long-term. The new cases referred from outside the district were invariably very complex cases referred for second opinion.

Of the children seen, 30% were male and 70% female. Over 40% of our sample were in the pre-school/infant school age range and 30% fell into the adolescent age group. We note that just over 10%

TABLE I
Cases of suspected and validated child sexual abuse by district of origin

District	Old case	New case	Suspected	Validated	Total
Newcastle	29	13	22	20	42
Other	7	17	14	10	24
Total	36	30	36	30	66

TABLE II
Cases of child sexual abuse by age and sex

Age (yrs/mths)	Male	Female	Suspected	Validated	Total
0-4.11	1	6	5	2	7
5-7.11	8	12	12	8	20
8-11.11	8	11	10	9	19
12-16.11	3	17	9	11	20
Total	20	46	36	30	66

TABLE III
Source of child sexual abuse cases referred to a child psychiatry department

Referral agency	New cases n	Old cases n	Total n	%
Other consultants (paediatrics/child psychiatry)	6	7	13	20
Statutory & voluntary social services	9	11	20	30
General practitioners	4	13	17	26
Education/child guidance	2	4	6	9
Legal	9	0	9	14
Internal (other child psychiatry department staff)	0	1	1	1
Total	30	36	66	100

TABLE IV
Professional time spent in 10 weeks on 54 families (66 children) where child sexual abuse was suspected or validated

Discipline	Hours
Medical: Consultant	86
Non-consultant	98
Non-medical	76
Total	260
Total time spent on old cases (n = 36)	160
Total time spent on new cases (n = 30)	100
Mean medical time per child	2.8
per family	3.4
Mean total time per child	3.9
per family	4.8

were under the age of five years. Fewer of the validated cases were under eight years of age (33%) compared with those who were merely suspected (47%). This may be an indicator of the problems in identifying sexual abuse in younger children.

The distribution of the referral sources is interesting. The highest percentage (30%) of cases came from statutory and voluntary social services agencies, but even this is an underestimate as some of those designated 'legal' had been initiated by legal departments acting for social services. One in five cases came from consultants working in paediatrics or child psychiatry who had requested second opinions. One in four of the cases were referred by general practitioners, though these were mostly cases referred for other conditions where the question of sexual abuse had been raised subsequently. Finally, one in ten of the children were referred from educational sources, including educational psychol-

ogists, school doctors and school nurses. A distinction needs to be made between the old and new cases with a heavy preponderance (60%) of new cases coming from social service agencies and legal sources.

An attempt was made to estimate the amount of time spent by medical and other professionals in relation to the 66 cases. At this time our assessment philosophy was for initial assessment to be made by medical staff before asking other disciplines to become involved. An average of 2.8 hours was spent by medical staff and in total just under four hours was spent on each case. This is an underestimate of the time spent on individual cases and staff commented that this was due to the great number of children being seen at the time of the study. The pressure of referrals was such that professionals were unable to complete individual assessments within four weeks and the same children were seen for further time beyond that recorded.

An alternative way of examining performance indicators is to look at the number of hours spent per family rather than per child. Two hundred and sixty hours were spent with 54 families averaging 4.8 hours per family. The seven families where more than one child was seen accounted for 19 out of the 66 children and they took up a total of 52.5 hours of professional time, i.e. mean 7.5 hours, range 3–12 hours per family. For the same reasons, this is also felt to be an underestimate of the actual time spent seeing families in which there are suspicions of child sexual abuse.

Comment

It is evident that much time is spent on cases of child sexual abuse; our data suggest a minimum of 184 hours of patient/family contact time by medical staff over a period of ten weeks, most of which is for assessment purposes. A single professional confining

him/herself to child sexual abuse cases would take about five weeks to complete this work. Alternatively, one senior member of medical staff working part-time would need to spend a minimum of five medical sessions per week for about ten weeks merely on clinical contact time. We have not attempted to assess the implications for non medical disciplines.

Our departmental policy is to do a careful and detailed evaluative psychiatric assessment and to work in the context of a multidisciplinary approach, in accordance with published guidelines (Kolvin *et al.*, 1988 and Butler Sloss, 1988). However, the amount of time recorded above was that spent on direct contact with children and families and excludes preliminary discussions with referral agencies, preparation of reports, attendance at Social Services case conferences or court appearances. Inevitably, because of medico-legal implications, preparation of these reports takes longer than routine reports and is often undertaken outside normal working hours. As most cases are second opinions, Court appearance is commonly necessary, with at least one whole day needing to be set aside. Fortunately, because of the high profile of the University Department, the Courts courteously set times for appearance, but we are aware that this does not always occur. Hence patient contact time constitutes only a fraction of the clinician's total involvement in a case. If, as our data suggest, medical patient contact time is on average about three and a half hours, we estimate the total time spent on each case will be at least three times that.

Performance indicators are statistics used to compare the performance of different district health authorities with the object of improving the provision of health care. A recent paper (Nicol, 1989) demonstrated how performance indicators based on the Körner minimum data set are of limited relevance to the professional activities of child and adolescent psychiatrists. We suggest that a further difficulty in applying such criteria is the type and complexity of the clinical problem, with cases of child sexual abuse occupying an inordinate proportion of professional time. Our data demonstrate that the time spent on assessment in these cases is very much higher than that of most other new referrals to a child psychiatry department. It is not unusual for an assessment to include more than one child in a family and we note that up to 12 hours have been spent on an initial assessment of a family, including all children. For these reasons, performance indicators are likely to reflect inadequately the clinical time spent on individual cases and fail to take into account the much longer time necessitated by complex child protection cases. Unless due allowance is made, those departments seeing a substantial number of such cases would fare poorly in performance indicator terms. So far no mention has been made of 'hidden' work

and time undertaken in relation to child sexual abuse; for instance, the report of the Royal College of Psychiatrists Working Group (1988) and subsequent correspondence has emphasised the role of child psychiatrists both in training and in consultative work with other disciplines. Such consultation may be a significant component of the workload but as yet there is no way of counting it for performance indicator purposes.

Conclusions

We estimate that the amount of patient contact time spent on child sexual abuse cases attending our university-based child psychiatry department would exceed the total working hours of a single senior professional for two weeks in every four and the total time devoted to cases is likely to be three times as much. However, full-time allocation to child sexual abuse work is not in the interests of either children, families or professionals (Butler-Sloss, 1988). In accordance with the Royal College of Psychiatrists Working Group (1988), we suggest that this type of clinical practice should be shared both within and across the professional disciplines working in child psychology and psychiatry.

We also are concerned that the extent of involvement in working with child sexual abuse cases is not recognised in the current methods of collecting information for performance indicators and as a result these statistics are of limited relevance to clinical work in this field.

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