

Child abuse and neglect: the role of mental health services

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Executive summary

Child abuse and neglect are now recognised as being ‘everybody’s business’. Aspects of prevention, recognition, assessment and treatment of child maltreatment all fall within the province of the various branches of psychiatry. This Council Report reviews these responsibilities.

Following a definition of child abuse and neglect, the Report summarises key documents published recently in England and their equivalents in Scotland, Wales and Northern Ireland. These include legislation (the Children Act 1989) and government guidance documents accompanying this legislation: *Working Together to Safeguard Children* (Department of Health *et al*, 1999), the *Framework for the Assessment of Children in Need and Their Families* (Department of Health, 2000a) and *Safeguarding Children in Whom Illness is Fabricated or Induced* (Department of Health, 2002). Following Lord Laming’s inquiry into the death of Victoria Climbié, the government published *What To Do If You’re Worried a Child is Being Abused* (Department of Health, 2003). Two documents deal with evidence of children and other vulnerable witnesses in criminal trial and provision of therapy for child witnesses prior to a criminal trial. The Carlile review, published by the National Assembly for Wales in 2002, highlights the vulnerability of children and young people treated and cared for in psychiatric in-patient units. Several documents deal with domestic violence and with patients as parents.

Several issues of practice are addressed in the next section. They include multi-agency work coordinated by Area Child Protection Committees (to be reconfigured as statutory Local Safeguarding Children’s Boards); and attention to culture, ethnicity and gender, both in terms of sensitivity to these issues and awareness of child maltreatment in different cultures. Confidentiality is a potentially contentious issue in a context in which information about patients needs to be shared to ensure the protection of a child. The storing of videotape recordings is addressed. Allegations against staff may involve child abuse, and clarity is required in dealing with these fairly.

The section on selected clinical issues highlights issues that were considered to be of particular salience in the field of child protection. These are vulnerability (including learning and other disabilities, and children looked after); transition from victim to abuser; domestic violence; sexual abuse by adolescents; sexual abuse by women; organised abuse; fabricated or induced illness; and the effects on children of adult mental disorder and substance misuse.

Two topics are included in the section on research findings, namely effects of abuse and breaking the cycle of abuse. These were selected as being of especial relevance to psychiatrists encountering child abuse.

The section on types of professional involvement is oriented towards practice and includes general guidance as well guidance for specific specialties. The

section discusses the principles of recognition of abuse, investigation and assessment of risk to children, assessment of treatment needs and provision; and medico-legal work.

Finally, there is a brief mention of training needs.

The document was reviewed by all Faculties of the College, and representatives from the Scottish, Welsh and Northern Ireland Divisions, to whom the authors are grateful for their helpful contributions.

1. Introduction

This report deals with the responsibilities and contributions of psychiatrists and their multidisciplinary teams in relation to all aspects of child abuse and neglect. It is intended to promote integrated practice across all professional groups. The legal aspects are based on English law, but it is hoped that the document will be helpful to professionals in other jurisdictions. In Scotland the law equivalent to the Children Act 1989 is the Children (Scotland) Act 1995, and in Ireland it is the Children's Act 2001.

Three basic principles should guide psychiatrists in relation to child abuse and neglect:

- There is a need to be constantly aware of the possibility of abuse or neglect, or the risk of this, when children are involved.
- The assessment of risk, and interventions to protect children, require a multidisciplinary and multi-agency approach.
- In general, the duty to patients, including that of confidentiality, is overridden by the duty to protect children.

Definitions

Child abuse and neglect

Child abuse and neglect include both acts of omission and commission in interactions between adults (or older adolescents) and children that have caused, or are likely to cause, enduring harm to the child. There are different forms of abuse and neglect, often occurring together in one family and affecting one or more children. They include, in decreasing order of frequency:

- (a) neglect
- (b) physical abuse and non-accidental injury
- (c) emotional abuse
- (d) sexual abuse
- (e) fabricated or induced illness.

Emotional abuse, as well as occurring alone, almost invariably accompanies other forms of child maltreatment. Some forms of abuse occur as discrete events, which may be repeated: these include physical abuse and non-accidental injury, sexual abuse and some forms of fabricated or induced illness. When repeated, these forms of abuse may come to typify the abuser-child relationship. Emotional abuse and neglect have to pervade the abuser-child relationship in order to merit their definition. Most parents, including some whose interactions with their children are abusive or neglectful, do not intend to harm their children. The child may, nevertheless, be harmed sufficiently for intervention to be warranted.

Significant harm

In the Children Act 1989, the term 'significant harm' replaces the terms 'child abuse' and 'neglect'. Significant harm is defined as ill-treatment or the impairment of the child's health (mental or physical) or development (physical, intellectual, emotional, social or behavioural) attributable to a lack of adequate parental care or control: section 31.

Relevance to all psychiatrists

Child abuse and neglect will be relevant to most psychiatric practice. Although mental illness or other incapacity in a parent can have a negative impact on the child, this does not necessarily reach the threshold of significant harm. However, unless this possibility of such harm is borne in mind, it is unlikely to be recognised. Substance misuse is highly prevalent in our communities and constitutes a particular risk to the children under discussion in this report. Child abuse and neglect may lead to a conflict of interest between child and parent, if the parent denies abuse that the child has described, or when the child cannot be cared for safely and adequately by one or both parents. This conflict may be mirrored in interactions between professionals who may see their primary responsibility as promoting the interests and needs of one particular member of a family. The child's and the family's needs can only be met adequately by inter-professional cooperation.

2. Relevant legislation and documents

Children Act 1989

The Children Act 1989 states the following important principles:

- The child's interests are paramount.
- Parental rights are subsumed under parental responsibility.
- Children are generally best looked after within the family, with both parents playing a full part (but their welfare must be safeguarded and promoted).
- Section 47 of the Act states that organisations are required to help local authorities with enquiries when a decision has to be made as to whether action is necessary, and that it is the duty of any person (including any health authority, special health authority or the National Health Service) to assist the local authority with those enquiries (in particular by providing relevant information and advice) if called upon by the authority to do so, unless it would be unreasonable in all the circumstances of the case.
- The presence of significant harm constitutes the threshold criteria that have to be satisfied before the court can consider making an order under the Act. In Scotland, the Children's Hearing System is the responsible body equivalent to the English court; this is a welfare rather than a judicial system.
- The 'welfare checklist' is a list of issues that need to be considered before an order is made. They include:
 - (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
 - (b) his physical, emotional and educational needs;
 - (c) the likely effect on him of any change in his circumstances;
 - (d) the child's age, gender, background and any other characteristics that the court considers relevant;
 - (e) any harm that the child has suffered or is at risk of suffering;
 - (f) how capable each of his parents and any other person in relation to whom the court considers the question to be relevant is of meeting his needs: section 1(3).
- According to section 17(10), child is deemed to be in need if
 - (a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority;

- (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services;
- (c) he is disabled.

A child is considered to be disabled if 'he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability'; 'development' includes physical, intellectual, emotional, social or behavioural development; and 'health' includes physical and mental health: section 17(11).

The Human Rights Act 1998 is not expected to alter the principle of the paramountcy of the child's interests in civil legal proceedings. In practice, however, some challenges to children's needs are being put forward on the basis of parents' right to family life. This is an emerging area of interest. The choice of appropriate legislation is discussed in *Safeguards for Young Minds* (White *et al*, 2004).

Working together to safeguard children

The document *Working Together to Safeguard Children* (Department of Health *et al*, 1999) sets out how all agencies and professionals should work together to promote children's welfare and protect children from abuse and neglect, including how to carry out investigations and assessment. It describes:

- the role and responsibility of different agencies and practitioners;
- joint working arrangements and training to be agreed by Area Child Protection Committees;
- the processes to be followed when there are concerns about a child suffering or being at risk of suffering significant harm;
- how professionals from all agencies should be alert to potential indicators of abuse or neglect; attention is drawn to the common sources of stress – social disadvantage, domestic violence, mental illness, drugs and alcohol, and the risk that abusers and potential abusers may pose to children;
- the need to work across the interface between adult and child services, and to give consideration to the needs of all family members while recognising that the child's safety and welfare are paramount.

The document also sets out the roles and responsibilities of services, as described below.

Health trusts

Health trusts should identify a named doctor and nurse to take a professional lead on child protection, and all health staff should be aware of local procedures, seeking advice from the named professionals as appropriate

Adult mental health services

Adult mental health services, including forensic, psychotherapy, alcohol and substance misuse, learning disability and old age psychiatry services, have a responsibility for safeguarding children when they become aware of a child at risk of harm. They must collaborate with children's welfare services. Colleagues in child mental health can help adult services by facilitating communication, especially when there are concerns about the duty of confidentiality. Hospitals must have written policies about the visiting of patients by children, who should only visit after it has been agreed that it is in their best interest to do so.

Child and adolescent mental health services

Child and adolescent mental health services will inevitably identify instances of abuse and suspected abuse. Consultation, supervision and training should be available in each service. These professionals may have a role in the initial assessment when their specific skills are needed, for example with very young children, children with communication disorders and those with severe emotional, behavioural or learning difficulties. Staff can provide a range of consultation services to other agencies, psychiatric and psychological assessment and treatment services for children and families, including treatment of adolescent abusers.

Framework for assessment of children in need and their families

Guidance entitled *Framework for the Assessment of Children in Need and Their Families* (Department of Health, 2000a) has been introduced for the assessment (by social services) of the needs of vulnerable and disadvantaged children, in order to determine which services would best meet the needs of the individual child and family. The detailed assessment will identify appropriate ways of helping these children by involving health, education and other agencies as well as social services. Child protection procedures will apply for children found to be suffering or likely to suffer significant harm, and in occasional circumstances emergency intervention will be required. For every child looked after by the local authority ('in care'), either under an order or accommodated voluntarily, or on the Child Protection Register, it is estimated that five further children should be identified as being 'in need'. The overall number will depend on the degree of deprivation in the local population.

The approach of the assessment is child-centred, developmental and systemic, taking into consideration the family, the wider environmental context and the family history. The parents' capacity to meet the child's developmental needs is assessed. The emphasis is on working cooperatively with families, building on strengths as well as identifying difficulties. The assessment will be a continuing process, during which necessary interventions will be made and services provided by the appropriate agencies.

Following a referral to social services, it is expected that a decision will be made within 1 working day as to whether action is to be taken. When more information is required, an initial brief assessment is undertaken within 7 working days. For children considered to be in need, a decision will be made to undertake a detailed core assessment within 35 working days. A child protection investigation under section 47 of the Children Act 1989 will be initiated for children at risk of significant harm. In both cases health and other professionals will become involved, including relevant mental health staff.

What to do if you're worried a child is being abused

The recent practice guidance published under the title *What To Do If You're Worried a Child is Being Abused* (Department of Health, 2003) followed the publication of Lord Laming's report of the enquiry into the death of Victoria Climbié (Department of Health & Home Office, 2003). It summarises the key processes detailed in *Working Together to Safeguard Children* (Department of Health *et al*, 1999) and the *Framework for Assessment of Children in Need and their Families* (Department of Health, 2000a). It also includes important guidance on information-sharing between professionals (Department of Health, 2003: Appendix 3). It deals with confidentiality, disclosure by consent (and in the absence of consent), the Human Rights Act 1998, the Data Protection Act 1998 and other statutory provisions.

Safeguarding children in whom illness is fabricated or induced

Safeguarding Children in Whom Illness is Fabricated or Induced (Department of Health, 2002) details the responsibilities of adult and child psychiatrists in the process of protecting children who are thought to be subject to fabricated or induced illness. It is recommended to be read in conjunction with a companion document published by the Royal College of Paediatrics and Child Health (2002).

Adoption Act 2001

The Adoption Act 2001 introduced new legislation aimed at facilitating and accelerating the process of adoption. It also adds 'exposure to domestic violence' as a factor of 'significant harm'.

Children as witnesses in criminal proceedings

Achieving Best Evidence in Criminal Proceedings: Guidance on Vulnerable or Intimidated Witnesses Including Children (Home Office, 2002) is a revised extension of the *Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings* (Home Office & Department of Health, 1992). Failure to keep to these guidelines may result in the evidence of the child being considered

inadmissible in criminal proceedings. *Vital Voices* (Scottish Executive, 2002) is an equivalent document relevant to the law in Scotland.

Therapy for child witnesses

Provision of Therapy for Child Witnesses Prior to a Criminal Trial (Department of Health, 2001) sets out the circumstances in which children can receive therapy prior to giving evidence in a criminal trial about their abuse. It stresses the paramountcy of the child's best interests and recommends prior discussion with the police and the Crown Prosecution Service. It outlines who should assess the child's therapeutic needs, who is eligible to provide therapy, and which forms of therapy are more or less desirable in these circumstances.

The Carlile Review

The Carlile Review, *Too Serious a Thing* (National Assembly for Wales, 2002), is a review of the safeguards for children and young people treated and cared for by the National Health Service in Wales. It was instituted as a result of allegations of abuse made by former patients of a child and adolescent psychiatric residential unit. The report highlights the vulnerability to abuse of young in-patients. This vulnerability is heightened by the close and often confiding relationship between the young person and certain members of staff, and increased when the unit is isolated from other child and adolescent mental health services (CAMHS). The review pointed out that a member of staff might transgress the boundary of trust in relation to one particular child, or might have a more general predisposition to abuse.

The allegations of children and young persons who are, or have been, psychiatric patients are less likely to be believed, perhaps because false allegations may be made by them. The review stressed the importance of adequate staff training in child protection procedures, and the importance of ensuring that robust procedures detailing how to deal with allegations against staff are in place in all CAMHS.

Domestic violence

Multi-Agency Guidance for Addressing Domestic Violence (Home Office, 2000), *Domestic Violence: A Resource Manual for Healthcare Professionals* (Department of Health, 2000) and *Domestic Violence* (Royal College of Psychiatrists, 2002) all provide guidelines for dealing with domestic violence – the physical, sexual or emotional abuse of an adult victim by an adult perpetrator in the context of an intimate relationship, which occurs in around 23% women and 15% men over their lifetime. These documents are designed to raise awareness among professionals about domestic violence between current or former partners. They emphasise the frequent links between domestic violence and child abuse as well as the psychological harm to

children that occurs when a parent is being abused. Local authorities are required to publish a policy on domestic violence and establish multi-agency domestic violence forums to monitor the problem, coordinate action and provide training locally. Health professionals have an important role in recognising domestic violence and are required to develop skills in asking appropriate routine questions as well as exploring the situation when violence is suspected or disclosed, to ensure the safety of the person and any dependent children.

Patients as parents

Patients as Parents (Royal College of Psychiatrists, 2002) outlines the importance of finding out whether patients are also parents and of ensuring that the parenting task is supported and the needs of the patient's children are met. This report also deals with the specific issue of protecting infants when the mother suffers from postnatal mental illness.

3. Issues of practice

Area Child Protection Committees

The Area Child Protection Committee (ACPC) is an inter-agency forum for agreeing how different services and professional groups should cooperate to safeguard children in that area and for making sure that arrangements work effectively. These Committees have responsibility for developing procedures within national guidelines, monitoring local practice including multidisciplinary work within teams and across agencies, and ensuring that required training is provided. Membership must include managerial and professional representation from health services, social services, education, police and probation services (in Scotland, criminal justice teams). Child and adult mental health, forensic and addiction psychiatric and other related services should be involved in the ACPC work as needed.

Culture, ethnicity and gender

In assessing and working with children and families, professionals must be sensitive to diverse family patterns, lifestyles and child-rearing practices in different ethnic and cultural groups. Nevertheless, children from all cultures are subject to abuse and neglect. Cultural and religious factors neither explain nor condone child abuse and neglect, and they must not be confused (Department of Health *et al*, 1999).

Confidentiality

Within a multidisciplinary team, different professionals may have different ways of handling the issue of patient records and confidentiality. Many of the professional obligations regarding issues of confidentiality for psychiatrists are addressed in *Good Psychiatric Practice: Confidentiality* (Royal College of Psychiatrists, 2001); see also Appendix 3 in *What To Do If You're Worried A Child Is Being Abused* (Department of Health, 2003). Although the consultant psychiatrist often has ultimate clinical responsibility for the patient, legal liability for disclosure rests with the person who breaches confidentiality.

The disclosure of personal information without consent may be justified where the patient or others may be exposed to risk of death or serious harm. When the risk to others is so serious that it outweighs the patient's right to privacy, the patient's consent to disclosure should be sought if practicable (General Medical Council, 2000). Children should be accorded the same degree of confidentiality

as adults, subject to an assessment of their capacity to act autonomously, depending on their age, developmental maturity and understanding.

Working Together to Safeguard Children (Department of Health *et al*, 1999: paras 7.41 and 7.42) states that the law permits the disclosure of confidential information without consent in some circumstances for the safety and welfare of a child:

'If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse, and unable to give or withhold consent to disclosure, you should usually give this information to an appropriate responsible person or statutory agency, in order to prevent further harm to the patient. In these and similar circumstances, you may release information without the patient's consent, but only if you consider that the patient is unable to give consent, and that the disclosure is in the patient's best medical interests.'

'Disclosures may be necessary in the public interest where a failure to disclose information may expose the patient, or others, to risk of death or serious harm. In such circumstances you should disclose the information promptly to an appropriate person or authority.'

Patients may request access to their clinical notes (the Access to Health Records Act 1990), and case notes should be written with this in mind, balanced against the need to write a full description of a patient's difficulties. Serious concerns should always be recorded in the notes. Reports written for other agencies, such as social services, should also be approached in this way, since the psychiatrist writing the report may not necessarily have control over its distribution once it has been lodged with another agency. (The issue of parents who wish to have access to their children's psychiatric records is not addressed here.)

Video recordings

Video recordings made of interviews with a child or members of the child's family must be preserved if they contain any disclosures, descriptions or enactments of abuse. They might subsequently be evidentially important. (There are local policies for the use of video recordings in mental health services.)

Allegations against staff

All allegations of abuse of children by a professional, member of staff, foster-carer or a volunteer should be taken seriously, and local child protection procedures must be followed. Allegations of current or past abuse must be referred to social services who will discuss cases involving a possible criminal offence with the police. If the allegations are substantiated, disciplinary procedures will be considered in relation to the employee concerned. The safety and welfare of any other children who may have been or are still in contact with the individual must also be considered (Department of Health *et al*, 1999).

Employing authorities need to review their procedures in order to ensure that they are responsive to the needs of members of staff following allegations against them. Their procedures should allow swift and sensitive responses and these should apply to all disciplines, irrespective of their employers.

4. Selected clinical issues

Vulnerable children

Professional responsibility is required in recognising child abuse and neglect in vulnerable children, in particular children with disabilities and children looked after in residential settings (Utting *et al*, 1997). There are a number of reasons for this greater vulnerability in these children, which include difficulties they may have in communication and therefore in reporting or disclosing abuse; their dependency on intimate physical care; social isolation, which is accentuated in institutional care; and being cared for by staff rather than by their own parents.

Children who have been abused previously are more vulnerable to further abuse, especially sexual abuse. It may well be more difficult to detect this since these children's already disturbed behaviour may mask indicators of the abuse and their accounts may not be believed.

Some children and adolescents who are looked after may use drugs and alcohol. This disruptive behaviour can mask issues of abuse, which may not be addressed by professionals. Indeed, drug and alcohol use may be seen as a reason for exclusion from some services.

Transition from victim to abuser

Although being an abused child increases the risk of becoming an abuser in adulthood, there is no inevitability about this transition. Certain factors have been shown significantly to pre-date sexually abusive activity by adolescent boys, including discontinuity of care, exposure to or experience of physical violence, and emotional abuse. Factors that have been shown to protect women abused in childhood from the likelihood of abusing or neglecting their own children include the ability to give a coherent account of their own childhood abusive experiences, the presence of a supportive adult during childhood and the presence of a supportive partner at the time of becoming a parent

Domestic violence

Domestic violence, not infrequently complicated by excessive alcohol or drug intake, is now seen as a form of child abuse, whether or not the child is directly involved. Attacks on the child's primary carer undermine some of the child's most basic rights to a sense of safety and protection, to a conflict-free atmosphere, to good moral standards and to healthy relationships. Instead, the child lives in an atmosphere of fear, hostility, shame and secrecy. There is often associated

physical abuse to the child, a raised incidence of sexual abuse, and sometimes neglect. The sequelae for the child are very similar to those of children who are repeatedly physically abused.

There are issues as to whether the child needs to be protected and removed from such a situation, and, if the parents separate, whether there should be contact with the abusive parent (Home Office, 2000). In some cases, addiction professionals may have a significant contribution to make to the discussion on prognosis and management of the parents.

Sexual abuse by adolescents

Sexual abuse by adolescents, mostly boys, has become widely recognised (Abel *et al*, 1987) and is no longer considered to be an acceptable variant of adolescent sexual development. Many adults who abuse children report the onset of their abusive activities in adolescence, and abuse by an adolescent cannot with safety be considered as something that 'burns out' in adulthood (Vizard *et al*, 1995). A significant proportion of those who abuse in adolescence are of low intellectual ability.

Child abuse by women

Harmful acts associated with fabricated or induced illness in children are usually committed by the mother. The main perpetrators of other types of abuse may be mothers or female carers. Sexual abuse by women and mother figures is much less common than that by men or father figures, constituting about 10% of all childhood sexual abuse; sometimes it is committed together with men. Because of the greater acceptance of physical intimacy between mothers and their children, sexual abuse by women can be difficult to identify. It can be highly intrusive and damaging, and some research indicates that it carries particularly serious sequelae, especially for boys.

Organised abuse

Many of those who abuse children do so in isolation. However, there are also organised forms of abuse involving more than one abuser and numerous children, some of whom are recruited into sex rings. Organised abuse may include formalised rituals; debate continues about the extent to which sexual abuse can be a part of sadistic or satanic practices. There are, in these cases, questions about the reliability, verifiability and credibility of the reports. Organised abuse also includes the use of children and young persons for prostitution, and for the production of child pornography.

Children in residential settings in particular may be subject to sexual abuse. These children, who are already vulnerable, are dependent on staff and are often isolated from confiding contact with adults outside the residential setting.

Fabricated or induced illness

Fabricated or induced illness requires the participation of three persons in a triangular relationship: the mother (usually), the doctor and the child. It may be brought about by:

- (a) the false reporting, by exaggeration or fabrication, of a child's symptoms by a mother (or, exceptionally, by a father or another caregiving adult) to a doctor;
- (b) the active fabrication of symptoms or signs by interfering with investigations and samples, e.g. contamination of urine samples with blood;
- (c) inducing illness and signs in the child by administration of drugs or poisons, interfering with intravenous or other lines, or imposed airways obstruction.

There may, in some instances, be escalation from (a) to (b) and (c). The child not infrequently also has a recognised medical condition.

The mother in such cases has one or more needs, which are fulfilled when her child is recognised as ill, or as more ill than the child actually is. Regardless of the mother's motivation, the child is at risk of significant harm, in one or more of the following forms:

- the child's health may be seriously impaired by the mother's direct action on the child, which may even lead to the child's death;
- the child is subjected to repeated and unnecessary investigations, hospitalisations and treatment;
- the child's normal social and educational development may be impeded;
- the child develops a false self-view of being a sick child, or feels confused about his or her state of health;
- the child may be trapped in the knowledge that there is false reporting about his or her state of health.

The child remains at risk as long as the pattern of care by this parent continues. Investigation of factitious illness by proxy is complex and may involve, temporarily at least, suspension of the full sharing of information that normally should characterise the relationship between doctor, parent and patient. Many professionals find this process stressful and difficult.

Effects on children of adult mental disorder, substance misuse and learning difficulties

The majority of adults with mental health problems do not abuse their children or intentionally or otherwise neglect them. However, all forms of mental disorder in a parent (or in a parent's partner) increase the risk of abuse and neglect of the child, with especially high risks associated with personality disorders, alcohol or drug misuse and learning difficulties. Substance misuse may complicate mental

illness in as much as third of cases. Substance misuse, psychosis, depression or personality disorders are present in the majority of parents involved in the non-accidental death of their child. The death often occurs when a parent loses control; sometimes people who are suicidal may kill their children before killing themselves, particularly following relationship breakdown.

Identification and assessment of children at risk are difficult, particularly as those involved in the care of the parent may wish to reduce stressful experiences and increase the self-esteem of their patient. Collaboration with social services can be seen as a threat to the therapeutic alliance. Some local authorities are developing joint protocols with mental health services to ensure routine assessment of the needs of all children who have a parent with severe mental illness. The responsibility for this lies with social services, who often involve child psychiatrists when there are serious concerns about emotional abuse, neglect, and immediate and long-term effects on the child's development.

The risk of mental health problems, especially of enduring conduct disorder in boys, is doubled in children of parents with mental disorders, and is particularly associated with hostility and conflict within the family, as well as the many features of social disadvantage commonly associated with the adult's problems. Child mental health professionals will be involved in direct treatment of children who have become disturbed or distressed while continuing to live with their parents, as well as those who require care away from home.

The role of adult and addiction psychiatrists, in addition to providing support and treatment for their patient, is to liaise with child care professionals and to provide, if required, an assessment of the parent, the parent's mental health problems, previous functioning and prognosis, rather than to provide a specific assessment of parenting capacity. The latter requires an assessment of the quality of the interactions between parent and child as well as analysis of detailed information and observations from a variety of sources over time. This is provided in some mother and baby units.

Child and adult psychiatrists are frequently instructed by opposing sides in proceedings under the Children Act 1989. It is important that their respective roles in relation to the welfare of the child and of the parent remain distinct, although there will be areas of overlap. In many cases the issue may not be the parent's potential for recovery from mental illness or substance misuse, but the harm to the child incurred while waiting for the situation to resolve. Fortunately, many children are adequately cared for by their healthy parent or relatives, protecting them from more serious consequences and from some of the distress and disruption associated with separation from or caring for their parent.

5. Research findings

The literature on child abuse is large and constantly expanding, with papers in general, psychiatric and specialist 'abuse-related' journals, books and government reports. From these, we have selected topics of particular relevance to the practice of psychiatry. This includes research on the effects of abuse on children and young people, and interventions to alleviate these effects and break the cycle of abuse. Where possible, the most rigorous and relevant research is cited. Each publication quoted represents a starting point in the area rather than a thorough exposition.

Effects of abuse

The effects of abuse are many and varied. As Kaplan *et al* (1999) have emphasised, the exact effects of abuse of specific types can be difficult to disentangle in the face of the many adversities often found in the environment and background of children who are abused, and the co-occurrence of different types of abuse. The available research on the consequences of emotional and physical abuse is summarised by Kaplan *et al* (1999) and Hart *et al* (1998); these consequences include interpersonal problems, cognitive impairment, aggression, suicidal behaviour and psychiatric disorders, such as depressive and anxiety disorders, conduct disorder and substance misuse. The neurobiological sequelae of abuse are discussed and reviewed by Glaser (2000).

The long-term effects of childhood sexual abuse have been well studied and are reviewed by Fergusson & Mullen (1999). Although the same caveats about the difficulty of disentangling the specific effects of abuse apply as in the studies on physical abuse, the short-term and long-term sequelae of childhood sexual abuse include significant interpersonal problems as well as psychiatric disorders such as depression, anxiety, substance misuse, eating disorders, self-harm and suicide (Kendall-Tackett *et al*, 1993). Not all children who are sexually abused develop these difficulties, and protective or resilience factors include the degree of family support available (Spaccarelli & Kim, 1995), factors related to the abuse itself, and peer relationships (Fergusson & Mullen, 1999).

The outcome for children affected by fabricated or induced illness has not been subjected to the same degree of rigorous research. The available information on prognosis has been reviewed by Jones & Bools (1999).

There is a growing literature on the later emotional and behavioural effects of parental alcohol and drug misuse in childhood (e.g. Cleaver *et al*, 1999).

Breaking the cycle of abuse

Child protection and the prevention of current or possible future abuse form the first, essential step in breaking the cycle of abuse. This includes alertness by all

professionals to risk factors, including parental substance misuse. All the studies of treatment outlined below must be considered in that context. Addressing the effects of abuse on children and adolescents should be the next step. This may occur within the context of other help (therapeutic, educational and social) being given to a child and the child's family and/or carers.

The effectiveness of the many psychotherapeutic approaches used with physically and emotionally abused children has generally not been thoroughly evaluated (Kaplan *et al*, 1999), and research studies have tended to use non-randomised methods which are more open to bias. However, a small number of studies (principally of work with parents) have demonstrated the benefit of a range of therapeutic interventions (including parent training and 'multi-systemic' therapy) in reducing levels of psychological distress and family problems (Oates & Bross, 1995; Stevenson, 1999). Cognitive-behavioural therapy (CBT) is the most widely studied treatment for sexually abused children. It has been used with pre-school children and their (non-abusing) carers (Cohen & Mannarino, 1997), and in adolescents. Its effectiveness has been reviewed (King *et al*, 1999), and more impressive treatment effects are seen with younger children. The evidence for CBT in comparison with other therapies (group, family and other individual approaches) for children has also been reviewed (Jones & Ramchandani, 1999). Overall, there is more evidence for the effectiveness of CBT than for other therapies. Descriptions of the practical use of therapies for sexually abused children are also available (Deblinger & Heflin, 1996).

Intervention in the field of factitious illness by proxy has been far less researched. Berg & Jones (1999) followed up a small number of children referred to a specialist programme. They concluded that some families can be reunited and do well following a specialist assessment and intervention, but continuing follow-up is important.

6. Types of professional involvement

Response to the recognition of actual or potential child abuse and neglect

Table 1 gives a summary of how child abuse and neglect may present. It is not all-inclusive and, in particular, does not deal with risks in the child's environment such as serious psychiatric illness, substance misuse and limited cognitive functioning in family members. However, the guiding principle remains that the relevance to children of problems in their carer is how the problem affects their care; for example, do the negative symptoms of a mother's schizophrenic illness result in some form of neglect, whether physical or emotional?

How to proceed when child abuse or neglect is suspected or risks identified

All National Health Service trusts have child protection guidelines drawn up in conjunction with the local Area Child Protection Committee and most, within these, have specific guidance for each group of professionals, including guidance for psychiatrists. These guidelines should be consulted. A judgement needs to be made on the degree of urgency: in urgent situations, the duty social worker or the child protection officer in the children's division of social services should be contacted immediately; in less urgent situations, it should be ascertained whether the child is known to social services, has an allocated worker or is on the Child Protection Register. Discussion with all professionals involved with the child is helpful. There is a named doctor for child protection in every trust, one of whose functions is to consult and advise in cases of suspected or actual child abuse or neglect. If in any doubt, the named doctor should be contacted, for instance when decisions have to be made about the seriousness of the situation and whether or not to involve social services directly. These cases should not be handled by a professional acting alone. In most situations a referral to social services for further investigation is the appropriate route. Social services may find there is no cause for serious concern, and should be sensitive to the role and future involvement of the referring professional.

Guidance for individual specialties

Adult psychiatry (including forensic, substance misuse, old age psychiatry and psychotherapy)

Like any illness, mental illness will affect the children in the family. The task of the adult psychiatrist is to consider whether the child's well-being may be significantly affected. Some situations are self-evident, for example when the

Table 1 Presentations of child abuse and neglect

Presentation	May be indicative of	Response
Non-accidental or unexplained injury Injurious punitiveness	Physical abuse	Social services and possibly police investigation Paediatric assessment
Inadequate feeding, failure to thrive Illness and injuries not appropriately attended to	Neglect of provision	Social services investigation Paediatric assessment
Child left alone Unsafe environment Variety or lack of continuity of caregivers	Neglect of supervision	Social services assessment
Various forms of parent-child interaction including scapegoating and rejection; emotional unavailability; developmentally inappropriate expectations Non-specific emotional, social and behavioural difficulties	Emotional abuse and emotional neglect	Psychological/psychiatric assessment Social services investigation
Illness that cannot be explained Child presented very frequently for attention or investigations Fabricated illness or disease Poisoning or other form of illness induction	Fabricated or induced illness	Reliant on paediatric diagnosis, with multi-disciplinary involvement If diagnosis confirmed, investigation by social services
Allegations of sexual abuse Inappropriate sexualised behaviour Sexually transmitted disease or pregnancy Genital injuries	Sexual abuse	Social services and police investigation Possibly paediatric examination
Unexplained developmental delay Unexplained major change in behaviour Depression, misery and avoidant behaviour (parasuicide, self-harm, running away)	Any of the above	Careful multidisciplinary assessment

parent or carer expresses ideas of harming the child, or is too ill and preoccupied to attend to the child's basic needs. However, other situations are less clear, among them the possibility of parental substance misuse; this needs to be looked for specifically, using available guidelines (London Child Protection Committee, 2003: pp. 65–66), and each situation needs to be considered on an individual basis. It is always important to ascertain who is involved in the care of the child and whether this is a satisfactory arrangement.

Discussion involving the psychiatrist's multidisciplinary team, particularly social work colleagues, may help in deciding what action is needed. Other colleagues can be consulted as mentioned above.

Occasionally, patients will reveal that they have perpetrated or are perpetrating sexual or other abuse. Even in cases in which the psychiatrist involved believes

the risk to be past or low, it is dangerous not refer for further investigation, and the public interest principle overrides any duty of confidentiality.

When a parent is in hospital or prison, psychiatrists need to consider potential risks to children in relation to contact visits. There should be designated 'safe areas' for visits by children to their hospitalised parents.

Elderly patients can present risks to children (usually their grandchildren); for example, risks of sexual inappropriateness in dementia or behaviours resulting from delusional ideas about children.

For these reasons, some training in child protection is required for all psychiatrists.

Learning disability

Concern may be expressed about the ability of parents with learning difficulties to care for their children appropriately and protect them from harm. It is important not to make assumptions in such situations, but to assess each case on an individual basis. A multidisciplinary assessment by the community disabilities team, including contributions from social work, occupational therapy, psychology and psychiatry staff, may be helpful in elucidating these issues. Such teams will also be able to make recommendations regarding the amount and type of support needed by the family.

Child and adolescent psychiatry

Child protection is an essential component of the training of child and adolescent psychiatrists and forms a significant part of their practice. Allegations of abuse or neglect may be made during the course of therapy with children; symptoms and patterns of behaviour may cause concern; working with parents and families, some of whom will be seen because of child protection matters, may bring to light serious parenting problems. In all such situations concerns need to be shared with social services in writing, with whom there should be clearly developed joint working and liaison practices.

Because of their close working relationships with paediatric specialists, child and adolescent psychiatrists will be consulted by their paediatric colleagues about child protection concerns. A child and adolescent psychiatrist may be the named doctor for child protection within a trust. Child and adolescent psychiatrists are often highly involved in the assessment of situations potentially harmful to children, especially in emotional abuse and neglect.

Investigation and assessment of risk to children

Investigation

Child and adolescent psychiatrists are sometimes involved in the investigation of child abuse and neglect and occasionally involved in or consulted about

police interviews, for example where the child has a psychiatric disorder or disability.

Assessment

The psychiatric contribution to the assessment of risk falls broadly into four categories:

- assessment of the parent;
- assessment of parenting;
- assessment of the child;
- assessment of the family.

Assessment of the parent

Adult psychiatrists, forensic psychiatrists, substance misuse psychiatrists, liaison psychiatrists and learning disability psychiatrists, together with their teams, can all make a vital contribution to the assessment of the risk posed by the parent to the child. Their contributions are both sought and valued by other professionals, including the courts, in collating information about the children and their circumstances. In particular, there is often a need for:

- assessment of the risks posed by parental mental disorder or cognitive disabilities;
- assessment of the risks posed by abusive parents or those with problems of violence or offending;
- assessment of the effects on a parent of substance misuse and the effects on their lifestyle and parenting (see London Child Protection Committee, 2003: p. 26);
- assessment of a parent when there is proof of fabricated or induced illness.

Marked personality disorders can have the most deleterious effects on the emotional care of a child, and adult psychiatrists should be prepared to assess such parents in cases in which there are significant concerns. Repeated episodes of attempted suicide, sometimes witnessed by children, may not necessarily reflect severe mental illness, but are often manifestations of failing coping skills, including serious difficulties in parenting.

When requested, assessment of the parent should lead to a stated diagnosis, outline of the treatment required and its probable duration, and the likely prognosis. It also needs to address the impact of the parent's difficulties on their functioning, and in which areas this might be relevant to their ability to meet the needs of their children. It should not be an assessment of parenting, which needs to include interactional assessments and other observations not usually within the brief of the adult psychiatrist (see below). In cases of personality disorder, it may be preferable for this assessment to be made by a forensic psychiatrist or psychotherapist.

Assessment of parenting

Parenting assessments are usually undertaken by social services, often in family centres, with input when needed and available from child and adolescent mental health services. Where the civil courts are involved, for example in care proceedings or contact disputes in which abuse is alleged, expert witnesses are instructed to advise the court on child and parenting issues. Such experts are usually child and adolescent psychiatrists but can be drawn from other specialties within the child and adolescent mental health team. Such parenting assessments look at the parents' ability to provide basic and emotional care, their ability to provide for the child's educational and social needs and their ability to protect the child from harm, within an assessment of the overall parent-child interaction. The nature of the child's attachment to the parents is also part of the assessment. Assessments are expected to provide:

- a prediction of future risk;
- an indication of the parents' capacity to change, the likely time scale for change, and whether this time scale accords with the child's needs;
- an estimation of the parents' likely compliance with treatment;
- the likely benefits of treatment;
- an indication of suitable, possibly specialist resources.

Assessment of the child

Assessments of children concern mainly the question of the child's vulnerability to abuse or neglect, particularly if the child has emotional, behavioural or physical needs. The child's resilience, either innate or because of environmental factors such as a relationship with a trusted adult, also needs to be assessed.

Child assessment orders can be sought from the courts when there is difficulty in seeing the child to make such an assessment. However, their duration of 1 week renders them of little use for child and adolescent psychiatric assessments.

Assessment of the family

The assessment of the family is concerned with family membership, and includes observing family interaction and functioning, as well as gaining an understanding of the rules and beliefs that underpin family life; these are in part based on the histories of individual family members and on the family's own history. A family assessment explores not only the difficulties but also the strengths and competencies of the family, its sources of support and stress, and the nature of the family's connection with its wider social context. Family functioning includes:

- the family's organisation in its adaptability, decision-making and conflict resolution;
- style and clarity of communication within the family;
- the family's emotional life, including expression of emotion;

- alliances within the family;
- identity of the family and of individuals within the family, including individual autonomy and intergenerational boundaries.

Assessment of and response to treatment needs

Following investigation, assessment of risk and protective measures, plans for the child and family – whether the child remains within the family or not – should incorporate treatment programmes when these are appropriate. These plans depend on a careful assessment of the treatment needs, which will vary greatly with each child and each family. Prevention is an important goal of treatment. Close collaborative work between agencies may result in the family being able to remain intact with suitable safeguards and/or treatment in place. Within adult mental health services, treatment for the parent may well preserve and promote parenting capacity. Appropriate support and help for the family from an early stage in a mental illness may prevent or minimise harm to the child.

Children and adolescents

Children who have experienced abuse, particularly when it has been repeated or chronic, need considerable support in overcoming its effects. Since there is no post-sexual abuse syndrome, let alone a general post-abuse picture, each child's needs must be individually assessed. Needs will vary depending on the type of abuse experienced. Children often require therapy: individually, in groups or within the family. Outcome studies suggest that cognitive-behavioural techniques are particularly effective for the amelioration of post-traumatic stress disorder and sexualised behaviours in children who have been sexually abused.

The issue of prevention is important especially for boys, including those with learning disabilities, who have been physically, emotionally or sexually abused and who may go on to sexually offending behaviour. It is also important for physically abused and neglected children and those exposed to domestic violence, who may become aggressive adolescents and adults.

Substance misuse in adolescence may follow earlier abuse and neglect and requires specific attention from accessible services.

If the perpetrator of abuse is an adolescent, treatment may involve adolescent services.

Parents

Parents who have a psychiatric illness or disorder, misuse substances or are at risk of further offending against children will need attention and appropriate treatment from accessible services. The parent may be also in need of other types of support, both practical and social. Direct input to change the person's way of parenting may be needed.

Parents who have themselves been abused in the past, including those who have experienced domestic violence, are likely to require help in overcoming the aftermath in order to enable them to attend to the needs of their children.

When a child is removed from a parent, the latter will need considerable support and this will fall to adult agencies caring for the parent. Suicide often becomes a greater risk at such times.

Medico-legal work

Children Act 1989 cases

Psychiatrists may be involved in care proceedings and contact or residence applications under the Children Act 1989. Psychiatrists usually act as expert witnesses, but may be also called as professional witnesses.

Criminal cases

Adult and adolescent forensic psychiatry services are likely to be involved whenever adults or juveniles are prosecuted for abusing or neglecting children. Rarely, general child psychiatrists are called upon, e.g. when they have interviewed a child. Expert testimony on the reliability of child witnesses is not usually permitted.

Compensation reports

Compensation reports for the Criminal Injuries Compensation Agency or in civil proceedings may involve any branch of psychiatry. Claims for compensation following childhood abuse can be made many years after the abuse occurred.

Contribution to reviews of life-threatening or fatal injuries to children

All psychiatrists may be required to contribute to Area Child Protection Committee (Part 8) reviews following serious injury to or the death of a child, if the perpetrator was known to, or under the care of, a psychiatrist. The purpose of these reviews, which are mandated in *Working Together to Safeguard Children* (Department of Health *et al*, 1999), is to highlight areas of practice that require revision or review, as preventive measures for future child protection.

7. Training

Psychiatrists

All psychiatrists need to receive specific training in child protection. One of the functions of Area Child Protection Committees is to act as a training resource for different professionals, including psychiatrists.

Medical students

Child maltreatment and its effects on mental health, and child protection, are important aspects of the medical student curriculum. Child and adolescent psychiatrists, as well as psychiatrists in other specialties, need to ensure that this subject is addressed.

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