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Introduction

Cycles of abuse

In 1995 an overview of 20 studies on child protection was published (Department of Health, 1995*a*). This proved to be a key document in stimulating new thinking about the future direction of children's services and in influencing policy development. It led to a lively and productive debate among social services and health care professionals and resulted in changes in practice.

One of the themes that has risen to increased prominence is the need to ensure that the mental health perspective is taken on board when looking at the needs of children and their families. A number of studies suggest that a significant proportion of children referred to child protection services are in contact with or cared for by an adult who is mentally ill or has a substance misuse problem. It is therefore essential that those working with children have a clear understanding of the impact of adult mental health and substance misuse on children. Conversely, all those working in adult mental health need to consider the possible effects of an adult's behaviour on individual children and ensure the individual patient's needs as a parent are addressed.

Thinking about the most appropriate and effective methods of intervention and treatment in child abuse cases has developed in line with growing knowledge of the effects of maltreatment on children. A number of key principles underlie the child protection system. These principles can be translated into the provision of services to other vulnerable groups, in particular older people and those with learning disabilities.

Over the past 20 years our understanding of child abuse has grown considerably and so our definition of abuse has changed. The first key principle is to agree a definition of abuse in whichever context we are working. In the 1960s the focus was on 'battered babies'; sexual abuse was highlighted in the 1980s; emotional abuse is becoming better understood in the 1990s, with a current focus on domestic violence in the home affecting all vulnerable people of whatever age or circumstances. Agreed definitions need to be matched by operational policies. The second key principle is a multi-agency response. Regarding children, this evolves from the Government's guidance on inter-agency cooperation (Home Office *et al*, 1991). The challenge is to ensure that successful collaboration is sustained and capable of maintaining the flexibility required to respond to the needs of vulnerable people. A third key principle is that assessment is needs led and should result in a differentiated response according to the type and level of need identified. The fourth key principle is the sharing of information between professionals and agencies. We must recognise the delicate issues surrounding the need to disclose information for the purpose of protecting a vulnerable person, while maintaining the requirements of our own ethical and statutory codes, highlighted in two Government documents (Department of Health, 1995*b*, 1996). A further key principle is that good practice is evidence based.

The last, and perhaps most important principle, is that children and vulnerable individuals and their families must be listened to. Communication and collaboration across all agencies and organisations is vital. Abuse can occur in any setting; hospital, residential, day services or the home, but is less likely to happen where there are good-quality services where people are respected and treated as individuals. This issue of *Advances in Psychiatric Treatment* aims to present succinctly current knowledge and the part that we as mental health professionals can play in the prevention of cycles of abuse.

Department of Health (1995*a*) *Child Protection: Messages from Research*. London: HMSO.
—(1995*b*) *Child Protection. Medical Responsibilities*. London: HMSO.
—(1996) *Protection and Use of Patient Information. Guidance from the Department of Health*. HSG 96/18 & Lassl. 96/5. London: Department of Health.
Home Office, Department of Health, Department of Education and Science & Welsh Office (1991) *Working Together Under the Children Act 1989. A Guide to Arrangements for Inter-Agency Co-Operation for the Protection of Children from Abuse*. London: HMSO.

Susan Bailey, Adolescent Forensic Service, Salford NHS Trust, Bury New Road, Prestwich, Manchester M25 3BL

Legal perspective

All professionals involved with children remain deeply concerned about the incidence and effect of abuse.

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It is salutary to remember how recently such behaviour has been widely recognised and described as abuse. In the late 1960s the concept of 'battered babies' emerged, usually in the criminal courts; this evolved into 'non-accidental injury' in the mid-1970s and sexual abuse in 1980s. Yet this represents nothing new in human behaviour and has been clearly documented under different headings for centuries. Professor Tardieu in Paris in the 1860s studied the bodies of children and wrote about the abuse he discovered. It took 60 years of lobbying to pass legislation in England to make incest a criminal offence, this only happened in 1908. In my experience at the Bar, buggery and rape of children was heard at the assizes along with murder and serious assault. We did not call it abuse, but it existed and always has done.

The abuse of children is almost always a criminal offence, as well as a reason for intervention of professionals concerned with the child, the family and the perpetrator. The criminal proceedings, if instituted, are likely to take priority over the long-term arrangements for the child, and the prospect of prosecution inevitably has a marked effect upon the alleged abuser, particularly upon his willingness to admit what has happened. There is a tension in the interface between the criminal law, with its focus upon the accused and his rights, and the needs of the child, whose welfare is one of a number of considerations. This tension is absent in the civil courts, where within Children Act proceedings the welfare of the child is paramount.

How can we protect children? Since the Children Act 1989, a child cannot be placed in care, other than voluntarily, without a court order; this equally applies to a supervision order. Therefore, the courts will require evidence of the abuse: non-accidental injury, sexual or emotional. Without some evidence of past offence or risk for the future, the courts are powerless to act. It follows that there is no point in initiating proceedings without sufficient evidence to support the concerns put forward. Even more importantly, there is no point in taking children away from a worrying situation unless there is a reasonable prospect that a court will agree with the course taken. Otherwise, the child will be returned home without safeguards.

The courts hearing these cases could not function without substantial contributions from mental health professionals, particularly child psychiatrists. Psychiatrists have an important role in training the judges. The courts rely upon psychiatrists to give impartial and objective evidence to help the court and in the best interests of the child.

In order for abuse to be dealt with in an effective manner for the benefit of all, the professionals responsible for dealing with any aspect of abuse (the police, social workers, mental health professionals, lawyers, magistrates and judges) have to learn to understand each other and to work together.

I believe, however, that we should be looking more broadly at the family and the repetition of abuse, where the child abused becomes, in due course, the abuser. It bears a certain similarity to children of violent parents becoming violent in turn. This is a matter more for psychiatrists than for lawyers but we may be, and indeed already are, drawn into considering the family as a whole. This is part of the philosophy of the Children Act 1989. (It has nothing to do with criminal law other than peripherally, and generally at the point of sentence.)

The effect of potential criminal proceedings makes an adult or a teenager very cautious about disclosing information and may be directly contrary to the best interests of the child. Some abusers are paedophiles and I exclude them from what follows. But I should like to see in place, even on a trial basis, something similar to the Denver, Colorado scheme in which a confession of abuse would be the prelude to constructive work with the abuser and with the family, without a prison sentence hanging over the abuser. Not all victims want to send the perpetrator to prison and potentially destroy the family unit. One possibility would be to have a committee, like the child protection committee, but comprising lawyers, representative of the Crown Prosecution Service and chaired by the local care judge who also tries criminal cases. That committee would assess the seriousness of the offences committed, and whether, if guilty, the perpetrator would require a prison sentence. If not, it could be known in advance that the perpertrator of the abuse would be placed on probation with stringent conditions and the prospect of a long sentence if he re-offended. He might be required to undergo therapy away from home. Such a scheme is not, as far as I can see, capable of implementation in the foreseeable future, as plea bargaining is prohibited. Section 98 of the Children Act 1989 gives immunity from prosecution in giving evidence in care proceedings but would not extend, in my view, to a confession not made in court. Also, the current climate of opinion would not tolerate it at present. But there is no reason not to float these ideas and hope the climate will change. If such committees were set up, the input of mental health professionals, particularly psychiatrists, would be crucial.

Rt Hon. Lady Elizabeth Butler-Sloss, DBE
Royal Courts of Justice, Strand,
London WC2A 2LL

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