

# Royal College of Psychiatrists Consultation Response

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**DATE: 23<sup>rd</sup> Sept 2010**

**RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS**

**RESPONSE TO: GMC: Call for evidence on doctors' roles and responsibilities in child protection**

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Child and Adolescent faculty.

This consultation was approved by: Dr Laurence Mynors-Wallis- Registrar

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## **GMC: Call for evidence on doctors' roles and responsibilities in child protection**

### ***Consent and confidentiality***

*Q1. What problems do you see in relation to consent and confidentiality when doctors work with children and their families where there are child protection concerns? If possible, please provide examples of good practice, or areas where problems commonly arise.*

Child psychiatrists often see children on their own as part of assessment or treatment work. In general, the process is collaborative and based on informed consent. However, if a child makes a disclosure that s/he is being hurt the psychiatrist will need to make a decision about whether the parents should be told and if it is safe to do so prior to contacting social services. A child may not consent to the parents being told, sometimes for fear of repercussions or for fear of distressing the parents. Careful thought needs to be given to the timing of sharing information and sometimes it may be necessary to override the child's wishes in order to ensure that the child's need for safety and support is met. If there are concerns that discussion with the parent will increase the risks to a child, a referral may need to be made to social services without the parent's knowledge in the first instance. The national guidance on information-sharing is helpful and clear (the pocket booklet)<sup>1</sup>. Adult psychiatrists may also identify child protection concerns which require alerting social services. This should be done in collaboration with the patient if possible but the risks may necessitate breaking confidentiality. Best practice would be for the psychiatrist to discuss their concerns with an experienced colleague before breaking confidentiality.

Parents can sometimes oppose a referral to social services, but again it may be necessary to make a referral without parental agreement in the interests of the child's safety and welfare. This can sometimes result in anger towards or complaints about the psychiatrist, if parents perceive the sharing of information, including information about parents themselves that has been gathered in the assessment process, as a breach of confidentiality and trust. It is important in such circumstances to reassure parents that the intention of a referral is to increase support to the child and family and not to take the child away, as that is a common fear. It can be helpful to point out that this is a (mandatory) requirement of professionals in such situations, as this can position the action of referral as a more neutral strategy. However, of course, in a minority of cases, there are circumstances in which the psychiatrist will be recommending that the child is removed to ensure his/her safety.

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<sup>1</sup> Department for Children, Schools and families (2008): Government information sharing guidance

### ***Relationships with parents, carers and the wider family***

*Q2. Do you agree with this? If possible, please provide examples of circumstances where a child's and family's needs and rights have been met and respected in the context of child protection proceedings, or occasions where they have been in conflict and how this conflict was managed by doctors.*

The reaction of families to a referral to social services can affect the relationship with the psychiatrist in a negative way and can impair trust and can, in some cases, cause the family to disengage. Nevertheless, it is still important to proceed with a referral, but to take all steps to keep avenues of communication open, to deal with family members in a respectful and neutral way and to continue to promote engagement. It is can be difficult sometimes for doctors to appreciate the extent to which parents can experience such referrals as humiliating and blaming of them or how negative their perceptions of public services can be. Awareness of such issues may be helpful in engaging families, despite the necessity to make a referral.

Strong feelings can be stirred up in the family by the notification of concerns to social services and in the psychiatrist by the plight of the child. Dealing with angry parents can be stressful. In such circumstances, it can be helpful to have an experienced colleague join in meetings with parents.

It can be helpful to meet with parents to discuss and share reports. If parents challenge sections of reports, they can be asked to provide their comments in writing, which can be appended to the report and shared with all parties, so that their points are considered.

### ***Doctors working in partnership***

*Q3. What are your views or experiences about how well doctors work with other doctors, professionals and agencies, when there is the possibility of harm to a child?*

Psychiatrists value working with other colleagues in such situations. Most psychiatrists work in multi-disciplinary teams and it is good practice to discuss situations of risk with colleagues in the team and seek advice and support as appropriate. More widely, child psychiatrists work well with paediatric colleagues. However, difficulties can arise with colleagues in social services in relation to different views on thresholds for intervention, with child psychiatrists (and other CAMHS colleagues) feeling frustrated sometimes by social workers not responding appropriately to identified child protection concerns. Child psychiatrists, by virtue of their training in systemic skills and in children's development, may be adept at identifying more subtle patterns of abuse such as emotional abuse, and may be frustrated by the effort needed for such concerns to be heard and acted on.

It can be challenging to find the right balance between time for direct work with children and families and time for report-writing and attendance at

meetings in order to share information and contribute to decision-making. Sometimes, in the child protection arena, the emphasis on meetings/reports can be at the expense of seeing children and this seems an unhelpful trend. Furthermore, it can be genuinely difficult to find the time to both write a report and attend a meeting to present it, as is the standard expectation for child protection conferences.

Child psychiatrists have concerns about the poor management of some multi-agency child protection meetings/conferences, with meetings starting late, rambling presentations, and insufficient time being given to collective and rigorous analysis of available information, which can result in poor decision-making. Child psychiatrists have experience of thinking about situations of complex and multiple risks (eg self-harm, risk to others, child protection) and are hopefully in a position to model clear thinking, identify risk and protective factors, and help analyse the complex information presented in such meetings.

Psychiatrists providing evidence for the courts should have received training in Court procedures and understand their duty with regard to the court.

*Q4. In your experience, what factors help or hinder clarity about who has what roles and responsibilities to protect children and young people? This might include, for example, local working arrangements, and apply to doctors working in different areas of practice, or the way doctors work with other professionals.*

Within the multi-agency context, there can sometimes be difficulties for social work colleagues in appreciating that different professionals have different roles in the child protection process, and they may then respond in a limited way to a referral from a child psychiatrist, thinking that they do not need to be involved if child psychiatry/CAMHS are already involved.

Psychiatrists can utilise local safeguarding leads such as named and lead doctors and nurses for advice where appropriate and for help in escalating concerns where necessary.

#### ***Doctors' knowledge skills and experience***

*Q5. What training and other support do doctors need to undertake their particular roles in child protection, for example, in preparing and training to give evidence to the family court? If possible, please provide examples where doctors are (or are not) receiving appropriate training or other support.*

It is important to make training interesting and relevant rather than just a mechanical exercise. The use of narratives from serious case reviews can be helpful in illuminating how child protection issues are connected to everyday clinical practice. Child protection training updates by local safeguarding boards can be useful in highlighting key issues locally and nationally.

Training for preparing court reports and giving evidence in Court is increasingly part of higher training in psychiatry. The Royal College of Psychiatrists provides training that meets the specific needs of psychiatrists in preparing for the family courts

The written guidance on child protection (eg new edition of Working Together, London Child Protection Procedures) is too lengthy and over-inclusive and is therefore not helpful to busy professionals. Guidance needs to be more succinct and user-friendly (like the pocket booklet on information-sharing).

***Other issues of interest***

*Q6. Is there anything else you would like us to consider when deciding the scope and content of guidance we give to doctors about child protection issues? For example: the factors that affect doctors' readiness to raise concerns of suspected child abuse or neglect or to act as a professional or expert witness. any gaps or issues lacking clarity in existing guidance available to doctors on child protection issues, from the GMC or other professional and government bodies*

Due to the nature of their work, most child psychiatrists have a good appreciation of child protection issues and are able to recognise these, but many have a worry that if a referral is made to social care, the response will be tardy and limited, and that in doing so, the psychiatrist's relationship with the family will be compromised and that there will be little benefit to the family. This dilemma may affect readiness to refer.

The stress of the work resulting from the difficult discussions with families, lack of patient satisfaction, and the amount of time required for multi-agency liaison may impact on the motivation of individuals to be involved in such cases.

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