The College

Child psychiatric perspectives on the assessment and management of sexually mistreated children

Prepared by a Working Group of the Child and Adolescent Specialist Section*

This document is concerned with the child psychiatrist's role and management of children who have been sexually abused. It has been produced in response to calls for clarification and guidelines on those aspects of child sexual abuse (CSA) which have caused debate or concern within the sub-specialty. Hence, it is not intended as a comprehensive review of all aspects of CSA. Several of the authors of this document have contributed to recent reports on the subject of CSA.[1,2,3] The present document is intended to provide a single source of information specifically orientated towards child psychiatrists.

Child sexual abuse has been defined as the involvement of children by older persons in the following types of sexual activities: exposure (viewing sexual acts, pornography and exhibitionism), touching of sexual parts (child or adult genitalia and post pubertal female breasts), sexual intercourse (oral, anal or vaginal, acute assault and chronic involvement), and other sexual acts (ejaculation of semen onto the child's body, sado-masochistic acts).[4] CSA has been increasingly recognised over recent years, although precise incidence and prevalence rates are not available.[5]

The child psychiatrist's perspective can complement that of other professionals. As our primary orientation is towards the recognition, prevention and treatment of psychiatric disorder in children, we are primarily concerned with CSA as a factor which has an impact on a child's psychological development. Irrespective of variations in work settings and referral patterns, cases involving CSA are forming an increasing proportion of the child psychiatrist's work.

The child psychiatrist's perspective can be distinguished from that of other professionals who come in contact with CSA. Police primarily approach CSA as a criminal act, whereas social services departments are primarily required to ensure the protection of children from activities such as sexual involvement and other forms of maltreatment.[3] The boundaries between professional roles are not rigid, and there is overlap. However, delineation of role is a pre-requisite for successful interdisciplinary working.[3]

*Members of the Working Party: Drs A. Bentovim, A. Bolton, P. Connell, A. Gath, J. Hendriks, Prof I. Kolvin, Drs D. Jones, J. Trowell, S. Wolkind and H. Zeitlin.

Child psychiatric services and CSA

With these background considerations in mind, we consider the different types of child psychiatric involvement.

Referrals for assessment and diagnosis

These referrals vary with the degree of pre-existing suspicion of CSA. However there are some typical situations:

(a) *Has CSA occurred?*

In some cases the referrer is not requesting an assessment of the child's psychiatric state, but is asking whether the psychiatrist thinks that sexual abuse has occurred. In general this type of referral is more appropriately dealt with by social services and/or police departments, especially where there is already a high likelihood of CSA. There are some situations where the child psychiatrist may wish to take on a diagnostic role, after consultation with social services and/or police colleagues, because of other factors, e.g. a very young child who is barely able to talk, a mentally handicapped child, suspicions arising in matrimonial disputes or a child who is severely psychiatrically disturbed. In some circumstances the child psychiatrist may be the person with the appropriate skills and expertise to discuss questions of abuse with the child and in these circumstances the benefit of assessment skills should not be withheld from the child.

https://doi.org/10.1192/pb.12.12.534 Published online by Cambridge University Press

(b) *Suspicion of CSA*

The referrer sometimes requests diagnostic assessment in cases where CSA is suspected. In these cases the possibility of CSA is at a lower level of suspicion as outlined in the document *Some Principles of Good Practice*.[8] Filtering of such referrals will lead to some being diverted to social services department/police for their investigation.

Other cases will be referred to the child psychiatric team for assessment of the overall psychological functioning of the child and family. In these situations the question of CSA becomes one of the issues to be considered by the child mental health service.

(c) *During help with an unrelated problem*

Sometimes during the assessment of a child for an unrelated problem, the possibility of CSA may emerge. In these instances the child psychiatrist would have to enquire further about CSA as he/she would concerning any other contributory factor affecting the patient. Additionally, the possibility of CSA may emerge during the child's treatment for a separate psychiatric problem.

Referrals for treatment services

Other referrals are received after an initial investigation by other professionals. In these instances possible referral questions include the extent and seriousness of the psychological impact of CSA on child and family, the likelihood of successful treatment for the child and parent(s), or a referral for treatment of psychiatric disturbance.

Treatment in these circumstances has to be based on reliable diagnosis of CSA. We think that the practice of treating a child with the primary intention of encouraging 'disclosure' to be likely to be confusing and possibly harmful for all parties.[1,p.208]

However, during the course of psychiatric treatment, new or additional clinical evidence of CSA may emerge, as the child develops trust in the therapist (see also under Confidentiality). We think that child psychiatric intervention is only justified in cases of CSA where the child and/or the family displays psychiatric disorder.[2,p.22]

Wider work by child mental health services

Consultation fulfils an important function in the interagency response to CSA. Selected child psychiatrists may become consultants in the proposed Specialist Advisory Teams, recommended by Lord Justice Butler Sloss[1] (or less formally if SATs do not materialise). We also emphasise the contribution that can be made to a district's training initiatives with under and post graduates. Recent reports[1,2] and research[6] have underlined the lack of adequate training and skills development among professionals. Additionally, the child psychiatrist can contribute in the planning of procedures and services as well as research initiatives.

The referral process

Most child psychiatrists accept referrals from a wide range of sources. The General Medical Council advises that reference should be made to the patient's general practitioner in these circumstances. Additionally if reference is dispensed with then the GP should be informed of diagnostic findings and recommendations before embarking on any treatment plan. The general practitioner is likely to have background information upon the child's growth and development, as well as the health status of other family members. Selected referrals must be seen urgently because some children will be under intense psychological pressure, and child protection decisions may be pressing.

The mode of presentation

Presentation usually occurs in one or more of five ways:[7]

(a) an account by the child
(b) disturbed behaviour, or change of behaviour
(c) physical signs or symptoms
(d) by association with other forms of maltreatment
(e) through allegations by parents, relatives, or other adults.

Some presentations are more indicative of CSA than others but pathognomic signs are not available.[8] Some children who have been sexually abused present via multiple modes, e.g. behavioural, physical, as well as an account by the child. In such a case, the probability of CSA is likely to be high. A single presentation of a less severe type will give rise to a lesser degree of suspicion.[8]

Although children respond with a wide variety of symptoms to sexual abuse, some symptoms do occur with relative frequency in populations of sexually abused children of different ages. For example, the child aged six or under may display sexualised behaviour; a child aged seven to twelve, anxiety related symptoms, sometimes with sexual pre-occupations; and in the teenager acting out behaviour, self harming, drug and alcohol abuse and prostitution are all associated with CSA. However, although these behaviour patterns may be relatively common they are not specific. That is, only a proportion of children with any one of these behaviour patterns will have suffered sexual abuse. Similarly only some sexually abused children demonstrate the groups of symptoms described.[2,8]

The basis for suspicion

Having noted the mode of presentation, the basis for suspicion of sexual abuse can then be weighed by the clinician. This includes considering who has been suspicious and for what reasons, the quality of the sources of information, as well as each person's capacity for objectivity. Crucial considerations include the presence of a vested interest or a pre-judgement of issues by anyone, whether professional or lay. The sequence of events associated with a suspicion of sexual abuse is noted. These steps enable the psychiatrist to tailor the assessment of the child without forming premature conclusions.[8]

Tailoring an assessment

As CSA is a complex and relatively new field of study and practice, only general guidelines are possible. Where a strong basis for suspicion exists, a full evaluation is justified, but a less strong basis for suspicion requires a less intrusive approach.[8]

As in any other psychiatric assessment, the assessment of the child is accompanied by a family assessment, including marital functioning and parenting ability. The approach should be non-accusatory and non-judgemental. Parents should be given the same courtesy as those of any other referred child and kept as fully informed as possible.[1,p.246,8]

Consent to clinical interview

The issue of consent to psychiatric assessment and the recording of information should be consistent with recognised good practice. Young people aged 16 and over may give consent for such treatment as if they had reached the age of full majority (Family Law Reform Act, England and Wales (1969), Section 8). For younger children, consent should be sought from parents or guardians and from the child according to his age and understanding. When the parent or guardian raises concern about CSA, consent to explore this issue is implicit in the referral. Consent is more complex when CSA is not openly raised by the parent or guardian. In cases involving low suspicion, where open-ended screening questions only are asked, consent to ask such questions is implicit. On the other hand, if the major focus of the individual assessment of the child is likely to be devoted to enquiry about CSA, then consent for this interview should be sought from parent or guardian. However, care needs to be exercised as to how parents are informed about this possibility, because intrafamilial sexual abuse may well be associated with parental pressure on the child to remain silent. An assessment interview immediately following discussion with the parent is one way of avoiding inappropriate pressure on the child. If the child is likely to be pressurised, a judgement must be made as to whether the situation constitutes an emergency. If it does, (e.g. potential for injury or abduction of the child, or the severity of the child's psychiatric condition) the doctor can make the decision, in conjunction with local colleagues, to proceed without consent. If, on the other hand, there is not such an emergency, yet the possibility of abuse remains high and consent is withheld, consultation with the local social services department and/or police as well as the defence union, is indicated to decide whether to seek a court order for transfer of parental rights. In all these circumstances the child psychiatrist may be required to justify the decision made.

A child who is in care of the local authority requires its consent to psychiatric assessment. Children who are Wards of the High Court or are under the jurisdiction of the matrimonial courts require the consent of the respective court before starting psychiatric assessment or treatment. The position with respect to a child on a place of safety order is uncertain, and therefore psychiatrists would be advised to seek parental consent for interview of such children, and if this is withheld the matter should be considered by the appropriate court. Consent for audio or video recording should be obtained from parent or guardian, along similar lines to the interview itself. Additional consent is necessary if the recording is used for teaching purposes.[8]

Recording the interview

An accurate record of the interview will be necessary for clinical and possibly legal reasons. While a videotaped record of the interview serves as an excellent record and may reduce the number of subsequent interviews, there are important additional considerations.[7,8] All records are discoverable and may be shown to the court. Additionally, the videotape will need to be stored for as long as the written record. It is not acceptable to erase or re-use videotapes in these circumstances. Sometimes videotaping inhibits the child and so may be contra-indicated for this reason.[1,p.210,8] Practical issues should also be considered such as the adequacy of the equipment, sound quality and lighting.[7]

An audiotape may enable a good record to be kept, and the appropriate sequence of events to be remembered accurately. Naturally non verbal cues are lost to an audiotaped record and will need to be augmented by a written report.[7] A written record should always be kept, and should be contemporaneous.

Confidentiality

This has been reviewed in the *Bulletin*.[9]

https://doi.org/10.1192/pb.12.12.534 Published online by Cambridge University Press

Overall, the psychiatrist is required to create a balance between the extent of which confidentiality can be maintained and the best interests of the child. The welfare and best interests of the child have to be regarded as of the first importance, superseding duties of confidentiality which the doctor may have to other persons, including parents.[2,p12–14;9;1,p198 and p211;8 and 10] Consequently, when the child is the psychiatrist's primary patient, parents cannot necessarily expect the benefits of confidentiality which they would normally rely upon to be accorded to them.

In practice, a psychiatrist normally involves the department of social services. In exceptional circumstances the psychiatrist may decide that the child's best interests can be safeguarded without breaching confidentiality. In so doing the psychiatrist adopts full responsibility for the child's protection from reabuse and may be required to justify such a decision. Such a move should only be considered by teams with specialist experience or following appropriate consultation.

The psychiatrist is obliged to reveal information to a court of law in any proceedings concerning the welfare of a child. If it is considered that revealing such information may be against the best interests of the child, arguments against discovery should be brought to the attention of the court. For example, it has been possible for a court, on hearing psychiatric evidence, to restrict dissemination of records, including video and audio recording, after forming an opinion that this protects the child's best interests. Although not obliged, it is desirable for the psychiatrist to reveal information to the child's guardian *ad litem*, if requested.

Many confidentiality issues arise because of the psychiatrist's need to share information with other professionals. As a general principle, parental consent should be sought before sharing medically confidential material with other disciplines. Similar consent is advisable when obtaining and reviewing information received from other professionals (although one doctor is free to share information relevant to the patient's welfare with another). If such consent is not forthcoming the situation may be discussed with the local social services department or the issue presented to an appropriate court. Many problems can be averted by full discussion with parents and guardians, as well as the child according to age and understanding, regarding potential sharing of information. However, we recommend that care is taken to respect confidentiality as far as possible.

Interviewing children

The interview follows the same principles as a general psychiatric examination of a child[11,12] with the addition of the following points:

(a) Different sorts of interviews about the possibility of CSA are possible, ranging from general exploratory questions in the context of the standard psychiatric interview through to an interview which attempts to facilitate and enable a reluctant child to talk about CSA.[7,13]

(b) Regardless of the type of interview, the psychiatrist should aim to encourage the child's spontaneous account, if at all possible.[1(p.208)]

(c) The duration of the interview should be appropriate to the child's age, understanding and level of comfort.

(d) Repeated sessions, probing the possibility of CSA, are unhelpful and may be harmful to the child.[1,p.208] This does not preclude the possible need for therapeutic sessions with the child where CSA is not being enquired about.

(e) Interviews should proceed at the child's pace and be conducted in a suitable setting.[1,p.208;7]

(f) It is essential that the psychiatrist approach each interview with an open mind as to the possible outcome, avoiding the biased concept of 'disclosure interview'.[1,p.206]

(g) It is desirable wherever possible to see the child on his/her own in addition to any assessments that may be conducted in conjunction with other members of the family.[7,14,22]

(h) Although a rigidly preplanned interview schedule is not recommended as it does not allow sufficient flexibility for the individual child, some degree of structure has been found to be helpful.[7,14]

In the first stage of an interview a general assessment of the child's functioning is sought. This includes the child's behaviour, emotions, relationships with peers and adults, attitudes towards family members, and any traumatic experiences. During this stage, a general rapport is developed with the child.

If there is a sufficiently well established basis for suspicion then the first stage may be followed by a second stage of "helping the child to tell" (Facilitation).[1,p.206] Here, the psychiatrist has to steer a course between the extremes of overly leading questioning and, on the other hand, being insufficiently enabling for the reluctant child. A further dilemma faces the clinician; on the one hand being aware that secrecy and an admonition not to tell are an integral component of familial cases of CSA, while on the other recognising that, despite clinical suspicion, the child's condition may be caused by factors other than abuse.

Facilitation may be achieved in several ways; use of toys and materials to help cue memories, type of questions and the manner in which they are put, enabling the child to relax, feel safe and understand the reason and purpose of the enquires being made. Such techniques are similar to other approaches which have been used when discussing sensitive topics with children, and have been described in detail in potentially sexually abused children.[7,13,14,15]

An important consideration is whether facilitative techniques are being used to establish whether anything has happened, or whether they occur at a later stage in the assessment, to establish more detail about something about which the child has already disclosed. Facilitating techniques are more appropriate in the latter situation.

The use of anatomically correct dolls requires special mention. They have become extremely popular in the assessment of suspected sexual abuse. We express concern at their use by persons without adequate training in their use, limitations, and in the interpretation of responses. There are only preliminary studies available on their use and the expected responses among abused and non-abused children.[7] Hence care is needed when interpreting children's responses when they are used. It is probably unnecessary to use them as a first stage of evaluation. They may be a useful adjunct to a facilitative second stage, particularly when children have become stuck for words and concepts with which to describe detail of sexual abuse. They may also be useful with young children when other signs, such as clear-cut physical findings, point to a strong likelihood of sexual abuse. The use of other, less contentious, techniques can be very helpful in this facilitative stage, e.g. drawings, of self and of family, use of standard small and large size dolls, puppets.[7]

It is useful to think of a checking stage at some point in the interview. During this phase checks can be made for the suggestibility of the child, the identification of the alleged abuser and further details of any alleged abuse. The interviewer should consider with whom the child may have already discussed alleged maltreatment. Such items may have been included at an earlier stage, but if not it is recommended that they are covered at this point. When checking with the child, the interviewer has to avoid transmitting a sense of disbelief to the child, which may cause much harm.

Finally, the last stage of the interview consists of an adequate closure for the child. If the child has struggled and expressed considerable emotion during the interview then it is appropriate to recognise this, but congratulation for disclosure is best avoided.

Interpretation of findings

At this point information gathered has to be interpreted and placed into context from the point of view of the child and family in question. The developmental perspective is all important at this stage, in order to make sense of findings. Clinical findings are also evaluated in relation to the relevant knowledge base. This consists of studies of populations of sexually abused children,[16] the psychology of children's memory, [17] the psychology and psychiatry of adult and adolescent sex offender behaviour,[18] the psychology of victimisation,[7] children in divorce and custody situations,[19] normal sexual development and knowledge,[20] as well as the descriptive clinical literature on CSA.[21] Other specialised bases of knowledge include fabrication[22] and the use of anatomically correct dolls.[7,13] In addition to these, the degree of facilitation employed in the interview has to be taken into account when forming conclusions. The child's spontaneously uttered comments are especially helpful in interpretation. The evaluator should consider alternative explanations and thereby retain an open minded approach even during the interpretation of findings.[1,p.206;7,p.42–46;8]

The conclusion that the child has been sexually abused is a composite one and not derived from one piece of data or source of information. In CSA, relatively greater reliance is placed on the child's account than on physical findings. This contrasts with the reliance upon medical examination in physical abuse. It is recommended that the psychiatrist's conclusions about CSA should be presented within a framework of the balance of probabilities or degree of relative certainty. (In order to reflect accurately areas of debate and uncertainty in the field). Finally, it is necessary to differentiate between CSA as an aetiological influence and diagnostic conclusions about the presence of psychiatric disorder.

Case management

In general, this is no different from other situations in which a child psychiatric team works with abused or neglected children and their families. However, such cases have attracted public interest which highlight issues of professional accountability, the nature of expert evidence and the conflict between the rights of the child to be protected from abuse and his rights, and those of his family, to be protected from intrusive investigation. Decisions as to whether an allegedly abused child should remain in or be removed from the care of his parents should not be a response to CSA in isolation but should rest upon a broad assessment of the quality of parenting available to the child, as well as of the varied pressures which may be exerted upon him. The child psychiatric team may play a part in such decisions and, if the child is removed, those regarding access. When CSA victims are placed outside the family, work with nurses, residential care workers and foster parents becomes of crucial value.[21] Effective working practices with other agencies are essential to good practice.[1,p.204,3] Case conferences are an essential focal point of interagency co-operation.[3,p.28] Child psychiatrists with a special interest in CSA should ensure that their CSA work is balanced with other non-abuse work.[1,p.249]

Court work

The child psychiatrist's increasing involvement in CSA has inevitably brought with it more court-related work. It is unfortunate that a relatively new field has had to enter the arena of legal decision making. The negative result of this process is to compel premature closure on issues which deserve more prolonged debate in clinical and research literature. Even experienced clinicians may be reluctant to accept referrals involving CSA because of the disruption to their timetable and the public exposure of clinical work which court work involves.

Despite these problems, we emphasise that forensic child psychiatric work is a necessary and important component of the overal multidisciplinary response to CSA. An objective report can be a great help to the court. Child psychiatrists may act for the guardian *ad litem*, the Official Solicitor, or at the direction of a Court by agreement with parties concerned. If a psychiatrist is asked by one party only, he should agree to the production of a report *only* if it is then made available with permission of the Court to all parties concerned. In these ways the child psychiatrist retains an essential neutrality and is able to act in the best interests of the child.

A forensic opinion may be sought on a child and family who have been the subject of earlier clinical psychiatric evaluation or further opinions may be sought on earlier forensic reports. Under such circumstances psychiatric expert opinion may be given by reading such reports, viewing or listening to tape recordings and by discussing the work with clinical colleagues. However, if it is considered that an earlier report allows for the possibility of different conclusions or recommendations, but does not provide a comprehensive picture, it may be necessary to consider additional psychiatric clinical evaluation of the child concerned.

Frequently, a second or expert opinion is sought within the adversarially influenced legal system. Child psychiatrists should direct paramount attention to the clinical indications for second opinions in order to avoid undesirable outcomes such as unnecessary re-interviewing children or others.

In general, psychiatrists are advised to obtain appropriate permission for all forensic work from Courts and parents or representatives to consult colleagues and Defence Unions as appropriate. As the law requires, each psychiatrist must retain independence and objectivity in order to act in the best interests of the child.

Conclusion

Child psychiatrists have the potential to contribute a great deal to the management of children and familes where sexual abuse is an issue. They are able to provide an integrated perspective on the physical, psychological, family and social aspects of CSA cases. Their skills in communicating with children, especially those who are disturbed, may be very valuable. Background knowledge of the child development field is an extremely useful basis for involvement in CSA cases, as well as under and post graduate training, and the planning of services. The psychological effects of CSA, both upon the individual and the family, have implications for treatment and management where again the child psychiatrist has much to contribute. There are several difficult and potentially contentious areas for child psychiatrists (e.g. confidentiality, consent, interdisciplinary working and interviewing practices) which, although taxing, are vitally important areas for our sub-specialty, and allow us to introduce a child psychiatric perspective to the interdisciplinary management of children who have been sexually mistreated.

References

[1] LORD JUSTICE BUTLER SLOSS (1988) *Report of the Inquiry into Child Abuse in Cleveland in 1987*. London: HMSO.

[2] DHSS (1988) *Diagnosis of Child Sexual Abuse: Guidance for Doctors*. London: HMSO.

[3] — & WELSH OFFICE (1988) *Working Together: a Guide to Arrangements for Interagency Co-operation for the Protection for Children from Abuse*. London: HMSO.

[4] OXFORDSHIRE JOINT CHILD PROTECTION COMMITTEE (1987) *Child Protection Procedures*. Oxford: Oxford Social Services Department.

[5] MARKOWE, H. (1988) The frequency of child sexual abuse in the UK. *Health Trends*, **20**, 2–6.

[6] BOAT, B. W. & EVERSON, M. D. (1988) Use of anatomical dolls among professionals in sexual abuse evaluations. *Child Abuse and Neglect*, **12**, 171–179.

[7] JONES, D. P. H. & MCQUISTON, M. G. (1988) *Interviewing the Sexually Abused Child*. London: Gaskell (Royal College of Psychiatrists).

[8] KOLVIN, I., STEINER, H., BAMFORD, F., TAYLOR, M., WYNNE, J., JONES, D. & ZEITLIN, H. (1988) Child sexual abuse, some principles of good practice. Report of Independent Second Opinion Panel, Northern RHA. *British Journal of Hospital Medicine*, **39**, 54–62.

[9] THE ROYAL COLLEGE OF PSYCHIATRISTS (1987) Confidentiality: Current concerns of child adolescent psychiatric teams. *Bulletin of the Royal College of Psychiatrists*, **11**, 170–171.

[10] GENERAL MEDICAL COUNCIL (1988) Annual Report for 1987. p 15. London: GMC Office.

[11] COX, A. & RUTTER, M. (1985) Diagnostic appraisal and interviewing. In *Child and Adolescent Psychiatry: Modern Approaches* (eds. M. Rutter and L. Hersov). London: Blackwell.

[12] HILL, P. (1985) The diagnostic interview with the individual child. In *Child and Adolescent Psychiatry: Modern Approaches* (eds. M. Rutter and L. Hersov) London: Blackwell.

[13] LEVENTHAL, J. M., BENTOVIM, A., ELTON, A., TRANTER, M. & READ, L. (1987) What to ask when sexual abuse is

suspected. *Archives of Disease in Childhood*, **62**, 1188–1195.

[14]VIZARD, E., BENTOVIM, A. & TRANTER, M. (1987) Interviewing sexually abused children. *Adoption and Fostering*, **11**, 20–25.

[15]MACFARLANE, K., WATERMAN, J., CONERLY, S., DAMAN, L., DURFEE, M., & LE LONG, S. (1982) *Sexual Abuse of Young Children: Evaluation and Treatment*. London: Guildford Press.

[16]PETERS, S. D., WYATT, G. E. & FINKELHOR, D. (1986) Prevalence. In *A Sourcebook on Child Sexual Abuse* (ed. D. Finkelhor) London: Sage Publications.

[17]CECI, S., TOGLIA, M. P. & ROSS, D. (1987) *Children's Eyewitness Memory*. New York: Springer-Verlag.

[18]ARAJI, S. & FINKELHOR, D. (1986) Abusers: a review of the research. In *A Sourcebook on Child Sexual Abuse* (ed. D. Finkelhor) London: Sage Publications.

[19]WALLERSTEIN, J. S. & KELLY, J. B. (1980) *Surviving the Breakup: How Children and Parents Cope with Divorce*. London: Grant MacIntyre.

[20]RUTTER, M. (1980) Psychosexual development. In *Scientific Foundations of Developmental Psychiatry* (ed. M. Rutter) London: Heinemann.

[21]BENTOVIM, A., ELTON, A., HILDEBRAND, J., TRANTER, M. & VIZARD, E. (1988) *Child Sexual Abuse within the Family: Assessment and Treatment*. London: John Wright.

[22]JONES, D. P. H. & MCGRAW, J. M. (1987) Reliable and fictitious accounts of sexual abuse in children. *Journal of Interpersonal Violence*, **2**, 27–45.

Approved by Council
October 1988

The Seventeenth Annual Meeting, 1988

The Seventeenth Annual Meeting of the College was held in Brighton on 5, 6, and 7 July under the Presidency of J. L. T. Birley.

Scientific Meetings

The Scientific Meetings were held at the Brighton Metropole Hotel.

Business Meeting

The Business Meeting was held on 6 July and was chaired by Dr J. L. T. Birley. It was attended by 110 Members of the College.

The minutes of the previous meeting held in Belfast on 1 July 1987 and published in the *Bulletin*, December 1987 were approved and signed.

The Report of the Registrar and the Annual Report were received and approved.

The Report of the Treasurer and the Annual Accounts for 1987 were received and approved.

The appointment of auditors was approved.

Registrar's Report

You will all have received copies of the Annual Report. I am going to tell you about the various College activities which have occurred since the Report went to print at the beginning of May.

The Working Party, chaired by the President and convened to prepare the College's response to Sir Roy Griffiths Report *Community Care: An Agenda for Action*, submitted its report to Council in June. The College is concerned not only about many of the proposals in this report but also about its underlying assumptions. In particular, we have not supported the key recommendation that local authorities take responsibility for assessing needs and providing community care for the mentally ill. Our comments have been forwarded to the Secretary of State for Social Services, have been widely circulated and will be published in the September *Bulletin*.

The College has recently completed another successful JPAC exercise in its applications for extra senior registrars in forensic psychiatry and mental handicap psychiatry; 15 extra posts in forensic psychiatry and 22 extra mental handicap posts have been approved. The College's Working Party on JPAC is now considering the number of registrar posts required in the specialty over the next ten years and we have been invited to present our report to JPAC in the middle of September.

Council has approved the establishment of a permanent Appeals Office to extend the College's fund-raising activities. Dr Michael Pare has been appointed Appeals Director. A new Appeals Committee will be established under the chairmanship of an influential non-psychiatrist and with a membership drawn from all walks of life. The first priority of the Appeals Office will be to secure the permanent establishment of the College's Research Unit. I should add that covenant forms for the Appeal are, as always, available from the Registration Desk.

I am pleased to report that Professor Brice Pitt has agreed to replace Dr Michael Pare as the College's Public Education Officer.