



editorial

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Child psychiatry and the law: when assessment threatens treatment

On 24 November 2005, the Lords of Appeal overturned previous childcare case law, effectively reinstating the distinction between the medical or psychiatric assessment and the treatment of a child. They upheld that the purpose of section 38 (6) of the Children Act 1989 was to grant an assessment of the child under an interim care order and that the power of the court to order local authorities to fund either the treatment of the child or parents in their parenting, did not fall within the remit of that section.

Is this merely a nuance of the law, with little relevance to current practice of child psychiatry? Unfortunately, the answer is no. Whereas medical treatments neatly fall within the provision of the National Health Service, psychosocial treatments do not. The complex array of problems that a struggling family faces blurs the boundary between psychiatric and social care. Often such problems can only be adequately tackled through specialist centres, and obviously such centres require funding. The decision introduced the very real possibility that once an assessment of a child's needs is completed, they are not then granted access to treatment.

The implications of this decision are thus far reaching. The central tenet of the Children Act 1989, the 'welfare principle', states

'the child's welfare is paramount in deciding all questions about his upbringing . . .' (White *et al*, 1990: p. 1).

This is echoed in the augmentation provided by the 2004 Act, whereby

'arrangements are to be made with a view to improving the well-being of children in the authority's area . . .' (p. 7)

However, the revised interpretation of section 38 (6) means that local authorities now only have a legal responsibility to fund an assessment of the child's needs. Under such an interpretation of this section, the responsibility to fund a necessary treatment becomes a moral one rather than a legal one. Moreover, owing to the constraint of tight budgets that every local authority must face, it is not always upheld. This decision to overturn the previous case law thus has potential to

undermine the welfare of the child through lack of necessary treatment being funded.

The issue of funding

Specialist centres dealing with the complex psychosocial problems of neglect and abuse may be recruited to assess the impact upon the child and what is required to ameliorate their condition. While this assessment is ongoing, the court can order funding to be made available by the local authority under section 38 (6) of the Children Act 1989. However, when the assessment begins to involve treating the child's difficulties, funding of the required input may now be stopped. This situation seems ludicrous but is based in reality.

The Cassel Hospital is one such specialist centre, a national centre for clinical excellence and a therapeutic community that deals with families with severe difficulties. The majority of these referrals are via the court, involve varying degrees of abuse and neglect in the history, and require intensive specialist input from both therapists and nursing staff. However, since the decision by the House of Lords, referrals of families have declined markedly, as referrers have been increasingly worried about ongoing funding. Furthermore, some families that are progressing well in therapy face a return to local services that are likely to be inadequate for their needs when their assessment becomes deemed a 'treatment'. Obviously this has grave repercussions for the children involved and it does not sit easily alongside the principle of 'first do no harm'. To undergo an assessment of the emotionally charged issues within a family, only to have to return home is intrinsically harmful and does not constitute a duty of care in any way.

Policy and children's welfare

The current Government guidelines for providing for the welfare of a child dictate that assessment should include 'a realistic plan of action (including services to be provided), detailing who has responsibility for action, a



editorial

timetable and a process of review' (Department of Health, 2000: p. 53). This would appear to be common sense. After all, would any clinician be content with diagnosing an acute abdominal complaint in a child and then sending them home? Would not a duty of care dictate that their condition be treated (i.e. 'action' taken) and that they be regularly reviewed? The same initiative also states that local authorities have a

'duty to safeguard and promote the welfare of children in their area who are in need and to promote the upbringing, wherever possible by their families, through providing a range of services' (Department of Health, 2000: p. viii)

This is reaffirmed within a range of other governmental policy documents. The Children's Fund was launched in November 2000 as part of the Government's commitment to tackle disadvantage among children and young people. The stated aim was to provide

'a responsive approach to developing services that address the difficulties faced by some children and their families' (<http://www.everychildmatters.gov.uk/strategy/childrensfund>).

Even with such policies in place, the response that many families are now facing is a firm 'no' to treatment. As a consequence of the new House of Lords' judgment, local authorities are now all too often bowing out of the funding of psychiatric treatment. The Government's objective of safeguarding families and their welfare cannot be met within this context.

Assessment v. treatment: a valid distinction?

The very issue of assessment has also proved a matter of legal debate. What should assessment consist of and who should receive it? As has been noted in previous case law,

'... it is impossible to assess a young child divorced from his environment. The interaction between the child and his parents or other persons looking after him is an essential element in making any assessment of the child' (Re C (A Minor) [1997]: p. 502).

It follows that an integral part of ensuring the welfare of a child is to take account of their environment, including the parents charged with 'the welfare'. Yet, if therapeutic intervention is deemed to centre round assisting the parents with their parenting, there is now no legal obligation upon a local authority to fund this work. Divorcing the child from their environment, including their parents, has no clinical validity whatsoever. It is merely a further indication of how limited current legislation appears to be in ensuring the child's well-being and of how dislocated that legislation is from the clinical picture.

At what point does assessment become treatment? The limited scope of section 38 (6) to order funding presupposes that assessment and treatment are two distinct entities. This is again at odds with the clinical reality.

'Assessment must include the capacity to respond to treatment, and hence any distinction between the two is quite false' (Kennedy, 2001).

Working with parents, their difficulties and the impact these difficulties have upon the nature and quality of attachment that the child exhibits are important elements in both the assessment and treatment of the child. Indeed, working in partnership with parents is a guiding principle of the Children Act 1989 (Department of Health, 1997) and a central element of the governmental strategy for helping children, young people and their families (<http://www.everychildmatters.gov.uk/caf>).

Assessment of a child cannot be truly divorced from treatment. Both frameworks must also address the part a parent plays in delivering effective and adequate care to the child. According to the Department of Health (2000)

'It is recognised that ... families have a right to expert practical support from universal services, such as health and education.'

This would appear to contrast starkly with the finding of the Lords of Appeal, namely that

'there is no ... right to be made a better parent at the public expense' (Kent County Council v. G & Others [2005]: p. 13).

The law, as it stands, would not appear to satisfactorily ensure the welfare of a child. Neither the 'welfare principle' of the Children Act 1989 nor public policy seems to be taken adequately into account. Present legislation to protect the interests of a child is, it would seem, outmoded and wanton. At the very least there are serious restrictions in the interpretation that carry with them significant clinical consequences. If we are to simply rely on the current reading of the letter of the law, children will now miss out on the specialist care they need.

The way to well-being

To adequately redress this disturbing situation, two avenues urgently need to be pursued. The first is a change to the interpretation of the Children Act 1989, to consign ample import to the place of treatment in ensuring the welfare of a child and the place of parents within that treatment. Section 38 (6) is too narrow for either of these important facets to have such a place. However, they do have a clear place within the 'welfare principle' and thus within the wider interpretation of the Children Act 1989. Furthermore, section 17 of the same Act places a responsibility on the local authority to 'safeguard and promote the welfare of children' and to provide a 'range and level of services appropriate to those children's needs.' One could justly argue that, even with the new distinction between assessment and treatment in section 38 (6), a wider reading of the Children Act 1989 could still legally enforce a duty of care to attend to the child's welfare. This would place the local authority once more in a position of having to fund treatment, regardless of the nuances of one particular section, and certainly would be more in keeping with governmental policy.

However, a change in interpretation will require a test case and probably an appeal. With the law thus restricted by the serious limitations of the current interpretation, a second avenue is for local authorities and



primary care trusts to collaborate in funding, again in line with the directives set down by the Government in the *Health and Social Care Standards and Planning Framework* to promote 'greater joint working and partnership between PCT'S, L.A.'s, NHS Foundation Trusts, NHS Trusts, independent sector and voluntary organisations . . .' as a means to 'putting patients and service users first through more personalised care' (Department of Health, 2004: p. 7). Otherwise, children will be lost between the cracks of multi-agency discord. Therefore a definite and unambiguous recognition of joint responsibility to fund treatment is needed to ensure the psychiatric well-being of children.

'A decision not to intervene at an early stage, on short term financial grounds, ends up with the local authority having to pay vast amounts in trying, ineffectually, to mop up the damage caused to a fragmented family' (Kennedy, 2001).

If early intervention can occur with joint help from the healthcare system, the long-term expenditure would probably be lessened. At a time when budgets are strained within the National Health Service, this is a difficult responsibility to be charged with, not least because of the short-term considerations against which financial plans are often conceived. To shirk this task, however, would be to shirk a responsibility for the welfare of the children in our care. In effect that is to willingly enact the neglect we purport to be treating. Unless some way is found via cooperation of agencies to break the cycle of abuse and deprivation to which children are all too often subjected, the disturbance will continue to be

transmitted across the generations. There is thus a moral and ethical obligation to ensure that both adequate childcare and parenting are pursued at public expense. Although jurisprudence has so far failed to address this, social and healthcare systems cannot.

Declaration of interest

None.

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