Workload and child sexual abuse: an argument for joint commissioning

Mary Cole and Margaret Vereker

Recent studies in child mental health show that fundholding general practitioners regard sexual abuse work as a priority service, and also that sexually abused clients take up more out-patient time than others in the same diagnostic group. This paper provides supporting data on the issue of workload and argues that specific purchasing arrangements should be made to cover this area of well recognised need.

Budgetary constraints mean that providers are becoming more rigorous about only accepting referrals for which they will be paid. In the Salisbury Child and Family Service, clinical referrals are only accepted from medical practitioners, and in common with 30% of the child and family services nationally, it has recently lost its attached social workers (Kurtz *et al*, 1994). Direct referrals from social services are not accepted and there is no specific specialist service for children and young people who have been sexually abused, although many present to the clinic with mental health problems such as anxiety, depression, behaviour or conduct disorders and self-harming behaviour.

Child sexual abuse is a major mental health problem requiring new resources in training and personnel (Hobbs & Wynn, 1987). Fundholding general practitioners (GPs) chose sexual abuse as a high-priority service (Mutale, 1995). This implies that there is a need in the community currently not met by services.

It was felt that locally there was unmet need for individual and family work with sexually abused children, and also a fear that our service would be swamped if these cases were accepted without a concomitant increase in staff and facilities. This study was designed to discover if these cases did generate more work than average and to examine the current interrelationship with social services.

Method

The study covered a four-month period (January–April 1996) and was designed in two parts. Firstly data were collected on all clinic cases, and secondly a comparison was made of sexually abused children and a control group of non-abused children. For the first part of the study key workers completed an assessment form of every open case they saw in Salisbury Child and Family Service. Details collected included age and sex, and a numerical rating given for the level of suspicion of sexual abuse:

0 No suspicion of sexual abuse
1 Low level of suspicion of sexual abuse
2 High level of suspicion of sexual abuse
3 Abuse alleged by index
4 Joint investigation complete
5 Case conference called
6 Prosecution under way
7 Prosecution unsuccessful/abandoned
8 Prosecution successful

The current involvement of social services and the need for further child protection work was noted. Child protection work was defined as the evaluation of risk of significant harm to a child and the statutory and legal steps needed to minimise or avert such harm. Data were collected on whether other members of the family alleged that they had been sexually abused in their own childhood. If necessary, key workers updated the forms during the study period.

In the second part of the study, all those who had scored 3 or more (clear allegation of abuse) were matched for age and sex against randomly selected zero-rated clients. It was noted how patients had first come into contact with our service, and how many days they had spent in hospital. Workload data were collected from the time of first contact. This included the number of times seen in out-patients, referrals or re-referrals to our clinic, types of therapies received, professionals from our team involved, inter-agency meetings held, and admissions to paediatric or psychiatric wards. It was also noted whether the case had been referred by us to social services. Comparisons were then made between the patients scoring 3 or more (3+ group) and the zero-rated controls.

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Table 1. Results of assessment form and client questionnaire

	Score on suspicion rating									
	0	1	2	3	4	5	6	7	8	Total
Number of children	151	34	7	7	2	1	2	1	1	206
Number with abused parents/relations (%)	9 (5.9)	4 (11.7)	3 (43)	3 (43)	1 (100)	1 (50)	1 (50)	1 (100)	0 (0)	23 (11.1)
Social services involved (%)	13 (9)	12 (35)	4 (57)	3 (43)	1 (100)	2 (100)	2 (100)	1 (100)	1 (100)	39 (18.9)
Further child protection work needed (%)	0 (0)	3 (8.8)	2 (28)	2 (28)	1 (100)	1 (50)	2 (100)	0 (0)	1 (100)	12 (5.8)

Results

A total of 207 forms were received. One patient in the 3+ group did not have their code number recorded and was lost to follow-up. The percentage of clients who made a clear allegation of abuse or had been investigated, conferenced or their case had led to a prosecution was 6.8% of the total. There was a further 20% where the therapist had some suspicion of undisclosed abuse. Three per cent of male clients and 12% of female clients scored greater than 3. In 11% of all cases another family member disclosed they had been abused, and 50% of the 3+ group had a relation who had been abused themselves (Table 1).

Table 2 shows the comparative workload involved in the 14 abused children and the 14 controls. The abused group were significantly more likely to have attended out-patients at least eight times (P=0.027). They were seen more than twice as often in out-patients and involved 50% more professionals. Staff attended 28 meetings involving this group, compared with one for the control group. Nine of the 14 abused children were admitted on at least one occasion and the average time in hospital was 41.7 days (range 2–177 days). Five of the 14 abused children were first seen by our service as emergencies after an event of deliberate self-harm. Four of the 14 abused cases had social services involvement initiated by this agency. The type of therapies actually received by the abused group and the controls is shown in Table 3.

Twelve of the 14 children in the abused group received multiple (2–4) interventions, compared with four out of 14 in the control group, three of whom received assessment and advice only.

Discussion

The prevalence of sexual abuse in our survey is 6.8%. This is consistent with other studies (Baker & Duncan, 1985). The higher rate of females compared with males is found in both clinical and general populations (Bentovim *et al*, 1988). A striking 50% of those scoring 3 or more had other family members who alleged they had been abused themselves, which is consistent with the concept that abuse arises not in isolation but in the context of disturbed family relationships which may repeat through the generations. Disclosure in the first year after sexual abuse is made by just over a third of those abused (Anderson *et al*, 1993). Our therapists identified a further 20% of cases in which abuse was a possible but unacknowledged factor, making a total (declared and suspected) of 26.8% of all cases seen during the study period.

Table 2. Comparative workload involved for 14 abused children and 14 controls

	Controls	(Average)	Cases	(Average)
Number of times seen in out-patients	96	(6.8)	231	(16.5)
Number of professionals involved	31	(2.2)	46	(3.3)
Number of referrals made	24	(1.7)	26	(1.8)
Number of interagency meetings (mostly statutory)				
Attended	1	(0.07)	28	(2.0)
Invited	1	(0.07)	42*	(3.0)
Number of times admitted	1	(0.07)	25**	(1.8)

*P=0.04; **P=0.022.

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The second part of our survey took clear allegation of sexual abuse as a cut-off point for inclusion in the abused group. The design of the questionnaire allowed a buffer zone of cases where the therapist felt some suspicion but abuse had not been alleged or investigated. The survey of workload data produced striking results. The anecdotal feeling of the workers that sexual abuse cases involved a high commitment in time and money was strongly confirmed. The randomisation process led to the chance inclusion of two of our most seriously mentally ill clients in the control group, and yet it did not approach the amount of out-patient time needed by the abused group. This supports the finding of the Leeds Survey (Wright *et al*, 1996) that physically or sexually abused patients took up a greater amount of out-patient time than would be expected for their numbers. In our study they received more types of therapy from a greater number of therapists than the controls. In-patient time was also high and multiple admissions were common.

It is recommended that all victims of sexual abuse receive abuse-specific counselling consisting of ventilating feelings, teaching prevention skills, and education aimed at reducing stigma and isolation, with additional interventions for symptomatic children (Jones, 1996). A review of the effectiveness of treatment suggests that therapeutic intervention does facilitate recovery and that abuse-specific, individual and family therapy should be undertaken (Finkelhor & Berliner, 1995).

Because of the mental health sequelae of child sexual abuse, many children present initially to child and adolescent mental health teams. In this study 57% of those children who alleged sexual abuse (score 3+) were unknown to social services. It is worrying that 12 out of 55 children (score 1–8) were thought by this team to need further child protection work. Prevention of further abuse is a prerequisite for treatment, and the Children's Act 1989 places the welfare of the child above all other considerations in statute law. Child mental health teams need to work closely with social services to assess the social risk of further harm and the clinical risk of deliberate self-harm. Five of the 14 cases were brought into contact with our service because of an act of deliberate self-harm, which is a measure of these children's emotional turmoil and neediness. Possibly a more proactive specialist service could have avoided some of these emergency presentations.

Many hours of non-contact time were taken up at interagency meetings, the majority of these being required by statute under the Children's Act. It is salutary to observe that key workers were unable to attend a third of those to which they were invited. Individual scrutiny of the notes gave a clear impression of the burdensome nature of the additional non-contact time involved in these cases apart from meetings. Telephone contact with social workers was often only achieved after many mutual attempts frustrated by unavailability. There is also often extra work involved in preparing court reports and attending court (although not in this particular group), which usually adds considerably to the workload.

The boundaries between child mental health and social services hindered efficient delivery of care for these children. Currently there is limited coordination between the agencies of assessment and therapeutic approaches. It would be mutually beneficial to have joint planning for the provision of assessments, legal aspects and therapy, including family work and specific treatment plans for the individual (particularly costly long-term individual work) in the context of specialist multidisciplinary teams. Collaborative working would provide a mechanism for research across agencies leading to informed future planning of services. It is essential that there should be joint commissioning of this service as recommended in the NHS Health Advisory Service thematic review (1995) and the *Health of the Nation Handbook on Child and Adolescent Mental Health* (Department of Health, 1995). This would help these agencies to offer an integrated assessment of need and a seamless delivery of social help and specific therapies for both children and their families.

We would also agree with the findings of Kurtz *et al* (1994) that current purchasing arrangements lack specific detail. Furthermore, in view of our findings, contracts should be negotiated on the basis that a proportion of the workload of

Table 3. Therapies received by abused children and controls

	Controls	Cases
Family therapy	5	10
Individual therapy (all types)	4	11
Cognitive-behavioural therapy	6	3
Abuse-specific therapy	0	5
Other	0	Art psychotherapy - 1 Anger management - 1

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child and adolescent mental health teams should be funded at a higher rate to allow for this group, who require greater time commitment. There should be dedicated provision for these children and an acknowledgement of the time needed for non-contact work, staff training and support. Many of these children suffer chaos, unclear boundaries and shifting responsibility in their home life. Services providing help for these children should not mimic this pattern.

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