and sometimes is, ages. If the court expects us to attend cases, attempts should be made for us to have priority so that we can find time to see our patients and perhaps, if we are lucky, have lunch.

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References

BUTLER-SLOSS, E. (1987) *Report of the Inquiry into Child Abuse in Cleveland*, London: HMSO.

SIMMONS, S. (1988) Money briefing. *B.M.A. News Review*, (December).

WORKING GROUP OF THE CHILD AND ADOLESCENT SPECIALIST SECTION (1988) Child psychiatric perspectives on the assessment and management of sexually mistreated children. *Psychiatric Bulletin*, **12**, 534–540.

DEAR SIRS

I welcome the document prepared by the Working Group of the Child and Adolescent Specialist Section on child psychiatric perspectives on the assessment and management of sexually mistreated children (*Psychiatric Bulletin*, December 1988). It is timely, balanced, clear and comprehensive. The one area where I feel further clarification is required concerns the advice that "in exceptional circumstances the psychiatrist may decide that the child's best interests can be safeguarded without breaking confidentiality". I wonder what might constitute such exceptional circumstances and how can the psychiatrist "adopt full responsibility for the child's protection from re-abuse" in such circumstances, without stepping outside of his role?

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DEAR SIRS

We would like to thank Professor Meadow for highlighting the primary direction and point of our document, which was to emphasise the signal contribution we have to make to children in families where CSA has occurred. We have the necessary skills to combine a view of physical, emotional and intellectual problems, child development, experience with children, communicating with children and assessment of children and families; and work and communication with related disciplines. We thought this was clear both from the whole document as well as our conclusions. However, we were primarily addressing our own colleagues not wider groups. Had we been doing so, our paper would have been less concerned with specific practical details and more focused upon our wider role.

The description of child psychiatric services and CSA appears to give rise to some misinterpretation about our role in relation to assessment and diagnosis, treatment and finally wider work. Most of the points which Professor Meadow makes were in fact contained within this section, but it was necessarily dense because we had much to cover in the document. For example, the last sentence of 'wider work by child mental health services' (p. 535) is a reference to the child psychiatrists' involvement in local procedures, and although we did not mention child protection committees, it is clearly that which is meant. However, his point about the child protection committee is well taken and we certainly agree that at least one child psychiatric slot should be mandatory. As for our involvement in treatment services, we recognise a role in relation to the disturbed child and family and not merely the overtly or grossly disturbed child. Under 'wider work' we emphasise the importance of consultation. The only area of work which we have recommended that child psychiatrists are not routinely involved in is the initial investigation of most cases, but again we see an important consultation role. Further, we *do* write ourselves into the initial investigation of complex cases involving very young children, severely disturbed, mentally handicapped and the suspicions arising in complex circumstances such as matrimonial disputes. We also see an important involvement either through consultation or directly in the investigation of institutional abuse where we could bring the degree of objectivity required.

In his last paragraph Professor Meadow makes the case about the work load. It is heartening to see the recognition by a senior paediatrician of the heavy work load that child psychiatrists often are asked to and do undertake. However, we would also note that some of the child abuse work load is not new. There is an increasing tendency for many of the child and family problems that have been dealt with within child psychiatry for many years to be re-assigned to the label of child abuse or sexual abuse.

Finally, while we would advocate a wider role for child and adolescent psychiatrists in CSA (and this has crucial manpower implications), it would be counterproductive to advise them to devote a disproportionate amount of their time to this problem. A balanced view is absolutely essential about the specification of our specific as well as our overlapping roles with other disciplines so that we maintain due respect for these professions' mandates and level of skills.

WORKING PARTY
Child and Adolescent
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DEAR SIRS

T. J. Dyer queries the assumption of the multidisciplinary nature of child psychiatry (*Psychiatric Bulletin*, February 1989). In my view, most medical

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