In the Child's Best Interest: The Contribution of Child and Adolescent Psychiatry

No Superior Interesse da Criança: Os Contributos da Pedopsiquiatria

ARTIGO ORIGINAL

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ABSTRACT

Introduction: Child and Adolescent Forensic Psychiatry involves a multidisciplinary assessment at the courts' requested to assist them in the process of justice delivery.

Material and Methods: Retrospective study which included 233 forensic requests to two child and adolescent psychiatrists from Coimbra's HP-CHUC Child and Adolescent Psychiatry Department between 1998 and 2012.

Results: Biographic, psychopathology, social and family aspects were analyzed. The response time throughout the process, the origin and nature of the request's and the type of process which originated the request were also assessed. The authors identified the involved professionals and whether they needed to go to court. When there were questions, they evaluated the capacity to answer them, the forensic difficulties and solutions found, and the presence of recommendations.

Discussion: The obtained results met the clinical experience and literature regarding demography and psychopathology. As for the difficulties, there were a number of aspects which could be improved by both parts, aiming to ameliorate the articulation between Health and Justice.

Conclusion: With this study it was possible to reflect on the authors forensic practice, in order to develop a closer partnership with the courts to promote the real 'best interests' of children/adolescents and their families.

Keywords: Child Advocacy; Child Psychiatry; Expert Testimony; Forensic Psychiatry; Portugal

RESUMO

Introdução: A atividade médico-legal, no âmbito da Pedopsiquiatria, consiste numa avaliação por solicitação dos Tribunais, para os assessorar no exercício da Justiça da família / da criança.

Material e Métodos: Estudo retrospetivo, que englobou 233 pedidos de exames periciais e informações clínicas de dois pedopsiquiatras do Serviço de Pedopsiquiatria do Hospital Pediátrico do Centro Hospitalar e Universitário de Coimbra, entre 1998 - 2012.

Resultados: Foram analisados aspetos biográficos, psicopatologia subjacente e contexto sociofamiliar. Foram avaliados também os tempos de resposta nos diferentes momentos do processo, a proveniência e a natureza dos pedidos, bem como o tipo de processo que lhes deu origem. Os autores identificaram, para cada caso, os profissionais envolvidos no processo e a eventual necessidade de comparência em Tribunal. Perante a existência de quesitos, avaliaram a capacidade de resposta aos mesmos, as dificuldades periciais e respetivas soluções encontradas, bem como a existência ou não de recomendações.

Discussão: Os resultados obtidos foram ao encontro da literatura e experiência clínica relativamente aos dados demográficos e psicopatologia. Quanto às principais dificuldades sentidas, identificaram-se diversos aspetos passíveis de aperfeiçoamento, por ambas as partes, com vista a uma melhor articulação entre a Saúde e a Justiça.

Conclusão: Com este trabalho foi possível refletir acerca da atividade forense dos autores, visando facilitar a articulação da Pedopsiquiatria com os Tribunais, em prol do verdadeiro superior interesse das crianças/adolescentes e suas famílias.

Palavras-chave: Defesa da Criança e do Adolescente; Pedopsiquiatria; Portugal; Prova Pericial; Psiquiatria Forense

INTRODUCTION

Different court requests are usually handled by child and adolescent psychiatrists, including requests for clinical information, court attendance notices or requests for forensic medical expertise. The authors aimed at a brief revision of the work developed in this area, in order to improve collaboration with justice.

In theory, based on the specific expertise in a certain area, any specialist physician can be notified to give a technical expertise on the facts and circumstances submitted to examination (Article 467th of the New Civil Procedure Code (*Código de Processo Civil*).[1] The expert must comply with different demands, although having the opportunity to present a reasoned refusal based on some impediments that are established in law, according with the Articles 469 and 470 of the New Civil Procedure Code.[1]

Medicine is at the service of the law, prompted to clarify and within the legal framework. A new approach as public official entrusted to the state, justice and the duty as a citizen is assumed, adequately and permanently getting familiar with scientific and legal literature.[2]

The intersection of different languages, aims and methodologies within the interface between child and adolescent psychiatry and the law must be recognized and balanced in order to reach the best response or to find a solution involving the least possible damage to children, young people and their families.[3]

Open-mindedness and critical thinking are part of the role as an expert, peer-reviewed and aimed at representing

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the interest of children/young people and writing a report in response to legal issues.[4]

A theoretical and practical expertise is crucial, involving solid knowledge on childhood and adolescence development and the effect of adversities, considering the influence of the family, the knowledge of psychopathology, the forensic presentation of mental disorders and the legal framework namely regarding promotion and protection, punitive-educational measures, informed consent, adoption and compulsory admission to psychiatric inpatient care. A specialized training in patient assessment is required, in different contexts and environments, as well as the knowledge on integrated therapeutic approach and healthcare programs.[2,5]

Diagnosis and medical treatment are the major aims of physicians, using physician-patient relationship as well as values such as confidence and confidentiality as therapeutic tools.[2,6] Even though medical treatment and follow-up are not included as part of the expert's aims, these should be taken into consideration.[2]

Therefore, different issues that by their nature are outside the scope of the law should be clarified by the expert, reason why the child's therapist should not be the designated expert, primarily because the therapeutic analysis has its own constraints, namely the proximity with the minor, preventing from maintaining the necessary detachment to carry out the expertise.[7]

This duality between the therapist and the expert can lead to unavoidable confusions that need to be adequately explained to the family, namely regarding the absence of confidentiality in cases requested by the legal authorities, clarifying the distinction between a medical examination and an expertise.[7] In addition, at the risk of any mistaken partiality interpretations, an adequate clarification of the different roles is crucial at the time of providing the information to the court by request of the family, namely regarding cases of non-compliance with parental responsibility.

Child and adolescent psychiatrists involved in a forensic expertise can be asked to act as professional witnesses in order to comment on a clinical follow-up or as an expert witness by request of the *Instituto Nacional de Medicina Legal e Ciências Forenses* (INMLCF).[8]

Ethical and medical confidentiality issues are frequently raised whenever child and adolescent psychiatrists are asked to share any information and opinion regarding their patients and an accurate analysis is crucial in order to determine which information should be made available, considering risks *vs.* benefits related to further possible implications in the therapeutic intervention for which a confidence relationship is crucial.[6,7]

This way of involvement is in contrast with the one provided by child and adolescent psychiatrists unacquainted with the clinical case and acting as expert witnesses. When an expertise is requested by the court, a formally detached assessment of the case is what really matters and a second opinion can eventually be requested or the access to the specific knowledge of the expert in child and adolescent psychiatry.[5]

Multidisciplinary expert assessment and adequate links with general psychiatry, paediatrics and social services are crucial and usually involved in forensic medical practice in the area of child and adolescent psychiatry and frequently requested to the healthcare services.[2]

Different reasons underlying a request for an expertise may exist, including cases of juvenile delinquency / crime (educational guardianship proceedings), alleged ill-treatment (neglect and/or physical or sexual abuse), decisions regarding parental responsibilities and/or residential placement (family, institution, visits scheme), assessment of the relationship between caregivers and the child (parental ability), student absenteeism situations, screening for psychopathology, consent to treatment (compulsory admission for medical treatment or compulsory outpatient treatment), assessment of witness credibility or dispute for compensation for damage (for instance, in cases of post-traumatic stress disorder after an accident).[4,8]

Forensic medical practice does not represent a 'classical' psychiatric assessment with its own diagnostic and therapeutic aims, rather involving an accurate technical procedure based on specific methodologies.[5] Medical reports correspond to a scientific rationale for reaching a clarification and orientation in doubtful and/or conflictive situations and therefore demanding for a clinical assessment as accurate and complete as possible. The collected information can be supplemented with ancillary tests, with the statement of other significant experts or with reports provided by different professionals and based on reference scientific literature[9] (Fig. 1).

Even though no formally validated model of report has ever existed, minor's identification, conditions of the examination, personal and family medical history, medical and mental examination, ancillary tests, diagnosis and forensic medical conclusions in response to the issues must be included in any forensic medical assessment.[4]

A concise report, even though as complete as possible, complying with what has been requested, should be made available, written in a clear language, with the department letterhead, adding page numbers and signed.

Considering the experience already obtained, the authors have provided for a reflection on their forensic medical work through the analysis and treatment of the filed information, aimed at providing a contribution to a better link between health and justice.

MATERIAL AND METHODS

Description of the study

This was a retrospective study involving all the requests for expertise examinations and clinical information sent to two child psychiatrists working at the Department of Child and Adolescent Psychiatry of the Paediatric Hospital of the *Centro Hospitalar e Universitário de Coimbra* (HP-CHUC) over a 15-year period, between 1998 and 2012.

The requests sent by the different judicial institutions and the INMLCF as well as the forensic medical reports

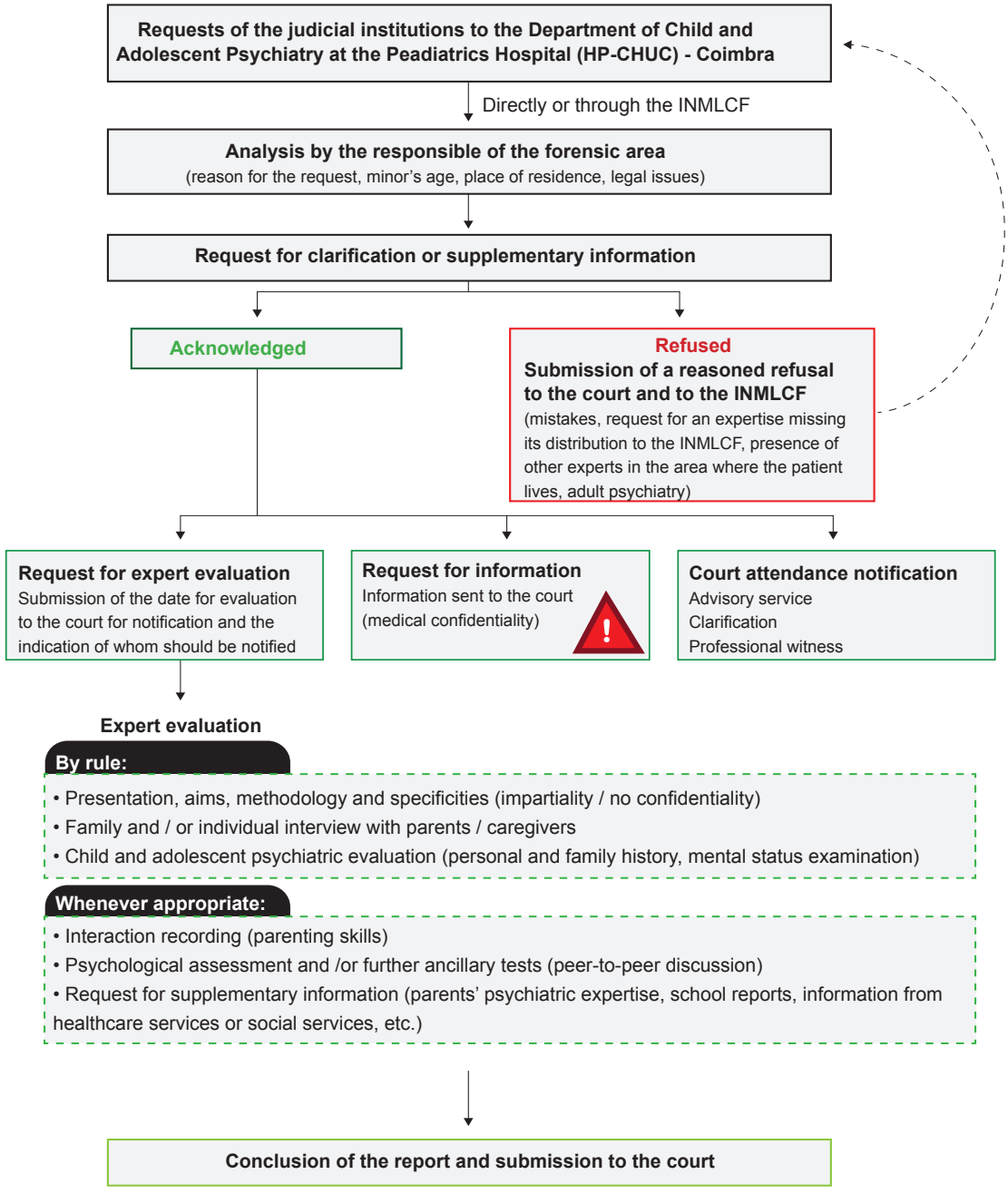

Figure 1 – Flow-chart

and medical information produced over the study period were analysed. Information regarding medical, judicial and sociodemographic characteristics was collected and subsequently stored into a Microsoft Access® database.

Population

A total of 233 requests were included in the study, regarding children, adolescents and young adults aged 0-25 years.

Both types of request (forensic medical expertise or request for medical information) were reviewed. Biographical aspects were analysed and the characteristics of the population were obtained (including age, gender, place of residence, education, underlying psychopathology and social and family context. Response times regarding the different moments of the procedure were also assessed, as well as the origin and nature of the requests, as well as the type of legal process.

Professionals involved in each case (child and adolescent psychiatrists, registrars, psychologists and social assistants) were identified, as well as court attendance requirements. Whenever any legal issues existed, responsiveness, any constraints and solutions found, as well as the presence of any recommendations were also assessed.

Data processing

IBM® SPSS® *Statistics (Statistical Package for Social Sciences*) software version 20.0 has been used for data analysis.

Inferential and descriptive statistical analysis has been used, including a frequency analysis involving median, range, standard deviation, standard error and 25th, 50th and 75th percentiles.

Mann-Whitney's test (independent samples) has been used for the analysis of variables such as minor's age, education and gender. Response times between court-INMLCF, INMLCF-Department of Child and Adolescent Psychiatry, within the Department (from when the request was received up to the moment of the initial interview) and times between the initial assessment and the conclusion of the report were calculated for the entire group and for the subgroup of forensic medical expertise by using Friedman test for paired samples; Wilcoxon test for paired samples has been used for the analysis of medical information. The differences between the remaining variables were obtained by using Kruskall-Wallis test for independent samples and Pearson's chi-square test has been used in the assessment of the relationship between the year of submission of the request by the court and the legal process and request types; *p*-values under 0.05 were considered as statistically significant, for a 95% confidence interval.

RESULTS

Male minors (59.23%) were mostly included in our sample, with an average age of 10.11 ± 4.73 years and showing no statistically significant differences regarding age and gender.

Most requests were submitted by the judicial court (*Tribunal Judicial*) (n = 144), followed by the public prosecutor's office (*Ministério Público*) (n = 42) and the juvenile and family court (*Tribunal de Família e Menores*) (n = 40), mainly from the district of Coimbra (n = 82), followed by Leiria (n = 38). From the 233 requests, mainly legal proceedings regarding parental responsibilities (n = 62) were found; inquiries (n = 62) and proceedings regarding promotion and protection of human rights (n = 56) and the suspicion of sexual abuse (n = 72) and other ill-treatment (n = 51) were the main reasons underlying the legal process. Almost the same percentage of legal process types has been found over the years, despite the variation shown in Fig. 2. A statistically significant relationship ($p = 0.036$) has been found between the process type and the number of interviews required for a report.

An expert evaluation has been mostly requested (74.68%), even though statistically significant differences ($p < 0.001$) were found between the type of request and the judicial institution; medical information is more frequently requested by the *Tribunal de Família e Menores* than by the remaining institutions. An average response time of 128.56 days has been found in a sample of 16 requests for medical information.

The evolution of the request types over the study period is shown in Fig. 3, showing a peak number of requests in 2006 and a clear reduction in the number of both types mainly from 2007 onwards, with an increase in the number

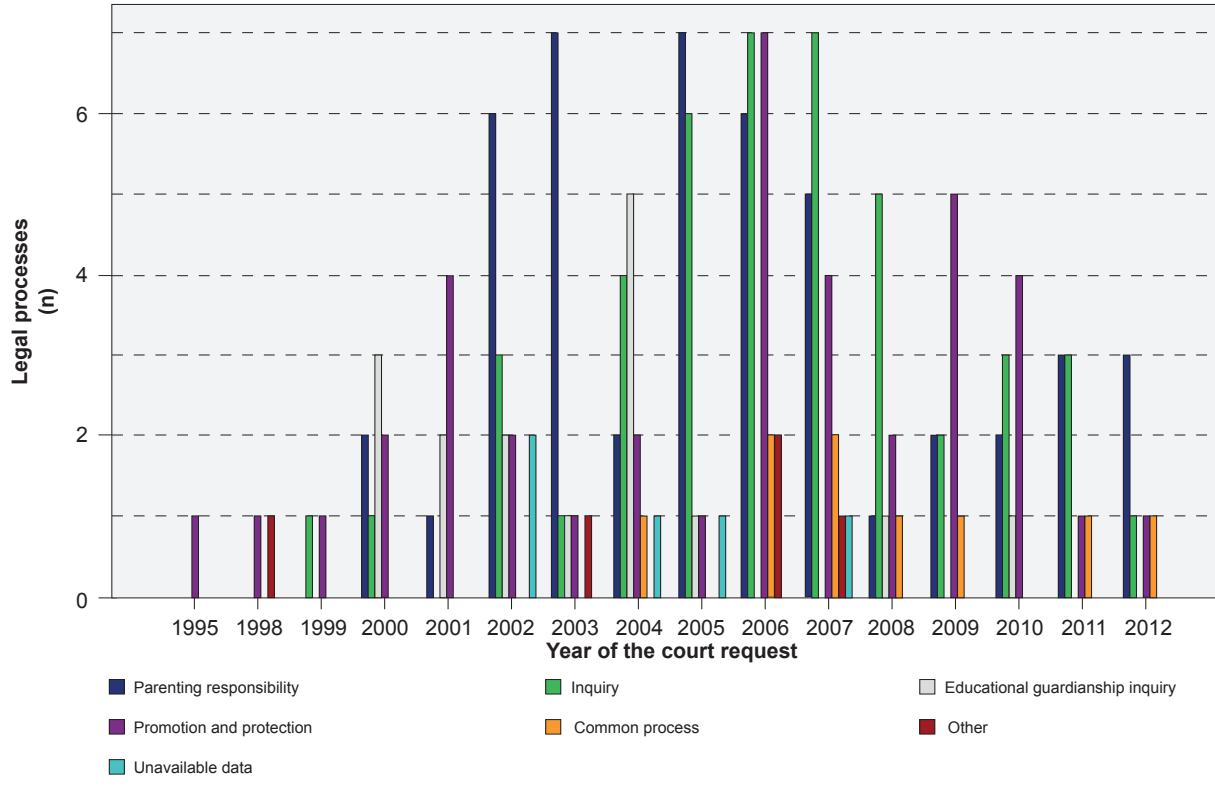

Figure 2 – Types of legal process leading to a child and adolescent psychiatric intervention

of medical information requests in 2007 and in 2011.

Expert court attendances have been requested in 40 situations, including as a professional witness, as an expert to provide clarifications on the report or just as an expert to assist in the interrogation of minors and statistically significant differences have been found ($p = 0.008$) between the number court attendances and the court type (higher from the *Tribunal Judicial*).

The presence of legal issues has been found in 53.65% of the cases, although in only 37.34% a complete response was made possible through an expert evaluation and recommendations were sent by the expert to the judicial institution in 66.52% of the cases. Whenever no legal issues existed, the number of interviews required for writing a report was statistically higher ($p < 0.001$) and four interviews were on average required, regardless of the presence of any legal issues.

Statistically significant differences ($p < 0.001$) were found between response times regarding the different institutions involved - Court - INMLCF, INMLCF – Department of Child and Adolescent Psychiatry and within the Department (from when the request was received by the expert up to the scheduled date of the expertise) and times between the initial interview and the report writing; a longer time has been spent in writing the expertise (65 ± 6.503 days, on average) – Table 1.

A single psychiatrist has been involved in 18.45% of the cases, while the additional collaboration of other experts, including registrars, psychologists and social assistants has been found in 81.55% of the cases. A registrar has been involved in around 50% of the cases.

Only in 11.16% of the cases was the expert evaluation confirmed as relevant, while no response has been mostly given to a feedback request sent by post to the court (84.12%). Different expertise constraints have been described by psychiatrists in 49.5% of the situations (n = 114).

A multiaxial diagnostic classification system for children and adolescents based on the International Classification of Diseases, 10th edition (ICD-10) has been included in

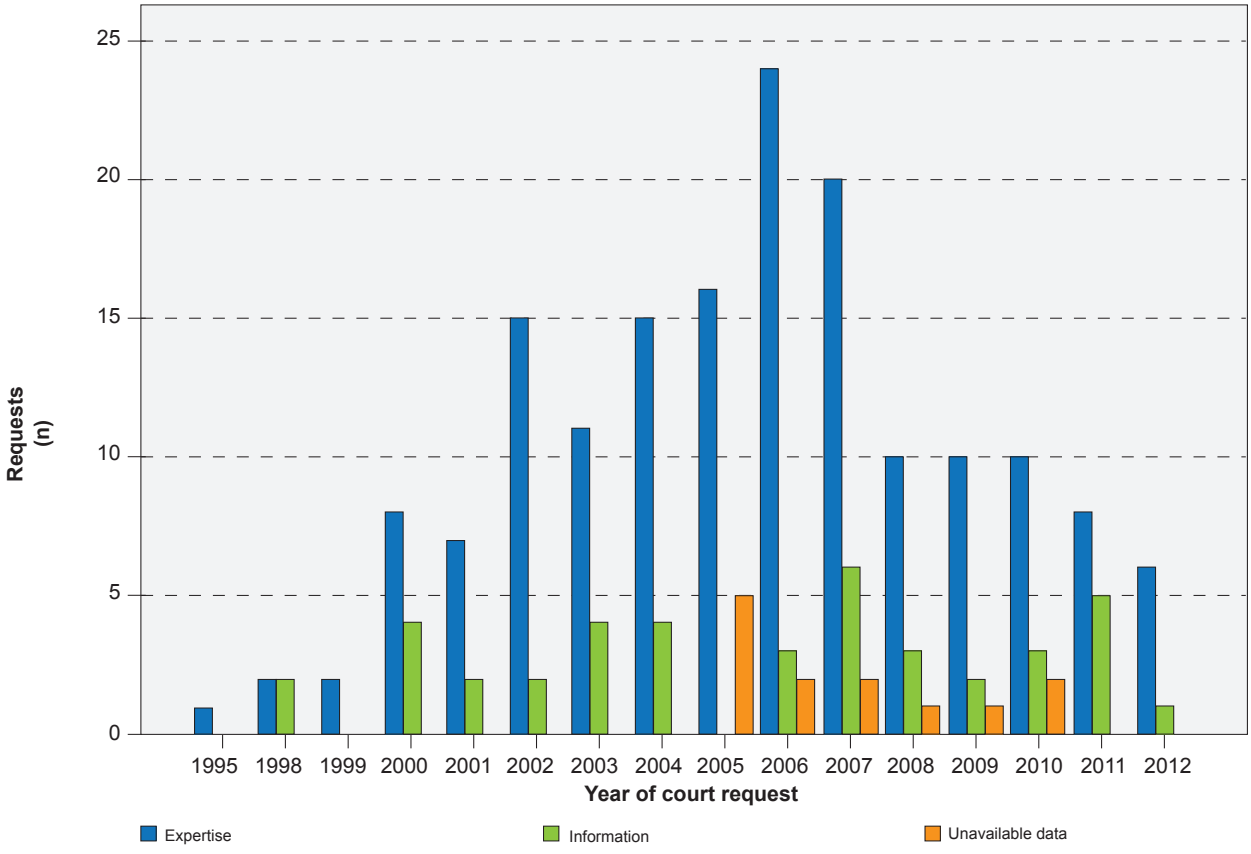

Figure 3 – Evolution of the types of request

Table 1 - Response time of the different institutions

Response time	Mean (days)	Standard error	Minimum	Maximum
Court - INMLCF	36	4,876	0	361
INMLCF – Department of Child and Adolescent Psychiatry CHUC	46	5,699	0	298
Within the Department of Child and Adolescent Psychiatry CHUC	64	7,648	0	395
Expertise – Court (initial interview up to the submission of the report)	65	6,503	0	617

the expert evaluation[10] in which axis I corresponds to the psychiatric diagnosis, axis II to specific learning disabilities, axis III to any cognitive impairment, axis IV to medical conditions and axis V to psycho-social factors (Fig. 4).

No statistically significant differences were found regarding whether or not an abnormality was found on each axis, even though constraints related to psycho-social factors stood out, with an impact on family dynamics, support network and the presence of parental psychopathology, as can be found within the axis V (n = 161).

DISCUSSION

The results obtained in the study were in line with the literature and the clinical experience regarding the demographic data and psychopathology. Different aspects on both sides were found that could be improved, related to the major constraints described by the psychiatrists, aimed at a better link between health and justice.

Even though the analysis of the variation of the number of requests is beyond our scope, a higher attendance of psychiatrists to court seems expectable in the *Tribunais Judiciais* due to the lower experience of these courts in the area of protection of minors than in specialised courts.

Different factors have contributed to an unreasonable time spent throughout the whole administrative procedure, including failing to provide the procedural documents of the file and different shortcomings frequently leading to delays in the original case opening, namely regarding the identification, the calls or the request for expertise bypassing the INMLCF and according with the place of residence.

Statistically significant differences ($p < 0.001$) between the different response times of the institutions have been found. This was explained by different issues, namely the need for different interviews and the fact that calls scheduling is managed by the courts, the use of ancillary tests, peer-to-peer discussion and finally the time spent for writing the report. Delays in providing the information on the outcome of parental psychiatric assessment as well as no-shows of examinees have also contributed to the delay.

The fact that, on average, more time has been spent throughout all the inter and intra-institutional bureaucratic procedures than the time spent with the expertise increases the need for a reduction in response times, which is crucial considering that 'time for children' is not the same as for adults. Any unreasonable delay in this procedure corresponds to maintaining possible risk situations, with an impact on child/adolescent psycho-social development. This may become particularly severe when involving ill-treatment situations, with an additional risk in terms of changed testimony and in which the utmost requirement for child protection from the alleged abuser is crucial. All the stakeholders should deeply reflect on the reasons for this delay throughout the different moments, aimed at the implementation of better strategies for procedure optimization.

The number of interviews required has been clearly increased by absent, excessive or inadequate legal issues, obviously leading to a higher delay in writing the report. The relevance of legal issues and its optimization should be reinforced, even though it should be mentioned that the multifactorial aetiology in the area of mental health does not allow for a simple cause-effect thinking at the time when risk and protective factors are considered, as well as for the fact that the assessment on the veracity of testimonies is not possible, as is often requested.

No feedback has been sent to 84.12% of the cases as requested by the experts to the judicial institutions and, even

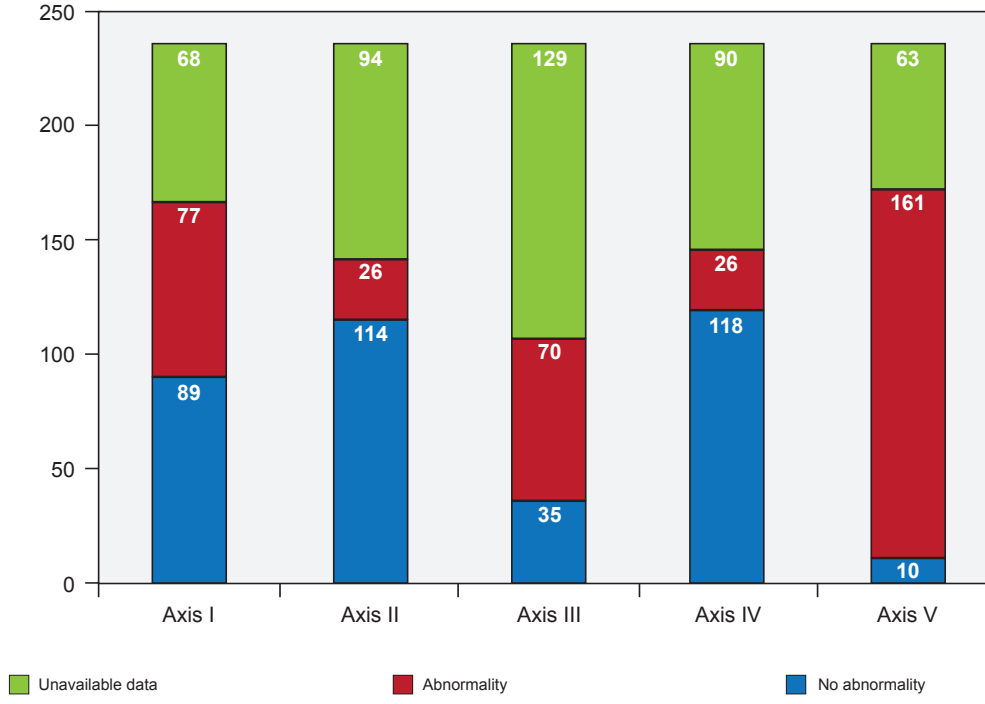

Figure 4 – Multiaxial diagnostic classification system

though we can perceive that an expertise has been helpful, this has prevented any conclusion on whether the needs were met and whether this was helpful for the orientation of the case.

Constraints have been described by psychiatrists in 49.5% of the situations (n = 114), including the need for the clarification of legal issues, clarification of shortcomings of failing to provide information, some of which could have been overcome by a more direct link between the expert and the court.

Even though not analysed, different constraints, other than those reflected in the results, remain for further reflection: an expertise scheduling overlapping the SNS (Portuguese healthcare system) waiting list, in addition to constraints regarding the conciliation of both lists whenever two experts are needed, rather than a single scheduling list for forensic medical practice, makes it harder to comply with deadlines, also affecting the clear demarcation of the different roles of child and adolescent psychiatrists, producing an unexplained no-show of the examinees to scheduled expertise and the need for the cancellation of urgent medical appointments of patients required to attend to court or the time spent in court hearings, sometimes postponed.

In addition, the request for an evaluation of parental ability exclusively sent to adult psychiatrists is recurrently found when it should also be requested to child and adolescents psychiatrists, in an interaction work, eased up by the placement of specialists in both areas at the INMLCF or in forensic departments at the hospital. In fact, the presence of psychopathology and/or personality disorders in parents should be considered in this type of evaluation (within the scope of forensic psychiatry and psychology), as well as a child psychiatric assessment and the study of family interactions. Parental psychopathology or lack thereof will hardly allow, on its own, to determine parenting skills, rather requiring the evaluation of the interaction between those parents and that child, which is the major expertise of child and adolescent psychiatry, particularly when supplemented with a specific training in family therapy.

This presentation and discussion reflect our vision as healthcare professionals, with the underlying partiality, even though its content included concrete and hardly refutable data. Knowledge on the same subject under the perspective of law experts, as well as their main constraints, seems crucial.

CONCLUSION

This study aimed at a reflection on the contribution of forensic child and adolescent psychiatry to the identification of improved links between health and justice and their major constraints.

Above all, the 'returned lives' of so many children and adolescents with the crucial contribution of the forensic expertise is what makes medical practice of child and adolescent psychiatrists one of their noblest and invaluable skills.

The involvement of child and adolescent psychiatrists, apart from clarifying and redefining, makes judicial decision easier and enriches each participant due to the training potential, namely for law and health trainees and registrars. The request for experts in Child and Adolescent Psychiatry is therefore crucial in collaboration with the courts.

The need for improved links between health and justice seems unquestionable and aimed at defending minors.

The authors wish to make the following recommendations, based on this study:

• Presence of a more direct way of contact (advisory, by email, by phone) between physicians and the court staff, allowing for a quicker clarifying of any doubts as well as for a feedback;

• Simple and objective legal issues in a systematic and optimized way, aimed at preventing from reports with insufficient or irrelevant information;

• Organization of a system for immediate communication of no-shows to the court and suggesting an expertise instead of simply sending information, whenever a therapeutic intervention is at risk;

• Feedback, by using a detachable form or by direct response to a questionnaire sent by email to the judicial institutions regarding the relevance of the report and any recommendations.

• Reinforcement of pre and postgraduate training in the field of childhood development and psychopathology within children's rights aimed at healthcare and law professionals (disclosure of scientific meetings and masters in law and psychiatry, bidirectional training protocols, etc.).

Considering the above and due to the unquestionable vocational motivation that should be assumed, the implementation of the sub-specialty of forensic child and adolescent psychiatry seems crucial, allowing for scheduling lists exclusively aimed at the forensic work within the departments and for an improved responsiveness.

We wish that this study may have provided a relevant contribution to improved bonds into this partnership, aimed at a more effective 'superior interest of the child'.

HUMAN AND ANIMAL PROTECTION

The authors declare that the followed procedures were according to regulations established by the Ethics and Clinical Research Committee and according to the Helsinki Declaration of the World Medical Association.

DATA CONFIDENTIALITY

The authors declare that they have followed the protocols of their work centre on the publication of patient data.

CONFLICTS OF INTEREST

The authors declare that there were no conflicts of interest in writing this manuscript.

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