An Evaluation of the use of the Children Act 1989 and the Mental Health Act 1983 in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS)

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The views expressed in the report are those of the authors, and not necessarily those of the expert panel or the Department of Health.
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1 EXECUTIVE SUMMARY

1.1 Background

This study, 'an evaluation of the use of the Children Act 1989 and the Mental Health Act 1983 in children and adolescents in psychiatric settings' has as its focus the use of these two Acts in child and adolescent mental health service (CAMHS) in-patient units. CAMHA-CAPS is a substudy of the National In-patient Child and Adolescent Psychiatry Study (NICAPS) which provides detailed data on the nature and use of such units.

1.2 Methods

1.2.1 CAMHA-CAPS used a multimethods approach to generate as wide a range of data as possible on the subjects under investigation.

1.2.2 A survey of the Child and Adolescent Faculty of the Royal College of Psychiatrists was completed. An open question was asked, to generate psychiatrists' opinions on the most central issues concerning the use of legislation to detain young people with mental disorder.

1.2.3 A stakeholder discussion day was held where themes from the faculty survey were considered. A structured focus group methodology was used to generate validated themes and recommendations.

1.2.4 Data from the NICAPS project day census of in-patient units and their study of referrals, admissions and discharges to all units over a 6 month period were analysed to examine the use of the Acts.

1.2.5 A follow-up study of those subject to detention was carried out 9-months post discharge, to investigate changes in legal status and outcomes.

1.2.6 A questionnaire was sent to all CAMHS in-patient consultants. This focussed on their knowledge, attitude and practice in legislation use in in-patient CAMHS.

1.2.7 A series of site visits to secure and forensic units was completed and services were assessed using NICAPS standards and a set of supplementary questions developed specifically for these services.

1.3 Key Findings

1.3.1 Where detention is formal rather than informal, psychiatrists almost exclusively use the Mental Health Act rather than section 25 of the Children Act to detain young people with mental health problems.

1.3.2 Detained patients tend to be older, with a substantial number aged 18 years or over.

1.3.3 Detained patients are more likely to have schizophrenia or personality disorder than informal patients, who are more likely to have eating or mood disorders. Detained patients have greater psychosocial complexity.
1.3.4 Consent obtained for treatment tends to be verbal rather than written.

1.3.5 Psychiatrists' knowledge of the Children Act and consent issues is lower than for the Mental Health Act.

1.4 Recommendations

1.4.1 The specific needs of young people should be considered in the new Mental Health Act. This should include clarification of the primacy of consent (parental and patient) for young people.

1.4.2 There is a need for training for health and social care staff in the use of the MHA, the CA, and in issues of consent. There may be particular value in joint training.

1.4.3 There is a need to address the issue of the apparent low level of psychiatrists' training in mental health law.

1.4.4 The consideration of CAMHS in the National Service Framework for children should address issue of consent, including the use of parental consent for the detention and treatment of young people on CAMHS in-patient units.

1.4.5 The range of agencies providing services for young people with mental health problems need to review and resolve the discontinuities in care that result from different services having different age based criteria.

1.4.6 There is a need for better liaison between CAMHS and adult mental health. Particular areas needing to be addressed include determining responsibility for admission for young people requiring formal admission, transferring care between services, and providing input for young people detained on general adult psychiatric wards.

1.4.7 NICE should produce guidelines on the use of medication and other treatment for young people with mental health problems. These should also address the use of rapid tranquillisation in in-patient services.

1.4.8 In-patient services must recognise the importance of obtaining informed and continuing consent. Services should be encouraged to avoid verbal and blanket consent.

1.4.9 Further research is needed into admissions under parental or local authority consent, and the choice between parental consent, child consent and the use of the MHA.

1.4.10 Further research is required into how young people from ethnic minorities interact with in-patient CAMHS.
2 INTRODUCTION

2.1 Background to the study

2.1.1 Policy and service context

The detention and treatment of children and young people with mental disorder is regulated principally by two pieces of legislation. First, there is the Mental Health Act 1983 (HMSO, 1983) which does not specify lower age limits in its use, and is currently under review. Secondly, the Children Act 1989 (HMSO, 1989) provides specific statutory rights for children and young people in relation to their assessment and treatment. There is overlap in the provision of the two Acts and some ambiguity in the relative value of the use of either. There are also concerns regarding clarity and ease of use for clinicians, and safeguards for the patient. Attempts have been made to clarify these questions and to provide guidance for practitioners (White et al 1996; Bailey and Harbour, 1999). A further issue of importance is parental and patient consent for the in-patient treatment of young people with mental disorder.

The ad hoc nature of service development in in-patient child and adolescent mental health services (CAMHS) has contributed to the shortage of good quality information on the utilisation of these services (House of Commons Health Committee, 1997). The prevalence of use of the Acts in children and young people is unclear. There is a need for better information on how the legislation is currently being used, to develop better safeguards, to inform the review of the Mental Health Act 1983, and to inform the national planning of services.

2.1.2 Research Context

Child and adolescent psychiatric in-patient care is a relatively under-researched area. Surveys in the past decade in England and Wales have described the volume, aspects of structure, staffing, and the patchiness of service provision (Chesson and Chisolm, 1996; Kurtz, Thornes and Wolkind, 1994 and 1996). There is little known about the use of the Mental Health Act and the Children Act in young people. A recent national survey of child in-patient units attempted to investigate clinicians’ use of coercive treatments, but a low response rate to these items meant results were limited in their generalisability (Green and Jacobs, 1998). The Audit Commission recently published a report of their national review of child and adolescent mental health services (Audit Commission, 1999) but this did not focus on the use of legislation in in-patient CAMHS.

The study reported here complements the work completed by the Audit Commission and the National Inpatient Child and Adolescent Psychiatry Study (NICAPS) project by describing the ways in which the Acts are used in in-patient CAMHS.

2.1.3 Purpose of the Research

In response to the review of the Mental Health Act 1983, the Department of Health identified a number of information needs and questions relevant to in-patient CAMHS. One key question related to the circumstances in which the Children Act or the Mental Health Act orders are used to detain young people. Other issues for investigation included:

i consent to treatment;

ii the relative rights and responsibilities of young people and their parents to make decisions,
the capacity of the law to protect the interests of young people

A programme of research into the use of Parts II and X of the Mental Health Act was commissioned by the Department of Health to support the review of the Act. This work did not focus on the detention of young people hence the decision to commission the study reported here.

This report is a companion to the NICAPS report (O’Herlihy et al, 2001), which explores the characteristics and use of child and adolescent psychiatric in-patient units in England and Wales. The study reported shared resources and methodology with NICAPS.

2.1.4 Research Questions

The following were the main *a priori* research questions investigated as part of the project.

| 1. | What is the rate of use of the Children Act (Section 25) and Mental Health Act (Parts II and III) to enforce the detention and treatment of children and young people in child and adolescent in-patient units in England and Wales? |
| 2. | What is the prevalence of use of the Children Act (Section 8 and Part IV) for children and young people in child and adolescent in-patient units in England and Wales? |
| 3. | For those children and young people subject to the use of Act, what is the intended purpose of the use of the Act? This might include to enforce detention or to enable the administration of treatment. |
| 4. | For those children subject to Section 3 of the Mental Health Act, what is the role of the nearest relative, including how often the nearest relative might have been deemed an inappropriate person to act in that capacity under the Mental Health Act? |
| 5. | For practitioners working in child and adolescent in-patient units in England and Wales, what is their knowledge of, attitudes to and practice in relation to the Mental Health Act and the Children Act? |
| 6. | For practitioners working in child and adolescent in-patient units in England and Wales, what is their knowledge of, attitudes to and practice in relation to issues of consent to treatment of children and young people? This will include the relative rights and responsibilities of young people and their parents to make decisions, and the use of the Children Act, Mental Health Act and common law. |
| 7. | What policies and procedures do child and adolescent in-patient units in England and Wales have in relation to the use of control and restraint (both for those subject to the Mental Health Act and the Children Act) and for those not? |
| 8. | What policies and procedures do child and adolescent in-patient units in England and Wales have in relation to consent to treatment? |
| 9. | What policies and procedures do child and adolescent in-patient units in England and Wales have in relation to those children or young people who wish to leave/discharge themselves? |
10. What policies and procedures do child and adolescent in-patient units in England and Wales have in relation to the use of common law?

11. What policies and procedures do child and adolescent in-patient units in England and Wales have in relation to the obligation to inform the responsible social services department of when they intend to provide, or do provide, accommodation for a child for a consecutive period of three months or more (Section 85 and 86 of the Children Act)?

12. What are the characteristics of patients admitted to child and adolescent in-patient units under the Mental Health Act or Children Act in terms of risk factors, diagnoses and behaviours? How do these patients differ from other in-patients not subject to either Act?

13. What is the length of stay for patients admitted to child and adolescent in-patient units who are subject to the Mental Health Act or Children Act? How does this differ from the length of stay of other in-patients not subject to either Act?

14. For children and adolescents who are subject to the Mental Health Act or the Children Act, at 9 month follow up what is their legal status under the Mental Health Act /the Children Act?

15. For children and adolescents who are subject to the Mental Health Act or the Children Act and are referred to in-patient units, at 9 month follow up: what tier of the mental health service, if any, is the child or young person in contact with?

2.2 The Legal Framework

This section addresses some of the legal issues that arise in relation to the provision of mental health services for children and adolescents.

The issues to be discussed here are:

- Consent to treatment
- The informal patient
- Restriction of liberty
- Treatment of children and young people
- Availability of legal advice

The term child or children is used throughout this section to include a child, adolescent or children and adolescents. The focus of the project has been those under the age of 18 years, although people over 18 were included where they were resident on CAMHS in-patient units. Also, the personal pronoun he or him is used in a number of places in this section to stand for both genders. This approach has been adopted to reflect the conventional use of personal pronouns in the legislation or judgements referred to in the text.

2.2.1 Consent to treatment
A comprehensive consideration with advice for practitioners on the general issues around children and consent is given in 'Consent, Rights and Choices in Health Care for Children' (BMJ Books, 2001), in this section we will focus on issues directly relevant to mental health services.

2.2.1.1 Parental consent

It is important to obtain the appropriate consent for the treatment of informal patients, including those where an order under the Children Act 1989 is in force. For young people under the age of 18, it will be important to consider the exercise of parental responsibility.

The concept of parental responsibility set out in the Children Act 1989 emphasises that it is the duty of the person with responsibility to care for a child and ‘to raise him to moral, physical and emotional health’. It is a responsibility which exists for the benefit of the child and not for the benefit of the parent. One aspect of the exercise of parental responsibility is the duty to consider whether medical treatment is in the interests of the child and accordingly to decide whether to give or withhold consent.

2.2.1.2 The child’s consent

In relation to children aged 16 or 17 years section 8(1) of the Family Law Reform Act 1969 (HMSO, 1969) provides that the consent of that person ‘to any surgical, medical or dental treatment which in the absence of consent would constitute a trespass to his person shall be as effective as it would be if he were of full age; and where a minor has, by virtue of this section, given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian’.

The consent of a child of sufficient age and understanding, even though under 16, may be valid. There is no absolute parental right by which a parent can require their consent to be sought. Whether the consent of a child in any particular case is valid will depend on the circumstances, including the maturity and intellectual capacity of the child to understand the nature of the advice and what is involved in carrying out the treatment.

The House of Lords held in Sidaway v Bethlem Royal Hospital Governors [1985] AC 871 that there is no specific doctrine of informed consent where the clinician relies on the consent of a young person. However, the tests set out by the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 will be relevant. The consent should be obtained by a person who is competent to ensure that the relevant preconditions set out in the Gillick case are satisfied. These are that:

1. the child will understand the proposed treatment;
2. the physical or mental health of the child is likely to suffer without the treatment; and
3. the best interests of the child require the treatment.

In Re C [1997] 2 FLR 180, this was described as involving (i) comprehending and retaining treatment information, (ii) believing it, and (iii) weighing it in the balance to arrive at a choice.

2.2.1.3 Refusal of Consent

Although the Gillick decision might have been taken to imply that a ‘Gillick competent child’ could also veto any proposed treatment, the House of Lords has since said that this is not so: Re R (A Minor) (Wardship: Medical Treatment) [1992] Fam 11, [1991] 4 All ER 177, CA. According to their Lordships,
all that Gillick decided that a competent child could give a valid consent, not that such a child could
withhold consent. This approach was followed in Re W (A Minor) (Medical Treatment) [1993] Fam 64,
[1992] 4 All ER 627, CA, in which it was further held that section 8 of the Family Law Reform Act 1969
does not empower 16 or 17 year-olds to veto medical treatment. In most cases, the consent of a parent, if
available, will be sufficient and application to the court should not be necessary: Re K, W and H (minors)
(Consent to Treatment) [1993] I FLR 854. The clinician would wish to consider whether and how to
proceed in the face of opposition from a young person, and could seek an order of the court.

2.2.1.4 The Powers of Local Authorities

Where a care order is in force, the local authority has parental responsibility and may give consent. The
parent retains responsibility, and as a matter of good practice should still be consulted. If the child is
accommodated, the local authority does not automatically have parental responsibility, although the
parent may have delegated responsibility to the authority on the child's entry to accommodation.

2.2.1.5 The Powers of the Courts

In the absence of any responsibility an authority could seek a court direction under section 8 of the
Children Act 1989 or through the exercise of the inherent jurisdiction of the High Court.

The court can override both a 16 year-old and a 'Gillick competent' child's refusal to consent to treatment:
Re W (A Minor) (Medical Treatment) [1993] Fam 64, [1992] 4 All ER 627, CA. It is more likely that the
court would find that a child refusing essential treatment would not be 'Gillick competent'.

A decision by a parent to consent or refuse to consent to an operation may be overridden by the court. In
Re C (A Minor) (Wardship: Medical Treatment) [1990] Fam 26, [1989] 2 All ER 782, CA, it was held
that where a ward of court was terminally ill, the court would authorise treatment to relieve the ward's
suffering, but would accept the opinions of medical staff looking after the child if they decided that the
aim of nursing care should be to ease the ward's suffering rather than to achieve a short prolongation of
life.

Where a child has made an informed decision to refuse treatment but his condition has become life-
threatening or seriously injurious, certain statutory provisions - for example, where the child is subject to
a supervision order - would appear to give the child the right to override a court order for treatment.
However; the court may make an appropriate order: In Re J (a Minor) (Medical Treatment) [1992] 2 FLR
165, the Court of Appeal held that treatment of a minor for anorexia could be authorised against her
wishes, though the decision as to treatment was one for the doctor: (see also more recently Re M (child:
refusal of medical treatment) [1999] 2 FLR 1097).

2.2.2 The Informal Patient

Section 131 MHA provides that "a minor who has attained the age of 16, and is capable of expressing his
own wishes" can enter hospital for treatment for mental disorder on an informal basis. This section
confirms the entitlement of the informal child patient who is "Gillick competent" to make his or her own
decision as to whether to enter a psychiatric hospital as an informal patient. The agreement of the
person/persons with parental responsibility is not required. The common law position in the case of the
refusal of consent a Gillick competent child is that the child can be admitted to a psychiatric hospital, and
assessed and treated, despite their opposition, if the person/persons with parental responsibility consents
to the admission (See paragraph 2.2.2.3, Refusal of consent).
2.2.3 The Implications of the Mental Health Act 1983 and its Code of Practice

In some cases, it will be necessary to consider the position of children being treated under the Mental Health Act 1983. Reference should be made to the Code of Practice (March 1999) published pursuant to section 118(4) of the Act. The Code of Practice sets out guidance in respect of children and young persons under the age of 18.

2.2.4 Restriction of Liberty

2.2.4.1 The Statutory Basis - The Children Act 1989

The liberty of children may only be restricted in accordance with provisions set out in section 25 of the Children Act 1989, the Children (Secure Accommodation) Regulations 1991, and the Children (Secure Accommodation) No 2 Regulations 1991. The Children Act 1989 Guidance and Regulations, Volume 4, Residential Care (Department of Health 1991), referred to subsequently as 'Guidance', Volume 4 supplements the statutory provisions. Secure tracking units are not considered here, since at the time of writing the provisions relating to them had not come into force.

Secure accommodation is defined as accommodation provided for the purpose of restricting liberty (section 25(1) of the Children Act 1989). The Guidance recognises that the interpretation of this term is ultimately a matter for the court, but states: "It is important to recognise that any practice or measure which prevents a child from leaving a room or building of his own free will, may be deemed by the court to constitute 'restriction of liberty'. For example, while it is clear that locking a child in a room, or part of a building, to prevent him leaving voluntarily is covered by the statutory definition, other practices which place restrictions on freedom of mobility, for example creating a human barrier, are not so clear cut (Guidance, Volume 4, paragraph 8.10).

The use of secure accommodation - by local authorities in respect of children looked after by them and for children accommodated by health authorities, NHS trusts and local education authorities and children accommodated in residential care homes, nursing homes and mental nursing homes - is permitted only where the criteria in section 25 of the Children Act 1989 are fulfilled.

Local authorities have a duty under the Children Act 1989 to take reasonable steps designed to avoid the need for children within their area to be placed in secure accommodation (schedule 2, para 7). Guidance states: "Restricting the liberty of children is a serious step which must be taken only when there is no appropriate alternative. It must be a last resort in the sense that all else must first have been comprehensively considered and rejected, never because no other placement was available at the relevant time, because of inadequacies in staffing, because the child is simply being a nuisance or runs away from his accommodation and is not likely to suffer significant harm in doing so, and never as a form of punishment ... Secure placements, once made, should be only for so long as is necessary and unavoidable. Care should be taken to ensure that children are not retained in security simply to complete a pre-determined assessment or treatment programme" (Volume 4, para 8.5).

Section 25 provides that secure accommodation may not be used in respect of a child unless it appears:

- that if he absconds, he is likely to suffer significant harm; or
that if he is kept in any other description of accommodation he is likely to injure himself or other persons.

A child may only be kept in secure accommodation for as long as the relevant criteria apply. Furthermore, a child under the age of 13 shall not be placed in secure accommodation in any community home without the prior approval of the Secretary of State to the placement of that child, and such approval shall be subject to such terms and conditions as he sees fit (reg 4).

The maximum period a child may have his liberty restricted without the authority of a court is 72 hours, either consecutively or in aggregate in any period of 28 days (reg 10(1)). There is some relaxation of this restriction to meet difficulties caused by the period expiring late on a Saturday, a Sunday or public holiday (reg 10(3)).

2.2.4.2 Applications to Court

Where the local authority is looking after a child, only the local authority may make the application for secure accommodation. Where a health authority, health trust or private hospital are accommodating a child they may make the application, but not if the local authority is looking after that child. (Children (Secure Accommodation) (No2) Regulations 1991).

There is also a rare group of cases in which powers may be acquired under the inherent jurisdiction of the High Court to act in the interests of young people. In Re C (a minor) (detention for medical treatment) [1997] 2 FLR 180 it was held that the court had power to exercise the inherent jurisdiction to order the detention of a child over 16 for the purpose of treatment. It could also authorise the use of reasonable force as a necessary incident of treatment. In the particular case the child was a patient in a clinic which was not "accommodation provided for the purpose of restraining liberty". The best interests of the child required that she was treated in the clinic. There was a gap in the legislation between the Mental Health Act and secure accommodation, which the court was prepared to fill. This is an area which requires consideration in the advent of any legislative change.

2.2.4.3 Detention Under The Mental Health Act 1983

2.2.4.3.1 Assessment- Section 2

Any person, including a young person, may be detained under section 2 of the Mental Health Act 1983 for up to 28 days on the grounds that the person is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period, and that he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

2.2.4.3.2 Treatment- Section 3

A patient may be detained initially for six months, with renewal for six months and thereafter for a year at a time, on the grounds that:

the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital;
in the case of a psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of the condition; and

it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under the section.

2.2.4.3.3 Detention of In-patients

An authorised doctor may detain an in-patient under section 5(2) for up to 72 hours, on the grounds that an application for compulsory admission under section 2 or 3 should be made. Nurses may use section 5(4).

2.2.4.3.4 Detention under part III of the MHA

Sections under part III of the Mental Health Act can be used to detain young people whose cases are considered at Magistrates' Courts and Crown Courts.

2.2.5 Treatment of Children and Young People

If a child is detained under the MHA the provision of some medical treatments for mental disorder, most commonly medication, is subject to the safeguards contained in the MHA. These safeguards include the requirement that a second opinion doctor assess the reasonableness of the proposed treatment. Other treatments for mental disorder are not subject to these specific safeguards, and then only the common law applies. These treatments may include psychological and social therapies as well interventions such as control and restraint, seclusion, destimulation and time out. Practitioners should be aware that any method of treatment involving restraint or restriction of liberty could be subject to the provisions in section 25 of the Children Act 1989.

2.2.6 After-care

2.2.6.1 The Children Act 1989

Section 24 of the Children Act 1989 provides local authorities with powers and duties to prepare the young people they are looking after for the time when they cease to be so looked after, and the provision of after-care advice and assistance. They apply to any young person aged under 21 who ceases, after reaching the age of 16, to be looked after by a local authority or accommodated by any health authority, NHS trust or local education authority, or in any residential care home, nursing home or mental nursing home, provided that he or she was accommodated for at least three months. Before a local authority begins to look after a child, or as soon as practicable thereafter, it shall make immediate and long term arrangements for the placement of the child and for promoting his or her welfare; the Children Act 1989 Guidance and Regulations, Volume 4, Residential Care (Department of Health 1991). Section 23 CA requires local authorities to provide children with accommodation while they are in their care and to maintain them.

These provisions should ensure that a proper admissions policy is in place for every establishment and a care plan for every child. This should contain the criteria for admission, the objectives of the placement, the way in which those objectives will be achieved, outcome expectations and the proposed actions following the placement. That policy should provide a context for after-care, although the extent to which these provisions are implemented in practice is questionable.
2.2.6.2 The Mental Health Act 1983

Section 117 of the Mental Health Act 1983 establishes a duty to provide after-care for certain categories of detained patients. The Mental Health Act Code of Practice (Department of Health and Welsh Office, 1999), paragraph 27.6, places a duty on the Responsible Medical Officer "to ensure that a discussion takes place to establish a care plan to organise the management of the patient's continuing health and social care needs". Paragraphs 27.7 and 27.8 list who should be involved and emphasise the importance of those who are involved being able to take decisions as far as possible on behalf of their agencies. This guidance is rather weakly worded and a stronger and more enforceable duty should be considered.

2.2.7 Availability of Legal Advice

It is important that all agencies and individual professionals involved in managing the mental health of children and young people should have ready access to good legal advice. The availability of that expertise and the different professional perspective is an essential benefit to the provision of an appropriate service. Knowledge and understanding of the legal framework should lead to better informed decision-making on policy and individual cases. Ultimately better all-round understanding should enable us to bring about improvements in the legal system itself as well as the quality of care provided to young people with mental health problems.
3 METHODS

3.1 The multimethods approach

The use of legislation in young people with mental health problems is an issue that is under-researched. It is very important when research is undertaken to inform policy, that the methodology chosen is inclusive. One potential way to attempt to achieve this is to adopt a multimethods approach. This essentially involves using a number of complementary discrete methods to obtain data. Once the data have been collected, cleaned and analysed, the themes that have emerged can then be examined from different viewpoints to establish those that are common. For this project, a number of separate methods were adopted, each producing a separate set of results. Some of the methods produced purely quantitative data, while others had a more qualitative or descriptive element.

3.2 Survey of the Child and Adolescent Faculty of the Royal College of Psychiatrists

3.2.1 Introduction

There are numerous groups of professionals involved when a decision is made to use either the Children Act or the Mental Health Act on a young person. All would be a good source of information. A survey of opinion was designed to rapidly access information on what were the central issues for study, and to inform the design of the other parts of the project. Given the relative accessibility of child and adolescent psychiatrists as a population, it was decided to use them.

3.2.2 Database of names

We obtained an up-to-date list of the membership of the Child and Adolescent Faculty of the Royal College of Psychiatrists. Only practising consultants resident in England and Wales were selected. This amounted to 505 individuals.

A letter and response form were sent by first class post to these 505 consultants. The letter outlined the reason for undertaking the survey, as well as highlighting the importance of this part of the project and thanking them for their time. An information sheet about the project was also enclosed. A database was prepared in which details of those included in the survey were held, as well as an indication of whether or not they had replied.

3.2.3 Follow-up

A total of 3 follow-up communications were sent. These were sent at two-week intervals, following a common theme. In the first instance, the psychiatrist was thanked for their time, and reminded about the project, and the letter and reply form they had already received. The final mail out included copies of the original reply form and a project information sheet, in case the original had not been received, or had subsequently been misplaced. In total, 258 forms were returned, a response rate of around 50%.
3.2.4 The response form

The ethos behind this study was to keep the initial question as open as possible, and to generate qualitative data for analysis. In this way, the respondents were not led into certain replies, as they might have been had more closed questions been used. This method has the benefit of minimising bias.

The response form contained one question: ‘Briefly, what do you think are the main issues relating to the use of the Children Act and the Mental Health Act in children and adolescents in psychiatric settings?’ The response form, aside from the question, also contained a reply box, about one third of the A4 page. Beneath were contact details for the research team. The reply space was deliberately limited in order to keep the resulting text at a manageable level. Responses varied in size. Some respondents wrote one line. Some did not use the response sheet, and wrote a separate document, the longest of which was in the order of 7 pages long, containing anecdotes and case vignettes. The majority of respondents used between one third and two thirds of the response box, some using bullet points, some free text.

3.2.5 Non-responders

Once the data collection phase was completed, investigation was made into the non-responders. During this phase, no effort was made to collect more data, merely to establish what proportion of the non-responders could not be contacted, and thus could be eliminated when calculating the response rate for this study. In the first instance, a sample of 10% of non-responders was randomly selected. A further letter was sent to the non-responder, asking them to confirm that they were still in practice, and resident at the address we had in our records. There was also a section for another person to indicate where the member was, were they no longer resident. A follow-up telephone call was made to the number associated with the address held for the individual. Finally, mental health leads for the all regions were contacted, and sent a list of non-responders for their area. They were asked to confirm the details held, and supply new details if possible. Following these exhaustive investigations, it was found that a number of individuals could not be traced, representing 8.7% of the total non-responders. This figure was extrapolated to the entirety of the non-responder population, and the denominator for response rate calculations adjusted accordingly.

3.2.6 Data entry

Of the 258 forms returned, there were 240 replies that could be entered and coded, the remainder were blank or unusable. Each of the 240 responses was entered into a spreadsheet by a member of the research team, divided into 800 component statements.

3.2.7 Coding and analysing the data

A content analysis was applied to these individual statements. For the first part of this technique, the 800 statements were read and considered by two researchers, and a list of themes compiled. As the coders read, a new theme was added each time a statement could not be categorised into the themes already noted. In this way, a long list of themes was produced. The two researchers then negotiated, and reduced this exhaustive list of themes into 12 categories, with a total of 50 themes within those categories. Both then re-analysed the raw data, re-allocating each statement into one of these new themes. At the end of this process, any statements on which the two researchers did not agree were the subject of negotiation. This then produced the definitive division of the data into 12 categories with 50 themes.
3.3 NICAPS day census

3.3.1 Introduction
As part of the NICAPS project, a census of all child and adolescent in-patient units was conducted to describe in detail the patients residing in the unit on a particular day in the year. After consultation with professionals in the units, the 19th of October 1999, was chosen as the census day. When choosing the census day the research team were advised to avoid mid term breaks, particularly the summer break and to avoid Fridays due to the number of units that are only open five days a week. The census day questionnaires were then sent to the data contact person in each unit three weeks prior to the census day of October 19, 1999. The data contact person in each unit organised the completion of these questionnaires by the consultant or relevant key worker for each young person on the in-patient list on October 19, 1999.

3.3.2 Question items

- The questionnaire included the questions under the following sections:
- Patient information (age, ethnicity, source of referral, place of patient at time of referral, source of funding)
- Mental Health Act and Children Act status at the time of admission
- Diagnosis
- Paddington Complexity Scale (Yates et al, 1999)
- Treatment
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers et al, 1999)

The Mental Health Act and Children Act Status questions were included in order to describe the use of legislation in these in-patient settings.

The diagnostic list was derived from the Paddington Complexity Scale and the tenth edition of the International Classification of Diseases and Related Health Problems (ICD-10 (WHO, 1992)). The Paddington Complexity Scale was developed to measure both clinical and environmental complexity factors and was included to identify psychosocial complexity factors associated with the in-patient population and allow comparison with the complexity factors the Audit commission identified in children and young people who presented to CAMHS professionals.

The HoNOSCA was designed primarily as an outcome measure to measure change in patient problems over time. In a previous national survey of Child and Adolescent Mental Health Services (CAMHS), the Audit Commission adopted the scale to obtain a snap shot of the range and severity of problems presenting to CAMHS professionals. The scales cover 15 categories of problems, each with five levels of severity ranging from 0 indicating no problem to 4 indicating severe to very severe problems. The glossary for the HoNOSCA score sheet was attached to the questionnaire. A question about whether the rater had been trained to use the HoNOSCA was also included.

3.4 NICAPS 6-month Activity study of units
3.4.1 Introduction

A 6-month prospective study was set up to collect information on the referrals, admissions to, and discharges from, child and adolescent in-patient units across England and Wales over a specified period that ran from the 31st July to the 31st of December 1999.

3.4.2 Multifunction nature of the questionnaire

This tool was particularly difficult to design as it served a number of functions. The referral, admission or discharge had to occur within the specified period. So for some the referral stage might only apply while for others the other two stages (admission and discharge) might also apply. To ease completion of the questionnaire it was agreed that the data should be collected on a case by case basis for whatever stage applied during the six-month period. This meant that if a patient was referred and then subsequently admitted staff could complete the relevant section of the questionnaire as it applied at different times within the specified period but that only one questionnaire was completed for that case. Only discharge data were analysed as part of the CAMHA-CAPS project.

3.4.3 Follow-up

The tool was also designed with the purpose of conducting a follow-up study for a cohort identified from the resulting data. Items were included on the Mental Health Act and Children Act in each section to allow for the identification of young peoples’ legal status at the time of referral and follow-up of cases where the Mental Health Act and/or Children Act applied during their stay at the unit.

3.4.4 Contents

The following topics were included in each of the four elements of the questionnaire:

**Referral element:** date; emergency status; Mental Health Act /Children Act status; who referred the patient and where the patient was at the time of the referral.

**Assessment element:** date; reason for not admitting if applicable

**Admission element:** date; diagnosis and consent

**Discharge element:** date of admission and discharge; diagnosis; abuse history; Mental Health Act/Children Act status; reason for delayed discharge if applicable; follow-up arrangements and patients destination following discharge.

3.4.5 Non responders

For each questionnaire all non-responders were followed-up by phone and post from January to September 2000.

3.5 Nine month follow-up of discharged patients with Children Act or Mental Health Act status
3.5.1 Introduction

As described in 3.4 above, part of the NICAPS project collected data detailing all referrals to, admissions to and discharges from all child and adolescent psychiatric in-patient units in England and Wales, for the period 1st July 1999 to 31st December 1999. Part of the ‘activity study’ questionnaire collected information on patients discharged, upon whom a section of either the Children Act or the Mental Health Act had operated. Apart from the cross-sectional analyses available for these data, we also had the opportunity to use this identified cohort of individuals to obtain more data about how both of the Acts are being used. We used the discharge population as the basis for identifying this cohort, as this was the cleanest and most complete part of the data. It was decided to conduct a follow-up survey on this cohort, on a date 9 months post-discharge. Results from the faculty survey as well as an investigation of the literature were the starting points for the questionnaire, which went through repeated iterations and expert panel commentaries before being finalised and sent to respondents.

3.5.2 Developing the questionnaire

The starting point for the follow-up questionnaire was the original 6-month ‘activity study’ questionnaire, to establish what information we would already have about these patients. Next an examination of literature was carried out, looking at the two Acts and what kind of information would be useful to have from this survey. Following instrument development and piloting we generated a separate questionnaire for those with status under the Children Act and those under the Mental Health Act.

3.5.3 Question items

The question items included in the questionnaires went through a long development process before the questionnaire was finalised and sent to recipients. Certain data were crucial to subsequent analyses, and the early stages essentially centred on ensuring that all of these were included, and that the resulting data would be of a high quality. The questionnaire went through 9 draft versions, and 3 iterations before finalisation.

As discussed above, it was decided to produce two questionnaires, one to collect data on the use of the Mental Health Act, the other on the Children Act. During the development stage, there were therefore, three classes of question items: 1) Those that appeared on both questionnaires, 2) Those that appeared only on the Mental Health Act questionnaire and 3) Those that appeared only on the Children Act questionnaire. Of these, the common section was longest, with the extra Mental Health Act section very short, the Children Act section long and complex. The sections are as follows:

Common items

1. Has the patient been readmitted
2. Services patient first referred to post discharge
3. All services patient has been in contact with
4. Patient’s current whereabouts
5. Details of any new in-patient unit/ adult ward/ paediatric unit
6. Reason for any delay in discharge
7. Reason for discharge
8. Sections of the Children Act applying
9. Sections of the Mental Health Act applying
10. Other statutes applying during stay
11. High court orders in place

MHA items

1. Referring clinician involved in decision to use the MHA
2. Purpose of using the MHA
3. Factors influencing use of the MHA
4. Who was the nearest relative
5. If not closest natural relative, what was the reason

CA items

1. Referring clinician involved in decision to use the CA
2. Purpose of using the CA
3. Factors influencing use of the CA
4. Did patient receive treatment
5. Consent by procedure
6. Consent given by whom
7. Consent obtained by whom
8. Was the person obtaining consent capable of administering the procedure
9. Dispute as to consent
10. Consent considered by court
11. Who was involved in dispute
12. Sides in the dispute

3.5.4 Format and design

The design of the questionnaires was similar to the original NICAPS questionnaires, so as to maintain a sense of continuity, through the new phase of data collection.

3.5.5 Identification of the cohort

This questionnaire was designed to collect data on those discharged during the study period who had Children Act or Mental Health Act status. It was therefore necessary to identify this cohort. All 6-month activity study questionnaires were checked, and those patients with CA or MHA status identified. Details were entered onto a spreadsheet, along with that patient's nine-month follow-up date

3.5.6 Sending the questionnaires

Questionnaires were sent to the individual named as completing the original activity study questionnaire. Reminder letters were sent at approximately 3-week intervals, followed by telephone calls. Where necessary, replacement questionnaires were sent. Data were entered directly into SPSS.
3.6 In-patient consultants' knowledge, attitude and practice of legislation use and additional issues

3.6.1 Introduction

An important part of the project proposal was the need to investigate the knowledge, attitude and practice of consultant child and adolescent psychiatrists, in relation to the use of the two Acts, and additional issues such as consent to treatment. A questionnaire was designed to collect this data.

3.6.2 Developing the Questionnaire

The design of this questionnaire was again complex due to the nature of some of the questions that we needed to ask. It was necessary to evaluate the knowledge of the consultants, without the questionnaire seeming too much like a test. A balance needed to be struck between obtaining good quality data and not putting the psychiatrists off, resulting in a poor response rate. The questionnaire was sent to all consultant child and adolescent psychiatrists working in in-patient units. As with the follow-up questionnaire, this one went through many versions prior to being sent out. The CAMHA-CAPS expert panel was used to finalise the question items.

3.6.3 Questions

The questions were divided into 4 sections:

1. Demographic questions, nature of the respondent's work and section 12(2) status.
2. Questions about guidelines in their practice
3. Questions asking for the respondent's attitude to and opinion of the Children Act, the Mental Health Act, and other aspects of their work
4. Questions on knowledge of legislation and additional areas of interest.

3.6.4 Identifying the sample population

The NICAPS master spreadsheet of in-patient unit details was used to identify all consultant in-patient psychiatrists.

3.7 Site visits to secure and forensic in-patient units

3.7.1 Introduction

The aim of this part of the study was to apply the NICAPS service standards to forensic and secure in-patient facilities. These standards and their development are discussed in detail in the companion NICAPS report. They will be summarised here.
3.7.2 Aims

We had two aims in developing the standards. First, to generate a broad range of standards to encompass all aspects of service provision relevant to in-patient child and adolescent psychiatric services, and second, to contribute towards the development of a definitive set of service standards that could be used in local service evaluations.

We intended the standards to represent 'ideal' practice and as such the level of service they described was not expected to be found universally. Any deficiencies between current practice and ideal practice would indicate a potential area for intervention. The size of this deficiency and the importance of the statement are factors which allow interventions to be prioritised. The aim of any standards-based service evaluation would be to gradually improve the quality of services using the principles of the clinical audit cycle.

A method for developing a set of “descriptors” for assessing services for people with depression has been recently described (Clinical Standards Advisory Group 1999). This relied on consultation with stakeholder groups and a literature search. Our methodology built on similar methods of combining evidence with expert opinion (Campbell et al. 1999) based upon the RAND/UCLA appropriateness method (Brook et al 1986).

3.7.3 Development process

The development involved four main stages: a literature review; consultation with an expert panel; editing and refining; and piloting in the field. We used information from the expert panel to supplement information from the literature review. This was done in an attempt to ensure that the standards covered the range of important issues, that they were up-to-date and that they took account of the views of relevant staff.

3.7.3.1 Literature review

Our review included published health services research, best practice guidelines and consensus statements produced by professional bodies and policy and guidance from the Department of Health. We added to the results of a systematic electronic literature search of relevant databases references obtained from consultation with the wide network of people involved in the project. We identified about 600 statements relating to best practice that formed the basis of the first draft of the standards.

We classified general statements as standards, and more specific statements as criteria within these. Each standard has typically four or five criterion statements. For example, a standard might state that units are parent-friendly, and a criterion statement might state that parents should be able make tea, coffee or soft drinks.

3.7.3.2 Expert panel

Each major professional group was represented in the 36 members of the NICAPS expert panel. A specialist solicitor was employed as a member of the research team and as a member of the expert panel because legal safeguards are so important for this patient group. We asked the experts to comment on each statement of best practice and to recommend new statements to fill any gaps in the content. We then incorporated all comments and listed any contentious or conflicting comments separately.
3.7.3.3 Editing and Pilot visits

This draft was then reduced using editing criteria which included: redundancy due to repetition; provenance (the evidence base of the statement); ease of measurement; achievability (how achievable statements were); local adaptability (how adaptable statements were to variations in local practice); acceptability; and relevance to the service. These techniques are based on previous work (Baker and Fraser, 1995).

These standards were used to inform the study generally and were also adapted into data collection tools for use on site visits. These included eight interview schedules, a checklist for documents and a checklist for the environment and facilities. A one-day visit was arranged to pilot the standards-based schedules and checklists. Subsequent editing resulted in a final set of around 450 statements arranged as 64 standards and their various criteria which were used as the final version for this study.

3.7.3.4 Derivation of the interview schedules and checklists

The service standards were adapted into interview schedules and checklists for use in the site visits. We identified data sources and methods most appropriate for each standard. For example, to collect data on the facilities we designed a checklist to use on a tour of the premises, whereas to collect data on patients’ involvement in their treatment decisions we asked patients themselves in a short interview. All visits were conducted in a single day. In all, seven data collection tools were developed including interview schedules for the consultant psychiatrist, charge nurse, head teacher, social worker, patients, trust management, and a checklist for the site inspection. All schedules and checklists were piloted.

There are problems using service standards as a purely confirmatory tool. For example, by merely recording if a standard has been attained or not, important information about why this has happened might not be noted. Similarly, there would be no opportunity to learn about practice which was not anticipated within the structure of the standards. To help address this, reviewers recorded interviewees’ comments after each standard, in addition to their routine coding of answers. Reviewers also asked about changes interviewees would like to make to improve the service the unit provided.

3.7.3.5 Extra items for secure and forensic visits

The original service standard-derived interview schedules were designed to be used on general child and adolescent in-patient units. As the units for this part of the study have a rather different client group, the schedules were not entirely appropriate. Rather than removing or altering existing schedule items, it was decided to develop additional questions directed at those issues pertinent to this specialised form of service. A review of literature on forensic and secure issues revealed certain key issues:

1. Compatibility between therapy, containment and schooling
2. Safety of the environment
3. Safety impact of staff training
4. Organisational isolation
5. Preparation of the patients for independent living

Questions were developed on these issues, and amended following comments from members of the research team and the CAMHA-CAPS expert panel.
3.7.4 Sampling of sites

Since there are only 2 forensic units and 2 secure units in England and Wales, all were visited. For reasons of expedience and time, the two Huntercombe Manor Intensive Care Units were treated as one unit.

3.7.5 Selection of co-visitors

Co-visitors were chosen for their experience in the area of forensic and secure CAMHS in-patient services. Three consultant in-patient psychiatrists were used, and one solicitor.

3.7.6 The visit procedure

A week before the visit, units were sent a letter giving a general explanation of the aims of the visit, a set of draft service standards and two interview schedules to give an idea of the kind of questions they would be asking. Questionnaires were sent in advance to the units for the recording of patients’ and parents’ consent to be interviewed. The following advice was given.

- Each visit would take a day to carry out.
- The researchers would arrive between 0900 and 1000.
- Patient consent forms would be collected and checked.
- Interviews would begin
- Co-visitors would meet for lunch, and discuss progress
- Remaining interviews/ other checks would be carried out after lunch
- Researchers would meet prior to departure to complete visit summary sheet.
- An example of a visit timetable can be seen in table 3.1

Table 3.1: Sample visit timetable

<table>
<thead>
<tr>
<th>Time</th>
<th>Co-reviewer</th>
<th>CRU team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30am – 10.00am</td>
<td>Meet at the unit, collect necessary consent forms for patient interviews</td>
<td>Meet at the unit, collect necessary consent forms for patient interviews</td>
</tr>
<tr>
<td>10.00am – 10.30am</td>
<td>Trust manager</td>
<td>Trust manager</td>
</tr>
<tr>
<td>10.30am – 11.30am</td>
<td>Consultant 1</td>
<td>Consultant 2</td>
</tr>
<tr>
<td>11.30am – 12.00am</td>
<td>Site inspection</td>
<td>Complete organisational diagram</td>
</tr>
<tr>
<td>12.00am – 1.00pm</td>
<td>Charge nurse</td>
<td>2 Staff nurses</td>
</tr>
<tr>
<td>1.00pm – 1.30pm</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>1.30pm – 2.00pm</td>
<td>Head Teacher</td>
<td>Head Teacher</td>
</tr>
<tr>
<td>2.00pm – 4.00pm</td>
<td>Meet patients</td>
<td>Meet patients</td>
</tr>
<tr>
<td>4.00pm – 4.30pm</td>
<td>Psychotherapist and Consultant psychologist</td>
<td>Family therapist and Occupational therapist</td>
</tr>
<tr>
<td>4.30pm</td>
<td>Complete “visitor’s summary” and Return</td>
<td>Complete “visitor’s summary” and Return</td>
</tr>
</tbody>
</table>
3.8 Stakeholder consultation day

3.8.1 Introduction

While the faculty survey was a useful way to obtain opinion from psychiatrists quickly, it nevertheless represents only the views of one profession working in this area. It was felt that to extract the central issues for the study to enable policy decisions in this area to be informed by the study, the views of all types of individuals working in this area would be needed. To this end, we held a day of discussions, using a focus group methodology (Morgan, 1997a) to extract central issues and to help to formulate recommendations.

3.8.2 Themes

Six main themes were identified from the faculty survey and from study data:

1) Issues around the use of the Children Act
2) Joint working among professionals
3) Guidelines on which Act to use
4) Parental responsibility
5) Issues around the use of the Mental Health Act
6) Consent and competence

3.8.3 Participants

Focus group methodology suggests a group of between 6 and 12 individuals is ideal for a task such as this (Morgan, 1997a). It was decided to aim for groups of 9-10 people, thus allowing for wastage of 40%, and still leave a big enough group to fulfil the methodological requirements. The following groups of stakeholders were identified:

1. Psychiatrists
2. Therapists
3. Social Workers
4. Nurses
5. Representatives from service-user organisations
6. Solicitors
7. Academics

Since a maximum of 30 individuals was required (10 persons per group, 3 groups in the morning session, 3 in the afternoon), it was decided to use a purposive sampling method, that is to say identify those people best suited to participating in the day, and invite them (Stimson, 1998). Where someone declined the invitation, a substitute was invited. Thus process continued until all places had been filled.

3.8.4 Structure of the day

Following registration, the participants were given a short introduction by Richard White, legal advisor to the project. The day was split into two parallel sessions, with a feedback session for the entire group after
Each of the parallel sessions took place before lunch, the other after, with a final plenary session before the close. Each parallel session saw the three sub-groups consider the issue allocated to them, guided by a moderator (Morgan, 1997b). The session itself was divided into two 45-minute parts, with a coffee break between. In the first 45 minutes, the group considered their issue, and those themes the faculty survey had raised. The outcome was a list of themes that the consensus of the group considered to be those central to that issue. This was the ‘member validation’ phase. After the break, the group task was to spend that 45-minute period formulating a list of recommendations, based on the themes from the member validation phase. Following the recommendation phase, all groups joined up for the feedback session. During this, one member of each group relayed the outcome of the member validation phase and the recommendation phase to the group, followed by questions from the floor. After the second feedback session, a plenary session with a more open format was held and all findings were considered by the plenary group.
4 RESULTS

4.1 Introduction

The results for the project are presented here by methodology, following the structure in the previous sections.

4.2 Survey of the child and adolescent faculty of the Royal College of Psychiatrists

In all, 258 questionnaires were returned, a response rate of 54%. This number of responses included 18 replies that were blank or otherwise considered unusable. Further investigations indicated that the addresses obtained were incorrect for about 10% of cases, and the denominator was adjusted to 480 members. The 240 useable replies provided 800 individual statements.

A total of 50 themes were derived from the statements and formed the basis for the coding frame. There was general consensus between the research team regarding the coding, with any areas of disagreement discussed until consensus was reached. Table 4.1 describes the range of themes and frequency of their inclusion in the members’ responses. Where one member had raised a theme more than once, only the first incidence was recorded.

Table 4.1: Range of themes reported and frequency of psychiatrists reporting them

<table>
<thead>
<tr>
<th>Theme</th>
<th>Count</th>
<th>Percentage of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing between the Children Act and the Mental Health Act</td>
<td>75</td>
<td>31</td>
</tr>
<tr>
<td>General issues around consent to treatment</td>
<td>57</td>
<td>24</td>
</tr>
<tr>
<td>General issues around Social Services Departments</td>
<td>46</td>
<td>19</td>
</tr>
<tr>
<td>The stigma associated with using the Mental Health Act</td>
<td>44</td>
<td>18</td>
</tr>
<tr>
<td>Young peoples’ rights in conflict with parental consent</td>
<td>42</td>
<td>18</td>
</tr>
<tr>
<td>General negative comments about the Children Act</td>
<td>37</td>
<td>15</td>
</tr>
<tr>
<td>General negative comments about the Mental Health Act</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Positive aspects of the Mental Health Act regarding treatment and detention</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Safeguards in the Mental Health Act</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Child protection issues</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>General issues around training</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>The medicalisation of social problems, and vice versa</td>
<td>21</td>
<td>9</td>
</tr>
</tbody>
</table>

*Note: only themes recorded by more than 20 members are reported.*
4.3 NICAPS day census

Data were collected from 71 (89%) of the 80 units. The results show that in total, 663 patients were in-patients on these units on the census day.

Of the 663 in-patients, 536 were informal, and 127 detained (19%). Patients were included in the 'detained' category if they had one of the following pieces of legislation in force on them:

- Children Act section 25 (Secure Accommodation Order)
- Mental Health Act section 2 (Admission for assessment)
- Mental Health Act section 3 (Admission for treatment)
- Mental Health Act section 4 (Emergency admission)
- Mental Health Act section 5 (Admission of existing patient)
- Mental Health Act section 35 (Remand to hospital for assessment)
- Mental Health Act section 36 (Remand to hospital for treatment)
- Mental Health Act section 37 (Hospital order for convicted persons)
- Mental Health Act section 38 (Interim Hospital Order)
- Mental Health Act section 41 (Restriction of discharge)
- Mental Health Act section 44 (Committal to hospital)
- Mental Health Act section 47 (Convicted prisoners removed to hospital)
- Mental Health Act section 48 (Other prisoners removed to hospital)
- Mental Health Act section 49 (Restriction of discharge of prisoners)
- Mental Health Act section 53 (Non-criminal prisoners)
- Mental Health Act section 136 (Mental disorder in public places)

These sections all enable the individual to be detained against their wishes. In addition, by S.31 of the Children Act (Care Order) the Local Authority acquires parental responsibility for the young person, and they can then give consent for admission and treatment subject to consultation with the person having parental responsibility. Since it is not clear from this data if the existence of the Children Act section is incidental to the admission, these cases were excluded from the detained group.

There is a final group that must be considered- those on the unit by parental consent. While not being formally detained, they may nevertheless be on the unit against their wishes. This is an important group which our methodology did not allow us to investigate. Consent is considered in more detail in the discussion.

The following 3 figures (3.1 to 3.4) show percentages of patients in each admission status category. It must be remembered that the comparison groups are different in size (the informal group about 4 times larger than the detained group). By using percentages, group effects can be seen more easily. The first three graphs show age group, gender and principal diagnoses by admission status.
The age bands were chosen because these are legally significant ages, in terms of consent and rights. The majority of the informal group are under 16, with just over a quarter aged 16 or 17, and a very few over 18. By contrast, the detained group are largely 16 or 17 (over half), with a quarter each under 16 and over 18. A $\chi^2$ test showed that the difference between the age bands for the informal and detained populations was statistically significant ($\chi^2 = 83.42$, 2df, $P < 0.001$).

The detained population was equally divided between the genders, with males only slightly more likely to be detained than females. A $\chi^2$ test showed that the difference between gender for the informal and detained populations was significant ($\chi^2 = 6.23$, 1df, $P = 0.013$).
The diagnosis shown here is the principal or probable diagnosis, so no account is made for co-morbidity. Diagnostic categories with very small numbers are excluded. The informal patients show a high propensity for eating disorders and mood disorder. Nearly half of the detained patients had a diagnosis recorded as schizophrenia, and over 15 percent personality disorder. A $\chi^2$ test showed that the difference between the diagnoses for the informal and detained populations was statistically significant ($\chi^2 = 139.75$, 16df, $P < 0.001$).

The differences between the informal and detained populations led to further analysis of the detained population, to investigate potential gender and age effects on diagnosis.

The previously observed high level of schizophrenia in the detained population is primarily found in the male patients and there were a number of females with personality disorder.
Having identified the detained population, this was further divided into sub groups of those detained under section 25 of the Children Act and the various sections of the Mental Health Act.

Table 4.2: Frequency of the use of section 25 of the Children Act and the Mental Health Act by unit speciality

<table>
<thead>
<tr>
<th>Unit speciality</th>
<th>Eating disorder</th>
<th>Mental Health Act</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>General psychiatric</td>
<td>0</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Learning disability</td>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Secure unit</td>
<td>0</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>119</td>
<td>127</td>
</tr>
</tbody>
</table>

The above table shows the Act used for detention by unit speciality. Of the 127 detained patients, only 8 were under section 25 orders. All of these were resident in learning disability units. The majority of the MHA patients were in general psychiatric units. The high numbers of sectioned patients in forensic and secure units was in line with expectations.
An important part of the project was to find absolute levels of the use of the Children Act and the Mental Health Act, for all sections.

Figure 4.6: Frequency of the use of the Children Act

In the census day population of 663, a total of 74 patients (11%) are subject to an order under the Children Act. It is possible for a section 25 secure accommodation order to be in place concurrently with other orders, for example a section 31 Care Order. None were found in this data, however.

Figure 4.7: Frequency of the use of the MHA

There were 138 patients detained or treated under sections of the Mental Health Act on the census day, comprising 21% of the total in-patient population. The majority were detained under section 3, with a number under section 2 and a smaller number under other sections.
It should be noted that there are discrepancies in the frequencies of some sections in both the Children Act and Mental Health Act, compared with the numbers given in table 3.2. This is because the above 2 graphs include data extracted from the 'other' sections of each dataset, and added to the section total where appropriate. There was a sub-group of patients (12) to whom a section of both Acts applied.

4.3.1 Patient information

Apart from demographic data, the day census questionnaire also included two sections designed to give more detailed information about the patient. The first of these used HoNOSCA (Health of the Nation Outcome Scale for Children and Adolescents), the second the Paddington Complexity Scale.

Figure 4.8: Moderate or severe HoNOSCA scores by admission status

The in-patient population can be seen to exhibit high levels of moderate or severe HoNOSCA scores in many of the categories. Breaking down the population into those detained and those with informal status, a few differences are evident, notably with regard to hallucinations delusions and disruptive, antisocial or aggressive behaviour, and self care (higher in the detained group); with emotional problems higher in the informal group.
The Paddington Complexity Scale was used to measure the complexity and variation of psycho-social factors associated with morbidity in young people. Individuals can have more than one of the above categories. Some of the key indicators are presented here. The level of complexity, for these factors, is considerably higher in the detained population than in the informal population.

**Ethnicity**

A variable on the original census day questionnaire recorded the ethnic origin of the patient. The following graph shows this for the population by admission status.
Although the distributions are very similar, the proportion of ethnic minority in-patients is higher for detained patients (20% compared with 15%; a $\chi^2$ test showed no significant difference, $P = 0.104$). This compares with a level of 10% for the general population (all ages). Looking at secure and forensic services, the non-white population rises to 22%.

### 4.4 NICAPS 6-month activity study of units

The NICAPS 6-month activity study collected data from 75% of units for referrals, admissions and discharges for the period 1st July to 31st December 1999. A cohort of this population was isolated for analysis: those discharged patients with Children Act or Mental Health Act status during their stay. In all, 816 discharges were made, 123 with CA or MHA status (15%).

The use of the Acts for this cohort can be broken down as follows.

**Figure 4.11: Use of the Children Act (n = 43)**

By far the largest group have section 31 Care Orders in place. Note that only two patients had a section 25 Secure Accommodation Order in force. One of these was resident in a general psychiatric unit, one in a secure unit, unlike the findings of the day census data analyses. It should be noted that Secure Accommodation Orders and Care Orders can be in force concurrently.

The use of the Mental Health Act can be broken down as follows.
Sections 2 and 3 dominate the use of the Mental Health Act, with a smaller number of other sections. Section 23 of the MHA, not previously mentioned, covers discharge.

Age band and gender were distributed fairly evenly.

Focussing on the under 16 group, the distribution across the diagnostic categories reveals that there are very few under 14's (13). It is noteworthy that up to the age of 13, conduct disorder is the most prevalent diagnosis (1/2), but from 14 onwards, this switches to schizophrenia (8/34). Diagnoses were as follows.
When diagnosis is analysed by gender, the male group is dominated by schizophrenia (23/59). The females show highest levels in mood (affective) disorders (14/63) closely followed by schizophrenia (12/63).

Finally, the length of stay for CA/MHA status patients was as follows.

This can be usefully compared with those patients without CA/MHA status.
Broadly, those patients with CA/MHA status tended to stay longer than those without. The respective means were 100 days for non-CA/MHA patients, and 210 days for those with CA/MHA status. A Kruskall-Wallis test showed that this difference was statistically significant ($\chi^2 = 14.05, 1$df, $p<0.001$).

### 4.5 Nine month follow-up of discharged patients with Children Act or Mental Health Act status

The cohort identified from the 6-month activity study gave 17 discharged patients with Children Act status, and 75 with Mental Health Act status. The initial mail out of questionnaires showed the following distribution of the sections of the Children act and the Mental Health Act:

**Figure 4.17: Mail out data: Children Act by section**
Questionnaires were sent for all patients in this cohort, with 16 of the CA questionnaires returned (94%) and 69 of the MHA forms (92%).

The data gathered from the follow-up of this cohort showed the following distribution of the use of the Children Act and Mental Health Act at discharge, and then at 9 months post discharge.
Data were collected on services and agencies accessed by patients post-discharge. The following graphs show the services the patient was first referred to (Figure 4.21), the second all services accessed (Figure 4.22). It should be noted that the categories are not exclusive, i.e., a patient could be referred to more than one.

The next graph looks at all referrals following discharge, where data were available.
As part of the follow-up process, we ascertained where those discharged were 9 months post discharge. The graph below shows that the vast majority are living at the family home, with small numbers in other locations.

Figure 4.23: Patient's place of residence at 9 months post discharge (all patients)
One important theme was delay in discharge. With units operating at or near full capacity, any delay in discharge will occupy a bed that might be needed by another patient. The following graphs show prevalence of reasons for delayed discharge, and the reason that the patient was discharged.

Figure 4.24: Reason for delay in discharge (all patients)
Delay due to lack of community follow-up may have a knock-on effect: if a unit is unsure as to whether they will be able to discharge a patient when the time is appropriate to do so, they may be more reluctant to accept some patients in the first place.

Figure 4.25: Frequency of reason for discharge

That patients were being discharged because a bed was needed could be cause for concern. Patients being discharged because of unsuitability or aggression could also be worrying, unless those patients are being transferred to a more appropriate location.

Apart from describing these patients and investigating what happened to them post discharge, this study also looked back at the use of the legislation. The following graphs shows the reasons given for using the two Acts. Again, these categories are not exclusive.
Figure 4.26: Reason for using the Children Act

Figure 4.27: Reason for using the Mental Health Act

Figure 4.28: Relationship of 'nearest relative' to patient

The denominator for these two groups is very different, and the small numbers involving the Children Act preclude close analysis. The prevention of self-harm is the primary motivation for both Acts, but it is interesting to note the difference in the level of prevention of harm to others, it being much higher for the MHA than the CA.

The next section deals with the 'nearest relative', relevant to the Mental Health Act only. The first graph shows that in the vast majority of cases, the parent is the 'nearest relative'.

Figure 4.28: Relationship of 'nearest relative' to patient
No patients had a court appointed nearest relative. The next graph shows, for those occasions where the 'nearest relative' was not the closest blood relative, the reason for this. It should be noted that the categories below are not exclusive. In total, there were only 10 cases where the nearest relative was not the closest blood relative. In one case, a section 31 CA Care Order was in place, and the Local Authority would thus, under section 27 MHA become nearest relative.

Table 4.3: Why the closest blood relative is not 'nearest relative'

<table>
<thead>
<tr>
<th>Reason nearest relative not closest relative</th>
<th>count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to contact closest relative</td>
<td>3</td>
</tr>
<tr>
<td>Sexual offences/ allegations of abuse</td>
<td>3</td>
</tr>
<tr>
<td>Closest relative unavailable</td>
<td>2</td>
</tr>
<tr>
<td>Closest relative incapacitated</td>
<td>2</td>
</tr>
<tr>
<td>Closest relative likely to use power to apply for discharge against welfare</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

Consent is an issue that is central for informal patients, and those with a Children Act status. The Children Act questionnaire gathered extensive data on consent: what kind of consent was obtained for various procedures; who obtained consent; from whom consent was obtained; and whether the person obtaining consent was qualified to perform the procedure. This latter point is important due to notions that consent must be informed -- if the individual obtaining the consent is not capable of performing the procedure, they may not be able to give sufficient information about it. The following graphs do not include all treatments offered, only those where consent would be an issue. Again the low numbers preclude any further analysis.

Figure 4.29: Form of consent by type of treatment
There seemed to be a high use of verbal consent, with a few occasions where written consent was obtained. On a few occasions, no consent was obtained.

**Figure 4.30: Person giving consent by type of treatment (one consentor)**
Figure 4.31: Person giving consent by type of treatment (multiple consentors)

Figure 4.32: Person obtaining consent by Treatment type
Table 4.4: Is the person obtaining consent qualified to perform procedure?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Drugs</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Cognitive therapy</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Behavioural therapy</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>CBT</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Group therapy</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Family work</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Parent work</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Social skills</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Creative therapies</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>OT</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

The level of consent being obtained by those not qualified to carry out the procedure was generally low, and for less crucial procedures. It is recognised that in some areas it is difficult to define 'qualified' for some procedures, as there is no recognised accreditation system. For this question, we relied on the respondent to make this judgement.

There are some items that were included in the questionnaire that elicited such a low response rate that they are dealt with here, in text form.

- In only one case was a statute other than the Children Act and Mental Health Act used during residence.
- On only one occasion did the High Court use its inherent jurisdiction.
- There was one case where a dispute arose over consent. That case came before the Court, and the patient was in favour of the treatment.

4.6 In-patient consultants' knowledge, attitude and practice of legislation use and additional issues

The questionnaire was sent to all (87) child and adolescent in-patient consultants. Of these, 11 were excluded since they had retired. Where a new consultant had entered post, they were added to the list. In total, 51 questionnaires were returned, 67% of the adjusted denominator.

4.6.1 Demographics

Of the 51 respondents, 14 (28%) were aged between 31 and 40, 23 (45%) were aged between 41 and 50, and 14 (28%) were aged over 50. Two thirds (34) of them are male, one third (17) female.

Four percent said they were not up to date with changes in the law regarding children's mental health, 37% said they were, while 57% said they partly were.
The following figure shows how consultants rated their access to legal advice.

**Figure 4.33: Consultants' access to legal advice rated**

Examining section 12 MHA approval, 41 (80%) were approved, 10 (20%) not. Of those approved, the following shows the frequency with which they used their section 12 status.

**Figure 4.34: Frequency of consultants' use of S.12 approved status**

Figure 4.35 shows the length of time that the respondent has been a consultant psychiatrist. Figure 3.36 shows the length of time they have been the consultant at their present unit.

**Figure 4.35: Length of time as consultant**
The next three figures describe the consultants’ legal training and court work. The first shows how many days training they had had on the law relating to children's mental health in the last two years. The next two show the number of times the respondent has appeared in court in their professional capacity in the last year, and the number of times they have prepared a report for court, also in the last year.

**Figure 4.36: Length of time as consultant at current unit**

**Figure 4.37: Consultants' number of days training in children's MH law in the last 2 years**
Figure 4.38: Number of consultants’ court appearances in last year

Figure 4.39: Number of court reports prepared by consultants in last year
Most consultants appeared to have little to do with the law, with a relatively small number acting frequently.

Respondents were asked if they had taken part in a Mental Health Act review tribunal. 47% had not, while 53% had done so. One respondent had acted as a Mental Health Act Commissioner. When asked if a police check had been carried out on them prior to their beginning work at their present unit, 63% answered that it had, 16% did not know, and 22% replied that it had not.

### 4.6.2 Attitudes

This section of the questionnaire investigated how the respondents felt about the two Acts, additional issues and the legal framework generally.

**Table 4.5: Consultants' attitudes to legislation use (percentage of sample)**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree (%)</th>
<th>Agree (%)</th>
<th>Neither agree nor disagree (%)</th>
<th>Disagree (%)</th>
<th>Strongly disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find the current legal framework easy to understand</td>
<td>0</td>
<td>33</td>
<td>27</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>I appreciate the flexibility of having two statutes to use</td>
<td>4</td>
<td>43</td>
<td>27</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Use of the MHA should be avoided on those under 18</td>
<td>2</td>
<td>8</td>
<td>20</td>
<td>43</td>
<td>27</td>
</tr>
<tr>
<td>The Children Act is time-consuming and ponderous</td>
<td>6</td>
<td>20</td>
<td>53</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>I am confused as to when to use the Children Act or the Mental Health Act</td>
<td>4</td>
<td>8</td>
<td>22</td>
<td>61</td>
<td>6</td>
</tr>
<tr>
<td>I would tend to use the Mental Health Act in preference to the Children Act because of the safeguards it has.</td>
<td>14</td>
<td>31</td>
<td>33</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>I would tend to avoid the Mental Health Act because of the stigmatising effect it has.</td>
<td>2</td>
<td>27</td>
<td>27</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>Guidelines are needed to clarify which Act to use when.</td>
<td>29</td>
<td>45</td>
<td>18</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>I would be in favour of an all-encompassing 'Incapacity Act' for children.</td>
<td>16</td>
<td>25</td>
<td>37</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>
I am confused by the issue of consent and refusal, and when parents can overrule their children's wishes

I would say I have a good working relationship with my local Social Services Department.

Training for Psychiatrists should include more information on legal issues.

Effective multidisciplinary working in my unit is vital to the smooth running of an in-patient unit.

Effective multidisciplinary working in my unit is compromised by differences between professional cultures.

The strongest influence on the unit's philosophy has been the consultant medical staff.

The general therapeutic milieu of the unit has a greater influence on patient wellbeing and outcome than the specific treatments that the patient receives while at the unit.

The different disciplines at the unit all have equal input into the decision making process.

Approved Social Workers are generally better informed about the use of the Mental Health Act than are psychiatrists.

I don't feel it is really necessary for child and adolescent psychiatrists to be S. 12 approved.

<table>
<thead>
<tr>
<th>Table 4.6: Consultants' opinions of factors affecting competence decisions in under 16's (number of respondents and percentage of sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor</strong></td>
</tr>
<tr>
<td>Child's understanding of the risks and benefits of treatment</td>
</tr>
<tr>
<td>Child's stage of cognitive development</td>
</tr>
<tr>
<td>Child's understanding of their illness</td>
</tr>
<tr>
<td>Nature of the illness</td>
</tr>
<tr>
<td>Age of the child</td>
</tr>
<tr>
<td>The child- parent relationship</td>
</tr>
<tr>
<td>Opinions of significant others</td>
</tr>
<tr>
<td>The doctor- patient relationship</td>
</tr>
<tr>
<td>The need for consensus</td>
</tr>
</tbody>
</table>

*Rather than rank the factors by the 'very important' category alone, a formula was used. Each 'very important' response was allocated a value of 3, 'important' 2 and 'fairly important' 1. Totals appear in the final column.

4.6.3 Knowledge
Three possible answers were available for each question: true, false, and I'd have to look it up. Respondents were asked to be honest in their answers. The answers given are divided into three categories: those concerning the Mental Health Act, those concerning the Children Act and those concerning other issues. The answers given are represented below in tabular form.

Table 4.7: Consultants' knowledge of the Mental Health Act

<table>
<thead>
<tr>
<th>Question</th>
<th>Right answer</th>
<th>% true</th>
<th>% false</th>
<th>% look up</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child detained under the MHA can be treated without giving consent</td>
<td>True</td>
<td>69</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>To admit a child for assessment under the MHA, the child must have a treatable psychiatric condition</td>
<td>False</td>
<td>29</td>
<td>63</td>
<td>8</td>
</tr>
<tr>
<td>To admit a child for treatment under the MHA, the child must be a risk to themselves or others</td>
<td>True</td>
<td>47</td>
<td>43</td>
<td>8</td>
</tr>
<tr>
<td>The MHA can only be used if there is no alternative way to bring about admission</td>
<td>False</td>
<td>8</td>
<td>90</td>
<td>2</td>
</tr>
<tr>
<td>Mental Illness is defined within the MHA</td>
<td>False</td>
<td>33</td>
<td>50</td>
<td>16</td>
</tr>
</tbody>
</table>

A final MHA question asked what the lower age limit for the use of the MHA is. All but one consultant answered correctly that there is none, save for one, who would have to look it up. In all questions, the majority of respondents gave the correct answer.

Table 4.8: Consultants' knowledge of the Children Act

<table>
<thead>
<tr>
<th>Question</th>
<th>Right answer</th>
<th>% true</th>
<th>% false</th>
<th>% look up</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child detained under section 25 of the CA can be treated without consent</td>
<td>False</td>
<td>0</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>The CA doesn't apply to those over 16</td>
<td>False</td>
<td>4</td>
<td>80</td>
<td>16</td>
</tr>
<tr>
<td>A section 25 order is valid indefinitely</td>
<td>False</td>
<td>0</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>If a child under 13 is to be detained under section 25, it is necessary to obtain the approval of the Secretary of State</td>
<td>True</td>
<td>35</td>
<td>14</td>
<td>51</td>
</tr>
<tr>
<td>A Care Order under section 31 can only be made in favour of the Local Authority</td>
<td>True</td>
<td>18</td>
<td>18</td>
<td>61</td>
</tr>
<tr>
<td>When a child is under a section 31 Care Order, the LA can order a doctor to use 'reasonable force' to administer treatment</td>
<td>False</td>
<td>8</td>
<td>49</td>
<td>43</td>
</tr>
<tr>
<td>Under section 20 CA, LA's are required to provide accommodation for orphaned and abandoned children</td>
<td>True</td>
<td>24</td>
<td>4</td>
<td>73</td>
</tr>
<tr>
<td>A child can be detained under S.25 CA ONLY if he has a history of absconding.</td>
<td>False</td>
<td>6</td>
<td>63</td>
<td>31</td>
</tr>
<tr>
<td>Section 40 of the CA deals specifically with mental illness</td>
<td>False</td>
<td>0</td>
<td>2</td>
<td>96</td>
</tr>
</tbody>
</table>

Although again those indicating a definitive answer are largely correct, the number of respondents indicating the need to look things up was higher than was observed for the Mental Health Act. This suggests that the level of knowledge of the Mental Health Act in consultants is higher than that of the Children Act.

The final group of questions deal with consent issues.

Table 4.9: Consultants' knowledge of the Consent
<table>
<thead>
<tr>
<th>Question</th>
<th>Right answer</th>
<th>% true</th>
<th>% false</th>
<th>% look up</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child's consent to treatment can be overridden by a parent's refusal</td>
<td>False</td>
<td>33</td>
<td>55</td>
<td>10</td>
</tr>
<tr>
<td>A parent's consent to treatment will override the child's refusal</td>
<td>True</td>
<td>77</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Children under 16 can only give consent for treatment if parental consent cannot be obtained</td>
<td>False</td>
<td>2</td>
<td>96</td>
<td>2</td>
</tr>
<tr>
<td>It is necessary to obtain consent for behavioural management techniques</td>
<td>True</td>
<td>71</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>A child under 16 can give consent to treatment only if they are deemed 'Gillick' competent</td>
<td>True</td>
<td>84</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

The level of knowledge in the area of consent was generally high, with most respondents answering correctly, and low levels of needing to look it up.

Underlying these questions, is the need to ensure that units are run within the framework of the law, including legislation, precedent and common law. While the level of knowledge is encouraging, that some consultants are answering incorrectly does give cause for concern. Where they would look the answer up, or consult colleagues, this indicates a willingness to discover the right answer. Before answering the questions on knowledge, respondents were asked how confident they were about the legal framework.

**Figure 4.40: Consultants' confidence of knowledge of the legal framework of in-patient CAMHS**

### 4.6.4 Practice

A section of the questionnaire looked at practice in two areas, guidelines for using or choosing between the CA and the MHA, and treating without consent. Of the 51 respondents, 8 reported that they used guidelines for choosing between the two Acts. In just 2 cases were these approved by their trust. Only 8 respondents reported having a procedure for treatment without consent.
4.7 Site visits to secure and forensic in-patient units

4.7.1 Introduction

A member of the project team, accompanied by a suitably qualified co-visitor, visited 4 units: 2 forensic and 2 secure. For a full description of the units, their capacity, location and funding source, see the NICAPS report (O'Herlihy et al, 2001) section 3.

4.7.2 Environment and Facilities

4.7.2.1 Proximity of units to adult units (standard 1)

All units were separate from adult psychiatric units.

4.7.2.2 Design and facilities (standard 2)

Three units were clean, comfortable and had a warm and welcoming atmosphere and one did not meet this standard.

All units contained a large room for family interviews. All units contained small rooms for individual interviews. Two units had a designated waiting area, one did not and one partly met this standard.

Two units had a place for seclusion as needed as part of an agreed therapeutic plan. In one unit a bedroom was used and another reported that they did not use this management strategy. Staff from three units reported that when a room is used for seclusion it was designed and arranged so as to minimise risk of injury. Staff from the three units reported that where a locked room was used for seclusion the child could be continually monitored.

All confidential case material was kept in locked cabinets or locked offices. In all 4 units drugs were kept in a secure place with the dispensary book.

Three units had adequate spaces for educational activities and one did not.

4.7.2.3 Patient privacy and dignity (standard 3)

All units were able to offer patients the option of a single bedroom. All patients reported that they could bathe and wash in privacy and in areas separate from the opposite sex. Most patients reported they could go out when they wanted to.

Only one unit had a specific room for physical examination and minor medical procedures. Two did not and one unit partly met this standard. Half the units had suitably located quiet rooms available. Three units had private rooms for meeting relatives and friends. One did not. All patients had access to a telephone. About half the patients reported that they did have access to a phone in a private place.

All but one unit had arrangements for the safe-keeping of patient's property. All units had arrangements for the safe-keeping of staff property.
Three of the units reported they had facilities to manage those who were threatening, or sexually harassing, eg segregation and a high level of supervision. One unit reported that they did not. Half the units had facilities to manage those who were severely overactive, eg low stimulation environments. Three units had facilities to manage those who were self-harming, eg high level of supervision in areas where there are clear lines of sight to enable staff to monitor patients.

4.7.2.4 Age-appropriate security (standard 4)

Three units had appropriate security within the unit eg certain doors could be locked if needed. All units had appropriate security externally to prevent unwanted visitors.

4.7.2.5 Patients and the ward environment (standard 5)

About half the patients said the decoration and furniture in the unit looked alright. Others said new furniture and decoration was needed and that the unit did not smell clean. Most patients found their unit comfortable to stay in. Nearly all patients felt encouraged to personalise their bedroom spaces. All patients were permitted to have personal audio equipment.

4.7.2.6 Emergency equipment and procedures (standard 6)

In two units a written procedure on display for evacuation in case of fire was found. This may mean that procedures were on display but that the reviewers did not find them in the time available. All units had panic buttons for staff to raise an alarm in an emergency. Two units had a way for patients to raise an alarm in an emergency and two did not. All units reported that there was an identified duty doctor available at all times.

4.7.3 Staffing

4.7.3.1 Training needs assessment (standard 12)

Three quarters of nurses reported their training needs had been assessed in the previous year. Only about half the therapists, social workers and psychiatrists had these needs assessed.

4.7.3.2 Education and training (standard 13)

Three quarters of the nurses interviewed had received training on touching and sexual attraction between staff and young people. All nurses and teachers had received training on child welfare and child protection issues. All nurses reported they had received training on the management of imminent and actual violence, breakaway techniques and restraint measures.

4.7.4 Access, Admission and Discharge

4.7.4.1 Provision and procedures ensure that in-patient care is available to all those who would need it (standard 18)

Just under half of the psychiatrists and social workers interviewed believed that children are admitted inappropriately to their unit because of deficits in other local services.
The average waiting time from referral to admission to the unit was reported by psychiatrists as being just over 1 month. Waiting list sizes were of around 3 patients. Nearly all of psychiatrists reported that patients who should be admitted had been refused admission due to lack of bed availability. They reported an average number per year of 11 patients refused admission for this reason.

4.7.4.2 Assessment and treatment are offered without unacceptable delay (standard 19)

Most psychiatrists reported that those at risk or with more severe conditions are given priority for assessment. Psychiatrists at two units used a standard tool or inventory when conducting risk assessments, these being their own.

4.7.4.3 There is equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence (standard 20)

Almost all staff said that their unit was culturally sensitive, and could for example offer a special menu when needed. Nearly all nurses and social workers reported that advocacy services were easily available. Site inspections found that advocacy services were easily available in only unit (and were unable to ascertain this information for one other unit).

Most nurses, social workers and site inspectors reported that that interpreters were easily available. Staff reported an average number of times in the last year that they had used interpreters was once. Over half of nurses and social workers said that their unit could not adequately meet the needs of those with a physical disability. Site inspections found that three units did not have doors of sufficient width to allow wheelchair access. Half of the units were found to have toilet facilities that met the needs of people with physical disabilities. All units had parking facilities that met the needs of people with physical disabilities. Site visits found that all but one unit did not have ramps for people with physical disability. Site visits also found that only one unit had a place where access for those with physical disabilities was restricted. All nurses and social workers reported that where necessary special arrangements could be made for families who needed to stay overnight.

4.7.4.4 Units are parent-friendly (standard 21)

Most therapists and social workers said that parents were supported and encouraged to participate in their child's care. The two units who responded to this item stated that they did not offer parents the opportunity to make tea, coffee or soft drinks, preferring to make drinks for them. Parents were able to have privacy when they needed it, for example in a family room where parents could meet.

4.7.4.5 Before discharge, decisions are made about meeting any continuing needs (standard 23)

Psychiatrists reported that there were usually difficulties in discharging patients due to limitations in community based services. These averaged about 6 cases per year. Psychiatrists reported that these delays were often caused by social services and adult mental health services (eg ‘lack of engagement between adolescent and adult mental health’). Discharge was reported to be typically delayed by about 12 weeks. According to psychiatrists and social workers, all units informed the patient's general practitioner and involved local services prior to discharge. They also reported that a discharge planning meeting was held for all in-patients.

All social workers reported that patients and parents knew the names of workers involved in follow-up after their discharge. Nearly all psychiatrists and social workers reported that patients and parents knew
before discharge the dates and times of appointments with the workers involved in their care after their discharge.

Psychiatrists and social workers all reported that ongoing care planning with the relevant social services departments was arranged for "looked after" patients.

Most teachers and social workers reported that plans for ongoing education were specifically arranged.

4.7.5 Care and Treatment

4.7.5.1 Evidence-based treatment (standard 26)

About two thirds of the nurses interviewed felt they knew enough about the treatment they provided. Nearly all staff interviewed reported they had access to good quality information about the evidence behind the treatments they provided. Most psychiatrists reported there were treatments where they would like to know more about the evidence of their effectiveness. These included for example, cognitive behavioural therapy, audit, psychodynamic psychotherapy, anti-psychotics for schizophrenia, or drug treatment for aggressive behaviour.

4.7.5.2 Access to other services (standard 27)

Nearly all psychiatrists reported they had good links with general and community paediatric services. Psychiatrists reported they generally used local GPs to meet the physical health needs of patients in their unit. Most consultants reported they had good links with adult mental health services. Consultants from one unit reported they did not have good links. All said that it was difficult when dealing with large geographical distances.

Consultants from half the units reported good links with paediatric neurological services. Consultants from one unit reported they did not have good links with substance misuse or alcohol services. Consultants from half the units reported good links with learning disability services. All consultants reported good links with laboratory services. Nearly all consultants reported good links with accident and emergency services. All consultants reported having good access to other practitioners able to provide a second opinion. Nearly all consultants reported good links with local general practitioner services.

4.7.5.3 Care planning (standard 28)

All units reported that all patients had a written management or care plan. Nearly all patients reported they knew they had a written care plan. Three quarters of patients reported they had been involved in developing their care plan, one quarter reported they had not been involved. All teachers and most therapists reported they were involved to some degree in the development and review of the plan. Nearly all patients reported they had not been given a copy of their care plan.

All consultants reported that the management plans were reviewed at regular intervals. When a care order was in place, all consultants reported that the Local Authority fulfilled the role of a parent eg attending review meetings. The Local Authority was reported to be able to give consent where necessary.

4.7.5.4 Meetings with key worker (standard 29)
Most staff reported there were regular meetings planned for all patients and their parents with their key worker. On average these were every 6.5 weeks. Most patients reported they had weekly meetings with their key worker. Most staff reported that parents were invited to review meetings.

4.7.5.5 Communication with the patient's family and local services (standard 30)

About half the consultants reported they contacted patients’ local GP on referral or admission and discharge only. About half reported contacting them following case conferences and review meetings. All consultants reported contacting local CAMHS following case conferences and review meetings. Nearly all consultants reported contacting patients’ local social services department following case conferences and review meetings.

4.7.5.6 Use of drugs and relevant guidelines (standard 31)

Most nurses reported they used rapid tranquillisation when necessary. About half of the nurses reported they did not have written guidelines for rapid tranquillisation. About half the nurses who reported they did use rapid tranquillisation also reported they did not have written guidelines for this.

4.7.5.7 School work (standard 32)

Three teachers from three units were interviewed. All teachers reported that all patients under the age of 16 received educational input. Most patients over 16 years were receiving some kind of educational input. Those that were not were generally not well enough to attend. Two teachers reported that there was enough time provided for education and one did not. Three teachers reported that each patient had a formal assessment of their educational needs. Two teachers reported that they liaised with the patient's own school and where possible maintained progress with the topics or lessons being covered at school. One pointed out that some patients may not have a local school.

One teacher reported that they did not provide educational outings, the other two did. All 3 provided educational videos, textbooks and games. One teacher reported that they did not have access to local school facilities as required. All three teachers reported that there were opportunities for patients to take exams. When asked about the relationship with parents, two of the teachers reported that this was “done by others”. One reported they did have a good relationship.

4.7.6 Information, Consent and Confidentiality

4.7.6.1 Patient access to information (standard 33)

Half the units were assessed as having a poor or very poor range of leaflets and posters on display. Most had copies of 'The Patient's Charter: Services for Children and Young People' (Department of Health, 1996) on display.

4.7.6.2 Key working (standard 34)

Staff reported that patient's views were nearly always taken into account if they are not satisfied with their key worker. There was high variation between units of proportion of patients who had a named social worker local to the unit.

4.7.6.3 Patient knowledge of staff names (standard 35)
All patients knew the name of their key worker or primary nurse. In two thirds of units staff did not wear name badges. Most units did not have a board on display with the names and photographs of staff. This might help patients and visitors know who staff are and help with security. Most patients knew who their named nurse was for a particular shift.

4.7.6.4 Information before admission (standard 36)

Most patients reported that they knew about the unit and the services offered before being admitted.

4.7.6.5 Patient involvement in treatment decisions (standard 37)

All patients reported that someone had spoken to them about the treatment they were receiving, for example what it was and how it could help them. All of the patients reported that they were provided with written information about their problems or treatment plan. Most staff reported that written information about treatments was provided, for example a leaflet. Most staff reported that they did not normally provide patients and parents with written information about their problems or condition. Almost all patients reported staff had explained to them what kind of problems they had. All patients reported that they could discuss their problems and treatment as much as they needed. Almost all patients reported they had not been offered a choice of treatments. Psychiatrists explained that a choice of treatments was not generally offered to patients or parents.

4.7.6.6 Access to health records (standard 38)

Most patients were not informed of their rights to see the health record and the limitations on those rights. All psychiatrists in adolescent units reported that they would normally show a patient over 16 their health record if they asked to see it. Psychiatrists also reported that the consent of a competent child or young person was always obtained before disclosing case material to parents.

4.7.6.7 Confidentiality (standard 39)

All psychiatrists and patients reported that confidentiality and its limits were explained. It was usually made clear to patients that this is extended beyond the clinical team only if the quality of their care and/or the safety of another depended on this and then only to those who needed to know.

4.7.6.8 Consent (standard 40)

Consultants were usually the staff who asked patients or parents for consent for treatment. In all the units it was reported that this was normally a person capable of performing the relevant procedure. All staff reported that whenever appropriate consent was obtained in writing. Most consent was given verbally. All patients reported that someone had asked them if they had agreed to the treatment they were receiving.

4.7.7 Rights, Safeguards and Child Protection

4.7.7.1 Restriction of liberty (43)

Most staff reported that they understood the definition of restriction of liberty, the circumstances in which it can be used, and the distinction from “time out”. Nearly all restrictions of liberty were reported to be recorded in the patient’s health record, including the indications for its use, the type of restriction, its duration, and the name of the person who authorised its use. Records were not checked to confirm this.
Nearly all units reported the running total number of hours of restricted liberty was monitored.

4.7.7.2 Patient rights (standard 44)

Staff from all units reported there were opportunities for children and young people to play with and meet others of a similar age, within the limits of the unit program. Staff from all units reported there was a choice of food which suited all dietary needs. All units had an area outside for patients' recreation. Staff from all units reported they were sensitive to the needs of different ages, eg bed times were varied and toys were provided for children and music for adolescents.

All patients reported they could ask to see the doctor on their own. In most units patients could ask to see a doctor of the gender of their choice. Almost all patients found unit staff polite and friendly.

4.7.7.3 Patient complaints (standard 45)

Complaints procedures were generally publicised although there were mostly no suggestion boxes for patients to use.

4.7.7.4 Control and discipline (standard 46)

All units reported that the “grounding” of patients was sometimes enforced by locking them in or by their physical restraint. Most units sent patients home for short periods as a disciplinary measure and in most units the availability of alternative accommodation, such as a patient's home, was a condition for admission.

4.7.7.5 Physical restraint (standard 47)

All staff reported that the circumstances and justification for using any physical restraint was recorded immediately.

4.7.7.6 Legal advice for staff (standard 48)

Staff from all units reported that legal advice was available to them when needed, although there was some variation within units. Most units did not give patients a copy of 'The Patient's Charter: services children and young people' (Department of Health, 1996).

4.7.7.7 Awareness of legal status (standard 49)

All nurses reported that the child protection status or Mental Health Act or Children Act status of patients was known to them.

4.7.7.8 Child protection (standard 50)

Most staff said they knew who the named professionals were, designated by the Trust to be responsible for ensuring child protection supervision. Most staff reported that local ACPC guidelines, Working Together under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses were available and accessible to them. Induction training of staff was reported to include child protection policies and procedures. Almost staff reported they had access to the business of the local Area Committee for the Protection of Children (ACPC), eg their development of procedures and
better practices in child protection. Most staff reported that induction training included the reporting of violent incidents.

4.7.7.9 Allegations of abuse (standard 51)

All staff explained that if significant abuse of any kind of a patient was suspected by a member of staff that the trust management would be informed. Most staff explained that any alleged abuser would be suspended. Almost all staff reported that there was guidance on dealing with allegations of abuse against staff which had been endorsed by the trust.

4.7.7.10 Children accommodated (standard 52)

Most staff reported that the trust informed the responsible SSD when a child is accommodated for a consecutive period of 3 months or more and when such a child leaves the accommodation.

4.7.7.11 Local Authority’s role with longer staying patients (standard 53)

Staff from almost all units reported that the local authority promoted contact between longer staying patients and their family in some way. Staff from all but one unit reported that there had been no staff subject to any legal action in the past year regarding the service at the unit.

4.7.8 Audit and Policy

4.7.8.1 All available information is used to evaluate the performance of the unit (standard 54)

All staff reported that there was a system in place for the reporting of violent incidents. Most psychiatrists reported that there was an agreed definition of 'violence'. Most staff reported having been involved in a clinical audit in the past year. Most staff regularly used outcome measures (for example any scales that measure patients' symptoms or problems, such as HoNOSCA). Over half of units used a computer database to manage patient information such as prescribing, diagnosis, admissions and discharges.

All staff reported that there was a system in place for the reporting of incidents involving the use of physical restraint. All Trust/CAMHS managers reported that the Trust monitored and investigated as necessary patterns of frequent use of physical restraint. All staff reported that there was a system in place for the reporting of incidents involving patients absconding. All Trust/CAMHS managers reported that the Trust monitored and investigated as necessary patterns of patients absconding. More than half of staff reported that there were arrangements where patients who ran away could be interviewed by a person not connected with the unit.

4.7.9 Location within a Public Health Context

4.7.9.1 The Health Authority has a recent written strategy, developed in consultation with all relevant parties, which addresses the provision of child and adolescent services (standard 60)

Most psychiatrists had been consulted as part of any process of commissioning in-patient services, eg as part of a health needs assessment.
4.7.9.2 The in-patient unit contributes to effective multi-disciplinary and multi-agency working, between health, education, social services (standard 62)

All psychiatrists had a social services link worker to help communication with the units’ local social services. All social workers (representative of all units) reported that patients’ local social services were encouraged to attend the unit. When psychiatrists were asked ‘Who was involved in developing admission criteria for the unit?’, responses tended to focus on all disciplines within the unit.

4.8 Stakeholder consultation day

The action plan for each of the groups was as follows:

4.8.1 Group 1: The Use of the Children Act

Themes

- A lack of resources can influence real choice. For health, admitting children with non-psychiatric problems can lead to disruption on wards. For social services, the implications are in terms of costs and staffing. There are young people who fall between the two Acts, into a grey area, and cannot be placed.
- Different agencies have different, conflicting priorities regarding parental responsibility. For health, it is the need to avoid risk, for example of leaving the child with an unfit parent. For social services, there is pressure to keep the child with the parents.
- A lack of knowledge of legislation, can lead to professional retrenchment.
- There is a lack of joint working, such as mental health services input into social services secure environment.
- There is a lack of evidence as to what treatments are ‘effective’.
- The Children Act is seen as synonymous with child protection.

Recommendations

- There should be a greater emphasis on joint training.
- There should be an emphasis on the development of joint services.
- There is a need for more research, an emphasis on evidence-based practice, and the dissemination of information relating to unmet need.
- Joint working must take place at the highest strategic level.
- There is a need for clarification and guidance on issues around parental responsibility and capacity.
- Use of the Guardian ad Litem should be encouraged, as it might provide some of the safeguards offered by the Mental Health Act, in a Children Act scenario.

4.8.2 Group 2: Joint Working

Themes

- There is a gap between section 25 Secure Accommodation Order and detention under the MHA.
- Variability exists in non-medical secure care settings of the availability of professionals to meet the mental health needs of children.
• There is a lack of consistency over age boundaries between agencies. There is also lack of consistency in roles and responsibilities of professionals within agencies across different districts.
• There tends to be an unwillingness of bodies to engage in joint funding, leading to young people being unable to access appropriate care. There is a culture of attaching funding responsibility to legislation, ie ‘MHA so it must be health’, despite major social care and educational needs.
• The use of the MHA entails statutory responsibilities for social services and health, but not for education.
• The principles of the CPA (care plan approach) apply to but are not mandatory in children.
• There is a lack of training and experience across disciplines (eg child and family social workers lack mental health experience).
• There is a paucity of section 12 approved child and adolescent psychiatrists, leading to the use of adult psychiatrists to make assessments.
• There is a lack of cohesion between children's services and adult services, leading to difficulties at this change-over.

Recommendations
• A mechanism should be introduced to include education into decisions about young people's mental health care.
• The use of CPA should be encouraged, as an instrument to identify those who should be working together in the child's interest, and to identify those responsible for providing funds.
• Moves should be made towards greater integration in funding of services.
• Improved joint education should be striven for, especially in cross disciplinary situations, ie child and family SW's awareness of mental health issues and legislation.
• More child and adolescent psychiatrists should be section 12 approved.
• There should be more innovative services to bridge the gap between children's and adult services.

4.8.3 Group 3: Guidelines on use of the Acts

Themes
• There is a lack of national guidelines on the use of the Acts.
• The necessity for continuity of informed consent should be recognised, as should the professional judgement of consent.
• There can be difficulties in discharge and follow-up care.
• It is important to hear the 'voice of the child' through independent advocacy services. Continuity of advocacy is important, when the young person moves around.
• The issue is not simply the choice between not only the Children Act and the Mental Health Act, but also the role played by the Education Act and the criminal justice system.

Recommendations
• National guidelines in this area should be formulated and implemented.
• Research is needed into informed consent in settings that treat and care for children. This should centre on the users, and also include all staff that might obtain consent.
• Improved training is required for all professions on legislation and related issues. This must include all who deal with these young people, such as ASW's and adult psychiatrists.
• There should be minimum standards for access to independent advocacy services, for all children with mental health needs.
• The creation of a legislative framework that reflects the needs of young people is required. This must address: mental health, education, care and aftercare and justice.

4.8.4 Group 4: Local Authority and Parental Responsibility

Themes
• There is a lack of resources and facilities, deleteriously affecting the ability of the Local Authority to be a better parent. There is also a lack of investment by Local Authorities in prevention (eg of the effects of emotional abuse).
• The differences in funding between 'child protection' and 'child in need', leads to pressure to diagnose children.
• The required skills to develop parental responsibility are not always available to Local Authorities.
• There can be a lack of continuity for looked after children if parental responsibility is invoked by the Local Authority. There is potential for a negative impact on the life of the young person.
• The mobility of this population can make progress difficult.
• There is a lack of training and awareness about parental responsibility- who has it and who does not, what it entails.

Recommendations
• A system for multidisciplinary assessment of capacity for parenting should be introduced. This would especially deal with supporting applications to court.
• The role of the non-statutory sector should be explored, in supporting the Local Authority and parents to adopt parental responsibility more effectively, for example respite. The non-statutory sector must be included in planning.
• Unmet need should be accurately recorded.
• The 'mental health' component should be separated from 'care'. The Local Authority should be required to provide care.
• There should be greater availability of independent advocacy, and an increase in the use of independent visitors.
• Training and awareness should be improved in what parental responsibility is, when it is invoked and how this is done. Roles should be defined within parental responsibility, to make good multidisciplinary working. The use of terms across agencies, should be defined to avoid confusion.
• There should be training for young people in how to get the best out of services, for example in coping skills.

4.8.5 Group 5: The Use of the Mental Health Act

Themes
• How much of the stigma attached to the use of the MHA is due to the Act, how much to the disorder, and how much the fact of admission to in-patient care?
• There are problems with professionals’ perception of the MHA - there is tension between the legal framework, the practitioner's ethical stance, a lack of awareness of alternatives and concerns over committing assault if not protected by the Act.
• The circumstances in which the Act is used can be problematic. There is a need to ensure it is used to mandate effective treatment. The influence of resources and other factors must be acknowledged.
• The advantages of the safeguards available (Mental Health Review Tribunals; requirement for second opinions; section 117 aftercare) must be recognised. If the MHA is not used, the young person is deprived of these safeguards.
• Recognition is needed that the Children Act and the Mental Health do not cover all eventualities.

Recommendations
• New legislation is required, to recognise and utilise the advantages of both the Children Act and the Mental Health Act.
• National guidance on the use of the Mental Health Act should be issued.
• Joint training should be improved.

4.8.6 Group 6: Consent and Competence

Themes
• There is a lack of an evidence base on the use of medication in young people.
• The process of obtaining consent should include professionals, parents and the young person. The location of parental responsibility must be ascertained.
• It must be recognised that there are discrete populations, from birth to 18, with different needs.
• There is a lack of advocacy services.
• It must be acknowledged that the child has the right to the most effective treatment.
• The issue of capacity should be central to all questions of consent. There is, however, a need to improve the criteria in this area.
• There is an illogical disparity between ages of responsibility, for example the age of criminal responsibility. A child can be held wholly responsible for their actions at 10 years if they have committed an offence, but cannot make a decision regarding their treatment until 18 years.

Recommendations
• The National Institute for Clinical Excellence should investigate and publish guidelines on the use of medication in young people.
• Practical and useable guidelines on age, capacity and consent must be developed, and widely disseminated.
• Minimum standards should be introduced for access to advocacy services for young people with mental health needs.
• There should be an investigation into the illogical disparity in ages of responsibility.
5 DISCUSSION

5.1 Introduction

This part of the report considers the issues raised by the results generated by this project. It is structured to follow the methodology of the project, considering the results of each element of the study in turn, with a final section drawing these findings together.

5.2 Key Findings

Where detention is formal rather than informal, psychiatrists almost exclusively use the Mental Health Act rather than section 25 of the Children Act to detain young people with mental health problems.

Detained patients tend to be older, with a substantial number aged 18 years or over.

Detained patients are more likely to have schizophrenia or personality disorder than informal patients, who are more likely to have eating or mood disorders. Detained patients have greater psychosocial complexity.

Consent obtained for treatment tends to be verbal rather than written.

Psychiatrists' knowledge of the Children Act and consent issues is less extensive than for the Mental Health Act.

5.3 Limitations of the study

We adopted a multimethods approach in order to attempt to address the main issues and questions detailed in the research brief. In a project with multiple aims some elements will always be more successful than others and this was certainly the case with CAMHA-CAPS. Our over-riding principle during the project was to focus our resources on those areas where there was the greatest priority for good quality evidence while attempting to ensure that we were collecting data which would enable a comprehensive overview of the services provided. In this section we will focus on some of the main limitations of this study.

The first limitation to be considered is the low response rate for some of the questionnaire surveys. The survey of the child and adolescent faculty of the Royal College suffered most, with only 54% of members returning the questionnaire. There is therefore the likelihood of response bias. However the main value of this element of the study was in informing the content of the later sections and these data will still have been of use for this.

A central consideration was to maximise the response rate for information describing basic unit characteristics from the general surveys and the censuses. We achieved high response rates for such items typically between 80 and 100%. However we need to acknowledge the possibility of non-response bias having entered error into our parameter estimates. We were able to ascertain through telephone...
enquiries that these non-responding units were not particularly unusual, so although there is a possibility of selection bias, its effect on our results is likely in general terms to be minimal. The same arguments are also likely to have validity for the 9-month follow-up element of the study.

This series of studies looks at those patients 'detained' and those on units 'informally'. There is a group who are in-patients by virtue of their parent's consent, be it their birth parents or the Local Authority through a care order. The study design did not enable us to collect data on the source of consent as part of this study. This is a limitation of the design that we adopted. However this is an important area in legal, policy and clinical terms that requires further research.

5.4 Faculty survey

5.4.1 Themes from the Research

We had anticipated from early discussions of themes for the research that professionals would identify as a particular concern the potential for conflict between the use of the Mental Health Act and the Children Act. In fact this conflict appears more apparent than real. The use of the Children Act for the purposes of taking action in respect of a child with mental health problems who required in-patient treatment was rare. However, there were cases where Children Act orders pre-dated the need for in-patient treatment. The frequency with which this question was raised may have been due to the sampling of all consultants, not just those who deal with the Acts on a regular basis. Furthermore publicity relating to high profile cases can give rise to uncertainty for practitioners.

Although professionals expressed anxiety about the stigmatising effect of the Mental Health Act, this was the statutory provision that they routinely used. What may be more contentious is the question of under what circumstances to use the Mental Health Act and under what circumstances to act with the consent of patient and/or parents/local authority. In particular it is the question of when to treat non consenting patients under parental consent that may actually be the most contentious. In this context and given publicity about the exercise of consent to medical treatment generally, it was no surprise that questions about consent featured. The legal framework in this area, considered in detail in section 2.2.1, is complex and has been the subject of developing case law. Although there is a relatively clear code established by case law and the Code of Practice under the Mental Health Act (Department of Health and Welsh Office, 1999), there remain some differences of opinion as to its implementation. The interaction of the exercise of parental consent and the consent or refusal to consent by children who may be competent, is not straightforward and may be difficult to manage in practice.

5.5 Day census

5.5.1 Introduction

The day census collected information on all patients resident in in-patient units on a particular day. This snapshot enables a description of the nature of the population, in terms of their age, gender, diagnosis and other variables. Some of the most interesting data concern the differences between those detained and informal patients.

It should be noted that this report does not cover those young people admitted to adult psychiatric in-patient services. This is addressed in the main NICAPS report (O’Herlihy et al, 2001).
5.5.2 Section 31 of the Children Act

In the analyses for this section, detained patients were those who were subject to a section of the MHA or section 25 of the CA that detains them against their will. While this is a convenient way to split the data, there are two other groups worthy of consideration. First there is a group of young people subject to section 31 of the Children Act, the care order, although it is not clear if these were obtained in order to effect admission or were incidental to it. By virtue of a care order the local authority acquires parental responsibility and shares it with a parent who has responsibility. In the event of a dispute, the local authority has power under section 33 to take decisions in the interests of the child, notwithstanding the opposition of a parent. This could mean that a local authority could give consent for the child to be admitted, as a parent might consent.

In practice it would be expected that a local authority seeking to exercise power to have a child detained would make use of the powers under section 25 of the Children Act, for initial detention followed by an application for a secure accommodation order. There is no reason to suppose that the powers under sections 31 and 33 were being abused by unlawful detention, and given the strict criteria of section 25, it seems unlikely. We do not, however, have the data to be certain. While small this may be a group which would merit further study.

5.5.3 Secure accommodation orders

The secure accommodation order has very strict criteria. A child who is being looked after by a local authority (whether subject to a care order or not) may not be placed, and if placed, may not be kept, in accommodation provided for the purpose of restricting liberty, unless it appears ‘(a) that he has a history of absconding and is likely to abscond from any other description of accommodation, and if he absconds, he is likely to suffer significant harm; or (b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons’ (section 25(1)).

If the authority seeks to have the child detained for more than 72 hours in any 28 days, it must obtain the authority of a court order (Children (Secure Accommodation) Regulations 1991, reg 10). Any detention for assessment or treatment of a mental illness would be likely to extend beyond that period, so that if that were the purpose of detention a court application would be required. Secure accommodation is usually used for very troubled individuals, and in a mental health context, is most likely be observed in forensic or secure settings.

There were in fact very few orders under section 25. In the day census, there were only ten patients subject to secure accommodation orders, compared with over 100 on section 2 or section 3 of the MHA.

5.5.4 Detained patients 18 and over

There were a number of patients over the age of 17. These, it is hypothesised, were long-stay patients who had been resident for some time at the unit concerned, or were resident in units that cover an age range beyond the 17th birthday. The data show that there are almost as many detained individuals 18 or over as there are under 16, and that two-thirds of them are female. That any over 17s were using these services could mean that units were having difficulty in finding appropriate placements for these young people. Another explanation might be that there are units which cross into the older age range. The relatively high frequency of detention in older adolescents probably reflects the increased prevalence of major psychiatric illness such as schizophrenia in this older age group. What it certainly reinforces is the demarcation between detained and informal patients, and the two Acts (by definition, this group are over 18 and are no longer children, so must be held under a Mental Health Act section).
5.5.5  Age, gender and diagnosis
The data present a clear picture of those patients detained. There was a large group of male adolescents with schizophrenia, as well as a distinct group of females, detained, with personality disorder. It had been anticipated that there would be a group of older adolescents with personality disorder, but that this group was predominantly female is surprising. It seems possible that this group had high levels of repeated self harm. We know that in the child group there were a large number of younger males with conduct disorder (NICAPS report), and it might be anticipated that this would be reflected in a number of older males with some form of personality disorder. They were not present in this sample of in-patient units. It is possible that they may have progressed to placement within the criminal justice system.

5.5.6  HoNOSCA scores
The HoNOSCA scores for the informal and detained groups did not differ greatly, save in two areas: hallucinations and delusions, and disruptive, antisocial and aggressive behaviour. This is consistent with the diagnostic profile of the two groups.

5.5.7  Paddington Complexity Scores
The Paddington Complexity scores for the detained group were higher than for the informal group in all categories, the effect being most marked for history of sexual abuse. The levels for the informal population were also high, and the even higher levels exhibited by the detained population demonstrate the vulnerability and complexity of this group.

5.5.8  Ethnicity
At the time of writing, no value was available for the proportion of ethnic minorities in the general population under 18. We cannot therefore calculate whether there was an excess of young people from ethnic minority backgrounds admitted to in-patient units. Our data do suggest that these groups may be over-represented in the detained population and in forensic and secure settings. In this these data have similarities with general adult and forensic mental health populations.

5.5.9  Length of stay
These data clearly demonstrate that patients with Children Act or Mental Health Act status stayed in in-patient care longer than those without.

5.6  Nine-month post-discharge follow-up

5.6.1  Changes in legal status
The data on the use of the Mental Health Act were consistent with expectations. Patients detained under Sections 2 and 3 were usually discharged from the section and then from hospital with very few needing to be re-sectioned or remaining on section at nine month follow-up.

The Children Act data are less simple. There was an increase in the use of section 17 (Children in Need) from 1 case at mail out (ie during the patient's residence in the unit), to 7 at discharge, then 6 nine months post discharge. This might be due to assessments being completed with the recognition that these individuals were 'in need' according to the provisions of the Children Act. Likewise, the use of section 20 (Looked after Children) also increases at the discharge and the 9-months post-discharge stages. This section covers the duty of a Local Authority to provide accommodation for children who have no one to
care adequately for them. It is possible that the five new cases fell into such circumstances, or were identified as such during assessment and treatment.

5.6.2 Delay in, and reason for discharge

Any delay in discharge will have an effect on the ability of the unit concerned to admit other patients. The mismatch between demand for in-patient care and the resource available makes this an even more serious problem. A bed occupied by a patient who is waiting to be cannot be used by anyone else. The data show that the most common reasons for delayed discharge were problems with follow-up support, finding a placement and funding. These are all service-related issues, and affected an appreciable number of patients. One further effect of delayed discharge is how this might contribute to decisions not to admit. If a unit is presented with an individual who may, from experience, prove difficult for them to discharge, then there is a possibility that this might influence the admission decision. Some patients waited several months before suitable accommodation could be found.

In most cases, the patient was discharged because they no longer required treatment. A proportion were, however, discharged due to some incompatibility between patient and unit. Three patients were discharged because the bed was needed. This again could be a cause for concern, depending on where they were discharged to.

5.6.3 Nearest relative

In the majority of cases, the nearest relative of the patient was the parent. Given the powers that the nearest relative has, it is crucial that any individual that would not have the child's interests at heart, or might mean to do harm to the child, be effectively displaced. The data show that in three cases, sexual offences or allegations of abuse led to the displacement of the nearest relative. In one other case, the closest relative was displaced since they were held to be likely to use the power to apply for discharge against the welfare of the child or the public at large.

5.6.4 Who should obtain the consent?

A person who was not competent to explain the 'Gilllick' conditions or make the judgement required by that decision should not be obtaining formal consent. The Children Act questionnaire gathered extensive data on consent: what kind of consent was obtained for various procedures; who obtained consent; from whom it was obtained; and whether the person who obtained it was qualified to perform the procedure.

It is notable that in the overwhelming majority of cases, reliance was placed on verbal consent. In some cases there appeared to be no consent. It may be that if the child is available for treatment or there is a global consent to admission and treatment, an assumption is made that this is a valid consent for all purposes. This approach needs to be treated with caution.

Some units have developed guidance for obtaining consent. Good practice might include an appropriate person discussing the treatment with the patient, explaining the details of the procedure and its advantages and disadvantages, and then asking if the patient understands and consents. This will require ensuring that treatment is understood, that consent to it is informed (including it being checked or renegotiated on an ongoing basis) and that the process of consent is recorded.

There are advantages in a documented procedure leading to written consent. It would help to ensure and to demonstrate that the procedure was undertaken accurately and carefully. It would also be of evidential value and would help to provide a legal safeguard.
5.7 In-patient consultant questionnaire

5.7.1 Demographics
This group of consultants has to deal with the most vulnerable group of young people, and it is important that their knowledge of the law is adequate for this task. With most feeling that their knowledge of the law was at least partly up to date, and most feeling their access to legal advice at least adequate, this would seem to be the case. It is interesting to note that while 80% of respondents were section 12 approved, few were using this facility frequently. Few respondents had regular dealings with the courts, with a small number interacting frequently. This is likely to be due to the kind of unit they have, dealing with the more forensic end of the client group, or possibly that they had made a conscious move to appear in this capacity.

5.7.2 Attitudes
The data on attitudes to legislation use are difficult to interpret. While respondents agreed that they appreciated having the flexibility of two statutes and did not feel confused about which to use when, there was a feeling that guidelines would be helpful as would more training in legal issues.

5.7.3 Knowledge
Generally, the consultants' knowledge of the Mental Health Act was good, with the majority of respondents answering questions correctly. Interesting are the quarter of respondents that wrongly stated that treatment cannot be given without consent under the MHA, and the 29% who wrongly asserted that for assessment under the MHA, a child must have a treatable psychiatric condition.

These and the other wrongly answered questions in this section indicate that there is a group of consultants that are not conversant with the provisions of the MHA. This may be due to lack of contact with the MHA, for example through practising primarily with younger children. The level of knowledge of the Children Act was also generally high, with no question showing a majority of incorrect answers. It is clear, however, that the level of uncertainty about answers was higher than for the MHA, with more respondents reporting that they would need to look up the answer. This is consistent with the hypothesis that generally, psychiatrists' knowledge of the Mental Health Act is better than for the Children Act. Consultants showed a generally good knowledge of consent and related issues.

There was a certain amount of confusion over the primacy of the child's or the parent's consent or refusal. One third of respondents wrongly asserted that the child's consent can be overridden by parental refusal. Fewer, (17%), wrongly answered that the child's refusal will override a parent's consent. While it is recognised that this is a confusing and contradictory piece of law, it is one that is important to be certain of, when dealing with patients where this may be an issue.

Generally, the level of knowledge of the legal framework is encouraging. That some respondents stated that they would have to look up answers, or consult colleagues indicates a willingness to discover the right answer. That, in some cases, important legal questions are answered wrongly, is an issue that needs attention, ideally in the form of more extensive or focussed training. The questions asked in the knowledge section were written to test legal knowledge, and it is on this basis that the results have been interpreted. There is a possibility, however, in some of the questions on consent, that respondents have misinterpreted the question as seeking a clinical response. Obviously, there is a difference between the bare legal necessities required for consent, and what constitutes best clinical practice. It is always best to obtain consent from the young person, even if it is not legally required.
5.8 Site visits

5.8.1 Standards met and not met
It must be remembered that the standards used to evaluate these services are statements of best practice. It was not expected that any unit would entirely fulfil every single one, and none did. What is encouraging is that all four units met or nearly met so many. It should also be remembered that the responses to a number of the standards concerning the environment are dictated by the architectural design of the building, about which nothing can be done, short of moving premises. Finally, it should be noted that these findings cover the units as they were on the day of the visit (Spring 2000). Two of the 4 have now moved to larger, purpose-built premises. There are also two new secure units under construction.

5.8.2 Environment and facilities
Of interest here particularly is the lack, in three units, of a specific room for the treatment of physical injuries. One unit did not have facilities for patients requiring segregation and a high level of supervision which might be assumed to be a necessity when dealing with this population. Educational facilities varied greatly, but the figures might be misleading since some units shared facilities with other units and services.

5.8.3 Staffing
All units met the standards for staffing well.

5.8.4 Access, admission and discharge
There were reports of problems with young people being refused admission due to unavailability of beds, on average 11 per year. If there is no capacity at this end of the service spectrum, then there are very few places for these disturbed, vulnerable young people to go. In such cases the alternate destination may well not be appropriate, and in some cases potentially damaging to the young person.

Difficulties in discharge due to limitations in community-based services were reported to have been a factor in about 6 cases per year. Social services and adult MH services were identified as particularly problematic. The typical delay in discharge was 12 weeks.

5.8.5 Care and treatment
Rapid tranquillisation is a technique that is occasionally employed to severely behaviourally disturbed patients. Approximately half the nurses interviewed reported that this technique was used, and half of them did not have written guidelines. There are legal implications, since without recognised guidelines, any nurse or doctor is in danger of dual liability: by criminal law (assault) and civil law (trespass to the person).

5.8.6 Information, consent and confidentiality
All units performed satisfactorily in this area.

5.8.7 Rights, safeguards and child protection
All units performed satisfactorily in this area.
5.8.8 Audit and policy
All units performed satisfactorily in this area.

5.8.9 Location within a public health context
All units performed satisfactorily in this area.

5.9 Bringing together the findings

5.9.1 Legal framework

The Mental Health Act and the Children Act have different purposes and different approaches. The Children Act restructured almost all of the legislative system relating to child welfare. It contains, however, no specific consideration of mental health issues, albeit there are sections that could apply to young people with mental disorder. Its core value is the welfare of the child. The Mental Health Act was enacted to update the law regarding people with mental disorder. Its core value relates to the treatment of mentally ill patients in a context where the public can be protected.

Both Acts can be applied to young people with mental disorder, and this is where difficulties can begin. There are some circumstances in which it is clear to all of the professionals involved that a particular section of one of the Acts is entirely appropriate, and no other can be used. This covers the majority of situations that might occur. There are, in fact, very few situations in which there is a genuine choice as to which Act should be used.

A secure accommodation order (Children Act section 25) can only be used where the child is a danger to themselves or others, and further will not enable the child to be treated without consent, unless the child, or their parents or those with parental responsibility have given it. This approach is not, objectively, as flexible as sections 2 and 3 of the Mental Health Act, which, where the criteria are fulfilled, will enable the child to be admitted and treated. The Mental Health Act also brings with it certain safeguards in the form of Mental Health Act Tribunals, second opinions and section 117 aftercare. It is easy to see why a psychiatrist faced with a choice might opt for the MHA route. There are other considerations, though, and other agencies invariably involved. Social services will be part of the decision making process, and there may well be child protection issues that must be considered.

5.9.2 The Use of the Children Act

The Children Act is designed to safeguard the welfare of young people. However, it almost invariably requires a court order for certain events to take place. It may therefore be viewed as cumbersome and time consuming by psychiatrists. It must be remembered that psychiatrists are more likely to be familiar with the provisions of the Mental Health Act, and potentially feel that it is a more clinically-friendly piece of legislation, couched in terms that they will be more familiar with. It is also true that a section can take place quickly, once the relevant personnel have been assembled.

Moreover, where the Children Act is being employed, there will usually be family issues and these can be very complex with conflicting agencies and individuals, disagreeing about what is in the best interests of the child, for example regarding placement. When a mental disorder is also manifest, the situation can be
more complicated still. Any psychiatrist's priority is likely to be to ensure that the child is assessed and treated for the condition they are suffering from. Where this requires in-patient treatment, it will be important to admit the young person expeditiously, and the Mental Health Act may well be the best way to do this.

The data collected shows that the majority of young people on in-patient units are there informally, notwithstanding that group admitted by parental consent. Of those with legal status, there are relatively few with Children Act orders in place, with the majority under sections 2 and 3 of the Mental Health Act. This would suggest that in most situations, the Mental Health Act is the preferred method for ensuring admission takes place. The Children Act sections observed may well have been largely pre-existing, and incidental to the admission.

5.9.3 The Use of the Mental Health Act

The Mental Health Act is clearly frequently used to admit young people to in-patient services. One of the principal objections to its use voiced by psychiatrists in the faculty survey was the perceived stigmatising effect. How this stigma is manifest and what its effects are is unclear. Another relevant factor in the use of the MHA would seem to be the practitioner's ethical stance. The faculty survey identified a number of individuals who stated that using the MHA on young people is unethical. Others asserted that the safeguards associated with the MHA mean that it was unethical not to use it. Attitude to the MHA is clearly a complex issue. There may be a lack of awareness of the alternatives to sectioning, as well as concern over the possibility of committing assault if deprived of the protection of the Act. Resources and the relationship with the local social services will also be influential.

5.9.4 Joint Working

It is important to acknowledge that sometimes decisions have to be made in acute and potentially dangerous situations, and the process for arriving at decisions needs to be able to work in such circumstances. Liaison between CAMHS and other agencies is crucial. This concerns not only social services, but education and criminal justice in some cases. Problems highlighted have included the lack of resources and an unwillingness or inability of agencies to engage in joint funding. In some cases, this may well prevent young people from accessing appropriate care. There has also been a reported tendency for funding to attach to legislation use, ie health for the MHA and social services for the CA, despite there being major mental health, social and educational needs. Another area of weakness highlighted is the interface between CAMHS and adult mental health services. This causes problems in two particular instances: where a young person is being transferred to the care of adult services, and the use of adult psychiatrists to carry out section 12 assessments.

5.9.5 Consent

Patients under a MHA section can be treated without consent. In-patient consultants' knowledge of consent was mostly adequate, with a certain degree of confusion regarding the situation where parents and patient are in conflict. In practice, most consultants faced with a case in which this was an issue would obtain legal advice, if not the guidance of the Court.

Use is made in in-patient care of blanket consent. This is a potentially hazardous path to follow - it is advisable to obtain consent for each treatment separately. Litigation has yet to reach the Court on this matter. It is advisable to obtain written consent wherever possible. While, legally speaking, verbal consent is equally valid, it will be harder to prove that it was obtained, should any dispute occur. Written
consent is also, generally, better evidence that the patient was properly informed about the treatment to be given. This will apply to both child and parental consent. For practitioner advice, see Reference Guide to Consent for Examination or Treatment, 2001 (Department of Health, 2001a).

The issue of consent has been considered in the White Paper that will become the new Mental Health Act (Department of Health, 2001b). It states

...it may well be in the best interests of the young person for care and treatment to be provided within the framework of mental health legislation. (Reforming The Mental Health Act: Part I - The new legal framework, paragraph 3.71)

In relation to 16 and 17 year olds, it states

...in new legislation a 16-18 year old person who does not consent...will only be treated under compulsory powers... (Reforming The Mental Health Act: Part I - The new legal framework, paragraph 3.72)

It seems unclear how Gillick competent children would be treated.

5.9.6 The Human Rights Act 1998

The Human Rights Act 1998 (HMSO, 1998) may have implications for any new mental health legislation. Questions about consent to treatment must take account of Article 6 of the Human Rights Convention, the right to respect for family life.

Detention under section 25 of the Children Act has been the subject of a challenge under Article 5 of the Human Rights Convention in Re K (a child) [2001] 1 FLR 526. The Court of Appeal held that the secure accommodation order was compliant with the convention. The problem remains about how to provide in statute for a child, as in Re C [1997] 2 FLR, who does not satisfy the criteria in section 25, and cannot be detained under the MHA. A new Mental Health Act needs to address whether there are sufficient safeguards for informal patients whose interests require them to be detained.

There is a strong argument that the informal admission of the Gillick competent child patient to in-patient psychiatric care against the child's wishes, on the authority of the person or body with parental responsibility violates the child's rights under article 5. This is an issue that practitioners ought to be aware of when deciding whether or not to use the MHA.

5.10 Recommendations

5.10.1 The specific needs of young people should be considered in the new Mental Health Act. This should include clarification of the primacy of consent (parental and patient) for young people.

5.10.2 There is a need for training for health and social care staff in the use of the MHA, the CA, and in issues of consent. There may be particular value in joint training.

5.10.3 There is a need to address the issue of the apparent low level of psychiatrists' training in mental health law.
5.10.4 The consideration of CAMHS in the National Service Framework for children should address issue of consent, including the use of parental consent for the detention and treatment of young people on CAMHS in-patient units.

5.10.5 The range of agencies providing services for young people with mental health problems need to review and resolve the discontinuities in care that result from different services having different age based criteria.

5.10.6 There is a need for better liaison between CAMHS and adult mental health. Particular areas needing to be addressed include determining responsibility for admission for young people requiring formal admission, transferring care between services, and providing input for young people detained on general adult psychiatric wards.

5.10.7 NICE should produce guidelines on the use of medication and other treatment in young people with mental health problems. These should also address the use of rapid tranquillisation in in-patient services.

5.10.8 In-patient services must recognise the importance of obtaining informed and continuing consent. Services should be encouraged to avoid verbal and blanket consent.

5.10.9 Further research is needed into admissions under parental or local authority consent, and the choice between parental consent, child consent and the use of the MHA.

5.10.10 Further research is required into how young people from ethnic minorities are accessing in-patient CAMHS.
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