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ALEX MEARS AND ADRIAN WORRALL

A survey of psychiatrists' views of the use of the Children Act and the Mental Health Act in children and adolescents with mental health problems

AIMS AND METHOD

To identify psychiatrists' concerns relating to the use of legislation in children and young people with mental health problems. Four hundred and eighty members of the child and adolescent faculty of the Royal College of Psychiatrists were asked to list their main concerns.

RESULTS

Two hundred and fifty-eight members responded. The four most reported themes were: choosing between the Mental Health Act and the Children Act; general issues around consent to treatment; issues with social services departments; and the stigma associated with using the Mental Health Act.

CLINICAL IMPLICATIONS

The range of themes identified from this survey have served to focus the evaluation of the use of the Children Act and the Mental Health Act in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS), and informed the design of subsequent data collection tools. The project report has now been submitted to the Department of Health for consideration.

Both the Mental Health Act 1983 and the Children Act 1989 can be used to compulsorily detain a child or adolescent exhibiting mental health problems. Various Sections of the Mental Health Act can be used, including Section 2 (admission for assessment) and Section 3 (admission for treatment). Section 25 of the Children Act can be used to detain a young person, but only if he or she fulfils certain specific criteria: a) if the child has a history of absconding and is likely to abscond from any other accommodation and is likely to be a risk to himself/herself if he/she absconds; or b) if he/she is kept in any other accommodation he/she is likely to injure himself/herself or others. The Children Act can also be used to give a local authority parental responsibility for the child, and thus the power to consent for admission and treatment. There are no definitive guidelines as to which Act should be used under what circumstances, although the issue has been considered in the NHS Health Advisory Service report (NHS Health Advisory Service, 1996). Further, little is known about the prevalence of the use of each of the Acts in such circumstances. The Department of Health has responded to this need for information by funding an evaluation of the use of the Children Act and the Mental Health Act in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS).

As part of CAMHA-CAPS, a survey of the members of the Child and Adolescent Faculty of the Royal College of Psychiatrists was carried out. The purpose was to ascertain members' views on the use of the two types of legislation for people under the age of 18, and ensure that CAMHA-CAPS addresses these issues.

Method

A questionnaire was sent to all 505 members of the Child and Adolescent Faculty with addresses in England and

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Table 1. Range of themes and frequency of psychiatrists who identified those themes

	n (%)
Choosing between the Children Act and the Mental Health Act	75 (31)
General issues around consent to treatment	57 (24)
General issues around social services departments	46 (19)
The stigma associated with using the Mental Health Act	44 (18)
Young people's rights in conflict with parental consent	42 (18)
General negative comments about the Children Act	37 (15)
General negative comments about the Mental Health Act	33 (14)
Positive aspects of the Mental Health Act regarding treatment and detention	27 (11)
Safeguards in the Mental Health Act	27 (11)

Only themes recorded by more than 10% of respondents are reported. A complete list is available from the authors upon request.

Wales. A single question was asked: "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?"

In all, four mailings were sent, comprising the initial mail out, two reminder letters and a final reminder enclosing a further copy of the original response form. These were sent at approximately 2-week intervals.

The responses were coded using a method used for a previous faculty survey (Worrall & O'Herlihy, 2001).

Results

Two hundred and fifty-eight forms were returned. This included 18 replies that were blank or otherwise considered unusable. Further investigation indicated that the addresses obtained were incorrect for about 10% of cases. The denominator was adjusted to 480 members, this giving a response rate of 54%.

The 240 useable replies provided 800 individual statements, which related to 50 separate themes. Table 1 describes the most frequent themes and frequency of their inclusion in the members' responses.

The most frequently reported themes were: choosing between the Mental Health Act and the Children Act (31% of the sample); general issues around consent to treatment (24%); issues with social services departments (19%); and the stigma associated with using the Mental Health Act (18%).

Discussion

This was an effective method of quickly obtaining psychiatrists' views, avoiding the constraints of presenting categorised response options.

There are, however, several limitations to the study, which must be borne in mind. In the first instance, the response rate of 54% appears low. This study must therefore be seen as illustrative rather than representative of members' views. Second, the frequency of responses is necessarily reliant upon the coding frame. Finally, the most important comments might not have been necessarily the most often reported. Such comments will, however, be considered in the design of subsequent parts of the project.

Choosing between the Children Act and the Mental Health Act

Choosing between the Acts was the most commonly reported theme among the psychiatrists surveyed. Many respondents highlighted the lack of definitive national guidelines in this area and a degree of confusion as to which statute has priority, and which is most appropriate for a given patient. The lack of agreement between psychiatrists and social services on which Act is most appropriate was also mentioned.

General issues around consent to treatment

The issue of consent for minors is a complex area, with statute, common law and precedent all interacting. The situation is further complicated by the fact that the child's age will affect the situation. Many psychiatrists reported confusion as to when consent was acceptable from the patient, or from parents, especially if there is a conflict. Further, there was also confusion as to a patient's competence to give consent, and if this was acceptable, whether, and under what circumstances, the parent's wishes could override this.

General issues with social services

When a minor is detained using the Children Act or the Mental Health Act, by necessity there will be an interaction between the consultant psychiatrist and the social services department. The respondents state that this situation sometimes results in disagreement.

Specifically, respondents mentioned a tendency of social workers to see the needs of the child as too closely linked to those of the parents, and to be reluctant to take positive action.

The respondents suggested that social workers are sometimes reluctant to use either piece of legislation. They suggested that social workers might not use the Children Act for a child who is mentally ill, and might not

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use the Mental Health Act because it would stigmatise the child concerned.

Stigma associated with the use of the Mental Health Act

Many respondents commented on the stigmatising effect of using the Mental Health Act, and the possible subsequent consequences for the individual concerned. Some mentioned specific consequences, such as difficulty of obtaining a visa for travel to the US. For some, fear of stigma led to a reluctance to use the Mental Health Act, and one described its use in those under the age of 18 as 'unethical'.

Conclusion

From this survey a range of themes has been identified, and these have informed the design of subsequent data collection tools. This includes a questionnaire for child and adolescent in-patient psychiatrists, to ascertain their knowledge, attitude and practice with regard to the use of legislation. Data collected from this and other components of CAMHA-CAPS will address many of these issues. Preliminary findings from this study were submitted to the Department of Health for consideration, prior to the drafting of the new Mental Health Act.

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Learning styles of psychiatrists and other specialists

AIMS AND METHOD

To describe how the Learning Styles Inventory was used to assess the preferred learning styles of a group of senior and specialist registrars from different specialities attending a management course.

RESULTS

Of the 272 doctors studied, the learning styles of psychiatrists (*n*=42) emerged as significantly different to the group as a whole, favouring reflective observation and concrete experience rather than active experimentation or abstract conceptualisation.

CLINICAL IMPLICATIONS

Knowledge of learning styles can help improve interactions with other specialities that adopt different learning strategies, and assist with the individual psychiatrist's lifelong learning. To engage the interest of medical students, psychiatrists may need to consider different teaching approaches in line with the prevalent learning style.

Doctors spend much of their time learning. When they qualify they may have spent nearly 20 years in full-time education. They will have been tested at various stages and become used to the idea of acquiring the knowledge that examiners expect of them. Learning, however, continues, both in the acquisition of skills needed in the clinical area and the facts needed to satisfy higher professional examiners. Doctors are almost unique among other professional groups in the number of examinations they sit and with the emergence of clinical governance there is an added weight placed upon lifelong learning. So, doctors need to continue learning. A better understanding of the way in which they learn must be valuable.

The business world has been interested in the idea of learning styles since the Second World War, with the Learning Styles Inventory devised by Kolb *et al* (1984) being the most widely-used tool. Although formulated to study organisational behaviour in the business environment, it is equally applicable to medical practitioners, both for doctors in training (Gatrell & White, 1999) and as a reflective tool used by experienced consultants (Brigden, 1999).

Kolb *et al* postulate learning as a four-stage cycle (see Fig. 1). The individual has experiences upon which he or she reflects and makes observations. These are then used to form concepts and generalisations. Experimental actions follow and these, in their turn, create new experiences. The Learning Styles Inventory described by Kolb *et al* (1984) measures individual strengths and weaknesses of the learner in these four stages (or modes) of the learning process. It is a simple self-description test that has nine sets of four descriptions with the respondent marking words that are most, through to least, like him- or herself. This then generates two axes, one being active experimentation (AE) *v.* reflective observation (RO), the other being concrete experience (CE) *v.* abstract conceptualisation (AC). These axes are then plotted out to give the four learning styles described in Fig. 1. For example, one set of four words is

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