Use of mental health legislation in a regional adolescent unit

Judith E. Nicholls, Carol A. Fernandez and Andrew F. Clark

The use of mental health legislation in a Regional Adolescent Unit over a 10 year period was reviewed. There was a trend of increasing use over time. This was thought to reflect changes in attitude and professional practice subsequent to the introduction of the Children Act 1989. Conversion rates of Section 5(2) were high and practitioners with appropriate training were involved in the majority of sections, indicating good practice.

Attitudes to consent to medical treatment by children and young people have changed radically in recent years. For many years they were regarded as being unable to give or withhold their own valid consent and treatment was prescribed on the basis of consent, obtained on their behalf, from their parents. Legal precedent, social change and the Children Act 1989 have all altered this view and practice. However, the issue of consent remains complex with legal, clinical and ethical arguments. In reality the whole issue is currently in some state of confusion.

The matter was first formally addressed in law by the Family Law Reform Act 1969 which stated that a child could give consent to treatment on reaching the age of 16 years but it said nothing about the ability of younger children. The 'Gillick case' subsequently extended the capacity to give consent to treatment to younger children provided the child understood the nature of the treatment.

The use of mental health legislation (Mental Health Act 1983 in England and Wales) to mandate psychiatric treatment in non-consenting children is rarely discussed. There is little available data about how frequently it is applied. Textbooks in child and adolescent psychiatry make little or no reference to its applicability (Hill, 1989; Graham, 1991; Rutter *et al*, 1994). By contrast the *Code of Practice to the Mental Health Act 1983* devotes five pages, consisting of 14 paragraphs of guidance, and explicitly states "There is no minimum age limit for admission to hospital under the Act" (Department of Health and Welsh Office, 1993).

Within the UK, wardship or the inherent jurisdiction of the High Court has been seen as a possible way of mandating treatment for physical or psychiatric disorder while also safeguarding a young person's civil rights. This remains the case in the treatment of life-threatening physical disorders (Devereux *et al*, 1993). With the recent changes in child care practice and legislation, use of mental health legislation in the treatment of psychiatric disorders has been briefly considered by Harris Hendricks & Richardson (1990), Jones (1991), Black *et al* (1991), and Pearce (1994).

Aims

In view of the paucity of data on the use of mental health legislation in children our aims were to review practice in an adolescent in-patient unit to establish the frequency of use and factors associated with its application. Our hypotheses were that we would discover an increasing use of mental health legislation over time and that it would be for older adolescents.

The study

The Irwin Unit for Young People is a 20-bed in-patient unit serving psychiatrically ill young people aged between 12 and 17 years. Its catchment area is the West Midlands Health Region (total population 5 000 000, adolescent population 400 000). Past records from 1983 (until end August 1993) were screened and all admissions who had been subject to detention under mental health legislation were identified. Details of age, gender, ethnicity, diagnosis, indication for detention, Mental Health Act Section applied, whether the applying social worker and one recommending doctor were members of the unit staff, and the outcome of any formal appeal were recorded from the notes and section papers.

Findings

During the study period there were 492 admissions. Thirty-three (6.7% of total) admissions (involving 30 patients) involved detention under the Mental Health Act at some stage during the stay. Excluding sections implemented in other hospitals prior to transfer, 52 sections were

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implemented by the unit. There were 14 Section 5(2), 21 Section 2 and 17 Section 3 implemented by the unit. Data were missing on two of these sections (both Section 2).

Of the total admissions during the study period, 60% were female. However, of the detained admissions, 63.6% were male. The mode age (50% of cases) taken from a sample year (1989: age range 12–16 years) was 15 years, with 16.7% age 16 years. Of those detained, the mode age (58% of cases) was 16 years; 3% were 13 years and 39% were 15 years. Of those aged 15 years, three were admitted in the period up to and including 1990, and 10 thereafter.

The main diagnoses of the admissions, ascertained from the medical notes of the admission, are set out in Table 1.

The reasons for detention were mainly to allow assessment and treatment in the interests of the young persons' own health. In eight cases the section papers also mentioned aggressive or violent behaviour towards others.

Of the 33 admissions, 22 were Caucasian, six Asian, four Afro-Caribbean and one mixed Asian/Caucasian. Our impression was of an over-representation of ethnic minorities within the detained group, but figures for the ethnicity of all admissions to the unit were not available to substantiate this.

There was an overall trend of an increasing percentage of admissions detained under the Mental Health Act over time (Table 2).

Of the 33 admissions that involved detention at some stage, 14 (42.2%) were admitted under mental health legislation. Of the 14 section 5(2) implemented, 86% of these converted to either Section 2 or 3. In 94% of cases a unit psychiatrist was one of the recommending doctors for Section 2 and 3. A GP made recommendations in 47% of cases. Of those sections requiring application by a social worker, 15 (41.6%) were completed by the unit social worker who was both an approved social worker and had experience of child care legislation. A further two (5.5%) involved a social worker from a children's team and the remaining 19 (52.7%) involved a social worker from an adult mental health team.

In total, nine appeals against detention were made, three against Section 3 and six against Section 2. All Section 3 were upheld. Two of the Section 2 were released, one by the hospital managers and one by the Mental Health Review Tribunal.

Table 1. Diagnostic mix

Diagnosis	Number of cases
Psychosis	17
Bipolar disorder	8
Depressive disorder	2
Obsessive–compulsive disorder	1
Anorexia nervosa	2
Anxiety state	1
Conduct disorder	2

Table 2. Admissions by year

Year	Total admissions (*n*)	Detained (*n*)	(%)
1983	38	0	(0)
1984	43	0	(0)
1985	45	0	(0)
1986	43	1	(2)
1987	42	2	(5)
1988	46	0	(0)
1989	45	4	(9)
1990	58	2	(3)
1991	38	6	(16)
1992	28	3	(11)
1993	44	9	(20)
1994 to end Aug	22	6	(27)

Comment

As predicted, we demonstrated increasing use of mental health legislation over time, particularly since 1991. The sex ratio and age distribution of sectioned patients differed from the total clinic population; more males and older adolescents were sectioned.

It is known that use of mental health legislation to mandate admission or treatment of psychiatrically ill young people within adolescent units varies considerably. Some units specifically state that their policy is not to admit young people under such circumstances citing safety issues, lack of staffing or resources, or damage to the therapeutic milieu as reasons. Others see adolescent units as having a lead role and responsibility in treating young people with severe psychiatric disorder, including psychoses, if necessary via mental health legislation (Steinberg, 1986; Hill, 1989).

This unit caters for adolescents with mental illness, including those with anorexia. Adolescent psychiatric disorder is more common in females, as represented in the preponderance of females in all admissions to the unit. It is likely that patients who are sectioned will be suffering from a psychotic disorder and in this population males are at greater risk, explaining the gender bias of detained patients.

The increasing frequency of use over time may reflect a change in attitude and professional practice subsequent to the introduction of the Children Act 1989. The Children Act has emphasised that children, even aged under 16, are able to give and refuse consent to medical examination or treatment, overiding parental wishes. As there

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is no lower age limit, if an otherwise competent child refuses essential psychiatric treatment the Mental Health Act can be used provided the patient is deemed incapable of giving informed consent due to a mental illness. However, there is some contradiction in that some legal precedents and the Mental Health Act Code of Practice state that no minor has the power by refusing consent to treatment to override a consent to treatment by anyone with parental responsibility. Within this unit mental health legislation was used predominantly in patients aged 16 years. Between 1983 and the end of 1990 two 15-year-olds were detained, but since 1991, ten 15-year-olds and one 13-year-old have been detained. These figures support the hypothesis of the impact of the Children Act 1989 on use of mental health legislation within the unit.

We do not consider that there were any changes in admission policy or diagnostic mix of the patients during the study period that could have accounted for the changes in use of mental health legislation over time.

On examining the sectioning process in more detail a number of interesting factors are evident. First the conversion rates of Section 5(2) are 86%, much greater than reported in adult studies (Mason & Turner, 1994). Taking the view that Section 5(2) should be used only if the use of Sections 2, 3 or 4 are not practicable or safe and that it is not purely an independent power of short detention this suggests appropriate usage of section 5(2) by the unit. This may be a reflection of the fact that all Section 5(2) were implemented by the consultant or senior registrar, who would have had good knowledge of the patient.

Second, in almost all cases one of the medical recommendations was completed by one of the unit psychiatrists. GPs were also frequently involved (in 47% of cases) and also the unit or children's team social worker (in 47% of cases). This suggests that the adolescents are being appropriately assessed prior to detention by those with training in adolescent psychiatry, use of child care and mental health legislation and by doctors who know them well.

Finally the fact that young people under 16 years are being detained under the Mental Health Act raises the question of statutory aftercare provision. Some of those who suffer severe mental illness with its long-term consequences are detained under Section 3 and therefore subject to Section 117 aftercare requirements as this makes no reference to the patient's age. However, Section 117 does not apply to those treated informally or solely detained under Section 2, but neither does it seem that other forms of statutory aftercare apply. The guidance regarding the implementation of the Supervision Register explicitly excludes young people aged under 16 from its remit and recent clarification from the NHS Executive similarly excludes them from the formal provisions of the Care Programme Approach although this does carry the rider that its principles should still be applied. It is clear that there is a group of young people in need of the protective framework of aftercare but for whom there are no specific and formal guidelines to aid good psychiatric practice.

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