

# Children's Participation Rights: Voicing Opinions in Inpatient Care

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Children's participation rights, embedded within legislation and policies, are increasingly becoming important in terms of their meaningful implementation in mental health practice. This paper explores ways that adolescents within an inpatient unit voice their opinions, based on participant observation, interviews and the analysis of documents. The voices of patients were encouraged only within the parameters of a specific form, content, time and place. The implications of these findings are discussed in relation to the culture of participation within CAMHS.

**Keywords:** Children's rights; participation rights; voice; adolescent mental health; inpatient care

## Introduction

This paper presents findings from a study to investigate children's participation rights conducted at an adolescent mental health inpatient unit in the United Kingdom. The ways in which children's rights to voice their opinion are incorporated in the daily lives of the young people and the challenges that remain in fully realising these rights are considered. The policy driven requirements to enable children's participation rights in practice is considered in relation to the traditional therapeutic culture of care.

## Background

There are three pieces of legislation pertinent to children with mental health problems and the recognition of their rights to participation. Internationally, the UN Convention on the Rights of the Child (1989) provides children, within article 12, with the right to consultation on all matters in their lives. This includes the right to be heard in any administrative proceedings, either directly or through a representative. In addition, children's views are to be given due weight in decision making. In national (UK) legislation, the Children Act (2004) sets out a duty on behalf of local authorities to provide services to children in need, which includes children who are experiencing mental health problems. Children's participation rights, and in particular their right to voice their opinion, are included within this statute. In conjunction with the Children Act (2004), children who use mental health services are also subject to the Mental Health Act (1983), although there are no specific rights statements for children in this legislation. Instead, the Code of Practice of the Mental Health Act, 1983 (1993) provides guidance in terms of children's rights to participation. Section 30, devoted to 'children and young people under the age of 18' indicates that children must be consulted and involved in decision making about their treatment and care as well as being provided with 'the least restrictive interventions possible'.

Most recently, these participation rights have been embedded in the *National Service Framework for Children* (DoH, 2003, 2004a, b, c) following the principles set out in the policy document *Learning to Listen: Core Principles for the Involvement of Children and Young People* (CYP, 2001) and *Building a Culture of Participation* (DfES, 2003). In *Learning to Listen* government departments and organisations working with children and young people are called upon to enable practitioners to develop the attitudes necessary to both value and ensure that children's rights to participation are implemented in practice. Moreover, it explicitly states that all children and young people must have an equal opportunity to participate regardless of disability. Therefore, their mental health status cannot be used as grounds to discriminate or prevent participation within child and adolescent mental health services. In *Building a Culture of Participation* government departments and organisations are guided to develop participatory practice with children and young people that is meaningful, effective in promoting change and part of the overall working ethos of the organisation. Practical guidelines are provided to help break a culture of care amongst staff teams that may be contrary to the principles of participation.

Although there is a burgeoning body of research in the area of children's participation rights in health (Alderson, Hawthorne, & Killen, 2005; Freeman, 2005; Franklin & Sloper, 2005; Lightfoot & Sloper, 2003), child protection (Winter, 2006), disabilities (Badham, 2004; Cavet & Sloper, 2004; Davis & Watson, 2000; Lightfoot & Sloper, 2003) and social policy networks (Tisdall & Davis, 2004) there is very little such research in mental health. The studies that have been conducted in child and adolescent mental health have focussed on eliciting the views of children and young people with regards to their treatment and care (Carroll, 2002; Claveirole, 2004; Farnfield, 1995; Laws, 1998; Laws et al., 1999; Spandler, 1996;) without specifically looking at their participation rights within mental health services. Other studies have focussed solely on the issue

of competence (Fundudis, 2003; Tan, Hope, & Stewart, 2003) or consent to treatment (Tan, Hope, Stewart & Fitzpatrick, 2003), rather than exploring participation rights and the voicing of opinions generally.

## Aims of the study and setting

The aims of the research were to explore the ways in which children's participation rights were implemented within an adolescent mental health inpatient unit. Elements of good practice were sought as well as potential barriers to involving children in their treatment and care. A further aim of the study was to document the children's experiences of psychiatric treatment from their own perspectives. In this way, they were given the opportunity during the research to voice their opinions regarding their treatment and care.

The unit provides beds for eight to ten young people, between the ages of 11 and 18 years. The young people who are patients in this type of mental health service typically experience mental health problems including behavioural or conduct disorders, eating disorders, psychotic disorders, self-harming and addiction problems, with a high rate of co-morbidity. The unit, categorised as a fourth tier service, is multi-disciplinary, employing mental health nurses and support workers within the inpatient facility as well as teachers, psychologists, psychiatrists, community psychiatric nurses (CPNs), social workers and counsellors within the day-patient facility. The young people in the inpatient facility attend the day-patient facility for education, lunch, individual treatment and group work. Outside of working hours, the young people engage in group work, one-to-one time with their key-workers, eat meals and sleep in the inpatient unit.

## Method

The researcher spent four months at the unit engaged in ethnographic research which involved becoming immersed in the culture of the young people in both the inpatient and day-patient facilities. The collection of data consisted of taking of field notes of observations of interactions amongst and between the practitioners and young people, and informal conversations between the young people, practitioners and the researcher as well as video-taping semi-structured and unstructured individual and group interviews. Other data were collected by analysing independent interviews provided by the young people, where they videotaped themselves in unstructured conversations together regarding their experiences, without the researcher's presence in the room. Additional written material (such as personal diaries, poetry, cards, drawings, etc.) that was not specifically elicited was nonetheless provided to the researcher by the young people. Data were analysed and organised with the use of NVivo, a qualitative analysis software package.

## Findings

A number of themes emerged under the topic of participation rights: consent, access to information, voice,

choice and decision making, medication, definition of participation, knowledge of children's rights as well as barriers to realising participation rights in practice (LeFrancois, 2006a,b; 2007). However this paper considers only the issue of children's voice, that is, their self-expression within the hospital generally. Issues relating to the formal voicing of opinion in relation to consent to admission and consent to treatment are detailed elsewhere (LeFrancois, 2006b; 2007).

For the most part, the practitioners in this study indicated an awareness of children's rights to express themselves and indicated that, for therapeutic reasons, the young person's voice is sought and deemed a positive contribution to treatment. The inpatient unit staff indicated that the expression of opinions was encouraged through the provision of a communication book that was available at all times. Moreover, the young people were made aware that they could speak with staff at any time, through one-to-one sessions and within group work.

However, the children expressed the view that there were qualifications to the practitioners' insistence that their views were important. In particular, they indicated that their views were encouraged only when the expressions were 'appropriate', as defined by the practitioners. For example, one commented during an interview with the researcher:

They ask you for your opinion and stuff like that but they say I am giving inappropriate answers... \_\_\_\_\_ (nurse) used to pick on \_\_\_\_\_ (young person) because she was so quiet. You know, they (staff) would say: 'Get your feet off the chair, you. Sit up. Keep your arms in front of you', and stuff like that. 'We don't want that!'. Maybe some people like \_\_\_\_\_ (young person) for example show people by body language how they are feeling.

In analysing patient files, this notion that opinions from the patients were allowed only when consistent with practitioners' interpretation of expressing oneself in ways that are 'age appropriate', not 'risky' and relayed in a positive and pleasant manner, were borne out. For example, consider the following quote written by a practitioner in a file:

He appears more sociable and less isolatory (sic) than in the previous admission but still uses prose and poetry (some with extremely graphic detail of self-harm) to put across how he is feeling.

In this way, both the form and the content of the young people's expressions are opened for scrutiny by the practitioners, sanctioning only expressions that are considered desirable from the perspective of an adult and a mental health professional. That is, in this example above, the use of 'prose and poetry' is considered an inappropriate form of expression, and 'graphic detail of self-harm' is considered inappropriate content. Conversely, the types of expressions that are encouraged are those that are consistent with practitioners' views, those that relate information that is uncontroversial as well as those that are expressed verbally and in a calm (unemotional) manner. Any expressions that may be more artistic, nonverbal, controversial (i.e.: discussing views on euthanasia at the dinner table or discussing mental distress outside of one-to-one sessions), with sexual content or that criticise the practitioners are likely to be silenced in some way. In

addition, the appropriate time and place for expressing views is determined by the practitioners. For example, one young person during an interview with the researcher explained the silencing of her voice within a setting that she felt was appropriate:

I've been told that...what I said was inappropriate...well, that it's not right at the table. I like making people laugh. I've got a good sense of humour and I used to try to cheer everyone up but I used to be told that I shouldn't be saying these things because it's not right. And I used to talk about how I felt, and I thought at the dinner table it is quite a good place because you are all together and you can all talk. You know, I wasn't talking about things to put off the people with eating problems but the staff would say: 'There are people here trying to eat and you're not helping'. But, I thought it was a good place to talk 'cos you're all together and it's quiet.

The ways in which practitioners silence the young people when expressing themselves in 'inappropriate ways' took a number of forms; telling the young person outright that the content and/or form of their expression was inappropriate; shouting 'shut up'; explaining that they are psychiatric patients in a hospital; or calling emergency meetings where the 'inappropriate' young person is surrounded by the practitioners and young people with focussed attention on making them conform to the practitioners' expectations of appropriate self-expression. It seems clear that practitioners would silence or reprimand the patients when they perceived them to engage in inappropriate communication. Another way in which they did this, exclusively directed at girls, was to make derisory comments that had sexist and ageist implications. For example, the researcher observed two different male practitioners making the following comments at different times:

You are like a bunch of old ladies.  
You are like a couple of old hens.

The effect of these comments was to silence the girls immediately. In both cases, the girls were complaining to each other about the style taken by two different practitioners who were not on duty at the time of the discussions. Rather than listening to their concerns and attempting to address them in some way, the practitioners' invoked derogatory stereotypes relating to gender, thereby dismissing their concerns and silencing them in one brief statement.

In relation to class, there appears to be a difference in terms of the effectiveness of practitioners to silence the young people. That is, although all of the young people were silenced repeatedly, based on the researcher's observations, the ability to resist the attempts by practitioners to silence them appears to be increased when middle class boys were being silenced by working class practitioners. The boy's abilities to talk using good grammar, clear speech and advanced reasoning skills (such as critical thinking, structured argument formation and skills in engaging in rhetoric) appears to have sometimes led these working class practitioners to give up in their attempts to silence these boys from middle-class families.

Regardless of the consistent attempts to silence the young people's voice, many of them explained that they also felt pressured to talk at times when they do not feel comfortable expressing themselves. That is, the practitioners' often insisted that they must share how they

are feeling and what they are thinking individually with the practitioners but also at times within group settings. This is experienced as distressing by many of the young people.

Another qualification many of the young people made to the notion that the practitioners' value their voice, relates to the extent to which practitioners acted in accordance with the young person's views. Consistent with the findings in the study by Farnfield (1995), it was felt by many of the patients in this study that their opinions were not given due weight and were not acted upon by practitioners. For example, one explained during an interview:

Sure they might listen to it but it don't mean they are going to take it into account. Sure they'll listen. It's a bit different listening from actually doing something.

Despite these limitations, some young people did feel that, on occasion, their views were listened to by the practitioners, something which can be perceived as positive by the young people. For example, some mentioned that one of the weekly group sessions was conducted in an environment where expressing opinions was encouraged in an open and tolerant way by the practitioners, as illustrated by the following comment made to the researcher during an interview:

In the Thursday group...staff do a lot of the talking and they ask us to give our own opinion. That's what I like about the Thursday group. I could give my own opinion without anyone dissing me because throughout my life a lot I've been, you know, people have been horrible to me for expressing my own opinion.

## Discussion

The denial of voice may occur for the young people in many contexts of their lives and the space within the inpatient unit to express oneself, when it is provided, is appreciated and may contribute positively to building their self-esteem. Certainly, it has been suggested that children and young people's participation leads to increased confidence and self-belief (DfES, 2003).

The concept of enabling young people to voice their opinions is enshrined in the UNCRC, the Children Act (2004), the Code of Practice to the Mental Health Act, 1983 (1993) as well as the *National Service Framework for Children* (DoH, 2003, 2004a, b, c). Regardless of demonstrating an understanding of the importance of voice, the encouragement of self-expression in the young people was often curtailed by the practitioners in this study. That is, the form and content of the young person's expressions were scrutinised by the practitioners and sometimes deemed either acceptable or inappropriate. Furthermore, self-expression in the young people was tolerated to a greater extent if engaged in at a time and place pre-determined by the practitioners. Otherwise, any form of self-expression not adhering to the practitioner and adult defined norm, was silenced. Moreover, there appeared to be some attempts by the practitioners to force the young people to express an opinion at times when they are unwilling to do so. Although this may be done in the name of therapeutic intervention, it must be noted that forced participation is contrary to the provision of children's rights to voice an opinion as set out both in

the legislation and subsequent policy documents. The overall exertion of power and control over the young person's expressions serves to greatly minimise any benefits relating to self-expression.

A further analysis of these issues by practitioners, including engaging in reflective practice within the staff team, may result in more depth of understanding around the needs and benefits in relation to children's rights to express their opinions. Moreover, examining the cultural, educational, familial and class-based experiences of the various individual practitioners and the impact these experiences may have on their level of comfort with encouraging self-expression in the young people should be recognised, so as to limit the extent to which personal values interfere with professional practice.

This study clearly had limitations in that it all took place in one unit. Thus the findings need to be treated with caution and in particular they may not represent other Child and Adolescent Mental Health Services. However, the DfES (2003) policy document highlights the need for all services to break down patterns of care that are inconsistent with the notion of children's participation rights. Work needs to be done to open up new ways of communicating and working with young people that incorporates an understanding of the purpose of children's rights rather than merely interpreting these concepts in relation to traditional therapeutic approaches to intervention (LeFrancois, 2007).

More research incorporating a wider range of therapeutic settings needs to be conducted within Child and Adolescent Mental Health Services in relation to children's participation rights. Particular issues relating to social class and modes of communicating amongst and between young people and practitioners should be explored. A willingness on the part of managers and practitioners to open their doors to researchers, to overcome feelings of intimidation in relation to being evaluated as well as demonstrating a commitment to being accountable for their approach to practice, all of which was the case in this study, may lead to opportunities to improve services in relation to children's rights.

## References

- Alderson, P., Hawthorne, J., & Killen, M. (2005). The participation rights of premature babies. *International Journal of Children's Rights*, 13, 31–50.
- Badham, B. (2004). Participation - for a change: Disabled young people lead the way. *Children & Society*, 18, 143–154.
- Carroll, J. (2002). Play therapy: the children's views. *Child and Family Social Work*, 7, 177–187.
- Cavet, J., & Sloper, P. (2004). Participation of disabled children in individual decisions about their lives and in public decisions about service development. *Children & Society*, 18, 278–290.
- Claveirole, A. (2004). Listening to young voices: challenges of research with adolescent mental health service users. *Journal of Psychiatric and Mental Health Nursing*, 11, 253–260.
- CYPU (2001). *Learning to listen: Core principles for the involvement of children and young people*. London, UK: Children and Young People's Unit.
- Davis, J., & Watson, N. (2000). Disabled children's rights in every day life: Problematising notions of competency and promoting self-empowerment. *International Journal of Children's Rights*, 8, 211–228.
- DfES (2003). *Building a culture of participation: Involving children and young people in policy, service planning, delivery and evaluation*. London: HMSO.
- DoH (2004a). *National Service Framework for children, young people and maternity services - core standards*. London: HMSO.
- DoH (2004b). *National Service Framework for children, young people and maternity services - the mental health and psychological well-being of children and young people*. London: HMSO.
- DoH (2004c). *National Service Framework for children, young people and maternity services - medicines for children and young people*. London: HMSO.
- DoH (2003). *Getting the right start: National Service Framework for children - standard for hospital services*. London: HMSO.
- Farnfield, S. (1995). *Research into the views of children, young people and their carers, of mental health services*. A report to the Southampton and South West Hampshire Health Commission.
- Franklin, A., & Sloper, P. (2005). Listening and responding? Children's participation in health care within England. *The International Journal of Children's Rights*, 13, 11–29.
- Freeman, M. (2005). Children's health and children's rights: An introduction. *The International Journal of Children's Rights*, 13, 1–10.
- Fundudis, T. (2003). Consent issues in medico-legal procedures: How competent are children to make their own decisions? *Child and Adolescent Mental Health*, 8, 18–22.
- Laws, S. (1998). *Hear me! Consulting with young people on mental health services*. London: The Mental Health Foundation.
- Laws, S., Armit, D., Metzendorf, W., Percival, P., & Reisel, J. (1999). *Time to listen: Young people's experiences of mental health services*. London: Save the Children.
- Le Francois, B.A. (2006a) 'They will find us and infect our bodies'. The views of adolescent inpatients taking psychiatric medication. *Radical Psychology*, 5, 1.
- LeFrancois, B.A. (2006b) "You don't have to enjoy it; you just have to do it": Participation and mental health services. *Accepted for publication*.
- LeFrancois, B.A. (2007) *Psychiatric Childhoods*, Submitted PhD thesis, Canterbury: University of Kent.
- Lightfoot, J., & Sloper, P. (2003). Having a say in health: Involving young people with a chronic illness or physical disability in local health service development. *Children & Society*, 17, 277–290.
- Spandler, H. (1996). *Who's hurting who? Young people, self-harm and suicide*. Manchester: 42nd Street.
- Tan, J., Hope, T., & Stewart, A. (2003). Competence to refuse treatment in anorexia nervosa. *International Journal of Law and Psychiatry*, 26, 697–707.
- Tan, J., Hope, T., Stewart, A., & Fitzpatrick, R. (2003). Control and compulsory treatment in anorexia nervosa: The views of patients and parents. *International Journal of Law and Psychiatry*, 26, 627–645.
- Tisdall, E. K. M., & Davis, J. (2004). Making a difference? Bringing children's and young people's views into policy-making. *Children & Society*, 18, 131–142.
- Winter, K. (2006). The participation rights of looked after children in their health care. *International Journal of Children's Rights*, 14, 77–95.