

“It’s Like Mental Torture”: Participation and Mental Health Services

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Abstract

This article discusses findings from an ethnographic research study looking at the ways in which children’s participation rights are incorporated within an adolescent mental health inpatient unit. The practitioners working within this setting have reinterpreted the concept of ‘participation’ to suit a coercive agenda associated with the authoritarian medical model of treatment used within child psychiatry. Indeed, the use of the term ‘participation’ has become a tool to enforce children’s compliance with adult (and practitioner) determined treatment plans. For the most part, the barriers to according children’s participation rights within this setting relate to the institution’s and practitioners’ protectionist stance vis-à-vis children who are deemed informally to be both vulnerable and incompetent.

Keywords

mental health; Children’s Rights; Child and Adolescent Mental Health Services; child psychiatry; participation; medical model; protectionism; compliance with treatment; coercion; competence; best interest principle

Introduction

This paper explores some findings from research into children’s participation rights, conducted at an adolescent psychiatric inpatient unit in the United Kingdom. In particular, the ways in which participation rights are incorporated in the treatment and care of the young people and the challenges that remain in fully realising children’s rights within mental health services are considered.

Background of the Study

Children’s rights in the UK have progressed to the point where recognition of their entitlement to have their views heard and to be taken seriously is mandated in legislation¹ and subsequent children’s policies within health and

¹ The three pieces of legislation that are pertinent to children with mental health problems and the recognition of their rights to participation are: a) The UN Convention on the Rights of the Child; b) The Children Act; c) the Mental Health Act.

social services.² However, this progressive legislation affecting children carries veto clauses, where the acceptance of the age-related notion of the acquisition of rational competence is implied as an adult defined measure of capacity, in the context of requirements to consult children and allow them to participate in decision making. For instance, the Children Act 2004 requires professionals to consult children “where the child has sufficient understanding to make an informed decision”, while the UN Convention on the Rights of the Child 1989 refers to consultation involving “the child who is capable of forming his or her own views...in accordance with the age and maturity of the child”. It is left to the adult to interpret ‘sufficient understanding’, ‘the child who is capable’ and the ‘maturity of the child’, often based on age. Adults are left in the position of determining children’s level of rationality.

As Piaget’s model of rational development has become a classic approach to framing an understanding of children’s abilities (James and James, 2005; Smith, 2002; Lowden, 2002), even amongst the general public (James *et al.*, 1998; Burman, 1997), the view that children are rationally incompetent persists. Nowhere is the acceptance of children’s irrationality more prevalent, both in terms of legislation, policy and practice, than in the area of child and adolescent mental health. Not only are individuals considered logically incompetent due to their status as children, but this assumption is reinforced by their status as psychiatric patients. The Code of Practice to the Mental Health Act, 1983 (1993, p. 114–120) stresses the importance of consulting children regarding their treatment, when they have acquired the necessary “understanding and intelligence” to do so, and in consideration of the child’s “emotional maturity, intellectual capacity and psychological state”. Again, similar to the Children Act, a vague statement, left to professionals to interpret, relating to the developmental acquisition of rationality in children easily serves to exclude children, particularly children with a psychiatric diagnosis - who may readily be defined as exhibiting an abnormal ‘psychological state’ - from having any direct involvement in their care. Instead of emancipating children, the vagueness of the legislation regarding children’s competence tends to reinforce the accepted cognitive inequality of children in relation to adults, which then helps to maintain the socio-political status quo.

Coppock (2002, p. 150) notes that children are presumed incompetent unless there is evidence to the contrary whereas, “(a)du(lt)s are presumed to be competent unless there is evidence to the contrary”. Furthermore, “it is virtually impossible to envisage a situation where a child or young person with a negative mental health label could ever refuse treatment” (Coppock, 1997, p. 157). Despite the

²) Most recently, participation rights have been embedded within the National Service Framework for Children (DoH, 2004a; DoH 2004b; DoH 2004c; DoH 2003) 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).

rhetoric within mental health services regarding user empowerment and children's rights, in practice children continue to be passive recipients of care from what is essentially a paternalistic service. This remains to be the case because the legislation and policies put into place to ensure children's rights to participation continues to be interpreted within a developmental framework, with emphasis placed on male definitions of 'rationality'. In addition, the model of practice within child and adolescent mental health - the medical model of treatment - readily places patients in a passive role, with professionals in a position of authority with respect to decision making. The very act of diagnosing children with a mental disorder immediately renders the children into a position where their own agency is considered lacking or undesirable. In this context, adults hold sole discretionary power in defining children as irrational, based both on their age and their psychiatric diagnosis, thereby stripping them of any rights they might otherwise have to make decisions that could influence their treatment.

Although the implications of being considered rationally incompetent are generally discouraging for children in that they are denied a voice (Mayall, 2000) and any sense of autonomy (Lowden, 2002; Dickenson, 1994), professional and legal rhetoric obscures these implications by insisting that the decisions made on their behalf are necessarily in 'the best interest of the child'/ren. In this way, the 'best interest principle', which is embedded in the legislation, serves not only as an additional adult veto to children's decision making in the name of protection of the vulnerable (James and James, 2005; Lowden, 2002; Woodhead, 1997), but also masquerades as decisions that children themselves will both appreciate and benefit from. However, it has been shown, for example in the case of child sexual abuse, that adult decisions based on protection, made without consultation with children, may actually act against children's best interests and lead to increasing their level of vulnerability in the face of perpetrators (Kitzinger, 1997). Also, it has been argued that the emotive appeal to protect children's 'best interests', by making decisions on their behalf, is actually an effective way of maintaining adult interests (Alderson *et al.*, 2005; Fitzgerald, 1994), while obscuring elements of social control (James and James, 2005; Mayall, 2000; Burman, 1997; Coppock, 1997; Kitzinger, 1997), social exclusion (Mayall, 2000; Qvortrup, 1997) and injustices against children, such as civil rights abuses (Lowden, 2002; Coppock, 2002; Coppock, 1997; Burman, 1997).

Aims of the Study and Setting

The aims of the research were to observe and document the ways in which children's participation rights are implemented within an adolescent psychiatric inpatient unit. The exploration and identification of elements of good practice were sought as well as potential barriers to involving children in their treatment

and care. The study was conducted in an adolescent psychiatric inpatient unit in the United Kingdom. The inpatient unit provides beds for eight to ten children, between the ages of eleven and eighteen years. The children who are patients in this type of facility typically experience severe mental health problems, with a high rate of co-morbidity.

Method

This study involved engaging in ethnographic research within both the inpatient and day-patient facilities. The researcher spent four months at the unit, immersing in the culture of the young people. Data was collected through taking field notes of: a) observations of interactions amongst and between the practitioners and the children; b) informal conversations with practitioners and children; c) internal policy documents; and, d) patient files. In addition, semi-structured and unstructured individual and group interviews with the young people and practitioners were videotaped. Finally, additional data was gained from personal diaries and other written material (poetry, cards, drawings, etc.) provided to the researcher by the young people.

Findings

After analysing the data and organising it with the use of NVivo, the following categories, among others, emerged under the topic of participation rights: choice and decision making, medication, 'participation' as well as barriers to realising participation rights in practice.³

Choice and Decision Making

The young people in the study felt that they had little to no choice regarding treatment within the inpatient unit. For example, in terms of engaging in group work, the young people indicated that they have no choice whether they wanted to participate or not. Group work consists of such things as playing skittles, volleyball, washing practitioners' cars on a hot summer day, watching videos, etc. The activities for the groups were decided by the practitioners, however the young people were asked for their input. The young people felt as though their input was taken up only if their suggestions were consistent with

³) Details of findings relating to consent to admission, consent to treatment, access to information, voice and knowledge of children's rights are presented elsewhere (LeFrançois, 2007b; 2006).

the practitioners' pre-arranged plans. One young person explained during an interview with the researcher:

Some of the groups can keep you from getting bored but it's just, you don't have an option on them. That's what I'm saying, you need to do it and fully participate in it. You don't get the choice to go into it or not, if you see what I mean. If you're here, you are going to do the activity, whereas at home you could choose. You've got, on the holidays especially, you've got an input in what you do ... (Here)(it)'s pretty much decided by the day staff. At the start of the week we can suggest things but they have final say about it and if we don't like it – tough.

Moreover, if the young people refused to participate in group work, there were consequences. These consequences ranged from: calling an emergency meeting where the young person was surrounded by the practitioners and the other young people and forced to explain their lack of participation in the group; having the group follow the young person to where they were and engaging in the group there (for example in young persons bedroom, outside, other room, etc.); explaining to the young person that by not participating they were breaking their treatment plan and would either be suspended, discharged or denied weekend leave to go home. One young person explained the following to the researcher during an interview:

Yeah, we don't have a way of getting out of it (participating in group work). Yeah, the group follows you so you have no way of getting out of it... Yeah, that's the thing, you can't get out of it, especially if they all come up following you wherever you go... Sometimes if you don't move, sometimes I don't want to move, they will put the group around you and stay with you and talk to you.

The young people felt quite strongly that there should be a choice in terms of participating in group work or opting out depending on such things as interest in the activity, individual needs, mood on a given day and personality. In terms of individual needs, it should be pointed out that many of the young people were taking medication that causes side effects such as fatigue, drowsiness, nausea and lethargy. Engaging in physical activities in the summer heat such as playing volleyball and washing practitioners' cars can be extremely difficult under these circumstances. During informal conversations with the young people while engaging in these activities, some young people expressed that the impact of being forced to engage in some activities was: "like mental torture"; "terrible"; "horrible". Despite these comments, there was also a view that some of the group work was beneficial to them. However, the young people felt they should be given credit for knowing when it was important to participate and knowing when it was reasonable to opt out.

Some of the young people mentioned that they felt they should have some choice over who was assigned to them as case manager and keyworker. The role of these two practitioners is to provide one-to-one support for the young people in the inpatient unit and to act as an advocate for the young people during clinical reviews. If the young people found their relationship not working with either of

these practitioners, they did not have the option to request a change. When asked about this during an interview with the researcher, the consultant psychiatrist indicated that changing workers was rarely allowed so as to ensure that the team continues to function well together:

Practitioner: There's usually a lot of resistance on the, I mean I don't, you know, I, it would be done in discussion with the team, uhm, we always talk about it. Uhm, I mean, the team are usually fairly happy with themselves that they got it reasonably right. Uhm, or maybe that that particular young person is being very manipulative, so, uhm, I would say a change is very very rare. Because, I think it is often an attempt at manipulation. I mean, maybe not always but you've got to have a happy team that can work together, you know, you've got to look at the staff team and sort of how they are feeling about things because, I mean, if you then start doing that you know you are going to have real problems within the team.

Researcher: Staff insecurities?

Practitioner: (Nods) And then that's going to affect the therapeutic programme.

Therefore, the concept of different personalities not meshing and/or gender issues and the desire to try to change practitioners if the young person felt that they may work better with someone else, was not encouraged and often considered manipulation on the part of the young people who request such changes. The result of this approach was that some young people who were not satisfied with their case manager or keyworker, tended not to request one-to-one sessions and hence received less support than they would otherwise have received. The practitioners' need to have good relationships with each other in order to maintain a strong team within the therapeutic environment seems to be prioritised over and above the individual needs of some young people, as per the words of the practitioner above.

The weekly review meetings were comprised of all the practitioners that are working with a particular young person. Decisions were made at this weekly meeting regarding weekend leaves, treatment options, progress thus far, etc. The young people were not invited to attend these meetings but were allowed to tell their case manager what decisions they would like to see made at the meeting. However, some young people mentioned that they spent months asking to have their treatment changed (particularly around medication) with only varying success after persisting with requests repeatedly to be brought to the review meetings. There was a general consensus amongst the young people that decisions that were made within these meetings rarely took into consideration the views of the young person, thus limiting their choice and decision making power. Although information from the young person may be relayed to the review committee via the case manager, the lack of the young person's presence in the room eliminated the potential for further discussion and elaboration on the part of the young person. As these meetings took place behind closed doors, it was not clear to the young people whether their views were ever raised let alone taken into account when decisions were made.

Professional meetings, which took place every few months, involved a case conference style meeting where parents and all the professionals involved in the young peoples' care, including teachers, out of town medical team, etc., attended to discuss progress, treatment plan ideas, discharge, etc. Although all the young people claimed that they were only allowed to attend the last 15 minutes of this meeting, during a group interview with the practitioners, there was lack of consensus as to whether the young people were actually allowed to attend the entire meeting or simply the last 15 minutes.

During interviews, the young people explained that they do not like to attend the professional meetings. Reasons for not wanting to attend, or not enjoying the experience if they did attend, stemmed around issues of knowing that the professionals had spent the majority of the meeting discussing them without their presence in the room. Moreover, there was a sense of feeling overwhelmed with this idea and feeling intimidated even walking into the room, let alone voicing an opinion that may be contrary to what the professionals had decided during the first part of the meeting. One young person explained during an individual interview with the researcher:

You can (attend) for the last fifteen minutes...(It was) scary...There's loads of people in there, all these professionals. I walked in, right, and some people that I didn't even know (were there) and I thought 'they've been discussing me for like an hour and a half' and then they all just looked at me as I went to sit down. It was horrible...They told me what was going to happen (care plan) and they said 'What do you think?' and I just said 'Yeah'. I hated it.

There was some acknowledgement from the practitioners that the young people generally did not choose to attend the professional meetings, explaining that it was because the young people felt overwhelmed by so many people being in the room and a lack of confidence. Despite this recognition, the practitioners did not engage in any reflection on the ways in which the professional meetings may be changed in order to accommodate the young peoples' presence and full participation. Instead, there seemed to be an acknowledgement that only the most mature and confident were capable of attending and engaging in meaningful interchanges with the professionals. Rather than discussing the implications of opening up these meetings to younger and less confident young people, the practitioners readily dismissed the notion that the young people were really interested in contributing to these meetings. For example, one of the practitioners commented, during the same group interview mentioned above, the following:

Sometimes it's just that they got some things going on that are more interesting to them outside, like you know, if they are going to go swimming or something, they would rather go swimming... with their mates than they would sit in a room like this with professionals asking them questions that they aren't sure they understand...I guess, they've been sitting in education, it's more like sitting in a classroom listening to stuff that doesn't really interest a young person of a certain age, but if they are quite mature then yeah they might want to be interested...

Although it was clear from the young peoples' perspective that they did not want to attend the professionals meetings, largely due to the intimidating nature of the forum, it is an inaccurate and simplistic argument for the practitioners to suggest that the young people were merely not interested in the content of these meetings. Rather, the young people continuously mentioned a desire to have more information about their treatment and care, and to have their views listened to, yet they were left feeling frustrated and uninformed. To suggest otherwise, is merely a way of justifying the further isolation of the young people from a participatory approach to treatment. The young people in the study, regardless of age, did not present as uninterested in the many decisions that were being made with regards to their immediate and future health and well-being. Although the young people were allowed to attend the last 15 minutes of professional case conferences, their participation was not facilitated in a meaningful and informed manner (Hart, 1992). The redesigning of case conferences, using practice principles of children's participation (Holland and O'Neill, 2006; Connolly and McKenzie, 1999; Sketchely and Walker, 2001; CROA, 1998; Michel and Hart, 2002) should be done in order to facilitate the young peoples' full involvement in a meaningful and informed manner.

When asked on interview regarding whether the young people should be involved in decision making, the practitioners within the inpatient unit and the consultant psychiatrist indicated that although they realised the young people felt that decisions were being made for them without their consultation, this was generally being done for reasons of their safety, best interest and due to their lack of maturity. One practitioner explained during a group interview:

A lot of the young people sometimes perceive that we are making decisions about them regardless of what their thoughts are... Well, and it could be because some of the young people come in here because they aren't capable of making decisions for themselves, to keep them safe. So, if you've got professionals going against them they get quite angry about that and they say 'Oh, you're just going to do what you want to do anyway'. So, it's pointless them coming in (to talk about what they want). I think that's how they see it... Well, you do reassure them that what we are doing is for their safety and if they say: 'Why can't I jump off the railway bridge' then they are going to get loads of reasons why they can't but if you can reason with them then you try it... As long as you explain to them the reasons why you are going against their opinion then, sometimes they just have to learn to accept that we are the adults and we do know best sometimes. We do know what keeps them safe.

The reliance on arguments based on incompetence, protectionism and the best interest principle, although relevant with some young people within some specific contexts, seemed to be extended to all of the young people in the inpatient unit, whether they have been formally assessed as lacking competence and/or in need of safety or not. The example, given often, of wanting to jump off a bridge, served to exaggerate the expressed wishes of the young people to an unreasonable extent, thus dismissing and derailing any dialogue around reasonable decision making with the young people.

Making Medication Decisions

As detailed elsewhere (LeFrançois, 2006) all of the young people in the study were prescribed some form of medication as part of their treatment. These medications ranged from anti-depressants, anti-anxiety medication, sleeping tablets and anti-psychotic medication. All but one of the young people expressed concerns about their medication but felt that their concerns were not taken into account in terms of making decision about using medication within their treatment plans. Some of the concerns regarding the medication were regarding the experience of side effects, fear of becoming unwell again once they stop taking them (and therefore needing to stay on them for life), a belief that some types of medication are ineffective and fear that the medication may alter one's identity. The young people felt as though their arguments were not listened to by the practitioners, despite repeated efforts to have the medication reviewed and stopped. In two separate interviews, two of the young people explained their reasons for wanting to come off their medication thus:

They won't take me off anti-depressants 'cos they reckon that's what's helping me. As soon as I do come off of them, if that is what's happening, I'm just going to go ppllloooo (motions downward)...I want them to take me off them now...while I am here so they (practitioners) can help me.

* * *

S/he (consultant psychiatrist) sorts out my medication and stuff, which I've had a long ongoing battle with him/her. I'm against any form of medication 'cos...I don't like to think of it as brain chemicals all in the wrong. That makes me feel that it's out of my control and medication put forward to solve those problems, again is out of my control. I don't like, you know, how these things can alter the way I think and the way I am...It's an anti-psychotic. It's supposed to change thought patterns, or alter, that's what I've been told...I don't like the idea that it changes who I am. They say they are fine but I don't want to lose something that is me... I think it's, I mean, I don't think that medication is the answer and I think people should be given a choice whether we want medication or not. I mean, it's your body and they shouldn't threaten you and things like that.

It is interesting to note that when the consultant psychiatrist was asked by the researcher about the diagnosis of the young person quoted directly above, it was indicated that it was 'Queried Psychosis'. When the researcher mentioned not being familiar with that particular diagnostic category, it was explained that it was unclear at this point whether the young person in question suffered from a psychotic disorder or not. Despite months of repeated requests to be taken off the anti-psychotic medication, this young person, who did not have a diagnosis of psychosis, was denied the right to stop taking the anti-psychotic medication. Those young people who wanted to stop taking their medication all mentioned making repeated requests. Most requests were denied. Moreover, the young people were monitored closely for compliance. However, these young people were clear that they were not 'forced' to take their medication but rather they were 'obliged' to in

order to avoid consequences. The consequences ranged from suspension, discharge or denying/forcing weekend leave on the young person. One young person defined this as ‘threatening’ the young people whereas another young person merely considered it ‘undo pressure’.

“Participation”

The term “participation” was used frequently by the practitioners within the inpatient unit, so much so that the young people regarded it as a negative and, at times, a punitive word. When asked during individual interviews what the word “participation” meant to them, overall the young people defined it as an obligatory action within group work that is non-negotiable and requires complete and practitioner-defined ‘appropriate’ focus and diligence. Some of the individual young peoples’ definitions were:

Joining in with everything, being part of things in group activities. But you don’t have to enjoy it, you just have to do it. I personally don’t enjoy it.

* * *

Taking part in everything...You have to take part in everything...We don’t have a way of getting out of it.

* * *

It’s acting in support of the group and in consideration of others and whatever and sometimes you want to be a rebel and not participate and refuse but my conscience comes into play and I think about the consequences and I stop myself.

* * *

You don’t have an option if you want to do a group or not. You’re in the group. You are here so you do it...To not participate isn’t just, if you are actually in the group but not doing the activity properly or acting in an appropriate way then they will call an emergency meeting. It (not participating) doesn’t mean you just refuse...if you’re not doing it the way they want you to they say you’re not participating.

As can be seen by these definitions, “participation” had come to mean “forced participation” within group work amongst the young people. Moreover, the way in which the young people participated was scrutinised, ensuring compliance not only in terms of involvement in the group but also in terms of the form that involvement must take (LeFrançois, 2007a; 2007b). The young people also described the types of consequences that may arise out of not participating. For example:

They call an emergency meeting...They want to know why basically. They don’t, if you’re not willing to participate 100% then they want to know why. They won’t leave you alone basically. They’re pretty desperate to find out...and when the person has found something to say, they’ll sometimes leave it...You have to find the reasons and say why.

The practitioners within the inpatient unit defined “participation” as compliance with treatment. During a group interview with them, two practitioners suggested the following:

Practitioner #1: If you comply with treatment.

Practitioner #2: Yeah, we’ve had to say that on occasion that this is a part of treatment and if you don’t want it (group work) there is no point in you being here so you have to go.

These views seemed to have been shared by the other practitioners in the interview, as was evident by their ‘agreeing’ nods. Although this appeared to be accepted wisdom amongst the inpatient unit practitioners, the practitioners at the day-patient unit varied in their opinion regarding “participation”. That is, of the five practitioners interviewed within the day-patient unit, four indicated that participation was something that occurs in a collaborative manner within the therapeutic relationship as well as in terms of evaluating the therapy and outcomes. In this way, it was repeated by all four practitioners that there is a choice involved on the part of the young person and that shared goals and collaboration were important from the onset to termination. In addition, two of these practitioners mentioned disagreeing with the approach taken at the inpatient unit that involved enforcing compliance with treatment by demanding participation of the young people with the threat of consequences. However, the fifth practitioner in the day-patient unit, the consultant psychiatrist, when asked about the young peoples’ participation, mentioned:

You know, but, but, I, I certainly wouldn’t be the, but then I’m ancient, so I certainly wouldn’t, you know I don’t think, for me, I don’t think the children should, you know, be in control of their treatment programme.

It was clear that most of the day-patient practitioners had a definition of participation that is consistent with the UNCRC use of the term, whether they were in agreement with that provision or not. However, the practitioners within the inpatient unit appear to have re-interpreted the term in such a way that they feel they are adhering to children’s rights to participation, however, rather than involving a choice and the emancipation of the young people, this involves a legislated manner to enforced compliance with pre-determined treatment plans. This is in direct conflict with the notion of children’s participation rights. Furthermore, it states very clearly within the UNCRC that participation is a choice not something that should be forced on children (Landsdown, 1995; Eekelaar, 1994). Moreover, with respect to the consultant psychiatrists’ interpretation of children’s participation somehow being equated with children taking

over control of their treatment, it should be noted that the concept of shared goals and collaboration mentioned by the other day-patient practitioners more closely matches the provision within the UNCRC.

Barriers to Realising Participation Rights

All of the practitioners in the inpatient and day-patient units were asked by the researcher what barriers they felt existed to realising children's rights to participation. For the most part, their responses related to deficits in the young people such as their diagnosis, age and maturity level, lack of knowledge and need for safety. With the exception of comments made by two day-patient unit practitioners, there were no barriers suggested that relate to practitioner shortcomings, institutional barriers or structural issues.

In relation to diagnosis, some practitioners claimed that the diagnosis itself and/or specific symptoms relating to the diagnosis are a major barrier to involving young people in their treatment and care. For example, some practitioners explained during interview:

The fact that they are, uhm, got mental health problems.

* * *

Experience might tell you if there is something they aren't verbalising but... We did have that difficulty with _____ (young person) and there was a lot of negative non-verbal interaction because he couldn't verbalise. That's another time that you can't seek young peoples' views is when their illness prevents them from actually being able to express their view.

The practitioners above, however, did recognise that generally non-verbal forms of communication were an acceptable means to engage young people in participatory practice. Moreover, the particular young person mentioned in the above quote was considered by the practitioners to be intellectually capable of providing his views but simply was not able to do so verbally. Despite this recognition, the link between the young person's level of competence, different available forms of communication and arguments regarding his diagnosis were not made in this case. Instead, the young person's 'illness' was considered sufficient justification for not according participation rights. This approach to dismissing a young person as not capable of providing meaningful views because of their diagnosis is consistent with the paternalistic approach inherent in the medical model of practice. The young persons' agency is denied based on the practitioners' 'experience' and understanding of young peoples' diagnoses rather than searching for modes of communication that may enable individual young people to express their views and then assessing each young person in relation to their level of competence.

Another barrier mentioned by the practitioners related to both the age and the maturity level of the young people. Examples of arguments based on these issues, taken from interviews with the practitioners are as follows:

Well, my, I mean my my, one of the barriers for me would be I think, immaturity. I mean, they are immature, uhm, and I think they feel very often that they can take a lot of decisions that they are not really ready to take. So, I think you have to protect them, you know, they are children at the end of the day. They aren't mature adults and, in my opinion, not ready to take some decisions that they might like to take.

* * *

Sometimes they just have to learn to accept that we are the adults and we do know best... We do know what keeps them safe.

* * *

Maturity rather than age (is a barrier)...The ability to reason and understand the information that they have been given. We have had 16 year olds that have not been as mature or we have a 13 year old at the moment that could quite easily pass as 18 (physically) and has quite a high understanding.

In the first two quotes above we have practitioners making generalised statements regarding the age, lack of maturity, and lack of knowledge of children vis-a-vis adults. The concern is that this type of stereotype of 'the incompetent child' due to membership in the category 'child' rather than 'adult' may be used to deny participation rights rather than actually going through the process of individually determining competence by assessing the ability to reason and understand information regarding specific situations that arise, as described in the third quote. There is a perception that many practitioners assume the young people they work with are incompetent, unless they prove otherwise rather than starting with the notion that they are competent until such time as they demonstrate that they are not. Moreover, given that the majority of the practitioners consider the young people as lacking understanding, as immature and as too young to participate in decision making, protectionist arguments relating to their need for safety was often explained as a barrier to participation and was used as a justification for not allowing the young people a voice. These arguments, when used in a generalised fashion without reference to individual children's assessments of competence as well as reference to concrete safety issues, serves to veil the exercise of professional and adult power, used to control and limit children's agency.

Regardless of the protectionist approach taken by most practitioners, two practitioners in the day-patient unit did provide an alternative view of the barriers to participation. In particular, it was suggested by these practitioners during an interview with the researcher that they felt that many of the young people in the hospital did have a higher level of competence than what may be acknowledged by other practitioners. In this way, these practitioners express some concern that

barriers to participation may relate more to the young people being considered incompetent when they are actually capable of contributing more than what they are allowed to do. It was mentioned further by these two practitioners that they felt some practitioners were overly concerned about losing control over situations rather than allowing young people to experiment with decision making. Moreover, these same practitioners noted that another barrier to the young peoples' ability to participate relates to the side effects of medication. That is, it was felt that the effects of medication on the young people may mask the ability of practitioners to recognise competence.

Conclusion

Although the acknowledgement of children's rights and children's participation generally is increasing, particularly in the UK with respect to consultation, practice needs to improve in terms of children's decision making (Sinclair, 2004). This is especially true in child and adolescent mental health settings, where an authoritarian medical model of treatment (Coppock, 1997) creates a culture of care that is alien to the concept of children's participation in decision making. This research highlights the importance of practitioners having a grounded understanding of the theory of participation, in order to avoid the reinterpretation of participation to meet the adult/practitioner agenda of control over the child/psychiatric patient. The purpose of participation, relating to the spirit in which the UNCRC was written and intended for the benefits of children, needs to be clarified in the context of child and adolescent mental health services. Moreover, much as in other services for children, attitudinal barriers need to be addressed and a culture of participation needs to be built (Sinclair, 2004).

Within the discourse of 'protection', 'risk' and 'best interest', James and James (2005) note that children in different circumstances (young offenders, abused children, teenage mothers, etc) are mostly treated collectively. This has also been shown to be the case with young people receiving mental health inpatient treatment. Given the great variability of children's capabilities, not only between themselves but also for an individual child at different points in time and within different contexts, the collective dismissing of children's active participation, both within and without mental health services, should be addressed by children's rights activists.

Smith (2002) indicates that allowing children to participate in decision making should not be connected to their biological age but instead should be assessed within a supportive environment based on how much understanding they have gained regarding their circumstances. Others have noted that the right not to participate must also be respected (Sinclair, 2004; Lansdown, 1995; Eekelaar, 1994). Arguably, very young children (Alderson, 2000) and even pre-mature

babies (Alderson *et al.*, 2005) are capable of engaging in participation. This study suggests that children with a psychiatric label are also capable of engaging in decision making and will put themselves forward to participate meaningfully in their treatment and care at times when they feel it is reasonable for them to do so.

The way in which practitioners are able to avoid engaging in participatory practice with the young people involves simply reinterpreting the concept of participation rights to suit the paternalistic bio-medical model of treatment employed in the institution as well as to suit the adult agenda of social control in relation to young people. This practice of reinterpretation leads to widespread rights abuses (LeFrançois, 2007b), and represents an abuse of power on the part of practitioners and the institution as a whole. The relations of power inherent in this practice is not only oppressive in its denial of children's agency but it is productive in its generation of a new discourse relating to 'participation' that is contrary to the spirit in which the legislation around children's participation rights was written.

Given the exploratory nature of this study, more research needs to be conducted in child psychiatry in order to enable the voices of those who are rarely heard. Moreover, given the richness of the data collected in this study, more research into children's participation generally should be conducted using an ethnographic design (Winter, 2006; Jans, 2004; Haudrup Christensen, 2004), along with participatory methods that include children, which allows for more depth of understanding gained from prolonged access to the children's lived experiences.

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