

Ethical quandaries in psychiatry

An occasional series

Legal and ethical problems in child psychiatry

Having just completed the presentation of a paper at a conference I was urgently summoned out of the room: a crisis had arisen with a young teenager in my District. Jill was in the head teacher's office at her school where she was being physically restrained from running away because she was making threats to kill herself. The GP and the social services had both recently been involved with Jill and her family for similar but less acute problems; they had been informed by the school of the present crisis. Three days earlier, Jill had been seen by the duty senior registrar in child psychiatry at the GP's request because she had threatened to harm herself. The acute situation had been contained and an urgent consultation had been arranged with an adolescent in-patient unit team for two days later. When the team met Jill and her family they felt she might benefit from admission but they also stated that this could not occur for at least two weeks. During the subsequent 24 hour period the situation had deteriorated to that with which I was presented. By chance the senior registrar was also present at the conference and she filled me in with some background detail. She did not feel that Jill was suffering from a psychotic or depressive illness but she was concerned about possible self-harm.

I telephoned the head teacher. He described how, with the help of one or two teachers in turn, he was preventing Jill from running away but it was clear that he felt the situation was impossible. Jill's parents were at home and the head teacher had spoken to them. Since he felt their presence at school might worsen the situation they had not come to the school, but they had given the head permission to make any necessary arrangements for their daughter. I explained what I knew about the situation and that I was trying to ascertain the availability of an in-patient place for Jill. Since information then was that a bed was unavailable, Jill might have to be taken into a social services placement (from the information I had the immediate issue seemed to be one of "care and control"). I suggested that the head teacher should contact the social worker involved to ask for further help in handling the acute situation.

A short time later there was an angry call from the GP who had spoken, I think, with social services (or

had received a call from social services). He seemed to have gained the impression that I had simply washed my hands of the problem. He informed me that it was a "psychiatric problem": if I did not do something he would simply arrange for an ambulance to take Jill to casualty. I explained what I was trying to do: I stressed that the social services needed to be involved as well, because the most important task was to ensure the child's safety.

A further telephone call from the head teacher followed; he informed me that social services had meanwhile told him that they would not be doing anything because it was "a psychiatric problem".

There was no bed available in the adolescent unit but the consultant in an in-patient unit for younger children was persuaded to take Jill despite grave concern about that unit's ability to care for a patient of this kind. I telephoned the head teacher and he told me that he had already been in contact with the police who had offered to transfer Jill to whatever destination was being arranged. The police contacted me shortly afterwards to confirm the arrangements I had made and then told me they would convey Jill to the children's unit. I breathed a sigh of relief.

My relief was short-lived. Very soon afterwards there was a further phone call from the head teacher. It transpired that the police had decided that in order to transfer Jill they would have to make a "technical arrest". The social worker had found out about this and had objected on the grounds that it infringed the child's rights. Eventually it was arranged that a "place of safety order" would be taken out; the police were then able to transfer Jill in the company of the social worker.

It had been a very trying morning, to say the least. What I found *most* troubling (when there was a chance to reflect) were two things: first, that the situation could so rapidly break down into professional conflict; second, the legal responsibilities of the various professions in relation to Jill. It seemed to me that she was "beyond parental control" and that the statutory powers consequent from this should have been brought into play immediately in order to ensure her safety. However, if this was viewed as a "psychiatric problem" would there have been a case for

either social worker, GP or police to use powers under the Mental Health Act?

In addition, if no child or adolescent psychiatric bed had been found and social services had remained insistent that they would not/could not have provided a placement, should admission to an adult psychiatric unit have been considered? I would have found that course very difficult on a number of grounds. The staff would not be used to dealing with young adolescents and would have been based far more in an illness model of disturbance rather than a developmental model; this might lead to severe management problems which could be detrimental to the patient. Another concern is that Jill would have been brought into contact with severely mentally ill adults which could have been extremely frightening for her or alternatively might have set her on the path of a 'psychiatric career'. With such misgivings about the potential detrimental effects of this course of action, would it be more correct to resist the pressure to act in that way and allow the risk of self-damaging behaviour?

The girl was taken into the children's in-patient unit from which she absconded a number of times. She was assessed as not suffering from a formal psychiatric illness, the opinion was that this was a behaviour disorder which would not respond to in-patient treatment; the most appropriate psychiatric contribution was felt to be by way of a consultation to the professionals involved.

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Discussion

We are given very little information about Jill and her family and the problem seems to be treated purely as one of diagnosis and disposal. It is very difficult for a general practitioner to comment on the ethical implications of this case without a description of the family background. Not even Jill's age is mentioned; I am assuming she is 13 or 14 years old.

As far as the GP is concerned, the following factors are likely to operate. He may have become increasingly involved in the family's turmoil, partly because the parents as well as Jill are his patients. This can make it difficult for him to separate out the interests of the child from those of the parents. He may identify with parents' anxiety that Jill will harm herself, especially if she has not got a past history of histrionic threats.

Such a degree of disturbance in a young adolescent is rare in the experience of an individual GP and it is reasonable for him to feel insecure, and treat the problem initially as he would a life-threatening

physical or mental illness, namely requesting urgent help and a sharing of responsibility. He will have little sympathy with an in-patient psychiatric adolescent unit that cannot find a bed for two weeks and will feel that the staff has a responsibility to admit promptly a young person who needs urgent in-patient assessment. The GP will naturally be very reluctant to invoke powers under the Mental Health Act and unless he has had considerable psychiatric experience, you would expect a decision as to whether to compulsorily admit Jill to hospital or not, to be made only after a domiciliary visit by a psychiatrist as well as the social worker. This is partly because the GP will not wish to be seen by the patient as being the only doctor responsible for compulsory admission; otherwise he may find it difficult to maintain a continuing relationship with Jill when she returns home.

My experience of these types of problems is that they are often dealt with in an unsatisfactory way, but that is the nature of the problem rather than due to the incompetence of the professionals involved. Jill has not got a definable disease that can be given a medical label and therefore it is unclear whether the doctors or social workers bear the primary responsibility to cope with the situation. However, following discussion with the adolescent in-patient team the understanding appears to have been that Jill would, initially at least, be managed as if she had a psychiatric illness. It was inappropriate to reverse this two days later by suggesting that care proceedings should be brought for a local authority placement. However, because this might come later and because of the social consequences of Jill's disturbance, social services need to be involved at an early stage, and a social worker allocated to the case.

The anger and chaos in the patient may be mirrored by tension and confusion between general practitioner, hospital doctor and social worker. The main emotion generated in each is likely to be a conviction that the other professionals are trying to evade their responsibility leaving you to carry the burden. If it is recognised that the situation is, and may remain a mess, and that nobody is to blame, then tension will diminish and it becomes easier to agree on a plan of management.

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Dr Sutton describes difficulties in managing a crisis in a young adolescent's life which raises issues of inter agency co-operation, professional responsibility, legal intervention and the availability of appropriate

placements. A number of specific problems continue to cause considerable difficulty in the management of this crisis.

Firstly, there is the problem of who took the central role and this appears to have been the headmaster. Dr Sutton writes that the GP and social worker originally referred Jill three days earlier, but neither seemed to be directly involved in this particular episode. The parents' role is unclear. They appear to have handed all responsibility to the headmaster, an equivocal situation and one that makes decision making very difficult.

The relative areas of professional responsibility and their apparent conflict is the second area of concern. The conflict between the social services department and psychiatric services seems to have its roots in the "labelling" of Jill's difficulties. The senior registrar who first saw the girl, and the adolescent unit staff who subsequently assessed her, all agreed that psychiatric intervention would be of benefit and planned this to begin two weeks later. Thus a need for psychiatric involvement was perceived and planned, although these were major problems regarding an emergency response. I agree with Dr Sutton that to apportion social or psychiatric responsibilities in this situation is unhelpful. However, under these circumstances it would be my view that the health service should provide a place if possible and that social services should facilitate getting Jill into it.

The third question of the appropriate use of the police and their powers of arrest was raised by the head teacher. This young person surely would not benefit from such a procedure and the fact that this is merely a "technicality" is no justification. The use of the Mental Health Act in a young adolescent is not something that I have found useful and close co-operation between parents, social workers and psychiatrists usually avoids this. As a child psychiatrist I would certainly prefer to use legal provisions for care rather than provisions of the Mental Health Act in a situation like this one.

I would agree whole-heartedly with Dr Sutton's anxieties about the suitability of placing this adolescent in an adult psychiatric ward and a social services placement is often preferable. However these places are often not available.

Staffing difficulties and the use of an illness model do often lead to management problems when young adolescents are placed in adult wards. However, I would not think that a high risk of self damaging behaviour is an acceptable alternative to a short admission. A 24–48 hour "defusing" admission has the potential for reducing this crisis to more manageable proportions, and allows scope for improving inter agency co-operation as well as greater family involvement. It seems that the situation was resolved in the end by social services taking responsibility for legal control via a place of safety order and the health

authority fulfilling its role by offering a psychiatric place.

Dr Sutton asks if there may have been any other ways of handling this situation. I would suggest that a meeting of social services, parents, and adolescent psychiatry staff after the initial consultation by the senior registrar would have been of great benefit. Planning for the period following a crisis but preceding admission is very helpful in these situations and allows for clarification of roles and responsibilities in a less pressurised atmosphere. Under the circumstances described I do not think that there was any alternative to offering a bed in the health service – fortunately one in the child psychiatric department was available!

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The case as presented raises a number of points from a social work perspective.

Firstly, and most obviously, is the lack of exploration and assessment of the crisis in any terms other than the "management" of Jill, and disposal of her to a situation where the anxiety of the headmaster, the GP, social services and the psychiatric team, is contained. It seems that "place of safety", "psychiatric problem", "technical arrest" and, ultimately, admission to a psychiatric unit, demonstrate attempts to engage medical/legal instruments in managing this anxiety and the 'taking of responsibility' by professionals.

In social work training and practice, the emphasis is that of seeing the individual client, and a given situation presented, *within the context of family relations and relationships with others including professional workers involved*. "Assessment" means taking the time to interview the person presenting as the problem, members of the family, and all significant others involved. (This will be familiar to those involved in ASW assessments under the Mental Health Act).

It would seem that the first response of the social services team to the situation with Jill should be to involve a duty social worker to attend the school at this point of crisis. Assessment would be, hopefully, joint assessment with Jill, the psychiatrist, the head teacher and, most important, the parents.

The parents had abdicated the responsibility and asked the head teacher to make arrangements for their daughter. Obviously, it would be absurd for a social services department (or anyone else for that matter) to begin to assess a situation and follow it through by making plans without full consultation and involvement of the parents. The parents do have the choice of admitting Jill to the care of the local authority under the Child Care Act 1980, Section II.

Again, it is important to recognise that it is the decision of the parents, not of social services. Only in circumstances where their response seems totally unreasonable, and that a Place of Safety Order needed to be sought, would the social services go against the parents' wishes. At that point, there would be the question of whether a magistrate would grant an Order in such circumstances.

The situation with Jill seems to have been further compounded by involving the police to provide transport. The responsibility for taking Jill to any agreed place of safety would surely be, in the first instance, with the parents and/or social services.

In addition, social work assessment would take into account not only the context within which the crisis had occurred, but also the consequences of resolution through admission to any institution. The concern expressed over admission to a psychiatric institution and contact with psychiatric patients has its equivalent in, for instance, the admission to a local authority children's home. The population of these

homes or "assessment centres" varies from week to week. Jill may come across other children who are already well versed in various forms of delinquent behaviour and, given the powerful influences of peers to children of this age, she may get some "expert" guidance in other methods of expressing her distress. The option of placement with a foster family who were experienced in caring for young adolescents would have to be considered as possibly the least damaging "holding situation".

It hardly needs stating that the use of the Mental Health Act seems both clumsy and potentially harmful in these circumstances, where a more comprehensive assessment of Jill's behaviour within its social context could be realistically set alongside the resources available to social services.

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Miscellany

Molecular genetics

An international symposium on *The Ethical Implications of the New Genetics for Psychiatry* will be held on 7 June 1989 which aims to provide a forum in which the scientific and medical communities can facilitate discussion with colleagues from other disciplines on the ethical and moral dilemmas posed by recent advances and potential discoveries in molecular genetics in relation to psychiatry. Topics include: schizophrenia, Huntington's Disease, genetic counselling, feminism, history of genetic research, liberatory biology, prenatal diagnosis and science & society. Participants include: Dr Jim Birley, Sir Douglas Black, Professor Ranaan Gillon, Dr Germaine Greer, Dr John Harris, Chris Heginbotham, Professor Peter McGuffin, Dr Bernadette Modell, Dr Robin Murray, Dr Adrienne Reveley, Professor Steven Rose, Professor Erick Strömberg and Julie Weleminsky. Registration fee: £40 (to include lunch and refreshments). Further information: Nadine Morgan, Conference Office, Institute of Psychiatry,

De Crespigny Park, London SE5 8AF (telephone 01 703 5411, extension 3170).

Professor Sir David Weatherall, Nuffield Professor of Clinical Medicine, University of Oxford, will give a lecture on *Human Molecular Genetics* on 10 May 1989 in the Mansfield Cooper Building, University of Manchester. Further details: The Secretary, The Centre for Social Ethics and Policy, University of Manchester, Oxford Road, Manchester M13 9PL (telephone 061 275 3463).

Appeal for funds

Mental Aid Projects is a registered charity whose aim is to care for the mentally handicapped and mentally ill by providing residential homes, day centres and group homes. It is funded in part by its local authority but this is insufficient to support all activities, future expansion of the charity, maintenance of premises, etc. Further information: Eric Cronk, Fund Raiser, Mental Aid Projects, "Fircroft", 96 Ditton Road, Surbiton, Surrey KT6 6RH.