Correspondence

Detention of children is needed at times

I am writing to thank Thomas *et al*[1] for raising the issues of younger children and the authorisation of admission and treatment. The Mental Health Act 1983 is the only UK legislation that deals solely with the treatment of mental disorders and has a number of inbuilt safeguards – including the mental health tribunal, which was utilised in the case and discussed in the article – which are important factors when considering the 'least restrictive' principle. In many ways, the Mental Health Act 1983 is less restrictive than relying solely on a parent to authorise an admission, as there is a greater opportunity for the patient to have the detention independently reviewed in a timely fashion.

I wanted to raise a number of points. First, it is important to recognise that the law divides the under 18s into two groups: those under 16, and those aged 16 and 17. For the first group, when assessing the ability to make decisions, the case law of Gillick is used and those who have sufficient understanding and intelligence to make their own decisions are referred to as Gillick competent.[2] For the second group, the Mental Capacity Act 2005 applies and they are referred to as having capacity, in the same way as adults. It is an important distinction, and still causes much confusion.

My second point risks confusing the issue of what parents can consent to further. Thomas *et al* state that ' . . . a parent may not lawfully detain or authorise the detention of a child', which was the established wisdom, but this has been challenged in a recent case, named by some as Baby Bournewood.[3] In this case, Judge Keehan ruled that the hospital admission of a 15-year-old child with Asperger syndrome, attention-deficit hyperactivity disorder and Tourette syndrome who was under continuous supervision and control, and who would be prevented from leaving the hospital, did not constitute a deprivation of liberty and so could be authorised by someone with parental responsibility. This flies in the face of the Cheshire West case discussed in the article.

My last point concerns the discussion about the 'doctrine of necessity'. It is also important to note that section 3(5) of the Children Act 1989 states that in an emergency or urgent situation a person who has care of the child but does not have parental responsibility may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare.'

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1 Thomas V, Chipchase B, Rippon L, McArdle P. The application of mental health legislation in younger children. *BJPsych Bull* 2015; **39**: 302–4.

2 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

3 *D (A Child) (Deprivation of Liberty)* (2015) EWHC 922 (Fam).

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Information for CAMHS patients about tribunals

Thomas *et al*[1] discussed the legal authority for detention of an 8-year-old child. The patient exercised his right of appeal with assistance from a solicitor and an independent mental health advocate and solicitor. The authors conclude that all clinicians working in child and adolescent services require knowledge of the law in relation to treatment of mental disorders in children.

We consider it equally important that any detained children and adolescents have access to information about the process of a mental health tribunal hearing to ensure they are able to participate fully but also in the least distressing way. All information for patients about the procedure at a tribunal hearing – available via the Royal College of Psychiatrists[2] or the First-tier Tribunal (Mental Health) website (www.gov.uk/mental-health-tribunal/what-happens-at-the-hearing) – is aimed at adult patients.

To ensure developmentally appropriate information, we worked with a focus group of young people on a child and adolescent mental health service (CAMHS) in-patient unit and composed a suitable leaflet. The final version has been approved by the First-tier Tribunal (Mental Health) CAMHS panel lead judge and also by the Royal College of Psychiatrists' CAMHS Faculty lead. The leaflet is available on the College website (www.rcpsych.ac.uk/pdf/CAMHS%20GUide%20to%20Mental%20Health%20Tribunals%20Feb%202016.pdf).

We hope that this information will be of benefit to detained young people such as the child in the case report.

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1 Thomas V, Chipchase B, Rippon L, McArdle P. The application of mental health legislation in younger children. *BJPsych Bull* 2015; **39**: 302–4.

2 Rutherford J. A guide to mental health tribunals (leaflet). Royal College of Psychiatrists, 2015. Available at: http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/guidementalhealthtribunals.aspx

doi: 10.1192/pb.40.2.106a

Mobile telephone apps first need data security and efficacy

The recent article on mobile telephone software applications (apps) in mental health practice[1] highlights many potential benefits of smartphone apps for mental health but also inadvertently demonstrates the challenges beyond what the authors may have realised. The paper refers readers to the National Health Service (NHS) Health Apps Library (http://apps.nhs.uk) when discussing psychological apps. However, in recent months the Library has been closed amid serious concerns that apps featured on the site may not be clinically effective[2] and may suffer from both security and privacy flaws that left patient data exposed.[3] This rapid change in the smartphone apps landscape came suddenly and rapidly and demonstrates how much we still do not know about using this technology for healthcare. What we do know is that a firm foundation in privacy, security and efficacy is critical. Just as we demand clinical evidence and safety data when considering a new medication, we should also demand the same high

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standards when considering a new app. The potential of smartphone apps for mental health is as bright as the authors allude to, but the challenges are turning out to also be greater than many realised.

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1 Marley J, Farooq S. Mobile telephone apps in mental health practice: uses, opportunities and challenges. *BJPsych Bull* 2015; **39**: 288–90.

2 Leigh S, Flatt S. App-based psychological interventions: friend or foe? *Evid Based Ment Health* 2015; **18**: 97–9.

3 Wicks P, Chiauzzi E. 'Trust but verify'–five approaches to ensure safe medical apps. *BMC Med* 2015; **13**: 205.

doi: 10.1192/pb.40.2.106b

Authors' reply: We are grateful for Dr Touros' interest in our article and his considered response.

Our article is a brief overview of a complex subject area which has scope for further detailed discussion. There is an emerging division between professional and patient-centred apps similar to that between prescribed and over-the-counter medications. As medical professionals we can make regulatory demands in our sphere of influence but apps for the general market will emerge independently of our influence; we will need an awareness of such apps to manage the complex issues that arise when patients raise questions about diagnosis and management after interacting with them.

We requested an update from NHS Choices and have been informed that the Health Apps Library is being upgraded following work on the assessment process by the National Information Board. The first apps are expected to have completed the new evaluation process in April 2016.

Declaration of interest
S.F. has developed an app called QDoc to assist self-management in psychiatric disorders.

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You too, YouTube?

The study by Gordon *et al*[1] looking at the portrayal of psychiatry in YouTube videos was novel, although it was disheartening to note their finding that our field is being depicted in a predominantly negative light.

In this context, I am writing to provide some details of my YouTube channel called 'Psychiatry Lectures' (www.youtube.com/channel/UCVZhg8unEqo0XUm8cHAIwbA/videos). This is a free-to-access educational channel featuring videos on psychiatry topics targeted at health professionals who see psychiatric patients. So far, I have uploaded 19 videos covering most of the major psychiatry topics, for example, schizophrenia, mood disorders and anxiety disorders. The average duration of the videos is 50 min and most videos end with a set of five multiple choice questions. The videos are in the form of PowerPoint presentations with my narration.

YouTube has an analytics section that is accessible to the channel's creator and that provides detailed statistics about viewership. Until 31 December 2015 the 19 videos had garnered over 34 000 views in 160 countries, with the top 5 nations in terms of views being the USA, India, UK, Australia and Canada. Viewer demographic details show a male preponderance (65%). With respect to age, the 25–34 group had the maximum number of viewers, followed by the 18–24 group. This suggests – and is supported by feedback in the comments section – that medical students and postgraduate psychiatry trainees form the bulk of the audience. In total, the videos have received 210 'likes' and only 6 'dislikes', indicating a high degree of acceptability in a discerning, mainly professional audience.

My YouTube channel may be considered as part of free open access medical education (FOAM). The FOAM movement, pioneered by emergency medicine physicians in Australia,[2] aims to offer medical students and doctors free access to medical information online, delivered in a variety of formats such as videos, slideshows, podcasts, articles, blogs and Twitter (#FOAMed).

The paper by Gordon *et al*[1] is a timely reminder to the psychiatric profession that we have to battle widespread misinformation, whether deliberate or well-intentioned, about our specialty, not only in traditional, mainstream media such as print and TV, but also in cyberspace. Constructive criticism, both from within and outside the profession, is definitely valid and welcome. But biased and baseless distortions about psychiatry only reinforce the already entrenched stigma, with far-reaching consequences ranging from inadequate recruitment of psychiatrists[3] to discrimination against patients.[4] Gordon *et al*'s suggestions on how psychiatry can fight back against this misrepresentation are worthy of consideration.

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2 Nickson CP, Cadogan MD. Free Open Access Medical education (FOAM) for the emergency physician. *Emerg Med Australas* 2014; **26**: 76–83.

3 Rajagopal S, Rehill KS, Godfrey E. Psychiatry as a career choice compared with other specialties: a survey of medical students. *Psychiatr Bull* 2004; **28**: 444–6.

4 Taggart H, Bailey S. Ending lethal discrimination against people with serious mental illness. *Br J Psychiatry* 2015; **207**: 469–70.

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No smoke without fire

In trying to explain why the portrayal of psychiatry on YouTube might be predominantly negative, Gordon *et al*[1] fail to consider the obvious – that the producers of negative videos may actually have a point.

It is hard to disagree with any of the accusations about overuse of drugs made by the lawyer featured in the first video on their list. Of the many speakers in the second clip, a couple make slightly exaggerated statements, but its main message,

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