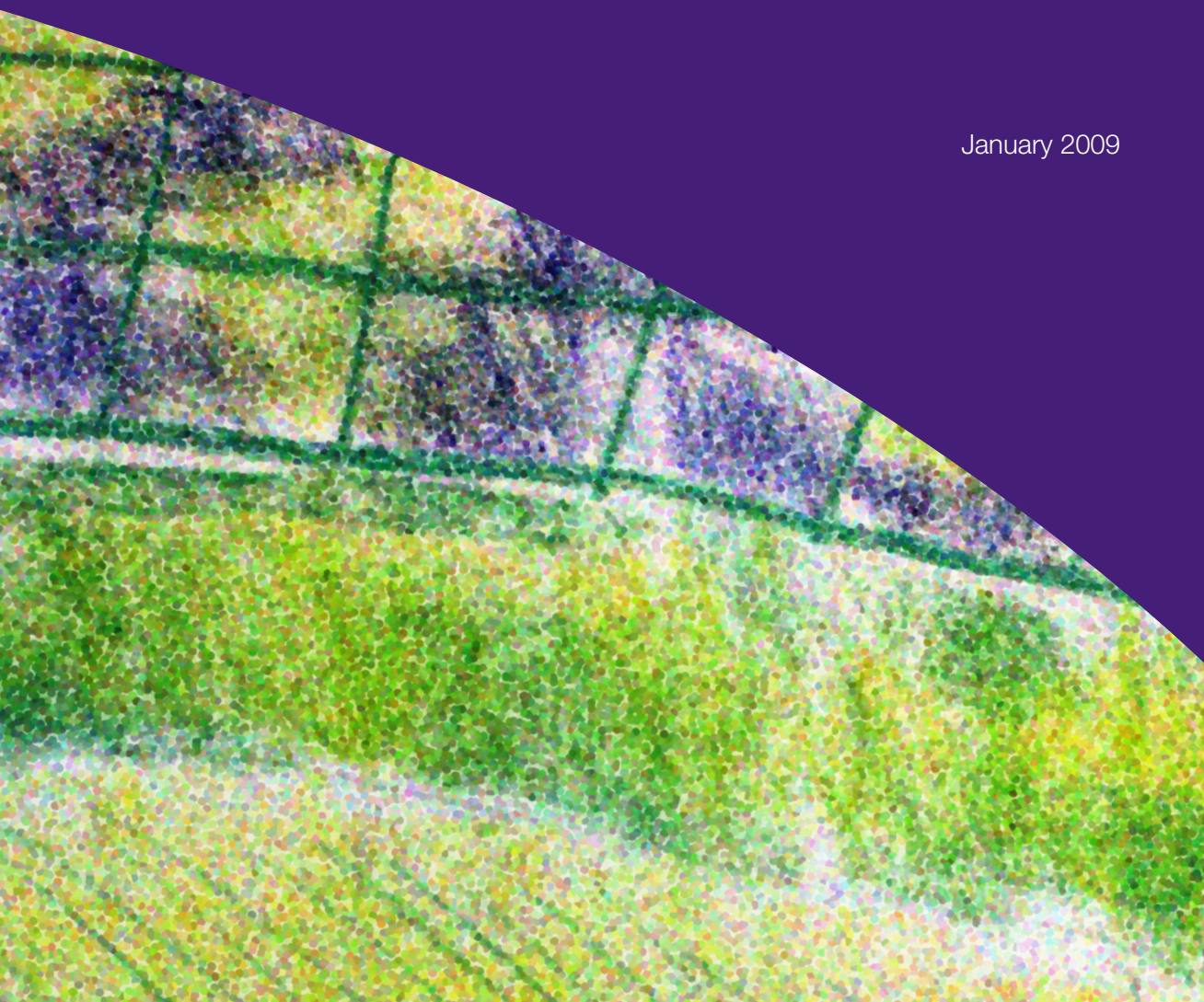


# **The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder:**

## A Guide for Professionals

January 2009



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## Introduction

This Guide is for mental health professionals working with children, young people and families in children and adolescent services (CAMHS) and adult mental health services. It will also be relevant to children services practitioners, such as those in child protection, and others with responsibilities for safeguarding and promoting the welfare of children and young people.

Its purpose is to explain the complex legal framework relevant to the provision of care and treatment to children and young people with severe mental disorders<sup>1</sup> who may require a period of in-patient care. It provides further guidance on the issues raised in Chapter 36 'Children and young people under the age of 18' in the Code of Practice to the Mental Health Act 1983 ('the MHA Code'). Like the MHA Code, this Guide is concerned only with practice in England (a separate Code of Practice has been issued for Wales).

The Guide is based on the guiding principles set out in the MHA Code which should be considered when making any decision under the Mental Health Act 1983 (the MHA 1983).

This Guide reflects the Department of Health's commitment to promoting appropriate care for children and young people. We hope that the care of this very vulnerable group will improve as a result of providing clear guidance as to the interrelationship between the various legal frameworks that may be applicable.

This Guide is not intended as a substitute for consulting with the relevant legislation, regulations and Codes of Practice, in particular, the MHA 1983, the MHA Code and the Reference Guide to the MHA 1983. Rather it is intended to provide an overview of the legislative frameworks with some practical case studies to assist reflective learning. Our thanks go to the legal teams, professionals and others who have contributed their expertise and views to the Guide.

We hope you will find it useful.

The image shows two handwritten signatures in black ink. The signature on the left is 'Jim Symington' and the signature on the right is 'Dawn Rees'.

**Jim Symington, National Lead for Legislation NIMHE**

**Dawn Rees, National CAMHS Strategic Relationships and Programme Manager**

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1. The term 'mental disorder' is defined in the MHA 1983 as 'any disorder or disability of mind' (section 1).

## Executive Summary

- i. The Guide follows the terminology used by the MHA Code and refers to 'child' or 'children' in relation to those under 16 and 'young person' or 'young people' in relation to those aged 16 or 17.
- ii. This guide has been prepared in the light of the amendments to the Mental Health Act 1983 (the MHA 1983), introduced by the Mental Health Act 2007 (the MHA 2007). It explains the changes to the MHA 1983 that have particular relevance to children and young people, including the provisions that have yet to come into force (access to Independent Mental Health Advocacy and the duty to provide age appropriate facilities<sup>2</sup>).
- iii. The legal framework governing the admission to hospital and treatment of children and young people with mental disorder is complex. Furthermore, there have been some important recent changes in legislation:
  - The changes introduced by the MHA 2007 will be relevant to children and young people of all ages.
  - The main provisions of the Mental Capacity Act 2005 (the MCA 2005), which came fully into force in October 2007, apply to 16 and 17 year olds.
- iv. To ensure that children and young people are cared for appropriately, it is essential that professionals understand the scope, purpose and interrelationship of the different legal frameworks.

### *Note on tables used in this Guide*

- v. The Guide includes tables summarising the relevant law. These are designed to provide an overview of the particular issue being considered and should be read in conjunction with the relevant explanatory text.

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2. The Independent Mental Health Advocacy Services are likely to be operational in April 2009, the provisions in relation to age appropriate accommodation in April 2010.

## *Arrangement of the Guide*

vi. The Guide is divided into two parts:

### **Part 1 – Care and treatment of children and young people with mental disorder: working within the legal and policy framework**

Part 1 considers the application of the law in relation to the care and treatment of children and young people. It identifies the areas in which determining the appropriate course of action is likely to be particularly complex, requiring a sound understanding of the different statutory regimes and common law principles. The interrelationship of these legal frameworks is explained.

vii. Chapters 1 – 7 in Part 1 cover the following issues:

- **general principles (Chapter 1):** considers areas that will be relevant to all aspects of the treatment and care of children and young people with mental disorder (policy context, human rights and children and young people, parental responsibility, confidentiality and sharing information).
- **decision-making in relation to the admission and treatment of children and young people: common issues (Chapter 2):** introduces the principles and concepts that practitioners will need to be familiar with, and apply, when considering either the admission to hospital or treatment for mental disorder of children and young people.
- **admission to hospital for assessment and/or treatment for mental disorder (Chapter 3):** considers the wide range of overlapping powers to authorise children and young people's admission to hospital for treatment (or assessment, followed by treatment) for mental disorder. This includes compulsory admission to hospital under the MHA 1983 with an explanation of relevant amendments to the MHA 1983 that have been introduced by the MHA 2007.
- **treatment, capacity and consent (Chapter 4):** considers the issues that are relevant to the treatment for mental disorder of children and young people. As with admission to hospital, there are a range of overlapping powers that can authorise children and young people's treatment for mental disorder, including the treatment provisions set out in the MHA 1983. These provisions, including the amendments that have been introduced by the MHA 2007, are explained.
- **discharge from hospital (Chapter 5):** outlines the Hospital Managers' duties in relation to making referrals to Tribunals under section 68 MHA



1983 and highlights steps to be taken to ensure that children and young people are able to exercise their rights to apply to the Tribunal.<sup>3</sup>

- **supervised community treatment (Chapter 6):** provides an overview of supervised community treatment (SCT) and highlights points that will be of particular importance if SCT is being considered for a child or young person.
- **treatment regulated under part 4A of the Mental Health Act 1983 (Chapter 7):** explains the provisions of Part 4A of the MHA 1983 which set out the circumstances in which SCT patients, who have not been recalled to hospital, can be treated.

## Part 2 – Additional Information and Resources

The four annexes cover the following areas:

- **Annex 1: An Overview of the relevant legislation:** provides an overview of the MHA 1983, highlighting the relevant changes introduced by the MHA 2007, and other statutory regimes relevant to children and young people with mental disorder. It seeks to provide practitioners with an understanding of the scope and purpose of the different statutory regimes (Mental Health Act 1983, Children Act 1989, Children Act 2004, Family Law Reform Act 1969 and Mental Capacity Act 2005).
- **Annex 2: Legal and policy framework for the provision of services to children and young people on discharge from hospital:** covers the importance of after-care planning, the Care Programme Approach and the statutory responsibilities for the provision of services for children and young people with mental health problems.
- **Annex 3 Glossary:** provides definitions of commonly used terms and abbreviations in relation to mental health care.
- **Annex 4: Resources Section:** provides suggested reading and additional resources for those wishing to obtain more detailed information on the law and policy relating to children and young people with mental disorder.

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3. On 3 November 2008 the functions of the Mental Health Review Tribunals for England were transferred to the new First-tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007. There is also a new right of appeal, on a point of law, to a new Upper Tribunal.



# Part 1

Care and treatment of children and young people with mental disorder: working within the legal and policy framework

Part 1 considers the application of the law to specific areas of decision-making in relation to the care and treatment of children and young people with mental disorder. It includes case examples, checklists and tables to illustrate the relevant statutory regimes and common law principles.

Practitioners requiring more detailed information on particular legislation should refer to Annex 1 and the materials noted in Annex 4.



# Chapter 1

## General principles

**1.1** Chapter 1 covers areas that will be relevant to all aspects of the treatment and care of children and young people with mental disorder:

- Policy context
- Human rights and children and young people
- Parental responsibility
- Confidentiality and sharing information

### Policy context

**1.2** Over the past ten years the importance of improving the physical, mental and emotional health and wellbeing of children and young people has been emphasised by government. This has been taken forward by a raft of policies such as *Every Child Matters: Change for Children*; *the National Service Framework for Children, Young People and Maternity Services: The Mental Health and Psychological Wellbeing of Children and Young People*; and *Care Matters: Time for Change*. Annex 4 provides a list of policies that will be of particular relevance to mental health professionals working with children and young people.

**1.3** The policies in relation to children and adolescent mental health services (CAMHS) have been reinforced by additional resources and the inclusion of measures in the public sector agreement deliverables to secure and maintain improvements in CAMHS.<sup>4</sup>

### Human rights and children and young people

**1.4** Those responsible for the care and treatment of children and young people with mental disorder should ensure that they are familiar with the Human Rights Act 1998 (the HRA 1998) and the United Nations Convention on the Rights of the Child (the UNCRC).<sup>5</sup>

4. HM Government (revised November 2007), PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people, A.7, p. 25. [www.hm-treasury.gov.uk/media/C/F/pbr\\_csr07\\_psa12.pdf](http://www.hm-treasury.gov.uk/media/C/F/pbr_csr07_psa12.pdf)

5. MHA Code 36.3.

*The Human Rights Act 1998* <sup>6</sup>

**1.5** The HRA 1998 incorporates the rights set out in the European Convention on Human Rights (ECHR) into UK domestic law. This means that if a person considers that their rights have been infringed by a public body (which include NHS agencies and local authorities) they may take legal action before the national courts, whereas before the HRA 1998 came into force, they had to pursue a complaint to the European Court of Human Rights (often a lengthy process).

**1.6** The HRA 1998 places an obligation on public bodies to work in accordance with the rights set out in the ECHR. Individuals working for public authorities, whether in the delivery of services to the public, or devising policies and procedures, must ensure that they take into account the ECHR rights when carrying out their day to day work.

**1.7** Individuals carrying out statutory functions under the MHA 1983, such as the Responsible Clinician (RC) and Approved Mental Health Professionals (AMHPs) will be considered to be public authorities for the purpose of the HRA 1998. This would include, for example, an RC working in a private hospital exercising their functions under the MHA 1983.

*The United Nations Convention on the Rights of the Child (UNCRC)* <sup>7</sup>

**1.8** The UNCRC sets out a range of civil and political, social, economic and cultural rights that apply to all individuals under the age of 18. Although it is not part of UK domestic law, by ratifying the UNCRC, the UK Government has agreed to do everything it can to take steps to implement it.

**1.9** Furthermore, our national courts and the European Court of Human Rights can take the UNCRC into consideration when adjudicating on cases relating to children and young people.

**1.10** The UNCRC seeks to achieve a balance between respecting the responsibilities of parents to make decisions on behalf, and in the best interests, of their child and enabling children and young people to exercise their rights. For example:

- Two core principles of the UNCRC are that the best interests of the child are a primary consideration in all actions concerning children (Article 3) and ensuring respect for the views of the child (Article 12).

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6. For further information see: [www.justice.gov.uk/whatwedo/humanrights.htm](http://www.justice.gov.uk/whatwedo/humanrights.htm)

7. For further information see: [www.everychildmatters.gov.uk/uncrc](http://www.everychildmatters.gov.uk/uncrc)

- The UNCRC requires States to respect the responsibilities, rights and duties of parents to make decisions in relation to their children but that this must be ‘in a manner consistent with the evolving capacities of the child’ (Article 5).
- The concept of the ‘evolving capacities’ of the child is central to the aims of the UNCRC. It recognises that as children grow and develop in maturity, their views and wishes should be given greater weight. Their development towards independent adulthood must be respected and promoted.

### *Respecting the rights of children and young people*

**1.11** The development of human rights law has contributed to the increasing recognition of the need to give greater weight to the views of children and young people as they develop their understanding and ability to make decisions for themselves. This is beginning to be reflected in the law in relation to admission to hospital and treatment and treatment for mental disorder. For example:

- In relation to admission to hospital, section 131 MHA 1983 provides that a young person who has capacity to make such decisions, cannot have their decision on whether or not to be admitted to hospital overridden by a person with parental responsibility.
- In relation to children under 16, the MHA Code suggests that it may be unwise to rely on parental consent to admit a Gillick competent child<sup>8</sup> who is refusing such admission.<sup>9</sup>
- Even where a child or young person is assessed as being unable to make a particular decision, their views should still be sought and taken into account.<sup>10</sup>

**1.12** Practitioners should always consider the points set out in 36.4 of the MHA Code. These include the expectation that all children and young people:

- should always be kept as fully informed as possible
- should receive clear and detailed information concerning their care and treatment, explained in a way that they can understand and in a format that is accessible to their age
- have as much right to expect their dignity to be respected as anyone else
- have as much right to privacy and confidentiality as anyone else.

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8. This term is explained at 2.10 below.

9. 36.43

10. 36.47

## Parental responsibility<sup>11</sup>

**1.13** When working with children and young people it is essential to identify the person(s) with parental responsibility for them.<sup>12</sup> This is because:

- **The person may be able to consent to the intervention:** In some circumstances, those with parental responsibility will be able to authorise the child or young person's admission to hospital and/or treatment. (Such consent can only be relied on if the decision falls within the 'zone of parental control'. This term is explained in Chapter 2 (2.39 – 2.48).)
- **It is good practice to involve those with parental responsibility:** Even where it is not necessary to obtain the consent of the person with parental responsibility for the child or young person's admission to hospital and/or treatment, it is good practice to involve those with parental responsibility in the decision-making process, subject to the child or young person's right to confidentiality, as discussed below.

**1.14** Usually, but not always, the person with 'parental responsibility' will be the child or young person's parents. Further information, including identifying those with parental responsibility, is given in Annex 1.<sup>13</sup>

## Confidentiality and sharing information

**1.15** The right to confidentiality applies to children and young people. Where they are able to make decisions about the use and disclosure of information they have provided in confidence, the views of children and young people should be respected in the same way as adults. (See below for information on assessing children and young people's ability to make decisions.)

**1.16** However, this right to confidentiality can be qualified or limited in certain circumstances. For example:

- Where child abuse or serious harm is suspected, the public interest may justify disclosure in accordance with the guidance *Working Together to Safeguard Children*.<sup>14</sup>
- In rare circumstances, such as where a competent child or a young person with capacity is refusing treatment for a life threatening

11. The term is defined in s3 (1) Children Act 1989. See also Chapter 2 of *The Children Act 1989 Guidance and Regulations: Volume 4 – Residential Care* for further information.

12. MHA Code 36.6.

13. See pages 95-99

14. Available at: [www.everychildmatters.gov.uk/workingtogether/](http://www.everychildmatters.gov.uk/workingtogether/)

condition, the duty of care owed to the child or young person may require those with parental responsibility to be informed and consulted.<sup>15</sup>

**1.17** The box below highlights two points to consider when working with those with parental responsibility and other carers.

### SHARING INFORMATION: POINTS TO NOTE

Simply asking for information from those with parental responsibility and other carers about the child or young person need not involve any breach of confidentiality, provided that in doing so, the person requesting the information does not reveal any personal confidential information that the parents or carers would not legitimately know anyway.<sup>16</sup>

If a child or young person does not wish their parents (or others with parental responsibility) to be involved in decisions about their care and treatment every effort should be made to fully understand the reasons for this and to ascertain whether any steps could be taken to address the child or young person's reasons for not wishing information to be shared.

15. The question whether those with parental responsibility can lawfully consent to the admission to hospital or treatment on behalf of the dissenting competent child or young person with capacity is a separate issue. This is considered in Chapters 3 and 4.

16. MHA Code 18.10.





# Chapter 2

## Decision-making in relation to the admission and treatment of children and young people: common issues

**2.1** Chapter 2 introduces the principles and concepts that practitioners will need to be familiar with, and apply, when considering either the admission to hospital or treatment for mental disorder of children and young people.

**2.2** Decisions concerning a child or young person's admission to hospital will be inextricably linked to decisions to treat once the child or young person has been admitted.<sup>17</sup> However these decisions are treated differently by the law.

**2.3** Accordingly, while this chapter considers the principles and concepts that are common to admission and treatment, their application to children and young people's admission to hospital and treatment are considered separately in this Guide. (See Chapter 3 (admission to hospital for assessment and or/treatment for mental disorder) and/or Chapter 4 (treatment, capacity and consent).)

**2.4** This chapter covers:

- Children and young people's consent to admission or treatment
- Assessment of children and young people's ability to make decisions
- The zone of parental control
- Deprivation of liberty

### Children and young people's consent to admission or treatment

**2.5** The valid consent of a child or young person will be sufficient authority for their admission to hospital or treatment for mental disorder.

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17. MHA Code 36.19.

**2.6** In order to be able to give valid consent, a child or young person must:

- have the capacity/competence to consent to the particular decision being considered (this is discussed below); and
- have sufficient information to make the decision; and
- not be subjected to any undue influence when making their decision.<sup>18</sup>

## **Assessment of children and young people's ability to make decisions about admission and treatment**

**2.7** The assessment of a child or young person's ability to make a decision must be made in relation to the particular decision at the time that it needs to be made.

**2.8** The law on the admission to hospital and treatment for mental disorder of children (under 16 years) is different from the law relating to the admission of young people (aged 16 and 17). In assessing a child or young person's ability to make decisions about their admission to hospital and/or their treatment on admission, practitioners will need to apply different tests, depending on the age of the patient. These are explained below.

## **Children under 16: assessment of ability to make decisions**

**2.9** Children who are able to make decisions about their admission to hospital and/or treatment are referred to as being Gillick competent.<sup>19</sup>

### *The Gillick competent child*

**2.10** A child who has attained sufficient understanding and intelligence to be able to understand fully what is involved in the proposed intervention will be regarded as competent to consent to a particular intervention, such as admission to hospital or proposed treatment.

**2.11** The concept of Gillick competence is said to reflect the child's increasing development to maturity.

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18. See the definition of consent to treatment, MHA Code 23.31.

19. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112.

**GILLICK COMPETENCE: KEY POINTS (THE MHA CODE 36.39-36.41)****Competence may vary depending on the nature of the decision:**

The understanding required for different interventions will vary considerably – a child may have competence to consent to some interventions but not others.

**Competence must be assessed for each decision:** The child's competence should be assessed carefully in relation to each decision that needs to be made.

**Competence may fluctuate:** a child may appear to be competent to make a decision on some occasions but other times not able to do so, for example, where the child's mental disorder is causing his/her mental state to fluctuate significantly. In such cases, consideration should be given to whether the child is truly Gillick competent at any time to take a relevant decision.

## 16 and 17 year olds: assessment of ability to make decisions

**2.12** The starting point in assessing whether a young person is able to make decisions about admission to hospital and/or treatment is the Mental Capacity Act 2005 ('the MCA 2005').

**MENTAL CAPACITY ACT 2005**

- This Act provides that all individuals aged 16 or over have full legal capacity to make decisions for themselves (the right to autonomy) unless they can be shown to lack capacity (defined in the MCA 2005) to make the particular decision at the time the decision needs to be made.<sup>20</sup>
- The MCA 2005 sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. Its main provisions apply to individuals aged 16 and over. However, in some areas there are some significant differences between the provisions relating to individuals 18 and over and those aged 16 and 17.
- An overview of the MCA 2005 is provided in Annex 1.

20. Mental Capacity Act 2005 Code of Practice, London:TSO, 2007, paragraph 1.2.

**2.13** However, a young person who is unable to make a decision will not always be covered by the provisions of the MCA 2005. There may be reasons why the young person is unable to make the decision which do not fall within the scope of the MCA 2005.

A young person may be unable to make a decision either because:

- She or he lacks capacity within the meaning of the MCA 2005; or
- For reasons of immaturity: due to the young person's age he or she is unable to make the decision in question.

### *Identifying the reasons for a young person's inability to make a decision*

**2.14** Guidance in both the Mental Capacity Act 2005 Code of Practice ('the MCA Code') and the MHA Code point out that not all young people who are unable to make a decision will lack capacity within the meaning of the MCA 2005. The Codes distinguish between a young person who has an 'impairment of, or disturbance in the functioning of the mind or brain' (who will fall within the provisions of the MCA 2005) and a young person who by reason of their lack of maturity is not able to make a decision (who will not be covered by the MCA 2005).<sup>21</sup>

**2.15** This distinction can be illustrated by the following two examples in the box below:

#### **YOUNG PEOPLE WHO ARE UNABLE TO DECIDE**

S is 16. She suffers from a psychotic illness. This illness is preventing her from making decisions about her care and treatment. She is adjudged to lack capacity within the meaning of the MCA 2005. Accordingly, decisions made on her behalf will be taken within the legal framework of the MCA 2005.

Y is 17. He is required to make a medical treatment decision about a life threatening condition. His life experiences and level of maturity make him unable to make the decision in question; his inability to make the decision is not linked in any way with an impairment or disturbance in the functioning of his mind or brain. (A young person such as Y is referred to being unable to make a decision 'due to immaturity'.)

This distinction is important because different legal consequences may follow if the young person's inability to make a decision does not fall within the MCA 2005. These are discussed in the text below and Chapters 3 and 4.

21. MCA Code 12.13 and MHA Code 36.23 and 36.37.

**2.16** In many of the cases in which mental health professionals are involved, the cause of the young person's inability to make a decision is likely to be rooted in an impairment or disturbance in the functioning of that young person's mind or brain, particularly when admission or treatment for mental disorder is being considered. However, practitioners need to be aware of the distinction (being unable to decide due to a lack of capacity and being unable to decide due to a lack of maturity) and the implications this may have in deciding the most appropriate course of action in relation to the young person concerned.

### *Young people who are unable to make a decision*

**2.17** Throughout this Guide, the term 'young person unable to decide' is used to refer to those young people who lack capacity within the meaning of the MCA 2005 to make a particular decision and those young people who are unable to make a particular decision for reasons of immaturity. However, as pointed out above, it will be necessary to distinguish between these two groups.

### *Inability to make decisions due to a lack of capacity under the MCA 2005*

**2.18** A person lacks capacity in relation to a particular decision if they are unable to make that decision 'because of an impairment of, or disturbance in the functioning of, the mind or the brain'.<sup>22</sup>

**2.19** An assessment of a person's capacity must be based on their ability to make a particular decision at a particular time. When assessing a person's capacity, a two stage test should be used:<sup>23</sup>

i. **Does the person have an impairment of, or disturbance in the functioning of, their mind or brain?** If not, the person will not lack capacity within the meaning of the MCA 2005.

ii. **Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?** The impairment or disturbance of their brain must affect the person's ability to make the specific decision at that particular time. People must be given all practical support to help them make a decision for themselves – see the second principle of the MCA 2005.<sup>24</sup>

22. Section 2(1) MCA 2005.

23. MCA Code 4.11 – 4.25.

24. Section 1(3) MCA 2005 and Chapter 3 MCA Code.

**2.20** A person is unable to make a decision if they cannot:

- understand the information about the decision to be made
- retain the information in their mind
- use or weigh that information as part of the decision-making process; or
- communicate their decision (by talking, using sign language or any other means).<sup>25</sup>

**2.21** A young person who is unable to make a particular decision ‘because of an impairment of, or disturbance in the functioning of, the mind or the brain’ will lack capacity within the meaning of the MCA 2005.

**2.22** However, in the case of a 16 or 17 year old, that young person’s inability to make the decision may be for some reason other than an impairment or disturbance in the function of the mind or brain and therefore fall outside the scope of the MCA 2005.

### *Inability to make decisions due to immaturity*

**2.23** The MCA 2005 will not apply if it is established that the reason for the young person’s inability to make a particular decision is because:

- the young person does not have the maturity to understand fully what is involved in making the decision; or
- the young person’s lack of maturity means that they feel unable to make the decision for themselves (for example, because they are overwhelmed by the implications of the decision).

### *Determining the basis for the young person’s inability to make a decision*

**2.24** Where a young person is not able to make a decision about their admission to hospital and/or treatment, practitioners should consider whether this is due to an ‘impairment of, or disturbance in the functioning of, the mind or the brain’ (and therefore lacks capacity within the meaning of the MCA 2005) or because the young person lacks the maturity to make the particular decision.

**2.25** The following points will be relevant to this assessment:

- If the young person’s mental disorder (such as a bipolar or delusional disorder) is affecting the way in which his or her mind or brain is working,

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25. Inability to make a decision is defined in s3 MCA 2005. See also the MCA Code 4.14



then this may be the reason why the young person is not able to make the particular decision. If that is the case, the MCA 2005 will apply.

- The MCA 2005 covers situations where the person's impairment or disturbance of the mind or brain is temporary. Furthermore, the impairment or disturbance can be caused by a wide range of factors such as severe pain, the effect of medication, or distress after a shock.
- Accordingly, a young person who is distressed, or suffering from the effects of medication or alcohol or illicit drugs, may be unable to make a decision. If this is because such factors have had an adverse affect on the young person's thought processes (i.e. the way in which their mind or brain is working), the young person's inability to make a decision is likely to be due to an impairment or disturbance of the mind or brain (however temporary). If that is the case, the MCA 2005 will apply.

## Assisting children and young people in decision-making

**2.26** Before deciding that a child lacks competence, or a young person lacks capacity, to make a particular decision, practitioners should take all practical and appropriate steps to enable the child or young person to make that decision themselves.<sup>26</sup>

**2.27** In the case of young children, practitioners can help children to develop competence by involving them from an early age in decisions and encouraging them to take an increasing part in the decisions about their care.

**2.28** The ways in which a child or young person can be supported to enable them to make a decision will depend on the decision to be made, the timescale for making the decision and the individual circumstances of the person making it. In all cases, the most effective means of communicating with the child or young person should be found.<sup>27</sup>

**2.29** The information necessary for them to make the decision should be explained to children and young people in a way that they can understand and in a format that is appropriate to their age.<sup>28</sup>

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26. See MCA Principle 2 and Chapter 3 MCA Code.

27. MCA Code 3.1 – 3.4.

28. MHA Code, 36.4.

Further information on ensuring effective communication is given in the MHA Code.<sup>29</sup>

**2.30** Providing appropriate help with decision making should form part of the Care Programme Approach (CPA) (or its equivalent).

## **Role of those with parental responsibility in decision-making where young people are unable to consent**

**2.31** Where a young person is unable to make decisions for him or herself, practitioners will need to consider whether they may make decisions concerning admission and/or treatment, relying on the MCA 2005, or whether those with parental responsibility can consent to the admission and/or treatment on behalf of the young person.

### *Where the MCA 2005 applies*

**2.32** Where the MCA 2005 applies, practitioners will be able to take decisions in relation to a young person's care and treatment if such decisions are in the young person's best interests and otherwise carried out in accordance with the principles and provisions of the MCA 2005. For example the MCA 2005 will not authorise the young person's 'deprivation of liberty' (this term is explained in 2.49-2.51).

### *Where those with parental responsibility may consent*

**2.33** Those with parental responsibility will be able to consent to the care and treatment on behalf of a young person, who is unable to make such decisions (whether or not the young person lacks capacity within the meaning of the MCA 2005), if:

- the decision to be made falls within the 'zone of parental control' (this term is explained in 2.39-2.48); and
- there is no statutory or other limitation. (For example, those with parental responsibility are not authorised to make treatment decisions on behalf of children and young people who are unable to consent to treatment provided as part of supervised community treatment.<sup>30</sup>)

29. MHA Code 2.2 – 2.7.

30. MHA Code 36.65. See also Chapter 7 below.

### *Involving those with parental responsibility*

**2.34** Those with parental responsibility should always be consulted about decisions concerning the young person's admission to hospital and treatment unless there are good reasons for not doing so. (For example, the consultation may not be appropriate if the young person has said they do not wish their parents to be involved.)<sup>31</sup> This is because:

- under the MCA 2005 anyone engaged in caring for the young person and close relatives must be consulted, if it is practicable and appropriate to do so, as to what would be in the young person's best interests and whether they have any information on the young person's wishes and feelings, beliefs and values.<sup>32</sup>
- in cases where those with parental responsibility are to be asked to consent to the proposed course of action, for example, the young person's admission to hospital or treatment for mental disorder, they must be given the information necessary to make such a decision.

### *Determining the appropriate course of action*

**2.35** In some cases, the decision-making powers of those with parental responsibility will overlap with the powers under the MCA 2005. In other cases, it will not be possible to rely on either the provisions of the MCA 2005 or parental consent.

**2.36** For example, if practitioners are concerned that the admission to hospital or treatment for mental disorder may involve a 'deprivation of liberty' (see 2.39 – 2.48) of the young person, or that parental consent cannot be relied upon, then admission to hospital under the MHA 1983 may be the appropriate course of action.

**2.37** If those with parental responsibility disagree with the proposed course of action (for example, admission to hospital or treatment), practitioners will need to consider the following three options:

- If it is applicable, making a decision in accordance with the MCA 2005,
- Relying on the powers in the MHA 1983 if the criteria for detention are met and either the MCA 2005 does not apply, or is not sufficient
- An application to the Court if the MHA 1983 cannot be used and either the MCA 2005 does not apply or there is doubt about whether it applies.

31. MCA Code 12.18 - 12.19. See also 'Confidentiality and Sharing Information' page 14, this Guide.

32. Section 4 MCA 2005.

**2.38** These points are considered in more detail in Chapter 3 (Admission to hospital for assessment and/or treatment for mental disorder) and Chapter 4 (Treatment, capacity and consent) below.

## Zone of Parental Control

**2.39** The term zone of parental control is used in the MHA Code to describe the types of decisions that people with parental responsibility will be able to make in relation to the child or young person's care and treatment.<sup>33</sup>

**2.40** Usually it will be the parent(s) of the child or young person who has parental responsibility but not in all cases. Information on parental responsibility and who may acquire this is provided at pages 24-25 and 95-99 of this Guide.

**2.41** The zone of parental control can be relevant to decisions in relation to admission and/or treatment of young people as well as children. The circumstances in which the zone of parental control will be relevant are explained in more detail in Chapters 3 and 4.

**2.42** There are no clear rules on what decisions may fall within the zone of parental control and each decision will need to be considered in the light of the particular circumstances of the case. The parameters of the zone of parental control will vary from one case to the next: they are determined not just by social norms, but also by the circumstances and dynamics of a specific parent and child or young person.<sup>34</sup>

**2.43** There are three main areas that need to be considered when assessing whether the decision falls within the zone of parental control. These are:

- i. whether the nature of the decision is one that falls within usual parenting decisions
- ii. whether there are any indicators that the parent might not be acting in the best interests of the child or young person; and
- iii. whether the parent has capacity to make the decision in question.
  - If practitioners are satisfied that these points are met, they may rely on the consent of the person with parental responsibility to the proposed admission or treatment.

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33. MHA Code 36.9-36.15.

34. MHA Code 36.12.

- The less confident the practitioners are that these points are met, the more likely it will be that the decision in question falls outside the zone of parental control.

### *Views of the child or young person*

**2.44** If the child had previously been Gillick competent or the young person had capacity in relation to the decision but subsequently lost competence/capacity, any views she or he had expressed should be taken into account and may act as parameters limiting the zone.<sup>35</sup>

### *Parental responsibility and capacity*

**2.45** The person responsible for the care and treatment of the patient must determine whether a person with parental responsibility has the capacity, within the meaning of the MCA 2005, to take a decision about the child or young person's treatment and whether the decision is within the zone of parental control.<sup>36</sup>

**2.46** If the person with parental responsibility lacks capacity to give consent to the admission or treatment of the child or young person, no one can give such consent on behalf of the parent.<sup>37</sup>

### *Parental responsibility and care orders*

**2.47** If the child or young person is subject to a care order, the local authority shares parental responsibility with the parents and can therefore consent to the admission or treatment.<sup>38</sup> There should be consultation with the child's parents unless to do so would not be in the child or young person's interests.

### *Determining the Zone of Parental Control*

**2.48** The box on page 28 sets out some key questions that may assist practitioners in determining whether the decision in question falls within the zone of parental control.

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35. MHA Code 36.47.

36. MHA Code 36.7.

37. Section 27 MCA does not permit decisions to be made on behalf of a person in relation to discharging parental responsibilities (save for matters concerning the child's property).

38. See section 33 of the Children Act 1989 and Annex 1.

## DETERMINING THE ZONE OF PARENTAL CONTROL: KEY QUESTIONS

**What is the nature of the decision?** Is this a decision that a parent would be expected to make, having regard to what is considered to be normal practice and any relevant human rights decisions? It might be helpful to consider the following factors:<sup>39</sup>

- The nature and invasiveness of what is to be done to the child or young person (including the extent to which the child or young person's liberty will be curtailed) – the more extreme the intervention the more likely it will be that it falls outside the zone.
- Whether the patient is resisting – treating a child or young person who is resisting needs more justification.
- General social standards in force at the time concerning the sorts of decisions it is acceptable for parents to make – anything that goes beyond the kind of decisions parents routinely make will be more suspect.
- The age, maturity and understanding of the child or young person – the greater these are, the more likely it will be that it should be the child or young person who takes the decision.

**What is the likely motivation for making the decision?** Are there any indicators that the parent might not act in the best interests of the child or young person?

- The actual decision could be one that is usual for a parent to make but the concern is that the parent is not going to make the decision based on what is in the child or young person's best interests. A factor to consider is the extent to which a parent's interests may conflict with those of the child or young person - this may suggest the parent will not act in the child or young person's best interests.
- For example, it might not be appropriate to rely on the consent of a parent in circumstances where the mental health of a child or young person has led to chronic battles over control in the home.<sup>40</sup>

**Is there any indication that the parent lacks capacity to make the decision?** All adults aged 16 or over are presumed to have capacity unless

39. MHA Code 36.12.

40. MHA 36.13.

41. Section 1(2) MCA 2005.

there is evidence to suggest otherwise. However, there may be cases where there is a concern that the parent does not have the capacity to make the decision in question.<sup>41</sup>

## CASE STUDY

### Dorothy

Dorothy is aged 13. She came to this country from Sierra Leone 5 years ago to live with her mother. She is withdrawn and isolated with delusional ideas. Her father visits this country from time to time, staying in the family home. Dorothy is taken to a local hospital under s136 MHA 1983 (removal to a place of safety) following an incident in the local park where she attacked her father. She is then transferred to an adolescent psychiatric unit on the basis of her mother's consent. Dorothy repeatedly asks to leave the unit but makes no attempt to walk out. Two weeks later her father visits the unit and states he wishes to discharge Dorothy saying that he plans to take her home to Sierra Leone.

### Commentary

Dorothy's ability to consent to her continuing care and treatment on the unit must be assessed. If she is able to consent, staff will need to determine that she does consent. If Dorothy is not regarded as able to make decisions about her treatment and care, which seems likely given her mental state, her mother will be able to consent to Dorothy's treatment and care on the unit if these decisions are within the zone of parental control. Her mother's consent can provide sufficient authority to give treatment and care for Dorothy, even if her father does not agree to this. (Under section 2(7) of the Children Act 1989 the consent of one person with parental responsibility will be sufficient).

Further information will be needed to ascertain whether these decisions about Dorothy's continuing care and treatment are within the zone of parental control. This will involve considerations about the nature of the treatment and care and whether Dorothy is resisting this. Although Dorothy has said that she wants to leave, it seems that she has not made any attempt to leave or resist the treatment. Accordingly, providing Dorothy's mother has capacity to make such decisions and there is nothing to suggest that she is not acting in her child's best interests, her consent could be relied upon (on the basis that these are decisions that fall within the zone of parental control). However, wherever practicable, both parents should be involved in decisions about Dorothy's care and treatment.

Furthermore, Dorothy's father is stating that he wants to take her back to Sierra Leone. It is likely therefore that he is also disagreeing strongly with Dorothy's care and



treatment on the unit. If that is the case, it may be unwise to rely on the consent of Dorothy's mother.

In cases where there is a clear conflict between the parents, rather than relying on the consent of one of the parents, it might be better to detain the child or young person under the MHA 1983 if the criteria are met, or (if the MHA 1983 is not applicable) apply to the court to authorise the care and treatment. (See MHA Code 36.5 and page 96 of this Guide.)

## **CASE STUDY**

### **Sala**

Sala who is aged 12 years was admitted some weeks ago to a private adolescent unit suffering from an acute psychotic illness. She lives with her mother, father, younger siblings and extended family. The family is from Bangladesh and the parents speak limited English. Sala's mother is considerably younger than her husband who is severely and chronically ill with lung disease. Sala's adult half brother is regarded as the head of the household. Despite the use of interpreters, it has not been possible to actively engage either parent in the treatment plan. Sala is reluctant to accept anti-psychotic medication, specifically refuses injections and requires considerable persuasion to accept oral medication. The parent's views have been communicated by Sala's half brother who is accorded considerable status and authority by the community social worker.

### **Commentary**

Sala's ability to make decisions about her care and treatment will need to be assessed. If it is decided that she lacks competence to make such decisions then treatment can be provided with the consent of those with parental responsibility for her, provided the treatment falls within the parameters of the zone of parental control. If it is not possible to facilitate effective communication between the treatment team and one of Sala's parents (assuming that they both have parental responsibility) then an application under the MHA 1983 could be made if all the conditions are met. If not, an application to court for an order authorising treatment and other forms of intervention will need to be considered.

## Deprivation of Liberty

**2.49** The term ‘deprivation of liberty’ derives from Article 5 of the European Convention on Human Rights (the right to liberty) which provides that ‘No one shall be deprived of his liberty’ save in the circumstances set out in Article 5, which include ‘the lawful detention of persons...of unsound mind’.

**2.50** In establishing whether there is a deprivation of liberty it is necessary to consider all the circumstances of each case, looking at a range of factors such as the type, duration, effects and manner of implementation of the measure in question and the impact on the person concerned. It is unlikely that one single factor will, in itself, determine whether the overall set of steps being taken amount to a deprivation of liberty. Case-law on this issue has identified various factors that are likely to be relevant.<sup>42</sup> For example:

- the use of restraint (including sedation) to admit a person to an institution where that person is resisting admission
- staff exercising complete and effective control over the care and movement of a person for a significant period
- the person being unable to maintain social contacts because of restrictions placed on their access to other people.

**2.51** The box below sets out some factors to consider when determining whether there is a deprivation of liberty.

### DEPRIVATION OF LIBERTY: FACTORS TO CONSIDER

Although the deprivation of liberty safeguards under the MCA 2005 only apply to individuals aged 18 or over, guidance issued in relation to these safeguards will be of relevance to determining whether a 16 or 17 year old is being deprived of his or her liberty. The guidance advises that the following points should always be considered:

- All the circumstances of each and every case.
- What measures are being taken in relation to the individual? When are they required? For what period do they endure? What are the effects of any restraints or restrictions on the individual? Why are they necessary? What aim do they seek to meet?

<sup>42</sup>MCA Code 6.49-6.53.

- What are the views of the relevant person, their family or carers? Do any of them object to the measures?
- How are any restraints or restrictions implemented? Do any of the constraints on the individual's personal freedom go beyond 'restraint' or 'restriction' to the extent that they constitute a deprivation of liberty?
- Are there any less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether?
- Does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?

*(Deprivation of liberty safeguards, Code of Practice to supplement the Mental Capacity 2005 Code of Practice, August 2008 Chapter 2)*

# Chapter 3

## Admission to hospital for assessment and/or treatment for mental disorder

**3.1** Chapter 3 considers the wide range of overlapping powers to authorise children and young people's admission to hospital for treatment (or assessment, followed by treatment) for mental disorder. This includes compulsory admission to hospital under the Mental Health Act 1983 (the MHA 1983) with an explanation of relevant amendments to the MHA 1983 that have been introduced by the Mental Health Act 2007 (the MHA 2007). Chapter 4 considers issues relating to the treatment of mental disorder, including the provisions of the MHA 1983 as amended by the MHA 2007.

**3.2** The following areas are covered in this chapter:

- determining whether hospital admission is necessary
- deciding on the legal authority for admission
- assessment for admission under the Mental Health Act 1983
- ensuring that the environment is age appropriate.

### Determining whether hospital admission is necessary

**3.3** Set out below are some preliminary questions to be considered in determining whether admission to hospital is the appropriate course of action.

#### CHECKLIST

##### Admission to hospital: preliminary questions

##### 1. What intervention is necessary?

Is admission to hospital necessary to meet the needs of the child or young person? For example, can support be provided appropriately in the community or are there other effective forms of care and treatment that the child or young person would be willing to accept?

## 2. What is the purpose of the intervention?

Considering the primary purpose of the intervention will indicate whether admission to hospital is required or whether another type of facility would be more appropriate.

Where the intervention requires the detention of the child or young person but the primary purpose of the intervention is not to provide medical treatment for mental disorder, consideration should be given to whether his or her needs would more appropriately be met within secure accommodation under section 25 of the Children Act 1989 (see Annex 1, page 100). This might apply, for example, if the child or young person is behaviourally disturbed and needs to be protected from harm.<sup>43</sup>

While the definition of mental disorder includes behavioural and emotional disorders of children and adolescents,<sup>44</sup> this is only one of the criteria that must be met in order for the child or young person to be admitted to hospital under the MHA 1983.

### CASE STUDY

#### Luke

Luke is 14 and has been accommodated by social services in a children's home at the request of his single mother on account of aggressive behaviour, truancy and damage to property. He has run away from the children's home many times and puts himself in high risk situations. He abuses solvents, cannabis and crack cocaine and is thought to be prostituting himself in order to fund his habit. Following police arrest, he threatens to throw himself off the nearby motorway bridge. Having been returned to the police station on a section 136, he is seen by a psychiatrist who considers that while Luke may have a mental disorder, this was not of a nature or degree that warranted his detention in hospital for assessment (or for assessment followed by medical treatment). However, the psychiatrist considers that Luke presents a high risk of harm to himself from his reckless behaviour.

As a 14 year old 'child in need' the Local Authority children's services have a role in maintaining Luke's safety but, because they have a collaborative relationship with his mother, they have relied on the 'no order principle' as

43.MHA Code 36.18.

44.MHA Code 3.3.

their main argument for not applying for a full Care Order, which would have given them parental responsibility. (The 'no order principle' is that a court should not make an order unless it considers 'that doing so would be better for the child than making no order at all'.) In the light of recent events, it is felt that Luke needs to be accommodated in a safe environment where his behavioural problems can be addressed. However, it is clear that Luke would run away from any such placement unless he is prevented from doing so.

### Commentary

- On the basis of the psychiatric assessment, it would appear that the MHA 1983 is not applicable as there is no evidence of mental disorder of a nature or degree that warrants Luke's admission to hospital under the MHA 1983.
- The primary purpose of any intervention will not be to provide treatment for mental disorder.
- If a suitable place is identified for Luke but it is clear that he will need to be detained there as otherwise he is likely to abscond, an application to the court for a secure accommodation order could be made. Section 25 CA 1989 sets out the criteria for such orders (see Annex 1).
- Recent guidance on the use of section 25 orders states:  
*Restricting the liberty of children is a serious step which should only be taken where the needs of the child cannot be met by a more suitable placement elsewhere. However, it should not be considered as a 'last resort' in the sense that all other options must have been tried without success. Such an approach could lead to the inappropriate placement of children and young people in the community, where their needs may not be met, possibly with highly adverse consequences...*<sup>45</sup>

45. Department for Children, Schools and Families The Children Act 1989 Guidance and Regulations. Volume 1 Court Orders, London: TSO 2008, 5.2.

## Deciding on the legal authority for admission

**3.4** In any case where hospital admission is thought appropriate, consideration will need to be given as to whether the child or young person be admitted informally or if admission under the MHA 1983 is required.

**3.5** The legal basis for the admission to hospital will depend on a range of factors, including the age and maturity of the child or young person and whether she or he has the capacity/competence to agree to the admission and whether a person with parental responsibility can consent on their behalf. This is because children and young people can be admitted informally if:

- they are able to consent and do so; or
- on the basis of parental consent; or
- (in the case of young people who lack capacity within the meaning of the MCA 2005) on the basis that the admission is in their best interests and does not amount to a deprivation of liberty.

**3.6** The particular issues concerning the following four groups of children and young people are considered on pages 40-43:

- young people aged 16 or 17 who are able to decide
- young people aged 16 or 17 who are unable to decide
- children under 16 who are Gillick competent
- children under 16 who lack Gillick competence

### *Overview of the routes to admission to hospital*

**3.7** Table 1 summarises the various circumstances in which a child or young person may be admitted to hospital for assessment and/or treatment for mental disorder. Further explanation is provided in the subsequent text.



**Table 1**  
**Admission to hospital for assessment and/or treatment**  
**for mental disorder: children and young people**

Legal Authority		YP able to decide	YP unable to decide	Competent Child	Child lacks competence
INFORMAL	YP/Child consents	✓ See s131 MHA	N/A – if unable to decide, cannot consent	✓ See the MHA Code 36.42	N/A - if lacks competence cannot consent
	MCA 2005	N/A – the YP does not lack capacity	✓ If YP lacks capacity within MCA & admission does not involve deprivation of liberty	N/A the main provisions of the MCA do not apply to under 16s	N/A - the main provisions of the MCA do not apply to under 16s
	Parent consents	N/A –YP's refusal cannot be overridden - s131 MHA	✓ If YP lacks capacity within MCA & within PZC	Where child refuses, MHA Code advises NOT to rely on parental consent	✓ If within PZC
FORMAL	MHA 1983	✓ If YP refuses or reasons for not relying on consent and MHA criteria met	✓ If informal admission not possible, or not sufficient and MHA criteria met	✓ If child refuses or reasons for not relying on consent and MHA criteria met	✓ If parental consent N/A or reasons for not relying on parental consent and MHA criteria met
	Court	✓ Apply if MHA criteria not met	✓ Apply if MHA criteria not met	✓ Apply if MHA criteria not met	✓ Apply if MHA criteria not met

**Key to table** ✓ = yes, can authorise admission; N/A = not applicable;  
YP = young person; PZC = parental zone of control

**3.8** The box below sets out some general comments to be referred to when considering this table. Further information on the steps to be taken in relation to the different groups of children and young people is then provided.

## GENERAL COMMENTS TO TABLE 1

### Admission under MHA 1983 should be the option of last resort

- The use of the MHA 1983 should only be considered if the options for informal admission are not applicable or not sufficient.
- Where the MCA 2005 is applicable and can be used safely and effectively to assess or treat a patient, it is likely to be difficult to demonstrate that the criteria for detaining the young person under the MHA 1983 are met.<sup>46</sup>

### Reasons for not relying on consent to admission <sup>47</sup>

- Informal admission is usually appropriate when the child, young person or person with parental responsibility, who has the capacity/ competence to do so, consents to the admission. However, in some cases admission under the MHA 1983 may be necessary even where consent has been given, especially if the patient presents a clear danger to themselves or others because of their mental disorder.
- Detention under the MHA 1983 should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

### Reasons for not relying on the MCA 2005 <sup>48</sup>

The MCA 2005 cannot be relied upon when admitting a young person to hospital if this results in the young person being deprived of their liberty. Other reasons why it may not be possible to rely on the MCA 2005 in preference to using the MHA include the following:

46. MHA Code 4.22.

47. MHA Code 4.9 - 4.11.

48. MHA Code 4.20 - 4.21.

- The young person lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element and has either already refused it, or is likely to do so.
- The young person's lack of capacity to consent is fluctuating or temporary and they are not expected to consent when they regain capacity.
- A degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the MCA 2005 because, exceptionally, it cannot be said to be proportionate to the risk to the young person personally.
- There is some other specific identifiable risk that the young person might not receive the treatment they need if the MCA 2005 is relied on and that either the young person or others might potentially suffer harm as a result.

### **MCA 2005 and decisions by persons with parental responsibility**

- Where a young person lacks capacity within the meaning of the MCA 2005, their admission to hospital may be authorised either by a person with parental responsibility (if this is within the zone of parental control) or by relying on the MCA 2005 (if this meets the requirements under the MCA 2005, such as best interests and the care regime on admission does not amount to a deprivation of liberty). (See page 31 for discussion on deprivation of liberty.)

### **Applications to the court**

- If there is no alternative basis for the admission to hospital for treatment for mental disorder of the child or young person, then an application to the court can be made. Legal advice should be sought.

### **Life threatening emergencies**

- In cases where failure to provide treatment is likely to lead to the child or young person's death or to severe permanent injury (and it is not practicable to obtain a court order first), then the child or young person may be admitted to hospital and treated without consent. However, legal advice should be sought if ongoing care and treatment is required as an application to the court may be required to authorise the actions taken. (See also Treatment and life-threatening emergencies on page 59).

## Young people able to decide on admission to hospital

**3.9** The MHA 2007 amends section 131 of the MHA 1983 so that 16 and 17 year olds who have the capacity to make such decisions, can either consent to, or refuse, admission to hospital for treatment for mental disorder. Their decision cannot be overridden by a person with parental responsibility.

**3.10** The young person's capacity to decide whether or not to consent to admission to hospital must be assessed in accordance with the MCA 2005. As discussed in Chapter 2, some young people may not lack capacity within the meaning of the MCA 2005 but, due to their immaturity, are nonetheless unable to make a decision. The situation for these young people is considered at 3.12 and 3.13.

**3.11** Young people who are able to make such decisions may be admitted to hospital for treatment for mental disorder in the following circumstances:

- *Informal admission:* the young person consents to the admission and there is no reason to believe that it would be unwise to rely on the young person's consent.<sup>49</sup>
- *Admission under the MHA 1983:* the young person refuses admission (or for some reason their consent is not considered sufficient)<sup>50</sup> and the criteria for admission under the MHA 1983 are met.
- *Admission authorised by the court:* if the criteria for admission under the MHA 1983 are not met, an application to the court could be made to override the young person's refusal (the MHA Code 36.23).
- *Emergency admission:* see 'life threatening emergencies' on page 39.

## Young people who are unable to decide about admission

### *Unable to decide about admission due to reasons of immaturity*

**3.12** A person with parental responsibility cannot consent to the admission on behalf of a young person who is unable to decide about the admission for reasons falling outside the MCA 2005.<sup>51</sup>

49. See 'reasons for not relying on consent to admission' above

50. See 'reasons for not relying on consent to admission' above

51. The MHA Code advises that in such circumstances s131 MHA 1983 applies – see 36.23. This is because although the young person is unable to give consent, s/he does not lack capacity within the MCA 2005 and therefore is deemed to have capacity for the purposes of s131(4). This sub-section provides that if the young person (who has capacity) does not consent to the making of arrangements for admission these may not be made on the basis of parental consent.

### 3.13 Accordingly, in such cases:

- *Informal admission*: will not be possible as admission cannot be arranged by either relying on the MCA 2005 or on the basis of parental consent.
- *Admission under the MHA 1983*: if the criteria for admission under the MHA 1983 are met.
- *Admission authorised by the court*: if the criteria for admission under the MHA 1983 are not met, an application to the court could be made.
- *Emergency admission*: see ‘life threatening emergencies’ on page 39.

### *Unable to decide about admission due to a lack of capacity*

**3.14** Young people who lack capacity to agree to their admission to hospital for treatment for mental disorder may be admitted without their consent in the following circumstances:

- *Informal admission in reliance on the MCA 2005*: a young person who lacks capacity within the meaning of the MCA 2005 may be admitted informally (if this is in the young person’s best interests and the other principles of the MCA 2005 are complied with) unless the admission and treatment amounts to a deprivation of liberty.
  - (Box on page 31 sets out factors to consider in determining whether there is a deprivation of liberty).
  - Unless it is not practicable or appropriate, those with parental responsibility must be consulted on whether the admission is in the young person’s best interests.<sup>52</sup>
- *Informal admission on the basis of parental consent*: where a young person is unable to decide about their admission, parental consent can authorise admission to hospital for treatment for mental disorder if:
  - The young person lacks capacity (within the meaning of the MCA 2005) to consent to the admission;<sup>53</sup> and
  - This particular decision falls within the ‘zone of parental control’.

The issues that will need to be considered in determining whether, in the particular circumstances of the case, the decision falls within the zone of parental control are discussed on page 26-29.

52. MCA Code 12.16 – 12.22

53. S131(4)

- *Admission under the MHA 1983:* This should be considered if:
  - the admission and treatment involves deprivation of liberty (and therefore the MCA 2005 does not apply) and either the decision is outside the zone of parental control or the person with parental responsibility does not (or lacks capacity to give) consent; or informal admission under the MCA 2005 or on the basis of parental consent is possible, but there are reasons for thinking that it is not sufficient.
- *Admission authorised by the court:* If the MHA 1983 is not applicable, it may be necessary to seek authorisation from the court.
- *Emergency Admission:* see ‘life threatening emergencies’ on page 39.

## Children who are Gillick competent

**3.15** Whereas section 131 of the MHA 1983 has special rules about the admission to hospital of 16/17 year olds, there is no equivalent provision for children under 16 who are competent to make decisions about their admission to, and treatment in, hospital. However the consent of a Gillick competent child is sufficient authority for the child’s admission and treatment.<sup>54</sup>

**3.16** Although case-law suggests that the refusal of a Gillick competent child can be overridden by the courts or a person with parental responsibility, the recent trend in other cases relating to children has been to give greater emphasis to the autonomy of a competent child.

**3.17** The child’s refusal is an important consideration in deciding whether the intervention should be authorised and its importance increases with the age and maturity of the child.

**3.18** Where the child is considered to be Gillick competent, the MHA Code advises that, given that the trend in recent case-law is to reflect greater autonomy for competent under 18s, it may be unwise to rely on the consent of a person with parental responsibility.<sup>55</sup>

**3.19** Gillick competent children may be admitted to hospital for treatment for mental disorder in the following circumstances:

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54. MHA Code 36.42.

55. MHA Code 36.43.

56. See ‘reasons for not relying on consent to admission above.’

- *Informal admission*: the child consents to the admission and there is no reason to believe that it would be unwise to rely on this person's consent.<sup>56</sup>
- *Admission under the MHA 1983*: the child refuses admission (or for some reason their consent is not considered sufficient) and the criteria for admission under the MHA 1983 are met.
- *Admission authorised by the court*: if the criteria for admission under the MHA 1983 are not met, it may be appropriate to seek authorisation from the court.
- *Life threatening emergency cases*: where the child's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent.<sup>57</sup>

## Children who are not Gillick competent

**3.20** Children who are not competent to make decisions about their admission to hospital for treatment for mental disorder may be admitted in the following circumstances:

- *Informal admission*: a person with parental responsibility may authorise the child's admission and treatment provided that this falls within the zone of parental control.
- *Admission under the MHA 1983*: This should be considered if:
  - the decision is outside the zone of parental control
  - the person with parental responsibility:
    - does not (or lacks capacity to give) consent; or
    - informal admission on the basis of parental consent is possible, but there are reasons for thinking that it is not sufficient.<sup>58</sup>
- *Admission authorised by the court*: If the criteria for admission under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.
- *Life threatening emergency cases*: as with a Gillick competent child, if failure to treat is likely to lead to the child's death or to severe permanent injury she or he may be admitted to hospital and treated without consent.

57. MHA Code 36.44.

58. See 'Reasons for not relying on consent' on page 38. See also 'life threatening emergencies' on page 39.

## CASE STUDY

### Ricky

Ricky is aged 15 and is an unaccompanied asylum seeker. He is accommodated by the local authority. He is diagnosed as suffering from PTSD (post traumatic stress disorder). He has been receiving out-patient treatment from his GP and local CAMHS service. Without warning, his physical health rapidly deteriorates. He refuses to eat, speak or leave his room. He is too unwell to be able to make a decision about his treatment nor will he accept admission to hospital because he 'does not trust the doctors.' Ricky's GP assesses that unless he receives immediate medical treatment, he is likely to die.

### Commentary

Ricky's severe physical ill-health does not appear to be related to his mental disorder. Accordingly, the MHA 1983 is not applicable. However, the GP can arrange for Ricky's admission to hospital to a paediatric ward on the basis that he requires emergency treatment for a life-threatening condition. In cases such as this, where failure to treat is likely to lead to the child's death, a child or young person can be admitted to hospital and treated without consent (MHA Code 36.44 and 36.51). However, an application to the court should be made as soon as possible to authorise further treatment. Given the absence of any person with parental responsibility, the local authority will consider whether an application for a care order in respect of Ricky is justified.

## Children and young people: Assessment for admission under the Mental Health Act 1983

**3.21** Individuals of any age can be admitted to hospital under the MHA 1983 but only if the requisite criteria are met.

**3.22** Detailed guidance on the assessment, and making applications, for detention in hospital under the MHA 1983, is set out in Chapter 4 of the MHA Code. The application is usually made by the Approved Mental Health Professional (AMHP)<sup>59</sup> and must be supported by two medical recommendations. However, where it is of urgent necessity for the person to be admitted and obtaining a second medical recommendation would cause undesirable delay, an application may be made on the basis of one medical recommendation (section 4 MHA 1983).

<sup>59</sup> An application may also be made by the person's Nearest Relative but this is rare.



### *Assessment for admission*

**3.23** The AMHP has a crucial role in the process of assessing whether a person should be admitted to hospital under the MHA 1983 (referred in this Guide as ‘the mental health assessment’).

**3.24** The AMHP will only make the application if satisfied that ‘in all the circumstances of the case’ it is the most appropriate way of providing the care and treatment that the patient needs. With the doctors carrying out the medical examination, the AMHP should identify and liaise with services which may potentially be able to provide alternatives to admission to hospital.

### *Mental health assessments of children and young people*

**3.25** The box below sets out some issues of particular importance in relation to the mental health assessment of children and young people.

#### **MENTAL HEALTH ASSESSMENT OF CHILDREN AND YOUNG PEOPLE <sup>60</sup>**

##### **Involvement of CAMHS Specialist**

- One of the professionals involved in the assessment should wherever possible be a CAMHS specialist.
- If that is not possible a specialist should be consulted as soon as possible. If the child or young person has complex or multiple needs other professionals may need to be involved (e.g. a learning disability CAMHS consultant).<sup>61</sup>

##### **Nearest Relative and person with parental responsibility**

- It will be important to identify the child or young person’s nearest relative for the purposes of the MHA 1983 and those people who have parental responsibility.
- AMHPs will be responsible for identifying the nearest relative and informing and/or consulting with this person as required under the MHA 1983.

60. MHA Code, Chapter 4, 36.3, 36.4 & 36.20.

61. MHA Code 4.39.

### Involve the person with parental responsibility

- The AMHP should, if appropriate and subject to the child or young person's views, consider consulting with their parents (or other people who have parental responsibility for the patient), if they are not the child or young person's nearest relative. Table 2 gives some examples of how the nearest relative and the person with parental responsibility may relate to each other.

### Interview the patient in a 'suitable manner'

- Ensure the information provided is age appropriate.
- Check whether the child or young person would like someone (such as a parent, carer or advocate) to be present at the interview.

## Identifying the nearest relative and the person with parental responsibility

**3.26** Sections 26 – 29 of the MHA 1983 set out the basis for identifying the nearest relative. These include a range of factors which are likely to change over the passage of time. Accordingly determining the patient's nearest relative will require an up to date knowledge of the patient's personal circumstances.

**3.27** In many cases, the nearest relative will also have parental responsibility, but this is not always so. Table 2 shows when a person may be able to be the nearest relative and/or have parental responsibility.

**Table 2. Children and young people: nearest relative and person with parental responsibility**

Person	Able to be the NR?	Able to have PR
Husband/ wife/civil partner (16/17 year olds)	Yes, unless deserted or permanently separated. The husband/wife/civil partner need not be 18 (S26(1),(3) & (5) MHA 1983)	No
Mother	Yes	Yes
Father	Yes, if father has PR	Yes, if married to mother at time of birth or later gained PR
Brother/sister	Yes, if 18 or over	Not unless the sibling is a person named in a residence order or has been appointed as a guardian <sup>62</sup>
Person named in Residence Order (s8 Children Act 1989)	Yes, to the exclusion of any other person while order in force (s28 MHA 1983). If more than one person named, they will have equal powers as the NR <sup>63</sup>	Yes, while order in force.
Guardian <sup>64</sup>	Yes, to the exclusion of any other person. If two guardians have been appointed they will have equal powers as the NR (s28 MHA 1983)	Yes. If under a special guardianship order this will be to the exclusion of other people with parental responsibilities (other than another special guardian) (s14C CA 1989)
Local authority	Yes, if care order under CA 1989 (S27 MHA 1983) unless there is a spouse or civil partner who could be the NR	Yes, if care order under CA 1989

62. This is not the same as guardianship under section 7 MHA 1983. See also the Reference Guide to the Mental Health Act 1983, paragraphs 3.23 and 3.25 in relation to guardianship and the nearest relative.

63. Although not explicit in s28 MHA 1983, the Department of Health shares the view expressed in Richard Jones, *Mental Health Act Manual*, 11th edition, Thompson, Sweet & Maxwell, 2008 (page 182) that if more than one person is named in the residence order, those named will have equal powers as NR. See also the *Reference Guide to the Mental Health Act 1983*, paragraphs 3.24 and 3.25 in relation to persons named in residence orders and the nearest relative.

64. This is not the same as guardianship under section 7 MHA 1983.

## CASE STUDY

### Vicki

Vicki is 17. She is accommodated by the local authority. She has been treated by professionals from her local CAMHS for some months, and recently has been staying as an in-patient during the week at a specialist psychiatric unit. Her mental health is now rapidly deteriorating; she is experiencing auditory hallucinations, she is very distressed and is no longer compliant with the treatment. She has been placed on a section 2 MHA 1983; however, her symptoms are not responding to treatment and it is agreed that she should now be placed on a section 3 MHA 1983. When Vicki was first accommodated she alleged that her father had abused her and her sister. Child protection services investigated her allegations, and could identify no evidence of abuse. Vicki's sister denied that she had been abused and the forensic medical examination of Vicki was inconclusive. Vicki was not placed on the child protection register. Vicki understands her legal position and she is clear that she does not want the AMHP to speak to her father, who is her nearest relative. She also does not want the AMHP to have any contact with her mother, who Vicki says is colluding with her father. The prospect of the AMHP talking to her father appears to be causing Vicki distress. Vicki's father is in regular contact with CAMHS. He is aware of all the allegations made by his daughter. He is apparently philosophical about these allegations, stating that the allegations are a consequence of her illness and she urgently needs treatment. He insists that it is his right as her nearest relative to be consulted and makes it plain that he will complain if he is not consulted.

### Commentary

Prior to admission under section 3 the MHA 1983, the AMHP must consult the patient's nearest relative unless it is not 'reasonably practicable' to do so. Practicability requires the AMHP to take into account the wishes of the patient and the impact that any such consultation may have on the patient's mental state (the MHA Code 4.58 – 4.64). In this case, if there is clear evidence that the process of consultation would distress Vicki then the AMHP might well be justified in not consulting her father. Following the detention process, an application to the county court to displace Vicki's father as nearest relative could be made by Vicki or an AMHP. One of the grounds for seeking the displacement of the nearest relative is that the person is not a suitable person to act as the nearest relative (section 29(3)(e)). This could include cases where there is evidence that the patient is distressed at the possibility of the nearest relative being involved in their care regardless of whether any abuse exists ( see 8.13 MHA Code). This might be the basis for seeking to displace Vicki's father as the nearest relative.

## Ensuring that the environment is age appropriate

**3.28** The MHA 2007 introduces an important new duty in relation to the admission of children and young people to hospital for treatment for their mental disorder.

**3.29** Section 131A MHA places a duty on Hospital Managers to ensure that the hospital environment in which a child or young person is to be accommodated is suitable for that patient, having regard to the patient's age, subject to his or her needs.

- This duty applies to all patients under 18, whether they are liable to be detained or admitted to hospital as an informal patient (including those who have been admitted informally on the basis of parental consent). It also includes children and young people placed on supervised community treatment orders (see Chapter 7) who are recalled to hospital or who are admitted voluntarily.
- The purpose of this provision is to ensure that children and young people are not admitted inappropriately on to adult psychiatric wards.

**3.30** When considering how to meet this requirement, the managers of the hospital must consult with a person who appears to them to have the requisite knowledge or experience of cases involving patients under 18. This person will usually be a child and adolescent mental health professional.

**3.31** The question whether the environment is suitable will depend on the particular circumstances of the child or young person. Relevant factors will, in addition to the age of the child or young person, include matters such as the nature and severity of the mental disorder, whether immediate admission is required and the likely length of admission (for example, if it is intended to be an interim measure until more suitable placement can be arranged).

**3.32** This duty is expected to be in force from April 2010 but hospital managers should take all steps they reasonably can to comply with the duty before that date.<sup>65</sup>

**3.33** The checklist below sets out some questions to consider in determining whether an environment is suitable, having regard to the patient's age and individual needs.

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65. MHA Code, Chapter 36, footnote 5.

## AGE APPROPRIATE ENVIRONMENT – QUESTIONS TO CONSIDER

### 1. What constitutes an environment which is suitable for a patient of this age?<sup>66</sup>

- Physical facilities: should be appropriate for children and young people.
- Staff have the right training, skills and knowledge: so they can understand and address children and young people's specific needs.
- Hospital routine conducive to their normal development: allowing the child's or young person's personal, social and educational development to continue as normally as possible. Younger patients need to have structure in their day and a planned timetable of activities including mealtimes, therapeutic activities, exercise and leisure.
- Educational opportunities: children and young people should have equal access to educational opportunities as their peers, in so far as they are able to do so, taking into account their mental health.<sup>67</sup>

### 2. Is there something about the patient which means you should use an environment that would not normally be deemed suitable?

- An environment that would be suitable for someone of the patient's age might not be a suitable environment for this patient.
- For example, a young person who is likely to require an admission for more than a few days and who will become 18 two weeks after admission may be better off being placed on the adult ward so that care does not have to be transferred within a very short time and therapeutic engagement with the adult team can start as soon as possible.

### 3. If no age appropriate environment is available, do the patient's needs justify using other accommodation instead?

- Such a situation may arise if there is an overriding need to ensure that the patient is admitted into hospital and where a hospital environment that is not age appropriate is better than no hospital environment at all.
- For example, a 16 year old in a psychotic crisis may have to be admitted immediately to a bed on an adult ward if no suitable CAMHS bed is immediately available

66. MHA Code 36.68.

67. MHA Code 36.77.

- While there may be crisis situations where the admission of a child or young person on to an adult ward is considered suitable because the main priority is providing a safe environment, this will only be acceptable in the short term. Thus, in the case described above, the 16 year old should be transferred to a CAMHS ward as soon as possible.<sup>68</sup>

## Role of hospital managers and children and young people detained under the Mental Health Act 1983

**3.34** Hospital managers have the primary responsibility for seeing that the requirements of the MHA 1983 are followed. In particular, they must ensure that patients are detained only as the MHA 1983 allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. These include:

- The right to apply to (and be legally represented at) a Tribunal for a review of the person's detention.
- Being informed about the section of the MHA 1983 under which they are detained, what this means in practice, and about the right to apply to a Tribunal.
- Being informed about the Commission<sup>69</sup> and the right to meet privately with the commissioners when they visit the hospital
- The right to be helped by an independent mental health advocate (IMHA) and how to obtain that help.<sup>70</sup>

**3.35** Unless the patient requests otherwise, the information should normally also be given to their nearest relative.<sup>71</sup> Involving parents and others with parental responsibility is discussed in Chapter 1.

**3.36** The box on page 52 sets out the specific responsibilities of hospital managers in relation to children and young people who are detained.

68. MHA Code 36.71.

69. Currently the Mental Health Act Commission but its functions will be transferred to the Care Quality Commission, which is expected to be introduced in April 2009.

70. Independent mental health advocacy services under the MHA are expected to be available by April 2009. See chapter 20 of the Code for more information.

71. See MHA Code 2.27 – 2.33 for situations where it may not be practicable to involve the nearest relative.

## **CHILDREN AND YOUNG PEOPLE: HOSPITAL MANAGERS' KEY RESPONSIBILITIES**

*On admission – ensuring an age appropriate environment*<sup>72</sup>

- Hospital managers must consult with a person experienced in CAMHS cases to consider how to ensure that the environment is suitable for the particular child or young person.
- This duty applies to all children and young people, whether or not they are detained under the MHA 1983.

*Provision of age appropriate information*

- Information (both written and oral) should be age appropriate and given by people with sufficient training and experience of working with children and young people.
- Children and young people have the same right to information as adults who are detained under the MHA 1983 or placed on Supervised Community Treatment (see Chapter 6)<sup>73</sup>

*Information about Independent Mental Health Advocates (IMHAs)*<sup>74</sup>

- Hospital managers must take whatever steps are practicable to ensure that children and young people detained under the MHA 1983 understand that help is available to them from IMHA services and how they can obtain that help.
- This must include giving the relevant information both orally and in writing.

*Allocating responsible clinicians (RCs)*<sup>75</sup>

- Local protocols should ensure that the RC is the available approved clinician with the most appropriate expertise to meet the child's or young person's main assessment and treatment needs.

72. Section 131A. This will come into force in April 2010.

73. S132 and 132A MHA 1983, see also s130D in relation to IMHAs

74. This duty is expected to be in force from April 2009

75. MHA Code 36.80 – 36.82



### *Hospital managers hearings and/or Tribunal review*

- Hospital managers' responsibilities in this area are discussed in Chapter 5.

### *Informal patients*

- Although the MHA 1983 does not impose any duties to give information to informal patients, they should be made aware of their legal position and rights. This will be particularly important for children and young people who may not be aware of their rights.

### *Information to local authorities*

- Hospital managers should set up systems to ensure that:
  - the relevant local authority is contacted on the admission of a child or young person who is subject to a care order or is 'looked after' <sup>76</sup>
  - they comply with the requirement to notify the local authority where a child or young person has been living if the child or young person is likely to be accommodated in hospital for three months or more (sections 85 and 86 of the Children Act 1989).
  - local authorities are alerted if the whereabouts of the person with parental responsibility is not known or that person has not visited the child or young person for a considerable period of time.

### *Education*

- While it is not the responsibility of the hospital managers to provide education for children and young people admitted to hospital, they will be responsible for contacting the appropriate authorities and liaising with these authorities to ensure that no child or young person below the school leaving age is denied access to learning merely because they are receiving treatment for mental disorder. <sup>77</sup>

76. S116 MHA 1983 (arranging visits etc) and the MHA Code 36.80.

77. MHA Code 36.77.



# Chapter 4

## Treatment, capacity and consent

**4.1** Chapter 4 considers the issues that are relevant to the treatment for mental disorder of children and young people. As with admission to hospital, there are a range of overlapping powers that can authorise children and young people's treatment for mental disorder, including the treatment provisions set out in the Mental Health Act 1983 (the MHA 1983). These provisions, including the amendments that have been introduced by the MHA 2007, are explained.

**4.2** The following areas are covered:

- Can the child or young person give valid consent?
- Authority to treat for mental disorder if the child or young person is not subject to specific treatment provisions set out in the MHA 1983
- The regulation of treatment under Part 4 of the MHA 1983. The new provisions concerning ECT under section 58A are explained.

### Can the child or young person give valid consent?

**4.3** Consent should be sought for each aspect of the child or young person's treatment as and when it arises. Even if the treatment being proposed can be given without consent under the MHA 1983, it is important to establish whether the child or young person is able to consent and whether the child or young person does consent.<sup>78</sup>

**4.4** The MHA Code defines consent as:

*... the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.*

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78. See the MHA Code 23.31-23.36, 23.37-23.41 and 36.53.

**4.5** If the child or the young person is unable to consent, they cannot then consent to treatment, even if they co-operate with the treatment or actively seek it.<sup>79</sup>

## **Authority to treat for mental disorder where the treatment provisions under the MHA 1983 do not apply**

**4.6** There are a range of powers that can authorise the treatment of children and young people.

**4.7** These powers include the MHA 1983 which sets out the circumstances in which special procedures will need to be followed in order for treatment for mental disorder to be given (in some cases, this can be without the person's consent). The treatment provisions are set out in Part 4 and Part 4A of the MHA 1983.

**4.8** Certain aspects of Part 4 are briefly described later in this chapter. Part 4A sets out specific provisions for the treatment of patients placed under Supervised Community Treatment. These are discussed in Chapter 7.

**4.9** This chapter first considers the basis on which treatment can be given to a child or young person in circumstances where the MHA 1983 does not apply.

**4.10** This will include situations where the child or young person has been admitted to hospital for treatment for mental disorder as an informal patient. This could be because the child or young person has been able to decide whether they wish to be admitted to hospital and has consented to this, or (in the case of a child or young person who has not been able to decide) on the basis of parental consent, or (in the case of a young person who lacks the capacity to decide) has been admitted in accordance with the MCA 2005 .

### *Treatment not regulated by Part 4 MHA 1983: Overview*

**4.11** Table 3 summarises the circumstances in which a child or young person can be treated for mental disorder if the treatment provisions of the MHA 1983 do not apply to them.

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79. See the MHA Code 23.32.

**Table 3**  
**Treatment for mental disorder: children and young people**

Legal Authority		YP able to consent	YP unable to consent	Competent Child	Child lacks competence
INFORMAL	YP/Child consents	✓	N/A	✓	N/A
	MCA 2005	N/A	✓ If lacks capacity within MCA & treatment does not involve a deprivation of liberty	N/A	N/A
	Parent consents	MHA Code advises NOT to rely on parental consent	✓ If within PZC	MHA Code advises NOT to rely on parental consent	✓ If within PZC
FORMAL	MHA 1983	If informal treatment* not possible, consider detention under the MHA if criteria are met.			
	Court	If MHA criteria are not met, apply to court			

Key to table ✓ = yes, can authorise treatment for mental disorder; N/A = not applicable; YP = young person; PZC = parental zone of control

**\*Note on scope of Part 4 MHA 1983**

Treatments such as neurosurgery for mental disorder and ECT for individuals under 18 are regulated under Part 4 of the MHA 1983 even if the patient is not detained under the Act (see sections 57 and 58A MHA 1983).

**4.12** The box below sets out some general comments in relation treatment of children and young people.

### **GENERAL COMMENTS TO TABLE 3 AND TREATMENT FOR MENTAL DISORDER**

#### **MCA 2005 and decisions by persons with parental control**

- Where a young person lacks capacity within the meaning of the MCA 2005, their treatment for mental disorder may be authorised either by a person with parental responsibility (if this is within the zone of parental control) or in reliance on the MCA 2005 (if this meets the requirements under the MCA 2005, such as best interests and the care regime does not amount to a deprivation of liberty).

#### **Reasons for not relying on the MCA**

- The MCA cannot be relied upon to authorise treatment for mental disorder if this results in the young person being deprived of their liberty.

#### **Decisions by those with parental responsibility**

- Where a child or young person has been admitted informally, on the basis of parental consent, it should not be assumed that consent has been given for all components of the treatment plan. The parent's consent should be sought for each aspect of the child or young person's care and treatment as it arises.<sup>80</sup>

#### **When detention under the MHA 1983 may be required**

- If the necessary treatment cannot be given on an informal basis, consideration should be given to whether the patient should be detained under the MHA 1983. That can only be done if the criteria for detention are met.

#### **Applications to the court**

- There may be cases in which treatment cannot be given on an informal basis i.e. with the consent of the child/young person/person with parental consent or (in the case of a young person who lacks capacity) in accordance with the MCA 2005, but the MHA 1983 does not apply.

80. See the MHA Code 23.31-23.36, 23.37-23.41 and 36.53

This might be because, although the treatment is needed, detention in hospital is not justified. In such cases an application to the court to seek authorisation for treatment may be necessary.

### **Treatment and life-threatening emergencies** <sup>81</sup>

If there is no other lawful basis on which to give the treatment and if the failure to treat is likely to lead to the child or young person's death or to severe permanent injury the child or young person may be treated without consent.

- Such circumstances may arise where:
  - the child or young person is able to make this treatment decision but refuses the treatment and there is no time for a MHA 1983 assessment or the criteria for detention under the MHA 1983 are not met; or
  - where a person with parental responsibility could consent but there is no time to seek their consent, or
  - the person with parental responsibility does not consent, and there is no time to seek authorisation from the court.
- The treatment must be no more than necessary and in the best interests of the child or young person.
- Treatment under these circumstances is limited to what is necessary to save the child or young person's life or prevent an irreversible serious deterioration of their condition. Once the child or young person's condition is stabilised, the legal authority for providing any further treatment must be clarified. For example:
  - Consent of the child or young person: if the child or young person is now able to consent to the treatment and does so consent;
  - Consent of a person with parental responsibility: if the person with parental responsibility is able to consent to the treatment and does so and this decision falls within the zone of parental control;
  - Treatment is given under Part 4 MHA 1983: if, following a mental health assessment, the child or young person is detained under the MHA 1983;

If none of the above situations apply and further treatment is required, it may be necessary to seek a court declaration to authorise the subsequent and on-going treatment. Legal advice should therefore be sought without delay.

81. MHA Code 36.44 and 36.51

## Treatment of 16 and 17 year olds who are able to consent to treatment

**4.13** Section 8 of the Family Law Reform Act 1969 provides that 16 and 17 year olds have the right to consent to their treatment and such treatment can be given without the need to obtain the consent of a person with parental responsibility.

**4.14** Young people who are able to consent to their treatment for mental disorder may be given such treatment in the following circumstances:

- *Treatment on the basis of the young person's consent:* If the young person is capable of giving valid consent and does so, then treatment may be given.
- *Treatment under the Mental Health Act 1983:* Consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met.
- *Application to the court:* If the criteria for detention under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.<sup>82</sup>
- *Life threatening emergencies:* where the young person's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent (see box on page 59).

**4.15** Relying on parental consent is not advisable:

- If the young person does not give consent to the proposed treatment the MHA Code advises against relying on the consent of a person with parental responsibility in order to treat the young person.
- Although in the past, courts have found that parental consent can override a young person's refusal in non-emergency cases, the trend in recent cases has been to reflect greater autonomy for children and young people who are able to make health-related decisions for themselves.<sup>83</sup>

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82. MHA Code 36.33.

83. MHA Code 36.33.



## Treatment of 16 and 17 year olds who are unable to consent

**4.16** Young people who are unable to consent to the proposed treatment for mental disorder may be treated without their consent in the following circumstances:

- *Treatment relying on the MCA 2005:* a young person who lacks capacity within the meaning of the MCA 2005 may be treated without their consent (if this is in the young person's best interests and the other principles of the MCA 2005 are followed).
  - The MCA 2005 will not apply if:
    - The admission would involve a deprivation of liberty (See page 31.)
    - The young person does not lack capacity within the MCA 2005.<sup>84</sup>
  - Unless it is not practicable or appropriate, those with parental responsibility should be consulted on whether the proposed treatment is in the young person's best interests.<sup>85</sup>
- *Treatment on the basis of parental consent:* whether or not the MCA 2005 applies, parental consent can authorise treatment for mental disorder if the young person is unable to make a decision about such treatment.
  - The consent of a person with parental responsibility can only be relied upon if it is within the 'zone of parental control'.<sup>86</sup>
  - The issues that will need to be considered in determining whether, in the particular circumstances of the case, the decision falls within the zone of parental control are discussed in Chapter 2.
- *Use of the Mental Health Act 1983:* If the MCA 2005 does not apply and the decision does not fall within the zone of parental control, consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met.
- *Application to the court:* If the MHA is not applicable, it may be necessary to seek authorisation from the court.
- *Life threatening emergencies:* where the young person's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent (see page 59).

84. See Chapter 2 for a discussion on the young person who is unable to consent due to a lack of maturity

85. MCA Code 12.16 – 12.22.

86. MHA Code 36.26.

## Treatment of under 16s who are Gillick competent

**4.17** Case-law has established that a Gillick competent child can give valid consent to treatment. (Assessment of a child's competence is discussed in Chapter 2).

**4.18** Treatment can be given to a Gillick competent child in the following circumstances:

- *Treatment on the basis of the child's consent:* If the child consents to the proposed treatment, it may be given without the need to obtain additional consent from a person with parental responsibility.
- *Relying on parental consent is not advisable:* If the child does not consent to the treatment, as with admission to hospital, it would not be wise to rely on the consent of a person with parental responsibility in order to treat the child.
- *Treatment under the MHA 1983:* Consideration will need to be given as to whether the conditions for detention under the MHA 1983 are met.
- *Application to the court:* If the criteria for admission under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.<sup>87</sup>
- *Life threatening emergencies:* Where the child's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent (See page 59).

## Treatment of under 16s who are not Gillick competent

**4.19** A child who is not Gillick competent can be treated for their mental disorder in the following circumstances:

- *Parental consent:* Consideration will need to be given to whether a person with parental responsibility may consent to the proposed treatment.
  - Some treatments will fall outside the zone of parental control.
  - If the child expressed an unwillingness to accept the proposed treatment when she or he was Gillick competent, it may not be appropriate for the parent to consent to such treatment.

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<sup>87</sup>. MHA Code 36.33

- *Use of the Mental Health Act 1983*: If the decision does not fall within the zone of parental control, consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met.
- *Application to the court*: If the criteria for admission under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.
- *Life threatening emergencies*: where the child's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent (see page 59).

## CASE STUDY

### Dan

Dan is 17 and has long standing learning difficulties compounded by heavy use of cannabis. He has developed early onset psychosis and has been admitted informally to an open (unlocked) adolescent hospital for assessment and treatment of his mental illness. Dan has settled into the routine and is complying with medication and therapy. His psychotic symptoms are settling down and medication is well tolerated. Although he does not have the capacity to make the decision about hospital treatment, he seems happy on the unit and has not expressed a wish to leave. His parents and community team are in full agreement with his care plan. From time to time, during less structured parts of the day, Dan walks out of the unit on to a busy road and puts himself at risk on account of his poor road safety and impulsive behaviour. It is therefore decided that the front door should be kept locked for a few days to prevent Dan taking these unpredictable trips out of the unit. Part of Dan's care plan is for staff to take steps to support him in going out and teaching him road safety awareness. Staff raise concerns about whether Dan is in effect being detained and if it is appropriate for him to continue to be cared for on an informal basis.

### Commentary

If Dan lacked capacity to decide about his admission to hospital, the legal basis for his informal admission would have been either parental consent (if his parents consented and this was considered to be within the zone of parental control) or by relying on the MCA 2005 (subject to ensuring that this was in Dan's best interests and the admission did not amount to a deprivation of liberty). Even if the MCA 2005 was the basis for Dan's admission, Dan's parents would need to have been consulted (see Chapter 2, 2.34).

The decision to lock the front door should trigger a reassessment of Dan's

informal status as it may no longer be safe to rely on the original basis for informal admission (the MCA 2005 or parental consent). This is because the MCA 2005 does not authorise a deprivation of liberty and parental consent can only be relied on if the decision is one which falls within the zone of parental control. (Consideration would also need to be given to the status of other patients in the light of the locked door.)

*Can the revised care regime be authorised under the MCA 2005?*

If the basis for Dan's informal admission was the MCA 2005 and he has been assessed as not having the capacity to make decisions about his treatment regime, the MCA 2005 can also be relied upon to make such decisions on his behalf if they are in his best interests. However the MCA 2005 does not give authority to deprive Dan of his liberty. It is clear that Dan's freedom of movement is being restricted and it will need to be determined whether his care regime amounts to a deprivation of liberty. The particular circumstances of Dan's case will have to be examined in detail. The views of Dan's parents will be relevant but will be only one of a range of factors that need to be considered (see the factors set out in 2.51 above).

A key question will be whether the restriction on Dan's liberty is a proportionate response to the likelihood and seriousness of harm to Dan. An important factor will be the duration of the restriction. Actions that are immediately necessary to prevent harm may not amount to a deprivation of liberty. However, if the restriction or restraint is frequent, cumulative and ongoing, or there are other factors present (for example, the person is unable to maintain contact with friends and family), then this may amount to a deprivation of liberty. Another factor to be considered is whether the care plan allows Dan to leave the unit at any time if accompanied by staff or members of his family. (See Deprivation of liberty safeguards, Code of Practice to supplement the Mental Capacity 2005 Code of Practice', August 2008, 2.8 – 2.12 and 2.19) In Dan's case, locking the doors for a few days may be too long and consideration should be given to less restrictive options, such as locking the doors for a few hours during less structured times during the day.

If it is not considered possible to shorten the time during which the doors are locked then consideration should be given to whether Dan's situation meets the criteria for detention under the MHA 1983.

*Can the revised care regime be authorised by parental consent?*

If Dan was admitted to the hospital on the basis of parental consent, consideration will need to be given as to whether this is sufficient to authorise Dan's revised care regime which, if it is proposed, will include the doors being locked for a few days. It may also be appropriate to consider whether parental consent is sufficient if Dan's informal admission was based upon the MCA

2005, but the MCA 2005 no longer applies because the care regime has been assessed as amounting to a deprivation of liberty (see the MHA Code 36.37).

In either case, the question is whether the decision to agree to the door being locked for a few days falls within the zone of parental control. There are a range of factors that need to be taken into account when considering this issue (see paragraph 2.48 above). As with deprivation of liberty, a key factor will be whether this is a proportionate response to the concerns about the likelihood and seriousness of harm to Dan. Can the front door be locked for shorter periods of time? If so, the care plan should be revised accordingly.

In Dan's case, the plan is not only to keep the door locked for a few days but also for staff to teach him road safety skills. Thus even though Dan is 17 years old, it may be considered that this is the type of decision that in these circumstances a parent might be expected to make and therefore falls within the zone of parental control. A key factor in reaching such a decision is that both parents agree with the proposal. If Dan appears unhappy with this arrangement, the decision would need to be reviewed and consideration given to whether he meets the criteria for detention under the MHA 1983.

## Treatments regulated under Part 4 of the Mental Health Act 1983

**4.20** Part 4 of the MHA 1983 is concerned with the circumstances in which treatment for mental disorder may be given. (For information on Part 4A of the MHA (Treatment of community patients not recalled to hospital) see Chapter 7).

**4.21** Some of the provisions in Part 4 authorise the treatment of patients without their consent. This Guide refers to such provisions as the 'compulsory treatment provisions of Part 4'.

**4.22** Not all patients who are detained under the MHA 1983 are subject to the compulsory treatment provisions of Part 4. Patients who are detained under s4 (emergency admission), s5(2) (doctor's holding power), s5(4) (nurses holding power), section 35 (remand to hospital for report) and sections 135 and 136 (place of safety) are not subject to these provisions.

**4.23** Furthermore, some provisions under Part 4 apply to patients whether or not they are detained under the MHA 1983. For example, treatments such as neurosurgery for mental disorder<sup>88</sup> and electro-convulsive therapy (ECT) for children and young people under the age of 18<sup>89</sup> are regulated by the MHA

1983. They can only be given if the procedures set out in the MHA 1983 have been followed.

**4.24** The main focus of this part of the Guide is to explain the changes to the provisions regarding ECT. However, a summary of the treatment provisions and key points in relation to Part 4 are set out below.

**Table 4**  
**Summary of treatments regulated under**  
**Part 4 MHA 1983**<sup>90</sup>

Section	Summary of treatment
57	<p>Neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive.</p> <ul style="list-style-type: none"> <li>• Applies to all patients, whether or not they are otherwise subject to MHA 1983.</li> <li>• Such treatment can only be given with the patient's consent and if the specified requirements are met (e.g. that a SOAD<sup>91</sup> certifies that it is appropriate for the treatment to be given).</li> </ul>
58	<p>Medication (after an initial three-month period<sup>92</sup>) – except medication administered as part of ECT</p> <ul style="list-style-type: none"> <li>• Applies to patients subject to the compulsory treatment provisions of Part 4.</li> <li>• Treatment can only be given if: <ul style="list-style-type: none"> <li>• <i>The patient consents</i> and the approved clinician in charge of the treatment/SOAD, certifies that the patient is capable of understanding the nature, purpose and likely effects of the treatment and that the patient has consented to it; or</li> <li>• <i>A SOAD certifies in writing</i> either that the patient is not capable of understanding the nature, purpose and likely effects of the treatment or the patient is</li> </ul> </li> </ul>

88. Section 58 MHA 1983

89. Section 58A 1983

90. It is possible that other forms of treatment may be added to sections 57, 58 or 58A by regulations.

91. Second Opinion Appointed Doctor – see Glossary

Section	Summary of Treatment
58 (cont'd)	capable and has not consented to it, but that it is appropriate for the treatment to be given.
58A	<p><b>ECT and medication administered as part of ECT</b></p> <ul style="list-style-type: none"> <li>• Applies to patients subject to the compulsory treatment provisions of Part 4 and all patients aged under 18 (whether or not they are detained).</li> <li>• <i>Patients capable of understanding the nature, purpose and likely effects of the treatment may only be given treatment with their consent</i> (either the approved clinician in charge of their treatment or a SOAD must certify that the patient is capable of consenting and has done so).</li> <li>• <i>Patients not capable of consenting may be given the treatment if certain requirements are met</i>, including that the SOAD considers it is appropriate for the treatment to be given and giving treatment does not conflict with an advance refusal of treatment.</li> <li>• <i>No patient who is under 18 may be given the treatment unless a SOAD certifies that the treatment is appropriate</i> (the specific provisions for under 18s are explained at 4.29-4.32)</li> </ul>
62	<b>Urgent treatment: sections 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary.</b>
63	<p><b>Other medical treatment for mental disorder (not falling within s57, s58 or s58A).</b></p> <ul style="list-style-type: none"> <li>• Applies only to patients subject to the compulsory treatment provisions of Part 4.</li> <li>• Treatment can be given to such patients without their consent if it is given by or under the direction of the approved clinician in charge of the treatment in question.</li> </ul>

92. The three month period applies once three months have passed from the day on which any form of medication for mental disorder was first administered to the patient during the patient's current period of detention under the MHA ("the three-month period").

**CASE STUDY****Jason**

Jason is aged 16. He is described as suffering from a psychotic illness and he presents a risk of absconding and harming himself. He has therefore been admitted under section 2 of the MHA 1983 to an adolescent intensive care unit. He is not compliant with any form of treatment. He is also refusing to eat in order to further harm himself.

**Commentary**

Jason's treatment is regulated under part 4 of the MHA 1983. He can be given medication for an initial period of three months (starting from the day that he was first given the medication following his detention under section 2) without his consent, provided this is under the direction of the approved clinician in charge of this treatment. After this three month period, the safeguarding provisions contained in section 58 MHA 1983 must be complied with to authorise the continued administration of medication. Other treatments for Jason's mental disorder, for example, the nursing and care that he is receiving in the unit and secure regime to ensure his safety, can be provided without his consent, if under the direction of an approved clinician in charge of the treatment in question ( section 63 MHA 1983).

**ECT summary of s58A MHA 1983**

**4.25** The MHA 2007 has introduced some important changes in relation to the administration of ECT. A new section – section 58A – has been incorporated into the MHA 1983. This provision applies to ECT and to medication administered as part of ECT. (Where ECT is referred to, this will include medication administered as part of ECT.)

**4.26** Save where urgent treatment is required under section 62 MHA 1983, patients who are subject to the compulsory treatment provisions under Part 4 but who are capable of consenting to this treatment may not be given ECT unless they do in fact consent.

*SOAD certificate*

**4.27** In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.<sup>93</sup>

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93. MHA Code 24.22.



### ECT and information

**4.28** All patients treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.<sup>94</sup>

## ECT: Provisions for children and young people

**4.29** The provisions concerning the administration of ECT introduce specific safeguards for patients aged under 18. Whether or not the child or young person is detained under the MHA 1983, section 58A provides that patients under the age of 18 can only be given ECT if a SOAD has certified that such treatment is appropriate.

**4.30** Individuals under 18 years of age can only be given ECT as follows: *(Where they are capable of consenting to the ECT):*

- They have consented to the ECT and
- A SOAD has certified in writing that
  - the patient is capable of understanding the nature, purpose and likely effects of the ECT and has consented to it; and
  - it is appropriate for the treatment to be given.

*(Where they are not capable of consenting to the ECT):*

- A SOAD certifies that:
  - the patient is not capable of understanding the nature, purpose and likely effects of the ECT but
  - it is appropriate for the treatment to be given; and
  - giving the patient ECT would not conflict with a decision made by a deputy appointed by the Court of Protection<sup>95</sup> or a decision of the Court of Protection which prevents the treatment being given.

**4.31** Unlike medication for mental disorder, there is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT).

94. MHA Code 24.24.

95. A deputy may be appointed by the Court of Protection to act for and make decisions on behalf of a person aged 16 years or more who lacks capacity within the meaning of the MCA 2005 – see s16 MCA 2005 and Chapter 8 of the MCA Code. Section 58A also refers to advance decisions and decisions made by a donee. These do not apply to individuals aged under 18.

**4.32** For children and young people under 18, a SOAD certificate by itself is not sufficient to authorise the treatment. Unless the patient is detained and subject to the compulsory treatment provisions of Part 4, clinicians must also have the patient's own consent or some other legal authority, just as they would if section 58A did not exist.<sup>96</sup> This is discussed below.

## ECT and informal patients under the age of 18

**4.33** For those children and young people who are not subject to the compulsory treatment provisions in Part 4, the SOAD's certification stating that it is appropriate for ECT to be given is not sufficient to authorise the treatment.

**4.34** It is not advisable to rely on parental consent to ECT as this is likely to be outside the zone of parental control.<sup>97</sup>

**4.35** The administration of ECT to a child or young person may be authorised in the following circumstances:

- *With the consent of child or young person who is able to consent:* Treatment may be given on the basis of the child or young person's consent if they are able to consent (see discussion above on children and young people's ability to consent to treatment (4.11 – 4.18))
- *Mental Capacity Act 2005 (for 16 and 17 year olds):* ECT may be provided to young people who lack capacity if this in their best interests, unless the treatment amounts to a deprivation of liberty.
- *Court authorisation:* This should be sought for children and young people who are unable to consent to ECT and the treatment cannot be given under the MHA 1983 (and for young people, where the MCA 2005 does not apply). Even where court authorisation is obtained, authorisation from a SOAD in accordance with section 58A MHA is required unless section 58A does not apply because the treatment is immediately necessary.

96. MHA Code 24.33, section 58A(7) MHA 1983.

97. MHA Code 36.60.

## ECT and emergency treatment

**4.36** Section 58A does not apply if the treatment is immediately necessary to save the patient's life or to prevent serious deterioration in the patient's condition. As a result:

- The requirement to obtain a SOAD certificate does not apply in such cases
- Patients who are subject to the compulsory treatment provisions of Part 4 can be treated without their consent (whether or not they have capacity to consent) under section 62 MHA 1983.

## Independent Mental Health Advocates (IMHAs) and ECT

**4.37** All children and young people for whom ECT is proposed should have access to Independent Mental Health Advocates (IMHAs) whether or not they are detained. This provision is due to be introduced in April 2009.

**4.38** Hospital managers must ensure that children and young people who are detained under the MHA 1983 are made aware of their right to help from an IMHA (see page 52).

**4.39** Where the child or young person is not detained, it is the doctor or approved clinician who first discusses with the child or young person the possibility of them being given ECT, who must take whatever steps are practicable to ensure that the child or young person understands that help is available to them from IMHA services and how they can obtain that help. This must include giving the relevant information both orally and in writing.<sup>98</sup>

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98. The MHA Code 20.12



# Chapter 5

## Discharge from hospital

**5.1** This chapter outlines the hospital manager's duties in relation to making referrals to Tribunals and highlights steps to be taken to ensure that children and young people are able to exercise their rights to apply to the Tribunal.<sup>99</sup>

**5.2** This chapter considers the following areas:

- Hospital manager's duties to make referrals to Tribunals.
- Systems to ensure referrals to Tribunals.

### Referrals to Tribunals: the role of hospital managers

**5.3** The MHA 2007 introduced some important changes in relation to the duty of hospital managers to refer patient's cases to Tribunals (section 68 MHA 1983). In summary:

- The hospital manager's duty to refer patients' cases to the Tribunal after six months has been extended so it now applies to patients detained under section 2 MHA 1983 as well and includes time spent on section 2 MHA 1983 before being detained for treatment under section 3 MHA 1983.
- Subsequent references must be made for patients under the age of 18 if the patient's case has not been reviewed for a year. This is a shorter period than for patients aged over 18 (3 years) and previously applied only to patients under the age of 16.
- The hospital managers must also refer patients who have been placed on a community treatment order (CTO) as soon as possible after the responsible clinician revokes the CTO.

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99. "Subject to Parliament, the functions of the Mental Health Review Tribunals for England are to be transferred from 3 November 2008 to the new First-tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007. There will also be a new right of appeal, on a point of law, to a new Upper Tribunal."

**5.4** Furthermore, the MHA Code advises that hospital managers should consider asking the Secretary of State to make a reference in respect of a patient who is unable to have their case considered by the Tribunal speedily following their initial detention or at reasonable intervals afterwards. Such cases include:

- where a patient's detention under section 2 MHA 1983 has been extended under s29 MHA 1983 pending the outcome of an application to the county court for the displacement of their nearest relative
- the patient lacks the capacity to request a reference.

## Systems to ensure referrals to Tribunals

**5.5** Hospital managers will need to establish systems to identify, in good time, cases that must be referred to the Tribunal, taking into account the difference in referral periods between patients aged 18 and over and those aged under 18.

**5.6** In relation to children and young people who are detained under the MHA 1983, hospital managers should ensure that:

- they are made aware of their right, and given assistance in applying to hospital managers' hearings and Tribunals and helped to obtain legal representation at an early stage
- Tribunals are notified that the patient is aged under 18
- a child and adolescent mental health service (CAMHS) specialist prepares a report for the Tribunal in cases where the responsible clinician is not a CAMHS specialist.<sup>100</sup>

**5.7** A 'CAMHS panel' of the Tribunal has been established with the object of ensuring, wherever possible, that at least one member with an understanding of the particular needs of under 18 year olds will be included as a member of the Tribunal when it is considering the case of a child or young person.

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100. MHA Code 32.19

# Chapter 6

## Supervised Community Treatment

**6.1** This chapter provides an overview of Supervised Community Treatment (SCT) and highlights points that will be of particular importance if SCT is being considered in relation to a child or young person.

### Supervised Community Treatment: an overview

**6.2** The provisions for SCT came into force in November 2008. They are set out in sections 17A-G of the MHA 1983.

**6.3** The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.<sup>101</sup>

**6.4** There is no age limit for SCT, although the number of children and young people placed on SCT is likely to be small. Patients who are placed on SCT are referred to as ‘SCT patients’.<sup>102</sup>

**6.5** Below is a summary of the key points for SCT.

#### SCT: KEY POINTS

*Eligibility:* SCT is available only to patients who have been detained in hospital for treatment for mental disorder.

*Making the CTO:* The patient’s Responsible Clinician (RC) may ‘by order in writing discharge a detained patient from hospital subject to his being liable to recall’ (section 17A). This is known as a ‘community treatment order’ (CTO). An Approved Mental Health Professional (AMHP) must state in writing that she or he agrees with the RC that the criteria for a CTO are met and it is appropriate to make the order.

101. MHA Code 25.2 – 25.3.

102. MHA Code 36.64.

*Criteria:* A CTO can only be made if the following criteria are met:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital;
- It is necessary that the responsible clinician should be able to exercise the power under s17E(1) MHA 1983 to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

*Conditions imposed as part of CTO:* Patients will be expected to comply with conditions:

- that are considered necessary or appropriate for one or more of the following purposes: ensuring that the patient receives medical treatment, preventing risk of harm to the patient's health or safety and protecting other persons;
- to make themselves available for an examination for the purpose of deciding whether to extend the CTO and for an SOAD to consider whether to authorise treatment under Part 4A. (These conditions are mandatory for all CTOs.)

*Power of recall:* The Responsible Clinician (RC) has the power to recall the patient to hospital if:

- the RC considers that the patient requires treatment for mental disorder in hospital and there would be risk of harm to the health or safety of the patient or to other persons if the patient were not recalled; or
- the patient has failed to comply with either one of the two mandatory conditions.

*Treatment of patients recalled to hospital:* the treatment of SCT patients who have been recalled to hospital is regulated under Part 4 of the MHA 1983 (see MHA Code 23.7 and 24.28 – 24.31).



*Revocation of CTO:* The CTO may be revoked if the responsible clinician considers that the patient again needs to be admitted to hospital for medical treatment under the MHA 1983 and an AMHP agrees with that assessment, and also believes that it is appropriate to revoke the CTO.

- If the patient requires in-patient treatment for longer than 72 hours after arrival at the hospital, the responsible clinician should consider revoking the CTO.
- The effect of revoking the CTO is that the patient will again be detained under the powers of the MHA 1983.

## Suitability of SCT for a child or young person<sup>103</sup>

**6.6** In considering whether SCT is suitable for a child or young person, practitioners may find it helpful to consider the following points:

- *Is the power to recall needed for this child or young person?*
  - The key factor in determining whether an SCT is suitable for the patient is whether the patient can safely be treated for mental disorder in the community only if the responsible clinician can exercise the power to recall the patient to hospital for treatment if that becomes necessary.
  - In making that decision, the responsible clinician must assess what risk there would be of the patient's condition deteriorating after discharge, for example, as a result of refusing or neglecting to receive treatment.
- *What are the views of those with parental responsibility?*
  - SCT may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. It would therefore be important to consult the child or young person and those involved in their care at an early stage.
  - Parents (or other people with parental responsibility) of SCT patients may not consent (or refuse) treatment for mental disorder on behalf of their child. However, if a child or young person who is placed on SCT is living with one or both parents, the person giving the

103. See MHA Code 25.6 – 25.20

treatment should consult with the parent(s) about the particular treatment, bearing in mind that if there is something that the parents would not accept, it would make it very difficult for the patient to live with their parents while on SCT.

- This dialogue should continue throughout the patient's treatment on SCT. If a parent is unhappy with the particular treatment or conditions attached to SCT, and the child is not competent to consent, a review by the patient's team should take place to consider whether the treatment and care plan, and SCT in general, are still appropriate for the child.<sup>104</sup>
- *Are those responsible for the child or young person willing and able to provide support?*
  - It may be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need.
- *Is the child or young person able to consent to the treatment plan under SCT?*
  - Although their consent to SCT is not required, in practice SCT patients will need to be involved in decisions about the treatment to be provided in the community, be prepared to co-operate with the proposed treatment and comply with the conditions attached to SCT. The child or young person's willingness to co-operate will need to be considered.
  - The child or young person's ability to make decisions about their treatment will be relevant to whether or not treatment can be given to them without their consent. This is discussed in Chapter 7.

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104. MHA Code 36.65

# Chapter 7

## Treatment regulated under Part 4A of the Mental Health Act 1983

**7.1** This Chapter explains the provisions of Part 4A of the MHA 1983 which set out the circumstances in which SCT patients, who have not been recalled to hospital, can be treated. It covers the following areas:

- Overview of Part 4A
- Conditions to be met before treatment can be given under Part 4A

### Overview of Part 4A

**7.2** Part 4A provides for the circumstances in which an SCT patient can be given treatment for their mental disorder. It applies to SCT patients who have not been recalled to hospital, including those who are in hospital without having been recalled, for example, if they have been admitted to hospital voluntarily.

**7.3** In this part of the Guide, reference to an SCT patient is to a patient who has been placed on SCT and has not been recalled to hospital.

### *Adult and child community patients*

**7.4** The provisions under Part 4A cover adult community patients (individuals aged 16 or over) and child community patients (individuals under 16).

- *Adult community patients aged 16 and 17:* Young people are considered to be adult community patients. Their capacity to consent to treatment must be assessed in accordance with the MCA 2005.
- *Child community patients aged under 16:* Practitioners will need to assess whether the child is competent to make treatment decisions, i.e. to ascertain whether the child is Gillick competent. (See Chapter 2 for an explanation of 'competence' and the assessment of competence.)

## PART 4A: SUMMARY OF KEY POINTS

The rules for SCT patients differ depending on whether or not they have the capacity to consent to the treatment in question.

SCT patients who have the capacity to consent to a treatment may not be given that treatment unless they consent. There are no exceptions to this rule, even in emergencies. The effect is that treatment can be given without their consent only if they are recalled to hospital.<sup>105</sup>

SCT patients who lack capacity (or in the case of a child, lacks competence) may be treated without being recalled to hospital. The circumstances in which treatment may be given to such patients are discussed below.

**7.5** The box above highlights the key provisions of Part 4A

## Conditions to be met before treatment can be given under Part 4A

**7.6** Treatment can only be given under Part 4A if:

- There is authority to give the treatment and
- Where there is a 'certificate requirement', this requirement has been met. (The certificate requirement generally applies to any treatment for which, if the patient was detained, would need to be certified as appropriate by a SOAD under section 58 or s58A before it could be given without consent.)

### *Authority to treat*

**7.7** The tables overleaf summarise the provisions concerning the authority to treat SCT patients. The first table shows when there will be authority to give treatment in non-emergency situations treatment. This relates to adult community patients (see sections 64B to 64D MHA 1983) and child community patients (see sections 64E and 64F MHA 1983). However for those treatments requiring a SOAD certificate, this would need to be obtained before the treatment can be given. Table 5 overleaf identifies the circumstances which give rise to a certificate requirement.

**7.8** The second table shows when emergency treatment can be given. The certificate requirement does not apply to emergency treatments.

105. MHA Code 23.14

**Table 5**  
**Treatment of community patients in non-emergency situations (sections 64B to 64F MHA 1983)**

Age & ability to consent	Authority for providing treatment
The patient has capacity to consent (if 16 and over) or competence (if under 16 years old)	<p>The patient consents to the treatment.</p> <p>Treatment CANNOT be given unless the patient consents to the treatment to be given.</p>
The patient lacks capacity to consent and is 18 or over	<p>Treatment can only be given if:</p> <ol style="list-style-type: none"> <li>1) The patient's attorney or deputy or the Court of Protection consents to the treatment on the patient's behalf <sup>106</sup> OR</li> <li>2) It is given by, or under the direction of the Approved Clinician in charge of the treatment; and <ul style="list-style-type: none"> <li>• There is no reason to believe that the patient objects to the treatment OR if patient objects, force is not required to give the treatment; and</li> <li>• Giving the treatment does not conflict with a valid and applicable advance decision to refuse the treatment OR a decision made by an attorney or by a deputy or the Court of Protection.</li> </ul> </li> </ol>
The patient lacks capacity to consent and is 16/17 years old	<ol style="list-style-type: none"> <li>1) The patient's deputy or the Court of Protection consents to the treatment on the patient's behalf;<sup>106</sup> or</li> <li>2) The treatment is being given by, or under the direction of the Approved Clinician in charge of the treatment; and <ul style="list-style-type: none"> <li>• There is no reason to believe that the patient objects to the treatment OR if patient objects, force is not required to give the treatment; and</li> <li>• Giving the treatment does not conflict with a decision made by a deputy or the Court of Protection<sup>107</sup>.</li> </ul> </li> </ol>
The patient lacks competence to consent and is under 16	<p>Treatment can be given by or under the direction of the Approved Clinician in charge of it, but only if there is no reason to believe that the patient objects to the treatment OR if patient objects, force is not required to give the treatment.</p>

106. 16/17 year olds cannot make Lasting Power of Attorneys therefore the reference to 'donee' in s64C MHA 1983 is not applicable to this age group

107. Section 64D(6) also refers to advance decisions to refuse treatments and decisions by donees (of Lasting Powers of Attorney (LPA)). These are not relevant to young people (16 - 17) as they cannot make either an advance decision or a LPA.

**Table 6**  
**Community Patients and Emergency Treatment**  
**(section 64G MHA 1983)**

Application	Authority for providing treatment
Patients who lack capacity (16 & over) or competence under 16)	<p>Emergency treatment can be given if:</p> <ul style="list-style-type: none"> <li>the person is reasonably believed to lack capacity/competence,</li> <li>treatment is immediately necessary; and</li> <li>if it is necessary to use force in order to give treatment: <ul style="list-style-type: none"> <li>the treatment needs to be given in order to prevent the patient from harm; and</li> <li>the use of force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.</li> </ul> </li> </ul>
Meaning of 'immediately necessary' (For ECT or medication administered as part of ECT see below)	<p>Emergency treatment is immediately necessary if it is crucial to:</p> <ul style="list-style-type: none"> <li>save the patient's life; or</li> <li>prevent a serious deterioration of the patient's condition and is not irreversible; or</li> <li>alleviate serious suffering by the patient and is not irreversible or hazardous; or</li> <li>represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to him/herself or others and is not irreversible or hazardous.</li> </ul>
ECT (or medication administered as part of ECT)	<p>Only the first two categories of immediately necessary treatments apply, namely to:</p> <ul style="list-style-type: none"> <li>save the patient's life; or</li> <li>prevent a serious deterioration of the patient's condition and is not irreversible.</li> </ul>
Decisions by those authorised to act under the Mental Capacity Act 2005	<p>Emergency treatment under section 64G can be given even if it conflicts with an advance decision to refuse the treatment (this will not be relevant to those under 18 as they cannot make advance decisions) or a decision of someone who has authority to refuse treatment on the patient's behalf (this may be relevant to young people who are SCT patients as a deputy can be appointed to make decisions in relation to 16/17 year olds).</p>
The certificate requirement does not apply to emergency treatment under section 64G.	

## Certificate requirement

**7.9** The information below summarises the provisions concerning the certificate requirements.

### CERTIFICATE REQUIREMENTS UNDER PART 4A MHA 1983<sup>108</sup>

- Part 4A patients may be given certain treatments for mental disorder only if a SOAD has certified that the treatment is appropriate, using a Part 4A certificate.
- A Part 4A certificate is needed for:
  - treatments which would require a certificate under section 58 if the patient were detained (this refers to medication after an initial three month period<sup>109</sup> – such treatments are referred to as ‘section 58 type treatment’); and
  - ECT and any other types of treatment to which section 58A applies (currently this is medication that is administered as part of ECT).
- However, a certificate is not required for section 58 type treatment during the first month following a patient’s discharge from detention onto SCT (even if the three month period in section 58 has already expired or expires during that first month).
- When giving Part 4A certificates, SOADs do not have to certify whether a patient has, or lacks, capacity to consent to the treatments in question, nor whether a patient with capacity is consenting or refusing.
- SOADs may make it a condition of their approval that particular treatments are given only in certain circumstances. For example, they might specify that a particular treatment is to be given only with the patient’s consent. Similarly, they might specify that a medication may be given up to a certain dosage if the patient lacks capacity to consent, but that a higher dosage may be given only with the patient’s consent.
- The certificate requirement does not apply to emergency treatments.

108. MHA Code 24.25 – 24.27.

109. The three month period starts on the day that the patient is first given medication under the compulsory treatment provisions under part 4 MHA 1983.

**Table 7**  
**Treatments and Certificate Requirements**

Type of treatment	Is there a certificate requirement which must be met in order for proposed treatment to be given?
Medication in the first month following a patient's discharge from detention onto SCT	<b>A certificate is NOT REQUIRED</b> (even if the three month period in section 58 has already expired or expires during that first month). (Section 64B(4))
Medication if s58 MHA 1983 would not apply (ie. the initial three month period has not expired)	<b>A certificate is NOT REQUIRED</b> during this period
Medication not falling within the above (ie. where s58 applies because the three month period has expired)	<b>Certificate IS REQUIRED</b> (unless immediately necessary – see below)
ECT	<b>A certificate IS REQUIRED</b> – A certificate will always be required for ECT unless it is immediately necessary (see below)
Medication that is 'immediately necessary'	<b>Certificate is NOT REQUIRED</b> for treatment that is 'immediately necessary' (64B(3)(b)).
ECT that is 'immediately necessary'	<b>Certificate is NOT REQUIRED</b> for treatment that is 'immediately necessary' (64B(3)(b)). For ECT the treatment will only be 'immediately necessary' if this is to save the patient's life or prevent a serious deterioration of the patient's condition and is not irreversible (64C(6))



# Part 2

## Additional Information and Resources



# Annex 1

## Care and treatment of children and young people: an overview of the relevant legislation

Annex 1 provides an overview of legislation relevant to children and young people with mental disorder. It seeks to provide practitioners with an understanding of the scope and purpose of the different statutory regimes. The resources section in Annex 4 suggests where more detailed information on the relevant legislation and policy can be obtained. The following legislation is explained below:

- A. Mental Health Act 1983
- B. Children Act 1989
- C. Children Act 2004
- D. Family Law Reform Act 1969
- E. Mental Capacity Act 2005

### A. Mental Health Act 1983

This section provides an overview of the Mental Health Act 1983 (the MHA 1983), including the changes introduced by the Mental Health Act 2007 (the MHA 2007) that will have a particular impact on children and young people.

### Purpose, scope and principles

The MHA 1983 provides for the treatment and care of people with mental disorder. In particular, it sets out the circumstances in which a person may be compulsorily admitted and treated in hospital. These powers of detention and compulsory treatment can apply to individuals of any age.

#### *Code of Practice to the Mental Health Act 1983*

The Code of Practice to the Mental Health Act 1983 (the MHA Code) provides guidance on the implementation of the law. This Guide refers to the 2008 version of the Code which takes into account the amendments introduced by the MHA 2007.

Individuals performing functions under the MHA 1983 must 'have regard' to the MHA Code. Professionals working with children and young people with mental disorders should therefore ensure that they are familiar with the MHA Code, which is applicable to all age groups. Chapter 36 of the MHA Code provides guidance on particular issues relevant to children and young people.

### *Meaning of mental disorder*

The MHA 2007 has introduced changes to the definition of 'mental disorder'. It is defined as 'any disorder or disability of the mind' (section 1(2)). This term could include behavioural and emotional disorders of children and young people (the MHA Code 3.3).

Although mental disorder is a broad definition, practitioners should note the following points:

- Dependence on alcohol or drugs is specifically excluded from this definition (section 1(3)). However, the effects of such dependence may fall within the definition (see the MHA Code 3.8 – 3.12).
- Learning disabilities fall within the definition of mental disorder. However, people can only be admitted to hospital for treatment (e.g. section 3) or made subject to guardianship (e.g. section 7) or supervised community treatment (section 17A) on the basis of learning disability alone if the disability 'is associated with abnormally aggressive or seriously irresponsible conduct' on their part. (See the MHA Code 3.13-3.17 and 34.6-34.10.)

### *Guiding principles*

The MHA 1983 (as amended by the MHA 2007) requires the MHA Code to include a statement of principles (section 118(2A)). These are set out in Chapter 1 of the MHA Code (see page 89). These Guiding Principles apply equally to children and young people. In addition, Chapter 36 of the MHA Code highlights some specific points that should always be borne in mind in relation to children and young people, (the MHA Code 36.4). These are set out in on page 90.

## CODE OF PRACTICE TO THE MENTAL HEALTH ACT 1983

### GUIDING PRINCIPLES

#### **Purpose principle**

Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

#### **Least restriction principle**

People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

#### **Respect principle**

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

#### **Participation principle**

Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

#### **Effectiveness, efficiency and equity principle**

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

## CODE OF PRACTICE TO THE MENTAL HEALTH ACT 1983 SPECIFIC ISSUES FOR CHILDREN AND YOUNG PEOPLE

**Best interests:** The best interests of the child or young person must always be a significant consideration.

**Information:** Children and young people should always be kept as fully informed as possible, just as an adult would be, and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age.

**Views of the child or young person:** The child or young person's views, wishes and feelings should always be considered.

**Least restrictive option:** Any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the option that is least restrictive and least likely to expose them to the risk of any stigmatisation, consistent with effective care and treatment, and it should also result in the least possible separation from family, carers, friends and community or interruption of their education, as is consistent with their wellbeing.

**Education:** All children and young people should receive the same access to educational provision as their peers.

**Dignity and respect:** Children and young people have as much right to expect their dignity to be respected as anyone else.

**Privacy and confidentiality:** Children and young people have as much right to privacy and confidentiality as anyone else.

## Admission to Hospital under the MHA 1983

The civil admission process, commonly referred to as 'sectioning' is set out in Part 2 of the MHA 1983.<sup>110</sup> The relevant provisions are as follows:

- Admission for assessment or assessment followed by medical treatment (section 2)

110. Part 3 of the MHA 1983 (admission to hospital) is via the courts and is not covered in this Guide.

- Admission for treatment (section 3)
- Admission for assessment in cases of emergency (section 4)
- Holding powers in respect of a patient already in hospital (section 5)

Sections 135 and 136 of the MHA 1983 provide powers to temporarily remove people who appear to be suffering from a mental disorder to a place of safety (which preferably will be a hospital where mental health services are provided but can be a police station). (See the MHA Code Chapter 10.)

### ***Admission to hospital: changes introduced by the MHA 2007***

Significant changes have been introduced by the MHA 2007 in the following areas:

- *Admission for treatment (section 3)*
  - The four categories of mental disorder have been removed.
  - The ‘treatability test’ is abolished.
  - The new ‘appropriate medical treatment’ requires medical treatment to be available which is appropriate in the patient’s case, ‘taking into account the nature and degree of the mental disorder and all other circumstances’ of the patient’s case.
- *Duty to provide an age appropriate environment (section 131A)*

This is discussed at 3.28 – 3.33 in Part 1 of this guide.

## **Treatment under the MHA 1983**

The MHA 1983 provides for the circumstances in which medical treatment for mental disorder can be given to a patient.

Chapter 4 (4.20 – 4.35) provides a summary of the treatments regulated under Part 4 of the MHA 1983 which concern the treatment of patients in hospital.

Chapter 7 provides a summary of the treatment provisions concerning patients on supervised community treatment (SCT) who have not been recalled to hospital)

Further information on the provision of treatment under the MHA 1983 is given in the MHA Code, Chapters 23 and 24.

## *Treatment: Changes introduced by the MHA 2007*

- *Medical treatment*

When it refers to medical treatment for mental disorder, the MHA 1983 means treatment the purpose of which is to ‘alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.’ (section 145(4)) The medical treatment must be for the patient’s mental disorder. It covers the treatment of physical health problems only where ‘such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder)’<sup>111</sup>

- *ECT (Electro-convulsive Therapy)*

Section 58A is a new provision introduced by the MHA 2007. Its impact on children and young people is discussed in Chapter 4 of this guide.

- *Supervised Community Treatment*

Part 4A of the MHA 1983 sets out the circumstances in which patients placed on supervised community treatment (SCT) (see below) and who have not been recalled to hospital may be given treatment without their consent. The application of these provisions to children and young people are explained in Chapter 7 of this guide.

## **Leave of absence and Discharge**

### *Leave of absence (section 17)*

The Responsible Clinician (RC) (the clinician with the overall responsibility for the patient’s case) may allow a detained patient to leave hospital for a given period and subject to any conditions that the RC considers necessary in the interests of the patient or for the protection of others.

### *Leave of absence and supervised community treatment*

When considering whether to grant detained patients leave of absence for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, RCs must first consider whether the patient should go onto supervised community treatment (SCT) instead.<sup>112</sup>

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111. MHA Code 23.4.

112. Section 17(2A) MHA 1983 and the MHA Code 21.9.



### *Discharge from hospital* <sup>113</sup>

The following points apply to patients who are liable to be detained in hospital under section 2 or section 3 of the MHA 1983. They may be discharged from detention by:

- **The Responsible Clinician (RC):** If at any time the RC considers that the criteria for the patient's detention are no longer met, the RC should discharge the patient.<sup>114</sup>
- **The Nearest Relative (NR):** The NR can seek to discharge the patient by giving the hospital managers 72 hours notice in writing of the intention to discharge the patient. This can be blocked by the RC during the 72 hours notice period by a "barring report" stating that if discharged the patient is likely to act in a manner dangerous to themselves or others).<sup>115</sup>
- **The hospital managers:** Hospital managers should ensure that patients are aware that they can ask the hospital managers to discharge them. Chapter 31 of the MHA Code provides guidance on the exercise of hospital managers' power to discharge detained patients and those that are subject to community treatment orders.
- **The Tribunal:** during each period of detention, patients can apply to the Tribunal to be discharged from detention. The powers of the Tribunal are set out in Part 5 of the MHA 1983. Chapter 32 of the Code provides guidance on the role of the Tribunal and the related duties on hospital managers and others.

### *Tribunals: changes introduced by the MHA 2007*

The MHA 2007 has introduced important changes to the duties of hospital managers to make referrals to the Tribunal. These are discussed in more detail in Chapter 5 in Part 1 of this guide.

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113. See sections 23,25 and Part 5 MHA 1983

114. The MHA Code 29.15-29.17

115. The MHA Code 29.18-29.23

## After-care

Section 117 MHA 1983 places a duty on primary care trusts (PCTs) and local social services authorities, in co-operation with voluntary agencies, to provide after-care to patients who have been detained under the MHA 1983 for treatment (e.g. section 3).

Further information on the legal and policy framework for provision of after-care services to children and young people is set out in Annex 2.

## Advocacy: Independent Mental Health Advocates

As from April 2009, patients who are liable to be detained in hospital, subject to guardianship or supervised community treatment, will have the right to help from Independent Mental Health Advocates (IMHA).

- IMHAs are specialist advocates who are trained specifically to work within the framework of the Act to meet the needs of patients.<sup>116</sup>
- Children and young people have the right to help from IMHAs in the same circumstances as an adult.
- Help from an IMHA is also available to a child or young person under 18 (whether or not they are detained under the MHA 1983) where ECT is being proposed.

## Powers in the community

The MHA 1983 includes powers in relation to patients who are living in the community (guardianship and supervised community treatment).

- **Guardianship (sections 7-10 of the MHA 1983):** may only be applied to individuals aged 16 or over. A guardian is appointed where this is necessary in the interests of the welfare of the patient or for the protection of others. The purpose of guardianship is to enable patients to receive care outside hospital when it cannot be provided without the use of compulsory powers<sup>117</sup>. Save for reflecting the new definition of mental disorder, no changes have been made to the criteria for guardianship by the MHA 2007.<sup>118</sup>

116. The MHA Code 20.2.

117. MHA Code 26.2.

118. The MHA 2007 introduces a new power to take patients for the first time to the place that they are required to live, if patients do not (or, in practice, cannot) go there themselves (s18(7) and MHA Code 26.26).

- **Supervised Community Treatment (SCT) sections 17A-G of the MHA 1983):** has been introduced by the MHA 2007, replacing supervised discharge with 'community treatment orders' ('CTOs'). Unlike supervised discharge, CTOs can apply to individuals of any age. See Chapter 7 for more information.

## B. Children Act 1989

The Children Act 1989 (the CA 1989) is relevant to all those working with children and young people. Its main provisions apply to all individuals aged under 18. Although the Act has been amended since 1989 (most importantly by the Adoption and Children Act 2002, the Children Act 2004 and the Children and Adoption Act 2006), the original framework remains intact. This section focuses on the areas of parental responsibility, secure accommodation, service provision and child protection.

### Purpose and scope

The CA 1989 brings together both the private law (governing legal relationships between private persons) and the public law (governing legal relationships between private persons and the state) in relation to children. It:

*...provides a single coherent legislative framework for the private and public law relating to children. It strikes a balance between the rights of children, the responsibilities of both parents to the child and the duty of the state to intervene when the child's welfare requires it.*<sup>119</sup>

### Parental responsibility

- **Definition**

This term is defined in section 3(1) CA 1989 as 'all the rights, duties powers, responsibilities and authority which by law a parent has in relation to a child and his property'.

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119. Department for Children, Schools and Families The Children Act 1989 Guidance and Regulations. Volume 1 Court Orders, London: TSO 2008 [www.dcsf.gov.uk/localauthorities/\\_documents/content/childrensactguidance.pdf](http://www.dcsf.gov.uk/localauthorities/_documents/content/childrensactguidance.pdf)

Parental responsibility:

*...is concerned with bringing the child up, caring for him and making decisions about him, but does not affect the relationship of parent and child for other purposes. Thus, whether or not a parent has parental responsibility for a child does not affect any obligation towards the child, such as the statutory duty to maintain him (section 3(4)(a)).*<sup>120</sup>

- **Decision making and shared parental responsibility**

Where more than one person has parental responsibility for a child or young person, each of them may act alone and without the other in meeting that responsibility (section 2(7) CA 1989).

This means that consent to admit or treat the child or young person may be given by one person with parental responsibility. However, the MHA Code 36.5 advises:

- It is good practice to involve both parents and others close to the child or young person in the decision-making process where practicable.
- If one person with parental responsibility strongly disagrees with the decision to treat and is likely to take legal proceedings to challenge the decision in court, it might be appropriate to seek authorisation from the court before relying on the consent of another person with parental responsibility.

- **Local authorities with parental responsibility**

Where a local authority has a care order in respect of a child or young person (see page 98), it shares parental responsibility with the parents or others with parental responsibility for the duration of the care order. The MHA Code (36.8) advises:

- Where a child or young person is looked after by the local authority, treatment decisions should be discussed with the parent(s) or others with parental responsibility.
- Those with parental responsibility will need to agree on who will be consulted about decisions relating to the child or young person's care and treatment.

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120. *ibid*

- Local authorities can limit the extent to which those with parental responsibility can exercise their responsibilities (section 33(3)(b)). (This will be relevant if there is a conflict between those with parental responsibility and the local authority.)
- **Emergency intervention to protect a child or young person**

All those working with children and young people should be aware that when they have care of a child or young person they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare' (section 3(5) CA 1989). Whether the intervention is reasonable or not will depend upon the urgency and gravity of what is required and the extent to which it is practicable to consult a person with parental responsibility.

#### Examples of emergency intervention

Keith, aged 11 is being treated on a paediatric ward. He becomes distressed and attempts to leave. He is vulnerable to harm beyond the safety of the hospital ward. **He can be prevented from leaving by any member of staff involved in his care.**

Jo, aged 16 is a resident of a children's home. She is putting herself at risk by climbing on to roofs or out of windows. **A member of staff caring for Jo can do whatever is necessary to secure her safety.**

- **Delegation of parental responsibilities to others**

Section 2(9) CA 1989 provides that individuals with parental responsibility for a child or young person may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf. The person to whom responsibility is delegated may already have parental responsibility for the child, for example, if that person is the other parent (section 2(10) CA 1989).

## WHO HAS PARENTAL RESPONSIBILITY?

Usually the parents of the child or young person will have parental responsibility but not always. More than one person may have parental responsibility for the same child at any one time (section 2(5) CA 1989). Below are examples of those who can have parental responsibilities:

- **Mother:** the child's mother will always have parental responsibility for her child unless the child has been adopted by someone else.
- **Father:** if the child's father and mother were married at the time of the child's birth; or if he has subsequently acquired parental responsibility, for example, through registration, court order or subsequent marriage to the mother.
- **Step-parents:** may acquire parental responsibility through a parental responsibility agreement or a court order.
- **Other individuals:** may acquire parental responsibility, for example, through a residence order (section 12(2) CA 1989) or adoption or by being appointed as the child or young person's guardian (Note: this is not the same as a guardian under section 7 MHA 1983.)
- **Local Authority:** will acquire parental responsibility under a care order (or interim care order) for the duration of care order (section 33(3) CA 1989) and, with restrictions, under an Emergency Protection Order (s44(4)(c) CA 1989). The local authority does not acquire parental responsibilities if the child or young person is voluntarily accommodated by the local authority.

### *Verifying parental responsibility*

Those taking decisions in relation to a child or young person with mental disorder should 'always request copies of any court orders for reference on the child or young person's medical or social service file'. Furthermore, if the parents of the child or young person are separated and the child or young person is living with one of the parents, steps should be taken to ascertain whether there is a residence order and if so, in whose favour.<sup>121</sup>

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121. MHA Code 36.6

The MHA Code at 36.6 makes reference to various orders. These are:

- **Care order:** this places the child or young person under the care of the local authority (section 33 CA 1989). The court will only make this order if satisfied that the child or young person is suffering or likely to suffer significant harm and that this is due to the fact either that the care being given to the child or young person is not what it would be reasonable to expect a parent to give or that the child or young person is beyond parental control. Care orders cannot be made for those aged 17 or over, or 16 if the person is married (section 33 CA 1989). A care order lasts until the child's 18th birthday unless it is brought to an end sooner (section 91(2) CA 1989).
- **Residence order:** this is an order of the court that sets out who the child or young person is to live with and gives that person parental responsibility. Such orders may be made in favour of any person, or persons, and may provide for the child or young person to live with one person at one time and other people at other times (sections 11 to 12 CA 1989).
- **Contact order:** this is an order by the court that requires the person with whom the child or young person lives, or is to live, to allow the child or young person to visit or stay with, or to otherwise have contact with the person named in the order (sections 11 to 11P CA 1989).
- **Evidence of guardian's appointment:** where the person(s) with parental responsibilities have died, a guardian can be appointed by a court order or by the person(s) with parental responsibilities, in writing i.e. in a will. The court can also make a 'special guardianship order' (see sections 14A-G CA 1989).
- **Parental responsibility agreements or orders under section 4 CA 1989:** these are the agreements (which must be in made in the form prescribed by regulations) or court orders that enable fathers (and step parents – section 4A CA 1989) to acquire parental responsibility.
- **Wardship orders:** these are orders made by the High Court under its inherent jurisdiction. Since the introduction of the CA 1989, the use of wardship has dramatically declined. (Note: Section 33 of the MHA 1983 makes specific provisions in relation to wards of court and the admission under the MHA1983, the use of guardianship, community treatment orders and powers exercised by the nearest relative. For example, the leave of the court must be obtained before an application is made for a ward of court to be detained in hospital under the MHA 1983.)<sup>122</sup>

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122. For further information see Reference Guide to the Mental Health Act 36.9-36.12.

## Secure Accommodation

Where a child or young person needs to be detained but the primary purpose is not to provide medical treatment for mental disorder, consideration should be given to using section 25 CA 1989.<sup>123</sup>

Section 25 CA 1989 applies to the restriction of liberty of both children and young people who are 'looked after' (this term includes children and young people who are voluntarily accommodated as well as those subject to a care order) by the local authority and of those accommodated by NHS bodies and local education authorities or placed in private psychiatric hospitals.<sup>124</sup> It does not authorise medical treatment.

### *Restriction of liberty without court order*

The maximum period during which a child or young person's liberty may be restricted without the authority of a court is 72 hours, either consecutively or in aggregate in any period of 28 days.<sup>125</sup> This applies to children and young people accommodated by health and local education authorities and those in private psychiatric hospitals.

### *Grounds for placing a child or young person in secure accommodation*

Under section 25 a court (the family proceedings court in non-criminal proceedings) may order that a child or young person is placed and kept in 'accommodation provided for the purpose of restricting liberty' (referred to as 'secure accommodation') if it is satisfied that the following grounds are met:

- that the child or young person has a history of absconding and is likely to abscond from any other type of accommodation; and
- that if the child or young person absconds, she or he is likely to suffer significant harm; or
- that if the child or young person is kept in any other type of accommodation she or he is likely to injure himself or other persons.

(The criteria are modified in criminal proceedings.)

### *The length of the order*

Initially, the maximum period of an authorisation is three months. Authorisation may be renewed for further periods of up to six months at a

123. MHA Code 36.17.

124. Children (Secure Accommodation) Regulations 1991 Regulation 7(1)(a) and (b).

125. Children (Secure Accommodation) Regulations 1991 regulation 10(1).



time.<sup>126</sup> A child or young person can only be kept in secure accommodation for the maximum period specified in an order and while the criteria are still satisfied.<sup>127</sup>

## Child Protection

### *Duties of local authorities to investigate suspected harm*

The CA 1989 imposes duties on the local authority to investigate and ‘make enquiries’. This duty arises in a number of circumstances including where there is reasonable cause for the local authority to suspect that a child or young person who lives or is found in its area is suffering or likely to suffer significant harm.<sup>128</sup> In these circumstances, the authority is required to make sufficient enquiries to enable it to decide whether it should take any action to safeguard or promote the welfare of the child or young person.

When determining what action to be taken, the local authority is required to ascertain the child or young person’s wishes and feelings.<sup>129</sup> The steps to protect and assist the child or young person under the CA 1989 could include: implementing the procedures of the CA 1989 to protect children and young people, initiating proceedings and/or providing services under the CA 1989.

### *Police powers in emergencies*

The police have powers to ‘remove and accommodate’ children and young people in emergencies. These powers are not court sanctioned and are time limited. A child or young person can be kept in police protection for a maximum period of 72 hours.<sup>130</sup>

### *Public law orders*

To protect children and young people, the court can make ‘public law orders’. This term includes emergency protection orders, interim care orders, care orders and supervision orders.

Orders can only be made if the ‘threshold criteria’ are met. These criteria are contained in section 31 of the CA 1989. The central concept of the criteria is whether the child or young person is likely to suffer, or has suffered significant

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126. Children (Secure Accommodation) Regulations 1991 regulation 12.

127. LM v Essex County Council [1999] 1FLR 988.

128. Children Act 1989 section 47.

129. Children Act 1989 section 47(5A).

130. Children Act 1989 section 46(6).

harm. The harm, or likelihood of harm, must be attributable either to the care given to the child or young person ‘not being what it would be reasonable to expect a parent to give’ or to the child or young person being beyond parental control.<sup>131</sup>

Even if the threshold criteria are satisfied, the court must not make any order unless it considers that doing so would be better for the child or young person than making no order at all.<sup>132</sup> All public law cases will involve the court having to consider fundamental human rights issues, in particular the application of Article 8 ECHR (the right to respect for private and family life).

## CASE STUDY

### Joe

Joe is aged 13 and lives with his grandmother. He has a residence order under the Children Act 1989 following Joe’s abandonment by his mother. Joe’s schoolteacher contacts the local authority’s child protection services. She is very concerned that Joe appears to be distressed and unhappy and says that he is being ‘poisoned by his granny.’ Following an investigation by the child protection team, it appears that Joe’s grandmother has been receiving treatment for mental illness for many years and recently stopped her medication. The local authority wants to arrange for Joe to be assessed and, if necessary, treated by CAMHS but his grandmother will not consent to this, maintaining that there is nothing wrong with her grandson.

### Commentary

In this case, it is not clear whether the problems Joe is facing are due to his mental disorder or as a result of his grandmother’s mental disorder. The local authority therefore needs to be able to arrange for Joe to be assessed to ascertain whether Joe does have a mental disorder and, if so, whether he requires treatment. Joe’s grandmother has parental responsibility (she is the person named in the residence order) but she is withholding her consent to an assessment being arranged for Joe. In such circumstances, the local authority should consider making an application for a care order under section 31 of the Children Act 1989. The grounds for such an order would be that Joe is suffering significant harm and that harm is attributable to the care that he is receiving from his grandmother. If a court granted an order then the local authority would share parental responsibility with Joe’s grandmother thus allowing the local authority to give consent for Joe to be assessed and treated as appropriate.

131. Children Act 1989 section 31(2)(b)(i) and (ii)

132. Re M(A Minor) (Care Order: Threshold Conditions) [1994] 2 FLR 577

## C. The Children Act 2004

### Section 10: Co-operation to improve wellbeing

This section requires local authorities and key partner agencies (including those Strategic Health Authorities and Primary Care Trusts that are responsible for any area falling within the local authority's boundaries) to co-operate in order to improve the wellbeing of children in that area.

### Section 11: Arrangements to safeguard and promote welfare

This section places a duty on a range of organisations, (including local authorities and NHS bodies) to make arrangements to safeguard and promote the welfare of children and young people. These organisations are required to make arrangements to ensure:

- Their functions are discharged having regard to the need to safeguard and promote the welfare of children; and
- That the services they contract out to others have regard to that need.

### Section 13: Local Safeguarding Children's Boards

This section requires every children's services authority in England to establish Local Safeguarding Children's Boards (LSCBs). The membership of LSCBs include local authorities, Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts. The objective of LSCBs is to co-ordinate and to ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children and young people.<sup>133</sup>

## D. Family Law Reform Act 1969

Section 8 of the Family Law Reform Act 1969 concerns the consent to treatment by young people aged 16 and 17. It states:

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133. For further information on LSCBs see: [www.everychildmatters.gov.uk/lscb/](http://www.everychildmatters.gov.uk/lscb/)

*The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment, which in the absence of consent, would constitute trespass to the person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.*

By virtue of this provision, 16 and 17 year olds are presumed to be capable of consenting to their medical treatment and any ancillary procedures involved in that treatment.

## E. Mental Capacity Act 2005

### Purpose, scope and principles

The Mental Capacity Act 2005 (the MCA 2005) provides the legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. It came fully into force in October 2007. The Code of Practice to the Mental Capacity Act 2005 (the MCA Code) provides detailed guidance on the implementation of the MCA 2005.

The main provisions of the MCA 2005 apply to individuals aged 16 or over and will therefore be relevant to decisions concerning the admission and/or treatment of 16 and 17 year olds who lack capacity to make decisions for themselves.

Section 1 of the MCA 2005 incorporates five principles, see below.

#### MENTAL CAPACITY ACT PRINCIPLES

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

## Mental Capacity Act 2005: summary

The main areas covered by the MCA 2005 are as follows:

- Capacity and test to ascertain if person lacks capacity
  - Individuals are presumed to have capacity to make their own decisions unless it is established otherwise.
  - The MCA 2005 includes a definition of, and test for, establishing whether a person lacks capacity (this is discussed in Chapter 2 of the Guide).
- Best interests
  - Anything done for, and any decision made on behalf of, a person without capacity should be done or made in the 'best interests' of that person.
  - Those making decisions on behalf of a person who lacks capacity must consider a checklist of factors. These include, 'so far as ascertainable', the person's past and present wishes and feelings.
- Informal decision-making
  - Individuals (professionals and informal carers) can take actions in connection with the care or treatment of a person lacking capacity to consent to a particular action without the need to obtain any formal authority.
  - The action must be taken in the best interests of the person who lacks capacity.
  - There are limitations on such actions, for example:
    - Restraint can only be used if the person taking the action reasonably believes that the restraint is necessary to prevent harm to the person who lacks capacity and the restraint used is proportionate to the likelihood and seriousness of harm (section 6 MCA 2005).

- Treatment cannot be given if the person has made a valid advance and applicable decision to refuse treatment in relation to the treatment proposed (section 26 MCA 2005).
- Formal decision making powers
  - The Lasting Power of Attorney (LPA) will enable individuals (aged 18 years or over) to appoint another person to make decisions on their behalf if in the future they lack the capacity to do so themselves. The LPA can cover welfare (including healthcare) and/or financial matters.
  - The Court of Protection has authority for a range of areas of decision-making for adults who lack capacity,<sup>134</sup> including the power to make declarations in relation to individuals' capacity to make certain decisions. The Court will also be able to appoint deputies to make decisions on welfare (including healthcare) decisions as well as financial matters.
- Advance decisions to refuse treatment
  - Where a person (aged 18 or over) makes a valid and applicable advance decision to refuse treatment, this must be upheld if at a later date the person no longer has the capacity to make such decisions.
  - Advance decisions will have the same effect as if the person had retained the capacity to make such decisions.
- Independent Mental Capacity Advocates (IMCAs)
  - IMCAs are available to support people who lack capacity when decisions are being made in relation to serious medical treatment or a long term change in accommodation.
  - However, IMCAs are generally only available when the person concerned has no friends or relatives who it would be appropriate to consult in determining what would be in the person's best interests.<sup>135</sup>

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134. Although there are some limitations; for example, section 27 excludes a range of decisions concerning family relationships such as consenting to marriage or a civil partnership. Section 28 provides that where the person is subject to the compulsory treatment provisions under part 4 of the MHA 1983, these provisions will apply to the exclusion of the MCA. Section 29 excludes decisions on voting.

135. In adult protection cases, access is not restricted to those who have no one else to support or represent them – see the MCA Code 10.66-10.68.

- Deprivation of liberty safeguards
  - The MHA 2007 amends the MCA 2005 by introducing a range of procedures to be followed in cases where individuals lacking capacity are to be deprived of their liberty. These are due to come into force in April 2009.
  - They apply only to individuals aged 18 or over.

### Assessment of capacity

An assessment of a person's capacity must be based on their ability to make a particular decision at a particular time. The assessment of a young person's capacity is discussed in Chapter 2.

An assessment that a person lacks capacity to make a decision must never be based simply on his or her age, appearance, assumptions about the young person's condition or any aspect of his or her behaviour (section 2(3) MCA 2005).

All assessments of a person's capacity should be fully recorded in their notes.

## Mental Capacity Act: young people and children

The main provisions of the MCA apply to all individuals aged 16 or over. However, there are some exceptions to this general application of the MCA which are relevant to the care and treatment of children and young people. These are:

- ***Young people aged 16 or 17 – limitations of MCA 2005's application***
  - Individuals under the age of 18 cannot make advance decisions to refuse treatment or a lasting power of attorney
  - The deprivation of liberty safeguards do not apply to individuals under the age of 18.
- ***Children – inclusion in limited specified circumstances***
  - The offence of ill-treatment or wilful neglect (section 44) applies to individuals of any age if they lack capacity within the meaning of the MCA 2005.
  - The powers of the Court of Protection are extended to make decisions relating to the property and affairs of a person under

16 in the circumstances when the Court thinks that it is likely that the person will continue to lack capacity after reaching the age of 18.

There is power to transfer proceedings from the Court of Protection to a court having jurisdiction under the Children Act 1989 and vice versa in relation to decision-making about personal affairs. In deciding whether to transfer a case from a court having jurisdiction under the Children Act 1989 to the Court of Protection the court must consider:

*...the extent to which any order made as respects a person who lacks capacity is likely to continue to have effect when that person reaches 18.*<sup>136</sup>

- The research provisions apply in relation to children, young people and adults (see sections 30-34 MCA 2005). Guidance on how the MCA 2005 will apply to research involving those under 18 is being developed.

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136. Regulation 3(3)(c) The Mental Capacity Act 2005 (Transfer of Proceedings) Order (SI 2007 No. 1899).



## Annex 2:

# Legal and policy framework for the provision of services to children and young people on discharge from hospital

This annex covers the following areas:

- The importance of after-care planning
- The Care Programme Approach (or its equivalent)
- Statutory responsibilities for services for children and young people with mental health problems

## The importance of after-care planning

After-care for all patients should always be planned prior to their discharge whether they have been informal patients or detained under the MHA 1983 and whether or not the duty to provide after-care services under Section 117 MHA 1983 applies to them.

- The discharge planning should be within the framework of the Care Programme Approach (CPA), or its equivalent (See the MHA Code 27.11).
- The planning of after-care needs to start as soon as the patient is admitted to hospital.
- Chapter 27 of the Code provides guidance on the duty to provide after-care to patients under section 117 MHA 1983.

## Care Programme Approach (or its equivalent)

As from October 2008 the Care Programme Approach (CPA) only applies to those individuals with a wide range of needs from a number of services, or who are at most risk.

- The Department of Health's *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance Department of Health*, published in March 2008 provides guidance on whether a patient requires the support of the CPA.
- In most cases, children and young people receiving care from specialist multi-disciplinary Child and Adolescent Mental Health Services (CAMHS) will benefit from receiving care through the CPA process or a system similar to the CPA.

- Standard 9 of the National Standard 9 of the *NSF for Children, Young People and Maternity Services* states:  
*When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the care programme approach.*
- As the CPA focuses on the complexity of the person's needs, there is no lower age limit.
- The CPA will need to be adapted to the particular needs of children and young people (see *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* pages 47 – 48)
- The use of the CPA needs to be co-ordinated with the other systems, for example, the (children's) Common Assessment Framework and any local systems for Looked After Children.
- All professionals and agencies need to work together to ensure minimum duplication of information and meetings and clarity of roles (especially who is leading) to avoid confusion and risk.
- The CPA needs to be seen in the context of other planning mechanisms for children with complex needs and agreement must be made locally on how to co-ordinate multi-agency care planning.

## **Statutory responsibilities for services for children and young people with mental health problems**

All children and young people who have been admitted to hospital for assessment and/or treatment of their mental disorder will be entitled to an assessment of their needs, followed by a decision on the services to be provided to meet such needs.

Below are the key statutory provisions which must be considered when planning the after-care of children and young people, irrespective of whether their care is being planned within the CPA process.

### **Duty to provide after-care services: Section 117 MHA 1983**

The MHA 1983 provides a specific duty for the provision of after-care services in relation to patients who were admitted to hospital under the MHA 1983 for treatment of mental disorder.

- Section 117 MHA 1983 requires the relevant health and local social services authorities to provide after-care services to patients who have been detained for treatment for their mental disorder (sections 3, 37, 47 or 48) until such time as they are satisfied there is no longer the need for such services.
- The duty has no age limitations. It will apply to children and young people who have been detained under the MHA 1983 to receive treatment for mental disorder.
- After-care is not defined in the MHA 1983 but includes social support, day care arrangements and accommodation.
- Section 117 services must be provided free of charge.<sup>137</sup>
- All patients who are entitled to after-care under s117 MHA 1983 should be identified and a record kept of what after-care is provided to them under this provision (the MHA Code 27.11).

## Duty of social services to safeguard and promote the interests of children ‘in need’: section 17 CA 1989

Part 3 of the CA 1989, ‘Local Authority Support for Children and Families’, gives powers and duties to local authorities to provide services, including accommodation, for children and their families. Of particular importance is section 17 which provides for the provision of services for children in need.

### Definition of a child ‘in need’

A child is in need if:

- she or he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority; or
- his/her health or development is likely to be significantly impaired or further impaired without the provision of such services; or
- if she or he is disabled (the definition includes a child or young person who is suffering ‘from mental disorder of any kind.’<sup>138</sup>)

These definitions are likely to cover all the children and young people who are covered by this Guide.

137. R v Manchester City Council ex parte Stennett [2002] 4 All ER 124.

138. Children Act section 17(11). Additional financial systems are in place for disabled children: s17A.

## Assessment under the Children Act 1989

*The Framework for the Assessment of Children in Need and their Families*: details the assessment process to be followed by local authorities.<sup>139</sup> Time limits contained in the *Framework for Assessment* include an initial assessment within seven working days and a core assessment within 35 working days. A core assessment is defined as:

*...an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her or care givers to respond appropriately to these needs within the wider family and community context. While this assessment is led by social services, it will invariably involve other agencies or independent professionals, who will either provide information they hold about the child or parents, contribute specialist knowledge or advice to social services or undertake specialist assessments.*<sup>140</sup>

Thus a key question for mental health professionals involved in decisions about the care and treatment of a child or young person is whether a core assessment has been undertaken.

## Services provided under section 17 Children Act 1989

Section 17 of the CA 1989 provides that local authorities shall:

- Safeguard and promote the welfare of children in their area who are in need and (so far as consistent with that duty) promote the upbringing of such children by their families by providing a range of services appropriate to those children's needs.
- Provide services designed to minimise the effect on disabled children of their disabilities and give such children the opportunity to lead lives which are as normal as possible.
- Make provision as they consider appropriate for the following services to be available with respect to children in need within their area while they are living with their families:
  - advice, guidance and counselling
  - occupational, social, cultural or recreational activities
  - home help (which may include laundry facilities)
  - facilities for, or assistance with, travelling to and from home for the purpose of taking advantage of any other service provided
  - assistance to enable the child/young person and their family have a holiday.

139. *Framework for the Assessment of Children in Need and their Families* (2000) DH.

140. *Framework for the Assessment of Children in Need and their Families* (2000) DH paragraph 3.11.

# Annex 3

## Glossary

**Approved Clinician (AC):** This is a clinician who has been approved by the Secretary of State (or the Welsh Ministers) to act as an approved clinician for the purposes of the MHA 1983. All Responsible Clinicians must be approved clinicians. An AC may be a medical registered practitioner, chartered psychologist, nurse (with relevant qualifications), occupational therapist or social worker. (See also Responsible Clinicians.)

**Approved Mental Health Professional (AMHP):** AMHPs are approved by local social service authorities and replace Approved Social Workers (ASWs). They can be social workers, nurses, occupational therapists and psychologists but not doctors. Detailed guidance on the responsibilities of the AMHP are given in the MHA Code, see Chapter 4.

**Care Programme Approach:** A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care co-ordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. (See also the Children's Assessment Framework.)

**Children and Adolescent Mental Health Services (CAMHS):** Specialist mental health services for children and adolescents cover all types of provision and intervention – from mental health promotion and primary prevention and specialist community-based services through to very specialist care, as provided by in-patient units for children and young people with mental illness. They are mainly composed of a multi-disciplinary workforce with specialist training in child and adolescent mental health.

**Commission:** The independent body which is responsible for monitoring the operation of the MHA 1983. At the time of publication, this is the Mental Health Act Commission (MHAC). However, its functions will be transferred to a new body, the Care Quality Commission, which is to establish a new integrated health and adult social care regulator, bringing together existing health and social care regulators into one regulatory body. It is expected that the new Commission will be established in April 2009.

**Common Assessment Framework (CAF):** A key part of delivering frontline services that are integrated and focused around the needs of children and young people. The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met.

**Community Treatment Order (CTO):** Written authorisation on a statutory form for the discharge of a patient from detention in hospital on to supervised community treatment.

**Court of Protection:** The specialist court set up under the MCA 2005 to deal with all issues relating to people who lack capacity to take decisions for themselves.

**Deputy:** A person appointed by the Court of Protection under the MCA 2005 to take specified decisions on behalf of someone who lacks capacity to take those decisions themselves.

**Hospital Managers:** The organisation (or individual) responsible for the operation of the MHA 1983 in a particular hospital. Hospital managers have various functions under the MHA 1983, which include the power to discharge a patient. In practice, most of the hospital manager's decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about discharge are normally delegated to a managers' panel of three or more people. In NHS bodies. None of the people on the manager's panel may be employees or officers of the organisation. In independent hospitals, managers' panels should not include people who are on the staff of the hospital or have a financial interest in it.

**Independent Mental Capacity Advocate (IMCA):** Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no one else to support them. The IMCA service is established under section 35 of the MCA 2005 and the functions are set out in section 36. The help provided by IMCAs is not the same as an ordinary advocacy service or the service provided by Independent Mental Health Advocates (IMHAs)(See also IMHA.)

**Independent Mental Health Advocate (IMHA):** An advocate available to offer help to patients under arrangements which are specifically required to be made under the MHA 1983. (These are expected to come into force in April 2009). IMHAs carry out different functions from IMCAs.

**Local Social Services Authority (LSSA):** The local authority (or council) responsible for social services in a particular area of the country.

**Medical recommendation:** this normally means a recommendation provided by a doctor in support of an application for detention or guardianship under the MHA 1983.

**Nearest relative:** A person defined by section 26 of the MHA 1983 who has certain rights and powers under the MHA 1983 in respect of a patient for whom they are defined as the nearest relative.

**Responsible Clinician (RC):** The approved clinician with overall responsibility for a patient's case under the MHA 1983. Certain decisions (such as renewing a patient's detention or placing a patient on supervised community treatment) can only be taken by the RC.

**Section 12 Approved Doctor:** A doctor who has been approved by the Secretary of State (or the Welsh Ministers) under the MHA 1983 as having special experience in the diagnosis or treatment of mental disorder.

**Second Opinion Appointed Doctor (SOAD):** An independent doctor appointed by the Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given.

# Annex 4

## Resources Section and Further Reading

### Children and adolescent mental health services review

Information about the external review of CAMHS including the final and interim report can be found at: [www.dcsf.gov.uk/CAMHSreview/](http://www.dcsf.gov.uk/CAMHSreview/)

### Children and young people

Department for Education and Skills, *Care Matters: Time for Change*, June 2007: [www.dcsf.gov.uk/publications/timeforchange/docs/timeforchange.pdf](http://www.dcsf.gov.uk/publications/timeforchange/docs/timeforchange.pdf)  
*Every Child Matters: Change for Children*: a range of publications are available at: [www.everychildmatters.gov.uk/](http://www.everychildmatters.gov.uk/)

*Working Together to Safeguard Children*: A guide to interagency working to safeguard and promote the welfare of children, April 2006

[www.everychildmatters.gov.uk/workingtogether/](http://www.everychildmatters.gov.uk/workingtogether/)

Department for Children, Schools and Families, *The Children Act 1989 Guidance and Regulations*. Volume 1 Court Orders, London:TSO 2008  
[www.dcsf.gov.uk/localauthorities/\\_documents/content/childrensactguidance.pdf](http://www.dcsf.gov.uk/localauthorities/_documents/content/childrensactguidance.pdf)

### Confidentiality

Department of Health, *Confidentiality: NHS Code of Practice*, November 2003  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)

### Human rights

Equality and human rights (Department of Health):  
<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/index.htm>

General information on human rights (Ministry of Justice):  
<http://www.justice.gov.uk/whatwedo/humanrights.htm>

UNICEF, *Implementation Handbook for the Convention on the Rights of the Child*, 3rd rev. ed edition (27 Feb 2008)

### Mental Capacity Act 2005 (as amended)

General information (Department of Health):  
<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/index.htm>



## **Mental Capacity Act 2005 Code of Practice and Deprivation of liberty safeguards - Code of Practice:**

[www.publicguardian.gov.uk/mca/code-of-practice.htm](http://www.publicguardian.gov.uk/mca/code-of-practice.htm)

Office of the Public Guardian (for advice on the Court of Protection and various aspects of the MCA): [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)

## **Mental Health Act 1983 (as amended)**

The Code of Practice, Mental Health Act 1983 (2008) TSO

[http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_4132161](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_4132161)

*Reference Guide to the Mental Health Act 1983* (2008) TSO

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_088162](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088162)

Further information on the amended Mental Health Act 1983 can be found at: <http://mhact.csip.org.uk/> and

[http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_089882](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_089882)

## **Mental Health Policy**

Department of Health, *National Service Framework for Mental Health: Modern Standards and Service Models*, 1999:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009598](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598)

Department of Health and Department of Education and Skills, *National Service Framework for Children, Young People and Maternity Services, Child and Adolescent Mental Health (CAMHS)*, 2004:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4089114](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114)

Department of Health and Department of Education and Skills, *Report on the Implementation of Standard 9 of the NSF for Children, Young People and Maternity Services*, November 2006:

<http://www.everychildmatters.gov.uk/EP00244/>

*Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* Department of Health, March 2008:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083647](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647)

**Race Equality**

*Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*, Department of Health, January 2005: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4100773](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773)

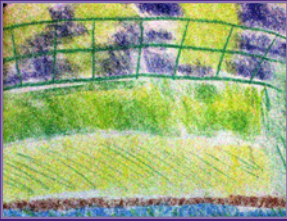
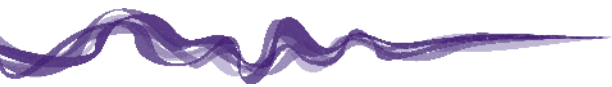
Improving Mental services for Black and Ethnic Minority Communities  
[www.actiondre.org.uk](http://www.actiondre.org.uk)

**Workforce**

*Mental health: New ways of working for everyone*: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074490](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490)

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