# Reforming the Mental Health Act: Consultation Response
# April 2021

## Summary

This is a joint response, informed by Article 39, Centre for Mental Health, *Just Equality*, Mind, the National Children's Bureau/Council for Disabled Children, and YoungMinds, a working group established by the Children and Young People's Mental Health Coalition. This response relates to England only.

We welcome the Government's commitment to the modernisation of the Mental Health Act. The White Paper and the proposed reforms should result in some welcome improvements in the care and treatment of children and young people aged under 18 detained under the Act.

However, whilst the proposed reforms to the mental health legislative framework will be applicable to all children and young people, we are concerned that the White Paper does not go far enough in setting out how the reforms will work in practice for this group. There is very little information in the White Paper relating to children and young people, and many of the proposed reforms will be dependent on future spending decisions.

We believe that more consideration needs to be given to how these proposals will work for children and young people and stronger commitments are needed to ensure the rights of all children in mental health inpatient care are protected. Further consideration also needs to be given to how the proposals align with legislation such as the Children Act 1989 and 2004.

Although official statistics do now include data on the number of children and young people aged under 18 detained[1], there is very little data on how many children and young people are admitted informally. The data that does exist suggests that at least a third of children are admitted informally.[2] As a result, it is difficult to draw an accurate picture of the state of inpatient care for children and young people. Safeguards therefore need to be in place to protect under 18s, both those that are detained and those who are admitted informally.

Throughout this submission, we will highlight areas of the White Paper that will need more consideration on how they will work for children and young people in practice. We will also set out where we see the proposals will have unintended consequences for this group.

## Key messages:

While we welcome the White Paper's emphasis on strengthening the rights of children and young people aged under 18 to have a greater say in their care, we are concerned that more attention needs to be given to how this can be achieved in practice.

- **Decision-Making:** There is an anomaly in the Act in how the safeguards apply to under 16s when it is presumed that they are not competent to make decisions for themselves and there is no statutory test for assessing their competence. The Mental Health Act review recommended that a formal test for assessing Gillick competence should be included in the Mental Health Act and we believe that this recommendation should be accepted.

- **Nominated Person:** The introduction of the Nominated Person is a welcome change, but there are particular risks for children and young people. It needs to be clarified the circumstances when a parent/carer is not chosen as a Nominated Person and the information that will be shared with them. There are also particular concerns where a Nominated Person poses a safeguarding risk to the child or young person, and the role of the local authority as the Nominated Person for children and young people in care.

- **Advocacy:** The White Paper agrees in principle to expanding advocacy for informal patients, but states that this will be subject to future funding decisions. Advocates provide a crucial source of support to informal patients, and we believe that the Government should commit unequivocally to expanding the rights to an advocate and ensure that all advocacy operates on an opt-out basis, in the forthcoming Mental Health Bill. At the very least, advocacy must be extended to all children admitted on an informal basis.

- **Out of area placements and admission to adult wards:** We are concerned that children and young people are still being placed in settings out of area and on adult wards. The current Code of Practice states that under 16s should not be admitted to adult wards. This duty should be strengthened and set out in forthcoming legislation. We also believe that the duty to notify the local authority when a child or young person is placed in an adult ward, or out of area, or if an admission lasts more than 28 days, should be set out in primary legislation.

- **The role of local authorities:** Our organisations have heard evidence that some children and young people who are clearly eligible for an Education, Health and Care Plan (EHCP) are being admitted to inpatient care without one. We would urge the Department of Health and Social Care to work closely with the Department for Education to make it clearer how the SEND framework should work for children and young people with mental health problems and ensure that admission to inpatient care should act as a trigger for assessment for an EHCP. If not an EHCP, we would like to understand what the statutory mechanism will be to ensure these children and young people are adequately supported, both while they are in inpatient care and during discharge arrangements.

- **Children and young people with learning disabilities and autism:** While welcoming the White Paper’s focus on the specific issues for people with learning disabilities and autism, we are concerned that the proposed reforms will not be sufficient in reducing their admission to inpatient care. it is vital that sufficient community support is in place for children and young people and their families. It is critical that families do not experience any legislative reforms as a reduction in the support available in cases where their child or young person is in crisis.

- **Detention criteria:** It needs to be ensured that by raising the threshold for detention, for example by requiring substantial likelihood of significant harm, this does not have unintended consequences for children and young people. Whilst raising the threshold for detention is positive, it must be done with safeguards for access to non-coercive care for children and young people.

- **Data collection**: There are significant gaps in available data on children in mental health hospitals, and the data that does exist can often be incomplete and difficult to access. As a result of this, it can be challenging to monitor whether children's rights are being upheld within inpatient settings. While the immediate focus should be on securing the basic information about children's admissions and detentions, in the longer term there should also be ambition for a much more detailed and useful amount of data to be recorded and reported, which can help to drive improvement.

The voices of children and young people will be crucial in the modernisation of the Mental Health Act. While we welcome the Government commissioning Rethink and YoungMinds to carry out direct consultation with young people, it was regretful that no child-friendly version of the consultation was made available online to help children, young people and those supporting them to respond directly. We would welcome further consultation from the Department of Health and Social Care with organisations who support children and young people with severe mental health problems to consider how this can be achieved.

To make sure the new legislation works in practice, it will be essential that the new Code of Practice is comprehensive and covers the right areas. We therefore urge the Government to make sure that a draft Code of Practice is published alongside any draft Bill, so that the proposed reforms can be looked at properly in the round.

## 1. Decision-making

1.1 There is a dichotomy in the Act in how the new safeguards proposed apply depending on whether the patient has capacity or not. For example:

- If the patient has capacity to make a decision, they are able to choose their own Nominated Person, but if they lack capacity then an Approved Mental Health Professional (AMHP) will appoint an interim Nominated Person.
- If a patient has capacity to make treatment decisions, and they disagree with the Responsible Clinician's treatment decision on a category 3 treatment, they can see a Second Opinion Appointed Doctor (SOAD) within 14 days. If they lack capacity to make the decision, they will see a SOAD after two months.
- If a patient has capacity to make an Advanced Choice Document, they can set out various treatment decisions which will carry legal weight if they lose capacity and are detained. However, patients who lack capacity cannot make an Advanced Choice Document.

1.2 Under the Mental Capacity Act 2005, people aged 16 and over are assumed to have capacity unless a capacity assessment shows otherwise. However, there is no assumption that children aged under 16 has the ability to make decisions for themselves. They can only do so if they demonstrate that they are Gillick competent. The dichotomy in how the safeguards apply to under 16s therefore becomes even more pronounced given that the starting point for children aged under 16 is that they are not competent to make decisions for themselves and that there is no statutory test for assessing their competence.

1.3 In relation to Advanced Choice Documents, the White Paper states that although a capacity authentication process would be helpful, it will not be mandatory when making an Advanced Choice Document. There needs to be further consideration as to how this will work for those aged under 16 due to the assumption that they would not have competence to create this document. Advanced Choice Documents need to be an effective safeguard for competent children who choose to create one. This will not be the case if, due to uncertainties about a child's competence, their Advanced Choice Document is not relied upon because it is questioned whether the child had competence at the time it was made.

1.4 The Mental Health Act review recommended that a formal test for assessing Gillick competence should be included in the Mental Health Act[i]. We see that having such a test would help to ensure that professionals understand how to assess under 16s competence. Such an amendment would need to be supported by guidance for practitioners on how to undertake such assessments.

1.5 What is more, there is a need for greater clarity on the circumstances in which parents can consent to under 16s' admission and treatment. For example, even though children who are admitted to hospital on the basis of parental consent will not have consented to the admission themselves, the safeguards available to detained patients will not apply to them. If a child is Gillick competent and refuses admission and treatment, the current Mental Health Act Code of Practice advises against relying on parental consent for admission. We believe that this needs to be set out in the Mental Health Act so it is clear that a competent child's refusal cannot be overridden by parental consent.

1.6 Under the Mental Health Act Section 131, 16 and 17 year olds with capacity can consent or refuse their admission, and their decisions cannot be overridden by parental consent. We therefore suggest that this provision is extended to under 16s who are competent to make decisions about their admission. It is worth noting that the recent case of *AB v CD and Others,*[3] Mrs Justice Lieven considered that 'the parents' right to consent to treatment on behalf of the child continues even when the child is Gillick competent to make the decision, save where the parents are seeking to override the decision of the child.

1.7 Currently, there is insufficient guidance on when it would be appropriate to rely on parental consent for the admission and treatment of a child who lacks competence. Where cases about admission of under 16s have reached the courts, further areas of uncertainty have emerged (or at least, not been resolved) over the circumstances in which a parent can consent to restrictions, such as inpatient admissions, on their child's behalf.

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[i] The review suggested that this test should be based on the 'functional test' under the MCA, although there should not be a presumption of capacity for under 16s.

1.8 The current position therefore creates significant legal and practical uncertainty for children, their parents and professionals working with them. We see that there needs to be much greater clarity on the types of circumstances where it might be appropriate for parents to provide consent to admission. We note that the Government intends to provide further guidance in the Mental Health Act Code of Practice. While further guidance is welcome, we consider that the clarity that is needed can only be achieved by legislative reform.

1.9 It needs to be noted that the law around decision-making for children and young people can be complex and ambiguous. Providing further clarity on decision-making in relation to the Act would be beneficial for children and young people, their parents, and professionals. In a situation where a parent or someone with parental responsibility posed a risk to the child/or was making decisions that were not in the best interests of the child, legislation and guidance must make clear that the needs of the child must be paramount.

1.10 Whilst the White Paper introduces some welcome safeguards for under 18s who are admitted informally, for example, the requirement for Care and Treatment plans to apply to all under 18s whether or not they are detained under the Mental Health Act, the Government has not accepted the Review's recommendations concerning under 18s admissions onto adult wards and out of area placements. We believe that the adoption of these recommendations is reconsidered to ensure important safeguards for under 18s are in place.

**Recommendation:** Section 131 of the Mental Health Act 1983 should be extended to under 16s who are competent to make decisions about their admission.

**Recommendation:** The Department of Health and Social Care should accept the Mental Health Act review recommendation that formal test for assessing Gillick competence should be included in the Mental Health Act. Guidance should also be produced to accompany this.

**Recommendation:** The Department of Health and Social Care should accept the Mental Health Act Review's recommendations concerning under 18s admission onto adult wards and out of area placements.

## 2. Nominated Person

2.1 We welcome the proposal that enables patients to choose a Nominated Person, and in particular children and young people should be able to choose who represents their interests and can act on their behalf when they are unable to. However, there are some particular risks for children and young people that must be considered.

2.2 Firstly, whilst parents, guardians and family members will be the right choice for many – it may not be for children and young people estranged from their families or who feel in danger within their families. There may also be issues where families have different perspectives to the young person's needs, or where a young person may be living independently from their family. Parents often do not receive appropriate support to manage their children's needs and access support services. The White Paper also does not take into account the important role that friends can play in supporting a young person, and this needs to be considered in the context of the Nominated Person.

2.3 The White Paper does seek to strike a balance to ensure that parents and carers continue to have rights to information and consultation on decisions about care if they are not the Nominated Person, which is welcome. For children under 16, the White Paper rightly points out that parents should still have certain rights to information about their child's care and to be consulted. However, it will be important to assess what this means in practice, and how these rights interact with those of children and young people and the Nominated Person, if the parent or carer is not the chosen person. Careful guidance must be given to children and young people on what information will be shared with parents if they are not the Nominated Person, especially if the child is Gillick competent. Parental responsibility does also extend to those aged 16 and 17, and this needs to be considered in the proposed changes.

2.4 Secondly, if a child is in care (on a care order, not under section 20) their nearest relative is currently automatically the Local Authority unless the young person is married or in a civil partnership (see section 27 of the Mental Health Act 1983), while those appointed as guardians (including special guardians) or named as the person with whom the child or young person is living under a child arrangement order will be the nearest relative (see section 28 of the Mental Health Act 1983). Whilst the White Paper mentions the role of parents, carers and guardians, there is little consideration of how the role of the Nominated Person will interact with the role of a Local Authority as a corporate parent or with guardians or those living with the child or young person under a child arrangement order. It would be important to have clarity on how these are going to be addressed in the reforms.

2.5 Thirdly, The Nominated Person introduces a layer of new safeguarding risks as children could potentially choose someone they are in an abusive/inappropriate relationship with, for example. We would welcome further clarity on the process if a child or young person chooses a Nominated Person who presents a safeguarding risk to them.

2.6 Currently some protective measures are taken for children and young people in care, with the nearest relative being the Local Authority. We would want to ensure that similar measures were in place to avoid children and young people in care choosing a birth parent who no longer has parental responsibility from being their Nominated Person.

2.7 While these children and young people should still be afforded choice in who their Nominated Person is, Local Authorities and Approved Mental Health Professionals (AMHPs) should work together so that if a child chooses a Nominated Person who poses some risk to them, there are mechanisms in place for that person to be discharged from the role (similar to current arrangements for appointing nearest relatives if the current nearest relative is not suitable). The paper currently does not mention how this can be done. There will need to be very careful guidance on how this will be explained to children and young people, so as not to give them a false illusion of free choice.

2.8 Finally it needs to be clarified what happens if an under 18 year old does not nominate anyone. If the child does not nominate, and so it falls to the AMHP, it is important that there are similar protections for children and young people in care as now, i.e., the local authority rather than parent should by default be nominated. The White Paper states that there should be guidance for the AMHP to use to decide who to appoint as the interim Nominated Person, but this should be stated in legislation and not just guidance.

**Recommendation:** The Department of Health and Social Care should further consider how the rights of a parent or carer to receive information if they are not the Nominated Person interacts with the rights of the child or young person.

**Recommendation:** The Department of Health and Social Care should further clarify the role of a Local Authority in relation to the Nominated Person and should also set out processes where a Nominated Person poses a safeguarding risk. This should be made clear within the Mental Health Act. It will also be necessary to consider how the proposals concerning the Nominated Person are intended to impact on Section 28 of the Mental Health Act 1983.

## 3. Advocacy

### 3.1 Expanding the role of advocates

3.11Article 12 of the UN Convention on the Rights of the Child grants all children the right to be heard and taken seriously in all matters affecting them. Access to advocacy is a key part of ensuring that all children are heard, and their rights are respected.

3.12 Independent Mental Health Advocates (IMHA) have a fundamental role in supporting children and young people in mental health hospitals. Article 39's recent report 'A Safe Space?' highlights the roles advocates play in supporting children to, among other things, communicate their wishes and feelings to medical professionals, shape their care and treatment plans, challenge their detention and plan for leaving hospital.[4]

3.13 The White Paper sets out positive proposals to expand the role of Independent Mental Health Advocates to offer a greater level of support and representation to patients detained under the Act. However, it needs to be ensured that these additional powers do not take power away from children and young people to make decisions, and that advocates continue to work alongside them.

3.14 Many advocates emphasise the importance of not taking power away from children and young people, instead highlighting the need to empower them where possible to make informed choices. It is crucial therefore that new guidance must accompany any changes to legislation to support advocates to use these new powers appropriately. Training for advocates must also explore how advocates work with the patient to take forward their views.

**Recommendation:** The Department of Health and Social Care should produce guidance setting out the new powers of Independent Mental Health Advocates and how they should be used. This guidance must include specific considerations for children and young people.

## 3.2 Advocacy for informal patients

3.21 While the Mental Health Act 1983 lays out clear rights, processes, and safeguards for those who are detained, including the right to an IMHA[5], this right does not apply to informal patient, in hospital on the basis of their, or their parents/carers', consent. The lack of access to advocacy for informal patients has been a longstanding concern.

3.22 According to data received by the Office of the Children's Commissioner for England, 4,127 children were admitted to inpatient mental health care in 2019/20; 1,690 (41%) of these were recorded as being informally admitted, with a further 666 (16%) without a recorded status.[6] The law concerning admission and treatment for children who are informal patients is extremely complex, but there is no legal requirement for them to receive information or support to understand it.

3.23 Although legally allowed to leave hospital, advocates have raised concerns that children who are informal patients are often under exactly the same conditions as those detained under the Mental Health Act. Furthermore, many young informal patients do not understand their rights and feel an underlying threat that if they in some way 'break the rules', they will be sectioned.[7]

3.24 Research conducted by the Office of the Children's Commissioner spoke to children and young people about their experiences of inpatient care as an informal patient.[8] Children who took part in the research felt they did not have a genuine choice, or that it was only based on what their parents wanted:

> *"Last time I said I'd go informally but again; it was under that thing of…I could agree to come informally on the Tuesday, or I could be sectioned and come in on the Wednesday. It's not a choice is it?'* – Teenage girl

> *"Yeah, my parents are involved, they said they wanted me to go anyway…they are [consenting]…it's always what they want as parents. So, nothing is actually your decision"* – Teenage girl

3.25 This not only raises serious questions about whether these children are there on the basis of consent but also about whether children they are also at risk of being unlawfully deprived of liberty as they do not really have the ability to leave.[9] Advocacy for informal patients is therefore crucial in helping children and young people who are informal patients to navigate these complex issues.

3.26 The gap in protection for informal patients has been addressed in a number of settings through the development of drop-ins and ad hoc or contractual advocacy provision for that group, but this often relies on the 'good will' of advocacy services, many of whom are not funded to help informal patients but do so anyway. Without a statutory right to advocacy for informal patients, there remains a significant risk of children in need of support not receiving essential advice, support, and representation.

3.27 Even for those with an existing legal entitlement, access to an advocate can rely too heavily on the setting in which a child is placed, and the knowledge and understanding of medical staff. There is also little available data on how many children are actually accessing an advocate. Research conducted by Article 39 has shown that of NHS Foundation Trusts contacted, only a third were able to provide data on the number of children who had received support from an advocate over the past three years.[ii]

3.28 A 2017 survey conducted by YoungMinds[10] with parents whose children had been admitted to inpatient care also found that 44% of parents said they had felt unable to challenge decisions about their child's treatment, while 52% said they did not know what rights their child or they have whilst in hospital.

3.29 The responsibility for commissioning IMHA services lies with local authorities[11] but research from the Office of the Children's Commissioner for England found that 68% of local authorities did not know the number of referrals/representations that had been made for mental health advocacy.[12] A more recent report from the Children's Commissioner also found that 13% of wards had not had any advocates visiting children there prior to March 2020.[13]

3.30 While the White Paper recognises that IMHAs are 'well placed to support informal patients to understand their rights' and its impact assessment makes a detailed case for expanding the right to an advocate to informal patients it states that, as it would create an 'additional burden' for local authorities and advocacy providers, 'expanding the statutory duty to all inpatients will therefore be subject to future funding decisions.'

3.31 We do not believe this is a strong enough response to a significant gap in rights protections. The Government should commit without qualification to expanding the rights to an advocate and ensure that all advocacy operates on an opt-out basis, in the forthcoming Mental Health Bill. At the very least, advocacy must be extended to all children admitted on an informal basis – particularly as they are the only group who can be admitted informally without their own consent.

3.32 What is more, while it is welcome that the White Paper says that children and young people who are informal patients will have a Statutory Care and Treatment Plan, there needs to be further clarity on how these will work for informal patients aged under 18. The White Paper states that the legislative basis for these plans for informal patients aged under 18 will be in Tier 4 contract requirements and not the amended Mental Health Act. We believe this could be potentially confusing and would like to better understand the rationale for using an alternative route to give plans for informal patients a statutory underpinning. Any safeguards

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[ii] 6 out of 18. We contacted those NHS Mental Health Trusts who had provided data to NHS England on children detained under the Mental Health Act. Two of those Trusts provided data that appears unreliable in that more children are recorded as receiving help from an advocate each year than were actually inpatients that year.

that are put in place to support informal patients, such as Care and Treatment Plans, should be on the face of the Mental Health Act.

**Recommendation**: The Government should commit to expanding the right to support from an advocate in the reforms to the Mental Health Act. This should:

- Ensure that all advocacy operates on an opt-out basis.
- Ensure that all those admitted informally have the legal right to an independent mental health advocate.

**Recommendation**: Local authorities are already required by law to report annually on their representation and complaints procedure under the Children Act 1989. A comparable duty should be introduced to report on the availability and quality of independent advocacy services to children and young people, covering all those eligible groups for whom the local authority has responsibility to arrange advocacy.

### 3.3 Improving advocacy services

3.31 We strongly agree advocacy services could be improved by enhanced standards for children's advocacy. This work is ongoing but there is a role for the Department of Health and Social Care to work with the Department of Education to ensure the needs of child mental health inpatients are adequately considered. It is vital that the relevant government departments oversee the development of one comprehensive set of advocacy standards applicable across all settings and covering all eligible groups of children and young people up to at least age 25.

3.32 In light of concerns about the variation in quality of advocacy services, there is a clear value to ensuring that advocates have a certain level of knowledge that is verified by an external body. This could help achieve consistency in the quality of services across the country and may also result in young people feeling more trusting of their advocate. A form of qualification could also help elevate the status of advocates within local authorities.

3.33 However, there are concerns about the role of an advocate becoming 'another professional' and advocates have emphasised the importance of life experience and empathy, rather than qualifications. Competence and knowledge would be better demonstrated through practice rather than theory. Concerns have been raised about increased 'professionalisation' creating barriers to those accessing the profession and reducing diversity.

3.34 Any new regulation framework must be developed in conjunction with those who have experience of using advocacy services, especially those facing the greatest inequalities, young people with SEND, racialised young people, those in trouble with the law and those in touch with immigration as those groups of young people have unique needs and challenges. This should be done alongside advocates and advocacy providers. It must also be proportionate in terms of the scheme's requirements and benefits – it is important to note that smaller providers would struggle with extra demands and with much of the current training and qualifications advocates have to do the work in their own time.

3.35 One option for further regulation could involve a national body for England with a regional organisation that would oversee regulation, standards, support and training for advocates and oversight of the service. This would allow for locally based advocacy but national monitoring and regulation.

3.36 It is also important to note the impact of the current funding and commissioning arrangements for children's advocacy services. Often organisations are encouraged to bid for services with unrealistic operating costs through a competitive contracting process. They then do not have sufficient funding to allocate to training, and many advocates are already poorly paid. While larger third sector organisations provide their own in-house training, there is no independent assessment of this. Short-term contracts build-in uncertainty and instability and do little to improve the quality of the services.

**Recommendation:** The Department of Health and Social Care must work closely with the Department for Education to ensure that the needs of children and young people in mental health inpatient care are adequately reflected in revised standards for advocacy.

**Recommendations** Steps should be taken immediately to ensure that advocacy provision is a key part of Care Quality Commission (CQC) inspections, which is not currently the case. This should also form part of the Ofsted Inspection Framework for children and young people with SEND and those who are looked-after.

## 4. Safeguarding

### 4.1 Out of area placements and admissions to adult wards

4.11 Research shows that children and young people placed in long term residential settings are vulnerable to abuse, achieving poor outcomes, and to dwindling contact with their families. For example, the recent CQC review on the use of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition found that people were not getting the care they need.[14] As such, measures need to be in place to safeguard and promote the welfare of children and young people.

4.12 NHS data shows that for the past three years over 1,000 (97%) children a year have been placed 'out of area', most of whom were detained under the Mental Health Act. In 2017/18, 518 of the 1,255 'out of area' admissions were considered to be 'inappropriate', based on an assessment of the child's clinical need, their individual preference, and any special circumstances.[iii]

4.13 It is also of concern that under 18s continue to be admitted onto adult wards and, contrary to government policy, such admissions include under 16s. The most recent information from NHS England (for quarter 2 of 2020/21) shows that 72 under 18s were

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[iii] Figures provided by NHS England in response to Freedom of Information request, 3 September 2020, Ref: FOI-2003-1157432. 'Out of area' relates to the Children's Commissioning Group hub area in which the child lives. The definition of 'inappropriate' did not just look at distance because 'more specialised in-patient services would normally serve a larger geographical area'. See National Audit Office (2018) Improving children and young people's mental health services, para 2.10

admitted to hospital during that period. This is an area in which it is difficult to find reliable and relevant data. For example, NHS England data showed that 592 children were placed on adult wards in 2019/20, three times the number in the previous year.[iv] Another concern is that the information provided does not include the reasons for admission to adult wards, so it is not possible to ascertain the reasons why such admissions were considered to be appropriate, nor how many were because all suitable NHS Children and Young People's Mental Health Services (CYPMHS) units were full.

4.14 The current Code of Practice states that it is government policy that under 16s should not be admitted to an adult ward, and if this does occur then the commissioner of the NHS CYPMHS inpatient services should be notified, and it should be reported it as a serious incident and investigated in accordance with the NHS Serious Incident Framework. This requirement needs to be strengthened and should be included in forthcoming legislation.

4.15 The White Paper agrees that the local authority should be notified when a child or young person is placed in an adult ward, or out of the area, or if an admission lasts more than 28 days. Although the White Paper states that this will be made clear in the Code of Practice, it does not elaborate on what the duty on the local authority would then be. Our experience is that notifications under sections 85 and 86 of the Children Act 1989 do not act as an effective safeguard and we would recommend stronger legislation and guidance in these areas. We therefore consider that the 28 day notification period should be included in the Mental Health Act with clarity on the action that local authorities must take when notified. It would also be necessary to consider how the proposed 28 day notification period is to align with the current notification requirements under sections 85 and 86 of the Children Act 1983.

4.16 It is very disappointing that the Government has rejected the recommendation made by the Independent Review of the Mental Health Act that providers be required to notify the CQC where a child/young person is placed in an adult unit, within 24 hours and that the CQC should record both the reasons for placement and its proposed length.

4.17 The White Paper also refers to the NHSEI's regional specialised commissioning teams who are delivering the Accelerated Bed Programme, which aims to eliminate inappropriate out of area placements, improving local bed availability aligned with community services, and eliminate inappropriate under-18 placements in adult wards. However, a succession of CYPMHS wards have closed down in recent years after being judged inadequate by the CQC or due to staff problems or worsening existing problems with availability of mental health inpatient care across the country.[15]

4.18 The Review further proposed that Government considers introducing a new right to provide financial and/or practical support to enable parents, carers, and other family members to visit a child or young person who is placed out of area. We believe this could make a real difference, enabling families to provide essential emotional support and be more involved in decisions about care and treatment.

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[iv] The number of children and young people aged 0-17 admitted in adult in-patient wards in the reporting period. This is a count of people, aged 0-17, who were on an adult ward at any point during the quarter. To avoid

**Recommendation:** There should be a statutory provision against children aged under 16 being placed on adult wards and the recommendations of the 2018 Independent Review of the Mental Health Act regarding improved CQC oversight should be introduced.

**Recommendation:** The duty to notify the local authority when a child or young person is placed in an adult ward or out of area or if an admission lasts more than 28 days should be set out in primary legislation. Statutory guidance should make clear that such a notification is trigger for an assessment of whether the child is in need under section 17 of the Children Act.

### 4.2 Involvement of local authorities

4.21 In order to ensure effective multi-agency working, we believe that for any child under 18, their Care and Treatment Plan should include a clear proforma which captures multi-agency working responsibilities during admission and at the point of discharge and must be completed by each relevant agency. There should be one organisation with responsibility to ensure this happens. This would help ensure the engagement of local authorities with the young person's care from an earlier stage and ensure not only that any need for additional local authority support is recognised, but also that the appropriate discharge planning takes place.

4.22 In addition, our organisations have heard evidence that some children and young people who are clearly eligible for an Education, Health and Care Plan (EHCP) are being admitted to inpatient care without one. We would urge the Department of Health and Social Care to work closely with the Department for Education to make it such clearer how the SEND framework should work for children and young people with mental health problems and ensure that admission to inpatient care should act as a trigger for assessment for an EHCP. If not an EHCP, we would like to understand what the statutory mechanism will be to ensure these children and young people are adequately supported both while they are in inpatient care and during discharge arrangements back to their homes and communities. The duty on Mental Health units to notify local authorities of admission should be part of the process of the CETR and followed up through the Dynamic Support/Risk Register process.

4.23 Under sections 85, 86 and 86A of the Children Act 1989, local authorities are required to arrange for visits and the provision of support to under-18s who are accommodated in NHS or independent hospitals for more than three months. The local authority must make arrangements to visit the child, take such steps as are reasonably practicable to enable them to determine their welfare is "adequately safeguarded and promoted" and consider what action might need to be taken.

4.24 However, research conducted by Article 39 found that children in mental health hospitals were not always prioritised because they were seen as being 'safe'.[16] Children were often not given social workers, and this could negatively impact discharge planning. Even for children who were already looked after by a local authority under section 20 or were in care under section 31 of the Children Act 1989 prior to admission, the process seems to be disjointed. Most local authorities kept no centralised records of either referrals under sections 85 and 86 of the Children Act 1989, nor of those children in their care who are admitted to mental health inpatient care. This makes it incredibly difficult to track whether the safeguard intended under the Children Act 1989 is working in practice.

4.25 In addition, mental health practitioners also report that involving children's social care in discharge planning can be challenging, with some local authorities seeming not to be aware of their section 117 duties. This can leave children and young people in a precarious position, feeling scared and uncertain about what will happen when they leave hospital, and for some under 18s the lack of appropriate accommodation meaning that their discharge from hospital is delayed. Additional guidance on funding arrangements for section 117 will hopefully address some of this. However, the requirement suggested above for Care and Treatment plans to include input from children's social care would also be an important means of addressing this problem given that discharge planning will be included in Statutory Care and Treatment plans. This could also have the benefit of ensuring that children's service is more aware of the care children and young people are receiving, and aware of those under 18s who have been detained.

**Recommendation:** Care and Treatment Plans for children and young people aged under 18 should include a clear proforma which captures multi-agency working and must be completed by each agency.

**Recommendation:** The Department for Education should make clear in guidance that children and young people with SEND who are admitted to inpatient care should trigger an assessment for an Education, Health and Care Plan to be put in place.

## 5. Children and young people with learning disabilities and autism

5.1 While welcoming the White Paper's focus on the specific issues for people with learning disabilities and autistic people, we are concerned that the proposed reforms will not be sufficient in reducing their admission to inpatient care. In addition, to achieve positive change, it is vital that sufficient community support is in place for children and young people and their families. It is critical that families do not experience any legislative reforms as a reduction in the support available in cases where their child or young person is in crisis.

5.2 The introduction of a duty to provide adequate community services is a positive change, and with more community support in place, this should prevent this group falling into crisis. We would suggest that setting a presumption that such services will be jointly funded would avoid such a duty foundering on the basis of arguments about who is responsible for funding.

5.3 We also welcome the proposals to place a duty on commissioners to create a local 'at risk' or 'support' register for people with a learning disability or autism. SENDIAS Services are critical agencies to feed into the registers in terms of capturing children and young people with autism who may not have Education, Health and Care Plans. However, for them to do so they would need additional capacity.

5.4 There is little evidence that inpatient settings are the appropriate response to mental health crises experienced by those with learning disability and autism. More often they are a holding setting whilst appropriate community support and placement can be arranged. One of the reasons they can become stuck is that they too often experience being in inpatient settings as traumatic which adds to the challenges they exhibit and therefore makes community placement more rather than less challenging. We therefore welcome the White Paper stating that no autistic person will have to stay in an institution because there is nowhere else to go.

5.5 However, we have some concerns about those areas who fail to provide alternative support and what will happen to individuals with learning disability and autism in those situations, and about the likelihood of where other less therapeutically based forms of incarceration might be employed.

5.6 We are also concerned that an unintended consequence of this could be an exacerbation of incidents of diagnostic overshadowing where an individual's mental health crisis is dismissed as an inherent part of their underlying diagnosis and there is a failure to recognise that levels of anxiety or challenging behaviours are evidence of a mental health issue additional to that diagnosis. It is vital that mental health resources are equally accessible to those with learning disability and autism where that is the appropriate service response. Effective and in-depth training will be key in making sure that there are no unintended consequences for children and young people with learning disabilities and autism.

**Recommendation:** The Department of Health and Social Care should set out what safeguards are in place to prevent individuals with learning disabilities and autism being held in less therapeutic settings due to the lack of community-based support.

5.7 In relation to the proposed reforms to provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition, we believe it likely that the safeguards will not work adequately until there is an expectation that community services are jointly funded and that CETRs include sufficient challenge of the adequacy of any educational provision for the child. Whilst putting Dynamic Support Registers and CETRs on a statutory footing is a good start, if CETRs are to be effective at holding the system to account and proper community planning for children and young people with learning disabilities and autism, they must have an understanding of whether or not education provision which meets the child's needs has been provided and if not, what can be done to address the issue.

5.8 In relation to pooled budgets and reporting on spend on services for those with learning disability and autism, there needs to be a read across between expectations around funding of services for those with learning disability and autism and the move towards putting Integrated Care Systems (ICS) on a statutory footing. ICS footprints and their integrated nature should provide a better basis for commissioning for this group of children and young people. Currently children's health commissioners within Clinical Commissioning Groups may typically only need to find a placement for a child in crisis once a year which means they tend to respond from a standing start to the crisis. The ambition of Integrated Care Systems could unlock effective partnership working between NHS commissioners, providers, local authorities, social care, education, and justice services.

## 6. Detention criteria

6.1 It needs to be ensured that by raising the threshold for detention, for example by requiring substantial likelihood of significant harm), this does not have unintended consequences for children and young people. Tighter criteria for detention should not become a reason not to provide support and treatment to this group. It also needs to be noted that tighter detention criteria will not necessarily reduce admissions, this will require the provision of alternatives to hospital admission.

6.2 There is also a potential conflict with including "welfare" as one of the categories of risk which can justify detention. Welfare is already a well understood concept in the context of the Children Act 1989 and 2004 and safeguarding children. Inclusion of this in detention criteria has potential to have far wider meaning for those aged under 18.

**Recommendation:** There should be greater investment in community-based provision to ensure that all children and young people get the support they need. There also needs to be enhanced safeguards for informal patients under 18, and this should be included in the Act.

**Recommendation:** The Department of Health and Social Care should reconsider the use of the word 'welfare' in the detention criteria.

## 7. Discharge arrangements

7.1 Where children and young people are likely to have care and support needs, post-18 transition assessments under the Care Act 2014 and the Children Act for looked-after children should be linked and considered as part of discharge arrangements and care planning.

7.2 The White Paper states that any children admitted to a mental health facility will by definition be suffering from a mental disorder and therefore should already be considered as a child in need. This is a continuation of current arrangements but should be clarified in the updated Code of Practice. In addition to this, the updated section 117 guidance needs to make responsibilities for discharge for children and young people much clearer.

7.3 Statutory Care and Treatment Plans also should seek to ensure multi-agency support for children and young people. For example, they should include sections which are to be completed by each relevant agency with details of support that the agency has provided pre-admission and will make available post discharge. CETRs are good templates for these multi agency plans. Statutory Care and Treatment Plans must be complementary to other support plans a young person might have in place, such as Education Health and Care Plans.

7.4 In relation to EHCP plans, we would welcome further clarification on why a child whose mental health needs were so severe that inpatient care was the only option did not have an EHCP on admission. We see that having an EHCP plan in place would be an appropriate vehicle for discharge. Where a child has a CETR either pre or post admission, we would expect any provisions identified in the CETR to be then mapped back to their EHCP or to trigger an EHCP if one did not exist.

7.5 What is more, clearer guidance is needed on plans for post discharge. For example, the hospital education provider and the home school should be in communication and this should be properly linked into discharge planning. Poor planning from discharge often impacts those transitioning between children's mental health services to adult mental health services, so clear plans and responsibility must be in place for this group.

7.6 Finally, the increased frequency of automatic referrals after the first reference will make no practical improvement on the current referral periods for under 18s under Section 3 of the Act. Under the proposals, adults detained under Section 3 will see automatic referrals reduce from every 3 years to every year. We believe that under 18s should have the same proportional reduction and should have automatic referrals reduced from every 1 year to every 4 months. This would also match the proposed changes to the first reference period.

**Recommendation:** The Mental Health Act Code of Practice should make clear how Section 17 provisions will be applicable in discharge planning for children and young people.

**Recommendation:** The Department of Health and Social care should update the Section 117 guidance to make responsibilities for discharge for children and young people clearer.

**Recommendation:** The referral period for under 18s under Section 3 of the Act should be reduced from 1 year to 4 months.

## 9. Resource

9.1 The White Paper states that the proposals set out will be linked to future funding decisions including at Spending Review 2021. It is crucial that proposals in the White Paper have committed funding put in place. What is more, whilst we welcome a duty to provide community services, adequate funding and resource must be dedicated to these services.

**Recommendation:** The Department of Health and Social Care should provide further clarity on how the proposals set out in the White Paper will be properly resourced.

**Recommendation:** The Government and NHSE should fully implement the commitments set out in the NHS Long Term Plan and the commitment to ensure that 100% of children and young people in need of support access it.

## 10. Data collection

10.1 The Independent Mental Health Act Review recommended that where data is recorded it should be split into age groups, yet the White Paper states that this is already the case. However, there are significant gaps in available data on children in mental health hospitals, and the data that does exist can often be incomplete and difficult to access. As a result of this, it can be challenging to monitor whether children's rights are being upheld.

10.2 Examples of existing gaps in published data, include:

- **Data on the number of children admitted to NHS Children and Young People's Mental Health Service Tier 4 units is available in two different sets of statistics and is inconsistent to data provided to external sources.** For example, in 2020, the Office of the Children's Commissioner highlighted that data provided to it by NHS England on children detained under the Mental Health Act, was "significantly different to the number provided in the Mental Health Services Monthly Statistics." Over a fifth of the children recorded as being detained under the Mental Health Act in the dataset the Children's Commissioner received was missing from the official, published data. This is concerning as the NHS monthly statistics are the only regularly published information, and therefore are relied upon to understand if the number of children and young people subject to detention is rising or falling. Furthermore, the data is not broken down further, for example by type of unit/ward, which limits its use.
- There is also **no published data available on the total number of children admitted to Tier 4 units as 'informal patients'** and the basis on which they have been admitted to hospital. This is significant when considering issues of consent, which we have highlighted as a key issue throughout the response.
- There is **no publicly available data from NHS England about how long children spend in hospital once they have been detained under the Mental Health Act**. Data does exist on the number of 'bed days' for children and young people, however, this is not broken down by type of unit, therefore making it impossible to draw any conclusions from the figures.
- **Data on the number of children admitted to hospital 'out of area' and whether this is considered to be 'inappropriate'** (based on an assessment of the child's clinical need, individual preference, and any special circumstances) **is not publicly available**. While regular data is available on the 'Total number of inappropriate out of area bed days' in the NHS Mental Health Dashboard, this is not disaggregated by age.
- **Inadequate data on children held in adult wards.** In 2019/2020, NHS England data showed that 592 children were placed on adult wards in 2019/20, three times the number in the previous year. However, NHS England has reported significant concerns about the quality of this data and no information is provided on the reasons for admission to adult wards, and there is no way to judge whether this is a result of capacity issues on children's wards. Section 131A of the Mental Health Act provides that where under 18s are admitted to hospital (whether or not they are detained under the Act) they should be accommodated in an environment that is suitable for their age (subject to their needs). The Code of Practice makes clear that no child should be placed in an adult ward, except in an emergency or in 'atypical' circumstances. However, accurate data collection and publication is essential to bringing an end to inappropriate and potentially harmful placements. This also needs to be consistent with, and cross-referenced against, data collected by the Care Quality Commission when notified of placements on adult wards.
- **Data on detentions of children in non-mental health wards.** In addition, there is no data published on the number of Mental Health Act detentions that take place on non-mental health wards – for example in A&E or on paediatric wards. As with adult

ward admission data, this would provide a much fuller picture on all children and is needed to understand the demand and pressure on inpatient mental health beds. For all children, including those referred for informal admission and detained outside mental health wards, there is no information about how long they wait for an inpatient ward once they have been judged as in need of support.

10.3 While the immediate focus should be on securing the basic information about children's admissions and detentions, in the longer term there should also be ambition for a much more detailed and useful amount of data to be recorded and reported, which can help to drive improvement. Currently there is very little publicly available data on what interventions are offered, and what the outcomes are for different patients. This makes it much harder to learn what works in inpatient care.

**Recommendation**: The reformed Mental Health Act should include a duty on the Secretary of State to ensure that national data on the experiences of children and young people as mental health inpatients is regularly collected and published. This should include data on the number of detained and informal patients broken down by type of unit (including those settings which are not mental health wards); ethnicity; reasons for admission; length of time waiting for a hospital place; out-of-area placements and their reasons; safeguarding referrals; serious incidents; the number of children receiving advocacy support; informal admission on the basis of a young person's consent or parent consent; length of time detained; satisfaction rates and the number of children placed on adult wards and length of stay.

## About the Children and Young People's Mental Health Coalition

The Children and Young People's Mental Health Coalition brings together over 200 organisations to campaign and influence policy, with and on behalf of children and young people, in relation to their mental health and wellbeing. The Coalition advocates for the better mental health of all infants, children and young people.

We do not represent any one organisation, approach, or professional group, but come together to provide a strong unified voice speaking out about children and young people's mental health. We are Chaired by Sir Norman Lamb.

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