WRITTEN EVIDENCE SUBMITTED BY THE CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH COALITION (MHB0006)

The Children and Young People's Mental Health Coalition is a collaborative network of over 350 organisations and individuals dedicated to advocating for and influencing policy in relation to the mental health needs of babies, children, and young people. We have been working to raise the profile of children and young people in the modernisation of the Mental Health Act 1983.

We welcome the introduction of the Mental Health Bill, which should result in some positive improvements in the care and treatment of children and young people aged under 18 detained under the Act. Both the Independent Review of the Mental Health Act 1983 and the Joint Committee on the draft Mental Health Bill highlighted the unique needs of children and young people and put forward recommendations to strengthen safeguards for their care and treatment. However, we are concerned that little consideration has been given to how the provisions in the Bill apply to under-18s and that the Bill does not go far enough to improve care for children and young people, both those admitted formally and informally.

This submission will focus specifically on children and young people and the Bill's compliance with the UN Convention on the Rights of the Child (UNCRC). Throughout this submission, we highlight areas of the Bill that need further consideration on how they will protect and promote the rights of children and young people, especially those aged under-16.

Summary

Whilst the Government has previously stated that they are committed to ensuring that children and young people benefit from the reforms' and 'that their rights are protected and upheld,[1] we still have concerns that children and young people have not been fully considered within provisions, with massive gaps remaining in relation to their rights. In particular, we are concerned about the following key areas:

- **Decision-making for under 16s:** We are concerned that no mechanism has been put in place in the legislation for assessing competency for under 16 year olds. The Independent Review recognised the lack of consistency in establishing competence for under 16s and for this reason, made the recommendation that there should be a statutory test for competence in this context. We believe that such a test should be included on the face of the Bill, accompanied by guidance for practitioners on how to undertake such assessments.
- **Strengthening safeguards for informal patients:** A significant number of children and young people are admitted to mental health settings informally. We believe it is crucial that informal patients aged under 18 have the same safeguards as those

detained under the Act. This should include extending advocacy on an opt out basis as well as statutory care and treatment plans to informal patients aged under 18.

- **Inappropriate 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 inappropriately and on adult wards, and that the Bill does not contain adequate safeguards to address this. We believe that the Bill should be amended to strengthen the requirement set out in the Code of Practice for under 16s not to be placed in adult wards, and the requirement to notify the local authority when a young person is placed out of area or in an adult wards should be set out in legislation.
- **Advanced decisions:** The Government previously committed to extending advance choice documents to children and young people, yet rather than introducing advance choice documents, the Bill gives legal weight to advance decisions under the Mental Capacity Act 2005 for adults detained under the Mental Health Act, meaning that children and young people will be unable to make advanced decisions. We see that advanced decisions should be extended to those aged under 18.
- **Learning disabilities and autism:** There are specific considerations and additional safeguards to be strengthened for children and young people with learning disabilities and autism. We welcome the aspiration to prevent autistic children and young people and those with learning disabilities being submitted to mental health inpatient units when there is no clinical need. However, we are concerned that without a clear requirement on both the NHS and local government to provide sufficient, high-quality alternative community provision to meet the needs of these children and young people, this risks being ineffective.
- **Nominated person:** We welcome the introduction of the nominated person, which will enable children and young people to choose someone who will represent their interests. Further work is needed to clarify how the role of the Nominated Person (NP) will interact with parental responsibility, particularly in scenarios where an Approved Mental Health Professional (AMHP) is appointing a NP for a child or young person who lacks competence/capacity.
- **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. There should be an ambition for a much more detailed and useful amount of data to be recorded and reported, which can help to drive improvement and monitor if children's rights are being upheld.

1. The rights of children and young people

1.1 In accordance with the UN Convention on the Rights of the Child (UNCRC), governments are to uphold the best interests of the child across all legislation and policies (Article 3). The following Articles are also relevant to the Mental Health Bill:

- **Article 12** grants all children the right to be hard and taken seriously in all matters affecting them. This applies to decision-making processes affecting individual children as well as children collectively.
- **Article 24** states that healthcare for children should be as good as possible and children and young people have the right to be both physically and mentally fulfilled. Through Article 24, States have the obligation to provide adequate treatment and rehabilitation for children with mental health and psychosocial disorders while abstaining from unnecessary medication.
- **Article 37** explicitly sets out duties around the exceptional circumstances of deprivation of liberty, and rights that must be upheld.

1.2 The UK Government has committed to giving due consideration to the articles of the UNCRC when making all new policy and legislation.[2] The Child Rights Impact Assessment is an indispensable tool to ensure that this commitment is respected across government. We would like to understand whether an assessment has taken place for the Mental Health Bill, and if not, for the government to agree to take one forward and publish.

2. Decision making for under-16s

2.1 Many of the safeguards set out in the Mental Health Bill rely heavily on consent, capacity and competence to make decisions.

2.2 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 have the ability to make decisions for themselves. They can only do so if they demonstrate they are Gillick Competent. This means that the starting point for children aged under 16 is that they are not competent to make decisions for themselves unless they can demonstrate that they can do so, and there are no criteria in place for determining their decision-making ability. Although there is a general understanding that a Gillick competent child can consent to interventions, there is a lack of clarity on how to assess whether the child is competent.

2.3 The Independent Review of the Mental Health Act recognised the lack of clarity and consistency in establishing competence for under 16s and for this reason, made the recommendation that there should be a statutory test for competence in respect of decisions made under the Mental Health Act. However, this recommendation has not been accepted by the Government and no test to determine decision making ability for under-16s has been included in the Mental Health Bill.

2.4 We are concerned that without a test to determine decision making ability, children under 16 will not be able to benefit fully from the rights and safeguards included in the Bill, for example, choosing a nominated person and benefitting from enhanced safeguards relating to refusal of treatment. We see that having such a test on the face of the Bill would help to ensure that professionals understand how to assess under 16s competence.[1] This

should be accompanied by guidance for practitioners on how to undertake such assessments.

Recommendation: The Mental Health Bill should be amended to include a statutory provision for a competence test for under 16s.

3. Strengthening safeguards for informal patients

3.1 A significant number of children and young people are admitted to mental health settings informally, that is on the basis of their own or parental consent. Research from the Children's Commissioner for England suggests that around one third of inpatients aged under 18 are informal, however, NHS Digital do not publish data on the number of young people admitted informally so it is impossible to track total numbers of young people in hospital or to identify trends.

3.2 Concerns have previously been raised that children and young people who are informal patients are often under exactly the same conditions as those detained, without access to safeguards that children formally detained have.[3] Many children and young people who are informal patients are also often unaware of their rights and often do not feel that their voices are listened to. We believe it is crucial that informal patients aged under 18 have the same safeguards as those detained under the Act.

3.3 Access to advocacy is a key part of ensuring that all children are heard, and their rights are respected. Currently, advocacy services are focused on those detained under the Mental Health Act. Informal patients in England do not have a legal right to advocacy.

3.4 The Mental Health Bill seeks to address this disparity in access advocacy, by expanding the right to access the services provided by an Independent Mental Health Advocate to informal patients in England who are not detained under the Act.[4] Whilst detained patients will receive an automatic referral to advocacy services under a new opt-out scheme, this will not be the case for those admitted informally. This means that informal patients will still be required to ask for support from advocates.

3.5 The lack of access to advocacy for informal patients has been a longstanding concern, and we are worried that children and young people admitted informally will continue to experience problems accessing an advocate under this new system.

3.6 We believe that the Bill should commit to extending advocacy on an opt-out basis for informal patients. At the very least, it 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. Implementation of opt-out advocacy and the extension of eligibility to informal patients should happen as soon as practically possible once legislation is passed and both measures should be introduced together at the same time.

3.7 What is more, the Bill introduces new Statutory Care and Treatment Plans for all patients admitted formally. The purpose of these plans is to help ensure that all patients

detained formally under the Mental Health Act have a personalised strategy in place for their care to help them achieve recovery and their discharge from the Act.

3.8 The 'Reforming the Mental Health Act White Paper' committed to putting care and treatment plans for under 18 year olds who are informal patients on a statutory footing, but this has not been addressed in the Mental Health Bill, and it is still not clear how this will be achieved, nor when. We believe it is crucial that under 18s are able to access the safeguards associated with Statutory Care and Treatment Plans regardless of the legal status of their admission.

Recommendation: The Mental Health Bill should be amended to extend advocacy for informal patients to operate on an opt-out basis, as in line for patients detained under the Act.

Recommendation: Care and Treatment Plans for informal patients aged under 18 should be included in the Mental Health Bill.

4. Admission to adult wards and out of area placements

4.1 We are concerned that children and young people are still being inappropriately placed in settings out of area and on adult wards, and that the Mental Health Bill does not contain adequate safeguards to address this. In 2021/22, there was a 32% rise in the number of people under 18 being admitted to adult wards (260 admissions in 2021/22 compared to 197 in 2020/21). Figures show that the number of notifications has dropped by 25% and are now similar to 2020/21 figures at 196 notifications.[5]

4.2 When young people are placed on adult wards they are denied the opportunity for peer support, to socialise with peers their own age, have limited access to educational opportunities and are around staff who are used to treating and tailoring care for adults not younger patients.[6] Research conducted by Article 39 highlights the negative experiences of young people placed on adult wards, with young people reporting how they found the environment 'terrifying' as a child and expectations to 'to behave like an adult.' [7]

4.3 The Joint Committee on the draft Mental Health Bill recommended stronger procedural requirements where inappropriate placements are considered to be put in place, including a requirement that such a placement is demonstrably in the child's best interests.[8] It is imperative that the Mental Health Bill strengthens safeguards against children and young people being placed in inappropriate settings.

4.4 As a first step, the Mental Health Bill should strengthen the requirement for under 16s not be placed in adult wards. 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 Children and Young People's Mental Health Services inpatient

services should be notified, and it should be reported as a serious incidence and investigated in accordance with the NHS Serious Incident Framework. We believe this safeguard should be strengthened and should be set out in the legislation.

4.5 Secondly, it was welcome that through the White Paper, the Government agreed that the local authority should be notified 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. It has been stated that this will be made clear in the Code of Practice, however, we believe this duty should be set out in legislation.

4.6 Further clarity is required on what the duty of the local authority would then be once they have been 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 1989, which requires local authorities to safeguard the welfare of under 18 year olds placed in residential settings and hospitals.

4.7 It is very disappointing that the government has rejected the recommendation made by the Independent Review that providers should be required to notify the CQC where a child or young person is placed in an adult unit or out of area within 24 hours and that the CQC should record both the reasons for placement and its proposed length. This decision should be reversed, and the Bill amended so that the CQC must be notified within 24 hours after an under 18 year old is placed on an adult ward.

Recommendation: The Mental Health Bill should be amended to include a statutory provision against children aged under 16 being placed on adult wards.

Recommendation: The duty to notify the local authority when a child or young person is placed on an adult ward or out of area, or if an admission lasts more than 28 days should be out in primary legislation.

Recommendation: The Mental Health Bill should be amended so that the CQC must be notified 24 hours after an under 18 year old is placed on an adult wards.

5. Advance Decisions

5.1 The Bill will give legal weight to Advance Decisions within the Mental Health Act. This means that adults will be able to record their advance refusal to a particular treatment in the event they lose capacity. An advance decision will have the same effect as a capacitous refusal of treatment and will ensure that the individual can access enhanced safeguards before that treatment can be given.[1]

5.2 Whilst Advance Choice Documents (in which advance decisions can be recorded) will be available to people of all ages, the Bill does not permit under 18s to make advance

[1] Making an advance decision does not give an absolute right to refuse that treatment under the Mental Health Act. It will simply enable access to enhanced safeguards and if those safeguards are followed correctly, treatment can still be given,

decisions. As such, someone under 18 could say in their Advance Choice Document that they refused a particular treatment they did not want in the future, but this would have limited weight. Specifically, it would mean that if the child or young person lacked capacity or competence to consent to treatment when it was offered, their advance refusal would not give them access to the enhanced treatment safeguards available to adults.

5.3 This means that rather than being on an equal footing, children and young people would be disadvantaged compared with adults.

Recommendation: The Mental Health Bill should extend advance decisions to children and young people aged under 18.

6. Children with learning disabilities and autism

6.1 As of September 2024, there were 200 under 18s in inpatients units who are autistic or have a learning disability.[9] The Bill makes welcome provisions to prevent the lengthy and harmful detentions of people with learning disabilities and autism under the Mental Health Act and to improve the care provided.

6.2 The aim of raising the threshold for inpatient admissions for children and young people under section 3 of the Mental Health Act is broadly positive, however, this cannot be done in isolation and at a time when waiting times and thresholds for mental health support across early intervention, targeted support and clinical access are high. In particular, for some children and young people, including those with learning disabilities and autism, the absence of high quality alternative community provision may mean that Tier 4 support will continue to be the only option for care and treatment in moments of crisis.

6.3 Many of the provisions included in the Bill also depend heavily on high-quality community care being in place. We believe current provisions in the Bill should be strengthened to ensure effective and sufficient community support is in place for both those with learning and disabilities and autism, as well as all children and young people.

6.4 Finally, the proposals to place Dynamic Support Registers and Care Education and Treatment Reviews on a statutory basis is a welcome step. Given that the measures were first introduced by the NHS Long Term Plan and have not led to a clear and sustained reduction in the numbers of children and young people with learning disability and autistic young people detained under the Act, the Mental Health Bill is an important opportunity to strengthen their requirements and deliver improved support for children and young people.

7. Nominated person

7.1 The introduction of the Nominated Person (NP) is an important safeguard. The role will have significant powers, including the power to discharge a patient. This role will apply to children and young people under the age of 18, and they will be able to appoint someone other than one of their parents (or person with parental responsibility) to act as their Nominated Person. Where a child or young person lacks competence or capacity to choose

a Nominated Person, an Approved Mental Health Professional (AMHP) can appoint someone on their behalf.

7.2 Whilst we welcome these changes and the right of children and young people to have autonomy over who they chose as their NP, we are concerned about how this provision will operate in practice for under 18s, particularly in relation to the role of parental responsibility. This was a concern shared by the Joint Committee on the Draft Mental Health Bill who recommended that the Government consult on how the NP provision will apply to under 18s in regard to potential conflicts with other legislation affecting children, such as the Children Act 1989.[10] The Committee called on the Government to come forward with new proposals to address this issue at an early stage in the Bill's process.

7.3 However, this issue has seemingly been left unaddressed within the new Mental Health Bill. As a result, the Bill fails to recognise and address how the role of the Nominated Person will interact with parental responsibility, particularly in scenarios where an Approved Mental Health Professional (AMHP) is appointing a NP for a care-experienced child or young person.

7.4 We consider that the Bill should be amended to include a hierarchy of individuals who could be appointed, depending on the child or young person's circumstances. For example, such a list would ensure that if a special guardianship order was in place, the AMHP should choose the special guardian (the elder, if there are more than one), rather than a parent. The failure to consider the Children Act 1989 orders and their relevance to parental responsibility is a serious omission, which are likely to give rise to confusion and uncertainty in practice.

Recommendation: The Mental Health Bill should be amended to include a hierarchy of individuals who could be appointed, depending on the child or young person's circumstances, when the AMHP is appointing where the child or young person lacks competence/capacity.

8. Data collection

8.1 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, it can be difficult to monitor whether children's rights are being upheld. Examples of existing gaps in published data include:

- There is no published data available on the total number of children admitted as informal patients and the basis on which they have been admitted to hospital i.e., on the basis of parental consent or their own consent.
- There is no publicly available data from NHS England about how long children spend in hospital once they have been detained under the 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 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. 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.

8.2 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.

9. Wider systemic change

9.1 The changes made in the Mental Health Bill cannot be seen in isolation from the rest of the mental health system - their success relies enormously on effective service provision, a strong workforce and sustainable investment. Without these factors in place, there is a serious risk to successful implementation of the reforms.

9.2 One of the most effective ways to reduce detentions under the Mental Health Act is to prevent people from reaching crisis point, by providing support at an earlier stage. The Bill has been introduced at a time when waiting times and thresholds for mental health support for children and young people are worryingly high. Years of underinvestment in mental health services means the NHS is often only able to see people with the most serious problems. This, and long waiting lists for services, mean young people are left to fall between gaps in support. Recent data shows that the number of children referred to emergency mental healthcare in England has increased by more than 50% in three years.[11]

9.3 The reforms set out in the Mental Health Bill cannot be seen separately from the challenges facing children and young people's mental health services. Urgent action is needed to address challenges such as high thresholds for support, waiting times and

transitions between services, to ensure that children and young people can access timely support before they reach crisis. It is crucial that the ten-year health plan and broader reforms prioritse action to address the challenges within the children's mental health system, without doing so, the reforms set out Mental Health Bill risk being undermined.

References

[1] Department of Health and Social Care (2021). Reforming the Mental Health Act: government response. Available from: https://www.gov.uk/government/consultations/reforming-the-mental-health-act/outcome/reforming-the-mental-health-act-government-response

[2] https://questions-statements.parliament.uk/written-statements/detail/2018-11-20/HCWS1093

[3] Article 39, A safe space? The rights of children in mental health inpatient care, November 2020

[4] House of Lords (2024) Mental Health Bill Explanatory Notes, available from: https://bills.parliament.uk/publications/56784/documents/5315

[5] Care Quality Commission (2024) Monitoring the Mental Health Act in 2022/23. Available from: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023/children-youngpeople#:~:text=Last%20year%2C%20we%20reported%20a,21%20figures%20at%20196%20notification

[6] Ibid

[7] Article 39, A safe space? The rights of children in mental health inpatient care, November 2020

[8] Joint Committee on the Draft Mental Health Bill. Draft Mental Health Bill 2022. Available from: https://committees.parliament.uk/publications/33599/documents/182904/default/

[9] National Autistic Society (2024). Number of autistic people in mental health hospitals: latest data. Available from: https://www.autism.org.uk/what-we-do/news/number-of-autistic-people-in-mental-health-ho-24

[10] Joint Committee on the Draft Mental Health Bill. Draft Mental Health Bill 2022. Available from: https://committees.parliament.uk/publications/33599/documents/182904/default/

[11] Gregory, A (2024) Children's emergency mental health referrals in England soar by 53%. *The Guardian*. Available from: https://www.theguardian.com/society/2024/feb/07/childrens-emergency-mental-health-referrals-in-england-soar-by-53

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