

19 Children and young people under the age of 18

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Why read this chapter?

19.1 Particular issues arise in relation to children (under 16 years of age) and young people (16 or 17 years old). In addition to the Act, other relevant legislation includes the Children Acts 1989 and 2004, the Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998. Professionals, practitioners and others responsible for the care of children and young people should be familiar with this legislation.

19.2 This chapter provides guidance on the role of those with parental responsibility for a child or young person; confidentiality and sharing information; how children and young people should be safeguarded where admission to hospital is not appropriate and on decisions related to admission and treatment. It should be read in conjunction with other chapters in this Code.

19.3 This chapter sets out some of the key factors including:

- some of the main concepts to be considered when providing care and treatment to children and young people, such as 'parental responsibility' and decisions within the 'scope of parental responsibility'¹
- assessing the competence of children and the capacity of young people to make decisions about their admission and/or treatment
- when informal admission might be appropriate and when the Mental Health Act 1983 (the Act) should be used
- specific provisions relating to the treatment of children and young people under the Act
- the duty to provide age appropriate services
- applications and references to the Tribunal, and
- general duties of local authorities in relation to children and young people in hospital.

¹ The term 'scope of parental responsibility' replaces the term 'zone of parental control' used in the Mental Health Act 1983: Code of Practice. Department of Health. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

General considerations

- 19.4** In addition to the Act, those responsible for the care of children and young people in hospital should be familiar with other relevant legislation, including the Children Acts 1989 and 2004, the MCA and the HRA. They should also be aware of the United Nations Convention on the Rights of the Child (UNCRC), and keep up-to-date with relevant case law and guidance.
- 19.5** When making decisions in relation to the care and treatment of children and young people, practitioners should keep the following points in mind:
- the best interests of the child or young person must always be a significant consideration
 - everyone who works with children has a responsibility for keeping them safe and to take prompt action if welfare needs or safeguarding concerns are identified
 - all practitioners and agencies are expected to contribute to whatever actions are needed to safeguard and promote a child or young person's welfare
 - the developmental process from childhood to adulthood, particularly during adolescence, involves significant changes in a wide range of areas, such as physical, emotional and cognitive development – these factors need to be taken into account, in addition to the child and young person's personal circumstances, when assessing whether a child or young person has a mental disorder
 - children and young people should always be kept as fully informed as possible 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
 - the child or young person's views, wishes and feelings should always be sought, their views taken seriously and professionals should work with them collaboratively in deciding on how to support that child or young person's needs
 - any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the least restrictive option and the 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
 - where hospital admission is necessary, the child or young person should be placed as near to their home as reasonably practicable, recognising that placement further away from home increases the separation between the child or young person and their family, carers, friends, community and school
 - all children and young people should receive the same access to educational provision as their peers
 - children and young people have as much right to expect their dignity to be respected as anyone else, and
 - children and young people have as much right to privacy and confidentiality as anyone else.

People with parental responsibility

- 19.6** Those with parental responsibility have a central role in relation to decisions about the admission and treatment of their child (see paragraphs 19.38 – 19.43 below). It is therefore essential that those proposing the admission and/or treatment identify who has parental responsibility.
- 19.7** Those with parental responsibility will usually, but not always, be the parents of the child or young person. Other people may also acquire parental responsibility. Where the parents are not married, it will be necessary to ascertain whether the father has gained parental responsibility (this might be by a court order, parental responsibility agreement, or (since 1st December 2003) as a result of the father registering his child's birth jointly with the child's mother).² The question whether the father has acquired parental responsibility will also be relevant when ascertaining who is the nearest relative under the Act³ (see paragraph 5.3 above in chapter 5).
- 19.8** Those taking decisions under the Act must be clear about who has parental responsibility. When seeking to identify who has parental responsibility for the child or young person, practitioners should always check whether the child or young person's medical and/or social service files include any relevant court orders, and request copies of any such orders. These orders may include care orders, child arrangements orders (which replace residence orders and contact orders),⁴ special guardianship orders, evidence of appointment as the child or young person's guardian, parental responsibility agreements or orders under section 4 of the Children Act 1989 and any order under wardship. Practitioners should always check with those caring for the child or young person whether any child arrangements orders, parental responsibility agreements or orders, or special guardianship orders have been obtained.
- 19.9** Where the parents of a child or young person (both of whom have parental responsibility), are separated and the child or young person is living with one parent in accordance with a child arrangements order (formerly known as a residence order), practitioners should be aware that the parents continue to share parental responsibility and both should be involved in making decisions about their child.
- 19.10** Where a special guardianship order is in place, the special guardian will share parental responsibility with the child or young person's parents. However, except for certain purposes specified in the Children Act 1989, the special guardian is entitled to exercise parental responsibility to the exclusion of any other person with parental responsibility for the child (apart from another special guardian) (see section 14C of the Children Act 1989).

² For a list of persons who may have parental responsibility see Reference guide to consent for examination or treatment. Department of Health. 2009. <https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

³ Section 26(2)(b) of the Mental Health Act 1983. <http://www.legislation.gov.uk/ukpga/1983/20/section/26>

⁴ Section 12 of the Children and Families Act 2014 amends section 8(1) of the Children Act 1989. <http://www.legislation.gov.uk/ukpga/2014/6/section/12/enacted>

Children looked after by the local authority

- 19.11** Where children or young people are looked after by the local authority (see section 22 of the Children Act 1989), it will be important to establish whether they are subject to a care order (or interim care order) or are being voluntarily accommodated by the local authority.
- 19.12** If a child or young person is voluntarily accommodated by the local authority, parents or others with parental responsibility have the same rights and responsibilities in relation to treatment as they would otherwise. Admission and/or treatment decisions should therefore be discussed with the parent or other person with parental responsibility who continues to have parental responsibility for the child.
- 19.13** If the child or young person is subject to a care order, the parents (and any others with parental responsibility) share parental responsibility with the local authority. The local authority and those with parental responsibility should negotiate and agree who should be consulted about admission and/or treatment decisions. However, where the local authority is satisfied that it is necessary to do so in order to safeguard or promote the child or young person's welfare, they can limit the extent to which parents (or others) may exercise their parental responsibility (see section 33(3)(b) of the Children Act 1989).

Confidentiality and sharing information

- 19.14** As with adults, children and young people have a right to confidentiality (see chapter 10). Where children are competent, and young people have the capacity, to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. (Paragraphs 19.24 – 19.37 below provide guidance on assessing a child's competence and a young person's capacity to decide.) However, as with adults, in certain circumstances confidential information may be disclosed without the child or young person's consent; for example if there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm. Practitioners should be familiar with the Department of Health's *Information Sharing: guidance for practitioners and managers* 2008, which includes guidance on assessing a child or young person's ability to make decisions about sharing information.
- 19.15** The same principles of confidentiality apply if a child who is competent, or a young person who has capacity, to make a decision regarding the information does not wish their parent (or others with parental responsibility) to be involved in decision-making about their care and treatment. Their decision should be respected unless the disclosure can be justified; for example, if there is cause to suspect that the child or young person is suffering or is likely to suffer, serious harm. Practitioners should encourage the child or young person to involve their parents (unless it is considered that to do so would not be the best interests of the child or young person). They should also be proactive in discussing with the child or young person the consequences of their parent(s) not being involved.

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Safeguarding children and young people where admission to hospital is not appropriate

19.16 Where a child or young person does not wish their parent(s) to be involved, every effort should be made to understand the child or young person's reasons with a view to establishing whether the child or young person's concerns can be addressed. For example, the child or young person may be receiving counselling that they do not want their parents to know about, but would be happy for their parents to be informed about more general aspects of their care and treatment. See also paragraph 10.6 on sharing information with carers, relatives and friends, which also applies to people with parental responsibility.

19.17 There is no minimum age limit for detention in hospital under the Act. It may be used to detain children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder, when they cannot be admitted and/or treated on an informal basis (see paragraphs 19.49 – 19.70 below), and where the criteria for detention under the Act are met.

19.18 Where practitioners conclude that admission to hospital is not the appropriate course of action, consideration must be given to alternative means of care and support that will meet the needs of the child or young person. The appropriate action will usually be to refer the child or young person's case to the relevant local authority's children's services, in accordance with local protocols for interagency working to safeguard and promote the welfare of children and young people.

19.19 In cases where admission to hospital under the Act is not appropriate, but the child or young person has significant needs which mean that the level and type of intervention is likely to amount to a deprivation of liberty, their placement in secure accommodation under section 25 of the Children Act 1989 may be required.⁵ This will be a matter for the local authority children's services to consider in the light of the provisions of section 25 of the Children Act 1989, and relevant Children Act 1989 guidance.⁶ Children who are not Gillick competent (see paragraphs 19.34 – 19.37) or young people who lack capacity (see paragraphs 19.26 – 19.30) whose needs are severe and long-term, and where deprivation of liberty is one necessary element of their education or care, may also be accommodated in other placements.^{6a}

⁵ Note that section 25 of the Children Act 1989 refers to 'restricting liberty'. The court held in *Re K (A Child) (Secure Accommodation Order: Right to Liberty)*, 2001. Fam 377 that a secure accommodation order is a deprivation of liberty within the meaning of article 5 of the European Convention on Human Rights.

⁶ Court orders and pre-proceedings for local authorities. Department of Education. 2014. <https://www.gov.uk/government/publications/children-act-1989-court-orders--2>

^{6a} See by way of example: *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council ('Cheshire West')*, 2014. WLR 2. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf and *Barnsley Metropolitan Borough Council vs GS and ES*, 2014. EWCOP 46. <http://www.bailii.org/ew/cases/EWCOP/2014/46.html>

Decisions on admission and treatment of under 18s

19.20 The decision to admit a child or young person to hospital is inextricably linked to the decision to treat them once they have been admitted. They are, however, different decisions and need to be considered separately. In addition, the law about admission and treatment of young people aged 16 and 17 differs from that applicable to children under 16. The following four concepts will be relevant to admission and treatment decisions of both children and young people:

- consent
- assessing capacity (young people) or competence (children) to make decisions
- the role of those with parental responsibility and the ‘scope of parental responsibility’, and
- deprivation of liberty (DoL).

These four concepts are discussed below.

Children and young people and consent

19.21 The valid consent of a child or young person will be sufficient authority for their admission to hospital and/or treatment for mental disorder; additional consent by a person with parental responsibility will not be required. It is good practice to involve the child or young person’s parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

19.22 Consent should be sought for each aspect of the child or young person’s admission, care and treatment as it arises. ‘Blanket’ consent forms (ie forms that purport to give consent to any proposed treatment) are not acceptable and should not be used.

19.23 A young person must have the capacity, or a child must have competence, to make the particular decision in question (see paragraph 19.24 below). They must have sufficient information to make that decision (see chapter 4) and not be subject to any undue influence when doing so (see paragraph 24.34). Unlike adults, the refusal by a competent child or young person with capacity under the age of 18 may in certain circumstances, be overridden by a court.⁷ In the case of *Re W (a minor) (medical treatment: court’s jurisdiction)*, the court decided that it has jurisdiction to override the refusal of a child or young person of treatment in circumstances that will, in all probability, lead to the death of the child or young person or to severe permanent injury; or where there is a serious and imminent risk that the child or young person will suffer grave and irreversible mental or physical harm.⁸ However, the court also emphasised that the child or young person’s refusal is a very important consideration when deciding whether treatment should

⁷ See paragraph 19.53 in relation to section 131 of the Act and informal admission of those aged 16 and 17.

⁸ *Re W (a minor) (medical treatment: court’s jurisdiction)*, 1992, 3 WLR 758.

be given, despite the child or young person's refusal, noting that its importance increases with their age and maturity. Guidance on the action that can be taken in cases requiring emergency life-saving treatment is set out below at paragraphs 19.71 – 19.72.

Assessing a young person's capacity and a child's competence to make decisions

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19.24 Before relying on the consent of a child or young person it is necessary to ascertain whether they can give valid consent. The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17. The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the MCA, while the test for children under 16 is determined by considering whether they are 'Gillick competent'.⁹ Practitioners with expertise in working with children and young people should be consulted in relation to these assessments. The different tests are explained in more detail below.

19.25 Practitioners should consider the following three questions which should be read in conjunction with the paragraphs below:

- has the child or young person been given the relevant information in an appropriate manner (such as age appropriate language)?
- have all practicable steps been taken to help the child or young person make the decision? The kind of support that might help the decision-making will vary, depending on the child or young person's circumstances. Examples include:
 - steps to help the child or young person feel at ease
 - ensuring that those with parental responsibility are available to support their child (if that is what the child or young person would like)
 - giving the child or young person time to absorb information at their own pace, and
 - considering whether the child or young person has any specific communication needs (and if so, adapting accordingly).
- can the child or young person decide whether to consent, or not to consent, to the proposed intervention?

Decision-making and young people

19.26 The MCA applies to people aged 16 or over, so young people must be assumed to have capacity to make the decision about a proposed admission to hospital and/or treatment unless it is established that they lack capacity, as is the case with adults (paragraphs 13.17 – 13.22).

⁹ See *Gillick v West Norfolk and Wisbech Area Health Authority*. 1986. AC 112. <http://www.bailii.org/uk/cases/UKHL/1985/7.html>

- 19.27** Section 2 of the MCA states that a person lacks capacity in relation to a matter if at the relevant time they are unable to make a decision for themselves in relation to the matter 'because of an impairment of, or a disturbance in the functioning of, the mind or brain'. It does not matter whether the impairment is permanent or temporary (see section 2(2)). Section 3 of the MCA then states that a person is unable to make a decision if they are unable to:
- understand the information relevant to the decision
 - retain that information
 - use or weigh that information as part of the decision-making process, or
 - communicate their decision (whether by talking, sign language or any other means).
- 19.28** The MCA also states that a person must not be regarded as unable to understand the information relevant to the decision if they are able to understand an explanation of it given in a way that is appropriate to their circumstances. It is therefore essential that steps are taken to enable a person to understand information, such as using simple language and visual aids (see section 3(2) MCA).
- 19.29** Where there are concerns that the young person is unable to make the particular decision, the young person's capacity should be assessed by a professional with expertise in working with children and young people. Wherever possible, consideration should be given to whether the decision could be delayed to a time when the young person might be able to make the decision.
- 19.30** If the young person is unable to decide about the proposed action at the relevant time 'because of an impairment of, or disturbance in the functioning of, the mind or brain', they will lack capacity as defined in section 2 of the MCA. The reason for the young person's inability to decide about the proposed admission or treatment may be because of their mental disorder. Alternatively, the young person's inability to decide might arise from a temporary 'impairment of, or disturbance in, the functioning of, their mind or brain' that does not amount to a mental disorder (eg an impairment or disturbance caused by the distress related to the proposed admission or treatment). In either case, the young person will lack capacity within the meaning of the MCA and the MCA will apply in the same way as it does for adults. It may therefore be possible for the particular decision to be made in accordance with the MCA for, and in the best interests of, the young person.
- 19.31** When assessing a young person's capacity to make the decision in question, practitioners should be aware that in some cases a young person may be unable to make a decision for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain (even if that is only temporary). In such cases, the person will not lack capacity within the meaning of the MCA. For example, a young person who is informed that they need to be admitted into hospital may, in the particular circumstances of the case, be unable to make a decision. This might be because they find themselves in an unfamiliar and novel situation, having never

before been asked to absorb that type and quantity of information, or they are worrying about the implications of deciding one way or the other.

- 19.32** In such cases (which are likely to be rare) every effort should be made to ensure that the young person is supported in making the decision (eg by involving those with parental responsibility and/or advocates). Steps should also be taken to explain fully and clearly why admission is thought necessary, what the alternatives to the admission are and why they are considered not to be the best option. Save where the case requires urgent action, the young person should be given the time that they need to think things over and ask for clarification.
- 19.33** It is important that practitioners are aware of the distinction between those cases that fall within the MCA and those that do not. If it is not clear whether the young person's inability to decide is because of an 'impairment of, or a disturbance in the functioning of, the mind or brain' or whether due to some other reason, a specialist opinion should be sought from a professional with expertise in working with children and young people. The relevance of this distinction to admission and treatment is explained below at paragraphs 19.53 – 19.64.

Decision-making and children under 16

- 19.34** Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. This is because in the case of *Gillick*,¹⁰ the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention. In such cases, the child is sometimes described as being 'Gillick competent'.¹¹ A child may be Gillick competent to consent to admission to hospital, medical treatment, research, or any other activity that requires their consent.
- 19.35** The concept of Gillick competence reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.
- 19.36** When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions.
- Does the child understand the information that is relevant to the decision that needs to be made?

¹⁰ *Gillick v West Norfolk and Wisbech Area Health Authority*. 1986. AC 112. <http://www.bailii.org/uk/cases/UKHL/1985/7.html>

¹¹ This term is used by the courts to refer to a child who has been assessed as having sufficient maturity and understanding to be able to consent to the decision in question (see *Re R (a minor) (wardship: consent to treatment)* [1992] Fam 11). It should not be confused with 'Lord Fraser's Guidelines' which concern the conditions which must be met before advising a child on sexual matters without parental consent (see *R(Axon) v Secretary of State for Health and the Family Planning Association*. 2006. EWHC 37 (Admin). <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html>).

- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

19.37 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.

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The role of those with parental responsibility and decisions within the scope of parental responsibility

19.38 Those who have parental responsibility for the child or young person, who may be able to provide parental consent to the proposed admission and/or treatment, should be identified. This is because, subject to the child or young person's right to confidentiality (see paragraphs 19.14 – 19.16), they should be consulted about the proposed decision concerning their child. In relation to 16 and 17 year olds, if decisions are to be made in accordance with the MCA (on the basis that the young person lacks capacity within the meaning of the MCA) those with parental responsibility should be consulted about the best interests of the young person (see section 4 of the MCA).

19.39 Parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision. The effect of section 131(4) of the Act in relation to the informal admission to hospital of a 16 or 17 year old, who has capacity, is that parental consent cannot be relied upon to override that young person's decision about their admission. In relation to decisions about such a young person's treatment, it is inadvisable to rely on the consent of a person with parental responsibility to treat a young person who has capacity to make the decision and has refused the treatment. Similarly, in relation to children, it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it. Although in the past the courts have found that a person with parental responsibility can overrule their child's refusal, such decisions were made before the introduction of the HRA and since then court decisions concerning children and young people have given greater weight to their views.¹²

¹² See for example *R (on the application of Axon) v Secretary of State for Health and the Family Planning Association*, 2006. EWHC 37 (Admin), in which the court expressed doubt as to why a parent should retain a right to parental authority relating to a medical decision where the young person concerned understood the advice provided by the medical professional and its implications. <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html>

19.40 In some circumstances, it will be possible for children lacking competence and young people lacking capacity to be admitted to hospital and/or treated on the basis of parental consent (see paragraphs 19.53 – 19.70). However, practitioners must be satisfied that it is appropriate to rely on parental consent. This is important because court decisions relating to parental consent have emphasised that there are limits to both the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made.¹³ For example, when making decisions on behalf of their child, parents must act in their child’s best interests. The limits to what a parent can consent to on behalf of their child is relevant to whether a deprivation of liberty has arisen (see paragraphs 19.44 – 19.48). This guidance uses the term ‘scope of parental responsibility’ to highlight the need to establish whether the particular decision can be authorised by parental consent or not. Those cases in which parental consent is sufficient are described as falling within the scope of parental responsibility.

19.41 Whether the particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case. Practitioners will need to consider a range of factors. These are set out below, under the two key questions that must be addressed (the term ‘parent’ is used to cover all people with parental responsibility):

- **First, is this a decision that a parent should reasonably be expected to make?** If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required. When considering this question, any relevant human rights decisions made by the courts should be taken into account. Significant factors in determining this question are likely to include:
 - the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. Relying on parental consent to authorise an intrusive form of treatment might be justified because it is necessary to prevent a serious deterioration of the child or young person’s health, but this would need to be balanced against other factors such as whether the child or young person is resisting the treatment; whether the specific form of treatment is particularly invasive and/or controversial (eg careful consideration should be given to the appropriateness of relying on parental consent to authorise electro-convulsive therapy (ECT))¹⁴
 - the age, maturity and understanding of the child or young person: the role of parents in decision-making should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person
 - the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision, and

¹³ See for example, *RK v BCC*. 2011. EWCA Civ 1305; *Nielsen v Denmark*. 1989. 11 EHRR (paragraph 72) *Gillick v West Norfolk and Wisbech Area Health Authority*. 1986. A.C. 112; and *Hewer v Bryant*. 1970. 1 QB 357.

¹⁴ Section 58A of the Act includes specific safeguards for all children and young people for whom ECT is proposed, whether or not they are detained under the Act – see paragraphs 19.80 – 19.88.

- whether the child or young person had expressed any views about the proposed intervention when they had the competence or capacity to make such decisions; for example, if they had expressed a willingness to receive one form of treatment but not another, it might not be appropriate to rely on parental consent to give the treatment that they had previously refused.
- **Secondly are there any factors that might undermine the validity of parental consent?** Irrespective of the nature of the decision being proposed, there may be reasons why relying on the consent of a person with parental responsibility may be inappropriate; for example:
 - where the parent is not able to make the relevant decision; for example, this may arise, if the parent lacks capacity as defined in the MCA, because of their own mental health problems or learning disabilities. In cases of doubt, the parent's capacity will need to be assessed in accordance with the MCA
 - where the parent is not able to focus on what course of action is in the best interests of their child; for example, where the parents have gone through a particularly acrimonious divorce, they may find it difficult to separate the decision whether to consent to their child's admission to hospital from their own hostilities
 - where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so that they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken, and
 - where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility,¹⁵ it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court.

19.42 If the decision is not one that a parent would reasonably be expected to make, or there are concerns about the validity of the consent of the person with parental responsibility, it will not be appropriate to rely on parental consent. In such cases, the proposed intervention must be lawfully authorised by other means. In cases where the proposed intervention relates to the assessment and/or treatment of the child or young person's mental disorder, they could be admitted and treated under the Act if the criteria are met. This is discussed below. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from a court before further action is taken. If there is doubt as to whether or not parental consent can be relied upon to authorise the particular intervention, professionals should take legal advice so that account may be taken of the most recent case law.

19.43 Whether persons with parental responsibility can consent to restrictions that would otherwise amount to a deprivation of liberty is considered below.

¹⁵ See section 2(7) of the Children Act 1989. <http://www.legislation.gov.uk/ukpga/1989/41/section/2>

Deprivation of liberty

- 19.44** Determining whether the admission to hospital and assessment and/or the treatment proposed amounts to a deprivation of liberty is as important for admission and treatment decisions concerning children and young people as it is for adults. Article 5 (the right to liberty) of the European Convention on Human Rights (ECHR) applies to individuals of all ages.
- 19.45** In establishing whether there is a deprivation of liberty the circumstances of each case should be considered, looking at a range of factors, such as the type and duration of the restrictions imposed on the person and the impact of such restrictions on that person. Paragraphs 13.44 – 13.47 provide guidance on assessing whether the particular circumstances give rise to a deprivation of liberty.
- 19.46** Decisions as to whether the child or young person's admission and/or treatment amounts to a deprivation of liberty must be considered on a case by case basis. Where children and young people are admitted informally, the question of whether the care regime amounts to a deprivation of liberty must be kept under regular review. This is because although initially informal admission might be appropriate because the child or young person's care plan involves only restrictions of liberty, a change in circumstances may mean that the restrictions placed upon the child or young person amount to a deprivation of liberty for which lawful authority will be needed.
- 19.47** An additional and significant factor when considering whether the proposed intervention in relation to a child or young person is a restriction of liberty or amounts to a deprivation of liberty is the role of parental control and supervision. Practitioners will need to determine whether the care regime for, and restrictions placed on, the child or young person accord with the degree of parenting control and supervision that would be expected for a child or young person of that age. For example, whereas it is usual for a child of under 12 years not to be allowed out unaccompanied without their parent's permission, this would not usually be an acceptable restriction on a 17 year old. Account also needs to be taken of the particular experience of the child or young person. For example, a younger child who has been caring for their parent, including shopping for the household and/or accompanying their parent to medical appointments, might not be used to being prevented from going out unaccompanied.
- 19.48** Prior to the Supreme Court's judgment in *Cheshire West*,¹⁶ case law had established that persons with parental responsibility cannot authorise a deprivation of liberty.¹⁷ *Cheshire West* clarified the elements establishing a deprivation of liberty, but did not expressly decide whether a person with parental responsibility could, and if so in what circumstances, consent to restrictions that would, without their

¹⁶ *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* ('Cheshire West'). 2014. AC 896. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

¹⁷ See *RK (by her litigation friend and the official Solicitor) v BCC, YK and AK*. 2011. EWCA Civ 1305. <http://www.bailii.org/ew/cases/EWCA/Civ/2011/1305.html>

consent, amount to a deprivation of liberty. In determining whether a person with parental responsibility can consent to the arrangements which would, without their consent, amount to a deprivation of liberty, practitioners will need to consider and apply developments in case law following *Cheshire West*. In determining the limits of parental responsibility, decision-makers must carefully consider and balance: (i) the child's right to liberty under article 5, which should be informed by article 37 of the UNCRC, (ii) the parent's right to respect for the right to family life under article 8, which includes the concept of parental responsibility for the care and custody of minor children, and (iii) the child's right to autonomy which is also protected under article 8. Decision makers should seek their own legal advice in respect of cases before them. (Chapter 26 provides guidance on the use of restrictive interventions.)

Informal admission and treatment

- 19.49** The law about admission to hospital and treatment for mental disorder of young people aged 16 and 17 differs from that of children under 16. In both cases, whether they are competent (in the case of children) or have capacity (in the case of young people) to decide about their admission and/or treatment is of central importance. (See paragraphs 19.24 – 19.37 for assessing the competence of children and the capacity of young people to make decisions.)
- 19.50** In relation to admission, children and young people may be admitted to hospital for treatment for mental disorder informally, on the basis of their consent (see section 131 of the Act (informal admission of patients). Where they lack capacity as defined in the MCA (16 or 17 year olds) or competence ('Gillick competence' in respect of under 16s) they can be admitted informally in the circumstances outlined below.
- 19.51** In all cases concerning admission and/or treatment, practitioners must determine whether the proposed intervention can be undertaken on an informal basis. Informal admission and treatment can be authorised by either the child or young person's consent, parental consent (where the child lacks competence or the young person lacks capacity) or in relation to young people who lack capacity, in accordance with the MCA. The following paragraphs provide guidance on how to determine whether such routes to informal admission and/or treatment are applicable. These should be considered in the light of the particular circumstances of each case. Where the proposed admission and/or treatment cannot be authorised on an informal basis, the criteria for detention under the Act must be met for the child or young person to be admitted under the Act or (where the Act is not applicable), the admission can be authorised by the High Court. The only exception to this is where a life-threatening emergency has arisen (see paragraphs 19.71 – 19.72).

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19.52 In cases where a child or young person cannot be admitted and/or treated informally, and the criteria for detention under the Act are not met, legal advice should be obtained on whether to seek the assistance of the High Court. The court's authorisation may be sought by way of an order or declaration, under its inherent jurisdiction, or for a section 8 order under the Children Act 1989. Whether the court is prepared to assist will depend on the facts of the particular case. It should also be noted that the Court of Protection can make a deprivation of liberty order in respect of young people aged 16 and 17.

16 and 17 year olds

Informal admission of 16 and 17 year olds with capacity to consent

19.53 The effect of section 131 of the Act is that where a young person aged 16 or 17 has capacity (as defined in the MCA) to consent to being admitted to hospital for treatment for mental disorder, they may either consent, or refuse to consent, to the proposed informal admission. If a young person has the capacity to consent to informal admission and gives such consent, they can be admitted, irrespective of the views of a person with parental responsibility (who cannot prevent the admission). If the young person with capacity does not consent to the admission, then a person with parental responsibility cannot consent on their behalf.

19.54 In some cases, the young person may be unable to decide whether or not to agree to their admission to hospital, but not because they lack capacity within the meaning of the MCA. For example, this might be because, despite every effort in helping the young person to make this decision, the young person finds the decision too difficult to make (see paragraphs 19.31 – 19.33 above). In such cases, it will not be possible for a person with parental responsibility to consent on their behalf. This is because section 131 of the Act only allows informal admission on the basis of parental consent if the young person lacks capacity within the meaning of the MCA.

19.55 Where the young person does not consent to their admission to hospital, but the admission is thought to be necessary, consideration should be given to whether the criteria for admission under the Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

19.56 If the young person is admitted informally, the considerations set out in paragraphs 19.58 – 19.64 will apply to their treatment.

Informal admission of 16 and 17 year olds who lack capacity to consent

19.57 Where a young person aged 16 or 17 lacks capacity it may be possible for them to be admitted informally, in accordance with the MCA, unless the admission and treatment amounts to a deprivation of liberty. In cases where the MCA cannot authorise informal admission, but the admission is thought to be necessary, consideration should be given to as whether the criteria for admission under the Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal treatment of 16 and 17 year olds with capacity to consent

19.58 Section 8 of the Family Law Reform Act 1969¹⁸ means that young people aged 16 or 17 can consent to their medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. Accordingly, treatment can be given if the young person, who has capacity, gives valid consent.

19.59 Where a young person has the capacity to consent to proposed medical treatment but refuses to consent, it would be inadvisable to rely on the consent of a person with parental responsibility in order to treat the young person (see above, paragraph 19.39). In such cases, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal treatment of 16 and 17 year olds who lack capacity to consent

19.60 Different considerations apply to a decision to treat a young person aged 16 or 17 informally where the young person lacks capacity or is otherwise not able to decide whether or not to consent to the proposed treatment.

19.61 Where the young person lacks capacity, the MCA will apply in the same way as it does to those aged 18 and over, and treatment may be given in accordance with the MCA, unless it amounts to a deprivation of liberty.

19.62 A person with parental responsibility may also be able to consent on behalf of the young person who lacks capacity to make decisions about their treatment. Factors to consider in deciding whether it is possible to rely on parental consent are in paragraph 19.41. The guidance at paragraphs 19.44 – 19.48 should be considered in relation to whether persons with parental responsibility can consent to restrictions that would otherwise amount to a deprivation of liberty.

¹⁸ Section 8 of the Family Law Reform Act 1969. <http://www.legislation.gov.uk/ukpga/1969/46/section/8>

- 19.63** A person with parental responsibility may be able to consent to the treatment on behalf of a young person who although unable to decide about the proposed treatment, does not lack capacity within the meaning of the MCA (the circumstances when this might occur is explained at paragraph 19.31). In such cases every effort must be made to help the young person in making the decision for themselves (see paragraph 19.32).
- 19.64** If it is not possible to provide treatment relying on the MCA or parental consent, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Under 16s

Informal admission and treatment of under 16s who are Gillick competent

- 19.65** Where a child who is Gillick competent to decide about their admission to hospital for assessment and/or treatment of their mental disorder consents to this, they may be admitted to hospital as an informal patient. A child who is Gillick competent and has consented to being admitted informally, may also be given treatment if they are competent to consent to the proposed treatment, and do consent. Consent will be required for each aspect of the child's care and treatment as it arises. This will involve an assessment of the child's competence to make the particular decision and, where the child is competent to do so, confirmation that they have given their consent.
- 19.66** Where a child who is Gillick competent refuses to be admitted for treatment it may be inadvisable to rely on the consent of a person with parental responsibility (see paragraph 19.39). In such cases, consideration should be given to whether admission under the Act is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal admission and treatment of under 16s who are not Gillick competent

- 19.67** Where a child is not Gillick competent then it may be possible for a person with parental responsibility to consent, on their behalf, to their informal admission to hospital for treatment for mental disorder.

- 19.68** If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child may be admitted and treated as an informal patient.
- 19.69** Consent will be required for each aspect of the child's care and treatment as it arises. This will involve consideration as to whether the child is competent to make decisions about their treatment, and if not whether such treatment can be authorised by parental consent.
- 19.70** If it is not considered appropriate to rely on parental consent for the proposed admission and/or treatment, for example because the consent of a person with parental responsibility is not given or the matter is outside the scope of parental responsibility (see paragraphs 19.38 – 19.43), the child cannot be admitted and treated informally. In such cases, consideration should be given to whether admission under the Act is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Emergency treatment

- 19.71** A life-threatening emergency may arise when treatment needs to be given but it is not possible to rely on the consent of the child, young person or person with parental responsibility and there is no time to seek authorisation from the court or (where applicable) to detain and treat under the Act. If the failure to treat the child or young person would be likely to lead to their death or to severe permanent injury, treatment may be given without their consent, even if this means overriding their refusal when they have the competence (children) or the capacity (young people and those with parental responsibility), to make this treatment decision. In such cases, the courts have stated that doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the child or young person's condition.
- 19.72** The treatment given must be no more than necessary and in the best interests of the child or young person. Once the child or young person's condition is stabilised, legal authority for on-going treatment must be established; this might be on an informal basis (see paragraphs 19.49 – 19.70) or in accordance with either a court order or, if the child or young person is detained, under part 4 of the Act (see paragraphs 19.78 – 19.89).

Assessing whether to make an application under the Act

- 19.73** At least one of the people involved in assessing whether a child or young person should be admitted to hospital, and if so whether they should be detained under the Act (ie one of the two medical practitioners or the approved mental health professional (AMHP)), should be a child and adolescent mental health services (CAMHS) professional. Where this is not possible, and admission to hospital is considered necessary, the AMHP should have access to an AMHP with experience of working in CAMHS, and the medical practitioners should consult a CAMHS clinician as soon as possible and involve them as closely as the circumstances of the case allow. In cases where the child or young person has complex or multiple needs, other clinicians may need to be involved, for example, a learning disability CAMHS consultant where the child or young person has a learning disability. (See chapter 14 for fuller information on the assessment process, and chapter 20.)
- 19.74** As part of their role in setting up an assessment (see paragraphs 14.49 – 14.56) AMHPs should consider whether to inform the relevant local authority children's services that an assessment is being arranged and request that any relevant information about the child or young person is provided prior to the assessment. The AMHP should consider with children's services whether a representative from children's services should attend the assessment. The AMHP should employ their best efforts to identify those who have parental responsibility, and who would be the nearest relative (see chapter 5).

Information to under 18s detained

- 19.75** Chapter 4 provides guidance on the provision of information to people detained under the Act and chapter 6 provides guidance on the role of independent mental health advocates. Both these chapters apply to children and young people.
- 19.76** Hospital managers should ensure that staff providing children and young people with information about their rights in accordance with section 132 of the Act have sufficient knowledge and experience to be able to provide information to children and young people and determine whether the information has been understood. Written information must always be made available. Such information should be age appropriate and include an explanation about when they have the right to see an independent mental health advocate (IMHA) under the Act and an explanation of how one can be made available.
- 19.77** IMHAs have an important role in ensuring that children and young people understand, and are able to exercise, their rights under the Act, such as applying to a Tribunal (see paragraph 19.107), and to the hospital managers for discharge from detention (see chapter 38 for further guidance). It is therefore essential that the IMHAs working in CAMHS (or providing assistance to under 18s who are admitted

to adult psychiatric wards – see paragraph 19.94 below) have experience of working with children and young people and an understanding of children’s services and relevant law and policy, as well as an in-depth knowledge of the Act.

Treatments for under 18s regulated by the Act

19.78 As with adults, treatment for mental disorder for under 18s is regulated by part 4 and part 4A of the Act. Chapters 24 and 25 provide general guidance and the following paragraphs highlight issues of relevance to children and young people under 18. Although in some cases the Act provides that treatment can be given to a child or young person without their consent, their consent should still be sought, wherever practicable. This will necessitate an assessment of the child’s competence or young person’s capacity to decide about the treatment proposed.

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Treatments requiring the patient’s consent (section 57)

19.79 Treatment covered by section 57 of the Act (primarily neurosurgery for mental disorder) cannot be given to a child or young person who does not personally consent to it, whether they are detained or not. These treatments cannot, therefore, be given to any young person or child who does not have the competence or capacity to consent, even if a person with parental responsibility consents. If such treatment is proposed in respect of a child or young person who has the competence or capacity to consent (such cases are likely to be rare), the requirements set out under section 57 of the Act must be met before the treatment can be given and these are explained in chapter 25 (paragraphs 25.7 – 25.10). The child or young person is eligible for help from an IMHA and must be informed of this right.

Electro-convulsive therapy (ECT) (section 58A)

19.80 The Act provides specific safeguards in relation to ECT for patients who are under 18.

19.81 As with adults, children and young people who are detained under the Act cannot be given ECT without their consent, if they are capable of consenting to the treatment, unless it is emergency treatment (see section 62 of the Act (‘emergency treatment’)). If they are not capable of consenting, or if it is emergency treatment, they may be given ECT without their consent in accordance with the rules described in chapter 25.

19.82 Children and young people on a community treatment order (CTO) who are competent (children) or who have capacity (young people) to make such treatment decisions cannot be given ECT without their consent, even in emergencies. If they are recalled to hospital ECT can be given in accordance with the treatment

provisions under part 4 of the Act. Part 4A sets out the circumstances in which children who are not competent, and young people who lack capacity, to consent can be given treatment, including ECT when on a CTO. Part 4A is explained in chapter 25.

- 19.83** Whether or not they are detained under the Act, except where emergency treatment is given under section 62 of the Act, no child or young person under the age of 18 can be given ECT without the approval of a second opinion appointed doctor (SOAD). This means:
- for children and young people who are ‘capable of understanding the nature, purpose and likely effects’ of ECT and consent to it, the SOAD must certify, in writing, that the child or young person is capable of consenting, they have consented to ECT, and it is appropriate for ECT to be given, and
 - for children and young people who are not capable of consenting to ECT, the SOAD must certify that the child or young person is not capable of understanding the nature, purpose and likely effects of ECT, but it is appropriate for ECT to be given. In addition, in relation to a young person who lacks capacity to consent to ECT, the SOAD must certify that giving the treatment would not conflict with a decision made by a deputy appointed by the Court of Protection, or the Court of Protection.
- 19.84** The legal authority to give ECT to children and young people who are neither detained under the Act, nor subject to a CTO and who lack the capacity (young people) or the competence (children) to consent to ECT will need to be clarified. (The approval of a SOAD is not in itself sufficient authorisation for ECT to be given.) This means that in the case of young people who lack capacity, the MCA could provide the necessary authority to give ECT, so long as this would not involve a deprivation of liberty.
- 19.85** Although the Act does not prevent a person with parental responsibility from consenting to ECT on behalf of a child who lacks competence, or young person who lacks capacity, to consent and who is neither detained under the Act nor a patient subject to a CTO, careful consideration should be given as to whether to rely on parental consent. This is because although there is no case law at present directly on this point, given the nature and invasiveness of ECT, it may lie outside the types of decision that parents can make on behalf of their child. The factors to consider whether it is possible to rely on parental consent are set out in paragraph 19.41 above.
- 19.86** In cases where ECT cannot be given on the basis of either the child or young person’s consent, or parental consent, or the MCA, consideration should be given to whether the child or young person should be admitted under the Act for ECT, if the criteria are met (or recalled to hospital, in case of a community patient).

19.87 In cases where the Act is not applicable, court authorisation should be sought. Although the application to the court should be made before a SOAD is asked to approve the treatment the views of a SOAD should be sought before making the application as the court is likely to wish to consider a SOAD's opinion before determining whether to authorise ECT. In practice, the issues the court is likely to address will mirror those that the SOAD is required to consider.

19.88 All children and young people, whether or not they are detained under the Act, are eligible for help from IMHAs if ECT is proposed and must be informed of this right.

Other treatments under the Act in respect of patients who are liable to be detained and CTO patients who have been recalled

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19.89 Part 4 of the Act sets out when people of all ages who are liable to be detained, or have been recalled to hospital from a CTO, can be given other types of treatment for mental disorder (see chapters 24 and 25).

Age-appropriate services

19.90 Section 131A of the Act says that children and young people admitted to hospital for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). This duty applies to the admission of all under 18s, whether or not they are detained under the Act and includes children and young people who are subject to a CTO, who are recalled to hospital, or who agree to informal admission.

19.91 This means that children and young people should have:

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs
- a hospital routine that will allow their personal, social and educational development to continue as normally as possible, and
- equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

19.92 The duty requires hospital managers to ensure that the environment in the hospital is suitable. When determining the suitability of the environment, they must consult a person whom they consider to have knowledge or experience in working with children and young people receiving in-patient mental healthcare and who are able to make this assessment (this will usually be a CAMHS professional). The duty applies to all in-patient mental health services, including highly specialised services such as eating disorder units, and learning disability services.

- 19.93** The Care Quality Commission (CQC) must be notified without delay if an under 18-year old is placed on an adult psychiatric ward for longer than a continuous period of 48 hours.¹⁹ Section 140 of the Act requires clinical commissioning groups to notify local authorities in their area of the hospitals that are designed to be specifically suitable for patients under the age of 18.
- 19.94** Section 131A does not prohibit all admissions of individuals aged under 18 to adult wards. Such admissions are permissible only in exceptional circumstances, where this is considered to be the most suitable place for an under 18 year old. These exceptional circumstances generally fall into two distinct categories, referred to in this guidance as ‘emergency situations’ and ‘atypical cases’ (see paragraphs 19.98 – 19.101).
- 19.95** In all cases, to be lawful, the admission of a person aged under 18 to an adult ward must be suitable for that particular individual at the time that the admission is being considered.
- 19.96** In all cases where an under 18 year old is admitted to an adult ward, the reasons for the admission should be recorded, including an explanation as to why this is considered to be suitable having regard to their age and why other options were not available and/or suitable. Details of whether action will be necessary to rectify the situation, and what action taken by whom, and when, should also be recorded.
- 19.97** In the case of children aged under 16, it is Government policy that they should not be admitted to an adult ward. If this occurs or if the child is treated in any other inappropriate setting due to lack of appropriate CAMHS beds, the commissioner of the CAMHS inpatient services should be notified. The commissioner should report it as a serious incident and investigate it in accordance with the NHS Serious Incident Framework.
- 19.98** In a small number of cases the child or young person’s need to be accommodated in a safe environment could, in the short term, take precedence over the suitability of that environment for their age (referred to as an ‘emergency situation’). Such situations will arise where the child or young person needs to be admitted urgently to hospital and accordingly waiting for a bed to become available on a CAMHS unit is not considered to be an acceptable option. An ‘emergency situation’ should be a rare and unusual case. It is not unusual for children or young people to require unplanned admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments.
- 19.99** There is a clear difference between what is a suitable environment for a child or young person in an emergency situation, and what is a suitable environment for a child or young person on a longer-term basis. In an emergency, such as when the patient is in crisis, the first imperative is to ensure that the child or young person

¹⁹ Care Quality Commission (Registration) Regulations. 2009. SI 2009/3112. Regulation 18.2(h): Any placement of an individual under the age of eighteen in a psychiatric unit whose services are intended for persons over that age where that placement has lasted for longer than a continuous period of 48 hours.

is in a safe environment. Once the initial emergency situation is over, hospital managers must ensure that action is taken to transfer the child or young person to more appropriate accommodation unless they have determined that the adult ward is the most appropriate environment for the child or young person. In determining whether the environment is suitable beyond the initial crisis, in addition to the appropriateness of the mental healthcare that can be provided on the adult ward, the hospital managers would need to consider issues such as whether the child or young person can mix with individuals of their own age, can receive visitors of all ages, and has access to education.

19.100 An 'atypical case' describes a situation where those arranging a young person's admission conclude that the best option for that young person is to be admitted to an adult ward even if a CAMHS bed were available. While likely to be rare, such cases may arise from time to time when the young person is very close to their 18th birthday and placing them on a CAMHS ward for a matter of weeks or days before transferring them to an adult ward would be counter-therapeutic and:

- the young person may express a preference to be on an adult ward, such as when they are under the care of the early intervention psychosis (EIP) team which has beds on an adult ward. The young person may prefer to have continuity of care from the EIP team rather than be admitted to a unit with different clinicians, or
- if a young mother requires admission for post-natal depression, admission to an adult mother and baby unit would allow the young mother to remain with her child, whereas admission to a CAMHS unit would not.

19.101 Where, whether owing to an emergency or because the admission is an 'atypical' case, it is considered appropriate for the child or young person to be admitted to an adult ward, it will still be necessary to ensure that appropriate steps have been taken to safeguard the young person. Discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the needs of that young person, might provide the most satisfactory solution; for example, young female patients should be placed in single sex accommodation. Wherever possible all those involved in the care and treatment of children and young people should be CAMHS specialists. Anyone who looks after them must always have enhanced disclosure clearance from the disclosure and barring service (DBS), including a barred list check, and that clearance must be kept up-to-date.

19.102 Where the placement of a child or young person on a CAMHS unit might have a detrimental effect on the other children and young people, hospital managers need to ensure that the interests of other patients are protected. However, the needs of other children and young people should not override the need to provide accommodation in an environment that is suitable for the patient's age (subject to their needs) for an individual patient aged under 18. This means that the detrimental impact on other young patients is not an acceptable reason for transferring a child or young person to an adult ward.

- 19.103** Children and young people aged under 18 should also have access to age-appropriate leisure activities and facilities for visits from parents, guardians, siblings, or carers.
- 19.104** Section 131A of the Act applies to under 18s who are detained in hospital, as a place of safety under sections 135 or 136 of the Act, but not to other places of safety. People under 18 may be admitted to adult hospital facilities in 'emergency situations'. A child or young person may be detained in a place of safety that is not specifically designated for under 18s if this is assessed to be a suitable environment for the child or young person at that time, given the particular circumstances. If, subsequently, the child or young person is assessed as requiring admission to hospital, the admission must be to an age-appropriate (and otherwise suitable) environment and this should be arranged as soon as possible. Section 131A should never be relied upon as a reason for detaining a child or young person under the age of 18 in a police cell rather than a hospital. The safety of the child or young person should always be central to the decision-making process.

Under 18s detention in a place of safety

- 19.105** As chapter 16 states, the process for identifying the most appropriate place of safety to which a particular person is to be removed should be clearly outlined in the local place of safety policy. This applies to children and young people as much as adults. Unless there are specific arrangements in place with CAMHS, the healthcare setting identified by local policies as the place of safety should be used, and the fact that this is attached to an adult ward should not preclude its use for this purpose. In addition, the policies should make clear that a person under 18 should not be removed to a police station as a place of safety unless there are exceptional circumstances, and clear reasons (which should be recorded according to the local policy and shared with relevant local authority children's services), why this is the most appropriate place in which to safeguard that child or young person (see paragraphs 16.43 – 16.52).

The responsible clinician and others caring for and treating under 18s

- 19.106** Wherever possible, those responsible for the care and treatment of children and young people should be CAMHS specialists. Chapter 36 provides guidance in relation to identifying responsible clinicians. In the exceptional cases where a young person is admitted to an adult psychiatric ward, the hospital managers should ensure that the clinical staff have regular access to, and make use of, a CAMHS specialist for advice and consultation.

The Tribunal

- 19.107** Children and young people who are detained under the Act have the same rights as other patients to apply to the Tribunal (see chapter 12). It is important that children and young people are informed of their right to apply to the Tribunal and are assisted in obtaining legal representation at an early stage. IMHAs have an important role in ensuring that children and young people understand, and are able to exercise, their rights under the Act. The IMHA's help in relation to applications to Tribunal will be particularly important, such as helping the child or young person contact a lawyer and understanding the role of the Tribunal, and what to expect at the Tribunal hearing.
- 19.108** A CAMHS panel of the Tribunal has been established so that, wherever possible, at least one member of the panel considering a child or young person's case will have experience of working with under 18s.
- 19.109** Professionals preparing social circumstances reports for the Tribunal must ensure that such reports include any information required in the Tribunal's Practice Directions.²⁰
- 19.110** Hospital managers should ensure that systems are in place to identify cases requiring referral to a Tribunal in accordance with section 68 of the Act. They have a duty to refer patients to the Tribunal under section 68(6) of the Act after a one-year period without a Tribunal hearing in relation to under 18s. Hospital managers should also consider asking that the Secretary of State refers a child or young person's case to a Tribunal under section 67 of the Act in cases where that child or young person is unable to have their case considered speedily by the Tribunal (see paragraphs 37.44 – 37.46).

After-care

- 19.111** Prior to their discharge from hospital all children and young people should have an assessment of their needs, on which a care plan for their after-care is based. Guidance on the duty to provide after-care under section 117 of the Act, is set out in chapter 33. Such guidance is applicable to individuals of all ages, but in relation to children and young people additional factors will need to be considered. This may include ensuring that the after-care integrates with any existing provision made for looked after children and those with special educational needs or disabilities, as well as safeguarding vulnerable children. Whether or not section 117 of the Act applies, a child or young person who has been admitted to hospital for assessment and/or treatment of their mental disorder may be 'a child in need' for the purpose of section 17 of the Children Act 1989. See also paragraph 19.118 below in relation to children and young people with special educational needs.
- 19.112** For information about after-care payments, see chapter 33 for relevant details covering children and young people.

²⁰ At the time of publication this was detailed in Annex E of Practice Direction. First-tier Tribunal, Health, Education and Social Care Chamber: statements and reports in mental health cases. Tribunals Judiciary. 2013. <http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Practice+Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf>

Community treatment order (CTO) and guardianship

- 19.113** There is no lower age limit for a CTO. The number of children and young people whose clinical and family circumstances make them suitable to move from being detained to being a community patient is likely to be small, but it should be used where appropriate (see chapters 29 and 31).
- 19.114** Parents (or other people with parental responsibility) cannot consent (or refuse consent) to treatment for mental disorder on a child or young person's behalf while the child or young person is on a CTO. If community patients under the age of 18 are living with one or both parents, the responsible clinician should consult with the parent(s) about the particular treatment (subject to the normal considerations of patient confidentiality). This dialogue should continue throughout the period of the CTO. If a parent is unhappy with the particular treatment or conditions attached to the CTO, and the child is not competent to consent (or young person lacks capacity to consent), a review by the child or young person's team should take place. This will be to consider whether the treatment and care plan, and CTO in general, are still appropriate for them.
- 19.115** The powers of guardianship under the Act apply to individuals aged 16 and over and may be appropriate for young people aged 16 and 17 (see chapter 30).

Education

- 19.116** Local authorities must make arrangements to provide suitable education for all children of compulsory school age. Suitable education means education suitable to their age, ability and aptitude and to any special educational needs (SEN) they may have. This education must be full-time, unless the local authority determines that, for reasons relating to the physical or mental health of the child, a reduced level of education would be in the child's best interests. Children and young people admitted to hospital under the Act should have access to education that is on a par with that of mainstream provision, including appropriate support for those with SEN. Practitioners and local authorities should work together to minimise any disruption to education, and in order to ensure that local authorities can meet their duty to provide suitable education, when a child or young person is admitted under the Act, they should be notified as soon as possible, ideally in advance of the placement. The duty on local authorities to ensure suitable education also applies when a child or young person is receiving treatment in an area where they are not normally resident.
- 19.117** Young people over the school leaving age should also be encouraged to continue learning. Under Raising the Participation Age legislation (part of the Education and Skills Act 2008),²¹ local authorities have duties to promote effective participation in education or training for 16 and 17 year olds including those admitted to hospital.

²¹ Education and Skills Act 2008. <http://www.legislation.gov.uk/ukpga/2008/25/contents>

19.118 When a child or young person with a statement SEN, a learning difficulty assessment (LDA) or an education, health and care plan (EHC plan) is admitted to hospital under the Act the local authority who maintains the plan should be informed, so that they can ensure that educational support continues to be provided. If necessary, the plan may be reviewed and amended to ensure targets and provisions remain appropriate. The local authority should also be involved in creating the discharge plan, so that the statement, LDA or EHC plan is revised as necessary to continue to reflect the child or young people educational, health and social care needs.

Transition from CAMHS

19.119 Young people's transition from CAMHS requires careful planning, which should start at least six months before the young person is due to leave CAMHS. The planning process should ensure the full involvement of the child or young person and (subject to issues of confidentiality) those who will be involved in their care, including those with parental responsibility. The young person should be listened to and helped to improve their self-sufficiency; they should be provided with appropriate and accessible information so they can exercise choice effectively and participate in decisions about which adult and other services they receive.

19.120 Where a young person has an EHC plan that includes agreed provision to support mental health then health commissioners must put arrangements in place to secure that provision. Commissioners should be aware that where appropriate, local authorities may maintain EHC plans up to the age of 25.

Duties of local authorities in relation to children and young people in hospital

19.121 Local authorities should ensure that they arrange for visits to be made to:

- children and young people looked after by them who are in hospital, whether or not they are under a care order, and
- children and young people accommodated or intended to be accommodated for three months or more by NHS-funded providers. Such visits must be undertaken in accordance with the relevant regulations.²²

19.122 Local authorities should consider whether it would be appropriate to provide financial support to enable families to visit children and young people placed in hospital, taking into account their duties to promote contact between children and young people and their families. Such duties arise when children and young people are being looked after by local authorities as well as when they are accommodated in hospital for three months or more. The provision of financial support to cover the travel costs of visiting might be essential for some families on low incomes, especially if their child has been placed out of area (see paragraphs 8A and 16 of schedule 2 of the Children Act 1989).

²² See Visits to Children in Long-term Residential Care Regulations. SI 2011/1010. 2011. <http://www.legislation.gov.uk/uksi/2011/1010/contents/made>

19.123 Section 116 of the Act also places duties on local authorities in respect of children and young people in their care by virtue of a care order and who are admitted to a hospital, independent hospital or care home in England and Wales. In such cases, local authorities are required to arrange for the child or young person to be visited and to take such other steps in relation to the child or young person while they are in a hospital, independent hospital or care home as would be expected to be taken by their parent(s).

19.123 Local authorities are under a duty in the Children Act 1989 to:

- promote contact between children and young people who are children in need, or looked after children, and their families, if they live away from home, and to help them get back together (paragraphs 10 and 15 of Schedule 2 to the Children Act 1989), and
- arrange for people (independent visitors) to visit, advise and befriend children and young people looked after by the authority wherever they are, if they have not been regularly visited by their parents (paragraph 17 of Schedule 2 to the Children Act 1989).

19.125 Local authorities should be alerted if the whereabouts of the person with parental responsibility is not known or if that person has not visited the child or young person for a significant period of time. When alerted to this situation the local authority should consider whether visits should be arranged.

19.126 Hospital managers should set up systems to ensure that directors of children's services are notified of cases in which their duty to visit and consider the welfare of children and young people in hospital arises (see chapter 37 for further details on the functions of hospital managers).

Related material

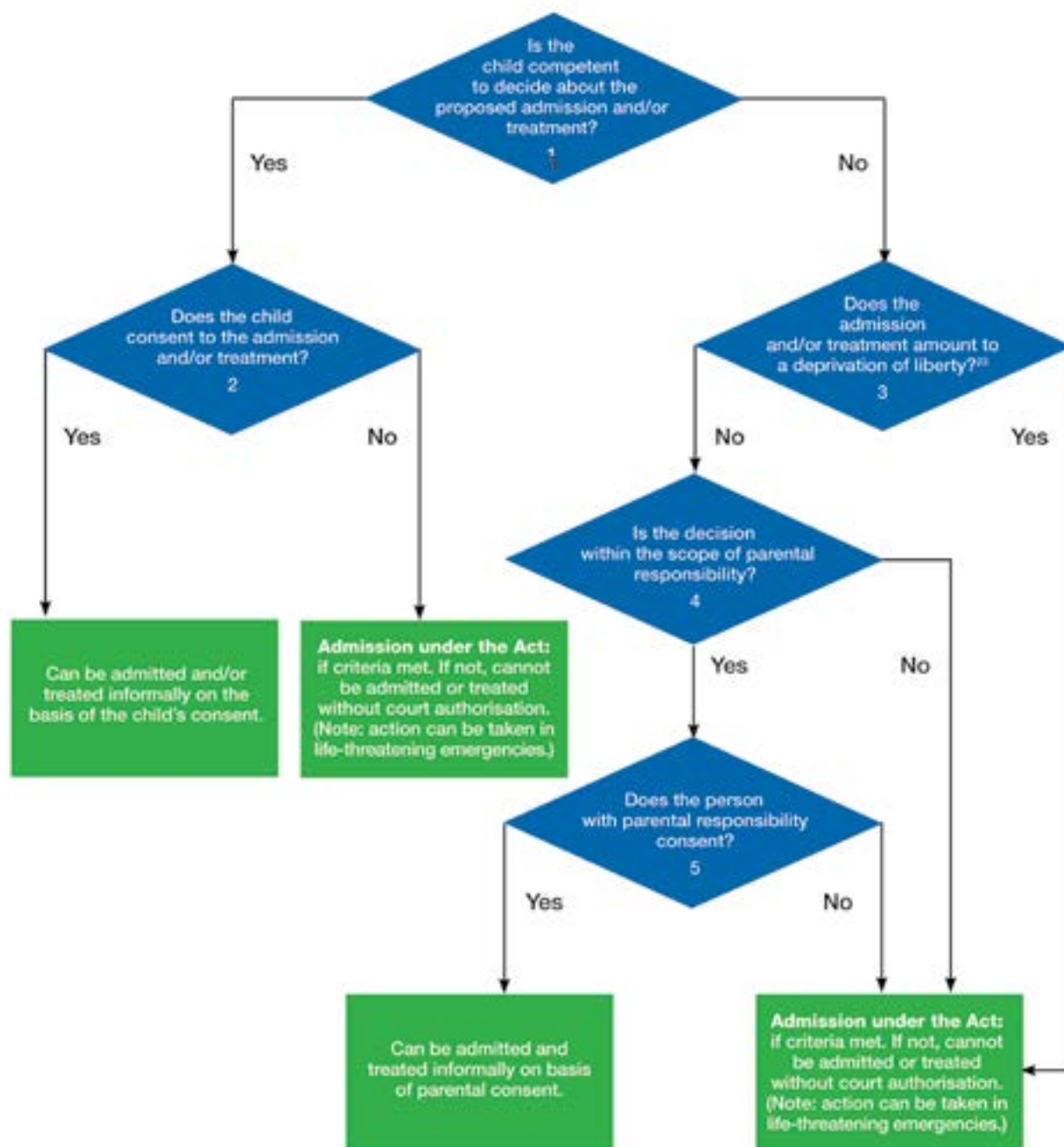
- Children Act 1989 and guidance:
<https://www.gov.uk/government/publications/children-act-1989-court-orders--2>
- Information Sharing: guidance for practitioners and managers. HM Government 2008. <https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers>
- NHS Confidentiality Code of Practice. Department of Health. 2003.
<https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>
- Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children. Department for Education. 2013.
<https://www.gov.uk/government/publications/working-together-to-safeguard-children>
- Disclosure Barring Service checks:
<https://www.gov.uk/disclosure-barring-service-check>

This material does not form part of the Code. It is provided for assistance only.

Notes to flowcharts

19.127 The following flowcharts are for assistance only and do not form part of the Code. They summarise the issues that practitioners will need to consider when determining the legal authority to admit and/or treat a child (under 16s) or young person (16 or 17 year olds). They should be read in conjunction with this chapter. The additional notes should be read with the corresponding boxes in the flow chart. The numbers in brackets refer to paragraphs of the Code. Annex D provides a written description of figures 7-9.

Figure 7: Informal admission and treatment of under 16s

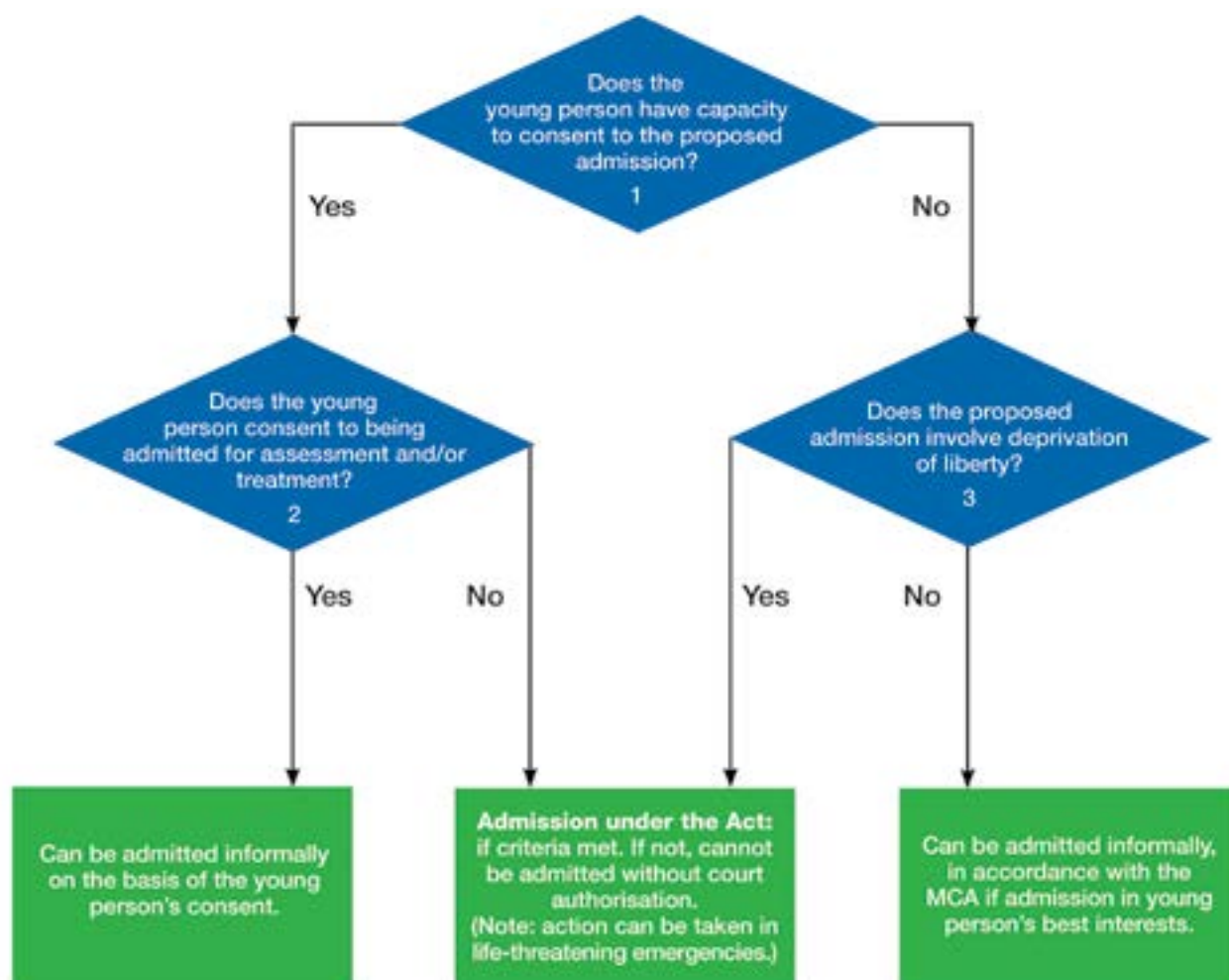


²³ Consideration should be given to whether a person with parental responsibility can consent to the admission or treatment which would, without consent, amount to a deprivation of liberty.

Additional notes to Figure 7

1. Is the child competent to decide about the proposed admission and/or treatment? It will be important to identify the decision to be made: decisions about admission need to be treated separately from decisions about treatment. Consider whether the child is competent ('Gillick' competent) to consent to the admission and/or treatment (see paragraph 19.34 – 19.37).
2. Does the child consent to the admission and/or treatment? The consent of a 'Gillick competent' child will be sufficient authority to admit and/or treat the child (paragraphs 19.65 – 19.66). Note: there may be reasons for not relying on the child's consent to admission (paragraphs 14.14 – 14.16). If a Gillick competent child does not consent to the proposed admission and/or treatment it would be inadvisable to override their refusal by relying on parental consent (paragraph 19.39).
3. Does the admission and/or treatment amount to a deprivation of liberty? Consideration should be given to whether a person with parental responsibility can consent to the proposed admission and/or treatment which would, without consent, amount to a deprivation of liberty (see paragraphs 19.44 – 19.48).
4. Is the decision within the scope of parental responsibility? (This is explained in paragraphs 19.38 – 19.43.)
5. Does the person with parental responsibility consent? A child who is not competent to make decisions about their admission and/or treatment may be admitted and/or treated if the person with parental responsibility consents to the particular intervention. If the person with parental responsibility is unwilling to consent to the admission and/or treatment, consider whether the criteria for admission under the Act are met.

Figure 8: Informal admission of 16 and 17 year olds

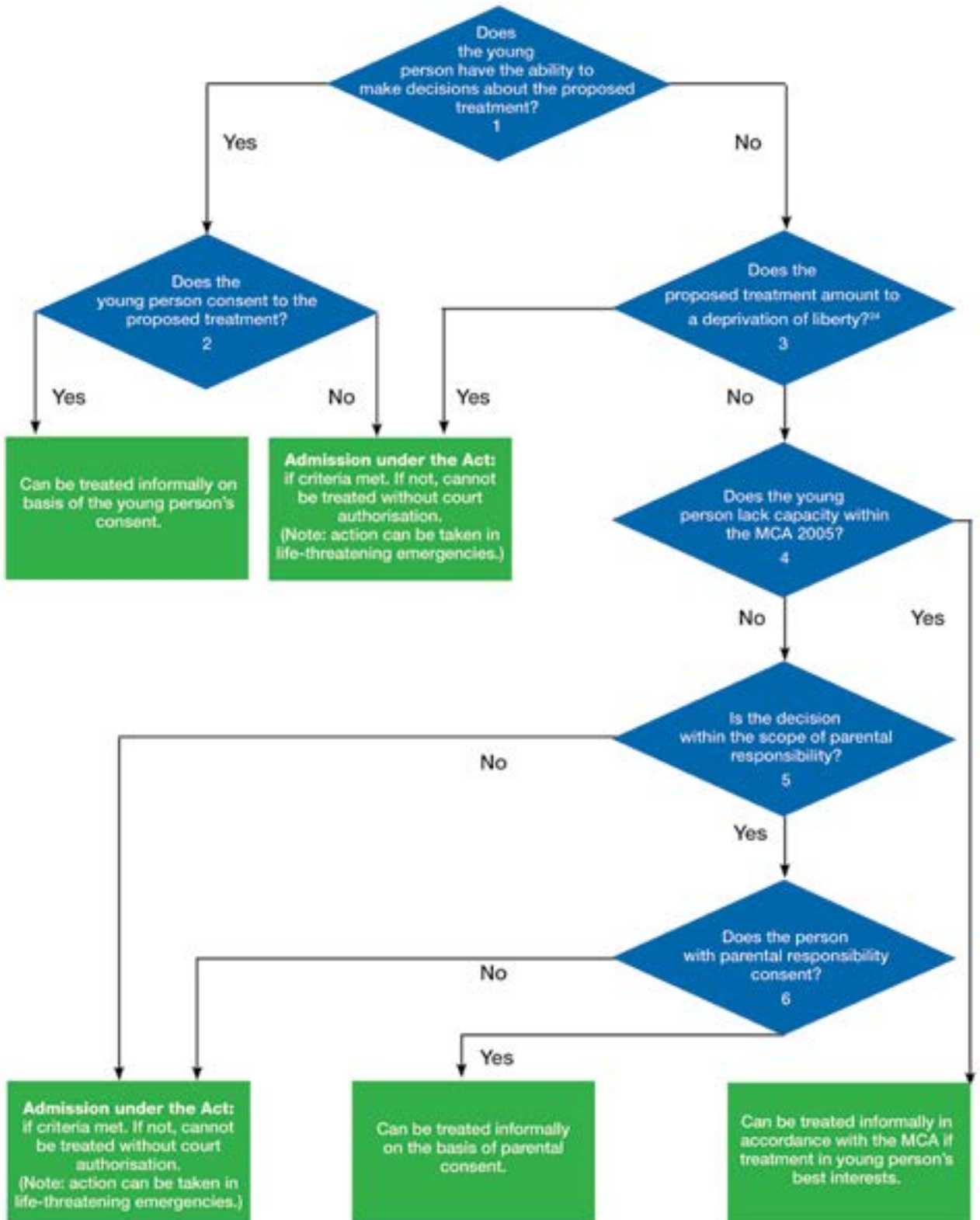


19

Additional notes to Figure 8

1. Does the young person have capacity to consent to admission? (See paragraphs 19.26 – 19.33.)
2. Does the young person consent to being admitted? The consent of a young person with capacity to consent is sufficient authority to admit them (paragraph 19.53). Note: there may be reasons for not relying on the young person's consent to admission to hospital (paragraphs 14.14 – 14.16). Parental consent cannot override a young person's refusal to being admitted (section 131 the Act, see paragraph 19.39).
3. Does the admission involve deprivation of liberty? A young person cannot be admitted informally if the admission amounts to a deprivation of liberty. If the young person lacks capacity, the admission is in the young person's best interests and does not amount to a deprivation of liberty then the young person can be admitted informally in accordance with the MCA (paragraph 19.57).

Figure 9: Informal treatment of 16 and 17 year olds



²⁴ Consideration should be given to whether a person with parental responsibility can consent to the admission or treatment which would, without consent, amount to a deprivation of liberty.

Additional notes to Figure 9

1. Is the young person unable to make decisions about the proposed treatment? If so, is this because they lack capacity under the MCA? Or are they unable to decide about the proposed treatment but not because they lack capacity within the meaning of the MCA? (See paragraphs 19.26 – 19.33.)
2. Does the young person consent to the proposed treatment? The consent of a young person who has capacity to make the decision is sufficient authority to treat the young person – (paragraphs 19.58 – 19.59). It would be inadvisable to rely on parental consent to authorise the young person's treatment when the young person has capacity and is refusing the treatment (paragraph 19.39).
3. Does the treatment involve a deprivation of liberty? Consideration should be given to whether a person with parental responsibility can consent to the arrangements which would, without consent, amount to a deprivation of liberty. (See paragraphs 19.44 – 19.48.) If it does amount to a deprivation of liberty, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).
4. If the treatment does not involve a deprivation of liberty, consideration should be given to whether the young person lacks capacity within the meaning of the MCA. If the young person lacks capacity, and the treatment is in the young person's best interests then the young person can be treated informally in accordance with the MCA (paragraphs 19.60 – 19.64).
5. If the young person does not lack capacity within the meaning of the MCA 2005, consider whether the decision is within the scope of parental responsibility (see paragraphs 19.41 – 19.42). Paragraphs 19.31 – 19.33 and 19.63 explain that there may be cases in which a young person is unable to decide about the proposed treatment but for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain (and therefore the young person does not lack capacity within the meaning of the MCA 2005).
6. Does the person with parental responsibility consent? In cases where the young person is unable to decide about their treatment but not because they lack capacity within the meaning of the MCA (see paragraph 19.31) it may be possible for the treatment to be given on the basis of parental consent, if the treatment is within the scope of parental responsibility (see paragraphs 19.41 – 19.42 and 19.63).

Examples

The following examples should be read in conjunction with the above text and the preceding flowcharts.

Example A

A 13 year old child is assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child has been in hospital before and is happy to return there. However, neither of the parents (both of whom have parental responsibility) consents. Given that it is not possible to rely on the child's consent (the child is not Gillick competent) or parental consent (the parents do not consent and no other person has parental responsibility) the child cannot be admitted informally in accordance with section 131(1) of the Act. If the child meets the relevant criteria, the child could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example B

A 14 year old girl is assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. She is severely anorexic and the proposed treatment is that she is fed by naso-gastric tube. The naso-gastric tube may need to be in place for several weeks in order to restore the child to a safe BMI (body mass index). The care team conclude that as this is a particularly invasive form of treatment and the girl is likely to resist the insertion of the tube, it would not be appropriate to rely on parental consent to authorise this intervention. Accordingly, even though a person with parental responsibility consents, the child is not admitted and treated informally under section 131(1) of the Act. If the child meets the relevant criteria, she could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example C

A 15 year old child is assessed as being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child does not consent to treatment in hospital. The child's parents are keen for the child to be admitted to hospital and give their consent. However, it is not considered safe to rely on the parent's consent where a Gillick competent child is refusing. Accordingly, the child cannot be admitted informally under section 131(1) of the Act as the child is competent to consent but does not do so. If the child meets the relevant criteria, the child could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example D

A 16 year old young person is assessed as needing a period of in-patient treatment. Under the MCA applies, he should be presumed to have capacity to make decisions. There is no evidence to show that he lacks capacity. The primary purpose of the intervention is to provide medical treatment for mental disorder. The young person consents to admission and treatment in hospital. The young person can be admitted to hospital and treated as an informal patient in accordance with section 131 of the Act without being detained.