A safe space?
The rights of children in mental health inpatient care
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# A safe space? The rights of children in mental health inpatient care

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About this report

This report is part of Article 39’s three-year project working with children and young people in England to highlight their views and experiences of mental health hospitals. There has been relatively little research bringing together the views and experiences of children and young people in mental health hospitals and this project aims to ensure that their voices are heard and help influence the development of law, policy and practice. Having originally planned to consult directly with children and young people, we had to change our approach when COVID-19 lockdown measures were introduced in March 2020. Given the sensitivity of many of the issues discussed we felt that any initial engagement with young people should be face to face. This short review looks instead at children and young people’s access to independent advocacy services and the concerns and issues which they bring to their advocates. Article 39 remains committed to working in partnership with children and young people and to hearing about their views and experiences directly. We look forward to picking up that direct work when it is safer to do so.

How we gathered information

Advocates across England working with children aged under 18 in mental health hospitals shared the experiences of the children and young people they worked with through interviews by phone and video call, a virtual group discussion and short online survey.

We gathered information from 10 different advocacy services covering five regions in England, focussing on the issues children and young people brought to them in 2019-20 and also on the impact of COVID-19 on advocacy in mental health.

We conducted a literature review and examined statistics published by NHS Digital and inspection reports by the Care Quality Commission. We also submitted freedom of information requests to 18 NHS Foundation Trusts, NHS England and the Ministry of Justice.

Acknowledgements

Article 39 is very grateful to the independent advocates who have helped us better understand the views and experiences of children and young people who spend time in mental health inpatient care. In addition, thanks go to the following committed individuals who provided comments on drafts of this report: Linzi Bagshaw, Lynn Brady, Alice Livermore, Camilla Parker, Kate Seneviratne-Wheatley, Simon Smith, Colette O’Sullivan and Harriet Waldegrave. Thank you to BCC Children in Need for funding this work and for their great support during COVID-19.
The focus of this report is children and young people aged under 18 with mental health needs that necessitate their admission to hospital, and who are either detained under mental health legislation or who are being treated ‘voluntarily’ as informal patients.

The report concerns children and young people with what is legally termed a ‘mental disorder’, defined in the Mental Health Act 1983 (MHA) as “any disorder or disability of the mind”.\(^2\) This broad definition covers a range of conditions, including anxiety, depression, eating disorders, learning disabilities and autistic spectrum disorders.\(^3\) While domestic and international law defines a child as a person under the age of 18,\(^4\) in the area of mental health law there are important distinctions between those aged 16 and 17 and younger children when it comes to consent to hospital admission and treatment. We therefore use ‘young people’ to refer to 16 and 17 year-olds and ‘children’ when talking about all those aged under 18, or just those aged under 16.

Our review is not limited to those hospital wards in which child are detained under the MHA, but looks at the experiences of all children in mental health inpatient care.

Mental health hospitals can be particularly unsuitable for children or young people with autism and/or learning disabilities where admission has been based on risk or the management of behaviour deemed to be ‘challenging’. Learning disabilities and autism are a lifelong part of a child’s existence; they are not treatable mental illnesses. Yet, despite hospitals not being an appropriate environment, children can end up in inpatient care for long periods when they should be receiving support in their communities. However, the experiences shared with us highlighted that many of the issues faced by children with learning disabilities and/or autism are shared by the wider cohort of children in inpatient care and there is much work to be done to ensure that all children receive the support and care they need, and to which they are entitled.

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**Article 39**

Article 39 is a small, independent charity which fights for the rights of children living in state and privately-run institutions (children’s homes, boarding and residential schools, mental health inpatient units, prisons and immigration detention) in England. We promote and protect children’s rights in England through awareness-raising of the rights, views and experiences of children; legal education; practice development; and policy advocacy, research and strategic litigation. For more information visit [article39.org.uk](http://article39.org.uk)

This report was written by Kamena Dorling, with the invaluable assistance of Karolina Kozlowicz and Carolyne Willow.
Executive summary

The proportion of children with a significant mental health problem, such as depression, anxiety or an eating disorder, has increased over the past three years, from one in nine in 2017 to one in six in July 2020. For many children and young people their mental health has worsened as a result of the COVID-19 pandemic. Prevention, through the promotion of good mental health, and timely help are key to addressing children and young people’s mental health problems but there is a growing, unmet, need for mental health services. For those children with serious mental health conditions who cannot receive the support in the community they desperately need, admission to hospital for inpatient care may be necessary. They might be detained under the Mental Health Act 1983 (MHA) – often referred to as being ‘sectioned’ - or admitted as an ‘informal’ patient on the grounds of the child’s or their parent/carer’s consent.

The MHA lays out clear rights, processes, and safeguards for those who are detained, including the right to be given information and the right to access support from an independent mental health advocate. Advocates have a fundamental role in supporting children in mental health hospitals. They can help them understand their rights and the complicated system in which they find themselves and participate meaningfully in decision-making processes affecting them. While an advocate cannot always ensure that a child’s wishes and views are acted upon, they can ensure their voices are heard and that breaches of their rights are challenged.

However, these safeguards do not automatically apply to informal patients. Over 3,500 children are placed in mental health inpatient care each year; of these, around two thirds are informal patients.

There is little published information on ‘informal’ child patients, where they are placed and reasons for admission. Although legally allowed to leave hospital, many are unable to do so. Many do not understand their rights and feel an underlying threat that if they in some way ‘break the rules’ they will be sectioned.

Furthermore, it is unclear how many children who are in hospital and legally entitled to an advocate are actually accessing one. Of the few NHS Foundation Trusts who provided data for this report, nearly all recorded that complaints had been submitted without the assistance of an advocate – despite the legal right to request the support of an advocate when making a complaint. Access to advocacy is too reliant on the systems and processes put in place by individual providers and individual members of staff.

Advocates shared with us the range of issues that children and young people bring to them, including:

- **Not feeling involved in the planning of their care and treatment, or listened to.** Many children and young people feel uncomfortable talking with members of staff directly, and advocates have a critical role in helping them communicate their views, wishes and feeling and participating in discussions and meetings.

- **Wishing to challenge their detention, or fearing that they might be ‘sectioned’ if they are an informal patient.** Many children and young people relied on advocates to help explain and support them through the process of going to a mental health tribunal to have their detention reviewed, although very few of these cases resulted in the child being discharged.
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- **Lack of contact with family and friends.** Last year over 1,000 children were placed in a hospital outside of the area in which they lived and some of the advocates we consulted worked with children placed over 200 miles away from their home. Parents and carers struggle to visit regularly and local authority support to help them do so can be patchy.

- **Restrictions on day-to-day life** which can result in frustration and boredom, including restrictions on watching television or accessing the internet, what they can eat, and what activities they can do.

- **Inappropriate use of restraint and seclusion or segregation,** and a failure by hospital staff to follow up when complaints are made about it. Last year, over 1,000 children were subject to restraint and isolation.

- **Children being kept in hospital for longer than needed** because of lack of appropriate community-based provision to which they can be moved, and/or a lack of coordination between hospitals and local authorities.

Many of the experiences shared in this report illustrate longstanding concerns about mental health inpatient care. Children and young people are kept in hospital for too long, without sufficient understanding of plans for their care and treatment and of their rights more generally. Too many are placed miles from their homes, far from family and support networks, without properly trained staff and at risk of harm. A lack of a child-centred, rights-based approach in some units can result in children feeling isolated, frustrated and bored. For some, far from providing therapeutic care which helps children recover and get well, mental health hospitals can cause further harm, where there are high levels of trauma and suffering through excessive reliance on coercive rules, restraint, seclusion and segregation. There have been at least 16 recorded suicides in child mental health inpatient units since 2016 and a succession of privately run hospitals have closed down after being judged inadequate by the Care Quality Commission (CQC) or due to staff problems.

In addition, a number of existing problems facing children and young people in hospitals have been exacerbated by the response to COVID-19, including delayed discharges, contact with family and friends and access to advocacy. For many children, face-to-face communication is vital for engagement and while many advocates tried alternatives such as putting up posters, sending letters, WhatsApp calls or online drop-ins, all felt that this was not an adequate substitute for their regular physical presence, especially when first meeting a child.

Addressing these problems requires fundamental change that can be difficult to achieve in a system that is complex, disjointed and chronically underfunded. Many government commitments made over the last five years have not yet materialised for children and young people. What is clear is that there needs to be urgent consideration of how the existing system of safeguards can be strengthened, including the protections offered to children both before and after admission. The inequality in legal protections for children admitted informally to inpatient care, combined with ongoing concerns about the grounds under which they may be admitted, is in urgent need of review, as is children and young people’s access to independent advocacy and the implementation of legislation setting out that children’s care and treatment should be provided in settings that are appropriate for their age and close to home.
Introduction

The proportion of children with a significant mental health problem, such as depression, anxiety or an eating disorder, has increased over the past three years, from one in nine in 2017 to one in six in July 2020. Children and young people’s mental health is affected by a range of factors, including abuse and trauma, family life and relationships, educational experiences, housing, poverty and experiences of discrimination such as racism or homophobia. Many children and young people have a long-term physical condition or a neurodevelopmental ‘disorder’ such as autism, which can affect their mental health. For many, the inequality and adversity that negatively impacts mental health has worsened under the COVID-19 pandemic, or they have experienced isolation, bereavement, neglect or abuse which has had an impact on their mental health.

Prevention - through the promotion of good mental health - and timely help are key to addressing children and young people’s mental health problems, and there has been significant, necessary, attention on this in recent years. Yet in 2018/19, only around 36% of children and young people with a diagnosable mental health condition were treated by NHS-funded community services. There is a growing, unmet, need for mental health support; underinvestment in services in the community; long waits for treatment and a lack of crisis services. Where a child with a serious mental health condition does not receive the support in the community they desperately need, or has needs that are so acute that they cannot be kept safe in other settings, they may end up being admitted to hospital for inpatient care.

Existing law and policy makes clear that any mental health care and treatment in the life of a child or young person should be the least restrictive option and should always be in their best interests. Admission to hospital should have a clear, therapeutic benefit and not simply be used because there is a lack of appropriate community support. It should result in the least possible separation from family, carers, friends and community or interruption of their education, with a managed process, clear timescales and a focus on keeping the length of hospital stay as short as possible. While children are in hospital, they should receive high-quality care and treatment that takes into account their individual needs. Yet this is often not the case. As was noted during the review of the Mental Health Act in 2018:

“... mental health problems lie on a spectrum, and most... new interest is at one end of the spectrum, with far less attention given to those at the other end of the spectrum, those with the most severe forms of mental illness. Yet those with the most severe forms of mental illness have the greatest needs, and continue to be the most neglected and discriminated against.”

Over the last five years, there have been several government-led initiatives in England aimed at transforming mental health provision for children and young people, including inpatient care. These have sought to ensure the numbers placed in hospital are reduced (or in the case of children with learning disabilities, almost eradicated), to ensure that children are placed close to home in settings that are appropriate, and to ensure that they receive the best possible care and can return home as soon as possible.
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Progress in children’s mental health inpatient care? A timeline

The Future in mind programme sets plans for improving mental health care over five years, including improved coordination between community mental health and inpatient care to prevent inappropriate admission and facilitate safe and timely discharge.

The Transforming care programme aims to improve the lives of children and young people with a learning disability and/or autism by developing community services as alternatives to inpatient provision and reducing both the numbers in hospital and the length of stay.

Under the NHS Five year forward view for mental health the government commits that: “by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements.”

The Independent review of the Mental Health Act recommends that every inpatient child or young person has access to an advocate and to a personalised care and treatment plan and for further consultation on the ability of parents to consent to admission and treatment for those under 16.

The Mental Health Units (Use of Force) Act 2018 requires all units to have a policy on the use of force, including steps to minimise it.

At the time of writing this legislation had not yet been commenced.

The Joint Committee on Human Rights (JCHR) report ‘The detention of young people with learning disabilities and/or autism’ highlights that young people are being detained unlawfully, subject to solitary confinement, and deprived of their right to family life. The Committee laments that ‘given the limited progress to date, we have no confidence that the target to reduce the numbers of people with learning disabilities and/or autism in mental health hospitals, set out in the NHS Long Term Plan, will be met’.

The Children’s Commissioner for England publishes a report stating that too many children with autism and/or learning disabilities are being admitted to, and kept in, hospitals unnecessarily and that poor and restrictive practices and sedation are being used.

In October, the government publishes its response to the JCHR reports and commits to bringing a number of the Committee’s recommendations, and those of the Independent Review of the Mental Health Act forward in its long awaited White Paper and mental health legislation.
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Children in mental health inpatient care – headline statistics

Over 3,500 children are admitted to hospital each year because of mental health problems.

Nearly half are aged 15 or under:
- 45% 0-15 years old
- 55% 16-17 years old

Around 1/3 of children in hospital are detained under the Mental Health Act 1983.

Last year, over 1,000 children were placed in a hospital outside of the area in which they lived, some as far as 300 miles from home.

1,049 children and young people under 20 were subject to physical, chemical, mechanical restraint and/or being kept in isolation.

592 children were placed in adult mental health wards in 2019/20, 3 times more than the year before.

The number of children with learning disability and/or autism in inpatient units has doubled since 2015:
- 205 (March 2020)
- 110 (March 2015)
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Despite successive and strong commitments from the government and the NHS, the availability and quality of care and treatment for children and young people who have mental ill health remains unsatisfactory and is often scandalous. Too many children continue to be placed in closed institutions, with too few or unqualified staff, far from family, friends and support. Too many children have a limited understanding of why they are in hospital, what their rights are and what the plan is for their care and treatment. Official reviews in recent years have pointed to a wide range of serious concerns, including the placement of children out-of-area, far from their homes; the placement of children on adult wards; that too many children are being admitted to, and kept in, hospitals unnecessarily; and the inappropriate use of seclusion, long-term segregation and restraint.

In the last decade, we have seen repeated media exposés and reports of the abuse suffered by inpatients in mental health hospitals, of poor ward environments, poor quality of care, coercive control, excessive length of stay and families’ concerns going unheard. While the revelations in the BBC ‘Panorama’ programme of abuse of patients with learning disabilities and autism at Winterbourne View in 2011 prompted the government policy response ‘Transforming care’, only two months ago 10 workers at Yew Trees Hospital in Essex were suspended amid claims patients were "dragged, slapped and kicked". At the time, eight adult female patients with autism or learning difficulties were living in the hospital.

In its review of the use of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition, the Care Quality Commission (CQC) found that the hospital environment, combined with a lack of specialised training and support for staff, increased the risk of patients being restrained, secluded or segregated. Out of 66 people, three children and 28 adults had been in long-term segregation for more than a year.

There have been at least 16 recorded suicides in Child and Adolescent Mental Health Services (CAMHS) inpatient units in England since 2016, with two suicides recorded in CAMHS hospitals in 2016, three in 2017, four in 2018 and seven in 2019, two of which were recorded at the West Lane Hospital in Middlesbrough before it was rated as inadequate by the CQC and shut down. Although the NHS has reiterated its commitment to “eliminating inappropriate out-of-area placements”, a succession of CAMHS wards have closed down in the last 18 months after being judged inadequate by the Care Quality Commission (CQC) or due to staff problems, worsening existing problems with availability of mental health inpatient care across the country.

Progress is hindered by the complexity of the mental health system, the lack of appropriate support for children and young people in the community and the widespread variation in provision between regions and local areas. There also remain significant gaps in available data and the data that exists can be confusing, incomplete and difficult to access, both of which makes monitoring whether children’s rights are being upheld challenging. Furthermore, whilst media stories and reports have highlighted the ways in which some children and young people’s rights can be at risk while they are in mental health hospitals, there is a lack of in-depth knowledge of the experiences of children and young people with acute mental health needs, the services, support and care they receive (or do not receive), and the changes and improvements they themselves want to see.
Children’s rights in mental health units

The law concerning children in mental health inpatient care is very complex and involves the interaction of a number of different legal frameworks. The diagram below outlines some of the key pieces of law and policy referred to in this report, but is in no way comprehensive. Further information on mental health hospitals, the process of admission and entitlement to independent advocacy is available in Appendix I.

The following rights under the European Convention on Human Rights (ECHR) are particularly relevant:

- **Article 2**, the right to life.
- **Article 3**, the right not to be tortured or treated in an inhuman or degrading way.
- **Article 5**, the right to liberty.
- **Article 8**, the right to respect for private and family life.

In addition, the European Court of Human Rights has stated that the ECHR “must be interpreted in harmony with the general principles of international law” and other international conventions ratified by the UK must be taken into account.

The **UN Convention on the Rights of the Child** grants every child the right to express their views freely, and to have these views given due weight in accordance with their age and maturity (Article 12) and provides that in all actions concerning children “the best interests of the child shall be a primary consideration” (Article 3). Article 24 further provides every child with the right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”.

The **UN Convention on the Rights of Persons with Disabilities** specifically addresses the need to protect the rights of children with disabilities (Article 7).
Children and young people have a right to be treated in accordance with the law, to have their rights upheld and their views, wishes and feelings respected. They have the right to be kept safe and treated as close to home as reasonably practicable, with their best interests central to all decision-making. Children and young people must have the least restrictive care and treatment as possible, with the least possible separation from family, carers, friends and community or interruption of their education.

Entitlement to advocacy

Independent mental health advocates (IMHAs) provide a vital additional safeguard for children and young people detained under the Mental Health Act 1983 (MHA). Working in partnership with other services, they “support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment” and help them to obtain relevant information and understand their rights. 31 This support can include helping children to self-advocate and/or representing them and speaking on their behalf.

The following children and young people are legally entitled to support from an IMHA:

- those detained under the MHA (even if on ‘leave of absence’ from the hospital), unless they are detained under certain short term sections (4, 5, 135, and 136).
- liable to be detained under the MHA, including those who are currently on leave of absence from hospital or absent without leave, or those for whom an application or court order for admission has been completed.
- conditionally discharged restricted patients.
- those subject to guardianship.
- those subject to supervised community treatment orders (CTOs).32

Informal patients are eligible for IMHA services if they are being considered for section 57 or section 58A treatment (i.e. treatments requiring consent and a second opinion). This includes people under the age of 18 who are being considered for electroconvulsive therapy (ECT).

The support advocates must provide includes helping patients to obtain information about and understand:

- their legal rights under the MHA.
- the legal rights which other people (e.g. nearest relative) have in relation to them.
- the particular parts of the MHA which apply to them.
- any conditions or restrictions placed on them.
- any medical treatment that they are receiving or might be given, and the reasons for that treatment.
- the legal authority for providing that treatment.
- the safeguards and other requirements of the Act which would apply to that treatment.
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Children and young people’s experiences

Inequality of rights protection

The MHA lays out clear rights, processes, and safeguards for those who are detained. Children have the right to be given information in an accessible age-appropriate format, including the section under which they are detained and why, and the right to access support from an independent mental health advocate. They have the right to challenge their detention through applying to a hospital manager or a mental health tribunal to be discharged. They have the right to complain to the CQC regarding their care and treatment.

A key concern raised by children’s independent advocates was that these safeguards do not automatically apply to informal patients who are in hospital on the basis of their, or their parents/carers’, consent – despite those children often living under exactly the same conditions as those detained under the MHA. Children in these circumstances were described as “informal in theory”, because their physical environment is the same as for detained patients (hospitals “can’t just leave the doors open because there’s always somebody in the unit who might abscond, so the place is on lockdown”). Children often do not understand what being an informal patient means legally, and they are consequently not aware of their right to leave the hospital.

“What does it mean to be an informal patient if you’re 12 and you’re a three-hour drive away from where you live? You can’t go anywhere. You can’t say “I’m just going to wander to the corner shop”. You can say that you want to go home for the weekend but what if your parents are saying they can’t cope with you this weekend?

3,500 children are placed in mental health inpatient care each year; of these, around two thirds are informal patients. However, there are no regularly published statistics on informal patients, where they are placed and reasons for admission. Of the 18 NHS Foundation Trusts Article 39 contacted for information, only 2 could provide information on whether informal patients in their units had been admitted on the basis of the child’s consent of their parents/carers’ consent.

Some children and young people feel an underlying threat that if they do not comply with the rules, or they try to leave hospital, they will be ‘sectioned’. Advocates reported that they had to work hard with young people to explain how the detention process works and to publicise what their rights actually are. There can also be a lack of understanding amongst family members, or a reluctance to let a child know that as an informal patient they have a right to leave, for fear that they might hurt themselves.

In one hospital, a young person with Autistic Spectrum Disorder aged 17 was an informal patient. She asked to go out for a walk with another patient but was told this was not possible. She did not understand why. Her advocate alerted medical staff to the fact that, as she was in hospital on an informal basis and over the age of 16, she should be allowed to go, or put on a holding power to prevent her from leaving. The manager admitted that they had tended to see the child “as younger than she is” and acknowledged that an error had been made.
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Entering hospital and getting help from an advocate

Advocates have a fundamental role in supporting children in mental health hospitals. They can help them understand their rights and the complicated system in which they find themselves and participate meaningfully in decision-making processes affecting them. While an advocate cannot always ensure that a child’s wishes and views are acted upon, they can ensure their voices are heard and that breaches of their rights are challenged.

“She always knew that I was available. That I was independent and a safe space.”

The MHA Code of Practice states that services have a duty to make sure that people understand how they can get help from an advocate. Where someone lacks the capacity to decide whether they want the help of an advocate, the hospital manager should ask an advocate to meet the person so they can explain directly how they can help.36

However, as discussed above, not all children and young people are legally entitled to an independent advocate. The law concerning admission and treatment for children who are informal patients is extremely complex but there is no legal requirement for them to receive information or support to understand. While access to advocacy has been addressed in a number of settings through the development of drop-ins for informal patients and ad hoc or contractual advocacy provision for that group, without a statutory duty to provide advocacy there remains a risk of children in need of support not receiving it.

Even for those with an existing legal entitlement, access may not be straightforward. Some units have a system of automatic referrals (known as ‘opt out’ or ‘open access’) where every child detained under the MHA is referred to an independent mental health advocate unless they specifically say they do not want to be.

However, there can still be delays of several weeks or longer (even in hospitals with an automatic referral system in place) before a referral is made. Moreover, not all settings offer an ‘opt out’ service, where children and young people are automatically offered advocacy on admission, so they may need to be regularly reminded of their right to an advocate.

In one setting, no advocacy contract was in place and there was a significant delay before a single advocate was commissioned to work with a young person, despite her having significant learning disabilities and support needs. The advocate’s first visit took place four months after the child was admitted, an incredibly long time for a vulnerable child.

Many children will be so unwell on arrival, and the process can feel so overwhelming, that it will be hard to take in information and it will need to be provided repeatedly throughout their time in hospital.

“We are reliant on how the nurse explains what advocacy is, and the nurse remembering, and if the young person refuses the first time, the nurse explaining why they are detained the next time and offering advocacy again.”

Some advocates provide every child and young person with an introduction letter containing mobile numbers, photos and an explanation of what an advocate is and what they can do, and signposting to further information on their rights – “we arm them with the information even if they don’t want to see us”.
Posters promoting advocacy may also be displayed in communal areas of the hospital. The importance of not closing a referral even if a child has stated that they do not wish to see an advocate was emphasised, alongside advocates regularly visiting hospitals to introduce themselves and check whether children wish to speak to them.

“Even if we do an introduction and the child or young person listens and says they’re fine, we don’t close the referral - we leave it open because often we do have clients that have Autistic Spectrum Disorder, for example, and they can say hello to you but not actually want to speak to you... then all of a sudden they might ask to speak to you and there might be a big piece of work... so we keep dropping in.”

While some young people will have specific questions regarding when they can leave, the process of being in hospital or the impact on their future, for those with learning disabilities or with more troubled backgrounds, an advocate may need to spend time talking to them and prompting them to see if they need help. The role can be challenging and developing a trusting relationship and effective communication is essential – it can take a period of time before the child has built up trust, or comes to understand what an advocate does.

Advocates told us that access to advocacy can rely too heavily on the setting in which a child is placed, the knowledge and the understanding of medical staff. Some felt that advocacy was seen as being simply about ‘making complaints’ or as something that anyone could provide, without appreciating the distinction between acting on what you feel is in the best interests of a child and focussing on their wishes and feelings.

Others felt advocacy was seen as a ‘box to be ticked’ and noted that advocates would be invited to meetings without the young person even being asked whether they wanted this.

“A lot of it has to do with how frontline staff perceive advocates – as a critical friend or someone who will tell tales.”

In some settings, staff specifically asked for help with giving children opportunities to say whether they feel safe and they asked for help with liaising between health and social care. Advocates would be regularly invited to ward rounds and encouraged to drop in at any time. In others it was felt that further training on the role of advocates, and awareness-raising for parents, was needed so that they are not seen as someone who can ‘cause trouble’ but a vital support role for children and young people and one who can help resolve concerns without them escalating. Advocates felt that they had to apologise for doing their job and sometimes would not even be given a space in which they could listen to, and have private conversations with, children.

It is unclear how many children who are in hospital are actually accessing an advocate. Of the NHS Foundation Trusts we contacted, only a third (6 out of 18) were able to provide data on the number of children who had received support from an advocate over the past three years. Two of those Trusts provided data that appears unreliable in that more children are recorded as receiving help from an advocate each year than were actually inpatients that year. Of those who could provide data, nearly all recorded that complaints had been submitted without the assistance of an advocate, despite the legal right to request the support of an advocate when making a complaint.37
While inpatient care is commissioned nationally by NHS England from NHS, voluntary and private providers, specialist community CAMHS services are commissioned locally by Clinical Commissioning Groups (CCGs) and the responsibility for commissioning IMHA services lies with local authorities. However, many independent and state inpatient services make their own arrangements for advocacy, with a number of ‘in house’ advocacy services.

When requesting data on children and access to advocacy in hospitals, Article 39 received a number of responses where NHS Foundation Trusts would claim that CCGs held the data but, when contacted, CCGs would deny this. Previous research has highlighted that 29% of local authorities surveyed did not know how advocacy services were provided for health complaints and 17% did not know how they were provided for mental health. The most instances of local authorities not knowing the number of referrals/representations that had been made were for special educational needs (SEN) and disabilities, health services and mental health advocacy. 38

A recent report from the Children’s Commissioner for England found that 13% of wards had not had any advocates visiting children there prior to March 2020. 39 Although the Care Quality Commission has recognised the need for strengthened safeguards in hospitals, 40 their inspection reports do not as a matter of course address whether or not advocacy is provided to children in inpatient care, or routinely comment on its effectiveness or the challenges faced by advocates.

Care and treatment

Children receiving inpatient care should be doing so under the Care Planning Approach (CPA), 41 which requires close interaction between patients and those providing care for them. A child should have support from a CPA coordinator, a full assessment of their needs, a written care plan, an ongoing review of their care, and consideration of their need for support from an advocate. 42 There should be regular multi-agency CPA meetings to review progress and consider options for the child returning home (or moving elsewhere). Clinicians, parents and young people should all contribute. In our discussions with advocates, they reported great value in everyone coming together and that this can help young people feel respected, included and listened to.

Yet, despite the existing statutory guidance on care planning, one of the main issues children and young people took to their advocates was their care and treatment. Many did not feel involved in their plan or felt uncomfortable talking with members of staff directly. They did not feel listened to. Advocates assisted by helping them to communicate their wishes and feelings, often through writing them down, and to prepare for, and participate meaningfully in, clinical meetings.

“I have supported young people to write letters to their consultants expressing how they feel and about changes to care and treatment plans and these have then been changed. This is less stressful for the young person and helps them to get their voice heard. It helps for them to know someone is on their side and what their rights are.”
“We’ve even supported a young person to write their own care plan because they felt like the staff weren’t getting it at all. We supported her to write a full document called ‘This is me’ which told staff everything she wanted them to know about her, their approach towards her, what she found helpful and not helpful, what she thought they didn’t already know.”

One young person, who is autistic, was due to be moved to a low secure unit and was feeling very anxious about the move. His advocate raised his concerns with staff, who explained the process to him and also contacted the new unit so that he could speak to staff there. His advocate also helped him prepare a list of worries, rituals and routines to give to staff in the new setting, as well as communication cards that he could use once there.

Challenging detention

Another key issue that young people bring to their advocates is the wish to review or challenge their detention. Advocates can explain the process of going to the mental health tribunal and help the child access legal advice. Mental health tribunal hearings usually take place in the hospital before a panel of three people: a judge (the chairperson of the panel), a medical member (a psychiatrist from a different hospital); and a specialist lay member (a professional with relevant experience). The panel will consider the child’s mental health and level of recovery, speak to the child and professionals involved in their care and examine up-to-date reports to decide if the child still fits the legal criteria for being sectioned, or whether they should be discharged from their section and possibly leave hospital.43

In order to make a valid application to the tribunal, a child must be able to understand that they are being detained against their wishes and that the tribunal is a body that will be able to decide whether they should be released.44 It is a low threshold but advocates found that whilst some children might very clearly want to leave they might not have the necessary understanding of the process and reason for the appeal. Parental understanding can also be an issue - in one case, a child with learning disabilities told an advocate that he wanted to appeal and as they felt he met the threshold they helped him to do so. However, his parent was unhappy because she did not believe that he understood the process. One advocate raised concerns that medical staff often did not respond well to a child’s wish to appeal, highlighting the need for an advocate to support them to engage with the process and access legal support.

In some instances, a child may be happy to remain in hospital but wish to be an informal patient rather than detained, because of the stigma of being ‘sectioned’ or because they want to feel that they have more control over their recovery plan and are getting better themselves. In these scenarios, we heard that it can still be difficult to challenge their detention because of concerns that they might run away. The issue of children and young people fearing the ‘stigma’ around being formally detained under the MHA is one that comes up repeatedly, suggesting that more can be done to ensure that children fully understand the implications (both positive and negative) of being sectioned.
A SAFE SPACE?

Where an appeal does not result in the outcome the child wanted, some advocates felt that the process itself can still be empowering as “they have used their anger in a positive way”, talked through why they were detained, heard the views of professionals and had the opportunity to express their views and wishes in a formal process. For others it can be extremely distressing. Some advocates pointed to the real need for a good solicitor to represent the child at appeal. To provide representation at a mental health tribunal, solicitors have to undergo training and be part of a panel, but there is no specialism in representing children specifically.

The success rate for these appeals is very low: of all the advocates who shared information, none of the appeals in which they had been involved was successful. Official statistics show that of the 1,223 appeals lodged in respect of children in 2019/20, only 54 resulted in absolute or delayed discharge.45

A young person was in hospital under section 3 of the Mental Health Act and wanted to appeal their detention. Before the appeal was heard they were sent home on extended leave due to COVID-19 and the decision was made to discharge them to the community but under a Community Treatment Order (CTO). The young person’s advocate explained to them that this was order made by their clinician for them to have supervised treatment in the community. The young person still felt that this was not what they wanted and so the advocate supported them to participate in meetings and make an informed choice about next steps. The young person decided to challenge this decision and in the end they were discharged to the community but not under a CTO.

Relationships with family and friends

Where hospital admission is necessary, the child or young person should be placed as near to their home as reasonably practicable, as placement further away from home increases the separation between the child or young person and their family, carers, friends, community and school.46 Yet, many of the advocates we consulted worked with children placed over 200 miles away from their home. They highlighted that being in hospital so far from their support systems can have an extremely negative impact on a child, particularly in terms of how frequently they see their close family members, who may be unable to visit regularly due to work or lack of resources.

Hospitals are rarely in town/city centres and therefore the ability to visit can be particularly challenging for those travelling by public transport, or travelling with younger siblings.

In one case, an advocate was working in Essex with a young person whose home was in Cornwall, over 300 miles away. Normal support mechanisms were only available remotely – they could have Facetime calls with family members but no visits and this was “extremely traumatic and distressing” for the child on top of them being unwell.
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The MHA Code of Practice reminds providers of their duties to promote human rights, including Article 8 of the European Convention on Human Rights (the right to respect for family life) by reviewing their policies covering visits from family and friends. It states that local authorities should consider providing financial support to enable families to visit adolescents in hospital “taking into account their duties to promote contact between children and young people and their families”. Funding is available from local authorities to reimburse travel costs for families visiting children in hospitals, but advocates reported that local authorities often refused or failed to respond to requests to fund travel. In some cases, the dispute around whether funding should be provided lasts for so long that the young person has been discharged before it is resolved.

Day-to-day life

“In some ways the young people are treated like small adults when they should not be. For example, access to social media and a smartphone is probably far more important to a young person than an adult. ‘Low level’ issues, such as choice of food and boredom, when occurring often enough or in layers can be difficult or frustrating to challenge but are important to the young person.”

Advocates told us that everyday restrictions can be the most difficult and affecting for young people. These include restrictions on what television programmes they can watch, what they can eat, when they can exercise or go outside, and what leisure activities they can do.

Being placed miles away from family is a direct result of the lack of mental health units across the country, and specific exclusion/acceptance criteria of some units. The southwest of England, for example, is poorly served with hospital units. This is despite an expectation under the MHA that local areas, including commissioners, local authorities, police and providers, should work together to ensure that people in need of urgent care have timely access to a hospital place that is close to home.

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

In one hospital the advocate supports the young people as a group to provide feedback to the management of the unit. This approach has allowed the views of the young people to influence their environment positively – for example, after the young people wrote a joint letter, changes were made by the unit to enable greater access to their outside area without the need for constant supervision.

In some hospitals, phone and tablets will be taken off children on arrival, and internet access might be significantly restricted to certain times of the day and/or supervised, with a blanket rather than personalised approach taken.
In one setting an advocate had to frequently raise the issue of access to technology in the face of an almost blanket ban, even when it was necessary for children and young people to do their homework. Now, following this help from an advocate, children have times when they can access internet with supervision and also have access in the evening.

Computer or telephone access might also be used as a reward or punishment for what is deemed good or bad behaviour. This not only can leave young people feeling frustrated and disempowered but is wholly inappropriate for some children with a learning disability or autism who may not understand the use of sanctions as a form of behavioural control.

While some units provide a number of leisure activities including trips to the cinema, wildlife parks and similar, others do not. Boredom can be an overwhelming problem for children and young people in hospital. Even where a full timetable is in operation, this may not reflect what they themselves would choose to do and the therapeutic benefit of them pursuing their own passions can be forgotten. This can be compounded by staffing issues because “hobbies are the first things to go if staffing is problematic”. Young people complain of their lack of autonomy and reliance on the behaviour of others – for example, not being able to go for a walk because staff were diverted to address an incident with another patient.

“Going on a bus was the best thing these children had done for a long time because they felt ‘normal’.”

One young person lived close to the hospital in which she was being treated and was passionate about drama. Staff in the unit had not considered that it might be possible for her to continue to go to her drama classes until an advocate supporting her raised this. The advocate also approached her school and it was arranged that she could go in for two hours a day. The hospital provided the necessary transport.

Hospitals can also be very stressful environments as young people are living alongside others with very serious health problems and can learn damaging behaviour from each other, such as ways to self-harm. One advocate spoke of “ligaturing becoming all the rage” and parents expressing their concerns about this in CPA meetings. Young people can find the atmosphere on wards very frightening and feel reluctant to be in communal spaces although they are encouraged to be. Many of the units are not purpose-built for children or teenagers, and the settings themselves can feel claustrophobic and intimidating.

“Young people feel like they are constantly being watched and can’t find the space to just be them.”

Insensitive day-to-day behaviour of staff members was also raised. In one example, young people complained that staff were saying inappropriate things in front of them – for example, saying that they could not wait for their shift to be over because the children had been an “absolute nightmare”, or talking about what they would do after their shift, ignoring the fact that the people they were speaking in front of could not themselves leave.
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Restraint, seclusion and segregation

Advocates reported that, while in some units real efforts were made to de-escalate or ‘contain’ children who may be hurting other residents and staff, in others there were misuses of restraint and seclusion, including the use of physical force to keep a child still, medicating them to keep them calm or separating them from other staff and patients. Where advocates worked with children and young people to raise complaints about use of restraint or concerns were raised, a common theme was inaction from the hospital.

One young person, aged 17, was in hospital due to an eating disorder. Having been subject to abuse at home she had a fear of sleeping in her own bed and would often refuse to sleep in her bedroom. Staff made no allowances for this and responded by using restraint to force her in to her bedroom. After restraint was used, no steps were taken to explain to the young person why it had been used, nor to review its use. This was worsened by the use of agency staff and often the young person would wake up in the middle of the night with an unknown man at the end of her bed after being put under one-to-one observation. After building up the courage to speak to an advocate, she was assisted to make a formal complaint about the type of restraint used and its use being inappropriate. The advocates had to “work hard to get the complaint heard”. Having attended a resolution meeting, they were still waiting for the outcome over six months later, despite the young person having already been discharged from the hospital. No feedback was given by the hospital to the young person.

A young person, hospitalised with an eating disorder, was restrained by staff so that they could insert a nasogastric (NG) tube. There were six members of staff sitting on her arms and legs to pin her down. The NG tube was then inserted incorrectly and had to be taken out and reinserted. An advocate helped the young person to register a complaint, which went to the unit manager who failed to respond then went on long-term sick leave. The matter was passed to another member of staff but months later had still not been formally responded to. This staff member was unable to find details of the incident in the unit’s records.

‘Seclusion’ – when a child is in isolation in an area away from other patients and not allowed to leave – and ‘segregation’ – where a child is not allowed to mix with other patients on a long term basis - were also raised as significant problems. Advocates reported failures to refer cases to them when segregation was being used so that they could participate in regular reviews (if that is what the child wanted). Instead they might find out ‘by accident’. Segregation was also reported as having been used for much longer periods than planned. In one case a child was only supposed to be in segregation for six weeks, but ended up in it for over four months. During this time the child’s advocate had to argue for them to have access to activities, television and outside space. Whilst advocates saw that seclusion was sometimes necessary and proportionate, the need for regular review of this use of confinement is essential.
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In England in 2018/19, 1,049 children and young people aged under 20 were subject to restrictive intervention with a total of 32,221 restrictive interventions. These include the use of physical and chemical restraint, seclusion and segregation. Over a third (369) of the young people were subject to prone (face down) physical restraint, despite guidance for the treatment of adults stating that prone restraint should not be used at all. A similar number were subject to seclusion or segregation.

One advocate shared the experience of a young person who had been placed in an adult mental health unit for a number of weeks, during which she was repeatedly physically and chemically restrained and placed in seclusion. Her subsequent formal complaints were dismissed on the grounds that she had been isolated from the adults on the ward, with no regard paid to the potential impact of that period of isolation either.

Leaving or moving hospital

A recurring issue raised by advocates was children being kept in hospital for longer than they need to be due to the lack of appropriate community-based provision to which they can be moved, and/or the lack of coordination between hospitals and local authorities.

Consideration about discharge options and needs should start well before any possible discharge date and should involve the child, their family, carers and staff from other services. However, advocates highlighted problems with discharge planning, including key people being absent from meetings and disagreements over responsibility for the child or young person (and therefore funding their care). This can be the case if there is a dual diagnosis of both mental health issues and a learning disability or autism. One advocate described it as “dehumanising for young people to hear arguments as to whether they are covered by health or social care”.

Under sections 85, 86 and 86A of the Children Act 1989, local authorities are required to arrange for visits and the provision of support to under-18s who are accommodated in NHS or independent hospitals for more than three months. The authority must make arrangements to visit the child, take such steps as are reasonably practicable to enable them to determine their welfare is “adequately safeguarded and promoted” and consider what action might need to be taken. However, advocates felt that children in these settings were not always prioritised because they were seen as being ‘safe’. Children were often not given social workers which could negatively impact discharge planning.

Even for children who were already looked after by a local authority under section 20 or were in care under section 31 of the Children Act 1989 prior to admission, the process seems to be disjointed. Of the 18 NHS Foundation Trusts we contacted, only 5 had recorded information on the number of child inpatients who were in the care of children’s services.

The process of discharge can be particularly difficult when a child turns 18 as different legislation applies and services are organised by different teams at a local level. The support provided is very different and there can be a lack of continuity for the child. Having built up a trusting relationship with an advocate they might wish for that advocacy relationship to continue in the adult setting or
in the community but unless that advocate is also working in the hospital to which they are moving, or they live locally, this is unlikely to be possible. There is also no requirement for local authorities to support parents or carers financially to travel to out-of-area placements once their child turns 18.

Impact of COVID-19

The pandemic has had, and continues to have, a significant impact on children and young people’s mental health and access to mental health services, leading to concerns that more people will end up in mental health detention and for longer periods.\(^59\)

In addition, a number of existing problems facing children and young people in hospitals have been exacerbated by the response to COVID-19, including delayed discharges, contact with family and friends and access to advocacy. For many children, face-to-face communication is vital for engagement and while many advocates tried alternatives such as putting up posters, sending letters, WhatsApp calls or online drop-ins, all felt that this was not an adequate substitute for their regular physical presence, especially when first meeting a young person.\(^60\)

“A face-to-face presence on the units is important for engagement levels and other technologies do not seem to be working as well for initial engagement with a young person. Once they have met you in person they are much more likely to want to text you or speak via phone/video call etc but we are unable to do any visits. It is also hard helping them to appeal without being able to support them to complete forms and meet with them and their solicitor for instance.”

Remote access also relies heavily on facilitation by medical staff, some of whom advocates told us would not facilitate video calls as they felt they were not appropriate. Pressures on staff meant that phone calls to the wards would go unanswered. All agreed that the response to COVID-19 had made it extremely difficult to promote independent advocacy.

“We were always a presence on the wards and this helped with relationship-building and often meant we were there at the time the young person needed us. But we are not there now so it gets forgotten about and we are reliant on staff reminding children.”

The concerns raised by advocates echoed those raised in separate research on the impact of lockdown measures which has highlighted the weakening of existing safeguards for children in hospitals. In June 2020, the Joint Committee on Human Rights (JCHR) published a report, *Human rights and the government’s response to COVID-19: the detention of young people who are autistic and/or have learning disabilities*,\(^61\) which found that young people’s rights were at risk through: unlawful blanket bans on visits; the suspension of routine inspections; increased use of restraint and solitary confinement; and the vulnerability of those in detention to infection. In October 2020, the Children’s Commissioner for England released a report highlighting that during lockdown family visiting was impossible or seriously constrained; and children had restricted access to independent advocacy. The Commissioner found a 67% drop in the number of advocates attending wards.\(^62\) Both reports illustrate the extent to which failures in protecting the rights of children in mental health inpatient care were exacerbated by the response to COVID-19.
Conclusion

Many of the experiences shared in this report illustrate longstanding concerns about mental health inpatient care. Children and young people are kept in hospital for too long, without sufficient understanding of plans for their care and treatment and of their rights more generally. Too many are placed miles from their homes, far from family and support networks, without properly trained staff and at risk of harm. A lack of a child-centred, rights-based approach in some settings can leave children feeling isolated, frustrated and bored. For some, far from providing therapeutic care which helps children recover and get well, mental health hospitals can cause further harm, where there are high levels of trauma and suffering through excessive reliance on coercive rules, restraint, seclusion and segregation.

These issues are not new and many of the solutions require fundamental change that can be difficult to achieve in a system that is complex, disjointed and chronically underfunded. What is clear, however, is that there needs to be urgent consideration of how the existing system of safeguards can be strengthened, including the protections offered to children both before and after admission. The inequality in legal protections for children admitted informally to inpatient care, combined with ongoing concerns about the grounds under which they may be admitted, is in urgent need of review, as is children and young people’s access to independent advocacy.

Good quality advocacy is an essential safeguard for children and young people, as they can benefit from having someone explain and help uphold their rights, or support them to express their needs and wishes where they are not able to do so themselves. But at present advocacy is not available to all and for those legally entitled to it, access is too reliant on the systems and processes put in place by individual providers and individual members of staff.

As the Care Quality Commission has recognised, we need to see “a strengthening of the safeguards that protect the safety, welfare and human rights of these people whose situation has rendered them highly vulnerable”. We need regular “external and independent scrutiny” to counter the development of closed cultures in some of the hospitals treating children and young people.63

It is deeply regrettable that in 2020 we have to make the case for children and young people to be treated and supported as close to home as possible and to be cared for in settings designed and staffed for their age and needs, and which welcome, seek out and respond with energy and enthusiasm to their views and experiences. Children and young people across the country trust their independent advocates with their concerns and their hopes, and they work with them to bring about change.

We are sorry the global pandemic stopped us hearing first-hand from children and young people, but we are most grateful to all of the advocates who so powerfully communicated what matters to the children and young people they serve.
Next steps

Having heard from advocates about the concerns and matters which children and young people take to them, and reviewing data and investigations into the treatment of children in mental health units, there are some changes which especially stand out as urgent and long overdue. These are set out below, and are limited to those most closely aligned to the issues children and young people shared with their advocates.

Many official pledges made in previous years – see our timeline on page 7 – have not yet materialised for children and young people. Too many children and young people are not getting the help they need to stay well at home, and when they do require hospital care and treatment, the location and quality of this is too often substandard.

We are still waiting for the implementation of the Mental Health Units (Use of Force) Act 2018 and the government’s promised White Paper on mental health. Both could significantly improve the protection of children’s rights in mental health units.

What must change

Legal protections

- Children admitted to mental health institutions on an informal basis must have the same legal protections as those children detained under the Mental Health Act 1983.
- As recommended by the Mental Health Act 1983 review, the government should undertake further consultation on the ability of parents to consent to admission and treatment for those under 16. Children and young people with direct experience of being admitted to a mental health unit must be at the heart of this consultation.
- There must be a statutory presumption that children will be cared for and treated in mental health units close to home.
- Legislation which already supports children’s care and treatment in wards and surroundings appropriate to their age must be implemented, with an end to children being placed on adult wards or in other environments which cannot meet their needs.
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Relationships with family and friends

- All providers of inpatient services should ensure children are able to have regular visits from family and friends and must ensure there are private, comfortable indoor and outdoor facilities in which they can enjoy time with them. Arrangements in response to the COVID-19 pandemic must ensure children’s right to respect for private and family life is properly balanced with their (and other’s) health rights. As with all aspects of their care and treatment, children’s own views, wishes and feelings about maintaining their relationships with the people important to them must be elicited and taken seriously.
- Local authorities should make financial support available for family members visiting hospitals through a system that is accessible, timely and non-stigmatising.

Understanding and using rights

- All providers of inpatient services should ensure that accessible information is available to all children and young people, whether they are informal patients or have been detained, which allows them to understand and use their rights.
- All staff working with children in mental health inpatient care should receive training on the relevant legal frameworks and children’s rights.
- Hospitals must work with children and young people to ensure a wide range of ways are available for them to communicate their views, wishes and feelings – about their individual care and treatment and wider policies and practice. This could include post boxes on wards and dedicated phone lines for accessing independent advocates.
- The government should undertake an independent review of children and young people’s views and experiences of the statutory complaints procedure, including their access to independent advocates.

Independent advocacy

- All children and young people receiving any kind of mental health support service should have an active (opt-out) offer of help from an independent advocate. This proactive offer of advocacy should also be available to young people before they move from CAMHS to adult mental health services or support in the community. In addition, the right to access help from an advocate should be actively promoted when there is a risk of rights violations, including after any use of restraint, segregation or seclusion.
- Providers should ensure that advocates are supported to have a physical presence in hospitals, including a means of regular access and a dedicated room in which they can talk to children and young people confidentially.
- The availability and quality of independent advocacy services for children and young people should be part of every Care Quality Commission inspection, and an explicit part of inspection reports.

Children’s rights monitoring

- NHS England should regularly collect and publish national data on children and young people’s views and experiences of mental health services as inpatients, including data on the types of, and reasons for, admission. Children and young people, their families and independent advocates should be consulted about the development of a national data set which helps to monitor the protection of children’s rights in inpatient mental health services.
Appendix I

Mental health hospitals

Mental health services for children and young people aged under 18 (known as ‘Child and Adolescent Mental Health Services’, or CAMHS) cover a wide spectrum of care, ranging from general advice and support given by general practitioners (GPs) and health visitors to specialist care, including the provision of in-patient psychiatric care. CAMHS in England offer care at four levels to children and young people with mental health problems who require hospital admission and include general services; specialist units for different groups, such as eating disorders and learning disabilities; specialist units for differing levels of need, such as psychiatric intensive care units (PICUs), low secure units and medium secure units; and adolescent forensic units.

Different levels of service exist depending on the level of need of the child or young person:

- **Medium secure services** accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who pose the highest risk of harm to themselves and others, including those who may have committed serious crimes.

- **Low secure services** accommodate young people who pose a lower but significant level of risk to themselves and others.

- **Psychiatric intensive care units** (PICU) are for children experiencing short-term behavioural disturbance (such as serious risk of either suicide or running away with a significant threat to safety) or those being assessed before moving to a long-term unit or returning home.

- **Children’s (for children aged 13 and under) and general adolescent (for children aged 13-18) services** provide inpatient care without the need for enhanced physical or procedural security measures.

All children’s mental health inpatient provision is commissioned nationally by NHS England.
How children are admitted to inpatient units

The Mental Health Act 1983 (MHA) outlines the circumstances in which individuals can be admitted to hospital and treated for a ‘mental disorder’ without their consent. However, detention under the MHA is intended to be used as last resort and children and young people can be admitted to hospital as ‘informal’ patients, without the formalities and procedures required for detention under the Act. The Mental Health Act 1983: Code of Practice (MHA Code of Practice) states that when practitioners are considering whether detention under the MHA (often referred to as being ‘sectioned’) is necessary, they ‘must always consider the alternative way of providing treatment and care’, including informal admission.

Determining the circumstances in which a child under 18 can be admitted informally engages a complex area of law. In summary, a child can be admitted on the basis of:

a) their consent, but only if they are able and willing to give consent, which requires consideration of their competence (if under 16) or capacity (if aged 16 or 17);

b) their parent’s consent, but only where the child is not able to make a decision about their care and treatment and the decision is within the ‘scope of parental responsibility,’ which will include consideration of whether there is a deprivation of liberty (the extent to which parental consent can legally be used to authorise what would otherwise amount to a deprivation of liberty has been subject to debate and legal proceedings in recent years and remains an area of contention); or

c) for 16 and 17 year-olds who lack capacity as defined by the Mental Capacity Act 2005, provided that this does not amount to a deprivation of liberty.

In order to detain anyone under the MHA, it is necessary to show that they are “suffering from a mental disorder of a nature or degree” that warrants their detention in hospital for assessment or treatment and that without this they pose a risk to their own safety or that of others. Under section 2, individuals are detained for up to 28 days. Under section 3, they can be detained for up to six months, which can be renewed for another six months and then on a yearly basis.

For a child to be detained under the MHA they should be seen by an Approved Mental Health Professional (who is usually, but not always, a social worker) and two psychiatrists - one of whom should have a specialism in child mental health. In an emergency, patients can be detained for up to 72 hours under section 4 if only one doctor is available. The first principle of the Mental Health Act 1983: Code of Practice is that “when it is possible to treat a patient safely and lawfully without detaining them under the MHA, the patient should not be detained”.

There are also several ‘forensic sections’ of the MHA which relate to those involved with the criminal justice system. These allow for a court to send someone to hospital for assessment or treatment before trial, to send someone to hospital instead of to prison, or to be transferred from prison to hospital. In rarer circumstances, an order may be made by the High Court for a child to be detained in a psychiatric or medical facility under the inherent jurisdiction of the court for the purposes of emergency medical treatment (for example, children with anorexia).
Deprivation of liberty and consent

The ‘deprivation of liberty’ legal framework aims to ensure that people are not arbitrarily detained. Article 5 of the European Convention on Human Rights, which has been incorporated into English law under the Human Rights Act 1998, states that everyone has the right to liberty and can only be deprived of this in limited circumstances and subject to strict legal procedures.

The case of ‘Cheshire West’ confirmed the three conditions that must be met for a deprivation of liberty to occur:

1) the person is confined;
2) there was no valid consent to the confinement; and
3) the state is responsible for the confinement.

The question as to whether a child or young person is confined is decided by comparing the restrictions imposed on them to those that would ordinarily be imposed on someone that age. For example, the constant supervision of a 10 year-old child may be unlikely to amount to a confinement whereas for a 12 year-old it might. For 16 and 17 year-olds, the Supreme Court held that they will be confined if they are under continuous supervision and control, and are not free to leave (the ‘acid test’).

If a 16/17 year old has the capacity to consent to the confinement and gives their consent, there will be no deprivation of liberty. If they do not or cannot consent, then they will be deprived of their liberty and it is not possible for their parent/s to consent to their confinement on their behalf – instead they will need to be detained under the MHA for their admission to be lawful.

A child aged under 16 with the competence to make such decision can consent to their confinement (in which cases there is no deprivation of liberty) or, unlike for 16 and 17 year olds, parents can consent on their child’s behalf if the restrictions fall within the ‘zone of parental control’ for a child of that age (who does not have a disability). For children who are the subject of care orders, an application must be made to court, because neither the local authority nor the parents can consent to a child’s confinement.
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Endnotes

1 While many reports looking at mental health care will include small consultations with children and young people, for example those by the Care Quality Commission and Children’s Commissioner for England, there is little published work specifically aimed at understanding the full nature of the children and young people's experience of mental health inpatient care. The following provide a useful overview: Children’s Commissioner for England (2017) Children’s Voices: A review of evidence on the subjective well-being of children with mental health needs in England, October 2017 and Children’s Commissioner for England (2017) Children’s Voices: A review of evidence on the subjective well-being of children in detention in England

2 Mental Health Act 1983 section 1 (2)

3 The Mental Health Act Code of Practice includes ‘behavioural and emotional disorders of children and young people’ in the list of ‘clinically recognised conditions’ which could fall within the definition of mental disorder. See Mental Health Act 1983: Code of Practice (2015) Department of Health, para 2.5

4 See UN Convention on the Rights of the Child, Article 1 and Children Act 1989, section 105


6 The proportion of children with a ‘probable mental disorder’, including emotional disorders, behavioural disorders, hyperactivity disorders, and less common disorders such as autism spectrum disorders and eating disorders, has risen in boys aged 5 to 16 from 11.4% in 2017 to 16.7% in July 2020 and in girls from 10.3% to 15.2%.

7 Children and Young People’s Mental Health Coalition (2020) CYPMHC annual report 2020

8 Centre for Mental Health (2020), Covid-19 and the nation’s mental health: Forecasting needs and risks in the UK, July 2020

9 Children and Young People’s Mental Health Coalition (2020) CYPMHC annual report 2020, p 5

10 NHS England, Children and young people webpage


12 Department of Health and NHS England (2015) Future in mind: promoting, protecting and improving our children and young people’s mental health and wellbeing; Association of Directors of Adult Social Services, Local Government Association and NHS England (2015) Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition; Department for Health (2012) Transforming care: a national response to Winterbourne View Hospital: Department of Health Review Final Report; NHS England (2016) Implementing the Five Year Forward Plan for Mental Health, states that: “Inappropriate use of beds in paediatric and adult wards will be eliminated. All general inpatient units for children and young people will move to be commissioned on a ‘place–basis’ by localities, so that they are integrated into local pathways. As a result, the use of in–patient beds should reduce overall, with more significant reductions possible in certain specialised beds”; NHS England (2020) NHS long term plan.

13 It is important to note that existing NHS data is incomplete, difficult to access and often contradictory. For more detail and links to sources of data see Article 39 (2020) Children in hospital (mental health) Statistics Briefing

14 National Audit Office (2018) Improving children and young people’s mental health services.

15 Education Policy Institute (2017) Inpatient provision for children and young people with mental health problems

16 Children’s Commissioner (2019), Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals


19 Care Quality Commission, Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition, October 2020

20 As reported in Daily Mail, ‘Teenager who spent four months in a now closed children’s mental health hospital unit claims staff let bloodied patients hurt themselves while they ‘sat in their office drinking coffee’, 27 January 2020. For more information around the circumstances surrounding the deaths of people in mental health inpatient care, see INQUEST (2019), Briefing: Mental Health Act Reforms; INQUEST (2016) INQUEST’s submission to the CQC review of investigations into deaths in NHS Trusts; and INQUEST (2015), Deaths in mental health detention: An investigation framework fit for purpose?

21 NHS England, Children and Adolescent Mental Health Service (CAMHs) Inpatient Services
Mental Health Services Tier 4 (CAMHS T4): general adolescent services including specialist eating disorder services

18s' mental health care is planned in accordance with the CPA. See, for example, NHS England, (CETRs) may be used.

If a problem, a learning disability or autism needs to be investigated credible allegation of abuse, it should be passed on to the relevant authorities. The right to information includes information (which must be given orally and in writing) about:

- the section of the MHA 1983 under which the adolescent is detained;
- their rights to apply to the First-tier (Mental Health) Tribunal ('the tribunal') and other powers of discharge;
- treatment provisions under the Act; and
- the role of the Care Quality Commission (CQC).

Section 132 of the Mental Health Act 1983 outlines the 'Duty of managers of hospitals to give information to detained patients'. The right to information includes information (which must be given orally and in writing) about:

- the section of the MHA 1983 under which the adolescent is detained;
- their rights to apply to the First-tier (Mental Health) Tribunal ('the tribunal') and other powers of discharge;
- treatment provisions under the Act; and
- the role of the Care Quality Commission (CQC).

The detention of a person who is ill in inappropriate physical and medical conditions could amount to a breach of Article 3. MS v UK [2012] ECHR 804. Article 3 also establishes a duty to both protect children from ill-treatment but also investigate credible allegations of ill-treatment MS v Croatia (No 2) [2015] ECHR 196.

This covers, among many other things, contact with family and the development of relationships with others. Where a child is detained in hospital this will be an interference with their, and their parents' right to respect for family life. Any such interference must be lawful, have a 'legitimate aim' and be 'necessary and proportionate'.

30 ZH (Tanzania) v Secretary of State for the Home Department [2011] UKSC 4

31 Mental Health Act 1983: Code of Practice, s 6.1
32 Mental Health Act 1983: Code of Practice, s 6.8
33 Mental Health Act 1983: Code of Practice, s130A–130L
34 Mental Health Act 1983 section 120(4). See also Care Quality Commission, Complain about the use of the Mental Health Act and Mental Health Act 1983: Code of Practice paras 4.54 – 4.64 for guidance on complaints
35 Mental Health Act 1983: Code of Practice, para 6.16
36 Chapter 4 of the Mental Health Act 1983: Code of Practice includes guidance on complaints.
39 Care Quality Review (2019) Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism Interim report
40 For those with learning disabilities and/or autism, NHS England’s policy on Care, Education and Treatment Reviews (CETRs) may be used.
41 Mental Health Act 1983: Code of Practice, para 34.3. NHS England’s specifications for Tier 4 services require that under-18s’ mental health care is planned in accordance with the CPA. See, for example, NHS England, Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): general adolescent services including specialist eating disorder services, 5.2.1.
42 MIND Briefing, Leaving hospital, 2020
43 VS v St Andrew’s Healthcare [2018] UKUT 250 (AAC), para 19
44 Figures provided by Ministry of Justice in response to Article 39 Freedom of Information request – 200921031, 14 October 2020
45 Mental Health Act 1983: Code of Practice, para 1.4
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47 Where a child is detained in hospital this will be an interference with their, and their parent/s’, right to respect for family life. Any such interference must be lawful, have a ‘legitimate aim’ and be ‘necessary and proportionate’.

48 Mental Health Act 1983: Code of Practice, para 19.122

49 “Local areas, including commissioners, local authorities, police and providers, should work together better to make sure that people receive the right care across organisations, including making sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the MHA.” Care Quality Commission (2015) Mental Health Act Code of Practice 2015 An evaluation of how the Code is being used p 3

50 Figures provided by NHS England in response to Freedom of Information request, 3 September 2020, Ref: FOI-2003-1157432. ‘Out of area’ relates to the Children’s Commissioning Group hub area in which the child lives. is

51 The definition of ‘inappropriate’ did not just look at distance because ‘more specialised in-patient services would normally serve a larger geographical area’. See National Audit Office (2018) Improving children and young people’s mental health services, para 2.10

52 Children’s Commissioner (2019), Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals, p18

The Mental Health Act 1983: Code of Practice defines seclusion as: “the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance” but there is no specific time limit. Prolonged seclusion is over a period of more than 48 hours. Whereas long-term segregation is described as required “to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multidisciplinary review and...commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis”

53 There is currently no publicly available disaggregated data on the ages of children subject to restrictive interventions.

54 NHS Digital Mental Health Bulletin 2018-19 Reference Tables, Table 7.1 at

55 Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions

56 When a child or young person’s stay is for 3 months or longer, the hospital must inform the local authority and the authority must then take such steps as are reasonably practicable to enable them to determine’ whether the child’s welfare is adequately safeguarded and promoted’ and consider what action might need to be taken. The authority must make arrangements to visit the child and guidance on visits outlines that some children may need the support of an advocacy services ‘skilled in the methods of non-verbal communications’. See Department for Education and Department for Health (2017) Statutory visits to children with special educational needs and disabilities or health conditions in long-term residential settings: Statutory guidance for local authorities, health bodies and health or educational establishments

57 In accordance with Visits to Children in Long-Term Residential Care Regulations 2011

58 Children’s Commissioner (2019), Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals

59 For example, 42% of people with pre-existing mental illnesses reported that their mental health had declined during the pandemic due to reduced support from mental health services. See Rethink Mental Illness (2020), Access to NHS mental health services for people living with severe mental illness and Rethink Mental Illness (2020), How Covid-19 limited my access to mental health support

60 NHS guidance from May 2020 Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic outlined that “those with a duty to support the patient in accessing in services should consider if there are any barriers to the patient being able to access IMHA services using digital technology means (eg accessibility issues) and should make reasonable efforts to overcome them.”

61 Joint Committee on Human Rights (2020) Human Rights and the Government’s response to COVID-19: the detention of young people who are autistic and/or have learning disabilities


63 Care Quality Review, ‘Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism Interim report’

64 Diagram adapted from Heidi Hales, Louise Warner, Jared G Smith, Annie Bartlett (2018) Secure settings for young people: a national scoping exercise, St Georges, University of London

65 Child and Adolescent Mental Health Services (CAMHS) Report, NHS England, July 2014, describes the range of Tier 4 services (pp11–12).

66 NHS England, Service Specification No: 170022/5 - Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder services

67 Section 1(2) of the Mental Health Act 1983 defines this as ‘any disorder or disability of the mind’.

68 See Mental Health Act 1983 section 131(1)


70 Mental Health Act 1983: Code of Practice, para 14.11.
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Children under the age of 16 can consent to admission if they have ‘sufficient understanding’ to ‘understand fully what is proposed’ (sometimes known as ‘Gillick competence’ from the case of Gillick v West Norfolk & Wisbeck Area Health Authority, 1986)

Under the Mental Capacity Act 2005, young people aged 16 or over are assumed to have capacity to make their own decisions unless they are assessed and found to lack capacity. Young people aged 16 or 17 can be admitted to hospital and treated for their mental disorder on the basis of their consent, if they are able and willing to give it. In such cases their consent ‘will be sufficient authority for their admission to hospital and/or treatment for mental disorder’. Mental Health Act 1983: Code of Practice, para 19.21.

See summary of Re: D (A Child) and comment from 39 Essex Chambers

The Mental Health Act 1983: Code of Practice notes (para 14.16) that notwithstanding a person’s consent, compulsory admission under the MHA 1983 should be considered where there is ‘a strong likelihood that they will have a change of mind about informal admission either before, or after they are admitted, with a resulting risk to their health or safety or to the safety of other people’.

Mental Health Act 1983, s2(4)
Mental Health Act 1983 s20

Before being admitted a child must also be assessed by a clinician at the facility to which the child is being admitted.

Department of Health, Mental Health Act 1983: Code of Practice, 2015

The specifications are available at: www.england.nhs.uk/commissioning/specservices/npc-crg/group-c/c03/

P v Cheshire West and Cheshire Council; P and Q v Surrey County Council [2014] UKSC 19

These are sometimes referred to as the ‘Storck limbs’ or ‘Storck components’ as they were first identified in the case of Storck v Germany (2005) before the European Court of Human Rights

If cases arise in which parents make private arrangements with an independent hospital for the admission of their child, the question would be whether the state knows, or ought to know, about the deprivation of liberty

Re A-F (Children) [2018] EWHC 138 (Fam)

Re D (A Child) [2019] UKSC 42

Re D (A Child) [2019] UKSC 42

See Chapter 19 of the Mental Health Act 1983: Code of Practice