

# Children and Young People and the Mental Health Act 2007<sup>1</sup>

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On 19th July this year the *Mental Health Act 2007* ('the MHA 2007') received Royal Assent. When it comes into force the MHA 2007 will introduce wide-ranging amendments to the *Mental Health Act 1983* ('the MHA 1983'). Although there have been significant improvements to the original Bill, the MHA 2007 retains controversial provisions such as the use of a broad definition of mental disorder and the creation of community treatment orders<sup>3</sup>.

The MHA 2007 has been described by the Mental Health Alliance '*as a missed opportunity for legislation fit for the twenty-first century*'<sup>4</sup>. This charge is particularly apt for children and young people<sup>5</sup>. The need for legal reform in relation to the treatment and care of children and young people with mental health problems has long been recognised. For example, in 1999 the Committee commissioned by the Government to advise on the reform of the MHA 1983 noted that there was a general agreement on the need for clarification in this area of law<sup>6</sup>. Although the MHA 2007 will clarify some issues, there remain a '*bewildering variety of overlapping methods to authorise both admission, detention and treatment against a young person's will*'<sup>7</sup>. Furthermore, the *Mental Capacity Act 2005* ('the MCA 2005'), coming into force in October this year, will introduce an additional layer of complexity as most of its provisions apply to 16 and 17 year olds but not those under 16<sup>8</sup>.

This article considers three areas in which the MHA 2007 has introduced some positive change in relation to children and young people: admission to hospital, age appropriate facilities and advocacy. It also highlights issues of continuing concern. It does so in the light of the *United Nations Convention on the*

1 Readers should note that this article was accepted for publication prior to the publication of the revised draft code on 25 October 2007 (available at [www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_079842](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_079842)). This draft code replaces the draft illustrative code to which reference is made in this article.

2 Mental Health and Human Rights Consultant; Consultant to the Children's Commissioner for England.

3 For an analysis of the concerns about Community Treatment Orders and children and young people, see the joint paper by the Office of the Children's Commissioner for England and the Royal College of Psychiatrists April 2007 available at: [www.childrenscommissioner.org/adult/ccnews/consultation.cfm?id=1971](http://www.childrenscommissioner.org/adult/ccnews/consultation.cfm?id=1971). See also the Joint Committee on Human Rights, *Legislative Scrutiny: Seventh Progress Report*,

*Fifteenth Report of Session 2006–7*, HL Paper 112, HC 555, 30th May 2007.

4 For the Mental Health Alliance's report on the Mental Health Act 2007 see: [www.mentalhealthalliance.org.uk/mentalhealthbill/Alliance\\_MHAct07\\_Final\\_Report.pdf](http://www.mentalhealthalliance.org.uk/mentalhealthbill/Alliance_MHAct07_Final_Report.pdf)

5 This paper refers to 'children' as those under 16 and 'young people' as 16 and 17 year olds.

6 Expert Committee, *Review of the Mental Health Act 1983*, November 1999, 112.

7 Jane Fortin, *Children's Rights and the Developing Law*, 2nd edition, (2003) Cambridge University Press, 142.

8 See section 2(5) MCA 2005 in relation to those under 16. Not all provisions apply to 16 and 17 year olds. For example a person must be 18 in order to make an advance refusal of treatment (section 24 MCA 2005).

*Rights of the Child* ('the Convention'), which was ratified by the UK government in 1991 and applies to all those aged under 18<sup>9</sup>.

## United Nations Convention on the Rights of the Child

Although the Convention is not part of UK domestic law, it is important because by ratifying it, States Parties (i.e. governments) agree to '*undertake all appropriate legislative, administrative, and other measures*' to implement the range of civil and political, economic, social and cultural rights set out in the Convention<sup>10</sup>. In the UK, the Convention is considered to have '*an increasing influence on the Government's and other policy makers' and practitioners' commitment to children's perspectives*'<sup>11</sup>. Furthermore, the Convention can be taken into account by the both domestic and European courts. Increasingly the European Court of Human Rights has referred to the Convention's provisions as '*being of persuasive authority*' when reaching decisions<sup>12</sup>. However the application of the Convention to children and young people with mental health problems is a neglected area. Although there is some discussion on this area in the UK Government's latest report to the Committee on the Convention on the Rights of the Child, which monitors compliance with the treaty, it is very limited<sup>13</sup>.

The Convention recognises that children are in need of protection but also emphasises that they are individuals with their own views and interests and should be able to exercise their rights. (The convention uses the term 'child' to include children and young people up to the age of 18). Thus two core principles of the Convention are that the best interests of the child is the primary consideration in all actions concerning children (Article 3), and that in all matters affecting them, children's views must be '*given due weight in accordance with the age and maturity of the child*' (Article 12). A key concept of the Convention is the '*evolving capacities*' of the child. This concept highlights the importance of ensuring that as children grow and mature, their views and wishes should be given greater weight. Article 5 (Parental guidance and the child's evolving capacities) provides:

*'States parties shall respect the responsibilities, rights and duties of parents... to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.'*

Thus parental direction and guidance has its limits – parents do not have absolute rights over their children. Article 5 seeks to provide a balance between respecting the responsibilities of parents to make decisions on behalf, and in the best interests, of their child and ensuring that the child is able to exercise his or her rights. The concept of the '*evolving capacities of the child*', which takes into account the child's age and maturity, is central to achieving the right balance<sup>14</sup>.

## Admission to hospital

Patients under the age of 18 can be detained under the MHA 1983. However, as the Joint Scrutiny Committee on the Draft Mental Health Bill 2004 noted, it is more common for them '*to be treated under common law or under the authority of those with parental authority who can override the young person's refusal*'.

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9 See Article 1.

10 Article 4.

11 Clem Henricson and Andrew Bainham, *The child and family policy divide: Tensions, convergence and rights*, Joseph Rowntree, 2005:  
[www.jrf.org.uk/bookshop/eBooks/1859353312.pdf](http://www.jrf.org.uk/bookshop/eBooks/1859353312.pdf)

12 Fortin (*op. cit* footnote 7), 49.

13 Available at:  
[www.everychildmatters.gov.uk/strategy/uncrc/ukreport/](http://www.everychildmatters.gov.uk/strategy/uncrc/ukreport/)

14 See *Implementation Handbook for the Convention on the Rights of the Child*, UNICEF (2002) 85–92.

When this happens the safeguards set out in the MHA 1983 do not apply to them<sup>15</sup>.

### Informal admission: context

An area that has caused confusion and uncertainty amongst mental health professionals is the circumstances in which it is appropriate to rely on parental consent to admit a person under the age of 18 to hospital for treatment for mental disorder. *Re W* provides authority for holding that those with parental responsibility may agree to informal admission, overriding the refusal of their child. In *Re W*, Lord Donaldson stated:

*'...no minor of whatever age has the power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court'*.

However, he added:

*'...Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with age and maturity of the minor.'*<sup>16</sup>

Thus, although the minor's refusal would need to be taken into account, case law appears 'to signpost to professionals that overriding a competent child or young person's opposition to major psychiatric treatment decisions could now take place outside the framework of statutory protection, providing parental consent was obtained'<sup>17</sup>. Another area of concern is the relationship between the parents and their child. Asking a parent to override the wishes of the child by agreeing to the admission might create, or exacerbate existing, tensions in their relationship.

The introduction of the *Human Rights Act 1998* provides a strong argument for adhering to the statutory framework for compulsory powers set out in the MHA 1983 rather than relying on parental consent. Richard Jones suggests:

*'It is likely that the Court [European Court of Human Rights] would hold that a parental consent to the admission of a mentally competent child to a psychiatric hospital violates Art.5 if the child objects to the admission.'*<sup>18</sup>

Overruling the views of children and young people who are able to make such decisions for themselves also engages rights under the Convention. For example it would be at odds with Article 12 of the Convention, which requires the views of the child to be given due weight in accordance with the child's age and maturity.

### Amendments to the MHA 1983

Although section 131(2) MHA 1983 provides that patients aged 16 and 17 who are capable of expressing their own wishes can agree to their informal admission, irrespective of their parents' wishes, it does not address a young person's refusal of admission. Recognising that such situations can raise 'complex ethical problems' and be 'stressful for all concerned'<sup>19</sup>, the Government's Draft Mental Health Bill 2004 removed the power of those with parental responsibility to override the refusal of treatment by patients aged 16 or

15 HL Paper 79-1, HC Paper 95-1, March 2005, 74.

16 *Re W (A Minor) (Medical Treatment)* 1992 4 All ER 627.

17 Anthony Harbour, 'Young People and Psychiatric Treatment' – paper presented to Children and Mental Health and Human Rights Seminar, Law School,

Northumbria University, 22 June 2007.

18 Richard Jones, *Mental Health Act Manual*, Thomson, Sweet & Maxwell, 10th edition, 486.

19 *Reforming the Mental Health Act, Part 1: The new legal framework*, (December 2000) CM 5016–1 paragraphs 3.70–3.72.

17<sup>20</sup>. However this provision was not included in the Mental Health Bill 2006 published in Parliament and it was only in response to concerns raised during the House of Lords debates on the Bill, that the Government introduced what is now section 43 MHA 2007. This will clarify the position for patients aged 16 or 17 by amending section 131(2) of the MHA 1983. The new sections 131(2)(3)(4) will provide that patients aged 16 or 17 who have the capacity to make such decisions can either consent or refuse to arrangements for their informal admission to hospital being made<sup>21</sup>. The young person's capacity will be determined in accordance with the Mental Capacity Act 2005<sup>22</sup>. Specific provision is made in relation to the young person's refusal:

*'If the patient does not consent to the making of the arrangements, they may not be made, carried out or determined on the basis of the consent of a person who has parental responsibility for him'. (Section 131(4))*

### **Situation for 'Gillick competent' children**

While the MHA 2007 clarifies the situation for 16 and 17 year olds who are capable of making decisions about their admission to hospital, 'Gillick competent'<sup>23</sup> children are not mentioned. A 'Gillick competent' child has been assessed as having attained a sufficient level of maturity, understanding and intelligence to make such decisions for him/herself. It is therefore unclear why that child should be treated differently from a young person who has capacity to make such decisions. Accordingly, during the Bill's passage through Parliament, arguments were put forward for an amendment to be introduced to make clear that where a child is assessed to have the competence to make decisions about admission to hospital, that child's refusal should not be overridden by a person with parental responsibility. In such cases, as with 16 and 17 year olds, consideration would need to be given to detaining the young person under the MHA 1983.

However the Government declined to introduce such a statutory provision, insisting that the best place to address this issue would be in the Code of Practice. The draft illustrative Code of Practice to the Mental Health Act ('the draft Code'), published in November 2006, advises clinicians that they should not rely on parental consent in the case of children who are 'Gillick competent' and refusing treatment, stating that if the child needs to be detained in order to give treatment for mental disorder then the MHA 1983 should be used.

### **Admission and children and young people lacking capacity/competence**

The MHA 2007 does not address the position of children and young people who lack capacity (16 and 17 year olds) or competence (those under 16). This is left to guidance in the draft Code. However, for the reasons outlined below, the guidance in the current draft Code requires further explanation.

The draft Code includes flow charts intended to assist practitioners in considering all the options available. These suggest that the first consideration for both under 16 year olds who lack competence and those 16 or 17 years who lack capacity is whether the primary purpose of the intervention is to provide medical treatment for mental disorder. (If the answer to this is 'no', powers under the *Children Act 1989* or other procedures may be more appropriate.)

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20 Clause 202 Draft Mental Health Bill 2004.

21 These provisions will come into effect on 1 January 2008 (Mental Health Act 2007 (Commencement No. 3) Order 2007).

22 See section 131(5)(a) MHA 1983 inserted by section 43 MHA 2007.

23 'Gillick competence' refers to a child who has a sufficient understanding and intelligence to be able to understand fully what is being proposed and to be capable of making up his/her mind about the matter. The term comes from *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

The draft Code states that in the case of a 16 or 17 year old who lacks capacity, the MHA 1983 must be used (subject to the conditions being met) where detention in hospital is required and the primary purpose of the intervention is to provide treatment for mental disorder. There is no discussion of, or reference to further information on, what might amount to detention.

For children under 16, if the primary purpose of the intervention is to provide medical treatment for mental disorder, the next question is whether the decision to authorise treatment falls within the 'zone of parental responsibility'. If the proposed intervention does not fall within the zone of parental responsibility (or parental consent is not given), then the MHA 1983 must be used (if the conditions are met). If the proposed intervention falls within the zone of parental responsibility, and the parent consents, the child can be admitted informally.

It is therefore important to know what falls within the zone of parental responsibility and what does not. However, no precise definition is given for this term. The draft Code suggests that it is the 'sort of decision that a parent would be expected to make' having regard to what is considered to be normal practice, adding that the parameters of this zone will depend on a number of factors, including the nature and invasiveness of the proposed intervention, the age and maturity of the child, whether the child is resisting and the extent to which the child's liberty will be curtailed.

### **The zone of parental responsibility and detention**

The connection between the zone of parental responsibility and what might amount to the child's deprivation of liberty is unclear.

To date the leading European Court of Human Rights ('the ECtHR') decision on the detention of a minor is that of *Nielsen v Denmark*<sup>24</sup>, which was decided nearly twenty years ago. In that case the ECtHR held that the hospitalisation of a 12 year old boy for over 5 months did not amount to a deprivation of liberty, but was the responsible exercise of the mother's custodial rights in the interests of her son. Nielsen has been subject to severe criticism for failing to give adequate protection to children's rights<sup>25</sup>. Arguably, in the light of the Convention and more recent ECtHR cases, if the case were heard today it would be decided differently.

Since the decision in Nielsen the case law concerning the detention of adults has developed considerably. In *Storck v Germany*,<sup>26</sup> the ECtHR held that in determining whether a person is detained, it is necessary to consider both the objective element and subjective element. The objective element is the specific situation of the individual, such as the type and duration of the measure. The subjective element is whether the person has 'validly consented to the confinement in question'.

How the objective and subjective elements of detention relate to children and young people has not as yet been considered either by the ECtHR or by the national courts. In his detailed analysis of ECtHR case law concerning deprivation of liberty, Mr Justice Munby concluded in the recent case of *JE v (1) DE (2) Surrey CC and (3) EW*<sup>27</sup> that Nielsen was 'about the proper ambit of parental authority, albeit that it concerned a child placed in a psychiatric institution', and did not assist in assessing whether an adult is detained. So far as the elements relevant to the question of whether there has been a deprivation of liberty, he commented:

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24 (1988) 11 EHRR 175.

26 Application number 61603/00, 16th June 2005.

25 See for example, David Feldman, *Civil Liberties and Human Rights in England and Wales*, Oxford University Press, 2nd edition, 459 and Jane Fortin (footnote 7) at 55.

27 [2006] EWHC 3459 (Fam) para 70.

*'...different considerations may apply in the case of a child where a parent or other person with parental authority has, in the proper exercise of that authority, authorised the child's placement and thereby given a substituted consent...'*<sup>28</sup>

In *Nielsen* the ECtHR acknowledged that the rights of the holder of parental authority cannot be unlimited and that it is incumbent on the State to provide safeguards from abuse. This suggests that whether a child is detained or not will need to be considered in the light of what restrictions would fall within the reasonable exercise of parental responsibility. There is a range of rights under the UN Convention on the Rights of the Child that are relevant to this question. The best interests of the child will be central to this debate. Article 3 of the Convention requires that in all actions concerning children, the best interests of the child is the paramount consideration. However the interpretation of the best interests of the child must be consistent with the Convention as a whole. For example, Article 16 provides that no child shall be subjected to 'arbitrary or unlawful interference with his or her privacy' and the child has the right to protection of the law against such interference. Furthermore, as discussed above, the Convention incorporates the concept of the 'evolving capacity' – Article 5 of the Convention requires the extent of parental guidance and direction to be 'conducted in a manner consistent with the evolving capacities of the child'. Thus what might be considered within the reasonable exercise of parental responsibility for a young child might not be acceptable in relation to a 15 year old teenager even when that teenager lacks the competence to make decisions about his or her treatment and care.

The scope of the zone of parental responsibility is an issue of crucial importance because those children who lack competence to make decisions for themselves, and are admitted on the basis of parental consent, will have fewer safeguards than those who are admitted under the MHA 1983. The right to a review of their detention by a MHRT will not be available to them, nor will they have a right to an independent advocate save in limited circumstances (such as if ECT is proposed)<sup>29</sup>. In the light of the changes introduced by the MHA 2007 to safeguard the rights of adults who lack capacity and are deprived of their liberty,<sup>30</sup> the lack of safeguards for children and young people in similar situations requires attention.

### Age appropriate facilities

Section 31(3) MHA 2007 provides for the accommodation of patients under the age of 18 (whether detained under the MHA 1983 or an informal patient). This provision was introduced by the Government in response to powerful lobbying by children's charities and the Mental Health Alliance, led by YoungMinds, together with strong support from peers and MPs. Section 131A MHA 1983 will require the hospital managers to 'ensure that the patient's environment in the hospital is suitable having regard to his age (subject to his needs)'. In introducing this amendment the then Minister for Health, Rosie Winterton explained:

*'We have used the word "environment" because what matters to a child or young person goes well beyond mere physical segregation from older people, as I am sure right hon. and hon. Members appreciate. By using the word "environment" we can ensure not only that children and young people have separate facilities, but that they are appropriate physical facilities, with staff who have the right training to understand and address their specific needs as children, and a hospital routine that will allow their*

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28 *ibid*, 77.

29 See section 130C(3) MHA 1983 inserted by section 30(2) Mental Health Act 2007.

30 See Chapter 2 MHA 2007, amending Mental Capacity Act 2005.

personal, social and educational development to continue as normally as possible. We do that by using the word “environment”, and by giving hospital managers a duty to ensure that that is the case.’<sup>31</sup>

In order to decide how to fulfil this duty, the hospital managers must consult a person ‘who appears to them to have knowledge or experience of cases involving patients who have not attained the age of 18 which makes him suitable to be consulted’; i.e. a person known to have experience in child and adolescent mental health services<sup>32</sup>. Primary Care Trusts (PCTs) in England (Local Health Boards in Wales) will be required to advise local social service authorities in their area of hospitals providing ‘accommodation or facilities designed so to be specially suitable’ for patients under 18<sup>33</sup>.

When describing the background to the amendment, the Minister referred to the findings of ‘Pushed into the Shadows: young people’s experience of adult mental health facilities’,<sup>34</sup> commenting that this report was ‘extremely timely in highlighting the bad experiences that some young people have had on adult psychiatric wards’. This report showed that not only are children and young people being admitted onto adult wards (despite national policy objectives seeking to prevent this) but that the level of the care provided to them often fell below an acceptable standard. Moreover, in some cases the children and young people’s experiences gave rise to serious concerns about their safety and welfare. Their descriptions also highlighted a persistent failure to recognise the rights of these young patients under the *UN Convention on the Rights of the Child*. For example:

- Failure of staff to involve and inform the children and young people about their care (Article 12 – Respect for the views of the child)
- Many of the children and young people did not feel safe on the wards and some were able to engage in harmful practices while on the wards such as misusing drugs or self-harming (Article 19 – Protection from all forms of violence).

Crucially, *Pushed into the Shadows* showed that children and young people are being admitted inappropriately onto adult psychiatric wards in contravention of Article 37(c) (Protection for children deprived of their liberty). This article requires States to separate children deprived of their liberty from adults ‘unless it is considered in the child’s best interests not to do so’<sup>35</sup>.

## Advocacy

Section 30 MHA 2007 requires that independent mental health advocates are made available to certain ‘qualifying patients’<sup>36</sup>. This term includes patients who are liable to be detained under the MHA 1983 (other than the short term powers such as emergency admission under section 4 and holding powers under section 5 MHA 1983), those subject to guardianship or community treatment orders and those for whom treatment under section 57 (such as psychosurgery) is proposed. Furthermore, patients under the

31 *House of Commons Debate on the Mental Health Bill* 18th June 2007, Col 1144.

32 See paragraph 104 of the Explanatory Notes to the Mental Health Act 2007.

33 Section 31(4) MHA 2007, amending section 140 MHA 1983. See also section 31(2) which amends section 39 MHA 1983 (Information as to hospitals) so that a court may request information from a PCT or local health board in Wales about the availability of accommodation or facilities for patients under 18 when considering its powers to order detention in hospital under Part III of the MHA

1983.

34 *Office of the Children’s Commissioner for England*, January 2007 [www.childrenscommissioner.org/documents/Pushed%20into%20the%20shadows%20report%20final.pdf](http://www.childrenscommissioner.org/documents/Pushed%20into%20the%20shadows%20report%20final.pdf)

35 See *Children’s Commissioner for England submission to the Mental Health Public Bill Committee*: [www.childrenscommissioner.org/documents/MHBillSubmission.pdf](http://www.childrenscommissioner.org/documents/MHBillSubmission.pdf).

36 It inserts sections 130A–130D before section 131 MHA 1983.

age of 18 for whom electro-convulsive therapy (ECT) is being proposed will qualify for such advocacy services whether or not they are detained.

The assistance given to qualifying patients includes ‘*help in obtaining information about and understanding*’ the relevant provisions of the MHA 1983, the person’s rights under these provisions and help in exercising these rights (by representation or otherwise). In relation to medical treatment, such help will cover information about any treatment being given or proposed, why it is being given or proposed, the authority for giving such treatment and the requirements that would apply if the treatment is to be given<sup>37</sup>.

The introduction of the right to advocacy will be of huge importance to those under 18. Many of the young people involved in the *Pushed into the Shadows* report commented on the inadequate information about their treatment and care. Some described feeling remote from the decisions made about them and highlighted the need for a greater provision of independent advocates who could speak up on their behalf<sup>38</sup>.

However, save in cases where ECT or treatment under section 57 is proposed, advocacy will only be available for those who are subject to the compulsory powers under the MHA 1983. This means that there is no requirement to make advocacy available when admission to hospital is being considered. This is a particular concern for individuals under 18. Admission to a psychiatric hospital can be traumatic for any individual, but especially so for children and young people. The assistance of an independent advocate to explain issues such as the person’s rights, the procedures involved and what to expect on admission would be invaluable in helping the child or young person (and where involved, the parents) decide whether to agree to the admission.

As discussed above, children who are not ‘*Gillick competent*’ and are admitted to hospital on the basis of parental consent will not have the right to advocacy. Although it is not clear from the draft Code, it would seem that in some cases (where this does not amount to a deprivation of liberty) young people who lack capacity could be admitted to hospital informally (and treated in accordance with the provisions of the *Mental Capacity Act 2005*). The provisions relating to independent advocacy services will not apply to these young people either.

## Conclusion

While the MHA 2007 is a marked improvement on the Bill originally introduced by the Government, there are still huge concerns about the potential impact of its provisions on people with mental health problems, including children and young people. The additional safeguards such as advocacy and the requirement to provide age appropriate facilities for children and young people are very welcome, although more guidance will be required to ensure that these safeguards are implemented effectively. The group least well served by the MHA 2007 are those children under 16, in particular those considered to lack competence to make decisions for themselves.

Governments are required to take measures to ensure that adults and children alike know about the principles and provisions of the Convention (Article 42). Raising awareness about the Convention rights amongst mental health professionals and all those working with children and young people with mental health problems, as well as parents and the children and young people themselves, will be an important means of safeguarding the dignity and welfare of all children and young people whether subject to the compulsory powers of the MHA 1983 or not.

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37 See section 130B MHA 1983 inserted by Section 30(2) Mental Health Act 2007.

38 *Pushed into the Shadows*, 43.