Written evidence submitted by the Children and Young People's Mental Health Coalition (MHB0056)

The impact of the draft Mental Health Bill on children and young people

Introduction

This is a joint response informed by the National Children's Bureau, British Psychological Society, Centre for Mental Health, Mind, *Just Equality*, YoungMinds, Article 39, UK Committee for UNICEF (UNICEF UK), a working group established by the Children and Young People's Mental Health Coalition.

We welcome the publication of the draft Mental Health Bill, which should result in some positive improvements in the care and treatment of children and young people aged under 18 detained under the Act. The 'Reforming the Mental Health Act' White Paper stated that all reforms to the mental health legislative framework will be applicable to all children and young people, however we have previously raised concerns that little consideration has been given to how the reforms will work in practice for children and young people. It is our view that the draft Bill misses a vital opportunity to strengthen safeguards for under 18 year olds, both those that are detained and those who are admitted informally.

This submission will focus on the question included in the call for evidence on the impact of the draft Bill on children and young people. Throughout this submission, we highlight areas of the draft Bill that need further consideration on how they will protect and promote the rights of children and young people, especially those aged under 16.

Summary

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

- **Addressing racial inequalities:** Whilst we welcome the aim of the Bill to reduce the disproportionate number of individuals from racialised communities subject to detention, we are concerned that action to address racial inequalities has been lost in the draft legislation. Inequalities in the disproportionate use of detentions under the Mental Health Act first emerge in childhood, and any action to address racial inequalities must consider the needs of children and young people.
- **Learning disabilities and autism:** There are specific considerations and additional safeguards to be strengthened for children and young people with learning disabilities and autism. We welcome the aspiration to prevent autistic children and

young people and those with learning disabilities being submitted to mental health inpatient units when there is no clinical need. However, we are concerned that without a clear requirement on both the NHS and local government to provide sufficient, high-quality alternative community provision to meet the needs of these children and young people, this risks being ineffective.

- **Assessing Competency for under 16s:** We are concerned that no statutory mechanism has been put in place in the draft legislation for assessing competency for under 16 year olds. The Independent Review recognised the lack of consistency in establishing competence for under 16s and for this reason, made the recommendation that there should be a statutory test for competence in this context. We believe that such a test should be included on the face of the Bill, accompanied by guidance for practitioners on how to undertake such assessments.
- **Advanced decisions:** The government previously committed to extending advance choice documents to children and young people, yet rather than introducing advance choice documents, the draft Bill gives legal weight to advance decisions under the Mental Capacity Act 2005 for adults detained under the Mental Health Act, meaning that children and young people will be unable to make advanced decisions. We see that advanced decisions should be extended to children and young people aged under 18.
- **Advocacy for informal patients:** We welcome the provisions in the draft Bill to expand the right to access an Independent Mental Health Advocated to all informal patients detained under the Act. However, informal patients will not be captured by the new 'opt-out' system that will be introduced for those detained, meaning that informal patients will still be required to ask for support from an advocate. We believe that the Bill should commit to extending advocacy on an opt-out basis for informal patients.
- **Nominated person:** We welcome the introduction of the nominated person, which will enable children and young people to choose someone who will represent their interests. Further work is needed to clarify the provisions included in the Bill where a child or young people has not chosen a nominated person and what parental consent means in this context.
- **Inappropriate out of area placements and admission to adult wards:** We are concerned that children and young people are still being placed in settings out of area inappropriately and on adult wards, and that the draft Bill does not contain adequate safeguards to address this. We believe that the Bill should be amended to strengthen the requirement for under 16s not to be placed in adult wards, and the requirement to notify the local authority when a young person is placed out of area or in an adult wards should be set out in legislation.
- **Discharge arrangements:** Currently no process is in place to support multi-agency planning. We would like to understand what the statutory mechanism will be to

bring agencies together to ensure children and young people are supported, both while they are in inpatient care and during discharge arrangements.

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

- **Data collection:** There are significant gaps in available data on children in mental health hospitals, and the data that does exist can often be incomplete and difficult to access. There should be an ambition for a much more detailed and useful amount of data to be recorded and reported, which can help to drive improvement.

1. Protecting children's rights

1.1 The UN Convention on the Rights of the Child (UNCRC) is an international legally binding agreement. Article 24 of the UNCRC states that healthcare for children should be as good as possible and children and young people have the right to be both physically and mentally fulfilled. Through Article 24, States have the obligation to provide adequate treatment and rehabilitation for children with mental health and psychosocial disorders while abstaining from unnecessary medication. Article 37 also explicitly sets out duties around the exceptional circumstances of deprivation of liberty, and rights that must be upheld. Across all legislation and policies, governments are to uphold the best interests of the child (Article 3).

1.2 The UK Government has committed to giving due consideration to the articles of the UN Convention of the Rights of the Child when making all new policy and legislation.[1] The Child Rights Impact Assessment is an indispensable tool to ensure that this commitment is respected across government. We would like to understand whether an assessment has taken place for the draft Bill, and if not, for the government to agree to take one forward.

2. Addressing racial inequalities

2.1 A key aim of the reforms is to reduce the disproportionate number of individuals from racialised communities subject to compulsory detention and treatment.[2] Whilst we welcome this aim, we are concerned that action to address racial inequalities has been lost in the draft legislation. No specific actions are included in the Bill that will address the underlying drivers of racial inequalities. In addition, the Inclusive Britain strategy sets out actions the government will take to tackle racial disparities, however reform of the Mental Health Act is not mentioned in this.[3]

2.2 The White Paper set out four guiding principles to the reforms: choice and autonomy, least restriction, therapeutic benefit and treating the person as an individual. The Independent Review noted that the final principle should embed equality into the legislation

such that care and treatment provisions respect individual diversity, including any protected characteristics under the Equality Act 2010.[4] Whilst the White Paper stated these would be embedded into the Act, the guiding principles are missing from the draft Mental Health Bill. It is unclear why the guiding principles have been omitted from the Bill. These principles are a key tool in enabling patients to hold settings to account over their care and in embedding equality in practice. We believe these principles need to be included on the face of the Bill to ensure all patients are protected and their rights upheld.

2.3 We know that inequalities in the disproportionate use of detentions under the Mental Health Act first emerge in childhood. A recent article by The Independent highlighted that Black and mixed-race children accounted for 36% of young people detained in acute mental health services despite making up 11% of the population (based on unpublished data from NHS Benchmarking).[5] Conversely, young Black people make up just 5% of those accessing community-based child and adolescent mental health services.

2.4 What is more, findings from the Office of the Children's Commissioner showed that Black children are less likely to admitted informally than their White peers - around 1 in 10 of these children are admitted informally compared to just over 1 in 3 White children - but are more likely to be held in secure wards or PICUs.[6] It is therefore crucial that any action taken to address racial inequalities considers the specific needs of children and young people.

2.5 Wider systemic change is also required to tackle racism and discrimination to ensure children and young people from racialised groups have better access to early mental health support in the community. Children who experience racism are more likely to experience low self-esteem, high levels of anxiety and depression, and reduced ability to recover from other kinds of trauma.[7] Racism and discrimination also exposes young Black people to multiple and significant risk factors for poor mental health.

Recommendations: The draft Mental Health Bill should be amended to include the guiding principles.

3. Children with learning disabilities and autism

3.1 While we welcome the intention of the Bill to see less people with learning disabilities and autism who do not have co-occurring mental disorders detained, there are specific considerations and additional safeguards to be strengthened for children and young people with learning disabilities and autism.

3.2 Firstly, the population of under 25s has significantly different demographic characteristics than the adult learning disabilities and autism inpatient population. Data from NHS Digital shows that of 1405 inpatients with a learning disability and autism aged

over 25, 77% are male. However, for 18-24 year olds, this drops to 60% and for the 190 patients under the age of 18, 74% are female. There is also a significant difference in the classification of conditions, with under 18s far more likely to be classified as autism only.

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

3.4 There have also been widespread concerns that removing people with autism and learning disabilities from section 3 of MHA will instead make them eligible for detention under different frameworks, including the Mental Capacity Act 2005 if they are 16 or above.[8] Under the Mental Capacity Act's proposed Liberty Protection Safeguards (LPS), those detained are much less likely to be able to access rights and safeguards to protect them, such as court or tribunal reviewing their detention, independent reviews of medical treatment and the rights to complain to the CQC and the right to aftercare. Unlike the current Deprivation of Liberty Safeguards, LPS will apply to young people aged 16 and 17 as well as adults. Unless the draft Mental Health Bill is amended to strengthen safeguards under the Mental Capacity Act, it could substantially weaken systems of independent scrutiny and for challenging detention in psychiatric settings for people with learning disabilities and autism. What is more, we want to highlight the situation for those aged under 16 who are admitted to hospital on the basis of parental consent, but who may not be able to access the safeguards the Act provides due to not being detained under the Act.

3.5 The proposals to place Dynamic Support Registers and Care Education and Treatment Reviews on a statutory basis is a welcome step, but the current proposals do not sufficiently address some of our concerns with how these measures are currently implemented. Given that the measures were introduced by the NHS Long Term Plan and have not led to a clear and sustained reduction in the numbers of children and young people with learning disability and autism detained, the Mental Health Bill is an important opportunity to strengthen their requirements and deliver improved support for children and young people.

3.6 To ensure there are sufficient high-quality services to prevent the escalation of needs, the Bill introduces a duty for Integrated Care Boards (ICBs) and local authorities to ensure that the needs of people with autism or a learning disability can be met. Little detail is provided on what is expected of ICB's and local authorities in relation to this duty, and the duty in its present form does not apply to children at all. The duty on the local authority refers to its 'market function' in the Care Act 2014, however this duty requires the local

authority to ensure an efficient and effective operation of a market in services for meeting adults' needs for care and support, it does not include children. As a result, this risks missing children completely from this duty. We believe this should be amended to include a specific requirement on local authorities and ICBs to work together to develop and deliver services to support children and families, in order to prevent crisis and admission to inpatient care.

3.7 The proposed timelines for CETRs lack the urgency required, 14 days after admission and a review every 12 months for a child or young person with learning disability is insufficient. Where young people between 18 and 25 do not have an Education Health and Care Plan, but would be eligible for one, the requirement on to make a request for an EHC Needs Assessment should be clearly set out.

3.8 While there is currently a significant focus on avoiding admissions, it is not clear if the avoidance of re-admissions is receiving a similar amount of attention and resources. In order to ensure that the system is working to support children and young people holistically and ensure that upon their release from Tier 4 setting multi-agencies are engaged in providing the necessary care required to prevent re-admission, there is a strong need to include the avoidance of re-admissions in the Strategic Service Planning. An important part of this would be down to the Dynamic Support Register which should be adapted to include those who are at risk of re-admission and contribute to a service plan that brings together professionals from across the support network. This will ensure that different agencies are offering a joined-up service and liaising across the relevant Local Authority and will act as an added level of accountability to multi-agency working.

Recommendation: The Mental Health Bill should strengthen the requirements to put in place Dynamic Support Registers and Care Education and Treatment Reviews.

Recommendation: The duty on local authorities and ICBs to ensure they can meet the needs of those with learning disabilities and autism should be amended to include a specific requirement to deliver services for children, young people and their families.

4. Assessing competency for under 16 year olds

4.1 We are concerned that no mechanism has been put in place for assessing competency for under 16 year olds, with no statutory test to assess this. Under the Mental Capacity Act 2005, people aged 16 and over are assumed to have capacity unless a capacity assessment shows otherwise. However, there is no assumption that children aged under 16 have the ability to make decisions for themselves. They can only do so if they demonstrate they are Gillick Competent. This means that the starting point for children aged under 16 is that they are not competent to make decisions for themselves unless they can demonstrate that they can do so, and there are no criteria in place for determining their decision-making ability. Although there is a general understanding that a Gillick competent child can consent to interventions, there is a lack of clarity on how to assess whether the child is competent.

4.2 The draft Bill puts children aged under 16 at a further disadvantage. When discussing competency, the Bill refers to the Mental Capacity Act which only applies to those aged 16 and over and no detail is provided on how to assess competence for those aged 16 and under. When discussing capacity to consent to make relevant decisions, the Bill refers to the Mental Capacity Act for people aged 16 and over and 'competence' for under 16s but gives no detail on how competence is to be determined.

4.3 Autonomy for under 16s is likely to be impacted by the absence of a test for competency, for example, choosing a nominated person and benefitting from enhanced safeguards relating to refusal of treatment. The Independent Review recognised the lack of consistency in establishing competence for under 16s and for this reason, made the recommendation that there should be a statutory test for competence in this context. However, this recommendation has not been accepted by the government. We see that having such a test on the face of the Bill would help to ensure that professionals understand how to assess under 16s competence.[i] This should be accompanied by guidance for practitioners on how to undertake such assessments.

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

Recommendation: S131 of the legislation should be amended to make clear that competent under 16s can consent to, or refuse, informal admission.

5. Advanced Decisions

5.1 In the White Paper, the government committed to extending advance choice documents to children and young people. However, rather than introducing advance choice documents, the draft Bill gives legal weight to advance decisions under the Mental Capacity Act 2005 for adults detained under the Mental Health Act. As advanced decisions can only be made by those aged 18 and over, this means that children and young people will be unable to make advanced decisions. Whilst the Bill does introduce a duty on responsible clinicians to consider young people's views, detained children and young people will be unable to access the enhanced safeguards associated with advance decisions.

Recommendations: The government should extend advanced decisions to children and young people aged under 18.

6. Advocacy for informal patients

6.1 The draft legislation expands the right to access an Independent Mental Health Advocate (IMHA) to informal patients who are not detained under the Mental Health Act.

[i] Article 39 is exploring the position taken in other jurisdictions.

We welcome this amendment, which will mean children and young people who are admitted informally will now be legally entitled to support and representation from an advocate concerning their admission and treatment.

6.2 The draft Bill introduces an 'opt out' system to ensure that all 'qualifying compulsory patients' in England have the opportunity to opt-in to IMHA services. However, this will not be the case for informal patients, who will not be captured by the opt-out system. This means that informal patients will still be required to ask for support from an advocate and receiving information about an advocate is dependent on the responsible person providing this. The lack of access to advocacy for informal patients has been a longstanding concern, and we are worried that children and young people admitted informally will continue to experience problems accessing an advocate under this new system.

6.3 Advocates have previously raised concerns that children who are informal patients are often under exactly the same conditions as those detained under the Mental Health Act. Furthermore, many young informal patients do not understand their rights and feel an underlying threat that if they in some way 'break the rules', they will be sectioned.[9] Advocacy for informal patients is therefore crucial in helping children and young people who are informal patients to navigate a complex system.

6.4 We believe that the Bill should commit to extending advocacy on an opt-out basis for informal patients. At the very least, it must be extended to all children admitted on an informal basis - particularly as they are the only group who can be admitted informally without their own consent. Implementation of opt-out advocacy and the extension of eligibility to informal patients should happen as soon as practically possible once legislation is passed and both measures should be introduced together at the same time.

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

7. Safeguards for informal patients

7.1 Whilst we welcome the introduction of statutory care and treatment plans within the Bill, we are concerned that these plans for informal patients will be placed on an alternative statutory footing. The White Paper stated that children and young people who are informal patients will have a statutory care and treatment plan, with a statutory footing, but the duty to provide one will not be in the amended Act. We would like to better understand the rationale for using an alternative route to give plans for informal patients a statutory footing. We believe that any safeguards that are put in place to support informal patients, such as care and treatment plans, should be on the face of the Bill.

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

8. Nominated person

8.1 We welcome the introduction of the nominated person, and in particular children and young people should be able to choose who represents their interests and can act on their behalf when they are unable to. We have previously raised concerns regarding the particular risks attached to children and young people and the role of the nominated person.

8.2 Firstly, the nominated person is an area in which the lack of a definition of competence in the Bill for under 16s is relevant. We question how it will be determined that a young person is competent to choose a nominated person if no definition or statutory test exists. As a result, we are concerned this could impact on a young person's autonomy to identify a nominated person and make decisions regarding their care and treatment.

8.3 The nominated person potentially introduces a layer of new safeguarding risks as children could choose someone who poses a risk to them. The draft Bill seeks to address this. The Bill states that when appointing a nominated person, this must be done in presence of a health or care professional or independent mental health advocate who must sign a statement stating that: both the patient and the nominated person have capacity or competence, that no undue pressure has been used to induce the patient to make the appointment, and that they have no reason to think that the nominated person is unsuitable to act. This addition to the Bill will go some way in addressing concerns around safeguarding and in protecting young people when making their nomination.

8.4 Provisions are included in the Bill regarding where a child or young person has not chosen their nominated person. For under 16s, the Bill states that the AMHP will choose a nominated person on their behalf and must give preference to firstly a local authority with parental responsibility for the patient and, secondly any other person who has parental responsibility. It should be noted that there could potentially be a number of people within a child or young person's life that have parental responsibility. Further detail is therefore needed for AMHP's on how to define parental responsibility in order to help them with this decision.

8.5 However, when the AMHP is appointing a nominated person for those aged 16 and 17, those with parental responsibility are not mentioned as an option in the same way as for under 16 year olds. We wanted to bring this to the attention of the Committee and to further understand why this is not consistent with provisions for under 16 year olds, particularly when parental responsibility does extend up until they reach the age of 18.

9. Admission to adult wards and out of area placements

9.1 We are concerned that children and young people are still being inappropriately placed in settings out of area and on adult wards, and that the draft Bill does not contain adequate safeguards to address this. NHS data shows that for the past three years over 1,000 (97%) children a year have been placed 'out of area', most of whom were detained under the Mental Health Act. In 2017/18, 518 of the 1,255 'out of area' admissions were considered to be 'inappropriate', based on assessment of the child's clinical need, their individual preference, and any special circumstances.[ii]

9.2 Children and young people also continue to be admitted onto adult wards, and contrary to government policy, such admissions include under 16s. The most recent information from NHSE (for quarter 2 of 2020/21) shows that 72 under 18s were admitted to hospital during that period. This is an area in which it is difficult to find reliable and relevant data. For example, data from NHSE showed that 592 children were placed on adult wards in 2019/20, three times the number in the previous year.[iii] Another concern is that the information provided does not include the reasons for admission to adult wards, so it is not possible to ascertain the reasons why such admissions were considered to be appropriate, nor how many were because all suitable NHS Children and Young People's Mental Health Services (CYPMHS) units were full.

9.3 As a first step, the Mental Health Bill should strengthen the requirement for under 16s not be placed in adult wards. The current Code of Practice states that it is government policy that under 16s should not be admitted to an adult ward, and if this does occur then the commissioner of the NHS CYPMHS inpatient services should be notified, and it should be reported as a serious incidence and investigated in accordance with the NHS Serious Incident Framework. We believe this safeguard should be strengthened and should be set out in the legislation.

9.4 Secondly, it was welcome that through the White Paper, the government agreed that the local authority should be notified when a child or young person is placed in an adult ward or out of area, or if an admission lasts more than 28 days. It has been stated that this will be made clear in the Code of Practice, however, we believe this duty should be set out in legislation.

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

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

9.5 Further clarity is required on what the duty of the local authority would then be once they have been notified. It would also be necessary to consider how the proposed 28 day notification period is to align with the current notification requirements under sections 85 and 86 of the Children Act 1989, which requires local authorities to safeguard the welfare of under 18 year olds placed in residential settings and hospitals.

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

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

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

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

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

10. Discharge arrangements

10.1 Section 117 places a duty on the NHS and local social services authorities to provide after-care to patients detained under the Act once they are discharged. We have previously heard evidence that involving children's social care in discharge planning can be challenging, with some local authorities seeming not to be aware of their section 117 duties. This can leave children and young people in a precarious position, feeling scared and uncertain about what will happen when they leave hospital, and for some under 18s the lack of appropriate accommodation meaning that their discharge from hospital is delayed.

10.2 Effective discharge planning is crucial to ensure that young people's care and treatment is continued, and it is vital that this takes a multi-agency approach. We believe that the process of multi-agency planning for discharge needs to be improved as currently no process exists to support this. We would like to understand what the statutory

mechanism will be to bring agencies together to ensure children and young people are adequately supported, and that their education and treatment is continued, both while they are in inpatient care and during discharge arrangements.

10.3 What is more, the Independent Review recommended that when a young person is admitted to inpatient care, they should be regarded as a Child in Need under Section 17 of The Children Act. This recommendation was rejected by the government on the basis that the child would already be a 'child in need' due to their mental health problems. We believe that statutory guidance should make clear that admission to inpatient care means that the child or young person is a Child in Need and that should trigger an assessment of their needs in accordance with Section 17. This is necessary so that they can continue to access support services both during and after their admission.

Recommendation: The government should clarify the statutory mechanism that will be put in place to ensure multi-agency planning for children and young people's discharge.

Recommendation: Statutory guidance should make clear that admission to inpatient care should require an assessment of their need as Child in Need under section 17 of the Children Act.

11. Resources

11.1 The changes made in the draft Bill cannot be seen in isolation from the rest of the mental health system - their success relies enormously on effective service provision, a strong workforce and sustainable investment. Without these factors in place, there is a serious risk to successful implementation of the reforms. Whilst we welcome the recent announcement of £150 million to better support people in crisis and enhance patient safety in mental health units,[10] we are concerned that no certainty has been provided on future funding decisions in order to implement the reforms. The White Paper stated that the proposals set out will be linked to future funding decisions, yet no clarity on funding of the reforms has been provided.

11.2 The best way to prevent people being detained under the Act is to prevent them from reaching crisis point. This relies on effective mental health services based in the community. However, there have been long standing issues with children and young people's mental health services, with a lack of adequate provision in place. A recent report from the Health and Social Care Select Committee on children's mental health stated that half of young people with a diagnosable condition do not receive the mental health support they need.[11]T he reforms set out in the draft Mental Health Bill cannot be seen separately from the challenges facing children and young people's mental health services. Urgent action is needed to address challenges such as high thresholds for support, waiting times and

transitions between services, to ensure that children and young people can access timely support before they reach crisis.

11.3 We also wanted to highlight the needs of young people with complex and varied needs, who require therapeutic care, but fall outside the remit of the Mental Health Act. These young people are often placed in unregulated accommodation due to a lack of suitable alternatives and whilst they often need significant health involvement, responsibility for their care is left to local authorities. A lack of appropriate resources is leaving many children and young people with complex needs without the support they need. The reforms in the Bill do not seek to address this, and we are concerned that without urgent action to increase the resources available in the system, young people will continue to fall through the gaps in care.

11.4 Whilst there has been growth in the children and young people's mental health workforce in recent years, significant issues still exist. Staff providing specialist and crisis provision to children, young people and families are reporting intolerable pressure and there is an urgent need to address support for staff. Waiting lists create pressure on caseloads and we have already seen with the recent children's social care review that unsustainable caseloads in the children's social care system has had a catastrophic impact on the safeguarding of children.

11.5 As the Royal College of Psychiatrists notes, current workforce constraints mean that changes to the Mental Health Act cannot be absorbed within the existing workforce.[12] For example, the Royal College of Psychiatrists undertook an independent assessment of the impact of the proposed reforms to the Mental Health Act on the psychiatric workforce to better understand how many additional psychiatrists would be required to deliver the reforms.[13] Based on the white paper, the research found that by 2023/24 an additional 333 Full Time Equivalent psychiatrists will be needed costing £40m per year, and a further 161 by 2033/34, costing £60m per year. We are clear that the Bill cannot be delivered without significant growth and investment in the workforce. As a first step, funding must be allocated to deliver the workforce for reforms, and this should be accompanied by a specific workforce plan.

11.6 Work also needs to take place to ensure the mental health workforce reflects the communities they service, and that values of anti-racism, diversity and inclusion are actively promoted. Cultural competency training should also be embedded in health workforce training and development.

12. Data collection

12.1 There are significant gaps in available data on children in mental health hospitals, and the data that does exist can often be incomplete and difficult to access. As a result, it can be

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

- There is no published data available on the total number of children admitted as informal patients and the basis on which they have been admitted to hospital i.e., on the basis of parental consent or their own consent.
- There is no publicly available data from NHS England about how long children spend in hospital once they have been detained under the Act. Data does exist on the number of 'bed days' for children and young people, however, this is not broken down by type of unit, therefore making it impossible to draw any conclusions from the figures.
- Data on the number of children admitted to hospital 'out of area' and whether this is considered to be 'inappropriate' (based on assessment of the child's clinical need, individual preference, and any special circumstances) is not publicly available. While regular data is available on the 'Total number of inappropriate out of area bed days' in the NHS Mental Health Dashboard, this is not disaggregated by age.
- Inadequate data on children held in adult wards. In 2019/2020, NHS England data showed that 592 children were placed on adult wards in 2019/20, three times the number in the previous year. However, NHS England has reported significant concerns about the quality of this data and no information is provided on the reasons for admission to adult wards, and there is no way to judge whether this is a result of capacity issues on children's wards. Section 131A of the Mental Health Act provides that where under 18s are admitted to hospital (whether or not they are detained under the Act) they should be accommodated in an environment that is suitable for their age (subject to their needs). The Code of Practice makes clear that no child should be placed in an adult ward, except in an emergency or in 'atypical' circumstances. However, accurate data collection and publication is essential to bringing an end to inappropriate and potentially harmful placements. This also needs to be consistent with, and cross-referenced against, data collected by the Care Quality Commission when notified of placements on adult wards.

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

Recommendation The draft Mental Health Bill should be amended to include a duty on the Secretary of State to ensure that national data on the experiences of children and young people as mental health inpatients is regularly collected and published. This should include data on the number of detained and informal patients broken down by type of unit

(including those settings which are not mental health wards); ethnicity; reasons for admission; length of time waiting for a hospital place; out-of-area placements and their reasons; safeguarding referrals; serious incidents; the number of children receiving advocacy support; informal admission on the basis of a young person's consent or parent consent; length of time detained; satisfaction rates and the number of children placed on adult wards and length of stay.

16 September 2022

References

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