WRITTEN EVIDENCE SUBMITTED BY DR CAMILLA PARKER KC (HON)

(MHB0019)

This submission focuses on the impact of the Mental Health Bill [HL] ("the Bill") on children and young people aged under 18. Although the Bill includes reforms which could have a positive impact on the experience of under 18s receiving mental health care, it pays insufficient attention to the specific needs of this age group.

I am making this submission in my personal capacity. I am a lawyer and through my independent legal and policy consultancy, *Just Equality,* I provide research, training and consultancy in the areas of mental health, human rights, capacity and consent. Much of this work is focused on law and policy relevant to children and young people with mental health needs. I worked as a consultant for the Department of Health, leading on the revision of the children and young people's chapter in the Mental Health Act 1983 Code of Practice (now chapter 19 of the 2015 Code) and authored *Adolescent Mental Health Care and the Law* (Legal Action Group 2020). I am an Honorary King's Counsel, having been appointed in recognition of "her excellent contribution to the fields of mental health and mental capacity law, in particular the development of law and policy relating to the mental health care of children and young people". I am a member of the Law Society's Mental Health & Disability Committee and the Children and Young People's Mental Health Coalition.

The areas covered in this submission are:

- Decision-making and children aged under 16 years: need for a statutory test
- Inappropriate settings: the need for safeguards for children and young people placed in adult psychiatric wards or placed out of area
- Treatment for mental disorder: the need for additional safeguards where nasogastric tube feeding is proposed

It should also be noted that, as the Joint Committee on the Draft Mental Health Bill emphasised, the success of the reforms set out in the Bill depends on adequate funding and workforce.[1]

1. Decision-making and children aged under 16 years: need for a statutory test

A significant gap in the Bill is the lack of a test to determine the ability of children aged under 16 to make decisions (referred in the Bill as "competence").

This is important because a person's ability to make decisions for themselves is a fundamental part of the reforms the Bill seeks to introduce. The Bill places great emphasis on enabling people falling within the scope of the Bill to make a range of decisions for themselves, such who they wish to appoint as their "nominated person"[2]

[1] HC 696 HL Paper 128, Joint Committee on the Draft Mental Health Bill, *Draft Mental Health Bill 2022,* Conclusions and recommendations, p.115, paragraph 20.

and making an "advance choice document".[3] However, such matters are dependent on the person having the "capacity" (if aged 16 and over) or being "competent" (if aged under 16).

The Bill neither explains what is meant by "competence", nor gives any guidance to professionals on how to determine whether a child aged under 16 is competent (i.e. is able to make the relevant decision).

Difference in approach depending on age

Whereas for under 16s the Bill refers to a child's competence and nothing more, for those aged 16 and over, the Bill provides that their capacity is to be assessed in accordance with the Mental Capacity Act 2005 (the "MCA 2005"). This means that where the Bill requires consideration of the person's capacity or competence, the age of the person dictates the approach to be adopted by the professionals tasked with making this determination.

If the person concerned is aged 16 or more, the professionals acting under the Bill must apply the MCA 2005 which:

- Sets out a test to determine whether a person lacks capacity[4]
- Provides individuals are assumed to have capacity unless evidence shows otherwise[5]
- Makes clear that individuals should not treated as unable to make the decision "unless all practicable steps" to help the person to do so have been taken without success"[6]
- Is supported by a Code of Practice, which along with expansive case law since the MCA 2005's introduction in 2007, provides guidance on the criteria, and process, for determining whether a person lacks capacity.[7]

If the person concerned is under 16, professionals are required to consider whether the child is "competent". No further guidance is given. This means that for those aged 16 and over a detailed legal framework for determining the person's capacity is engaged, but for those aged under 16, the Bill is silent.

The need for a test for a child's ability to decide to be included in the Bill

Without a statutory test for determining a child's ability to make the decision in question, professionals may feel uncertain as to whether the child is able to make the decision and therefore conclude that the child has not demonstrated that they are competent.

This is because children are presumed to be unable to make decisions for themselves unless they can demonstrate that they are **able** to do so. Accordingly,

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[2] See Mental Health Bill, clause 23 and Schedule 2.
[3] See Mental Health Bill, clause 42.
[4] Mental Capacity Act 2005, sections 2 and 3.
[5] Mental Capacity Act 2005, section 1(2)
[6] Mental Capacity Act 2005, section 1(3)
[7] Department of Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, TSO, 2007.

under 16s will be considered to lack competence unless the person assessing their ability to decide is satisfied that they are competent.

If not competent to make the relevant decision, the right to make the range of decisions set out in the Bill does not apply. For example, the Bill provides that the appointment of the nominated person is subject to the witness (health or social care professional, or Independent Mental Health Advocate (IMHA)) stating that they have no reason to think that the child lacks competence.[8]

Without a means of determining whether a child aged under 16 is competent to make the decision in question, the reforms that are intended to increase "the role of the patient in decision-making regarding their care and treatment" are likely to bypass this age group. The "potentially positive reforms are likely to be illusory in practice".[9]

Absence of test for a child's ability to decide: human rights implications

This concern is relevant to the following rights:

- *Article 8 of the European Convention on Human Rights (ECHR) (Right to respect to private and family life):* the range of decisions set out under the Bill engage this right e.g. choice of nominated person; deciding whether to have a care, education and treatment review, engaging in discussions about care and treatment, making an advance choice document.

- *Article 12 of the UN Convention on the Rights of the Child (CRC*): which is concerned with respect for the views of the child "…the views of the child being given due weight in accordance with the age and maturity of the child". The Committee of the CRC's General Comment on this article highlights the importance of promoting the child's right to be heard and participate in decisions that concern them. Paragraph 135 emphasises the need to "challenge presumptions about children's capacities".[10]

There is also a question whether the approach adopted in the Bill may constitute discrimination against children aged under 16 (article 14 of the ECHR (prohibition of discrimination) together with article 8) and article 2 of the UN Convention on the Rights of the Child (CRC) (Non-discrimination)) given that this group of children are treated differently in the Bill from those aged 16 and over. It would be helpful for the Government to explain why this difference is considered to have a legitimate aim and to be proportionate measure.

Addressing arguments against the inclusion of a statutory test

[8] Mental Health Bill [HL], Schedule 2, paragraph 3(2)(c)(iii).
[9] Children and Young People's Mental Health Coalition, *Mental Health Bill: Decision-making for under 16s*
[10] Committee on the Rights of the Child, *General Comment No. 12 (2009) The right of the child to be heard*

In response to the response to the Joint Committee on the Draft Mental Health Bill's recommendation that the Government should have a wide-ranging consultation on the "…introduction of a statutory test for competency, or 'child capacity', for children under 16" the Government set out various reasons for not doing so. These are considered below, with comments:

i) *Government's view: "The MHA is not the appropriate forum for setting a statutory test for child competence in wider settings": Response:* ***The Bill is the right place***

A test is needed for the Bill given that so much emphasis is placed on the person having the capacity or competence to make the decision and the detrimental effect on under 16s if no test for their ability to decide is included. Including a test in this Bill would not prevent future legislation including such a test for broader application.

ii) *Government's view: "Gillick competence remains the accepted competence test for under 16s across all settings": Response:* ***There is no clear and consistent test for competence***

While the concept of the "*Gillick* competent child" is generally understood, how to determine a child's competence is not. As noted by Independent Review of the Mental Health Act 1983 (the MHA Review), "there is no consistent approach to establishing competence" and therefore recommended that a statutory test for determining a child's decision-making ability should be introduced.[11]

iii) *Government's view: "…setting out a statutory test for competence in the MHA could potentially put under 16s in a more complicated position, particularly those assessed as having competence to consent to decisions under the MHA definition but who would be considered not to have competence using the existing test of Gillick of competence, or vice versa." Response:* ***The government's reasoning is unclear.***

The Government is right in that a child might be considered to be competent to make some decisions under a test included in the Bill but not competent to make decisions in relation to matters outside mental health legislation (and vice versa). However, that is the nature of decision-making. This would be the case with any test applied given that the question whether the child is competent to make a decision is decision specific and time specific: the question to be asked is whether this child can make this decision at this particular time. A child may therefore be found to make some decisions but not others.

iv) *Government's view: "…the best place to set out how practitioners should assess children and young people's competence and capacity under the act is*

[11] Independent Review of the Mental Health Act 1983, *Modernising the Mental Health Act: Increasing choice, reducing compulsion*, December 2018, 173.

in the code of practice" ***Response: legislation, not the Code is the right place***

Given its importance, the Code is not the right place to include a test for a child's ability to decide (competence). As noted above, there is a stark difference in the Bill between those aged 16 and over (the MCA 2005 will apply) and those aged under 16 (no definition of competence, no explanation on how to determine whether a child is able to decide).

During the Committee debate on the Bill on 22nd January 2025 and in response to the proposed amendment (tabled by Lord Meston) to include a test for a child's competence in the Bill,[12] the Minister for Patient Safety, Women's Health and Mental Health, Baroness Merron reasserted the Government's rejection of such a statutory test.[13]

One of the reasons given by Baroness Merron for saying that the proposed amendment was not acceptable was that the "functional test", which forms part of the amendment is not "appropriate or compatible with the UN Convention on the Rights of the Child". The reference to the functional test is the part of Lord Meston's proposed test which asks the person assessing the child's ability to decide to consider whether the child can understand the relevant information, to retain that information, to use and weight that information and communicate their decision.

It is not clear why the Government has concluded that the "functional test" contravenes the UNCRC, particularly given that the MCA 2005 applies to young people aged 16 and 17, who therefore fall under the UNCRC (see Article 1). They are also considered to be a "child" under the Children Act 1989.

2. Inappropriate settings

The Joint Committee on the Draft MH Bill recommended that the government must use the Bill to "strengthen the protections in the MHA against children and young people being placed in inappropriate settings, such as adult wards or placements out of area". Although the government agreed that under 18s should not be placed in inappropriate settings, it declined to take action through legislative reform.

The Joint Committee on the Draft MH Bill, noted that in 2020, the Children's Commissioner's Office found that 21% of under 18s who were inpatients were placed more than 50 miles away from their home and that the Care Quality Commission (CQC) data shows that 191 under 18s were admitted to adult wards in 2020/21, which increased to 249 in 2021/22.[14]

The CQC's report, *Monitoring the Mental Health Act in 2022/23*[15] raises more recent concerns about inappropriate placements. For example, the CQC continues to see

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[12] Tabled by Lord Meston and supported by Baroness Brridge and Baroness Bennett of Manor House (Amendment 147)

[13] Mental Health Bill [HL] Vol 842, 22nd January 2025

[14] HC 696 HL Paper 128, Joint Committee on the Draft Mental Health Bill, *Draft Mental Health Bill 2022,* Conclusions and recommendations, p.72, paragraph 223.

children and young on adult wards or general wards "often for extended periods and in locations far away from home", which "can present serious risks for them". The CQC also notes the use of section 136 suites "because of a lack of alternative beds" and that:

> "We have also seen young people who needed a psychiatric intensive care environment waiting on an acute mental health ward, which can pose serious risks to their safety."[16]

While noting that the number of under 18s' admissions to adult wards decreased in 2022/2023 (196 notifications), the CQC report highlights the negative impact on those children and young people who are admitted to adult wards:

> "We are concerned about the suitability of adult wards for children who require mental health treatment. By their nature, children on adult wards are often not able to socialise with others their own age, miss out on peer support and have limited access to educational opportunities. In addition, staff who are often used to treating adults may not tailor the care they provide to meet the needs of younger patients."[17]

The CQC's report also highlights concerns about out of area placement, citing relatives who make the point that such placements will make "it difficult to have regular contact with families and can make the experience of being detained feel more isolating". In addition:

> "…out of area placements can also present challenges when patients are ready to be discharged, such as securing appropriate community support back in the person's local area."[18]

Similar conclusions were reached by a study that considered the impact of out of area placements. Although noting that such admissions were beneficial for a minority of under 18s, the study concluded:

> "At-distance admissions lead to additional distress, uncertainty, compromised continuity of care and educational, financial and other practical difficulties, some of which could be better mitigated."[19]

Inappropriate settings: human rights implications

The placements of under 18s in inappropriate settings will engage article 8 of the ECHR (and given the CQC's concerns that such situations can give rise serious risks

[15] Care Quality Committee, *Monitoring the Mental Health Act in 2022/23,* chapter on Children and Young People, March 2024.
[16] Care Quality Committee, *Monitoring the Mental Health Act in 2022/23,* chapter on Children and Young People, March 2024.
[17] Care Quality Committee, *Monitoring the Mental Health Act in 2022/23,* chapter on Children and Young People, March 2024.
[18] Care Quality Committee, *Monitoring the Mental Health Act in 2022/23,* chapter on Children and Young People, March 2024.
[19] Roe, J., Holland, J., et al, *Experiences and impact of psychiatric inpatient admissions far away from home: a qualitative study with young people, parents/carers and healthcare professionals* BMJ Ment Health. 2024 Apr 25;27(1):e300991. doi: 10.1136/bmjment-2024-300991

for the children and young people concerned), potentially articles 2 and 3 of the ECHR.

Relevant rights under the CRC are as follows: article 6 (right to life and maximum survival and development); article 16 (right to privacy); article 20 (children deprived of their family environment); article 23 (rights of children with disabilities); article 24 (right to highest attainable standard of heath and health facilities) and article 37(prohibition of torture, cruel, inhuman degrading treatment or punishment).

Article 37(c) of the CRC makes specific provision for children deprived of their liberty:

> "(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances."

In addition, it must be recognised that such matters are relevant to children and young people aged under 18 who have been admitted informally (i.e. not detained under the MHA 1983 because, for example they, or their parents have consented to the admission).

Article 25 of the CRC applies to all under 18s, whether or not they have been detained under the MHA 1983. This Article states:

> "States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement."

This raises the question as to what extent periodic reviews are undertaken in relation to the care and treatment of under 18s who are informally admitted to inpatient psychiatric units.

The Children Act 1989 requires that hospitals should inform local authorities where an under 18-year-old is being accommodated in a hospital for three months or more, whereupon the local authority should arrange visits and the provision of support to that child or young person, under 18s who are accommodated in hospital for three months or more, but it is not clear whether compliance with this requirement is monitored.[20]

In comparison there are detailed provisions for the periodic review of the care arrangements provided to under 18s who are in the care of local authorities (guidance referring to them as "looked after children").[21]

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[20] Children Act 1989, sections 85 and 86. Joint Guidance on this duty was issued by the Department of Education and Department of Health in 2017 (*Statutory visits to children with special educational needs and disabilities of health conditions in long-term residential settings).*

3. Treatment for mental disorder

As the Independent Review of the MHA 1983 noted, the European Court of Human Rights (ECtHR) has

> "…increasingly recognised that providing non-consensual treatment constitutes a serious interference with the individual's right to autonomy, requiring suitably strict procedural safeguards: see, for instance, X v Finland [2012] ECHR 1371"[22]

One area that has not been addressed by the Bill is that under the MHA 1983, treatments such as nasogastric tube feeding do not engage any of the additional safeguards set out under Part 4 of the MHA 1983. This means such treatment can be given under section 63 of the MHA 1983, without the person's consent and the only requirement is that the treatment is given "under the direction of the approved clinician in charge of the treatment". There is no independent review of this treatment decision.

Treatment for mental disorder (lack of independent review): human rights implications

This gap in safeguards – which is relevant to people of all ages - engages article 8 of the ECHR and the equivalent provision in the CRC (article 16).

One approach to address this gap in procedural safeguards would be to amend section 58A so that the requirement that a SOAD (second opinion approved doctor) certifies that it is appropriate for the treatment to be given (for under 18s this would apply whether or not they are detained under the MHA 1983).[23] However, a requirement that such treatment is authorised by the High Court might better reflect the level of scrutiny required for such an invasive form of treatment.

Conclusion

The points raised do not provide a comprehensive analysis of the human rights implications of the Bill on children and young people. However, they are of key importance to the operation of the Bill and /or the promotion and protection of under 18s' human rights.

I hope that the above comments are helpful to the Joint Committee in its inquiry on the Mental Health Bill. I would be happy to provide further information if that would be helpful.

(Jan 2025)

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[21] Local authorities' duties are detailed in *The Children Act 1989 guidance and regulations, Volume 2: care planning, placement and case review,* Department for Education, July 2021.
[22] Independent Review of the Mental Health Act 1983*, Modernising the Mental Health Act: Increasing choice, reducing compulsion,* December 2018, p.244, paragraph 7.
[23] This is explained in *Mental Health Act 1983: Code of Practice,* Department of Health, 2015, paragraphs 19.80-19.88.