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CHAPTER 1

Introducing child mental health and the law

With the increasing complexity of culture and society comes confusion. Several changes in UK legislation affecting children's mental health have taken place over the past two decades. These have included the Human Rights Act 1998 (HRA) and the case law deriving from it, the Mental Capacity Act 2005 (MCA) and, in 2007, the amendments to Mental Health Act 1983 (MHA). We therefore find ourselves in some difficulty concerning the clarity of what can and cannot be done to look after young people's mental disorders and safeguard their rights.

Fortunately, there are already good guides written specifically for clinicians on both the MHA and the MCA: *A Clinician's Brief Guide to the Mental Health Act* (Zigmond & Brindle, 2016) and *A Clinician's Brief Guide to the Mental Capacity Act* (Brindle *et al*, 2015). These cover a lot of ground, and Zigmond & Brindle's book includes how to become section 12 approved and the process of tribunals and making appeals. Neither, however, was intended to deal with the particular problems of the law as it relates to children and adolescents with mental disorders. Complementing these volumes, this book will focus on the rather peculiar relationship between a young person with a mental health disorder and the law, as mediated by family, community and doctors.

The last book published by the Royal College of Psychiatrists on child psychiatry and the law (Black *et al*, 1998) has a good deal of information about assessing parenting capacity and how to act as an expert witness, but it now seems curious that it mentions the MHA only in passing. This must indicate some quite significant shifts in the preoccupations of the specialty of child and adolescent psychiatry and its scope of practice.

In this book I will not cover court work or how to act as a witness. I will instead focus on essential elements of children's mental health law. For clinicians acting as expert witnesses many guides are available, such as *Expert Psychiatric Evidence* (Rix, 2011), which has a chapter dedicated to reports for family proceedings relating to children. Richardson & Casswell (2010) also provide useful advice. Clinicians acting as expert witnesses need to be aware of regulations in the new Children and Families Act 2014 (Part 2, section 13). It seems from recent

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case law that a more rigorous approach is being adopted by the courts (Hirst, 2015), and it is likely that quality standards for expert witnesses will be developed in the future.

So what does a clinician working in child and adolescent mental health services (CAMHS) need to know about the law? The new Code of Practice for the MHA begins:

> 'In addition to the Act, those responsible for the care of children and young people in hospital should be familiar with other relevant legislation, including the Children Acts 1989 and 2004, the MCA and the HRA [Human Rights Act]. They should also be aware of the United Nations Convention on the Rights of the Child (UNCRC), and keep up-to-date with relevant case law and guidance' (Department of Health, 2015: para. 19.4).

These demands are quite considerable, and the current book is intended to help by bringing all of this information together. The final section of this chapter ('Notes on individual chapters') provides a synopsis of topics covered.

Summary of major developments

Since 1998 a great deal has changed in the medico-legal landscape of children's mental health. The Care Quality Commission (CQC) assumed responsibility for monitoring the MHA in England and Wales in 2009. The preoccupation with failings in child protection has led to the issuing of a new *Working Together to Safeguard Children* booklet (HM Government, 2015*a*) only 2 years after the previous one. The Supreme Court has taken over the judiciary functions of the House of Lords, and a landmark case in the Supreme Court in 2015 (*Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)* [2015]) has widely been interpreted as ending the principle of the Bolam test (see p. 39) which had been established in 1957.

Case law has continued to evolve concerning the deprivation of liberty, culminating in the so-called Cheshire West case. In fact, this judgment was given on the combined cases of Cheshire West and P and Q (*P v Cheshire West & Chester Council and another and P and Q v Surrey County Council* [2014]). Some aspects of the case are relevant to adolescents, as P and Q (also known as MIG and MEG), were aged 16 and 15 at the start of the proceedings, but 18 by the time of the final hearing in 2010. Therefore, this judgment is being viewed carefully for applicability to this age group. The judgment, delivered by Lady Hale, clarified that the definition of deprivation of liberty meant that a person is 'under continuous supervision and control and [...] not free to leave'. Moreover, 'what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities' (para. 46).

But what are the implications of this case for children and young people? When a clinician is considering admission to hospital for a reluctant young person this is an important question and is causing much concern. Before

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Cheshire West, a deprivation of liberty was considered to involve three components deriving from European law: an objective element, i.e. actual confinement for a non-negligible period of time; a subjective element, i.e. that valid consent to the confinement had not been given; and that the State was responsible for the deprivation of liberty. Case law had established that although someone with parental responsibility could authorise restrictions on the liberty of their child, these could not amount to deprivation of liberty (see *RK (by her litigation friend, the Official Solicitor) v BCC & Ors* [2011].

In the case of P and Q, the conclusion was that they had both been deprived of their liberty and that the deprivation was the responsibility of the State. At paragraph 54 of the judgment, Lady Hale says that similar constraints would not necessarily amount to a deprivation of liberty 'if imposed by parents in the exercise of their ordinary parental responsibilities'. This point was picked up by Lord Neuberger at paragraph 72, in making the case that Article 5 of the Human Rights Act (that is, the right to liberty and security of person – see Chapter 2) would not normally be engaged in the situation of children living at home. However, albeit in a not very strong statement, he doubts that this would include those living with foster parents.

Thus, a deprivation of liberty applies only when the State or its agents (e.g. foster carers) are involved: not parents or adoptive parents.

The new criteria for the deprivation of liberty are that the person lacks the capacity to consent to their care/treatment arrangements; that they are under continuous supervision and control; and that are not free to leave. These elements together have been called the acid test for the deprivation of liberty, and this finding has clearly exercised all concerned and caused widespread and costly chaos. One renegade judge has ignored it, the Law Society (2015*a*) has issued guidelines about what constitutes a deprivation of liberty, and the Law Commission is currently processing the results of a consultation exercise which seems likely to form the outline of a new parliamentary Bill. As part of this project (Law Commission, 2015), it is possible that there will be a proposal to extend the MHA to enable treatment of mental disorders to proceed that involve a deprivation of liberty. There is also a possibility that the new system proposed to replace the Deprivation of Liberty Safeguards – called protective care – would extend to 16- and 17-year-olds.

Cases of adolescent refusal of treatment also continue to vex both clinicians and the courts in the face of mounting recognition of adolescent autonomy. Similarly, for some time now the emphasis has been shifting away from parental rights towards parental responsibility.

On a larger canvas, at the time of writing, the future of the Human Rights Act 1998 has been brought into question by the UK government. Debates in both the House of Commons and the House of Lords have occurred, with the former Prime Minister David Cameron (a Conservative) expressing interest in a British Bill of Rights. It is not known yet what this

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will mean for the Human Rights Act, which was introduced by the previous Labour government.

More familiarly to psychiatrists by now, there have been the changes to the MHA, which was amended in 2007, with a new Code of Practice issued in 2015 (Department of Health, 2015). The amendments to the Act have included changes to terminology, roles and aspects of treatment. For example, the definition of mental disorder has changed, and there is now a requirement in some sections for appropriate medical treatment to be available. There is the introduction of approved clinicians, responsible clinicians and approved mental health professionals. There are also some specific changes to aspects of treatment that affect individuals under 18 years of age, such as the requirement for age-appropriate environments and rules governing the administering of electroconvulsive therapy.

And finally, there have been recent changes to family law, and I highlight some of these in the next section.

The state of mental health services and the role of the CQC

The most recent report of the CQC (Care Quality Commission, 2015) on the MHA marks 5 years since this body took over the monitoring function from the Mental Health Act Commission in England. In it, attention is drawn to the fact that there is insufficient provision of tier 3 and 4 services in CAMHS and that provision and access to CAMHS are not good enough. As I will discuss in Chapter 6, there do not appear to be systems in place yet for collecting data on the number of young people detained under the MHA. The CQC has been much more concerned about the admission of children and young people to adult wards. Consequently, its system of monitoring is restricted only to young people admitted to adult wards for more than 48 hours: even admissions to such wards for less than this period are not counted.

For the adult population in England, the total number of patients detained under the MHA at the end of March 2014 was 23 531, an increase of 6% on the previous year; and the number of available beds had reduced by 8% since 2010–2011 (Care Quality Commission, 2015).

For the CAMHS clinician in many parts of the country the main concern is the lack of available beds for young people who need emergency admissions. Even if a young person can be admitted to a paediatric ward in a crisis there can be lengthy delays before a suitable tier 4 bed can be found in an adolescent unit, and then this is often far from home.

A large change to the organisation of services was brought about with the Health and Social Care Act 2012, discussed by Zigmond & Brindle (2016: p. v). This is a complex piece of legislation concerning the decentralisation of the National Health Service in England and the introduction of commissioning boards and clinical commissioning groups. This, however, need not concern us here.

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The structure of the court system in England and Wales prior to 2014

The structure of the court system in England and Wales has always been rather complicated and it changed considerably in 2014.

Prior to 2014, magistrates' courts could deal with family proceedings and could make some court orders under the Children Act 1989. County courts dealt with a wider range of court orders and complex cases from the magistrates' courts. Beyond this, the family division of the High Court would hear appeals from the magistrates' court, adoption cases, wardship cases and cases involving inherent jurisdiction. The Court of Appeal was next in the hierarchy and finally the House of Lords. Thereafter, cases might go to the European Court of Justice, based in Luxembourg. A simplified structure is shown in Fig. 1.1).

The principle of judicial precedent means that every court is bound to follow decisions in the court above it in the hierarchy and courts of appeal are bound to their own past decisions. Not all cases are reported publicly.

The structure of the court system in England and Wales after 2014

The Crime and Courts Act 2013 has created a new single family court in England and Wales. Before April 2014, family cases were dealt with at family proceedings courts (which were part of the magistrates' courts), at county courts or in the family division of the High Court. Since April 2014, all family cases are dealt with in the single family court.

Magistrates' courts and the new single county court are no longer able to deal with family proceedings, and family proceedings courts have ceased to exist.

Fig. 1.1 The hierarchy of courts in England and Wales before 2014 (after Martin, 2005).

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Fig. 1.2 The hierarchy of courts in England and Wales after 2014 (adapted from Courts and Tribunals Judiciary, 2012).

However, as the family court can sit anywhere in England and Wales, in practice hearings will tend to be held in county or magistrates' court buildings.

The new family courts deal with parental disputes, local authority intervention to protect children, and domestic violence remedies and adoption. They also handle divorce petitions, and the financial provisions for children after divorce or relationship breakdown.

The judicial functions of the House of Lords were taken over by the Supreme Court in October 2009 (Fig. 1.2). The nature of the proceedings determines the court in which they are heard.

It might be helpful at this point to give some definitions. Common law refers to law that has been developed by the cumulative body of judicial decisions, i.e. by cases that have been heard in the courts. The principles thus derived are then applied to future cases, unless the new material can be legally distinguished from what has gone before. Common law is trumped by statute law, which refers to laws made by a legislative body, i.e. Acts of Parliament. Common law should not be used when there is a statutory alternative. It is also helpful to know that private law concerns relationships between private individuals, and public law is about relationships between individuals and the State.

The state of the family justice system

Statistics from the Ministry of Justice (2015*a*) indicate that, of the 60 902 cases starting in the family courts in England and Wales in January to March 2015, nearly half were divorce cases.

Since 2012, there has been a general upwards trend in the number of applications for non-molestation domestic violence protection orders and in the number of adoption orders issued.

In terms of public law orders (essentially those concerning child protection and including care or supervision orders and emergency

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protection orders), the most common types of order applied for in January to March 2015 were care orders (72% of children involved in applications), followed by emergency protection orders (6%) and discharge of care orders (6%).

The average time for the disposal of a care or supervision application made in January to March 2015 was 29 weeks.

The number of private law cases (largely cases under section 8 of the Children Act) started in January to March 2015 in England and Wales was 10 569 (Ministry of Justice, 2015*a*).

Since April 2013, legal aid has been available for private family law cases (such as those involving contact or divorce) only if there is evidence of domestic violence or child abuse and for child abduction cases. These changes are causing popular concern, as such evidence, especially of domestic violence, can be hard to produce. Legal aid remains available for public family law cases (such as adoption).

Other changes in the family justice system are reviewed in the document *A Brighter Future for Family Justice*, issued jointly by the Ministry of Justice and Department for Education (2014). This document indicates that between January 2011 and March 2014, cases concerning section 8 private law orders took on average 15–20 weeks from application to first full order.

The Crime and Security Act 2010 introduced two measures to protect victims in the immediate aftermath of the reporting of a domestic violence incident: domestic violence protection notices (DVPNs) and domestic violence protection orders (DVPOs). Police forces have been implementing these new powers since March 2014.

If the perpetrator and the victim live together, the DVPN or DVPO can exclude the perpetrator from the home or from coming within a specified distance of the home. These are temporary measures to allow time for other measures, such as applying for a civil injunction, to be taken (Ministry of Justice, 2015*a*).

The Children and Families Act 2014 introduced several new requirements and procedures. These include the new child arrangements orders (CAOs), which replace contact and residence orders (see Chapter 3); a 26-week time limit for completing care and supervision cases; and restricting the use of expert evidence (Law Society, 2015*a*). The Act also includes provisions for adoption and contact, introduces new controls over the expert witness and describes the new education, health and care plans (EHCPs). Finally, it has introduced a clause into the Children Act 1989 that encourages the court to presume, unless the contrary is shown, that involvement of each parent in the life of the child will benefit the child's welfare.

The scope of the book

In this book, I use the word 'children' to describe those up to the age of 16, and 'adolescents' and 'young people' interchangeably to mean people between the ages of 16 and 18.

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The Mental Health Act 1983 applies to England and Wales. Wales has its own Code of Practice for the MHA, due to come into practice in October 2016. It has a section on children and young people.

The Mental Capacity Act 2005 applies to England and Wales, and the Lord Chancellor has a duty to consult with the Welsh Assembly in compiling its Code of Practice. Therefore the MCA Code of Practice applies to both countries.

Scotland and Northern Ireland have their own legislation.

Notes on individual chapters

In Chapter 2 the Human Rights Act 1998 is described. This is a significant piece of legislation which is having an impact at many levels of society. Although the principles of the European Convention on Human Rights were ratified by the UK in the 1950s, since the Human Rights Act became enshrined in UK law it has become much easier for individuals to draw attention to their rights when they are infringed and to seek redress. It also highlights the rights of children as individuals. This chapter includes a number of important cases heard in the courts that have had a direct effect on psychiatric practice.

Chapter 3 deals with the Children Act 1989 and its amendments of 2004. The main points are parental responsibility, the private and public law elements and why a child or young person might need to be assessed using this legal framework

Consent is covered in Chapter 4, with an emphasis on why you need it and how you get it. The Montgomery case is briefly described and the impact this may have on gaining consent. The rest of the chapter inspects the key cases that have been heard before the courts involving consent and refusal, and also surveys professional guidelines. Finally, there are some notes on decision-making concerning admission and treatment.

Chapter 5 deals with confidentiality and its limits (which, it turns out, are many) in the doctor–patient relationship. Clinicians need to be aware of the professional guidelines and also the seemingly broadening definitions of the public interest.

In Chapter 6 the MHA is summarised. There is no lower age limit in using the MHA to detain a patient, and a case has recently been published illustrating its use with an 8-year-old child (Thomas *et al*, 2015). Figures showing how widely the MHA is used with children and young people are hard to find.

It should be mentioned here that, although not directly concerning the MHA, the confusing term ‘zone of parental control’ only ever appeared in the 2008 version of the MHA Code of Practice for England (but not in that for Wales). In the current version of the Code (Department of Health, 2015) it has been replaced by the more restrained term ‘scope of parental responsibility’, which I mention in Chapters 2 and 4. Viewed against the

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background of the increasing recognition of children's human rights, this concept appears to be highly questionable, particularly for children who lack competence and are, by definition, the most vulnerable. These are the children whose mental disorder does not warrant using the MHA and who fall into the gap left between the MHA and either the Children's Act or the MCA.

But all this looks set to change as a result of the Law Commission review (Law Commission, 2015) and the replacement of the deprivation of liberty safeguards with something else. We can only hope that it does not make things more complicated.

Other topics discussed in Chapter 6 are section 131 of the MHA and the highly publicised use of section 136 when it has led to detentions of children and young people in police cells. Of equivalent political importance is the great difficulty clinicians face in finding beds for children and young people needing urgent in-patient care (Faculty of Child and Adolescent Psychiatry, 2015*a*). The resulting placement of children with mental disorders in states of distress and risk at great distance from their homes has seemed to many clinicians to be an outrage.

In Chapter 7 the MCA is outlined. Its applicability to young people is limited to 16- and 17-year-olds and the now notorious deprivation of liberty safeguards (DoLS) cannot be used for anyone under 18. Clinicians need to know about the principles of this Act, capacity assessments and also the interaction between this Act and the MHA.

Finally, Chapter 8 considers aspects of juvenile justice. It includes information about secure accommodation and restraint, and an overview of the points of contact a young person known to CAMHS might have with the criminal justice system. The so-called forensic sections of the MHA are outlined at the end.

This book has been written to meet the needs of practising clinicians, who often have to make decisions in situations of complexity. However, it cannot tell clinicians what to do in particular circumstances and, of course, it will only be up to date until the next change in the law. References are given to enable readers to explore other sources of information, should they have the time to do so. My intention has been to make the subject, in the words of Dickens's Mr Kenge, plain and to the purpose:

> 'It could not, sir,' said Mr Kenge, 'have been stated more plainly and to the purpose, if it had been a case at law.'
> 'Did you ever know English law, or equity either, plain and to the purpose?' said my guardian.'
>
> (Charles Dickens, *Bleak House*, 1852–1853).

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