

Legislation relevant to children and young people

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Legislation

- Legislation relevant to children
 - Human Rights Act
 - United Nations Convention on the Rights of the Child
 - Children Act
 - Mental Health Act 1983
 - Mental Capacity Act
- Deprivation of Liberty and restraint

Human Rights Act

The HRA 1998 incorporates the rights set out in the European Convention on Human Rights (ECHR) into UK domestic law. This means that if a person considers that their rights have been infringed by a public body (which include NHS agencies and local authorities) they may take legal action before the national courts, whereas before the HRA 1998 came into force, they had to pursue a complaint to the European Court of Human Rights (often a lengthy process).

The United Nations Convention on the Rights of the Child (UNCRC)

Our national courts and the European Court of Human Rights can take the UNCRC into consideration when adjudicating on cases relating to children and young people.

The United Nations Convention on the Rights of the Child (UNCRC)

- The UNCRC seeks to achieve a balance between respecting the responsibilities of parents to make decisions on behalf, and in the best interests, of their child and enabling children and young people to exercise their rights.
- Two core principles of the UNCRC are that the best interests of the child are a primary consideration in all actions concerning children (Article 3) and ensuring respect for the views of the child (Article 12).

The United Nations Convention on the Rights of the Child (UNCRC)

- The UNCRC requires States to respect the responsibilities, rights and duties of parents to make decisions in relation to their children but that this must be ‘in a manner consistent with the evolving capacities of the child’ (Article 5).
- The concept of the ‘evolving capacities’ of the child is central to the aims of the UNCRC. It recognises that as children grow and develop in maturity, their views and wishes should be given greater weight. Their development towards independent adulthood must be respected and promoted.

Children Act 1989

- *The Children Act 1989* was introduced to attempt to consolidate the earlier laws governing children.
- There act is underpinned by a number of guiding principals
- The welfare of the child is paramount.
- Wherever possible, children should be brought up and cared for within their own families.

Children Act 1989

- Parents with children in need should be helped to bring up their children themselves; this help should be provided as a service to the child and his family and should be provided in partnership with the parents.
- The act defines a Child in need as a child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a Local Authority; or a child whose health or development is likely to be significantly impaired; or further impaired, without the provision for him of such services; or a child is disabled.

Children Act 1989

- Children should be safe and be protected by effective intervention if they are in danger.
- Children should be kept informed about what happens to them, and should participate when decisions are made about their future.

Children Act 1989

- The concept of parental responsibility replaced that of parental rights; Parents will continue to have parental responsibility for their children, even when their children are no longer living with them. They should be kept informed about their children and participate when decisions are made about their children's future.

Children Act (Parental responsibility)

- When working with children and young people it is essential to identify the person(s) with parental responsibility for them.
- The person with parental responsibility may be able to consent to the intervention: In some circumstances, those with parental responsibility will be able to authorise the child or young person's admission to hospital and/or treatment. (Such consent can only be relied on if the decision falls within the 'zone of parental control').

Children Act (Parental responsibility)

- Usually, but not always, the person with 'parental responsibility' will be the child or young person's parents.
- It is good practice to involve those with parental responsibility: Even where it is not necessary to obtain the consent of the person with parental responsibility for the child or young person's admission to hospital and/or treatment, it is good practice to involve those with parental responsibility in the decision-making process, subject to the child or young person's right to confidentiality.

The legal aspects of capacity and consent in children and young people

- There are a number of pieces of legislation, as well as guidance, relating to the ability of children (under the age of sixteen) and young people (sixteen and seventeen year olds) to make decisions for themselves. Guidance does vary between countries in the United Kingdom and clinicians should be aware of the legislation within their particular location.

The legal aspects of capacity and consent in children and young people

- In all parts of the United Kingdom, legislation concerning the treatment of young people is different from that relating to the treatment of children.
- At the age of sixteen, a young person can be presumed to have the capacity to consent; however, a young person under the age of sixteen may also have the capacity to consent, depending on their maturity and ability to understand what is involved.
- In England and Wales, the starting point in assessing whether a young person is able to make decisions about all aspects of their care and treatment is the Mental Capacity Act 2005 (MCA 2005).

Mental Capacity Act 2005

- The MCA 2005 starts with the premise that all individuals over the age of sixteen, have the capacity to make decisions for themselves, unless they can be shown to lack capacity. The Act sets out a single clear test for assessing whether a person lacks capacity to make a particular decision at a particular time. The Code of Practice outlines a two-stage test of capacity:

Mental Capacity Act 2005

1. Does the person have an impairment of the mind or brain?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Mental Capacity Act 2005

- In assessing an individual's ability to make a decision the following areas need to be explored:
- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)?

Mental Capacity Act 2005

- The MCA 2005 sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. Its main provisions apply to individuals aged sixteen and over.
- However, in some areas, there are some significant differences between the provisions relating to individuals aged eighteen and over and those aged sixteen and seventeen.

Mental Capacity Act 2005

- A young person who is unable to make a decision will not always be covered by the provisions of the MCA 2005.
- There may be reasons why the young person is unable to make the decision which do not fall within the scope of the MCA 2005. Guidance in the MCA 2005 Code of Practice states that there may be cases when young people are unable to make a decision, but this may not be because they are judged to have an 'impairment of, or disturbance in, the functioning of the mind or brain'.

Mental Capacity Act 2005

- The guidance highlights that a young person may not be able to make a decision by reason of their lack of maturity- this group will fall out of the scope of the MCA 2005. In determining the basis for a young person's inability to make a decision the clinician must consider a number of factors:

Mental Capacity Act 2005

- Does the young person have a learning disability?
- Is the young person's mental state impacting on their ability to make decisions?
- Are temporary factors impacting on a young person's ability to think clearly - for example, pain, shock, intoxication?
- Before coming to a decision that a young person lacks capacity, appropriate steps must be taken to try and enable the young person to make the decision themselves.

Mental Capacity Act 2005

- In circumstances when a young person lacks capacity, as defined by the MCA 2005, practitioners will be able to make decisions in relation to a young person's care and treatment, if such decisions are in the young person's best interests and otherwise carried out in accordance with the principles and provisions of the MCA 2005.

Mental Capacity Act 2005

- When assessing the young person's best interests, the person providing care or treatment must consult those involved in the young person's care and anyone interested in their welfare - if it is practical and appropriate to do so. This may include the young person's parents. Care should be taken not to unlawfully breach the young person's right to confidentiality.

Mental Capacity Act 2005

- When disagreements about the treatment, care or welfare of a young person aged sixteen or seventeen arise, the case may be heard in either the Court of Protection or the Family Courts, depending on the particular circumstances of the case. It should be remembered that any orders made under the Children Act 1989 will expire on a young person's eighteenth birthday.

Mental Capacity Act 2005

- When a young person lacks capacity, not within the meaning of the MCA 2005, those with parental responsibility can make the decision for the young person with the following provisos:
 - the decision to be made falls within the 'zone of parental control';
 - there is no statutory or other limitation.

Mental Capacity Act 2005

- In England and Wales, children (below the age of sixteen) who are deemed to have capacity to make decisions for themselves are often termed 'Gillick competent'.
- Assessment of the capacity of a child to make a decision about their care and treatment follows the same principals as for adults and young people.

Mental Capacity Act 2005

- They must understand the nature, purpose and possible consequences of proposed investigations or treatments you, as well as the consequences of not having treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decision to others, can they consent to that investigation or treatment.

Mental Capacity Act 2005

- It should be noted that capacity to consent depends more on young people's ability to understand and weigh up options than on age.
- It is important to remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences.
- The child's competence should be assessed carefully in relation to each decision that needs to be made.

Mental Capacity Act 2005

- Although case-law suggests that the refusal of a Gillick competent child can be over-ridden by the Courts, or a person with parental responsibility, the recent trend in other cases relating to children has been to give greater emphasis to the autonomy of a competent child. However, it may be prudent to seek legal advice in these circumstances.

Mental Capacity Act 2005

- For children and young people under the age of sixteen who lack capacity, one parent can give consent for the treatment or investigation to take place. If parents disagree about the proposed treatment and this cannot be resolved informally, then legal advice should be sought to establish if an application should be made to the court

Mental Health Legislation

- Every part of the United Kingdom has legislation in place to ensure that those with mental illness (of whatever age) receive the care and treatment they need. Practitioners should be aware of the principals of the mental health legislation covering the area in which they work.

Mental Health Legislation

- In England and Wales, the principal pieces of legislation governing the treatment of people with mental health problems are the Mental Health Act 1983 (MHA 1983) and the subsequent Mental Health Act 2007 (MHA 2007). These Acts make provision for the compulsory detention and treatment in hospital of those with mental disorder.

Mental Health Legislation

- Mental Disorder is defined in the Mental Health Act 2007 as 'any disorder or disability of the mind'.
- It includes conditions such as schizophrenia, depression, personality disorder, autism and learning disability.
- A person with a learning disability is not considered to be suffering from mental disorder for most purposes under the Act; or to require treatment in hospital, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct.

Mental Health Legislation

- The fact that somebody has a mental disorder is not sufficient grounds to compulsorily admit them into hospital. They can only be detained in hospital under the Mental Health Act in the interests of their own health or safety or with a view to the protection of others. In addition, there is a requirement that appropriate treatment must be available if patients are to be subject to detention.

Mental Health Legislation

- The Mental Health Act 1983 and 2007 can be used, where appropriate, in children and young people of any age. The decision about whether to use the Act is often complex and will be dependent on a number of factors including:

Mental Health Legislation

- Whether she or he has the capacity to agree to the admission; children and young people who have capacity to consent and do so can be admitted informally;
- Whether a person with parental responsibility can consent on their behalf; a parent can consent to an admission for a child under the age of 16 who lacks capacity;

Mental Health Legislation

- Whether a young person lacks capacity within the meaning of the MCA 2005; a young person who lacks capacity can be admitted on the basis that the admission is in their best interests and does not amount to a deprivation of liberty.

Mental Health Legislation

- Admission under Mental Health Act legislation should be a last resort and informal admission is usually appropriate when the competent child, young person or person with parental responsibility, consents to the admission.
- There are some occasions when detention may be appropriate even in these circumstances.

Mental Health Legislation

- Detention should be considered if:
- There is a clear risk to the patient or the public as a consequence of their mental disorder;
- There is a history of non-compliance with treatment;
- Admission into hospital may result in the young person's deprivation of liberty;
- A young person lacks capacity or refuses to consent to an important component of the proposed treatment;
- Consent or capacity is fluctuating.

Mental Health Legislation

- Individuals of any age can be admitted to hospital under the MHA 1983, but only if the requisite criteria, as described above, are met.
- The MHA 2007 introduced an important new duty in relation to the admission of children and young people to hospital for treatment for their mental disorder.

Mental Health Legislation

- There is now an obligation to ensure the hospital environment into which the child or young person is admitted is age appropriate and suitable for their needs. This duty applies to all patients under the age of 18 whether they are detained or informal. The purpose of this provision is to ensure that children and young people are not admitted inappropriately onto adult psychiatric wards.

Deprivation of Liberty

- Part II of the Mental Health Act 2007 (MHA 2007) made amendments to the Mental Capacity Act 2005 (MCA) by the introduction of deprivation of liberty safeguards (previously referred to as "Bournewood" safeguards). These came into force on 1 April 2009.

Deprivation of Liberty

- The aim of the amendments to the MCA is to remedy the "gap" identified by the case of HL v UK (App No 45508/99, 5 October 2004), otherwise known as Bournemouth after the hospital at the centre of the case. In HL v UK, the European Court of Human Rights (ECtHR) ruled that a man diagnosed with autism was deprived of his liberty and that this had been in breach of Article 5 of the European Convention on Human Rights (ECHR).

Deprivation of Liberty

- Deprivation of liberty was not defined. The Court merely confirmed that it was different from restriction of liberty and said that the difference was one of degree or intensity.
- As originally drafted, the MCA allowed restrictions to be placed upon the liberty of people lacking capacity. The amendments set out a new procedure in England and Wales for depriving people lacking capacity of their liberty in certain circumstances

Deprivation of Liberty

- New sections inserted into the MCA allows for a person to be deprived of his or her liberty if:
- this is necessary for life-sustaining treatment or for the performance of "vital acts".
- the deprivation is giving effect to a relevant decision of the court; or
- the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).

Deprivation of Liberty

- The deprivation of liberty provisions apply to people aged 18 or over who have a disorder or disability of the mind, who lack the capacity to give their consent to plans made for their care and who are deprived of their liberty within the meaning of Article 5 ECHR despite not being subject to formal detention under the Mental Health Act 1983 (MHA 1983).

Deprivation of Liberty

- The provisions cover hospitals (NHS or private) and care homes registered under the Care Standards Act 2000 and such deprivation will be unlawful unless the institution obtains an authorisation under the new provisions.
- In other settings, the deprivation will be unlawful unless the Court of Protection has made an order.

DOLs and Young People

- The case of *Re RK* [2010] EWHC 3355(COP) (Fam) concerned RK, a 17½-year old-woman who suffered from autism, ADHD, severe learning disability and epilepsy, and displayed aggressive and self-harming behaviours.

DOLs and Young People

- RK was moved to care home placements by the local authority under s.20 of the Children Act 1989 after her family became unable to care for her at home. The issue for the court was whether RK was deprived of her liberty in the care home placements. If she was, then being under 18, the DOLS regime would not apply, and the local authority would have to apply to the court for declarations authorising the placement, with the consequent reviews.

DOLs and Young People

- Mostyn J held that there was no deprivation of liberty, either on the facts, or as a matter of law. He held that where a child is placed under s.20 CA 1989 and the parents have a right under s.20(8) CA 1989 to refuse consent to the placement, there can be no deprivation of liberty.

DOLs and Young People

- Any restriction on RK's freedom was the result of RK's parents exercising parental responsibility by consenting to the placement, and thus the 'subjective' limb of the test for a deprivation of liberty could not be met. Nor was the objective test met, according to the judge, because RK's care came nowhere near involving depriving her of her liberty.

DOLs and Young People

- RK lived at the residential placement from Monday to Friday but attended school each day. She returned to her parents' home every weekend. While at the placement, she was allowed unrestricted contact with her parents, and was subject to close supervision at all times, but was apparently not restrained or subject to a particularly strict behavioural management regime.

DOLs and Young People

- The door to the placement was not locked, although if RK had tried to leave, she would have been brought back. In response to a submission that these arrangements amounted to confinement because they restricted PRKs autonomy, the judge said: “I am not sure that the notion of autonomy is meaningful for a person in RK’s position.”

DOLs and Young People

- He concluded: “I find it impossible to say, quite apart from s20(8) Children Act 1989, that these factual circumstances amount to a ‘deprivation of liberty’. Indeed it is an abuse of language to suggest it. To suggest that taking steps to prevent RK attacking others amounts to ‘restraint’ signifying confinement is untenable.

DOLs and Young People

- Equally, to suggest that the petty sanctions I have identified signifies confinement is untenable. The supervision that is supplied is understandably necessary to keep RK safe and to discharge the duty of care. The same is true of the need to ensure that RK takes her medicine. None of these things whether taken individually or collectively comes remotely close to crossing the line marked ‘deprivation of liberty’.”

DOLs and Young People

- Further, the local authority was not detaining RK under any 'formal powers', as would be the case if, for example, a care order was in place. RK's parents could remove her from the placement if they chose to withdraw their consent to it (even though on the facts of the case, there was no practical possibility of RK's parents doing any such thing without the local authority's assistance and provision of an alternative care package). If RK's parents have decided not to remove her from the placement, the judge found it difficult to see how the State could be said to be responsible for her detention.

DOLs and Young People

- The decisions of the European Court of Human Rights in *Neilson v Denmark* [1988] 11EHRR 175 and of this court in *Re K* [2002] 2WLR 1141 demonstrate that an adult in the exercise of parental responsibility may impose, or may authorise others to impose, restrictions on the liberty of the child. However restrictions so imposed must not in their totality amount to deprivation of liberty. Deprivation of liberty engages the Article 5 rights of the child and a parent may not lawfully detain or authorise the deprivation of liberty of a child.

Legal Aspects of Physical Restraint

Physical Intervention and Restrictive Physical Intervention have been jointly defined by the Department for Children, Schools and Families (formerly the DfES) and the Department of Health.

"Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment."

Legal Aspects of Physical Restraint

Guidance from the DCFS states that;

“There is no legal definition of when it is reasonable to use force. That will always depend on the precise circumstances of individual cases. To be judged lawful the force used would need to be in proportion to the consequences it is intended to prevent. The degree of force used should be the minimum needed to achieve the desired result.”

Legal Aspects of Physical Restraint

The use of all forms of physical intervention and physical contact are governed by the criminal and civil law. The unwarranted or inappropriate use of force may constitute an assault. In addition the application of physical restraint may infringe the human rights of a child or young person. However in certain circumstances the use of a Restrictive Physical Intervention can be justified:

Legal Aspects of Physical Restraint

- In school and education settings Section 93 of the Education and Inspections Act 2006 allows the use of reasonable force;
- In social care residential settings Regulation 8 of the Children's Homes Regulations 2001 authorises "*the taking of any action immediately necessary*";
- In foster care Regulation 13 of the Fostering Services Regulations 2002 permits the use of physical restraint.

Legal Aspects of Physical Restraint

- In all cases the use of Restrictive Physical Interventions has to be justified by there being;
 - the likelihood of injury to the child or young person, or
 - the likelihood of injury to others, or
 - the likelihood of serious damage to property.

Legal Aspects of Physical Restraint

- **Additionally;**
 - **In schools Restrictive Physical Intervention may be justified:**
 - **to prevent the committing of any offence, or**
 - **to maintain good order and discipline.**
 - **In social care settings Restrictive Physical Intervention may be justified:**
 - **to prevent the running away of any child or young person “*lawfully detained*” (usually a child or young person remanded to local authority accommodation).**

Legal Aspects of Physical Restraint

- Restrictive Physical Interventions should be only be used when a situation warrants immediate action. De-escalation techniques should always be used to avoid the need to employ a Restrictive Physical Intervention, unless the risk is so exceptional that it precludes the use of de-escalation.
- The de-escalation techniques should be appropriate to the child or young person, acknowledging that the member of staff may not speak the child or young person's first language or that the child or young person may not have sufficiently developed language skills to be able to respond to verbal de-escalations.

Legal Aspects of Physical Restraint

- The use of Restrictive Physical Interventions is also governed by the principles of ethical practice. The intervention should;
 - be in the best interests of the child or young person,
 - be reasonable and proportionate to the circumstances,
 - use the minimum force necessary for the minimum time necessary,
 - be based on a comprehensive risk assessment,
 - have regard for other young people or adults present, and
 - respect the safety and dignity of all concerned.

Legal Aspects of Physical Restraint

- As soon as possible after the incident the member of staff should be de-briefed by an appropriate person. The de-brief should allow for reflection and the relevant individual should be prepared to deal with the emotions raised by the incident.
- The response of the child or young person should be sought and he or she should also be allowed to reflect on the incident. The risk assessment should be reviewed.

Legal Aspects of Physical Restraint

Monitoring

- Monitoring depends on good recording of episodes of Restrictive Physical Intervention and the use of a database may be advisable. Senior managers should monitor episodes of Restrictive Physical Intervention both individually and by establishment. However narrative records will always be important for monitoring practice.
- In schools, responsibility for monitoring the use of Restrictive Physical Interventions lies with the Head teacher who should provide an overview report at least annually of the incidence and management of RPI in the school to the Governing Body. In turn, the Governing Body, should also be aware of its duties to safeguard children and young people and should pay due regard to the Local Safeguarding Children Board's policies and procedures.
- In residential establishments monitoring will take place as required by the Children's Homes Regulations. Local authorities may have additional requirements involving oversight by Elected Members and the Local Safeguarding Children Board.
- Monitoring serves two purposes. At the individual level it allows for improved practice with the individual young person, whilst at the strategic level it has the potential to influence policy and practice.

Summary

- There is complex legal framework relevant to the provision of care and treatment to children and young people.
- The development of human rights law has contributed to the increasing recognition of the need to give greater weight to the views of children and young people as they develop their understanding and ability to make decisions for themselves.
- However there are occasions when the adults with the responsibility for the care and treatment of young people have to make decisions and take actions in their behalf to ensure their well being.

Summary

- Case law results in an ever changing legal landscape.
- If in doubt – seek legal advise!!!!