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Transfer guidance under Mental Health Act 1983 for children detained on welfare grounds

# Procedure for the referral for assessment, and transfer to and from hospital (under Part II of the Mental Health Act 1983) of a child held in secure accommodation under welfare grounds in England

Version 1, 08 November 2021

# Contents

# 1 Introduction

This document – the *Procedure for the transfer to and from hospital (under Part II of the Mental Health Act 1983) of a child held in secure accommodation on welfare grounds* – is designed to help staff work well with colleagues to ensure that there are no unacceptable delays in providing a child[1] in secure accommodation with inpatient mental health care if that is what they need. Staff will also need to be familiar with the most recent version of the Code of Practice to the Mental Health Act, in particular, chapter 19 relating to children.[2]

The vulnerability of children, arising from their age and lack of maturity, makes it unacceptable for them to remain in a secure setting without immediate access to the level of health oversight and expertise that their mental disorder requires. Hence, the expectation of a short time frame – **seven days** from the secure setting making a referral for inpatient treatment – to complete the transfer to hospital.

The children this document relates to are looked after children who have been placed in secure accommodation on what are referred to as welfare grounds, under section 25 of the Children Act 1989 or under the inherent jurisdiction of the High Court. Where children are under a care order, with parental responsibility shared between parents and the local authority, it is vital that robust mechanisms are in place for close liaison with local authorities and, where appropriate, with families about decisions to be made. The important principle of parental involvement in the hospitalisation of their children applies to looked after children in secure accommodation as it applies to children in the community. The right of children to consent to treatment also applies to those in secure accommodation.

The document does not apply to children who have been placed in a secure children's home by the HM Prison and Probation Service (HMPPS Youth Custody Service Placement Team) following criminal proceedings. A different transfer procedure (under Part III of the MHA 1983) applies to those children. That procedure is set out in a separate document – the *Procedure for the referral for assessment, and transfer to and from hospital (under Part III of the Mental Health Act 1983) of a child held in custody in England*.

[1] The Children Act 2004 uses child/children as a term throughout, and therefore reference to child/children is used throughout this document.
[2] Department of Health (2015) Mental Health Act 1983: Code of Practice

The reduction of inequalities in access and outcomes should be central to the mental health transfer process. Staff should make explicit in their plans how they have considered the duties placed on them under the Equality Act 2010. Services should be culturally appropriate, and communications should be appropriate and accessible to meet the needs of diverse communities.

# 2 Glossary

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| Access assessor | The mental health clinician at an inpatient unit who is responsible for receiving and assessing referrals for admission of a child and for helping determine which unit, if any, is the most appropriate |
| AMHP | Approved mental health professional – a social worker or other professional approved by a local authority to carry out certain functions under the Mental Health Act 1983, including the application for detention of a child in secure accommodation. |
| ANMSU | Adolescent national medium secure unit (network) |
| CA 1989 | Children Act 1989 |
| CCG | Clinical commissioning group |
| CPA plan | Care programme approach plan. The plan sets out arrangements for any continuing need for mental health services after a child's discharge from hospital. |
| CYPMHS | Children and young people's mental health service |
| Health and justice commissioning | NHS England and NHS Improvement health and justice commissioners have responsibility for the commissioning of health provision in all secure settings for children and young people. The commissioning is delivered through 10 teams across the seven NHS England and NHS Improvement regions. |
| Looked after child | A child under a care order, or a child accommodated by the local authority under section 20 of the Children Act 1989 |
| Mental health team | A generic term for the range of different mental health services available in Secure Children's Homes |
| MHA 1983 | Mental Health Act 1983 |

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| MHCM | Mental health case manager (also known as children and young people's mental health services case manager). The MHCM should be contacted once transfer to hospital is being considered. |
| SCH | Secure children's home |
| Specialised commissioning | NHS England and NHS Improvement specialised commissioners have responsibility for the commissioning of mental health inpatient services for children and young people. Specialised commissioning is delivered through regional specialised commissioning teams. The relevant team for the purposes of the transfer procedure is the one that covers the child's home area. |
| Referral and access assessment process for children and young people into inpatient services | The NHS England and NHS Improvement national protocol that sets out arrangements for referral, assessment and admission to inpatient CYPMHS inpatient units. Also known as the specialised mental health services operating handbook protocol. Each specialised commissioning team holds a copy of the protocol, with a list of useful contacts (for their own region only) at the back. |

# 3 Summary

3.1 This document outlines the procedure for transferring to and from hospital under Part II of the Mental Health Act 1983 a looked after[3] child who is in secure accommodation on welfare grounds. The procedure covers the duties of secure children's homes (SCHs) in identifying and transferring children, and the action that must be taken by other agencies involved. The procedure applies to SCHs in England, as they are in the jurisdiction of the Mental Health Act 1983.

3.2 The purpose of the guidance in this document is to ensure a fast and clinically appropriate response to a child who might need admission to hospital under the Mental Health Act. It covers the way children are assessed and referred for treatment, transferred to the inpatient service they need, and discharged after treatment.

[3] Looked after children are children subject to a care order under section 31 of the Children Act 1989 or accommodated by a local authority under section 20 of the Children Act 1989

3.3 Given the urgency required when responding to the severe mental health needs of children, good practice indicates that a transfer should be completed within seven days of making the referral for inpatient treatment.

3.4 The manager of an SCH has a vital role to play in ensuring that healthcare, registered managers and front-line workers are aware of and comply with the procedure for transfer, and that contact details for external partners in the procedure are kept up to date (to avoid delay.

3.5 Even when children are under a care order their parents may still have an important role to play in their life. Parents should be informed and involved in decision making, unless there is clear advice to the contrary from the relevant local authority. It should also be remembered that children might have the capacity to consent to informal admission to hospital and treatment themselves, and that this option should be considered as part of the deliberations about admitting them to hospital.

# 4 The children covered by this document, and the legal framework

## 4.1 The children covered

The document sets out the procedure to be followed when **looked after children**, placed in secure accommodation under section 25 of the Children Act 1989 (CA 1989) as a result of concerns about their welfare, require compulsory admission to hospital under the Mental Health Act 1983 (MHA 1983). The relevant provisions are set out in Part II of the MHA 1983, at section 2 and 3.

The document does not apply to children who have been placed in an SCH by the HM Prison and Probation Service (HMPPS) Youth Custody Placement Service as a result of criminal proceedings. A different transfer procedure (under Part III of the MHA 1983) applies to those children. That procedure is set out in a separate document.[4]

[4] NHS England (2021) *Procedure for the transfer to and from hospital (under Part III of the Mental Health Act 1983) of a child held in custody in England*

## 4.2 The legal framework

### 4.2.1 The Children Act 1989 and Children (Secure Accommodation) Regulations 1991

A child is a 'looked after child' primarily if they are the subject of a care order made under section 31 of the Children Act 1989 or if they are accommodated by the local authority under section 20 of the Children Act 1989.

When a child is under a care order (section 31, CA 1989), including an interim care order, the local authority looking after them acquires parental responsibility. They share this with the child's parent(s), who retain their parental responsibility, but the local authority can specify the extent to which parents can exercise their responsibility.

When a child is accommodated (section 20, CA 1989), parents have parental responsibility and the local authority does not.

When a child under the age of 18 is looked after, the local authority with care of the child can apply to the Family Court for authorisation to place the child in secure accommodation. Under Section 25(6) Children Act 1989, the child must be legally represented. If the court is satisfied that the grounds set out below are made out, it will make an order under section 25 of the Children Act 1989.

The grounds for making an order under section 25 are that the child:

- has a history of absconding and is likely to abscond from any other accommodation that is not secure;

**and**

- if the child does abscond, he/she is likely to suffer significant harm;

**or**

- if the child is kept in any other type of accommodation, he/she is likely to injure him/herself or other persons.

Under Regulations 11 and 12 of Children (Secure Accommodation) Regulations 1991 the court can authorise that a child is kept in secure accommodation for a maximum period of three months initially, and it can subsequently authorise further periods of up to six months each. There is no limit on the number of extensions that can be applied for.

A child under the age of 13 years cannot be placed in secure accommodation without approval by the Secretary of State.[5] The exception to this is if the child is 12 years old and has been arrested.[6]

The court can make a section 25 CA 1989 order in relation to a child who is accommodated by the local authority on a voluntary basis under section 20 of the CA 1989.

### 4.2.2 The Mental Health Act 1983

Part II of the Mental Health Act 1983 (MHA 1983) provides the legal framework for the process of assessment under the MHA 1983, which may lead to a child being admitted to and detained in hospital if the statutory criteria for admission for assessment and/or treatment exist, and the procedures set out in the MHA 1983 have been followed. Applications for detention in hospital for assessment and/or treatment under the MHA 1983 can be made either by the nearest relative of the child[7] or by an approved mental health professional (AMHP).[8]

The assessment of children and young people under the MHA 1983 is a legal process that is subject to stringent statutory rules. Both the AMHP and doctors assessing under the MHA 1983 have responsibilities to ensure that assessments are subject to the principle of least restriction and that all the conditions outlined in the MHA 1983 and Code of Practice are considered. The role of NHSE/I and local CCG commissioners is to identify an appropriate bed should an application for admission under the MHA 1983 be made. This is informed by an Access Assessment.

**Assessment of Children and Young People under the Mental Health Act 1983**

- Each area should have an arrangement under section 140 MHA 1983 where the CCG advises the local Authority AMHP service on bed availability for situations of special urgency. This includes children and young people.
- Decisions about who has nearest relative responsibility is dependent on identifying parental responsibility and whether the child is subject to a care order or has a guardian.[9]

[5] Regulation 4 The Children (Secure Accommodation) Regulations 1991
[6] Section 38 Police and Criminal Evidence Act 1984
[7] Section 26 - 28, MHA 1983
[8] Section 11(1), MHA 1983
[9] Section 26 - 28, MHA 1983

- Issues around consent and capacity will be considered by the AMHP during assessment under the MHA 1983

**Section 2**

Section 2 MHA 1983 allows for a patient to be detained for a period of up to 28 days for assessment. The AMHP's (or rarely the nearest relative's) application is supported by two medical recommendations, (at least one by a Section 12 MHA 1983 approved doctor) and must confirm that:

- The child is suffering from a mental disorder
- The disorder is of a nature or degree which warrants the detention of the child in hospital for assessment (or for assessment followed by treatment) for at least a limited period
- The child ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

**Section 3**

Section 3 of the MHA 1983 allows for admission of a patient to hospital for treatment. The initial section 3 period can last for up to six months, can be renewed for a further six month period and annually thereafter if detention criteria remain met. The AMHP's (or rarely the nearest relative's) application is supported by two medical recommendations, (at least one by a Section 12 MHA 1983 approved doctor) and must confirm that:

- the child is suffering from a mental disorder[10]
- their disorder is of a nature or degree that makes it appropriate for them to receive medical treatment in a hospital
- it is necessary for the health or safety of the child or for the protection of other persons that s/he should receive such treatment and it cannot be provided unless s/he is detained under this section
- appropriate medical treatment is available for them.[11]

[10] Section 1 of the MHA 1983 defines mental disorder as 'any disorder or disability of the mind'. The Mental Health Act 1983: Code of Practice (DH, 2015) comments, at para 2.4: 'Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.'
[11] Section 3, MHA 1983

4.2.2.1 Patients detained under s.2 or s.3 MHA 1983 have a right to apply to the tribunal and/or hospital managers for the section to be discharged. The nearest relative can apply for the discharge of the patient, though there are some statutory limitations on when this will be effective. The Responsible Clinician must discharge the patient when they are satisfied the statutory criteria for detention are no longer met.

### 4.2.3 The Mental Health Act Code of Practice

The Code of Practice is statutory guidance. It includes detailed guidance on the issues to be considered when deciding whether compulsory detention in hospital is necessary.[12]

### 4.2.4 The Mental Capacity Act, the Court of Protection and interface with the MHA 1983

The Mental Capacity Act 2005 (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment (including residence). It applies to people aged 16 and over.

The MCA is supported by the MCA Code of Practice, which is statutory guidance on how to use and apply the MCA on a day-to-day basis.

If someone over 16 lacks the capacity to make a decision and the decision needs to be made for them, the MCA states the decision must be made in their best interests.[13]

The MCA sets out a checklist of factors to consider when deciding what is in a person's best interests.

Where a child aged over 16 lacks capacity to make decisions about their care, residence or treatment, the Court of Protection may be asked to make an order determining what is in the child's best interests, including where they should live and how they should be cared for. Where the care plan required in their best interests amounts to a deprivation of liberty, the Court can also authorise this including placements in a secure setting.

[12] DH (2015) Code of Practice, chapter 14
[13] Section 4, Mental Health Capacity Act, 2005

It should be noted that the Deprivation of Liberty Safeguards framework cannot be used for a person under the age of 18. However, from April 2022[14] the Deprivation of Liberty Safeguards framework will be replaced by the Liberty Protection Safeguards, which will apply to anyone 16 years old or over.

One important aspect of assessment is whether a child with capacity or competence to consent to informal admission in hospital is prepared to consent. The factors to be considered in relation to children are set out in chapter 19 of the MHA Code of Practice.[15] Children aged 16 and 17 should be assessed for capacity to consent in accordance with the Mental Capacity Act 2005, while children under 16 should be assessed for competence to consent (known as *Gillick* competence).[16] Consent is one of the issues the AMHP will take into consideration when deciding whether detention under the MHA 1983 is necessary.

### 4.2.5 The Inherent Jurisdiction of the High Court

The inherent jurisdiction of the High Court (which can include wardship in relation to children) is a doctrine of the English common law that a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal. In essence it can be used to 'fill in the gaps' of existing statute and case law relating to vulnerable children at risk of significant harm.

The High Court has gradually extended the use of the inherent jurisdiction to the group of vulnerable children who require protection for certain reasons. The inherent jurisdiction cannot be used where the result sought could be achieved under another legal framework such as the Children Act, the Mental Capacity Act or the Mental Health Act.

The inherent jurisdiction is wide and versatile and as such can occasionally be used to authorise secure placements for children where for some reason on the facts of the case, other legal frameworks are not appropriate, and the court is not precluded from making an order by s.100 CA 1989.

[14] This is the planned implementation date at the time of publishing this guidance.
[15] Chapter 19, Mental Health Act 1983; Code of Practice.
[16] Sections 2 and 3, Mental Capacity Act 2005; and Gillick v West Norfolk and Wisbech Area Health Authority 1986 AC 112

# 5 Transfer to hospital

## 5.1 The importance of early action

It is essential that any child thought to require inpatient treatment is identified, assessed and, if clinically appropriate, transferred to hospital as early as possible to ensure prompt and appropriate treatment of their mental health needs. Delay can make it more difficult to find a suitable hospital place at a later stage, as well as holding up access to the specialist care needed. This is as important for children in secure accommodation as for those living in the community.

For children aged 17, early planning and assessment is particularly important because at 18 they will be too old for inpatient care provided by children and young people's mental health services (CYPMHS), however liaison with adult services would be appropriate.

## 5.2 The providers of CYPMHS inpatient care and treatment

The preferred placement for a child needing inpatient care is one that combines the best treatment for their mental health difficulties, proximity to home, and the least restrictive environment. For children held in secure accommodation under section 25 CA 1989, the extra degree of security needed will mean that the likely placement options are, in rising degree of security, the following Tier 4 facilities:

- an inpatient bed in an open CYPMHS unit psychiatric intensive care unit (PICU)
- a CYPMHS low secure unit
- a medium secure CYPMHS unit – these units form a network called the Adolescent National Medium Secure Unit (ANMSU) network.

For a copy of the referral form, please contact england.specmh@nhs.net.

All units are contractually required to be members of the Quality Network for Inpatient CYPMHS (QNIC), which sets service standards, promotes self-review and peer review, and encourages the sharing of good practice.

NHS England and NHS Improvement has legal responsibility for commissioning inpatient CYPMH inpatient services. This specialised commissioning is delivered through the seven NHS England and NHS Improvement regions.

## 5.3 Procedure for referrals and reports

### 5.3.1 Summary of immediate actions to take

If a child has a mental health disorder that exceeds the ability of available mental health services in the SCH to meet their need, the Head of Healthcare (or nominated member of staff) at the SCH should:

- Consider whether the child has the capacity or competence to consent to hospital admission.
- Notify the child's social worker (who will liaise with family as appropriate and their own AMHP service local to the child's home area).
- Ring the mental health case manager (MHCM) in the relevant specialised commissioning team (the one covering the child's home area) for advice about the process and the level of security that might be needed, and to discuss the degree of urgency.
- Notify the GP and CYPMHS psychiatrist working in the SCH of the need for assessment.
- Notify the approved mental health professional (AMHP) local to the SCH of the possible need for assessment under the MHA 1983.
- Ensure that the first part of the referral form for the access assessor is completed fully.
- Ensure that the completed access assessment referral form is sent to both the access assessor and the MHCM, in accordance with the national protocol governing access to CYPMH inpatient services (see footnote 12), and contact the commissioners in the clinical commissioning group (CCG) for the child's home area, to notify them that payment will be needed for a second recommendation under the MHA 1983.
- Keep the child as fully informed as possible, explaining the process in a way they can understand and in a format that is appropriate to their age.

### 5.3.2 Referral for access assessment

In line with the national protocol,[17] referral into CYPMH inpatient services is made on the form referenced at Appendix 2 of this document. The clinician and Head of

[17] The NHS England and NHS Improvement CYPMHS Specialised Mental Health Services Operating Handbook Protocol provides the guidance for CYPMH Inpatient services and the process for Secure CYPMHS Referrals. A copy of the protocol and/or referral form can be requested by contacting england.specmh@nhs.net.

Healthcare (or nominated member of staff) at the SCH work with health and other care staff to gather the background information that is needed to support the MHA assessment process and to complete the referral for access assessment. This information is about the child's medical condition, their care status, any health or special educational needs, presenting risks and the details of the section 25 order and why it was granted. The issue of whether the child has capacity or competence to consent to admission, and whether they have consented, is covered in the form.

Where the child has a learning disability and/or autism, the outcome of the most recent CETR (Care, Education & Treatment Review), if one has taken place, will also be relevant to any decision to admit the child to hospital. If there has not been a recent CETR, one may be of assistance before any final decision as regards detention subject to the MHA is made.

It is crucial to ensure that all parts of the referral form are completed accurately, and as fully as possible, as failure to do so is one of the common causes of unnecessary delay.

The MHCM or their CYPMHS lead commissioner at NHS England and NHS Improvement will consider, based on the early conversation with the Head of Healthcare (or nominated member of staff) at the SCH, whether inpatient care is appropriate, in circumstances where an access assessment referral is received prior to an MHA assessment and/or application for admission being made, and, if so, which inpatient unit would be best for the child. Where it is considered appropriate for the child to be admitted to a medium secure unit, the section towards the end of the form after section 23 (stipulating the additional information required for referral to a low or medium secure placement) should be completed. The referral form should be sent to the ANMSU network unit nearest to the SCH.

### 5.3.3 Contacting the approved mental health practitioner (AMHP)

At the same time as submitting the referral for access assessment, the Head of Healthcare (or nominated member of staff) at the SCH contacts the AMHP in the area of the SCH to inform them that the child is in need of assessment under the MHA 1983 and that the process of access assessment prior to consideration of transfer to hospital has been initiated.

The AMHP should be given contact details of the clinicians and commissioners involved. Unless different arrangements have been agreed locally between the

relevant authorities, AMHPs who assess patients for possible detention under the MHA 1983 have overall responsibility for co-ordinating the process of assessment.

The duties of the AMHP are set out in the MHA 1983 and related Code of Practice (Chapter 14). They include satisfying themselves that detention in hospital is the most appropriate way of providing the care and treatment that is needed and is the least restrictive option.

### 5.3.4 The Access Assessment Report

This should be completed by the access assessor.

### 5.3.5 Referral form sent to MHCM and the access assessor

The referral form should always be sent to the MHCM in the relevant specialised commissioning team (the one for the child's home area) as well as to the access assessor in the relevant NHS England and NHS Improvement CYPMHS inpatient unit (the one provided by the MHCM). The access assessor is a mental health clinician based at the inpatient unit and is often the inpatient unit's consultant psychiatrist – this enables the clinician to conduct a simultaneous assessment with the appropriate medical practitioner based in the secure setting's healthcare service

If the access assessor is not also the clinician for the inpatient service where it is proposed that the child is admitted to, there needs to be a second assessment (admission assessor), to establish that it is appropriate to admit the child to a specific service. If the child is to be admitted to the ANMSU service, this will be scrutinised by the weekly referral meeting.

### 5.3.6 The two medical recommendations required for detention

The MHCM will liaise with the access assessor and the commissioning manager local to the SCH in order to determine who will provide the two medical recommendations required by the MHA 1983. One of the medical recommendations may be provided by the access assessor, or assessor for admission if their assessment falls within the requisite timeframes for the MHA 1983 and the AMHP approves, but other doctors to consider are the GP and psychiatrist at the SCH, or the doctor from the local mental health team.

### 5.3.7 Resolving problems

If there are problems with any of the above arrangements or contacts, the matter should be escalated to the appropriate Mental Health commissioner at NHS

England and NHS Improvement (the one in the specialised commissioning regional team that covers the child's home area). The Head of Healthcare (or nominated member of staff) at the SCH should also seek advice and help from the appropriate Health and Justice commissioner (the one in the region that covers the SCH where the child is placed). The resolution of problems with MHA assessments can be included in local s140 MHA agreements.

Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs. Doctors and AMHPs should be ready to consult other professionals, especially care co-ordinators and others involved with the patient's current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

Where there is an unresolved dispute about an application for detention, it is essential that professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary, on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).[18]

### 5.3.8 Information to the child and those close to them

Once the arrangement for assessment procedure has been initiated, the child continues to be cared for in their current SCH.

Now, and at each subsequent stage of the transfer procedure, the Head of Healthcare (or nominated member of staff) and the AMHP keep the child informed about what is happening and what is likely to happen next. They also notify people close to the child, the responsible local authority and – unless there are clear reasons to the contrary – the child's parents. Further guidance about informing the local authority, parents and other relatives, and other relevant services is included at the end of this section.

[18] Mental Health Act 1983 Code of Practice Department of Health 2015

If there is any delay in the process or in a suitable bed becoming available, there should be discussion between the SCH, MHCM at NHS England and NHS Improvement, the local CYPMHS team and the admitting team, where one is identified, about what steps can be taken and/or additional provision accessed in the interim to support the SCH to meet the child's needs. The AMHP will need to be kept informed if there is delay in identifying a bed so the application can be completed once this is identified.

### 5.3.9 Role of the AMHP

It is the AMHP's duty to convene an MHA 1983 assessment in line with the MHA and Code of Practice, and to notify or consult with the nearest relative. If the AMHP is satisfied the statutory criteria are fulfilled, they will make the formal application for compulsory detention for treatment to the unit where the child is to be admitted. A named hospital must be identified for the application to be completed. Though in community settings the role of the AMHP would involve co-ordinating transport, in these settings the SCH would co-ordinate this.

## 5.4 What can help avoid delay

### 5.4.1 Have a robust system in place

The relatively infrequent need for transfer makes it important that the Manager of the SCH has a clear system in place for implementing the procedure outlined above. The Head of Healthcare (or nominated lead) at the SCH will be very clear about the process and they will ensure that the healthcare team have:

- an up-to-date contact detail list for the AMHP service
- up-to-date contact information for the relevant CCGs, NHS England and NHS Improvement specialised commissioning teams and local authorities for **all** the children in their SCH
- up-to-date contact information for the Health and Justice commissioner in the team covering their SCH
- a copy of the national protocol (*Referral and Access Assessment Process for Children and Young People into Inpatient Services, for PICU, LSU and MSU*) for their region, and knowledge that the protocol includes the process for referral and access assessment for inpatient services, the national referral form, and contact details for the MHCMs and the CYPMHS consultant psychiatrist local to their SCH.

### 5.4.2 Act with urgency

Each referral will be unique in terms of circumstances but having in mind the timescale of seven days from referral by the SCH to transfer to hospital should help focus everyone's attention on responding quickly when the need arises for inpatient treatment.

It is also helpful if staff know that the inpatient units have stated timescales for reviewing and making a decision about a referral and for responding to the referrer:

- For PICUs – the timescale is 24 hours.
- For low secure units – the timescale is 24 hours for responding to emergency cases and 48 hours for urgent cases.
- For medium secure units – the ANMSU network cannot provide emergency cover but can provide a rapid response to contribute to the assessment and management of imminent harm to others in the context of the child's mental disorder. The network will provide advice to referring clinicians to ensure that any subsequent referral is appropriately directed to medium or low security.

Early contact with the relevant MHCM at NHS England and NHS Improvement is essential and, the more comprehensive the referral to the access assessor, the greater the chance of minimising delay. This is the case generally, but it is particularly important if the situation is very serious. Healthcare and other staff from the SCH can help by giving their view about the severity of the referral, including, if appropriate, why they consider it to be an emergency.

### 5.4.3 Ensure staff confidence about data protection provisions

There are no data protection issues that prevent residential staff in an SCH from sharing information about a child's history and background with healthcare staff, the MHCM, the AMHP and the access assessor. By virtue of their current situation, these are children at risk of significant harm and therefore relevant exemptions apply under the Data Protection Act 2018 and GDPR (General Data Protection Regulation (EU) 2016/679) permitting disclosure of relevant proportionate information to inform the assessment process. Having information from all relevant sources is more likely to result in an accurate and comprehensive assessment of their needs and risks. This applies equally to healthcare staff. They must ensure that information that they hold about a child, including the possible need for transfer

and information relevant to risk, is shared with others, in line with their local information sharing protocol.

### 5.4.4 Understand how difficulties in securing an appropriate placement are dealt with

#### 5.4.4.1 If the criteria for admission to inpatient treatment are met but there is no capacity within NHS England and NHS Improvement-commissioned provision

The lack of available placement in an NHS England NHS Improvement commissioned unit should not delay the transfer of a child in need of hospital treatment. The access assessor will discuss other possible options with the MHCM. The MHCM must do a risk assessment of the situation, based on the impact of any delay in transferring the child, and keep the case under regular review, in close liaison with the SCH caring for the child.

If there is any delay in the process or a suitable bed becoming available there should be discussion between the SCH, the MHCM at NHS England and NHS Improvement, the local CYPMHS team and if appropriate the admitting team about what steps can be taken and/or additional provision accessed in the interim to support the SCH to meet the child's needs safely.

The responsible MHCM and Health and Justice commissioner should both be alerted, to mediate and support an individual package of care, outside the dedicated, specialist CYPMHS where clinically appropriate, that will enable the risk to be managed.

#### 5.4.4.2 If the criteria for admission to inpatient treatment are not met

If the referral does not appear to meet the criteria for admission, the referrer will need to know the reasons for that recommendation. The relevant inpatient unit will report back to the doctor in the SCH and will give as much advice and support as possible about alternative treatment options, management of the child's care, and placement options.

#### 5.4.4.3 If the secure setting is unable to continue to meet the need

If, after the above advice, the SCH does not feel able to continue to meet the needs of the child, the Health and Justice commissioner responsible for commissioning the CYPMHS in the SCH (the one local to the SCH) will need to meet with the multidisciplinary team in the secure setting, to discuss a care plan for the child and

potentially offer to resource additional services in the interim, with a view to the child achieving recovery and therapeutic benefits from an enhanced package of care.

This care plan can be discussed with the assessing unit that did not accept the referral and used as a basis for improved understanding of the threshold for admission and of the care and treatment that can be provided by different inpatient units, including those in the ANMSU Network.

A solution might also be found in another SCH, through discussion between the healthcare teams in different SCHs about where the child's needs could be met.

## 5.5 Arranging the transfer

If a bed is available, the admitting inpatient unit liaises directly with the referring clinician to agree the timescale and process for admission. This is done verbally, so that transfer can be made as quickly as possible, with the full written report sent later. Note that transfer should take place within seven days of the SCH making the referral for inpatient treatment. If it appears that this may be difficult to achieve, the Head of Healthcare (or nominated staff member) should notify the relevant MHCM and the relevant Health and Justice Commissioner.

The admitting unit will already have the information it needs from the referral form[19] and section papers. If there are any additional risk issues that have arisen after completion of the referral form, it is important that these are properly handed over to the new team.

The AMHP is responsible for ensuring that all the necessary arrangements are made for transporting the child to the inpatient unit, and agencies should cooperate fully with the AMHP to ensure safe transport. There should be an agreed system in place so that AMHPs are not negotiating arrangements on an ad hoc basis.[20] Generally, the SCH provides transport to the inpatient unit and the inpatient unit provides transport back to the SCH after treatment.

[19] The NHS England CAMHS Specialised Mental Health Services Operating Handbook Protocol provides the guidance for Tier 4 services and the process for Secure CAMHS Referrals. A copy of the protocol can be requested by contacting england.specmh@nhs.net.
[20] DH (2015) Code of Practice, chapter 17

If necessary, a child can be transferred to a CYPMH inpatient service out of hours. Where admission does take place out of hours, or at the weekend or a bank holiday, the MHCM will need to be alerted to this on the next working day.

## 5.6 Key people and services to inform and contact

### 5.6.1 Involve the child so far as possible

Children should always be kept as fully informed as possible and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age. The child's views, wishes and feelings should always be sought, their views taken seriously, and professionals should work with them collaboratively in deciding on how to support that child's needs.[21]

### 5.6.2 Involve people in the child's life

Those who are co-ordinating the child's care should ensure that services with an interest in the child are aware of transfer decisions and arrangements. This is important so that the child can benefit from what everyone has to offer, and so that arrangements for the next stage of the child's care can be made in good time and include the right combination of services. The importance of co-ordinating in this way applies to all settings: both the secure setting where the child is held and the hospital to which the child is transferred.

### 5.6.3 Local authorities

As the child is looked after the local authority responsible for them must be closely involved. It is preferable for contact at this stage to be with the child's social worker or their manager, as they need to know that the child is about to be moved to another location and they need to be part of planning the next stage of care.[22] Local authorities are required to have a care plan for each looked after child and the plan will need amending[23] if the child is to be transferred to hospital from the SCH.[24] The social worker or their manager should be included in discussion about who is best placed to keep the child's parents up to date about what is happening (see below).

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[21] DH (2015) Code of practice
[22] Regulation 15 of The Children (Secure Accommodation) Regulations 1991 makes provision for the Local Authority looking after the child to appoint 3 people to review the child's accommodation
[23] There are a number of procedural steps a local authority must go through before any significant change in a care plan; these are all set out in the *Care Planning, Placement and Case Review (England) Regulations 2010*.
[24] Department of Health (2015The Children Act 1989 guidance and regulations: Volume 2 Care planning, placement and case review

They should also ensure that, if the child is returning to an SCH in a different local authority, the new local authority is informed of the move.

### 5.6.4 Parents and other relatives

It is good practice to involve parents in decisions made about children. There is a duty on the Local Authority to inform parents and others of intention to apply to keep a child in an SCH,[25] provided under Regulation 14 The Children (Secure Accommodation) Regulations 1991. The local authority is under a duty (s.34 Children Act 1989) to allow reasonable contact between a child in care and their parents/guardians etc. unless it would be contrary to the welfare of the child. Section 22(4) of the Children Act 1989 generally requires the local authority to ascertain the wishes and feelings of a number of people, including parents, as far as reasonably practicable and before making the decision. This would include any decision to change placement. The level of contact between children in care and their parents and other family members will vary with individual circumstances. It will be important to check, with both the child and their social worker, how parents and other relatives should be informed about and involved in the child's transfer to hospital. It may also be important to contact the Responsible Clinician at the admitting unit, as on occasion there may be a clinical reason to restrict or limit such contact. As explained in the MHA 1983 Code of Practice (para 19.13), the local authority should negotiate and agree with parents about who should be consulted about admission and treatment decisions. Guidance on parental contact must be recorded one way or the other and followed throughout.

Where the local authority has confirmed that parents should be involved and informed, the information needed by parents is similar to that needed by parents of any child receiving care and treatment in hospital. It includes knowing who their point of contact is at the hospital, how and when they can speak to their child's doctor, and how they will be involved in planning for their child's care and discharge. They need to know the arrangements for visiting their child and for telephone contact to and from their child in between visits. Parents eligible for travel warrants need to know if they cover hospital visits, including for pre-discharge and other planning meetings. The Code of Practice reminds local authorities of their

[25] Section 25 of the Children Act 1989

duty to ensure that looked after children in hospital are visited and to consider financial support to enable families to stay in contact with children.[26]

Parents should also be informed of the arrangements for seeking feedback about their child's care and treatment and they should be encouraged, both during the stay and on discharge, to pass on their views and recommendations.

Where children are competent, and have the capacity to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. However as with adults, in certain circumstances confidential information may be disclosed without the competent child's consent, for example if there is reasonable cause to believe that the child is suffering or is at risk of suffering, significant harm. Practitioners should encourage the child to involve their parents or others with parental responsibility in decision making about their care and treatment.[27]

### 5.6.5 Relevant services

The following list is not exhaustive but, for example:

- Give early notice of a transfer decision to the relevant CYPMHS **consultant psychiatrist** or equivalent from the child's home area. This is good practice because, on their release, the child might be discharged to that person under the Care Planning Approach (CPA) framework.

- If the child has alcohol and/or drug problems, information from any **substance misuse service** at the SCH can help ensure that the admitting inpatient unit has up-to-date information about the child's circumstances and any treatment programme. On release, they can provide similar information to community services.

- **Advocates** have an important role to play, listening to child's concerns and in some cases liaising on their behalf with SCH staff, inpatient staff and parents.

[26] DH (2015) Code of Practice, chapter 19, paras 121-122; The Children Act 1989, Schedule 2; and DH (2015) The Children Act 1989 guidance and regulations: Volume 2 Care planning, placement and case review
[27] DH (2015 Code of Practice 19.14 and 19.15

# 6 Return from hospital, and arrangements for after-care

Once the clinical team providing inpatient treatment decides that the criteria for detention under the Mental Health Act 1983 are no longer met, discharge from hospital needs to be arranged. It will also be necessary to discuss the situation with the local authority that has the care order or is otherwise looking after the child, so that it can decide whether to seek a further section 25 order (enabling the child to be returned to secure accommodation on discharge from hospital).

Section 117 of the MHA 1983 places a duty on CCGs and local authorities, in cooperation with voluntary agencies, to provide or arrange after-care services following discharge from hospital for patients who have been detained subject to s.3 MHA.[28] After-care plans for a looked after child need to be integrated with the existing care plan for the child and with any existing provision provided as a result of that plan.[29] It will, therefore, be essential for the relevant local authority to participate in the care planning meetings and section 117 meeting at hospital so that the discharge planning is incorporated into the local authority care plan from the onset and so that everyone involved is clear about where the child is moving to, when and how the transfer will be made, and what help will be provided after transfer.

The discharge steps are as follows:

- The responsible clinician in the unit informs the local authority that the child no longer requires treatment in hospital and invites attendance at the unit's discharge planning meeting.

- The unit convenes the discharge meeting, to discuss the arrangements for s.117 after-care if applicable, and to agree a Care Planning Approach (CPA) care plan that will be incorporated into the child's looked after care plan. The arrangements include the ongoing mental health services needed and the setting to which the child will be discharged.

[28] DH (2015) Code of Practice, chapter 19, para 33.2
[29] DH (2015) Code of Practice, chapter 19, para 111; and DH (2015) The Children Act 1989 guidance and regulations: Volume 2 Care planning, placement and case review

- The meeting should be attended by relevant staff from the unit, the allocated social worker from the local authority and, if appropriate, the child's parents.

- If the child is to be discharged to secure accommodation, healthcare workers in the receiving SCH must be invited to attend the meeting and, as a matter of good practice, they should make every effort to do so. If they cannot attend, this must not delay the child's discharge from hospital. Any uncertainty about which SCH the child will transfer to, and/or when, is a matter for resolution by the MHCM and Mental Health commissioner who would have to liaise with the Secure Welfare Co-ordination Unit.

# 7 The role of CCGs and NHS England and NHS Improvement specialised commissioning teams in relation to transfers

The first assessment of a child's possible need for hospital treatment for mental disorder is funded by the SCH, as part of their healthcare provision.

Decisions after that need to involve the child's CCG and the mental health team (MHCM/s and the Mental Health commissioner) in the NHS England and NHS Improvement specialised commissioning team in the child's home area, because of their respective roles in funding assessments and placements:

- The specialised commissioner is responsible for funding **placements** provided by NHS England and NHS Improvement – including PICUs, low secure units, and medium secure units in the ANMSU network.

- MHA assessments are funded through the CCGs.

- CCGs will be responsible alongside the local authority for S117 aftercare where applicable, and therefore should be involved all the way through the process. NHS England and NHS Improvement rather than the CCG has s.117 commissioning responsibility in relation to children while in a SCH.[30]

[30] Regulation 14, 15 and Schedule 1, paragraph 4, The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

## 7.1 Establishing the responsible mental health commissioner

Healthcare staff, both in the SCH and in the NHS Trust, need to know which CCG and NHS England and NHS Improvement specialised commissioner to contact and what information to pass to them, to help them make timely decisions about mental health care and treatment.

- The appropriate specialised commissioner is the one in the NHS England and NHS Improvement specialised commissioning regional team covering the child's home area.

- NHS England and NHS Improvement commission inpatient services and secure settings mental health care services. The appropriate CCG for children in secure accommodation in England, in the case of transfer to hospital under the MHA 1983, is the one where the child was registered with a GP before being placed in secure accommodation.[31] If the child was not previously registered with a GP, the appropriate CCG is the one where the child habitually resided before entering secure accommodation. Note that this contrasts with the majority of other healthcare services for children in secure accommodation, for which the appropriate CCG is the one in which the secure setting is located. The local authority for a looked after child should be able to identify the responsible CCG commissioner for the child.

There are some responsible commissioner differences between England and Wales. If in England, NHS England and NHS Improvement commission the inpatient beds. In Wales, NHS Wales commission inpatient beds. In Wales, the responsible commissioner is determined by the usual residence of the child rather than GP registration before entering secure accommodation. When making decisions about children whose last known residence, or habitual residence, was in Wales, and who are deemed to require transfer to hospital under the MHA, practitioners should contact the Welsh Health Specialised Services Committee in the first instance. Contact details are at Appendix 3.

A key message for healthcare staff is that disagreement or confusion about establishing the responsible commissioner must never delay or adversely affect

[31] Who Pays? Determining which NHS commissioner is responsible for making payment to a provider, August 2020.

treatment. An arrangement can be sought between commissioners for interim payment while commissioner responsibility is being determined.

NHS England and NHS Improvement Health and Justice Commissioners also have a role to play. They have responsibility for the commissioning of health provision in all secure psychiatric hospital inpatient settings for children, including welfare only SCHs. They will want to be kept informed about any difficulties relating to assessments of children and interim support pending placement for inpatient treatment. The relevant team for the purposes of the transfer procedure is the one that covers the SCH where the child is placed.

## 7.2 Reducing delay and providing high-quality care

To facilitate the smooth implementation of the transfer procedure, it can be helpful for commissioners to bear in mind the following aspects of good practice.

#### 7.2.1.1 Providing high-quality care

- Promote and support timely assessments.
- Be pro-active about ensuring that everything is in place to support a child's care, including arrangements for their discharge and possible return to their home area.
- Take part in the section 117 requirements for discharge and aftercare support.
- Support the work around CPA care planning
- Ensure that local children's mental health service and other services have early notice of a child's release date.