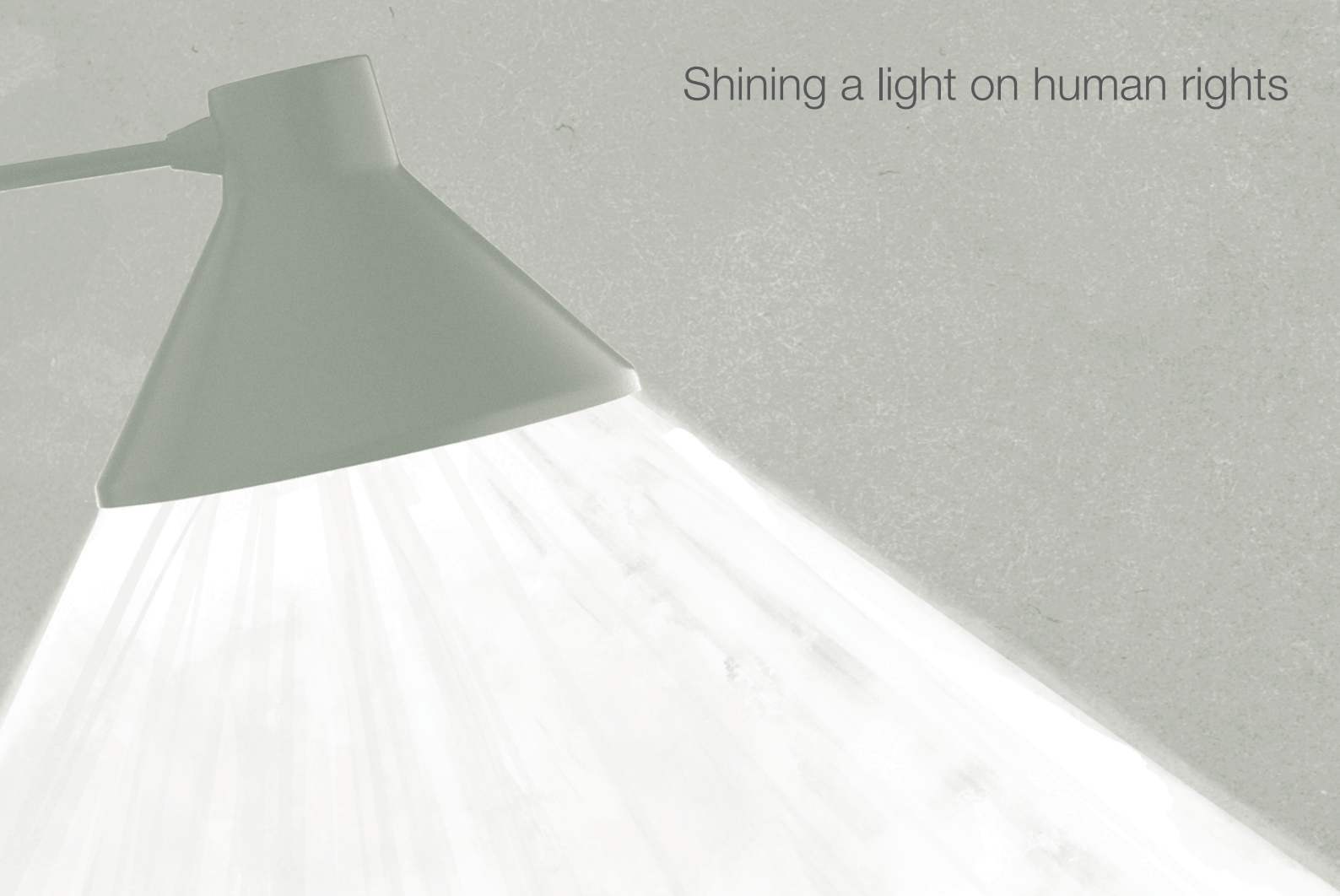
Shining a light on human rights



Mental Health Care for Children and Young People and Human Rights:

A practitioner's guide

The British Institute of Human Rights
bihr.org.uk

About this booklet

This booklet is about human rights in mental health settings for children and young people. It is aimed at professionals working in hospitals but some of the information may be useful for work in the community. We use the term 'practitioner' throughout to include anyone working in these settings (e.g. qualified and unqualified workers). We use the term 'young people' throughout to mean any person using mental health care under the age of 18.

Lots of information in the booklet may also be useful for people using services, their family, carers or advocates (BIHR has also produced a range of resources aimed at people using mental health services, see www.bihr.org.uk).

This booklet was written by the British Institute of Human Rights (BIHR), in partnership with **The St Aubyn's Centre**. The service is working with BIHR on our project called **Delivering Compassionate Care: Connecting Human Rights to the Frontline**. The project aims to place human rights at the heart of mental health services, helping to ensure frontline staff have the knowledge and skills to fulfil the vital role they can play in upholding the dignity and human rights of patients. The project is funded by the Department of Health, therefore the information in this booklet focuses on English law and bodies.

BIHR would like to thank the practitioners at St Aubyn's centre for their help in producing this booklet, particularly the Human Rights Leads for their ideas, advice and guidance.

This booklet should be read in conjunction with our other resource '**Mental Health, Mental Capacity and Human Rights: A practitioner's guide**'. That resource contains more information about how UK law protects human rights, key rights for mental health/capacity services and where to find more information/support.

Mental health care for children and young people

Many of the aims of services helping children and young people who are experiencing mental health, emotional and psychological issues align with human rights values. These include:

- supporting young people to be involved in their care and treatment plans
- young people being treated with dignity and respect in their interactions with services
- ensuring family members/carers are able to participate in discussions

Autonomy, control and participation are all key human rights values and are protected by the **right to respect for private life** (Article 8, Human Rights Act 1998). This and all the other rights in the Human Rights Act (HRA) apply to young people the same as they apply to adults.

This booklet aims to give practitioners the knowledge and confidence to use human rights in practice to design and deliver rights-respecting mental health services to young people. The booklet is arranged around three key issues for practitioners, identified by our partner.

Finding your way around

1 **This booklet is for information purposes only. It is not intended, and should not be used, as legal advice or guidance.**

one

Seclusion vs de-escalation

Resorting to seclusion when de-escalation methods fail when working with young people who present with behaviours of concern will raise human rights issues. This part of the booklet is for practitioners working with young people below the age of 16* in mental health hospitals. It suggests what a human rights approach to seclusion and de-escalation could include. (Please see the note opposite about this booklet not being used as legal advice or guidance.)

Recognising the difference between de-escalation and seclusion

What is seclusion?

Seclusion is the supervised confinement and isolation of a patient, to a designated area, where they are prevented from leaving. It is a restrictive intervention used only when immediately and absolutely necessary to contain severe behavioural disturbance which could harm others. It should not be used as a form of punishment and it should not form part of a treatment programme. (See MHA Code of Practice chapter 26.103-108)

What is de-escalation?

De-escalation is the gradual resolution of an episode where a patient is showing signs of agitation which could lead to a behavioural disturbance that harms others. These methods should be tailored to the person's needs and requirements and can use both verbal and non-verbal modes of communication. Family members can also feed into de-escalation techniques. (See MHA Code of Practice chapter 26.24-27)

Where a young person is detained under the MHA and is exhibiting behaviours of concern, there may be circumstances where it becomes necessary to restrict their right to liberty in order to protect the rights of other patients or staff. The key issue for practitioners is to ensure that this is the least restrictive intervention possible in order to achieve a legitimate aim (e.g. keeping other people safe).

Seclusion should only be used as a measure of last resort when all other alternatives (such as de-escalation techniques) have been tried and have failed. Practitioners should refer to the MHA Code of Practice to ensure that they are meeting the seclusion safeguards and procedures set out (see chapters 19 and 26).

Potential human rights issues for practice

This could include:

- seclusion of a young person against their will or without parental consent (where the young person lacks competence or capacity to consent – see page 11) without access to legal safeguards to protect their right to liberty (e.g. those in the MHA)
- secluding a young person detained under MHA as routine, rather than as a last resort
- secluding a young person as a punishment or way to encourage good behaviour
- extreme seclusion techniques which have a serious impact on the young person which could amount to inhuman or degrading treatment
- failing to act to protect other patients/staff members from serious harm from a young person exhibiting behaviours of concern

* For young people aged 16+ not detained under the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 (MCA) can be used where there are concerns about a young person's capacity to consent to an intervention. The MCA sets out the framework for practitioners to carry out a capacity assessment and make a best interests decision. See section 6 of the MCA and chapter 26.60 of the Code of Practice.

Seclusion and informal patients

For patients not formally detained under the MHA, the Code of Practice discourages use of seclusion. It states that in an emergency situation involving an informal patient and, as a last resort if seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the MHA should be undertaken immediately (see MHA Code of Practice chapter 26.59 and 26.106).

Therefore this part of the booklet assumes that seclusion techniques would only be used for young people detained under the MHA, or where assessment for detention follows immediately after.

Key rights for seclusion vs de-escalation

Right to liberty

(protected by Article 5 in the Human Rights Act)

Seclusion will engage a young person's right to liberty. This right can be restricted in specific circumstances, such as detention under the MHA. Even if a restriction on liberty is for a lawful reason, there are still human rights safeguards which must be in place.

Relevant practitioners' duties:

- to respect this right: not interfering where possible
- to protect this right: applying the procedural safeguards written into the right

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 15** for more information, including your other duties.

Right to be free from inhuman or degrading treatment

(protected by Article 3 in the Human Rights Act)

This right protects people from being treated in a way which causes them serious mental or physical harm, or humiliates them. This is an absolute right which means there can never be a lawful reason to treat someone in this way. (Less serious psychological trauma or physical harm is covered by Article 8, opposite.) Extreme seclusion interventions may be a risk to this right.

Relevant practitioners' duties:

- to respect this right: not breaching in any circumstances
- to protect this right: taking action to protect a person from a known and immediate risk of serious harm, often called **safeguarding**

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 12** for more information, including your other duties.

Right to respect for private life (protected by Article 8 in the Human Rights Act)

This right includes people's **autonomy** (having control over their own life and decisions about care and treatment) and people's **well-being** (which protects people from less serious psychological trauma or physical harm). This right can be restricted where the intervention is lawful, for a legitimate reason and proportionate. For seclusion purposes this includes evidencing that:

- all other options had been explored
- this form of intervention was absolutely necessary
- it was used for the shortest period of time possible

Relevant practitioners' duties:

- to respect this right: not interfering where possible unless it is lawful, for a legitimate reason and proportionate
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

A human rights approach to seclusion vs de-escalation

This could include:

- ✔ empowering the young person about their rights, particularly their right to liberty and to autonomy
- ✔ explaining the difference between de-escalation and seclusion and when these might be necessary
- ✔ working with the young person before behaviours of concern escalate, to explain why their behaviour might impact on other people's rights and how that could be avoided
- ✔ consulting with the young person (and their family/carer where appropriate) about their care and treatment and agreeing a care plan, including dealing with behaviours of concern
- ✔ using seclusion only as a last resort after all other de-escalation methods have been tried and not worked
- ✔ ensuring seclusion interventions are used for as short a time period as possible with a regular review process to assess appropriateness

Worked example: de-escalation

Jermain is 14 and has been an informal patient on a mental health ward for several months. He has made little progress with his treatment plan and has started to exhibit behaviours of concern. He refuses to take part in planned activities and swears at staff who try to encourage him. Staff have started to discuss what they should do if his behaviour escalates and Jermain becomes a risk to others.

Frank, a nurse on the ward, arranges a meeting with Jermain and his family and expresses the team's concerns about his behaviour. Frank gives Jermain information about his right to liberty, and right to respect for private life which includes autonomy. But Frank makes it clear that if Jermain's behaviour escalates to a point of violence, de-escalation techniques may have to be used. Frank explains this is because they have a duty to protect the rights of the other patients and staff who may be at risk if Jermain's behaviour escalates. Frank explains that there are also seclusion techniques, that would involve removing Jermain to a room by himself, for as short a period of time as possible, to calm down. However, Frank is clear that seclusion would only be used if absolutely necessary and all other de-escalation methods had failed.

In consultation with Jermain and his family, some de-escalation techniques are agreed which staff can try when Jermain's behaviour becomes concerning, to avoid resorting to seclusion.

one: Decision-making flowchart

Seclusion of young people in mental health hospitals

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This flowchart is for practitioners considering whether to seclude a young person in a mental health hospital

Which of my Human Rights Act duties are triggered?

- **Duty to protect the young person from inhuman and degrading treatment**
- **Duty to respect the young person's right to private life (autonomy)**
- **Duty to respect the young person's right to liberty**

Duty to **protect** the young person from inhuman and degrading treatment

Step 1: Is the impact of seclusion on the young person likely to cause them serious harm?

YES

Take immediate action to prevent this by considering other options or ways to reduce the impact of the seclusion on the young person.

Move to step 2

NO

If the decision to seclude is against the young person's will, this is likely to interfere with their right to private life.

Move to step 2

Duty to **respect** the young person's right to private life (autonomy)

Step 2. Are you considering secluding a young person against their will?

YES

The right to private life protects the person's right to make their own decisions without outside interference. This right is non-absolute so if you need to interfere with it, you have to follow this 3 stage test:

1. Lawful: Is the young person detained under the MHA or has an emergency application been made?
2. Legitimate reason: what are you trying to achieve through seclusion? For example, protecting others from immediate risk?
3. Proportionate: Is the seclusion the least restrictive step you could take to achieve that aim?

YES TO ALL

Move to step 3

NO TO ANY

Seclusion is not likely to be rights compliant. Reconsider your decision.

NO

Move to step 3

Duty to **respect** the young person's right to liberty

Step 3. Are you still considering secluding the young person?

NO

Exit the flowchart

YES

A seclusion will restrict the young person's right to liberty. This right is non-absolute but you will need to ensure the correct procedural safeguards are in place and working effectively.

If the young person is detained under the MHA you will need to show:

- reasonable measures have been taken to avoid having to seclude
- the young person is informed of their rights and the reasons why it is lawful to seclude them
- the seclusion ends as soon as it stops being necessary and proportionate
- there are regular reviews to consider the need for seclusion to continue

If the young person is not detained under the MHA and you think seclusion is necessary, arrange a MHA assessment as soon as possible.

Explaining the steps in the flowchart

Flowchart information: Does the intervention amount to a seclusion?

To determine whether the action taken is a seclusion, consider the particular circumstances, for example:

- Is the young person being supervised in isolation away from other patients as a necessary step to manage an immediate risk? Remember, seclusion should never form part of planned treatment.
- If the person tried to leave the room they are in (this could be their own room) would they be prevented from doing so?
- If the intervention started out as a de-escalation strategy, has the young person been supervised in a particular area for a significant period of time (taking into account the impact of the situation on that person)?

If the answers to any of these questions is no, then the intervention may not be a seclusion. It may have more features of a de-escalation where the young person's right to autonomy may still be an issue. See MHA Code of Practice chapter 26 for more information.

Step 1. Is the impact of seclusion on the young person likely to cause them serious harm?

The threshold for inhuman and degrading treatment is very high. Is there evidence of serious psychological trauma or physical harm as opposed to a temporary loss of control over the situation? The MHA Code of Practice recognises that seclusion can have particularly adverse implications for children and young people. It states decisions to seclude should be made by a trained child and adolescent clinician and include careful assessment of the potential effects of seclusion, particularly for those with histories of trauma and abuse (MHA Code of Practice chapter 26.57).

Where there is no evidence that a seclusion has reached the high threshold for inhuman and degrading treatment, the right to respect for private life might be relevant as it includes well-being; this protects people from less serious psychological trauma or physical harm.

The right to respect for private life also protects people's autonomy so will be relevant where you are considering secluding a person against their will. It places a positive obligation on practitioners to take steps in situations where this right is at risk.

Step 2. Are you considering secluding a young person against their will?

To determine whether an interference with the young person's right to private life is lawful, you need to follow the three stage test:

1. **Lawful:** is there a law which allows the interference? The MHA is the only law that can permit seclusion in hospital. It can help to protect the young person's rights by introducing safeguards including a Mental Health Act assessment and review tribunals. (The Children Act permits interventions to safeguard or promote a child's welfare, but this would not authorise actions that amount to a deprivation of liberty, such as seclusion. See MHA Code of Practice chapter 26.61)

2. **Legitimate reason:** you must have a legitimate aim you are trying to achieve, and these reasons are set out in the right itself, including protecting the rights of other people (such as from harm). Note: the MHA Code of Practice states that seclusion can only be used to protect others from risk of harm, and not to protect the person from themselves.

3. **Proportionate:** the way you achieve that aim must be proportionate. You will need to show you have considered all other, less restrictive options. If seclusion is used, factors to avoid a disproportionate response might include shortening the period of seclusion, making the young person more comfortable and making the experience less intrusive.

Step 3. Are you still considering secluding a young person?

As seclusion is a very restrictive intervention, there are additional procedural safeguards required to protect the young person's right to liberty.

There is detailed guidance in the MHA Code of Practice on who can authorise a seclusion and how reviews should happen (see MHA Code of Practice chapter 26.112).

Supporting young people with eating disorders

Supporting young people in mental health services who have eating disorders is likely to raise human rights issues. You will need to consider your duty to protect their right to life, and to avoid inhuman/degrading treatment, as well as your duty to respect the young person's right to private life, particularly their autonomy. You will need to be clear about all the circumstances, which rights are absolute and when you can balance non-absolute rights. It will be important to include the young person (and their family/carer/advocate where appropriate) in these decisions and ensure proportionate (least restrictive) actions.

In life threatening situations where a young person is refusing lifesaving treatment and a serious intervention (such as forced feeding) is being considered, a court order should be sought to ensure all human rights considerations can be taken into account. Where a young person deemed 'Gillick competent' refuses consent to treatment, a court can overrule their decision if this could lead to death or severe permanent injury.

Potential human rights issues for practice

- failing to take reasonable steps to protect a young person where you know their life is at risk due to an eating disorder
- forced feeding of a young person with an eating disorder against their wishes where the impact on them is so severe it amounts to inhuman or degrading treatment
- intervening in the decision of a young person to skip meals or engage in extreme dieting where they are 'Gillick competent' / assessed as having capacity
- failing to spot the warning signs of an eating disorder for a young person in your care (such as skipping meals, purging etc.) to provide early intervention mental health support if appropriate

A human rights approach to supporting young people with eating disorders

This could include:

- ✔ empowering young people about their rights, including to participate in decisions about their care/treatment, to have their views heard, to make their own decisions if 'Gillick competent' / assessed as having capacity, or be supported as far as possible to do so
- ✔ spotting early signs of an eating disorder if possible and sensitively raising this with the young person or their family/carer if appropriate
- ✔ discussing all care and treatment options with the young person, explaining that you have a duty to protect their right to life and to be free from inhuman/degrading treatment, but also to respect their autonomy (including explaining that some rights are absolute and cannot be breached, but some can be restricted provided the correct process is followed and it is proportionate)
- ✔ discussing in a sensitive way why more restrictive interventions (e.g. forced feeding) may have to be used as a last resort if their life is at risk
- ✔ agreeing a treatment plan with the young person, and their family/carer if appropriate
- ✔ keeping the treatment plan under close review and discussing regularly with the young person

two

Autonomy

The right to respect for private life includes people's autonomy; having a say over care and treatment and making their own decisions. In addition to the Mental Health Act (MHA), the 'Gillick competency' test and the Mental Capacity Act (for people aged 16 and over) are legal frameworks to assist you to fulfil your legal duty to respect young people's autonomy (see MHA Code of Practice chapter 19.24-37).

Mental Health Act

In very severe manifestations of eating disorders where compulsory feeding may be necessary to prevent physical complications and to treat the underlying mental disorder, compulsory admission under the MHA may be permitted. In these circumstances, practitioners should discuss this with the young person (and their family/carer/advocate if appropriate) to decide which section of the MHA is most appropriate for the young person. This type of intervention should be regularly reviewed and be the least restrictive option, taking into account the human rights of the young person. In particular, to protect their autonomy, you should take into account 'Gillick competence' and the MCA (for over 16s).

Mental Capacity Act (aged 16 and over)

For young people aged over 16, you should assume that they have capacity to consent to treatment. If you have concerns about their capacity to consent due to an impairment of their mind or brain (including mental illness), the MCA sets out a legal test to assess capacity. This looks at whether the person is able to understand, remember, weigh up the pros and cons and communicate their decision. Remember that capacity is decision-specific and can fluctuate (see our other booklet 'Mental Health, Mental Capacity and Human Rights: A Practitioner's guide' page 14).

Gillick competence (under 16s)

The 'Gillick competency' test helps practitioners to assess whether a child under 16 has 'sufficient maturity' to make their own decisions. When the young person has enough understanding and intelligence to fully appreciate what is involved in their treatment, they will be able to consent for themselves. In this situation, the child's right to autonomy and to make their own decisions outweighs the parent's view or decision. (Gillick v West Norfolk, 1984).

If a child is assessed as not having sufficient maturity to consent to treatment, someone with parental responsibility can consent for them. The young person's welfare or "best interests" must be the first concern. This includes consideration of their human rights.

If a young person refuses life-saving medical treatment (for example, force-feeding) that their parents wish them to receive, the law is more complex. In these instances, legal advice and a court order are likely to be necessary, to ensure that all human rights considerations can be fully taken into account.

Key rights for supporting young people with eating disorders

Right to life

(protected by Article 2 in the Human Rights Act)

This includes a positive obligation on practitioners to take reasonable steps to protect a young person's life where it is known to be at immediate risk (see box below).

Relevant practitioners' duties:

- to protect this right: taking reasonable steps to protect where there is a known and immediate risk to a person's life - see below

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 10** for more information, including your other duties.

What does my duty to 'take reasonable steps' to protect life involve?

Practitioners will have a duty to take reasonable steps to protect life where:

- you know, or ought to know (e.g. because it has been reported to you) that there is a real, immediate and identifiable risk to the life of the young person; and
- there are reasonable steps, within the scope of your powers, you could take to avoid that risk

Legal case: Osman v UK (2002)

The courts have set out what 'reasonable steps' to protect life might include. These are not steps which put an impossible or disproportionate burden on the public authority but could include:

- obtaining access to additional information to help you make a decision
- undertaking risk assessments or mental health assessments
- observing a person known to be at risk of taking their life
- ensuring all public officials involved in the care of a person at risk have access to all relevant information

Right to be free from inhuman or degrading treatment

(protected by Article 3 in the Human Rights Act)

This right protects people from serious abuse or neglect which causes mental or physical harm, or humiliates them. Where a young person has an eating disorder this could cover:

- lack of food leading to the young person being at risk of inhuman/degrading conditions
- serious interventions to protect their right to life, which could lead to inhuman or degrading treatment, such as forced feeding

Whether something is 'inhuman or degrading' depends on the impact on the young person. You should consider their personal circumstances such as their age, mental or physical health, gender etc.

Relevant practitioners' duties:

- to respect this right: not breaching in any circumstances
- to protect this right: taking action to protect someone from a known and immediate risk of serious harm, often called **safeguarding**

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 12** for more information, including your other duties.

two

Right to respect for private life

(protected by Article 8 in the Human Rights Act)

This right protects the young person's **autonomy** and **well-being**. This could include:

- participating in decisions about their care, including consent to treatment and meal plans
- respecting the choices and decisions of young people who are 'Gillick competent' / assessed as having capacity, even if the decisions may be considered unwise, such as extreme dieting
- self-neglect which is less serious than inhuman or degrading levels but which has an impact on the young person's well-being

Relevant practitioners' duties:

- to respect this right: not interfering where possible unless it is lawful, for a legitimate reason and proportionate
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

Worked example: young person with eating disorder

Anna is 15, has been diagnosed with anorexia and her condition is deteriorating. She has been detained under s3 of the MHA for three months. Initially, she complied with her meal plan and was showing signs of improvement. However, she has since become fixated with an online forum that promotes anorexia, which she accesses through her mobile phone. She is now refusing to comply with her meal plan and staff are becoming concerned about her drastic loss of weight and her physical health. Anna's mental health is also deteriorating and she has started self-harming, in one instance slamming a door onto her arm, almost causing a fracture. In her most recent therapy session with her psychiatrist, Anna raised the issue of force feeding. She has read about it on the forum and is very clear that she does not want that kind of treatment. Anna tells her psychiatrist that she would take her own life if the hospital try to force her to eat.

The hospital staff meet to discuss their growing concerns about Anna's condition. Staff discuss their positive obligation to protect Anna's right to life and consider all the steps they could try before Anna's weight and physical health becomes critical. They are all agreed they will discuss these steps with Anna but if these do not work they would have to apply for a court order for permission to force feed her. Lucy, a nurse on the ward, has a good relationship with Anna and arranges a meeting with her and her family.

Lucy explains that the hospital has a duty to take steps to protect Anna's right to life. Lucy says that staff want to do all they can to respect Anna's autonomy (protected by her right to private life) and that they don't want to force feed her. But Lucy also explains that if the threat to Anna's life becomes so serious, they might have to seek a court order for permission for force feeding. Lucy makes it clear to Anna that this isn't a threat, but that she is just explaining what their legal duties to Anna are as someone in their care whose right to life is at serious risk. Lucy goes through the steps they'd like to try, including revising the meal plan with Anna so that she has more input, increasing her therapy sessions, and joining a support group on eating disorders. Anna agrees to these steps.

Finally, Lucy raises her concerns about Anna using her mobile phone to access the forum. She tells Anna that accessing her phone is part of her right to privacy and to family life, but that the hospital can restrict those rights where necessary to protect her other rights (including her well-being). Lucy knows that Anna also uses her phone to keep in touch with her boyfriend, which has been noted as an important support network. Lucy suggests a trial period where Anna keeps her phone but with blocked internet for the online forum. Anna agrees and they will meet again in a weeks' time to review progress.

Private and family life for young people on the ward

Many procedures and practices in mental health hospitals for young people will engage their right to respect for private and family life (protected by Article 8 in the Human Rights Act). For example, restricting access to phones or the internet, lack of privacy in rooms, or restrictions on family contact.

Potential human rights issues for practice

- blanket policies banning or restricting the use of phones or internet access
- preventing a young person from engaging in an intimate relationship with their peer (including sexual relationships for 16+ year olds)
- restrictions on visits by family members or friends, including where practitioners might think those relationships unwise
- preventing informal patients from leaving the hospital to meet with family or friends (which would also be an interference with their right to liberty, protected by Article 5) or inappropriate use of section 5 of the MHA to keep a young person from leaving the ward
- open door room policies giving the young person little or no privacy
- failing to include the young person in decisions about their care and treatment or ignoring the views of a young person who is Gillick competent / assessed as having capacity in favour of your/their parent/carer's views
- placing a young person in a hospital at a distance from their family and home, with little chance of maintaining their family relationships

A human rights approach to private and family life on the ward

This could include:

- ✔ consulting the young person and involving them in decisions about their care/treatment
- ✔ respecting the views and decisions of young people who are 'Gillick competent' / assessed as having capacity, and supporting those who are not to be involved in decisions as much as possible
- ✔ continuing to consult and regularly reviewing treatment as the young person matures/ their care needs develop and ensuring they understand what steps they can take if they become unhappy with how treatment decisions operate in practice
- ✔ reviewing hospital policies/practices which may interfere with young people's private or family lives to ensure they are lawful, for a legitimate reason and proportionate
- ✔ supporting young people to maintain family/ other relationships by facilitating visits where possible, being flexible about visiting times, letting family/friends know about any financial support for travelling to visit, allowing off-site visits where possible and facilitating/encouraging use of other types of communication such as phone/video calls, use of social media etc.

three

Right to respect for private life and family life

(protected by Article 8 in the Human Rights Act)

The right to **private life** includes:

- **autonomy:** participating in decisions about their care or treatment, including consent to treatment and respecting those decisions where the young person is 'Gillick competent' or has been assessed as having capacity
- **privacy:** having their own private space

The right to **family life** includes:

- supporting young people to maintain existing relationships with family members and others
- developing relationships with other people

Relevant practitioners' duties:

- to respect this right: not interfering where possible unless it is lawful, for a legitimate reason and proportionate – see below
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

When is it lawful to interfere with a young person's private or family life?

Interferences with this right have to be justified, using the three stage test:

1. **Lawful?** Is there a law/policy that allows you to interfere with this right? E.g. the MHA.
2. **Legitimate reason?** These are set out in the right. E.g. are you acting to protect the young person's/other people's safety or well-being?
3. **Proportionate?** Have all other alternatives been explored and is this the least restrictive intervention possible?

In real life: respecting private and family life on the ward

The St Aubyn Centre is a Tier 4 service. Young people are admitted from all over the country, potentially separating them from their family and friends for many weeks. An ongoing problem for staff, common to many mental health in-patient services, has been managing access to mobile phones and the internet. There are additional concerns around internet grooming, exploitation and inappropriate usage. This made staff fearful of being blamed for allowing such access and potentially placing a young person in a vulnerable position. This resulted in young people not having access to phones and the internet. Following their involvement in BIHR's Delivering Compassionate Care project, St Aubyn applied a human rights approach and individualised care planning:

- Mobile phones: previously the service policy banned young people's use of mobile phones due to safety concerns (both harm to the young person or them using the phones for harm). The policy was reviewed and now all young people have access to their mobile phones, with safety concerns being managed on an individual basis, giving more responsibility to the young person. This has improved young people's ability to maintain contact with their family and friends and provided staff with a framework for managing the access issue.
- Internet access: this had also been restricted due to safety concerns. The service drafted a new policy, allowing young people access to the internet, with safety concerns being addressed by staff on an individual basis. The aim is to further improve young people's contact with their family and friends, and gives staff a clear framework to respect rights and uphold their duties to protect against harm.

The rights protected by our Human Rights Act:

Right to life
(Article 2)

Right not to be tortured or treated in an inhuman or degrading way
(Article 3)

Right to be free from slavery or forced labour
(Article 4)

Right to liberty
(Article 5)

Right to a fair trial
(Article 6)

Right not to be punished for something which wasn't against the law
(Article 7)

Right to respect for private and family life, home and correspondence
(Article 8)

Right to freedom of thought, conscience and religion
(Article 9)

Right to freedom of expression
(Article 10)

Right to freedom of assembly and association
(Article 11)

Right to marry and found a family
(Article 12)

Right not be discriminated against in relation to any of the rights contained in the Human Rights Act
(Article 14)

Right to peaceful enjoyment of possessions
(Article 1, Protocol 1)

Right to education
(Article 2, Protocol 1)

Right to free elections
(Article 3, Protocol 1)

Abolition of the death penalty
(Article 1, Protocol 13)

This booklet has been produced for staff delivering health and care services. If it has helped you to deliver rights-respecting care BIHR would love to hear your examples. You can email your real life examples of positive changes to your practice on info@bihr.org.uk.

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