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Shared Insights

Managing children with complex needs in crisis

Speakers

Rebecca Fitzpatrick – Partner and Head of Health Advisory and Inquest team at Browne Jacobson
Professor Ralph Sandland – Academic from the University of Nottingham's School of Law and Co-Director of the Centre for Mental Health and Human Rights
Dr Robyn McCarron – Consultant Child and Adolescent Psychiatrist and Associate Clinical Director at Cambridgeshire and Peterborough NHS Foundation Trust
Chris Hayden – Deputy Chief Operating Officer at Sheffield Children's NHS Foundation Trust
Ed Pollard – Partner at Browne Jacobson

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Introduction

In this session, hosted by Becky Fitzpatrick, Partner and Head of Browne Jacobson's Health Advisory and Inquest team, we explored the legal frameworks and best practice for managing children and young people with complex needs in crisis.

There has been an increase in children and young people experiencing a placement break down or experiencing crisis following discharge from mental health admissions. Such vulnerable young people at the point of crisis can often be admitted to an acute hospital, which is an inappropriate setting. This raises a range of legal and practical challenges with significant implications for other services and patients.

This session explored the legal frameworks applicable to children in crisis both within and outside psychiatric settings, including powers of restraint, places of safety, consent to treatment and deprivation of liberty. Speakers addressed the importance of collaboration between services, values-based approaches to crisis management and practical strategies for supporting children and young people with complex needs, illustrated through case studies and lived experience.

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How we can help

Browne Jacobson is proud to offer a team of specialist healthcare lawyers providing legal services to NHS bodies, local authorities, commissioners and independent sector providers of mental health services.

Our team has a wealth of experience in mental health law and mental capacity law, including deprivation of liberty, making us well-equipped to provide expert advice on a broad range of legal issues. This includes:

- Detention and treatment of patients, both adults and children, under the Mental Health Act.
- The interaction between the Mental Health and Mental Capacity Acts.
- Deprivation of liberty for young people and children, including applications to the High Court or Court of Protection to authorise the deprivation.
- A wide range of safeguarding issues, including those involving vulnerable young people and children who are being accommodated in settings not suitable to their needs.
- Mental health related inquests.
- Training for staff and legal teams on all of the above topics.

Legal frameworks for managing children in crisis

Professor Ralph Sandland – Academic from the University of Nottingham's School of Law and Co-Director of the Centre for Mental Health and Human Rights

Professor Sandland explained that both the Mental Health Act (MHA) Code of Practice and NHS England's guidance on 'Urgent and emergency mental health care for children and young people' provide guidance on dealing with children in crisis. However, both documents presuppose that the child is known to the system, the crisis is anticipated and that when the crisis happens, everyone knows what to do. The focus of this session was more on the unforeseen crisis, and when a child presents 'out of the blue'.

Professor Sandland identified three aspects to consider:

1. Controlling bodies.
2. Controlling space.
3. Medical interventions.

These three factors should be considered when looking at a crisis both outside and inside of a psychiatric hospital.

Crucially, whatever interventions are utilised, they must be human rights compliant. The intervention must not amount to torture or inhumane or degrading treatment. The intervention will only be lawful if it is reasonable, proportionate and the least restrictive option.

A crisis outside of a psychiatric hospital – community setting or public place

Controlling bodies

Those involved in the child's care have the power to do what is reasonable in the circumstances to promote the child's welfare (s.3(5) Children Act 1989). If the child's behaviour is problematic or dangerous, restraint may be legally permitted. There are a range of other legal powers that permit proportionate restraint.

For example, if someone is put in fear of attack, s.3 Criminal law Act 1967 permits reasonable use of force in the prevention of a crime. Case law has also confirmed a common law power enabling individuals to take appropriate steps to prevent a breach of the peace (*R (Laporte) v Chief Constable of Gloucestershire Constabulary* [2006] UKHL 55) and a power to take reasonable steps to protect others from the imminent risk of significant harm (*Munjaz v Mersey Care NHST* [2003] EWCA Civ 1036). Where the young person is over 16, powers under s.6 Mental Capacity Act 2005 may also be available. Where restraint is used for a child with a mental disorder, the MHA Code of Practice guidance should be followed wherever possible (*C v A Local Authority* [2011] EWHC 1539 (Admin)). These powers allow staff to take appropriate and steps to manage the immediate emergency situation, but do not permit a deprivation of liberty beyond a very short period of time.

Controlling space

Powers are available under s.136 and s.135 MHA to remove a child to a place of safety, where there is reasonable cause to suspect they are suffering from mental disorder and are unable to care for themselves, are being ill-treated, neglected or kept otherwise than under proper control. The place of safety will often be in a medical setting, which segues into medical interventions. For younger children where the decision is within the zone of parental control, someone with parental responsibility may be able to consent to a restrictive care plan. An older Gillick competent child may also be able to consent to admission. Where restrictive interventions and a care plan amounting to a deprivation of liberty are required, particularly for young people aged 16-18, an application to the Court of Protection may be required to authorise the care plan.

For younger children where there are high levels of restraint or restriction, or where the child is subject to a care order, an application to the High Court is likely to be required to authorise the arrangements. In all cases where the child has a mental disorder, the MHA is also potentially available.

Medical interventions

A child or young person can be given medication if they are competent and consent to such treatment. To give valid consent, the child/young person must have the requisite capacity/understanding. There are separate tests for capacity dependent on whether the person is under or over the age of 16 (Gillick competency for under 16s, Mental Capacity Act (MCA) assessment for those aged 16 and over). Those with Parental Responsibility can consent on behalf of children and young people, but there are limits to this, fand decisions should be within the reasonable parental sphere (see *Re D (Deprivation of Liberty)* [2015] EWHC 922 (Fam)).

In a case of absolute crisis, where there are real concerns about self-harm or harm to others, it should be remembered that there is no case where the court has found liability for any intervention aimed at saving life or preventing harm.

A crisis within a psychiatric setting

Controlling bodies

NHS England guidance states that in a crisis, there should be gateways into the appropriate places, including gateways into Child and Adolescent Mental Health Services (CAMHS) or more significant interventions, such as hospitalisation. Hospitalisation can be on informal or a compulsory detention basis. Informal hospitalisation under section 131 MHA is only permitted with the consent of the young person or their parent. In practice it may be inappropriate to admit a young person informally with only their parents' consent in complex cases.

Controlling space

A child who is admitted to a psychiatric hospital on an informal basis can be restrained where deemed necessary by appropriate staff. However, any use of force must be human rights compliant.

There is fairly new legislation about the use of force in mental health units (Mental Health Units (Use of Force) Act 2018) which focuses on ensuring the use of force is appropriate and proportionate. If seclusion or isolation/long term segregation are required, MHA detention should be urgently considered. Where the MHA is not an option but seclusion or long term segregation are needed, a court application may be required.

Medical interventions

A Gillick competent younger child or a child with the relevant capacity over 16 will be able to consent to treatment on their own behalf. Those with PR have the right to make decisions for a child up to 16 and in some cases 18. Courts have held that some decisions require the consent of both parents e.g. circumcision/certain vaccinations. In an emergency treatment can be given to safeguard the child's welfare. The primary driver in all cases will be what is in the child's best interests. Where the child is MHA detained, the MHA consent to treatment provisions in relation to treatment for mental disorder will apply and override the normal legal framework. MHA powers include urgent treatment under s.62 MHA where it is necessary to save a person's life, to prevent a serious deterioration in their condition, to alleviate serious suffering by the patient or to prevent the patient from being a danger to themselves or others.

Deprivation of liberty

Professor Sandland reminded delegates that the Deprivation of Liberty Safeguards do not apply to anyone under the age of 18. However, people under the age of 18 can of course be deprived of their liberty and so an alternative authorisation framework must be used such as the MHA or a court order. Where the decision is within the zone of parental responsibility, someone with PR may be able to consent to a deprivation of liberty for a child under 16.

A huge difficulty with these cases is that the MHA is frequently not available because the child or young person's difficulties are 'behavioural' rather than representing a disorder that meets the criteria for MHA detention.

Grey areas and discussion

Ed Pollard highlighted that there are a lot of grey areas when dealing with children in crisis. There are several different but intertwining legal frameworks, and it can be difficult to pick the right avenue – sometimes, it may be necessary to go down a combination of avenues.

A delegate queried whether a patient can be prevented from leaving a place of safety in a situation where the s.12 assessing doctors have made their recommendations for detention, but no mental health bed is yet available, and where the patient does not pose an immediate threat to themselves or others and the period of detention under s.136 MHA has expired. Ed explained that this often comes down to a risk balance analysis – i.e. the risk of detaining the patient without formal authority vs. the risk of allowing them to leave. In detaining the person without authority, there would be potential risks around assault and unlawful detention but if there is a clear, clinical basis for detaining the patient then such claims would be unlikely come to fruition. There is also the risk of breaching human rights, but there are two types of breach that can occur: (1) substantive breach – where had legal frameworks been followed, the situation would have been different from what occurred; and (2) procedural breach – where had the legal frameworks been used, the situation would have been no different. Only a substantive breach attracts financial damages. In the scenario posed (someone is 'detainable' but not 'detained') this would likely amount to a procedural breach, attracting no or minimal damages.

Another delegate commented that psychiatric liaison teams should be supporting the patient and emergency department staff while a child or young person (or adult) is awaiting a psychiatric bed in A&E. Another highlighted that the MHA assessing team should provide recommendations regarding observations for the child/young person whilst waiting for a psychiatric bed, e.g. 1:1 observations, and to contact the police if the patient goes AWOL.

Another delegate commented that they sometimes rely on section 4B MCA in this situation. However, Becky clarified that whilst this section can be useful in relation to a person over the age of 16, it can only be relied upon to legally deprive someone of their liberty if the public authority is in the process of seeking a decision or order from the court. This section is only applicable in emergency situations where immediate action is required to provide life-sustaining treatment or perform vital acts necessary to prevent serious deterioration in the individual's condition.

A question was raised in relation to the legal powers of ambulance service personnel. Both Professor Sandland and Ed agreed that ambulance personnel have limited powers and can face very difficult scenarios. Ambulance personnel can use the MCA if they believe the patient lacks capacity to make decisions around their care, treatment and conveyance to hospital. Provided they document their assessment and best interests' decision effectively, they will generally be protected from liability. However, if the MCA is not an option (e.g. if the person has capacity), then it would be wise to involve the relevant mental health trust as quickly as possible and to raise a safeguarding alert, because the power to force conveyance in this situation is limited.

One delegate commented that in some areas of the country (e.g. Nottingham), both a paramedic and a mental health nurse attend 999 jobs. This has been very successful in helping the ambulance service to consider their powers and to link in with the relevant mental health trust to action gatekeeping and MHA assessments for those who require admission and safety plans for people who remain at home.

A values-based approach to crisis management

Dr Robyn McCarron – Consultant Child and Adolescent Psychiatrist and Associate Clinical Director at Cambridgeshire and Peterborough NHS Foundation Trust

Dr McCarron explained that she is an inpatient psychiatrist and that navigating 'grey areas' is part of her day-to-day role. She always comes back to values-based psychiatry. As a unit, they work on the values of respect, safety and discovery and always try to stay true to those principles.

'Safety' means in relation to the immediate situation but also in respect of long-term risks. When working with people in crisis, the temptation is often to manage the immediate safety and containment. But you also need to be mindful that young people are at a crucial stage of their development and it's likely that, due to adverse childhood experiences or genetic loading, they're going to need a long-term relationship with health services. Services need to think about the long-term risks. Police involvement, restraint and rapid tranquilisation can have a long-term impact on a young person's personality and mental health profile. Her service sees a significant number of people with complex PTSD stemming from crisis management. Services therefore need to ensure in responding to a crisis, they're not doing more harm than good.

Dr McCarron suggested three areas that need consideration: containment, collaboration and pragmatism.

Containment

In her role as Consultant Psychiatrist, Dr McCarron said she is providing containment for the young person and their family but also for the system. There is a need to step back and look at bigger picture to help the young person at the centre of the crisis.

It can be unhelpful to get into a battle between services, asking whether the crisis sits with mental health or with social care. What is helpful is if mental health leans in anyway. There might be aspects that are the responsibility of social care, but Dr McCarron sees her role as coming in to support the system, using her expertise from psychiatry to manage the network. She thinks about containment not just in psychical terms but also in terms of psychological safety. Professionals need to feel safe in their decision making and the actions they take. If there is some fear or uncertainty, how can mental health services support other services to have faith?

Collaboration

When working with adolescents, there can be messy emotions and messy life experiences. There is a temptation to take on the young person's persona, or to take on the parent role and admonish other services for not doing this or that. But services need to step back into the adult position and think about how they can all work together to contain the person. If services share the problem, they can work together as a network around the child, without it being 'us' or 'them'.

Collaboration needs to be embedded during normal practice and not just in times of crisis. Building relationships between mental health and social care is key, so that there is mutual trust and good working relationships.

Pragmatism

There are lots of different legal frameworks, but sometimes it's a bit of a fudge and services need to consider what the 'least worst' option is. How can the different legal frameworks be used to produce the best outcome? This comes back to collaboration, and thinking about how services can work together to find a meaningful middle ground, both now and in the longer term. How can services create safety now, in moment of distress, that doesn't create further trauma and mistrust in the future? How can services help a young person with experience of abuse and trauma feel contained?

This can be really hard, especially with bed pressures and an exhausted and scared network – the temptation can often be to push away.

However, Dr McCarron's take home message is, wouldn't it be better if we all lean in? Only then can we create containment and change.

Lived experience and collaborative solutions

Chris Hayden – Deputy Chief Operating Officer at Sheffield Children's NHS Foundation Trust

Chris explained that Sheffield Children's Hospital is both an acute and mental health provider. They have tier 4 inpatient beds and a large community mental health team. Chris discussed the lived experience of a young person in crisis.

Lived experience case study

Chris spoke about the lived experience of a young man with severe learning disability (LD) and autism. Following an episode of violence at home, he was heavily restrained and brought to A&E, which was a traumatic experience for him.

The young person was initially kept in A&E for a week before being transferred to Sheffield Children's Hospital and admitted to an inpatient ward. He initially required 4:1 care. There were protracted discussions about whether he could be admitted to a specialist LD ward, however he didn't have any mental health needs.

Essentially there had been a breakdown in his family life, and he needed a long-term placement. Sheffield had to close 14 beds for months whilst they sought such a placement.

The young person spent five months on an acute ward, during which time he had no access to outside space. Sheffield brought LD nurses in and tried to make the environment as best as they could, but it was still not a suitable setting. His care arrangements had to be authorised by the High Court.

Chris mentioned that this is not an isolated case, and that Sheffield have two to three similar cases per year – the problem has worsened recently as long-term placements are so hard to find. The typical scenario is that the young person doesn't need a tier 4 bed, as they don't have mental health needs, but there has been a breakdown in their social network. There are protracted discussions whilst services try to work out where young person is going to go.

The drama triangle

Chris referred to the 'drama triangle', where organisations tend to fall into one of three roles – victim, villain and hero. However, this can be unhelpful and Chris highlighted the need to move to a more empowering dynamic in these difficult cases. The victim should be more of a creative, the villain more of a constructive challenger, and the hero more of a coach.

Child in crisis framework

Sheffield is currently developing a 'child in crisis' framework. This will be aimed at children who are experiencing psycho-social issues, such as a breakdown in home life. They are trying to develop a step-by-step approach and a checklist, so that everyone knows what to do in such a crisis. There also needs to be a proper escalation process. Chris knows that in some areas, there are daily MDT meetings between social care, integrated care boards (ICBs) and mental health services, to try to resolve these cases in a constructive manner. There is also a need to ensure the care being provided is lawful – thinking about consent, parental responsibility and authorisation for any deprivation of liberty – and ensuring that everything is documented properly.

A success story

Chris handed over to Rae McGlone, the Clinical Lead for Sheffield's LD and autism team. Rae explained that she was involved in the young person's case from a contingent staffing point of view. He had experienced significant trauma and it was important for Rae's team to be skilled in therapeutic de-escalation techniques.

Rae's team needed to build up trust with the young person and his parents. They worked for five months with the psychiatry and hospital team to understand him and his family's trauma. Prior to discharge there was a lot of thinking and planning around preventing readmission.

It was very important for the team to come up with a robust plan. The young person's parents were also keen for him not to be discharged out of the area.

Rae reported that the young person is now doing exceptionally well. He has a home school package and can express what he wants and what he doesn't want to do. It's a great success story – he lives a short distance from his family home, has a good relationship with his siblings, and is close to his supporting and loving parents. His case demonstrates what can be achieved with collaborative teamwork.

Questions and comments

Collaboration for success

Collaboration helps in all these situations, both internally (within an organisation) and externally with partner organisations. Acute trusts, mental health trusts, ICBs, independent care providers and local authorities all need to come together for there to be a successful outcome – both for the child in crisis and from a legal perspective. Collaboration will avoid lengthy court cases, which put children, families and clinicians through extra strain.

Pinch point – when the MHA is not available

There is a clear pinch point with children and young people. When a child/young person is not deemed to be detainable under the MHA, because their issues are behavioural or social rather than mental, the MHA option falls away. People then often begin to panic, as the MHA can often be seen as the 'easy' way out.

However, there are plenty of other ways to support a child or young person who is not MHA detainable – such as through the MCA or the inherent jurisdiction of the High Court. However, the most effective solution is multi-agency collaboration, to create a package of arrangements around young person.

The new Mental Health Bill has recently finished its route through Parliament recently and is nearing Royal Assent. The Bill will create a new, slightly refined test for detention under the MHA, making it harder for people to be detained. The Bill will also make it unlawful for those with LD or autism to be detained long term under the MHA unless they have a co-occurring mental disorder. The new Mental Health Bill won't therefore help to solve these conundrums by making it easier to detain people. There needs to be a greater focus on collaboration and people coming together to find solutions.

It's important for services to be clear on what legal framework they're going to use in crisis situations, to protect everyone involved – clinicians, the organisation and primarily the patient. Services should seek legal advice at an early stage, either from their in-house team or external legal support.

Understanding psychiatry and its pressures

One delegate commented that services need to understand each other's systems and pressures better. Many acute clinicians feel a bit lost when dealing with a mental health crisis, and more resources on this would be beneficial.

Dr McCarron agreed and commented that psychiatry is quite an art. It's about moment-to-moment ethical decision making and always comes back to values.

Thinking about risk is crucial, but we also must ensure that we're acting in a way that is rights based. Children in crisis are often very distressed and this distress can transfer over to clinicians. In Dr McCarron's view, mental health services have a role to play in supporting teams that are looking after these distressed children.

Dr McCarron commented that there is rarely a right answer with psychiatry, but understanding the moment-to-moment decision making is crucial. Understanding why the young person is not detainable for example, particularly if they're trying to harm themselves. Clinicians need to think about whether detention under the MHA is the right thing to do, as it has long term implications. Having a good relationship with local mental health teams is key to understanding the decisions made. Services need to collaborate and navigate through the problems together.

CYP APEx course

Several delegates recommended the Children and Young People: Acute Psychiatric/Psychosocial Emergencies (CYP APEx) course, which the Royal College of Paediatrics and Child Health and Royal College of Psychiatrists are supportive of. CYP APEx is designed to ensure collaboration between services and clinicians. The core principle of the course is to bring psychiatrists, paediatricians, children and young people's emergency department doctors and nurses, mental health nurses and paediatric nurses together to all follow the same approach.

Rebecca Fitzpatrick
Partner

+44 (0)330 045 2131
rebecca.fitzpatrick
@brownejacobson.com

Ed Pollard
Partner

+44 (0)330 045 2107
ed.pollard
@brownejacobson.com

Key takeaways

- **Multiple legal frameworks apply** – Managing children in crisis requires understanding various legal frameworks including the Children Act, MHA, MCA, inherent jurisdiction of the High Court, and human rights law. Any intervention must be reasonable, proportionate and the least restrictive option.
- **Seek legal advice early** – Services should be clear about which legal framework they are relying on in crisis situations and seek legal advice at an early stage to protect clinicians, the organisation and primarily the patient.
- **The MHA is not always available** – When a child's issues are behavioural or social rather than mental health-related, the MHA may not be an option. The new Mental Health Bill will make detention criteria more restrictive, particularly for those with learning disabilities or autism.
- **Values-based approach** – Crisis management should be anchored in values of respect, safety and discovery. Consider both immediate safety and long-term risks, as crisis interventions can have lasting impacts on a young person's trust in services and mental health.
- **Containment, collaboration and pragmatism** – Mental health services should provide containment for the young person, family and the wider system. Services need to work together to find the "least worst" option and avoid falling into the "drama triangle" of victim, villain and hero.
- **Collaboration is essential** – Successful outcomes depend on multi-agency collaboration between acute trusts, mental health trusts, ICBs, independent care providers and local authorities. Building relationships during normal practice, not just in crisis, is crucial.
- **Lean in, don't push away** – Services should "lean in" to support each other and create containment and change for vulnerable young people.
- **Browne Jacobson resources** – We have a dedicated mental health page on our website, which includes a link to all of our mental health and mental capacity related articles.

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Rebecca Fitzpatrick
Partner

+44 (0)330 045 2131
rebecca.fitzpatrick
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Ed Pollard
Partner

+44 (0)330 045 2107
ed.pollard
@brownejacobson.com

Mark Barnett
Partner

+44 (0)330 045 2515
mark.barnett
@brownejacobson.com

Victoria Colclough
Partner

+44 (0)330 045 2133
victoria.colclough
@brownejacobson.com

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