UK Parliament POST

POSTNOTE

Number 685 November 2022

Mental Health Act Reform - Children and Young People

The UK Government has published a draft Mental Health Bill to amend the Mental Health Act (MHA) 1983. The proposed changes focus on increasing patient autonomy and reducing assessment and detention under the MHA. This briefing covers how and when the MHA is used to treat children and young people (CYP) aged under 18, rates of MHA use and outcomes for CYP and how it interacts with other legislation. It also covers stakeholder perspectives on the potential impact of the reforms on CYP and further policy considerations.

Overview

- Data on children and young people (CYP) detained under the MHA 1983 are limited.
- A shortage of specialist inpatient beds has contributed to CYP being detained in inappropriate settings, such as adult wards.
- Complex overlapping legal and ethical frameworks apply to medical treatment and decision making for those aged under 18. Many stakeholders argue that this is not adequately addressed in the draft Bill.
- Key reforms in the draft Bill that impact CYP include: new detention criteria; removing autism and learning disabilities as a reason for detention under section 3; a new duty on professionals to consider explicitly the patient's wishes and feelings; the ability to choose a 'Nominated Person'; and extending the statutory right to advocacy.
- Many stakeholders argue that realising the benefits proposed through MHA reform will require improved access to CYP mental health services and better data collection.

Background

The Mental Health Act (MHA) 1983 regulates compulsory detention and treatment of people with a mental disorder in England and Wales (see Box 1).[1] In response to year-on-year rises in MHA use,[2–4] and in recognition of longstanding racial inequalities in its application[5] the Government commissioned an Independent Review of the MHA, published in 2018.[6] Its recommendations were taken forward in the Reforming the MHA White Paper 2021,[7] which received over 1,700 responses in the public consultation.[8] The Government's draft Mental Health Bill, published in June 2022, is intended to give effect to these legal and policy approaches.[9] The reforms aim to reduce assessment and detention under the MHA and give patients who are detained more autonomy and choice in decisions about their care.

A Joint Committee on the Draft Mental Health Bill was established in July 2022 to scrutinise the draft Bill. Further information on the White Paper, the consultation and the draft Bill is available in the Commons Library briefing on Reforming the Mental Health Act. This POSTnote is focused on children and young people (CYP) aged under 18 years. It complements the POSTnote on MHA Reform – Race and Ethnic Inequalities. As healthcare policy is devolved, the reforms described here apply only to England and Wales. Concurrent mental health law reforms are taking place in Scotland and Northern Ireland.[10–14]

CYP and the MHA

There is no minimum age limit for detention under the MHA and, in line with most countries in Europe, the criteria for detention are the same for CYP and adults.[15] When the MHA is applied to CYP however, there are additional legal and ethical considerations. The ability of CYP to consent to treatment varies with development and their participation in decision-making has to be balanced with that of their parents or those with parental responsibility for them.[16–18]

The Parliamentary Office of Science and Technology, Westminster, London SW1A 0AA
02072192840 post@parliament.uk parliament.uk/post @POST_UK

Box 1: Key features of the Mental Health Act (MHA)
Where a person is considered to require inpatient psychiatric care and it is not possible for them to be admitted as an informal patient, for example because they do not consent to receiving treatment in hospital, they can be detained in hospital and treated without their consent under the MHA. This is sometimes called being a formal patient or being 'sectioned'. Two doctors and an Approved Mental Health Professional, typically a social worker, undertake a MHA assessment to decide if the criteria for detention under the MHA are met: that the person has a mental disorder, defined as "any disorder of the mind or brain", and it is deemed necessary for the patient's own health or safety or for the protection of others. The MHA Code of Practice provides guidance on how to apply the MHA. It advises that for CYP a Child and Adolescent Mental Health Service (CAMHS) professional should be involved in the MHA assessment.[19]

Following the MHA assessment, patients can be admitted:
- under **Section 2**, for up to 28 days for assessment
- under **Section 3**, for assessment and treatment, initially for 6 months, but renewable thereafter.

The MHA is also the statutory basis for the diversion of offenders with mental disorders from the criminal justice system and into hospital for treatment.

Rates of MHA use in CYP

There are a number of potential data sources on MHA use.[6] Variation between datasets and differences in the figures reported make it difficult to understand how the MHA is used and changes over time.[16,20–22] Official statistics about uses of the MHA in England are published annually by NHS Digital, and CYP have only been included since 2016. According to these data, 1,134 new detentions of CYP were recorded in 2020/21; however NHS Digital notes that the total will be higher as detentions data are "incomplete".[23] The children's charity Article 39 found that in 2017/18 reported data on the total number of CYP admitted to CAMHS inpatient units varied between 3,338 in the Mental Health Bulletin Annual report, to 4,611 in the NHS Mental Health Dashboard.[24] Using NHS Digital data, Article 39 report that between 2016-2020, 40-50% of CYP inpatients were detained under the MHA. In 2016 the Care Quality Commission (CQC) reported that a third of CYP inpatients were detained under the MHA.[25] In 2020 the Children's Commissioner's Office reported the proportion to be 54%.[22] NHS England data suggest the proportion was 88% in 2020/21, a slight increase from 2017/18 estimates (82%).[26] There are no published data on the number of CYP admitted to hospital informally (either under their own consent or the consent of their parents).[16,22,24]

The Independent Review recommended that an accurate national baseline of MHA use be established, together with a national MHA data hub to pull together and analyse MHA data. Stakeholders have emphasised that improved data collection and reporting on MHA use in CYP are crucial in planning services and improving CYPs' mental health.[27–31] The White Paper contained a commitment to improve mental health data quality as part of the NHS Mental Health Implementation Plan[32]; however, the Government response does not provide further detail and the draft Bill does not make reference to data.

Variation in MHA use between groups

According to NHS Digital data in 2020/21, around 70% of CYP detained under the MHA were female.[23] This trend is reversed in adults.[23,33–35] There is limited research on why MHA use varies by gender. Some studies suggest that aggressive behaviours in girls may be more likely to result in contact with mental health professionals[36] and in boys, with the criminal justice system.[20,22] Children aged 15 and under are less likely to be admitted under the MHA compared to those aged 16 to 17.[37]

A 2020 report from the Children's Commissioner's Office found that the proportions of children from different ethnic backgrounds in CAMHS inpatient units reflected the general population. However, Black children were more likely to be held in a secure unit than their White peers, less likely to be admitted informally and more likely to be admitted via a criminal justice route.[22] A 2021 academic systematic review on involuntary care of CYP identified a small number of studies that included data on ethnicity. These data suggest that young people from a Black rather than a White ethnic group were more than twice as likely to be admitted under the MHA.[37] These trends reflect race and ethnic inequalities in compulsory detention and treatment under the MHA found in adults (see POSTnote on MHA Reform – Race and Ethnic Inequalities).

Interaction with other legislation

CYP mental health care law is complex. The MHA overlaps with other legislation, notably the Children Act 1989 and the Mental Capacity Act (MCA) 2005 as well as case law (see Box 2).[16,17] The Independent Review highlighted the challenges this creates for practitioners, CYP and their families, especially around consent to treatment and the role of parental responsibility.[6]

Decision making in under-18s

The law makes a distinction between the decision-making ability of those aged over and under 16. The MCA applies to those aged 16 or over, who are presumed to have mental capacity to make decisions about their own care, unless it is established they do not.[17] Those aged under 16 are presumed to be unable to make decisions for themselves, unless it is established that they are 'Gillick competent' to make the decision in question (see Box 2).[38]

Under the Children Act 1989 (as amended), the term 'parental responsibility' is defined as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property"[39] (see Commons Library briefing on Children: parental responsibility). The decision-making role of those with parental responsibility decreases as the age of the child increases.[40] Historically, admission and treatment of CYP was based on parental consent, with limited use of the MHA, but legislative and social changes have altered this practice.[41,42] The Supreme Court decision in *Re: D*[43] confirmed that parents cannot consent to restrictions placed on their 16- or 17-year-old child which, without such consent, would amount to a deprivation of liberty (Box 2). In practice, unless a person aged 16 or 17 consents to their admission for inpatient psychiatric care, the MHA will likely be needed to authorise their admission to hospital. Parents of a child aged under 16 may be able to consent to their child's hospital admission where the child lacks competence to make such decisions and the decision falls within the proper exercise of parental responsibility.[44] However, the MHA Code of Practice advises against relying on parental consent to overrule a Gillick competent child's refusal of hospital admission or treatment.[19]

Box 2: Legislation and case law on CYP mental health

Mental Capacity Act (MCA) 2005
The MCA sets out how decisions can be made for people aged 16 or over who lack the mental capacity to do so. Unlike the MHA, the MCA applies to both physical and mental health interventions. The MCA allows people to make 'Advance Decisions' to refuse specified medical treatment in the future, if they are aged 18 or over and have capacity at the time it is made. These are legally binding.

The Government recently ran a consultation on proposed changes to the MCA Code of Practice and implementation of the Liberty Protection Safeguards (LPS), which will replace the current Deprivation of Liberty safeguards and apply to people aged 16 and over (see Commons Library briefing on Implementing the Mental Capacity (Amendment) Act 2019).

Deprivation of Liberty (DoL)
Article 5 of the European Convention on Human Rights (ECHR) provides that everyone has a right to liberty. In *Re: D* (2019), the Supreme Court confirmed that a DoL occurs if the person is confined "in a particular restricted place for a not negligible length of time", no valid consent has been given and the state is responsible for the person's confinement.[43] Whether those aged under-18 are confined centres on whether the restrictions on a child's liberty fall "within normal parental control for a child of that age".[43,45]

Gillick competence
The House of Lords decision in *Gillick v West Norfolk* (1989) held that a child aged under 16 can consent to medical treatment if they are deemed by professionals to have the maturity and intelligence to understand what is involved.

Children Act 1989
The Children Act 1989, as amended, provides a framework for the child protection system in England and applies to all those aged under 18.[39] It establishes the paramount nature of the child's welfare and places a duty on a range of agencies to safeguard and promote the welfare of children (see Commons Library briefing on An overview of child protection legislation in England).

Outcomes from MHA use in CYP

Hospital care

The number of CYP with mental health difficulties has increased since the pandemic and this has exacerbated problems with accessing CAMHS[46–48] (see POSTnote on Children's Mental Health and the COVID-19 Pandemic). The MHA specifies that CYP admitted to hospital should be accommodated in an environment that is suitable for their age. In January 2021, NHS England commissioned 1,350 CAMHS beds from a combination of NHS and private providers.[49] CQC reports on 2020/21[50,51] suggest that a national shortage of specialist inpatient beds has led to "an increase in the numbers of CYP being cared for in inappropriate settings",[50] such as general paediatric wards or adult wards. If the admission of a child or young person to an adult ward continues for longer than 48 hours, the CQC must be notified.[19] CQC data indicate that the number of CYP admitted to adult wards for more than 48 hours was 191 in 2020/21[50] and, according to provisional data, increased to 249 in 2021/22.[52] Most admissions were under the MHA and were due to a lack of age-appropriate alternatives.[52]

CYP are more likely than adults to be admitted to an inpatient unit outside the area in which they live.[6,52] A report by the Children's Commissioner's Office found that in 2020, 21% of CYP inpatients were placed more than 50 miles from home.[22] Where out of area placements (OAPs) are due to capacity constraints, they can have a negative impact on CYPs' mental health and education, preclude work with families and hamper discharge planning.[28,53,54] In 2022, NHS Providers stated that six out of ten NHS Trust leaders had to use OAPs because of a lack of local CAMHS inpatient beds.[55] The White Paper states that NHS England and NHS Improvement has identified a need to improve the national distribution of inpatient beds and its Accelerated Bed Programme aims to eliminate inappropriate placement of CYP in adult beds and inappropriate OAPs.

Alternative placements

CQC monitoring of the MHA found that community-based provision is key to reducing levels of detention in hospital and preventing inappropriate admissions.[50] A 2021 report by the Commons Health and Social Care Committee on CYPs' mental health found that in "most cases the most compassionate and effective care" for CYP is in the community. It recommended that the Department of Health and Social Care accelerate the shift towards increased community-based provision and a reduced inpatient bed base as a national priority, and that a national strategy be set out to establish jointly commissioned health and social care services.[28]A 2022 review of court judgments on applications to deprive children of their liberty found evidence of CYP being held, sometimes under the MHA, in inappropriate settings due to a shortage of secure mental health inpatient beds for children who need this provision.[56]

CYPs' experiences of detention under the MHA

Outcomes of CYP detained under the MHA are not well known.[37,57] A 2020 Children's Commissioner's Office report on the experiences of CYP inpatients found that most of the CYP they spoke to found being detained under the MHA very difficult. Some CYP reported hiding their feelings to "get off the section" and that many informal patients felt coerced into consenting or had no choice as it was decided by parents.[53] There is very little research on CYPs' experiences of inpatient care (whether detained under the MHA or as informal patients) or the experiences of their parents or carers.[42,58,59]

Potential impact of the reforms on CYP

The Government acknowledges that there were concerns as to how the reforms would impact CYP.[8] It states that the MHA Code of Practice will be reviewed after the draft Bill is passed and concerns about CYP will be further addressed. Many stakeholders argue that the lack of focus on CYP in the draft Bill is a missed opportunity to clarify the complex legal frameworks that apply to under-18s.[31,60–62] There is concern that it could lead to unintended consequences for CYP and their parents or others with parental resposibility.[31,62,63]

Two areas of potential reform, proposed in the Independent Review or White Paper, that have not been taken forward in the draft Bill, and which stakeholders argue may have benefited CYP are:

- **A formal test of decision-making competence in those under 16**. Some stakeholders are concerned that without this and clarification on the role of parental consent, those under 16 will not benefit from the additional rights and

safeguards in the reforms, as many of these are dependent on having the relevant competence or capacity.[31,62,63]

- **Further safeguards to prevent CYP being placed in inappropriate settings.** The Government has stated that the Code of Practice will make clear that LAs should be notified when a child or young person is placed in an adult ward or out of area, or if an admission lasts more than 28 days. However, some stakeholders have called for this duty to be set out in legislation.[61,64]

Key reforms included in the draft Bill that stakeholders highlight as specifically impacting CYP are briefly summarised below.

Grounds for detention

The draft Bill proposes new detention criteria to reduce the use of the MHA. These changes include requiring clinicians to show that without the use of the MHA, "serious harm may be caused to the health or safety of the patient or another person", and to consider the extent of the harm and how soon it might occur. 74% of respondents to the White Paper consultation agreed with this proposal.[8] Some stakeholders have raised concerns that the changes could have adverse impacts on CYP. The Royal College of Psychiatrists argues that increasing the level of risk needed for detention could delay intervention and that current tools used to measure and predict risk, especially in CYP, are not very robust or always used. They suggest that clinicians will need further guidance on interpreting the criteria and assessing risk.[62] The Children and Young People's Mental Health Coalition suggests that without increasing provision of community-based alternatives, raising the threshold for detention may prevent support and treatment being given to CYP and is unlikely to reduce admissions to hospital.[31]

Autism and learning disabilities

The draft Bill proposes removing autism and learning disabilities (LD) as reasons for detention under section 3 of the MHA (see Box 1). This would mean that outside the criminal justice system, autistic people and people with LD could not be detained for longer than 28 days, unless the patient has a co-occurring mental health condition that warrants detention under the MHA. This change aims to reduce the number of autistic people and people with LD of all ages in mental health hospitals, in line with the NHS Long Term Plan.[65]

This is something that charities such as the National Autistic Society have been campaigning for, and has wide stakeholder support.[66–68] However, several stakeholders have raised concerns that this proposal may have unintended negative consequences, because of the lack of community-based support. This includes concern that autistic people and those with LD may still be admitted to hospital but under alternative legal frameworks, such as the MCA, which have fewer safeguards than the MHA.[61,62,69–71] Other concerns are that there may be an increase in the reliance on co-occurring diagnoses in autistic people and people with LD to enable them to stay in hospital.[62,71] There is also concern that it could increase the number of autistic people and people with LD being diverted to the criminal justice system.[31,62,71]

Treatment decisions

In the consultation on the White Paper, stakeholders noted the complexities associated with advance choice decision making in CYP.[8,62] In workshops led by the charity YoungMinds, young people with experience of the MHA expressed the importance of being consulted about treatment options and supported to input meaningfully into their care.[72] The draft Bill introduces a new duty on professionals to consider explicitly the patient's past and present wishes, feelings, beliefs and values in making treatment decisions, to support patient choice and autonomy. For advance decisions to refuse treatment, the draft Bill mirrors the patient's rights under the MCA (Box 2); as such this right is only available to those aged 18 and over. Some stakeholders, such as the charity Mind[73] and the Children and Young People's Mental Health Coalition[64] have argued that not giving under 18s the right to make advance decisions to refuse treatment means they will not benefit from enhanced safeguards that apply to adults.

Nominated Person (NP)

Currently the 'Nearest Relative' (NR) has certain rights and responsibilities if a person is detained under the MHA. The NR must be over 18, is chosen from a fixed hierarchical list and among other things, can object to the admission. The draft Bill proposes to replace the NR with someone nominated by the patient. The 'Nominated Person' (NP) must be over 16, (unless the patient is under 16, in which case the NP must be over 18) and will have extended rights. The White Paper consultation asked whether those aged under 16 should be able to choose a NP (including someone who does not have parental responsibility for them), where they have 'Gillick competence' to make this choice (see Box 2). 67% of respondents agreed with this proposal.[8] Young people who participated in the YoungMinds workshops were positive about this change.[72] While supporting the intention behind this reform, many stakeholders, including clinical and charity groups, have raised concern about how this will interact with the roles of others, especially those with parental responsibility. They have called for safeguards for CYP and additional support to help them decide who to appoint as their NP.[31,62,63,74]

Patient advocacy

Independent Mental Health Advocates (IMHA) are trained to work within the framework of the MHA and are independent of mental health services. In the draft Bill, the statutory right to an IMHA would be extended to all mental health inpatients, whether in hospital informally or detained under the MHA. This is widely supported by stakeholders;[72,75,76] however several have called for advocacy to be offered on an "opt out" basis for informal patients, in line with the proposed offer to patients detained under the MHA, for CYP to particularly benefit.[64,77]

Further policy considerations

Many experts argue that realising benefits proposed through MHA reform will require also improving access to, and experience of, CYP mental health services.[29,63,78,79] Experts argue this includes: significant investment in community services and more joint working between health, social care and education;[47,80,81] expansion and training of the mental health workforce;[81–83] reducing waitlists;[84,85] addressing regional variation in services;[86] and improved data collection.[29,31] Some stakeholders argue that the draft Bill is a missed opportunity to improve CYPs' mental health by not legislating for early intervention and preventative measures.[81]

POST is an office of both Houses of Parliament, charged with providing independent and balanced analysis of policy issues that have a basis in science and technology. POST is grateful to Dr Susan Walker for researching this briefing, to the Nuffield Foundation for funding her parliamentary fellowship, and to all contributors and reviewers. For further information on this subject, please contact the co-author, Dr Abbi Hobbs.

References

1. Mental Health Act 1983. Statute Law Database.
2. Sheridan Rains, L. *et al.* (2020). Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model. *BJPsych open*, Vol 6, e88.
3. Keown, P. *et al.* (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. *Br J Psychiatry*, Vol 213, 595–599.
4. Care Quality Commission (2018). The rise in the use of the MHA to detain people in England.
5. Barnett, P. *et al.* (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, Vol 6, 305–317. Elsevier.
6. Independent Review (2018). Modernising the Mental Health Act - increasing choice reducing compulsion.
7. Department of Health & Social Care *et al.* (2021). Reforming the Mental Health Act.
8. Department of Health and Social Care (2021). Reforming the Mental Health Act: government response.
9. Department of Health and Social Care, M. of J. (2022). Draft Mental Health Bill.
10. Scottish Mental Health Law Review (2022). Scottish Mental Health Law Review.
11. Lynch, G. *et al.* (2017). Mental Capacity Act (Northern Ireland) 2016. *BJPsych Bull*, Vol 41, 353–357.
12. Latif, Z. *et al.* (2012). Mental Health Legislation in Ireland: A Lot Done, More To Do. *The Journal of the American Academy of Psychiatry and the Law*, Vol 40, 4.
13. Farrell, A.-M. *et al.* (2022). Mental Health Policies And Laws On The Island Of Ireland. *SSRN Journal*,
14. Lynch, G. *et al.* (2018). Modernising the Mental Health Act: getting the balance right. *The Lancet*, Vol 392, 2532–2534.
15. Salize, H. J. *et al.* (2002). Compulsory admission and involuntary treatment of mentally ill patients-legislation and practice in EU Member States. 166.
16. Parker, C. (2020). Adolescent Mental Health Care and the Law. Legal Action Group.
17. Bowers, M. *et al.* (2010). Legal dilemmas for clinicians involved in the care and treatment of children and young people with mental disorder. *Child: Care, Health and Development*, Vol 36, 592–596.
18. Paul, M. (2004). Decision-making about children's mental health care: ethical challenges. *Adv. psychiatr. treat*, Vol 10, 301–311.
19. Department of Health (2015). Mental Health Act 1983: code of practice. The Stationery Office.
20. Roe, A. (2022). What do we know about children deprived of their liberty? An evidence review. Nuffield Family Justice Observatory.
21. Hayes, D. *et al.* (2021). Adolescent inpatient mental health services in the UK. *Arch Dis Child*, archdischild-2020-321442.
22. Children's Commissioner (2020). Who are they? Where are they? Children locked up.
23. NHS Digital Mental Health Act Statistics, Annual Figures - 2020-21. *NHS Digital*.
24. Article 39 (2021). Child mental health inpatients statistics briefing.
25. Care Quality Commission, D. (2016). Monitoring the Mental Health Act in 2015/16. HM Government.
26. NHS England (2022). Personal correspondence from NHS England.
27. Grimm F, Alcock B, Butler J, Fernandez Crespo R, Davies A, Peytrignet S, Piroddi R, Thorlby R, Tallack C. (2022). Improving children and young people's mental health services: Local data insights from England, Scotland and Wales. The Health Foundation.
28. Health and Social Care Committee (2021). Children and young people's mental health. House of Commons.
29. Young People's Health Partnership (2021). *Young People's Health Partnership response to the Department for Health and Social Care's White Paper 'Reforming the Mental Health Act'*.
30. Care Quality Commission (2018). Are we listening? Review of Children and Young People's Mental Health Services.
31. Children and Young People's Mental Health Coalition (2021). Children and Young People's Mental Health Coalition response to the White Paper consultation.
32. NHS (2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24.
33. NHS Digital (2018). Mental Health Act Statistics, Annual Figures 2017-18.
34. NHS Digital Mental Health Act Statistics, Annual Figures 2018-19. *NHS Digital*.
35. NHS Digital Mental Health Act Statistics, Annual Figures 2019-20. *NHS Digital*.
36. Kaltiala-Heino, R. (2010). Involuntary commitment and detainment in adolescent psychiatric inpatient care. *Soc Psychiat Epidemiol*, Vol 45, 785–793.
37. Walker, S. *et al.* (2021). Clinical and social factors associated with involuntary psychiatric hospitalisation in children and adolescents: a systematic review, meta-analysis, and narrative synthesis. *The Lancet Child & Adolescent Health*, Vol 5, 501–512.
38. Gillick v West Norfolk and Wisbech Area Health Authority (1985) 2 A11 ER 402.
39. Children Act 1989. Statute Law Database.
40. Lord Denning Hewer v Bryant [1970] 1 QB 357 at 369, [1969] 3 All ER 578 at 582.
41. Nicholls, J. E. *et al.* (1996). Use of mental health legislation in a regional adolescent unit. *Psychiatr. bull.*, Vol 20, 711–713.
42. Tan, J. O. A. *et al.* (2003). Control and compulsory treatment in anorexia nervosa: The views of patients and parents. *International Journal of Law and Psychiatry*, Vol 26, 627–645.
43. Re D (a child) [2019] UKSC 42.
44. Re D (A Child) (Deprivation of Liberty) [2015] EWHC 922 (Fam).
45. Parker, C. (2022). Deprivation of liberty: Legal reflections and mechanisms. Briefing. Nuffield Family Justice Observatory.
46. Children's Commissioner (2022). Briefing on Children's Mental Health Services – 2020/2021.
47. Mental Health Network (2021). Reaching the tipping point. NHS Confederation.
48. NHS Digital (2021). Mental Health of Children and Young People in England, 2021 Wave 2 follow up to the 2017 survey.
49. Brown, J. *et al.* (2021). NIHR Evidence Review: Experience of children and young people cared for in mental health, learning disability and autism inpatient settings. National Institute for Health and Care Research (NIHR).
50. Care Quality Commission (2022). Monitoring the Mental Health Act in 2020/21.
51. Care Quality Commission (CQC) (2021). State of Care 2020/21.
52. Care Quality Commission (Provisional figures, to be published shortly.). *Monitoring the Mental Health Act 2021/22*.
53. Children's Commissioner (2020). Children's experiences in mental health wards.

54. Ougrin, D. *et al.* (2018). Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: a randomised controlled trial. *The Lancet Psychiatry*, Vol 5, 477–485. Elsevier.
55. NHS Providers (2022). Written evidence submitted by NHS Providers (CYP0068) to the Health and Social Care Committee Report on Children and Young People's Mental Health.
56. Roe, A. *et al.* (2022). Deprivation of Liberty: A review of published judgments. Nuffield Family Justice Observatory.
57. Atti, A. R. *et al.* (2021). Compulsory treatments in eating disorders: a systematic review and meta-analysis. *Eat Weight Disord*, Vol 26, 1037–1048.
58. Wallström, R. *et al.* (2021). 'Don't abandon me': Young people's experiences of child and adolescent psychiatric inpatient care supporting recovery described in blogs. *International Journal of Mental Health Nursing*, Vol 30, 117–125.
59. Martin, K. (2019). A critical realist study of shared decision-making in young people's mental health inpatient units. *Doctoral thesis, UCL (University College London).* 1–1. UCL (University College London).
60. Laing, J. (2022). Reforming the Mental Health Act: Will More Rights Lead to Fewer Wrongs? *Medical Law Review*, Vol 30, 158–176.
61. Law Society (2021). The Law Society response to Reforming the Mental Health Act White Paper.
62. Royal College of Psychiatrists (2021). Response to MHA White Paper consultation.
63. Mind (2021). Mind response to MHA White Paper.
64. Children and Young People's Mental Health Coalition (2022). Written evidence submitted by the Children and Young People's Mental Health Coalition (MHB0056) to the Joint Committee on the Draft Mental Health Bill.
65. Department of Health & Social Care (2019). NHS Long Term Plan.
66. National Autistic Society (2019). Transforming Care.
67. Care Quality Commission (2020). Out of sight – who cares?
68. Health and Social Care Committee (2021). Treatment of autistic people and individuals with learning disabilities. House of Commons.
69. Lucy Series (2022). No loss of safeguards for people with autism or learning disability taken 'out' of the Mental Health Act. *The Small Places*.
70. RK, A. A. (2022). Draft Mental Health Bill now published. *Mental Capacity Law and Policy*.
71. Care Quality Commission (2021). Response to the Reforming the MHA White Paper.
72. Young Minds (2021). Mental Health Act Review Report.
73. Mind (2022). Reforms to the Mental Health Act welcome, but need scrutiny.
74. Rethink Mental Illness (2021). Rethink Mental Illness Consultation Response – Mental Health Act White Paper.
75. Article 39 (2020). A Safe Space: The rights of children in mental health inpatient care.
76. Children's Commissioner (2022). Written evidence submitted by the Children's Commissioner for England (CYP0109) to the Health and Social Care Committee Report on Children and Young People's Mental Health.
77. VoiceAbility (2022). Written evidence submitted by VoiceAbility (MHB0054) to the Joint Committee on the Draft Mental Health Bill.
78. Royal College of Psychiatrists (2021). Estimating the impact of proposed reforms to the Mental Health Act on the workload of psychiatrists.
79. Centre for Mental Health (2021). Response to the Mental Health Act White Paper.
80. Royal College of Psychiatrists (2021). Country in the grip of a mental health crisis with children worst affected, new analysis finds. *Press release*.
81. Child Mental Health Charter (2019).
82. NHS Workforce Statistics - April 2021 (Including selected provisional statistics for May 2021). *NHS Digital*.
83. Royal College of Psychiatrists (2019). Royal College of Psychiatry Census 2019.
84. Children and Young People's Mental Health Taskforce (2015). Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health and Social Care.
85. YoungMinds (2022). Mental Health Waiting Times Harming Young People.
86. Children's Commissioner (2022). Children's Mental Health Services 2020/21.