

Monitoring the Mental Health Act in 2020/21



Care Quality Commission

**Monitoring the Mental Health
Act in 2020/21**

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Foreword

In our last report, *Monitoring the Mental Health Act in 2019/20*, we highlighted how mental health services had adapted to the COVID-19 pandemic, and the effect that this has had on patients, carers and staff. This year's report reflects on the full year under the cloud of the pandemic. This has been, of course, a time of unprecedented stress on services, staff, and on patients managing under restrictions introduced in response to the pandemic, as well as their detention in hospital under the Mental Health Act (MHA). There has been much tragic loss of life in mental health services, as everywhere else.

But both this year's and last year's reports also describe a story of resilience. In our discussions with patients, carers, advocates and staff during the year, people were appreciative of each other's efforts. Some arrangements introduced in response to the pandemic have led to small improvements in patient care, for example better access to communications technology for contacting friends and relatives, or avoiding silo working between inpatient and community services.

In this report, we continue to emphasise the importance of person-centred care. This means, for example, maximising patient involvement in care-planning and decision-making. Despite strains on services, we still are able to report a number of good practice examples in this report.

NHS digital statistics on the use of the MHA, published in October 2021, while incomplete, suggest that during 2020/21 the overall use of the MHA increased by about 4.5%.¹ This rise may in part reflect reduced access to community mental health services during the pandemic. It may also be that the reduction of inpatient bed capacity at the start of the pandemic led to an increase in the use of the MHA for the remaining bed capacity. This is not new; the impact of reduced bed capacity on use of the MHA was noted over a decade ago.²

As discussed in this report, Black or Black British people are disproportionately likely to be detained under the MHA or be subject to community treatment orders; have longer periods of detention and more repeated admissions. They are also more likely to be subject to police holding powers under the MHA. It is commendable that the key motivation behind the current reform of the MHA is the injustice of this, as well as a wish to reverse the trend of rising detentions more generally. That reform process must, of course, look wider than mere changes to the wording of the statute. For example, MHA statistics for 2020/21 suggest that the rates of detention in the most economically deprived areas are more than three and a half times higher than the rate of detention in the least deprived areas.

Detention under the MHA is an intervention of last resort, but it can become necessary for want of any practical alternative or other resource that might otherwise have been available. At different points across mental health care people experience difficulty in getting access to the care they need, when they need it. The impact of this can be devastating.

In 2020, our report *'Out of sight – who cares?'* highlighted how not getting the right support early on could lead to people with a learning disability and autistic people being admitted to hospital. Even though these environments are often not therapeutic for people with a learning disability and autistic people, a lack of community alternatives has led to people being unable to leave, sometimes for years. In many cases, this has increased the risk of people being restrained, secluded or segregated.

As part of our ongoing work in this area, in December 2021 we published a progress report to highlight what has been achieved so far and which areas need more focus. To complement this, in this report we take an in-depth look at the findings from the Independent Care (Education) and Treatment Reviews for people with a learning disability and autistic people in long-term segregation, and the impact this has had on people and their families. A full progress report will be published in Spring 2022.

The data in this report on admissions of children and young people to adult facilities reflects the fact that, at times during the year, there were no available beds in suitable child and adolescent inpatient services to meet the needs of patients. The continued difficulty in discharging people with learning disability or autistic people from unsuitable services is, in part, due to the lack of alternative community placements or support.

Across the system, high bed occupancy levels slows inter-hospital transfers, and delays moving to lesser security when patients are ready for this. Addressing these areas of difficulty is not just a matter of increasing inpatient bed capacity, although that may be necessary in some cases. It is also about introducing system-wide solutions, including roles that track and review individuals and their care, and a focus on alternatives to admission and facilities for discharge to community services. We welcome government's acknowledgement of the need for development in mental health services, and the Health and Social Care Committee's establishment of an expert panel to evaluate progress on commitments.³

We also welcome the government's proposal to strengthen the role of CQC in monitoring the use of the MHA by extending the scope of our monitoring to those who commission services under the MHA.⁴ We feel this will strengthen our ability to take a system-wide view in monitoring the operation of the MHA. We are confident that this will be an addition to, and not a substitute for, our core statutory and National Preventive Mechanism function of visiting detained patients in hospital. We look forward to further discussion with DHSC in relation to the MHA reforms.



A handwritten signature in black ink that reads "Burnage".

Jemima Burnage

Deputy Chief Inspector Hospitals
and Lead for Mental Health

Summary

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. The MHA also provides more limited community-based powers, community treatment orders and guardianship.

This report sets out CQC's activity and findings from our engagement with people subject to the MHA and review of services registered to assess, treat and care for people detained using the MHA during 2020/21.

How we work

CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. We visit and interview people currently detained in hospital under the MHA, and we require actions from providers when we become aware of areas of concern or areas that could improve. We also have specific duties under the MHA, such as to provide a Second Opinion Appointed Doctor (SOAD) service, review MHA complaints, and make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also work to highlight and seek action when we find practices that could lead to a breach of human rights standards during our MHA visits. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM carry out regular visits to places of detention to prevent against torture, inhuman or degrading treatment. Find out more information about this important role and our activities in the UK NPM annual reports.

As described in our last report, during the COVID-19 pandemic we suspended our routine on-site visits to carry out MHA monitoring reviews, to avoid spreading the infection between services. Throughout 2020/21, we replaced site visits with remote monitoring, where we aimed to provide support to services through video calls to patients, carers, advocates and many staff. On-site visits started again in July 2021.

Evidence used in this report

This report is largely based on feedback letters on the 620 remote monitoring letters following reviews of 682 wards carried out during 2020/21. These involved private conversations with 1,895 patients and 1,111 carers. We also spoke with advocates and ward staff. We have quoted from these letters in the report and, in the main, have not identified the services concerned, with some exceptions when we are describing good practice.

In addition, we have engaged at a policy level with a range of stakeholders in the use of the MHA, handled 2,280 complaints and contacts from patients and others, and took part in 77 Independent Care Education and Treatment

Reviews (IC(E)TRs) of patients with a learning disability and autistic people who were being held in long-term segregation.

It is with thanks to all these people, especially people detained under the Act and their families, who have shared their experiences with us. This enables us to do our job to look at how services across England are applying the MHA and to make sure people's rights are protected.

Evidence in this report also draws on quantitative analysis of statutory notifications submitted by registered providers, activity carried out by our SOAD service and complaints and/or concerns submitted to us about the way providers use their powers or carry out their duties under the Act.

The evidence in this report has also been corroborated, and in some cases supplemented, with expert input from our subject matter experts and specialist MHA reviewers to ensure that the report represents what we are seeing in our regulatory activity. Where we have used other data, we reference this in the report.

Throughout our report, in line with the Mental Health Services Dataset (MHSDS) we use the term 'Black or Black British people', recognising that this is a broad ethnic group that includes people from Caribbean or African ethnic backgrounds.

Key messages

Through our MHA monitoring activity in 2020/21 we found:

1. **The workforce is under extreme pressure.** The pandemic has placed additional stresses on staff, patients and carers. Many patients and carers have told us that they appreciate the extra efforts made by staff to mitigate the effects of lockdown restrictions and there has been some good practice. But staff are now exhausted, with high levels of anxiety, stress and burnout, and the workforce is experiencing high levels of vacancies. The negative impact of working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights.
2. **Community services are key to reducing levels of detention in hospital.** Not getting the right help at the right time can lead to symptoms worsening and people needing inpatient care. During the pandemic this has been a particular concern for children and young people. We have seen an increase in the numbers of children and young people being cared for in inappropriate settings while they wait for an inpatient bed. The Independent Care (Education) and Treatment reviews have also shown the impact of a lack of community care, with people being admitted to hospitals for prolonged periods of time.
3. **Urgent action is needed to address longstanding inequalities in mental health care.** We remain concerned that Black or Black British people are more likely to be detained under the MHA, spend longer in hospital and have more subsequent readmissions than White people.

Reliable local and national data is key to identifying inequalities in care and measuring progress towards closing these gaps. This needs to be a focus across integrated care systems. We are keen to see the rollout of the patient and carers race equalities framework, a tool to help mental health trusts work with Black and minority ethnic communities to achieve practical change. We recognise that some factors in inequality are broader than health care provision.

1. Service provision during the pandemic



Key points

- Services have continued to experience unprecedented pressure during the ongoing pandemic, which has placed additional burdens on staff. We heard that in many services staff were leaving for higher paid roles, or leaving active nursing because of burnout, putting additional pressure on the remaining nurses.
- With social distancing and other restrictions in place, services have had to balance a duty of care towards patients at the same time as upholding the principle of least restriction. Overall, we found that services rose to the challenges that this placed on their patients and staff.
- However, the combination of lockdown restrictions and staff shortages meant that many patients experienced a poorer service. This included, for example, limited access to leisure and therapeutic activities.

In last year's report, we highlighted the unprecedented challenge that mental health services faced from the pandemic. With social distancing and other restrictions in place, services had to balance a duty of care towards patients at the same time as upholding the principle of least restriction. We noted that many services were reconfigured to reduce the numbers of occupied beds, enable patients with COVID-19 to be cared for separately, and manage staff shortages.⁵

Overall, we found that services rose to the challenges of lockdowns and the additional burdens that this placed on their patients and staff. However, we heard varying accounts about the impact of the pandemic, and changes made in response to this, on patients and staff. While some people we spoke with told us they felt supported, others were less positive.

Nursing, medical and multidisciplinary staff, patients, relatives and advocacy expressed how well staff worked together to support patients during lockdown and how supportive management had been. Staff across the teams expressed being valued and enjoying their work.

Hartington Unit (acute adult), Chesterfield Royal Hospital, April 2021

The team had to adapt to multiple changes in light of the pandemic. In March 2020 the recovery ward was closed for a period of time, with staff redeployed to the two acute wards upstairs. On reopening, the ward has been used as an overspill for the acute wards, although it was not designed for this use [and] was not ligature-free.

Staff told us that the ward closure and changes to the ward remit had taken their toll on staff morale. Staff were highly motivated to work in a recovery-oriented setting and found the shift to acute care difficult. The staff team said they had coped with the changes due to a supportive ward manager, their team cohesiveness and mutual respect for one another. They understood that decisions had to be made regarding safe management of patient groups but did not always feel included in decision making that affected them or acknowledged for their efforts.

Acute ward, March 2021

In some instances, reconfigurations helped to improve multidisciplinary working between teams and in turn improve patients' experience. For example, at one service, community team staff were brought in to help manage staffing shortages on an acute mixed gender ward. We heard that this led to a much better understanding and ongoing liaison between the teams, and supported care planning and discharge planning. This highlights how, in more normal times, functional splits between inpatient and community teams can create barriers that need to be overcome for effective care planning (see section on care planning).

Staff told us that the community mental health team staff had supported the ward onsite at the beginning of the pandemic when staffing levels decreased. This had enhanced both teams' skill sets and improved liaison between the two teams. Staff felt that this had considerably improved the patient pathway from admission to discharge.

Juniper Ward, Bowmere Hospital, Cheshire and Wirral Partnership NHS Foundation Trust, June 2021

Many of our remote reviews reflected patients and carers' experience of staffing pressures. For example, a frequent complaint from patients was that there were not enough activities and/or contact with nursing staff. Carers also found it difficult to contact the ward staff. Staff members also told us of the stresses of nursing during the pandemic, in some cases with many colleagues absent.

One patient told us that the, "staff are great" but that sometimes staff are not available when they wanted to speak to someone, for example if they were dealing with something on the ward. Another said there had been, "a few incidents of people kicking off and arguing... staff are good at sorting that stuff out... must be a stressful job, they handle it really well the staff are pretty awesome."

Acute mixed gender ward, March 2021

Escorted section 17 leave was sometimes cancelled due to lack of staff. Although staff told us that they always tried to avoid postponing leave, one patient told us that twice they had arranged a walk with their relative as part of their escorted ground leave and the patient reported that their relative was already waiting in the grounds when it was cancelled on both occasions. The relative also shared similar concerns.

Medium secure unit, April 2021

Patients we spoke with told us there were very few groups happening on the ward and most of those that were had very little therapeutic value. One of the patients we spoke with told us that they rarely had 1:1 time with their named nurse since they had been admitted. The majority of the time their named nurses had either been off sick or on annual leave and no one had thought to reallocate them. They were also often allocated to bank or agency staff who they didn't know. They also added that those patients who were openly displaying distress got the 1:1 time with staff.

Staff morale was low. The ward manager told us how staff had had to manage the pandemic, retrain and get used to redeployed staff, manage a few difficult admissions and move site and be up and running within 11 days. This had resulted in several staff needing referrals to occupational health and some had requested a temporary reduction in hours.

Carers and patients we spoke with felt that due to the lack of specialised eating disorder trained staff, the unit failed to deliver the service it promised to new admissions. Patients and carers felt that communication with staff was often poor. It was felt this was due to the few substantive staff trying to compensate for the bank and agency staff who didn't know the ward and or patient group. A carer told us that sometimes it could take staff a week to return a call or email.

Eating disorder unit, November 2020

In many services, we heard that staff were leaving for higher paid roles in community teams, or leaving active nursing because of burnout. In one service, we were told that they were not able to fill nursing posts at the same rate that nurses were leaving. This put additional pressure on the remaining nurses, which increased the likelihood of them also leaving.

Some specialist services – such as women's secure services – told us that it could be hard to retain staff due to the needs and behaviours of the patient group, but they tried to manage this with additional support and training opportunities.

In a number of services, staff, and sometimes patients, told us that they were concerned about an increase in levels of disturbance, threat of violence and actual violence from patients towards staff. In many cases, we heard concerns that staff may not be able to actively manage incidents because the pandemic had delayed training courses, including physical intervention training and some induction training, further reducing the number of staff able to actively manage incidents.

Staff told us patient acuity was higher than in the past and this combined with COVID-19 restrictions exacerbated and escalated situations. Staff felt some of the patients being admitted to the wards were not suitable for an acute environment because of the risks of violence they posed. They had cited incidents where police were called to support the ward staff ... One staff member told us about an incident that they felt could have been avoided had the staffing levels been increased accordingly. They told us the patient's behaviours had escalated throughout the day and it could have been predicted that there may be an incident. Staff felt that staffing levels should have been increased in light of the increased risks.

Acute male ward, March 2021

Staffing shortages and reconfigurations of services also meant that services had to make changes to their therapeutic activities. Pandemic restrictions stopped many community activities.

Use of section 17 leave had reduced as community facilities such as the Alzheimer's café, the petting zoo and dementia-friendly arts performances were closed. Most patients were not physically strong enough to take extended walks, but staff did take individual patients out for car trips when this was feasible. Staff tried to increase on-ward recreational and therapeutic activity to offset the reduced availability of activities in the community. Occupational therapy and psychology input continued on the ward during the pandemic. Activities on the ward included sing-alongs, sensory therapy, hand-massages, art, music, baking and reminiscence therapy, as well as celebrations of special occasions.

Specialist neurocognitive/dementia care ward for men, March 2021

In some cases, for example where therapy staff had been redeployed onto wards, we heard that this had helped to improve patient engagement in activities.

...in response to revised government guidance, Therapy Education Department (TED) staff were exclusively completing patient activities on the ward. We spoke with two TED staff who said they noticed patient engagement with activities had increased when they were based on the ward. They said the rapport they had with patients had improved and they had gained the trust of patients who previously did not engage with their team. The patient said he was happy with the level of activities on the ward and did not feel bored.

During the start of the pandemic therapy staff and therapeutic involvement workers (TIW) were redeployed to the wards across the hospital. All the staff commented on how the ward environment and morale had significantly improved. They told us the redeployment of this staff meant the ward had adequate numbers of staff to deliver activities to patients which in turn improved therapeutic relationships and outcomes. As a result of the learning from the redeployment the therapy staff have now set up outreach group comprising of therapy involvement workers, ward staff and technical instructors and occupational therapists to deliver outreach work to hard to engage patients.

Rampton Hospital, male treatment wards, October 2020

However, in other cases, staffing shortages had limited patients' opportunities to take part in activities. In one case, we identified that this was rooted in gaps in occupational therapy staff posts.

Although patients told us about music groups, art therapy, cookery groups and exercise, such as the gym and using the multi-use games area, patients also told us how boring it was on the ward recently. We were told that some days patients just sat in the communal areas not engaging in any activities. Patients told us how long the evenings and weekends were due to less activities.

One patient told us 'they don't meet my needs here... I walk around all day in circles like a trapped animal.'

Medium secure admission ward for men, March 2021

Other restrictions imposed by pandemic tested the effectiveness of some services. For example, we heard that on some eating disorder units infection prevention control (IPC) measures had stopped staff from eating meals with patients, even though this was part of their therapy. On one remote review, both staff and patients told us that not sharing meals detracted from the therapeutic experience. It was especially difficult for patients that had had multiple admissions to the unit and had to get used to the changes.

The provision and availability of psychological therapies also varied across mental health inpatient services. Some services had a wide range of therapies that met the needs of patients.

We heard about a range of psychological therapies available to patients. This included dialectical behaviour therapy and cognitive behaviour therapy, in addition to substance misuse and anger management groups. Several patients we spoke with told us they found these sessions helpful and looked forward to attending them. Patients also attended cognitive analytic therapy, which is a collaborative therapy that examines the way the individual thinks, feels and acts, and the experiences and relationships that underlie this (typically from childhood or early life attachments). We heard how this had been very beneficial for patients as it is a treatment that is person-centred and targets individual needs in addition to helping them to identify their own manageable goals for behavioural change.

Maple Ward (female low-secure), Waterloo Manor Independent Hospital, December 2020

However, in other services issues with staffing numbers meant that there was limited capacity to provide psychological therapies to all those who would benefit. For example, an inspection of one trust in winter 2019 showed that the service had a low number of clinical psychologists providing therapeutic input compared to similar trusts. We said that the trust should ensure they have the capacity to provide support and cover for clinical psychologists, and ensure that there is psychology input to the acute wards at all times. The pandemic may have delayed action on this, but also exacerbated its impact:

The consultant psychiatrist and ward manager told us that the psychology input for the ward wasn't sufficient to support patients in one-to-one sessions, group work and psychological assessments of individuals. They reported that staff also valued reflective practice especially at present due to the extra stress of managing COVID restrictions and the surge in patient numbers. They told us that one clinical psychologist was covering three wards so that [the ward] only had a psychology resource for one day a week.

Male acute ward, November 2020



2. Person-centred care during the pandemic

Key points

- In 2020/21, we have continued to engage with services over patient involvement in care. While we have seen some good practice of services empowering patients, this is variable and some services continue to fail to explain patients' legal rights effectively.
- Access to advocacy services has been variable during the pandemic. While digital technology has given people continued access to these services, not being able to visit the wards has limited their effectiveness.
- Many services have improved patients' access to digital technology over the pandemic period. While this can raise some security issues, these should be manageable and we urge services to maintain such access as far as possible.

Care planning

Effective care planning is vital for patient wellbeing, and patients must be as fully involved in their care planning as possible. As well as remaining a key focus of our monitoring, the importance of shared decision making is emphasised in the MHA Code of Practice and in guidance from the National Institute for Health and Care Excellence (NICE).

Published in June 2021, NICE guideline NG197 '*Shared Decision Making Between Patients and Clinicians*' stresses a values-based approach where clinicians discuss risks, benefits and consequences of care with the patient, in the context of that person's life and what matters to them. The guidance further suggests that services should appoint a senior leader to work with service user champions to raise the profile of the voice of people who use services, and help shared decision-making to be embedded in their organisations.⁶

While people with severe mental disorders may not always have capacity to fully engage in shared decision-making, it is important that they are not labelled as 'lacking capacity' overall and, as a result, excluded from shared decision-making. Mental capacity is a decision-specific concept, meaning that it can differ on a decision by decision basis, and NICE guideline NG108 '*Decision making and mental capacity*', published in October 2018, echoes

generally accepted good practice in expecting services to support the people using them to build capacity to make decisions.⁷

Explaining legal rights

Providing people with clear and accurate information on their legal position and rights is essential, and provides the foundation for shared decision-making and person-centred care. This includes making sure that people are aware that their hospital has a duty to give them information about their legal position and rights.⁸

The importance of providing patients with clear and accurate information on their legal position and rights cannot be overstated and should be the foundation on which any wider shared decision-making and person-centred care is delivered.

This was illustrated by a June 2021 Court of Protection hearing, *University Hospitals Dorset NHS Foundation Trust and Anor v Miss K*, which related to a proposed caesarean delivery of a baby carried by a mother detained under section 2 of the MHA.⁹

In this case, there was a lack of information sharing across clinical teams. As a result, the obstetrician responsible for gaining consent for a caesarean delivery was unaware of the degree of the patient's mental disorder, or that it had already been decided that the baby would be removed from her care immediately at birth. This meant that when the obstetrician obtained the patient's 'consent', the patient wasn't given the right information about plans for the baby or her role in its future. The patient's 'consent' was, at this point, possibly invalid due to incapacity, but was also invalid because she was misled by the comments made by the obstetrician about how she should surely want to have (and keep) a healthy child. It was only because the patient's condition deteriorated that the procedure did not go ahead and the case was taken to the Court of Protection.

We expect services to have procedures in place to inform patients of their legal position and rights under the MHA, and to record that they have both given the person this information and whether it is thought they understood it. People using mental health services are often particularly unwell when being admitted to hospital, so services need to strike a balance between ensuring that people are aware of and understand their rights, especially the right of appeal, while avoiding causing distress through overly repetitious 'reading of rights'.

On the following remote review, we were concerned our patient interviews showed that nearly half of patients did not fully understand their rights. We were particularly concerned that although information about their rights was given on admission, it was not repeated in time to make an appeal about their detention to the Mental Health Tribunal.

Staff, normally the named nurse, gave patients information as required by section 132 MHA on admission then again when detention status changed. Following detention under section 3 of the MHA this was repeated at care programme approach (CPA) meetings and at managers' hearings. Where patients lacked capacity to understand the information it was repeated on three attempts and then referred to multidisciplinary team meetings for further discussion.

Low secure unit for men, December 2020

Services also need to make sure that they take a person-centred approach to when and how often they attempt to inform patients of their legal position and rights under the MHA.

At one service we inspected, it was the organisation's policy that people using the service were read their rights on a monthly basis. This did not take account of the fact that on the ward we visited three out of five of the people using the service had severe cognitive impairments and significant communication needs. In addition, it was not clear from the records that the information given was individualised to people's needs. We saw several completed section 132 rights records for these patients, which showed no increase in understanding over time. In one case, a relative had questioned this routine monthly approach, observing that their relative had no understanding of the rights being read at a care programme approach meeting. In response, according to the record, the head of care stated in response that this was a legal requirement and inaccurately, that all people using the service had their legal rights read on a monthly basis. As a result of our inspection, the hospital was required to change its approach.

Where patients are informally admitted to hospital on a voluntary basis, it is important to ensure that they are given the right information, in a way that they can understand, so they can make an informed decision. On one NHS ward we visited, an informal patient had not been given adequate information, and therefore had not fully understood the terms of their admission to the ward. In response to our concerns, the ward manager raised this matter with the home treatment team making the referral, and also audited use of holding powers.

A patient told us they had been offered an informal admission, which they agreed to, but thought this was linked to helping them with their accommodation needs and thought they could come and go as they pleased. This was what they believed they were agreeing to and they said the admitting professionals did not express any concerns about their wellbeing. Once on the ward, when they asked to go out, they were detained. They said they felt deceived. We reviewed their notes and found nothing to contradict their reported experience, such as an explanation of what had been agreed. Staff confirmed this and said they had to explain to the patient that this was a mental health hospital. Staff told us another patient had been admitted informally but ward staff said the patient did not have capacity to agree to this and they were detained on a holding power and then transferred to seclusion within 45 minutes of their arrival on the ward.

Acute ward, March 2021

Involving patients in care planning

In previous reports we have highlighted our concerns over the quality of care plans and the lack of involvement of patients in the care planning process.

While we have found some examples of good practice, we continue to find examples of poor patient involvement. For example, in one acute admission ward for men we visited, we found no evidence that patients were involved in devising their care plans:

We reviewed two patients' positive behaviour support plans. We found that although they contained individual detail about the patient, were up-to-date, and contained information about patient's rights, there was still no evidence that patients were involved in devising the plans. This reflected what patients told us about not being aware of their care plans despite having regular one-to-one sessions with the nursing staff.

Acute ward, November 2020

In response to our challenge over how the service would better involve patients in their care, the ward improved the supervision of qualified staff

and carried out an in-depth review of intervention plans. In addition, the service introduced a masterclass for all ward-based staff to look how planning would be completed in a collaborative manner with patients and, where this isn't clinically possible, that there is a clear rationale documented in the intervention plan.

Where we have raised concerns previously, many services have made improvements in response. For example, on a visit to a female ward in June 2019 we raised several actions relating to care planning and patient involvement. On our remote review of the service in November 2020 we heard about significant improvements from patients and staff.

Patients we spoke with told us they were involved in the care planning process. Care plans were reviewed monthly as a minimum, and initial plans were normally drafted within two days of admission. Patients told us they were also involved in drafting their care programme approach notes. Patients said their views and wishes regarding care and treatment were taken into account and that they felt listened to by staff. One patient told us that staff communicated well with each other, which meant that she did not have to repeat herself, which was positive for her.

The ward manager updated us that:

- Information was recorded when detained patients were involved in discussions about their rights and this was discussed daily at the morning meeting, audited weekly by deputy ward managers and the MHA administration office. This was also recorded on the patient information notice board and was an agenda item in staff meetings.
- Work had been carried out to ensure care plans were used consistently and patients were involved. Weekly audits were in place and any issues raised with staff.
- Discussions take place with patients with reference to advance planning.
- A new pathway had been developed; 'Working towards discharge'. This started on admission and staff worked collaboratively with patients to identify goals and plan for discharge

**Iris Ward (female adult) St Helens Hope and Recovery,
November 2020**

Where people are involved in their care planning, they often report a more positive experience, feeling more in control, and having better relationships with staff.

The patient I spoke with said that the commitment of staff to her had allowed her to keep control of her own care. She said that:

- even when she disagreed with plans for her care, staff took time to explain the reasons for decisions made.
- she was included in the development of her care plans and her views were given credibility and considered.
- she said that when she was feeling paranoid that staff would reassure her and gave an example that if she felt her food was not safe, that staff would sit with her and eat the same meal.

Hayeswater Ward, Edenfield Centre, Greater Manchester Mental Health NHS Foundation Trust, March 2021

All patients had an individualised activities' plan which set out a range of therapeutic and recreational activities seven days a week. Patients we spoke with told us they were involved in the care planning process. Care plans were reviewed monthly as a minimum, and initial plans were normally drafted within two days of admission. Patients told us they were also involved in drafting their care programme approach notes. Patients said their views and wishes regarding care and treatment were taken into account and that they felt listened to by staff.

Patients were unanimously positive regarding staff. Comments included: "Brilliant staff. They are very supportive"; "Staff are really good. They are funny, you can have a laugh with them."; "It was so good the way staff dealt with the situation [a personal matter]. They were so supportive. I can't fault them at all - I've never met staff like it."

Maple Ward (low-secure ward for female patients) Waterloo Manor, Leeds, December 2020

The consultant psychiatrist told us they encouraged patients to participate in their weekly ward reviews, which was confirmed by the Independent Mental Health Advocate. One patient commented that the control was 50/50 between them and the doctor. Another patient commented that they had been listened to and the doctor had changed their method of medication.

Mulberry 2 Ward, Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, December 2020

Through our monitoring activity, we heard about a new approach that Birmingham and Solihull Mental Health NHS Foundation Trust is piloting for care planning arrangements. Every week a named nurse has a one-to-one with the patient and creates a document describing the patient's views and wishes, and the ward staff's assessment of the week, including any incidents, activities, leave, and social interactions. The multidisciplinary team (MDT) then discusses this document with the patient, summarises the discussion and generates a 'recovery and discharge' actions form. This states what needs to be done, who needs to do it and when it needs to be achieved by. They print the review and actions and give them to the patient. This process is repeated weekly, which should ensure that care plans never go out of date and decisions are made in partnership with the patient.

We welcome the government's proposal to introduce a statutory care and treatment plan as part of the MHA reforms. This should provide an opportunity to require services to show evidence of co-production with the patient. Where patients are too unwell to participate, there should be proper evidence rather than generic statements, like 'patient too unwell', 'patient declined'.

Given that the proposed principles for the Act emphasize the importance of patient autonomy, any decisions to override a patient's current or past wishes also need to be recorded prominently with accompanying rationale. In addition, we have suggested that a statutory care plan should include headings requiring information on communication needs; the views of relatives or carers (or, as proposed, the nominated person); and plans to introduce an advocate to the patient. These issues are particularly important for people in the early weeks of detention when they may have difficulty articulating their own views and wishes.

Advocacy

Access to advocacy services has been variable during the pandemic. While digital technology allowed patients to continue to access advocacy services remotely, many advocates told us that not being able to visit wards limited their activity.

The Independent Mental Health Advocate (IMHA) I spoke with told me that they had a good relationship with the responsible clinician and other staff, and that staff were very helpful in organising the weekly remote IMHA 'surgery'. This was popular with patients and had been an effective way of maintaining communication with them during lockdown. Patients confirmed they had contact with the IMHA through video calls and found the remote IMHA 'surgery' especially helpful. They were confident that the IMHA was able to speak on their behalf.

Acute ward, March 2021

The IMHA and advocacy contract manager told us that referrals to the service dropped off when they were unable to visit in person. There were no referrals for three consecutive months, but these picked up again once IMHAs were able to visit the ward again. They said this emphasised the importance of site visits.

Male acute ward, March 2021

We encouraged the use of video calls across a number of services, particularly where uptake of advocacy services had fallen. However, we recognise the limitations of remote services including, for example, access to digital devices on wards and some patients not feeling comfortable in taking part in video calls.

As a result, we urged services to restart physical visits as soon as it was safe to do so. For example, on one remote review at a rehabilitation unit in October 2020, we were told by the Independent Mental Health Advocate (IMHA) that the advocacy provider would not allow her to make visits in person, although she was not shielding and the unit was allowing visits. We asked the ward manager to challenge this with the advocacy provider and it was agreed that the IMHA could restart her visits.

During the pandemic, some advocacy services changed their referral procedures to only accept referrals through a web-based form. In some cases, we heard that this could lead to reduced take-up. Advocacy services should aim for systems where patients can seek help through any means of communication, to ensure that their services are fully accessible, as in the following example.

During the pandemic, additional support measures had been put in place. All IMHAs had an email address so that they could be contacted directly by patients and staff supporting them. This had been proved to be a positive route for access to an IMHA. IMHAs could also be contacted directly through their mobile phones or the office number.

**Pine Ward, Hartley Unit, Mersey Care NHS Foundation Trust,
December 2020**

We support the government proposals to strengthen the advocacy role, improve training, encourage culturally appropriate advocacy and, provided that this is not at the expense of smaller providers, look at accreditation for advocates.¹⁰

In our response to the white paper consultation, we also suggested that current commissioning arrangements for advocacy services limit their effectiveness.

For many services there are different advocates for Mental Capacity Act and MHA advocacy, and in some cases a third, generic advocacy service. This can lead to confusion.

The MHA administrator advised that the roles of the different advocacy services were included in the induction training. However, the independent mental health advocate raised concerns that patients requiring support provided by the independent mental health advocacy service were being referred incorrectly to other advocacy services.

Women's personality disorder unit, March 2021

The legal duty to commission IMHA services rests with the local authority where a hospital is based.¹¹ We have previously highlighted that not all local authorities meet this duty, and this continues to be the case. In practice, some IMHA services are commissioned according to where the patient is normally resident. In some London services, we find that many wards have patients from a range of boroughs, all of which have commissioned different IMHA services.

The IMHA from Rethink told us that there were three different IMHA services for this ward depending in which London borough the patient lived, and that this caused confusion at times for patients. She signposted patients outside of her area.

Male acute ward, November 2020

As a result of commissioning deficits, some national services and independent hospitals that take patients from many different areas have resorted to commissioning their own IMHA service. This is often the only practical solution and, although there is a theoretical risk to the independence of the advocacy service, we have not yet encountered any serious problems.

Local authorities have many strains on their budget and must make difficult funding decisions. We are concerned that many local authorities are unable or unwilling to commission IMHA services that are sufficiently resourced to meet the needs of the area they serve, especially in terms of funding visits to wards and engagement with patients without specific instruction. As a result, we find that patients can have very different experiences of an IMHA service, depending on where they are detained in England. Commissioning an advocacy service should not be just about funding sessions when a patient 'instructs' an advocate. As highlighted in last year's annual report, the pandemic has highlighted how important ward visits, 'drop-in' sessions or surgeries and ward meetings are in supporting patients to use advocacy services.¹²

As part of the MHA reforms, we have suggested that centrally-funded IMHA services should be considered. As part of this, services should be coordinated across integrated care systems to ensure that funds are distributed fairly in accordance with need.

Blanket restrictions

In our monitoring visits and remote reviews we have sought to encourage services to challenge outdated, institutionalised and overly restrictive practices in favour of patient choice and a human-rights based approach. The MHA Code of Practice is clear that blanket restrictions – defined as rules or policies applicable to groups of patients irrespective of individual risk assessment – should be avoided, unless they can be justified as necessary and proportionate.¹³

We believe that our emphasis on this has had a profound impact on many services. As a result of our activities, many services have made changes and put in place processes to monitor and review restrictions, to ensure that these are justifiable and, wherever possible, applied according to individualised patient risk assessments.

We reviewed the progress of the trust action plan completed following our last MHA monitoring visit in March 2019 and note ... A staff and patient consultation had taken place after our last visit to review restrictive practices. This considered all the identified blanket restrictions on the ward... the majority of these rules had subsequently been removed and the ward would continue to hold these events in order to review restrictive practices.

The IMHA told us that the ward culture had developed into a much less restrictive culture over the last few years. One patient told us, "I've been here a few times in the past and it's much better now...it used to be really restrictive, but they are gradually stopping that now and the rules are less strict. I genuinely think that it's one of the best wards I've been on now."

Child and adolescent mental health services (CAMHS) ward, March 2021

We continue to have positive engagement with services over maintaining least restrictive practice, even in services with necessarily higher levels of physical security.

We spoke with patients who told us that, since our last MHA monitoring visit, there had been changes made to reflection time. This was no longer mandatory. Patients had a choice to either go to their rooms or engage in activities. The bedroom doors were not locked and patients had the freedom to leave their rooms.

Learning disability ward, Rampton Hospital, March 2021

Patients told us that they felt safe on the ward; the ward environment was settled and the atmosphere on the ward was good; [and] ...the ward practised [the principle of] least restriction. The patients described the ward environment as being conducive to a pre-discharge ward in that most areas were open and accessible such as the kitchen area. They felt the ward was preparing them for the next part of their recovery journey.

Rehabilitation ward, Rampton Hospital, February 2021

During the pandemic, when opportunities for off-site leave were reduced, many services relaxed their implementation of smoke-free policies.¹⁴ In our last report, we stated that we expect services to make renewed efforts to encourage people to stop smoking to reverse these temporary backwards steps.¹⁵ Through our monitoring activity, we heard examples of the steps that some services have taken to address this, including allowing patients to smoke e-cigarettes in their own rooms.

Rules on the use of electronic cigarettes had been relaxed so they could be used in bedrooms. Staff said this had gone well and they planned to keep this relaxation of the rules.

Low secure rehabilitation ward for men with a personality disorder, March 2021

We do not view the smoke-free policy as an unjustified blanket restriction, although, particularly in the early stage of implementation, we raised concerns where it was introduced primarily in terms of privation (patients being told that they could not smoke cigarettes on site after a certain date) that was not balanced with opportunity (patients being offered positive support and alternatives to cigarettes).

We expect services to continue to encourage people who use services to stop smoking as part of their efforts to support people to adopt healthier lifestyles (see section on food and nutrition).

Access to digital technology

In previous reports, we have raised our concerns about blanket restrictions around the use of mobile phones on wards.¹⁶ Last year, we highlighted that many services had relaxed their rules around the use of mobile phones and

access to the internet because social distancing restrictions were preventing people from having visitors. We supported this approach and set out our expectations that services should maintain this access after the pandemic, unless there were clear reasons why this should not happen.¹⁷

In general, services seem to be maintaining access to mobile phones. For example, at one service, we heard that patients who were previously restricted as to when and how they could use their phones, were now able to use their phones on the wards in line with individual risk assessments. The service had also created an IT room in one of the spare rooms.

At our last MHA monitoring visit, we found that patients could only use their mobile phones in the laundry room or dining room, under the supervision of a member of staff, or while on leave from the ward. During this review, staff told us that patients were able to use their mobile phones in accordance with their individual risk assessments and after signing a mobile phone contract. One patient told us that they used their smart phone on the ward. A landline cordless telephone and electronic tablet were also available which patients could use.

On our last visit there was no patients' computer and patients did not have access to the internet on the ward. During this review, staff told us that a spare room on the ward had been converted into an information technology room.

Psychiatric intensive care unit (PICU), March 2021

In some cases, the use of ward-based equipment for video calls is limited by staff availability, and may be poor substitute for individual devices.

Staff pressures were limiting communication, for example use of Skype. One relative told us that they would like to use Skype but needed staff to facilitate this so 'did not think it would happen.'

Medium secure unit, complex needs, April 2021

We have found that most concerns around allowing access to digital devices, such as misuse of cameras and use of social media breaching other patients'

confidentiality, can be managed without a total ban on phones. However, we recognise that there are still some risks in allowing access to digital devices. For example, over the summer of 2020 we were told that some patients on a rehabilitation ward in a medium secure unit had been using synthetic cannabinoids (Spice, or K2) on the ward. The ward had identified that the drugs may have been ordered via the ward laptop and posted to the ward. When we carried out a remote review in October 2020, we heard that they had managed to reduce the problem through increased vigilance from staff and limitations on access to the laptop.

We recognise that allowing some but not all patients to have access to a mobile phone could lead to patients with access being bullied or exploited, for example to obtain drugs. As a result, this needs to be taken into account when making decisions about access.

At another medium secure unit, we initially challenged limitations on access to mobile phones after 8pm, but accepted the rationale provided by the hospital. We heard that there had been some safeguarding issues relating to personal relationships, as well as some evidence of cyber-bullying and intimidating behaviour. We heard that the situation was kept under review, and that people were supported to learn about safe use of social media and safe, healthy relationships. The ward continued to provide access to smart phones during the day and patients could also keep in touch with family using video calling apps on the hospital's equipment. At the time of our remote review, one patient had recently watched her grandmother's funeral service on the television.

However, services need to ensure that all decisions are made according to individual risk, and are not blanket rules. Services should also provide patients and staff with clear explanations of the ways in which access to communications can be legitimately restricted in relation to individual risk. We will continue to challenge decisions that we feel do not meet the principle of least restriction.

The ward has developed into a much less restrictive culture over the last few years. However, patients still regularly raised the current restrictions placed on access to leave and mobile phones, which was linked to observation levels and not individually risk assessed. This was often viewed as punitive and too generalised by patients. The IMHA told us that patients also gave feedback that because their mobile phones were automatically taken away after distress behaviour, they found it harder to recover.

Low secure rehabilitation ward for women, March 2021

Internet access was supervised for all patients and not based on individual risk assessment. For patients, the issue around internet access was compounded by the fact that although they were allowed smartphones on leave, subject to individual risk assessment, they were not currently allowed on leave. Staff said smartphones were not allowed on the pond trip, even though this was outside of the perimeter. This impacted on patients' ability to communicate with friends and family, given connection issues with the ward's tablet computer. Patients wanted the restrictions on smartphones to be relaxed and staff said similar requests had been raised in community meetings. They said these were hospital policies which would need to be changed. Following our visit, we asked the hospital to review its policies to consider relaxing the rules around access to smartphones on the ward during the pandemic, with a view to maintaining such access in the longer term.

Low secure rehabilitation ward for men with a personality disorder, March 2021



3. Ward environments

Key points

- Many parts of the mental health hospital estate need upgrading. Wards are often unsuitable sensory environments, particularly for autistic patients. The use of dormitory wards can also leave patients feeling unsafe.
- In many hospitals, patients and staff complained to us about poor internet coverage. Not only does this stop patients contacting their friends and families, but it also interrupts online medical or legal consultations and tribunal hearings.
- Catering still needs serious improvement in some services. Bad food encourages take-away use and obesity, and people detained for health purposes should expect decent, nourishing food.

“The environment is not autism friendly if you are having a meltdown.”

Patient on an eating-disorder ward

Mental health inpatient wards are often noisy and bustling environments. This can be a challenge for all patients, who can feel trapped in a space that is not conducive to recovery. However, these types of environments can be particularly distressing for autistic people who may be at risk of sensory overload.

For example, on our review of a specialist eating disorder ward in January 2021, staff told us that there were a relatively high number of patients with diagnosed or suspected autism in the hospital. The lead nurse for autism had carried out work to help ward staff develop their skills in working with people with autism and had helped develop and refine care plans, but patients and staff told us that the environment was not friendly for autistic people or people with sensory challenges. The service had previously insulated walls and ceilings and fitted sound-reducing panels to walls, but was in consultation with a specialist sound engineer as the problems of noise persisted. They were also developing sensory rooms on wards in consultation with patients and a specialist company.

Steps that other services have taken to reduce noise levels include attaching rubber feet to moveable furniture on hard floor surfaces, and ensuring there are quiet spaces. We also heard that staff needing to stay on the wards during the pandemic had highlighted previously unidentified environmental challenges, such as noisy doors.

During a period of lockdown staff stayed on the ward to support patients and reduce the risk of contamination. This experience helped staff identify several improvements to improve patient care. For example, doors that had banged at night were fixed to ensure they were less disturbing to patients.

Men's rehabilitation ward, November 2020

Dormitory wards in particular can be noisy environments that can be distressing to patients. Although likely to be a consequence of aging infrastructure, larger wards can add to problems with noise and disturbance, which can also create problems for patient involvement and engagement. For example, at one trust we heard that patients and visiting relatives who used hearing aids struggled with communication because of the level of background noise.

Even when dormitory wards are managed well, and in accordance with the guidance '*Delivering same-sex accommodation*'¹⁸, we have heard that people do not always feel safe in these environments.

Dormitory rooms were organised depending on the amount of male or female patients admitted to the ward. One patient said he did not like sleeping in a dormitory room as he felt unsafe. This was due to the person in the next bed responding to him in a threatening manner. Staff said they were aware of this and monitored this issue closely.

Older adults' ward, December 2020

As stated previously, we do not think that dormitory accommodation should be acceptable in any mental health inpatient unit.¹⁹ The government has pledged over £400 million to make progress on replacing dormitories.²⁰

A number of larger wards were scaled back at the start of the pandemic, although this of course added to pressures over bed availability and the numbers of beds increased again as local infection rates declined.

The intensive assessment model being used to develop initial formulation and treatment plans was very proactive and facilitated early discharge or transfer from the ward. Staff were very positive about working to this model. We are aware that this creates significant demands on clinical staff time requiring intensive engagement with patients, and to maintain this patient numbers need to be kept at a manageable level. We were informed that this was better managed when bed numbers were 12 but this have now risen to 15 and this has put a strain on staff trying to meet key performance indicator targets and can affect the quality of care.

Acute ward, November 2020

The funding pledge to replace dormitory wards is welcome. However, there are many other improvements required in mental health inpatient environments that will similarly be dependent on adequate capital funding being available.

Sexual safety

The reconfiguration of wards at the start of the pandemic could create challenges for services in meeting the requirements for single-sex accommodation.²¹ Positively, the only breaches of guidelines we saw were when single-sex day spaces were temporarily unavailable. In many services these spaces were not in demand anyway.

While gender segregation alone cannot address all concerns around sexual safety,²² many services aim to group patient rooms so that women do not need to pass men's rooms to get to their own rooms, and vice-versa. This is not a requirement of guidance on same sex accommodation, and is not always possible due to the infrastructure of the ward. However, where this can be arranged it can add to patients' sense of sexual safety.²³

During the pandemic, some service reconfigurations meant that these types of arrangements could not be maintained. In these instances, we found that services had taken steps to maintain patients' sense of safety, for example having staff allocated to specific areas where people were shielding.

The designation of 'shielding' versus 'non-shielding' patient areas had meant that there was no longer a 'male' and a 'female' corridor to the ward. This was mitigated for by allocation of staff to designated areas.

Rehabilitation ward, March 2021

For some services, the reconfigurations offered an opportunity to introduce single-sex wards that may continue post-pandemic.

Reconfiguration of the wards into female and male and reduction from 22 to 19 beds had been necessary to manage COVID-19. This had worked well. Feedback from a female patient was that being on a single gender ward "felt safer and more relaxed".

Acute ward, March 2021

We also heard about good practice in proactively addressing sexual safety:

The ward was piloting the sexual safety project on the ward. Staff ensured patients were involved in this project. They collected patient views by circulating postcards to patients on a weekly basis. No concerns had been flagged up by patients. The feedback was reviewed by the reduction in restraint lead. Staff showed compassion when speaking about this topic and a good awareness that this piece of work could be retraumatising for some patients. Staff offered support to patients and a safe space to talk, if needed.

**Ward 1 (high dependency acute ward), Harplands Hospital,
North Staffordshire Combined Healthcare NHS Trust,
March 2021**

WiFi connectivity issues

In last year's report, we highlighted our concerns around the availability and quality of WiFi on mental health wards.

Over the last year, we have heard frequent complaints from patients, staff and even the Tribunal service about WiFi signal availability (see section on the First-tier Tribunal). In some hospitals, detained patients have had to use their own mobile phone accounts to speak with families, and even lawyers, at their own expense.

All the patients we spoke with told us that telephone and internet connectivity was poor on the ward. They told us that this regularly affected their conversations with families and on occasions their right to private communication with the advocacy service and solicitors. Most patients told us that they could not use the ward WiFi and they paid for access to the internet on their mobile phones but still could only access the internet and calls to telephones in certain parts of the ward and that this regularly disconnected.

Women's PICU, March 2021

Patients told us the WiFi connection was "really quite terrible", that the signal was poor and if you were able to get a signal it was constantly breaking up. Patients used their own mobile phones instead. Although the trust had provided a tablet computer for patients to have video calls with friends and family, patients had not been able to use them due to the poor WiFi coverage. Staff told us the only place where the video calls worked was a communal day room with no privacy for the callers.

Acute ward, March 2021

As a consequence, many of our remote reviews have requested that services address their WiFi coverage. In a number of cases, services have replied that they are installing signal boosters or other technological fixes.

“The WiFi issue is currently a high priority piece of work within the organisation. The trust IT operations manager has advised that there are currently issues with WiFi at the unit and the trust was currently carrying out improvements, including adding and relocating wireless access points. All technical specification changes with remote servers with the Mental Health Tribunals have been rectified and a support team is on standby for every Mental Health Tribunal. The trust is also assessing a more significant capital investment to substantially improve WiFi access or a technical solution”.

Response to remote review, acute ward, November 2020

Food and nutrition

The catering arrangements and quality of food available on mental health wards is an area for concern, with patients often telling us that the standards of meals provided is not good enough.

Meals were described as poor in terms of quality and quantity. Patients and staff both reported that portions sizes were often too small and that meals were served on plates that were not appropriate in size or design for an adult.

Patients told us that they were not offered second helpings even if they were still hungry and there was food leftover. One patient said they ate chocolate after a meal as they were frequently still hungry. They told us “the food is not enough to feed a chihuahua”. The second patient told us “food is bad and there’s not enough of it. Its rubbish, not much selection and not much protein”.

However, patients had access to hot and cold drinks and fruit including a range of fresh fruit delivered from a local farm, which staff prepared in individual pots for patients to access when they wanted.

Medium secure unit, April 2021

Over 2020/21, as part of the Adult Secure Clinical Reference Group, we have worked with NHS England and NHS Improvement to develop guidance on '*Managing a healthy weight in adult secure services*'.²⁴ This guidance will be useful for all hospitals that detain patients, including those that are not specifically designed as secure hospitals, as it encourages services to work with patients on improving their diet and lifestyle. We have seen some good practice in services, for example:

Staff encouraged healthy eating and one patient had lost a considerable amount of weight whilst on the ward, which meant that they were now eligible for treatment that would have been dangerous for them before they lost the weight.

Women's ward, medium secure unit, March 2021

In October 2020, the Independent Review of NHS Hospital Food published its report recommending measures to improve standards for patients' food, including statutory standards.²⁵ We welcome the inclusion of this in the Health and Social Care Bill,²⁶ as improving the standard of meals provided to patients in hospital will help to support implementation of healthy weight strategies.



4. Leaving hospital

Key points

- We continue to have concerns about the quality of aftercare planning and multidisciplinary team support following discharge from hospital.
- We welcome moves to replace the care programme approach with a more flexible, responsive and personalised approach, but are concerned to see some signs of local authority resources being withdrawn from discharge planning processes.
- Disputes over which local authority is responsible for funding a person's aftercare can lead to people being detained in hospital longer than necessary. We welcome the work underway to explore ways to determine which local area is responsible for the aftercare of a person.

Discharge planning

The MHA Code of Practice is clear that discharge planning should begin as soon as a patient is admitted under the MHA, and all detained patients should have an aftercare plan.²⁷ In previous reports we have raised our concerns about the quality of aftercare planning.²⁸

When people are discharged from hospital, they should have support from a multidisciplinary team that supports both their social needs as well as their clinical needs. In 2019, the Community Mental Health Framework set out proposals to replace the Care Programme Approach (CPA) with a more flexible, responsive and personalised approach.²⁹ It seems likely that this will be applied to civil (rather than forensic) patients. It recognises the need to adopt clearer multidisciplinary-based approaches and integrating clinical and social care to address people's holistic needs, rather than the current system of a single care co-ordinator coping with an overwhelming workload.³⁰

Although we welcome proposals to develop care co-ordination and planning, they come at a time when we are concerned to see some signs of local authority resources being withdrawn from discharge planning processes. For example, in a review of a ward for older people in October 2020, nearest relatives told us that there had been issues with social workers not being allocated or attending section 117 meetings in order to facilitate safe and appropriate discharge and follow up.

Over the last year the Local Government and Social Care Ombudsman found against a number of clinical commissioning groups for failures under section 117 of the MHA.^{31,32} During this period, we have also investigated and upheld a complaint against a number of agencies relating to a failure to provide statutory aftercare.

A complaint investigation about aftercare provision

We investigated a complaint relating to aftercare provision following an inpatient admission that had included a period detained under section 3 and involved transfer between services.

We upheld many aspects of the complaint. Although aftercare planning should have started from admission, no assessment was carried out despite the patient giving six weeks' notice of her intention to discharge herself from hospital. A care assessment was finally completed by a duty social worker three months after discharge, following repeated requests from the patient. We found this to be inadequate for reasons that included the following:

- this was too late
- the assessment did not fully consider underlying entitlement to section 117 aftercare despite recording that she had been detained
- there was no record of care needs relating to confirmed diagnoses of autism, obsessive compulsive disorder (OCD), anxiety and trauma
- it was wrongly concluded that support needs were met by the patient's family, although the family was providing support precisely because there were no section 117 aftercare arrangements in place to meet her needs
- the assessor did not consider whether existing support should be as part of section 117 aftercare, instead focusing solely on a request for direct payments to fund psychotherapy. As the assessment later concluded, direct payments cannot be used to fund health interventions, but this was not communicated to the complainant in a timely way.

In response to the complaint, the manager of the community mental health and autism team acknowledged the assessment was "limited" but should be viewed as an initial "screening". As an initial screening, we found that the document failed to meet an acceptable standard for the reasons outlined above. We note this in the context that the complainant justifiably argued that failure to take account of her autism during her hospital admission was a significant contributory factor to her diagnosed conditions on discharge.

The complainant, her current psychiatrist, community psychiatric nurse and social worker told us they contacted had made several attempts to get services to meet their duties to provide aftercare under section 117 of the MHA. Aftercare arrangements were finally in place only after almost three years from leaving hospital.

We recommended that the complainant be reimbursed the money she had spent on providing for her own aftercare while services failed to meet their duties, with compensation for considerable anxiety, distress and loss of opportunity for recovery.

We discuss the working of the CPA and aftercare provision for patients who are remitted back to prison after transfer to hospital under the MHA in the section on the MHA and mentally disordered offenders.

Determining which authority has a duty to provide aftercare

In August 2020, NHS England's revised guidance, *'Who Pays? Determining responsibility for NHS payments to providers'*, set out the framework to establish which NHS organisation has responsibility for commissioning an individual's care and which has responsibility for paying for that care.³³ Where the patient usually lives, known as their 'ordinary place of residence', will influence this decision.

There can be complicated and long-running disputes over which authorities are responsible for providing aftercare services under MHA section 117 to patients discharged from detention in hospital. This is in part because detention, especially out of area, can complicate the question of ordinary residence, but also because the duties are shared across health services and local authorities. The intense pressures on local authority budgets can mean that accepting liability for a complex aftercare package are likely to increase pressures on already under-funded budget-heads where services have been curtailed to make cost savings. It is not surprising that disputes arise.

Section 117 of the MHA states that where there is a dispute over the location of a person's ordinary residence, the authorities concerned may ask the Secretary of State make a decision.³⁴ For example, in 2020, the Secretary of State was asked to determine a case where a patient was detained in Swindon, but had been placed in that local authority as part of an ongoing aftercare package following a previous detention in Worcester. The Secretary of State accepted the argument by Swindon that Worcester should have continued liability, even though this would be contrary to paragraph 19.64 of the Care and Support Act statutory guidance.³⁵

In March 2021 the High Court ruled against that decision, upholding the position of the statutory guidance.³⁶ In response, the Secretary of State has taken the case to the Court of Appeal. The Department for Health and Social Care has stated that decisions around similar cases are paused while the final

decision about the correct approach to determining the ordinary residence for people detained under section 117(3) is considered by the Court of Appeal.³⁷

We recognise that the government is exploring ways to determine which local area is responsible for the aftercare of a person, particularly in more complicated personal histories that have included placements out of area.³⁸ But it is important to resolve the ongoing uncertainty quickly and restart dispute resolution, as this could lead to delays in making aftercare arrangements, and could mean that patients are being detained in hospital longer than is clinically necessary, which can be extremely distressing and lead to relapse.



5. Tackling inequalities

Key points

- NHS digital statistics, published in October 2021, show significant inequalities in the use of the MHA, with a marked difference in the rates of Black or Black British people detained under the MHA, as well in the length of their hospital stays and numbers of repeated admissions.
- Reform of the MHA is shining a spotlight on these inequalities, and we welcome the introduction of the Patient and Carer Race Equality Framework (PCREF) pilots, which aim to help mental health trusts work with ethnic minority communities to achieve practical change.
- Through our monitoring activity, we have seen positive action in tackling racist behaviour on wards. Services are also more aware of the discrimination and exclusion experienced by LBGT+ people.
- Face masks and visors created communication barriers for deaf patients, although the adoption of clear masks addressed this in part. Not all services have enough access to support for staff, such as signing interpreters.

As we highlighted in our 2018/19 report, taking away a person's liberty so that they can be treated in hospital has a major impact on that person's life, work and family and as a result, it is essential that this is carried out in a manner that respects their human rights.

Tackling inequalities in health and care is a core ambition of CQC's new strategy, and our equality objectives for 2021 to 2025 recognise the need to focus on the quality of care for people who are most likely to have poor experience or outcomes from care, including people detained under the MHA.^{39,40}

This applies to all people with serious mental illness, and especially people detained under the MHA and people who may not have mental capacity to make some important decisions, such as decisions about their care and treatment or where they live. In that context, CQC and the services we monitor must have an awareness of intersectionality, or how factors such as a person's ethnicity, age, disability, education, sexual orientation, gender identity, immigration status, socio-economic circumstances, can lead to discrimination or disadvantage an individual.

We will be using our monitoring and regulatory activity to make sure that health and social care services understand and are taking steps to tackle

inequalities in care. This includes having an awareness of how characteristics such as a person's ethnicity, age and gender influence the quality of care they receive. In our equality objectives we highlight the following groups as an initial focus across the whole of CQC's work:

- people from Black and minority ethnic groups
- people with a learning disability and autistic people
- people with dementia
- people who need accessible communication including Deaf people and people who do not speak English
- Lesbian, gay, bisexual and transgender people.

In its final report, the Commission for Equality in Mental Health highlighted that services should be accountable for reducing inequalities in access, experience and outcomes.⁴¹

As highlighted in our January 2022 Insight briefing, reliable, quality evidence is a fundamental tool in identifying, tackling and improving service equality. However, we are concerned that poor recording of ethnicity is masking equality issues. Only through having access to reliable local and national data will services be able to identify gaps and measure progress towards closing them with benchmarking against other services. We encourage services to support system-wide efforts in tackling existing, and preventing future, health inequalities by improving how data to monitor equalities is captured and used. Solutions will require a system response, working with their communities.

Tackling racism

It has been a longstanding concern that not everyone detained under the MHA is treated equally. NHS digital statistics, published in October 2021 on the use of the MHA, while incomplete, suggest that in 2020/21:

- known rates of detention for people identified as 'Black or Black British' were over four times those of people identified as 'White'
- Black or Black British people have longer periods of detention and more repeated admissions, and are more likely to be made subject to police holding powers under the MHA
- known rates of community treatment order (CTO) use for the 'Black or Black British' group were over 10 times the rate for the White group.⁴²

The process of reforming the MHA has highlighted the overrepresentation of certain minority ethnic groups of people who are subject to detention or CTO. Urgent action is required to address this longstanding inequality.

We recognise that some factors in inequality are broader than health care provision. Structural disadvantages, such as barriers to accessing earlier health interventions; poverty; education; insecurity of housing and lifetime

experiences of trauma and exclusion due to racism, are the background against which admission and discharge from hospital under MHA powers take place. NHS digital statistics for 2020/21, published in October 2021 also suggest that the most economically deprived areas had rates of detention more than three and a half times higher than the rate of detention in the least deprived areas.⁴³

As the disadvantages and racism that people with protected characteristics face do not only occur when they undergo an MHA assessment, it is unlikely that rewriting the legal criteria for the use of the MHA powers will have an effect on this.

We welcome new guidance from NHS England and NHS Improvement that sets out the steps that mental health services need to take to fight stigma and inequalities across the sector. *'Advancing Mental Health Equalities Strategy'*, published in October 2020 included a commitment to develop a Patient and Carer Race Equality Framework (PCREF). This is an approach to help mental health trusts work with ethnic minority communities to achieve practical change.⁴⁴ It stems from a recommendation from the 2018 Independent Review of the MHA, aimed at addressing racial disparity in access, experience and outcomes of Black or Black British people in mental health services.⁴⁵

We are keen to see the rollout of the PCREF, and have followed developments of the PCREF pilot sites, having benefited from presentations and training from people who use services, carers and staff at South London and Maudsley NHS Foundation Trust. Once developed, the PCREF will be rolled out by NHS England across all mental health trusts in 2022 and will be considered in our well-led assessments.

All health and social care services should have zero-tolerance towards racism and should be engaged with promoting equality, as part of their legal duties under the Equality Act 2010. It can be more challenging to manage the racist language or acts of people detained in hospital under the MHA, but where services are aware of racism or equality issues they must take action to address these.

During remote monitoring of a women's ward in March 2021, we were told that the ward was trying to implement a zero-tolerance approach to racist language towards staff by patients "although it was often very hard to press charges". We accept that patients and staff must be supported to report racist incidents to the police, although it is clear that this cannot always be expected to lead to prosecution, or that this would necessarily resolve the problem.

The *Norfolk Safeguarding Adults Review*, published in September 2021, suggests that there can be a 'taboo' of addressing racism expressed by patients with cognitive impairments. The review acknowledges that there are no quick fixes to addressing such racism, but suggests that the principles of restorative justice (that is constructive learning via mediation between a victim and the offender) have promise.⁴⁶ In response the safeguarding board produced a seven minute briefing on managing racial abuse towards staff from people who lack capacity, which may be of use to services.⁴⁷

During our monitoring of Rampton Hospital in February and March 2021, we heard positive accounts of action taken to address racist incidents by some of the patients, directed towards both patients and staff.

Staff and patients reported incidents of racism on the ward. Patients and staff were supported to report these incidents to the police, IMHA supported patients, safeguarding processes were followed. In addition to this, the speech and language therapist offered educational sessions to patients about the impact racism has on people.

The clinical nurse practitioner is developing a package around racism and hate crimes and is planning to deliver sessions to all patients. Also, a theatre group who offer a play-type activity about racism are being approached. This theatre group has been used in the past and was found to be helpful.

Rampton Hospital, March 2021

In response to our request for assurance over the hospital's broader actions to address racism and other equality issues, we were pleased to hear the positive action they were taking to address this.

Spotlight on equalities work at Rampton Hospital

Despite COVID-19 lockdowns throughout most of the year, more than 100 Rampton Hospital staff from all bands and varying disciplines participated in Equality Diversity and Inclusion (EDI) workshops. In these workshops staff reflected on why EDI matters to them as individuals, to their work teams, the trust, and the NHS. In the second part of the workshop, they explored and identified implicit biases, microaggressions and/or trauma in themselves and others at work and finally discussed how they will challenge and address inequalities, discrimination, bullying and harassment at work.

The hospital is developing a training package for all clinical and non-clinical staff, with input from psychologists to explore issues such as racism through a compassionate and curious forum.

A multidisciplinary team, in partnership with patients and the involvement team are in the process of co-producing a training manual for patients, which will include recognising and reporting hate incidents, discrimination, bullying and harassment.

During Black History Month, LGBTQ month and hate crime awareness week, information has been communicated across the hospital relating to preventing, recognising and reporting hate incidents as well support for perpetrators and victims of these hate related incidents.

From a patient perspective, a range of activities are provided throughout the year to celebrate and raise patient awareness of EDI matters. In addition to religious celebrations such as Christmas, Hanukah, Eid and Diwali, the day care service centres with external partners, LGBTQ Foundation and SACHMA (a charitable organisation providing culturally responsive support to people of African and Caribbean descent), host events such as LGBTQ film nights, Bollywood dancing, Windrush and Black History Month.

In January 2020 the hospital carried out a patient survey on racism, bullying and harassment to establish the views on prevalence and support needs of patients. The summary report detailed the findings from 87 respondents and provided a discussion of the themes that emerged, and recommendations elicited from the patients.

All the above have helped the staff of differing backgrounds, bands and professions to address and challenge racism and to seek and receive appropriate support. There has been an improvement in Workforce Race Equality Standards (WRES) data and in recruitment, promotion and retention of ethnic minority staff. There are good examples of ethnic minority staff being supported in their professional development.

Lesbian, gay, bisexual and trans people

In recent years, health and social care services have generally improved their awareness of the discrimination and exclusion experienced by many lesbian, gay, bisexual and transgender (LGBT) people in their care. The government's national LGBT survey of 2017, which had over 108,000 responses, showed that LGBT people feel their specific needs go unaddressed when accessing healthcare.⁴⁸ The government's subsequent LGBT action plan sets out the ambition that LGBT people should be able to easily access healthcare when they need it most, and feel comfortable disclosing their sexual orientation or gender identity so that they get the best possible care.

In our experience, some of the ways in which LGBT people's needs are failed in inpatient mental health care can be through assumptions of heteronormative family structures (perhaps especially in older peoples' services, for example by initially failing to recognise a patient's same-sex partner); feelings of exclusion, or indeed typecasting, in wider cultural matters; fear of disclosing sexual identity as if this might be treated as part of a mental health problem; and the fear of bullying, violence or sexual assault from other patients.

Across the system, we have seen examples of excellent care that can be built on. For example, in the high secure sector, Ashworth hospital has shown exemplary practice in its sensitive, caring and intelligent approaches to trans patients' care, which was reflected in other patients' attitudes on the wards. The treating team at the hospital contributed heavily towards the interim NHS England guidance for secure hospitals about caring for transgender patients, including questions of balance between security and patients' rights relating to gender identity.

You said that LGBT patients were made welcome on the ward by staff and peers. You had staff who understood their needs and offered specific support. Patients were addressed by their chosen pronoun.

Hayeswater ward, Edenfield Centre (medium secure), Greater Manchester Mental Health NHS Foundation Trust, March 2021

Deaf patients

Over the last year, the increased use of personal protective equipment (PPE), in line with infection prevention control measures, has created communication barriers for some groups of people. During our monitoring visits, we saw some good examples of how services had adapted to manage these potential new barriers. For example, at one remote visit with a learning disability unit in November 2020, we heard that staff wore a large name badge with picture of themselves so patients could more easily recognise their faces when wearing PPE. For deaf patients, staff used a clear face visor to help with lip reading.

However, irrespective of the difficulties introduced by the pandemic, services can struggle to meet the basic communication needs of deaf patients. For example, at one service we heard that there were no staff available who had British Sign Language skills available on the ward for a deaf patient, which meant they were unable to communicate with staff. In response to our concerns, the service sought extra training for staff, including British Sign Language, and sought support from the local service for deaf people.

Although the unit team had tried to meet the needs of patients with British Sign Language (BSL) as their first language, including access to interpreters, texting, pictures and lip reading, one Deaf patient who was detained under the MHA could not fully communicate with staff and other patients. There were no signing staff on the unit for the patient to communicate with and there were long periods during the day when the patient was unable to communicate with staff. The IMHA and carer both felt that the patient's communication needs were not being met and that this left the patient isolated at times.

The carer described the communication problems as longstanding and told us their relative was treated as 'a second-class citizen' due to their deafness.

It was not clear from documentation sent following an interpreter-led interview with one detained patient with BSL as a first language whether there had been clear opportunity to understand their section 132 rights.

Learning disability unit, November 2020

6. The MHA and our concerns for key groups of people



Key points

- As highlighted in our 2020/21 State of Care report, there have been increasing concerns around the impact of COVID-19 on the mental health of children and young people, and services' ability to meet this increased demand.
- We are particularly concerned about the number of reports of children and young people being placed in unsuitable environments while they wait for an inpatient child and adolescent mental health (CAMHS) bed.
- While we support the government's objective to reduce hospital admissions for people with a learning disability and autistic people under the MHA, this can only be achieved by an increase in community support, including trained staff, and high-quality alternatives to admission.

Children and young people under the MHA

As highlighted in both our 2020/21 State of Care report⁴⁹ and provider collaboration review on children and young people's mental health,⁵⁰ there have been increasing concerns around the impact of COVID-19 on the mental health of children and young people, and in turn concerns about services' ability to meet this increased demand.

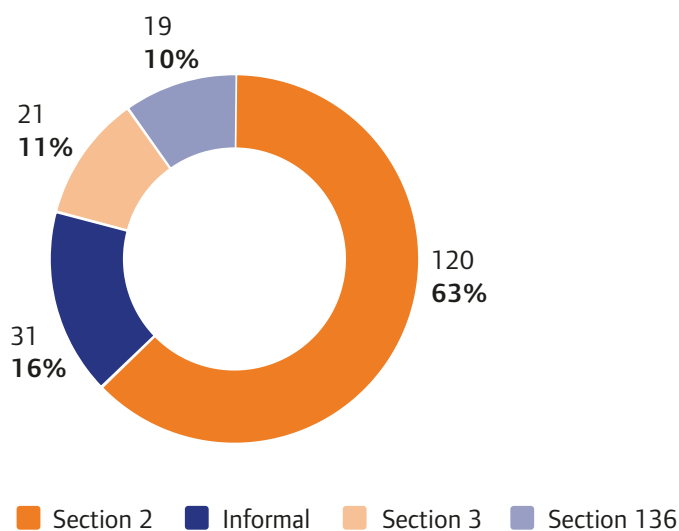
We are particularly concerned about the number of reports of children and young people being stuck in unsuitable environments while they wait for an inpatient child and adolescent mental health (CAMHS) bed. As highlighted in NHS Confederation's report '*Reaching the tipping point*', this reinforces concerns expressed by providers about availability of beds.⁵¹ We have had many approaches from providers seeking advice or leverage over what to do about this, and see this often through our monitoring work.

For example, in June 2021 we were alerted by an IMHA of the admission of a 15-year-old to a seclusion room on a low secure ward. The young person had never been in hospital before and did not require this level of physical security, but no other bed was available. Although she was quickly moved on to a more appropriate placement, the patient was traumatised by the experience. We heard that the whole episode had not been handled well;

initially the seclusion room en-suite was locked and she was given a bedpan, and had no bedding provided until she asked for it. She was allowed access to the visitors' room during the day after expressing distress to staff over being in the seclusion facility.

As part of our monitoring role, providers have to notify us when a patient under the age of 18 is cared for on an adult ward for more than 48 hours. This enables us to consider visiting or other follow-up action in individual cases, and provides intelligence for our regulatory role in inspecting the wider health and care services. In 2020/21 we were informed of 191 such placements, shown by legal status at figure 1. All but 31 (16%) of such admissions were under the MHA.

Figure 1: Notifications of placements on adult wards lasting 48 hours or more by legal status on admission, April 2020 to March 2021, England



Source: CQC notifications.

Most of these extended admissions of children and adolescents to adult facilities are due to a lack of an age-appropriate alternatives (figure 2). The number where an adult bed was positively identified as clinically or socially appropriate (for example because the adolescent was nearly 18, or was otherwise mature such that a CAMHS placement would be unhelpful or risky) accounts for only about 7% of the total.

Figure 2: Notifications of placements on adult wards lasting 48 hours or more by age range and reason given for the use of an adult bed, April 2020 to March 21, England

Reason	Under 16	16-17	Not specified	Total
Immediate admission required for safety of the child	13	85	0	98
No alternative CAMH inpatient or outreach service available	10	54	3	67
Not specified / other	3	9	1	13
An adult ward was clinically the preferred option	0	11	0	11
An adult ward was socially the preferred option	0	2	0	2
Total	26	161	4	191

Source: CQC notifications.

Most admissions (n=125) were to adult acute wards and psychiatric intensive care units (PICUs) (n=26).

Nineteen notifications specified that admission was to a health-based place of safety (a health-based location normally used for assessment when a person appearing to have mental disorder is brought there under police powers). As these are essentially single-occupancy, and not specifically an 'adult' service, in some cases this may be the least-worst option. For example, in one case the use of a place of safety enabled family members and specialist CAMHS staff to stay with the very young patient overnight, which could not have been managed due to pandemic restrictions had the child been placed on an acute ward.

However, not all child or adolescent patients being cared for in acute, PICU or health based places of safety had access to CAMHS, with 29 notifications explicitly stating that they did not have access to this service.

Most services (162, or 85%) told us that the patient had access to advocacy services, although this was not necessarily advocacy specifically for children and young people. Eleven notifications explicitly told us that no advocacy was available, including three health-based places of safety (where independent mental health advocacy services would not normally operate).

We are also concerned that admissions of children and young people to adult wards are increasing. In the first three months of 2019, we were notified of 45 admissions lasting 48 hours or more. Over the last two years this has increased; in 2020 there were 56 notifications during the same period, and in 2021 there were 66 admissions in the first three months.

This is supported by the November 2020 report from the Children's Commissioner. *'Who are they? Where are they? Children locked up'*, which

similarly suggested that these types of admissions were rising. This was based on data of a reported 205 such admissions (regardless of length of stay) in the first three months of 2020 compared to 74 in the same period over 2019. It is acknowledged in the report that there may be data quality issues with those notifications. The Children’s Commissioner further suggested that the overall number of child admissions to adult mental health wards “suggests a lack of capacity in children’s wards”.⁵²

While this is likely to be the case, preventing inappropriate admissions is not simply a matter of providing more specialist beds. Demand can be reduced through the development of robust community-based provision and flexibility in the specialist support offered to wider hospital-based services. We welcome NHS England’s announcement of a funding boost for children’s mental health services, including £10 million capital funding to provide extra beds at units.⁵³ However, we are aware that this will be in a context of considerable reduction in services – including community services that could provide alternatives to hospitalisation – over several years.

People with a learning disability and autistic people

We support the government’s objective to reduce hospital admissions for people with a learning disability and autistic people under the MHA or other alternative legal framework.⁵⁴ However, this can only be achieved with sufficient investment in community resources, including trained staff.

Under the MHA, people with a learning disability have to show ‘abnormally aggressive or seriously irresponsible conduct’ to be admitted to hospital. This is not currently the case for autistic people. We welcome proposals in the reform of the MHA to strengthen these admission requirements, and also extend these to include autistic people to prevent avoidable admissions. However, changes to legal thresholds alone will not prevent admission to hospital, and need to be supported by an increase in community support and high-quality alternatives to admission. We are encouraged that this is acknowledged in the government’s response to its White Paper consultation.⁵⁵

We welcome the intention to introduce a legal duty on commissioners to ensure an adequate supply of such community services. At present, the MHA only provides specific legal duties on commissioners to designate beds available for general emergency admissions, or that are suitable for patients under the age of 18. These duties are frequently not met. As such, we would welcome a widening of our MHA monitoring remit to extend to commissioning bodies, as was also suggested in the White Paper.

Since 2018, we have carried out thematic work to review restrictive practices in the care of autistic people, and people with a learning disability, most of whom were detained under the MHA. We have focused on chemical, manual and mechanical forms of restraint, and forms of seclusion and segregation. We gave formal evidence to the Joint Committee on Human Rights (JCHR) and are pleased that its findings and recommendations echo our own.⁵⁶ We published a report on the findings from our thematic review in December entitled *Out of Sight – Who Cares?*⁵⁷ We are encouraged that the government has accepted in full or in principle all our recommendations as they relate to

the Department of Health and Social Care, and will look to work with other agencies over the implementation of the rest.⁵⁸

In September 2021 we published *Home for Good*.⁵⁹ This celebrates the stories of eight people who successfully transitioned from long-term hospital placements to thrive in community services across England, and outlines the common threads of success including multi-agency partnership; person-centred planning with family involvement; and appropriate accommodation.

Throughout 2020/21, MHA Reviewers took part in Independent Care and Treatment Reviews (IC(E)TRs) of people with autism and/or a learning disability who were held in segregation in hospitals. We discuss these reviews and their findings in detail in the section on Independent Care and Treatment Reviews.

7. The MHA and mentally disordered offenders



Key points

- The forensic inpatient system is under stress due to capacity, leading to delays in patient transfers and discharge. Although this might require an expansion of bed numbers, there must also be investment in community forensic services and case management at commissioning level to address this.
- We urge the upcoming mental health needs analysis of prison populations to consider whether prisoners have equal access to mental health hospital care as the rest of the population.
- We are concerned at the number of patients returned to prison without adequate care plans in place for their ongoing management of mental health conditions.
- We welcome the introduction of new sentencing guidelines for mentally disordered offenders, but effectiveness of diversion also relies on resources to ensure that courts are provided with relevant information about an offender's mental disorder, and to provide community-based options where appropriate.
- We welcome government plans to introduce a power of supervised discharge in the forthcoming mental health bill, aimed at closing a legal gap preventing discharge of some restricted patients. But we urge that such a power be carefully constructed to be used only where absolutely necessary.

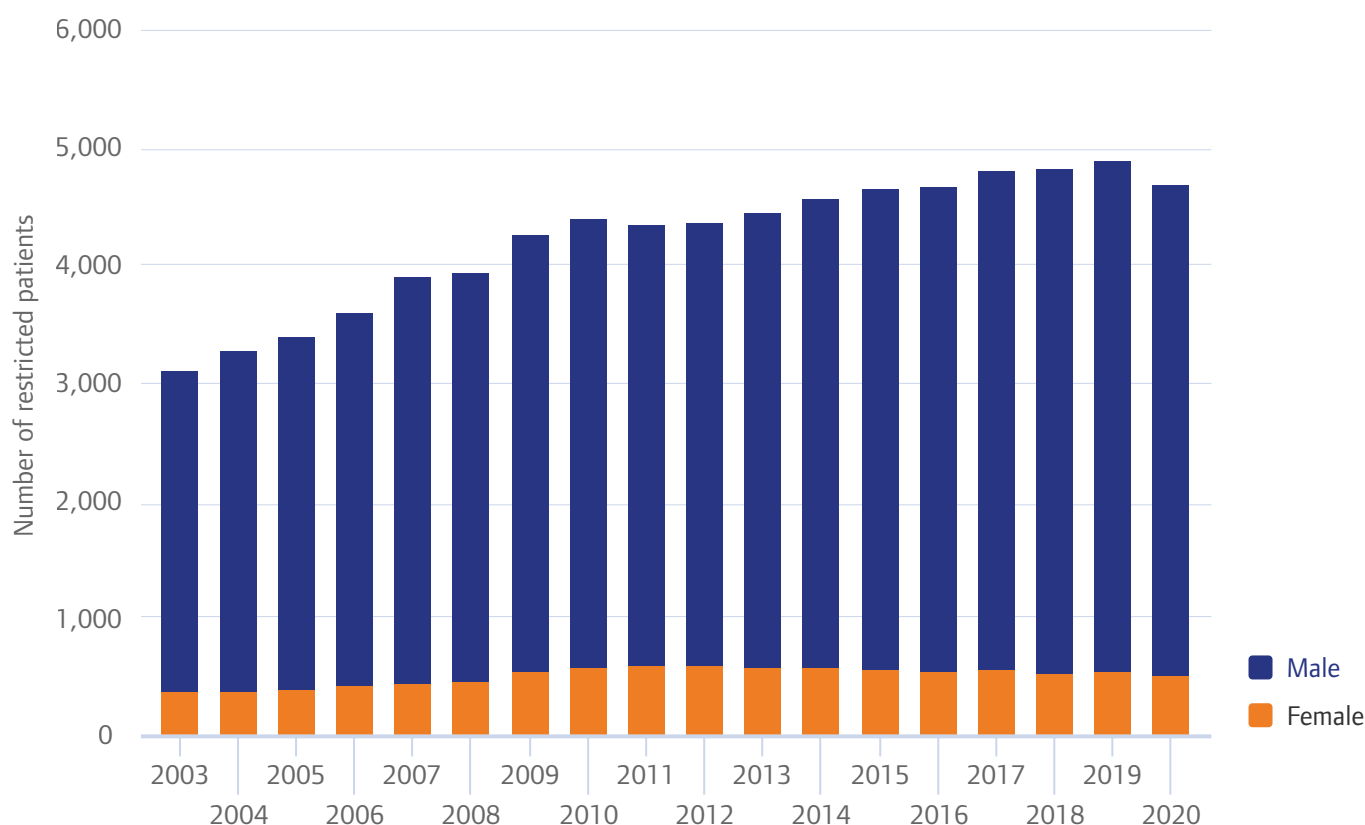
The MHA is the statutory basis for the diversion of mentally disordered offenders into hospital for treatment. Such diversion may take place before or after conviction or sentencing. It includes hospital orders applicable by the courts and a power for the Secretary of State for Health and Social Care to allow transfer from prison to hospital. Patients can be made subject to restrictions on the basis of public protection, meaning that the Secretary of State (rather than Tribunal) retains a veto over granting of leave and clinical decisions to discharge. When discharged, people under restrictive orders may be subject to set conditions and monitoring by the Ministry of Justice. They can also be recalled to hospital if certain criteria are met.

On our monitoring reviews and visits to forensic hospital wards, we speak to patients subject to these powers, as well as having meetings with relatives,

staff and advocates. We also maintain wider, policy-level engagement with regional commissioning bodies, professional bodies and the Ministry of Justice to keep the working of the MHA under review.

Every year there are roughly 1,500 admissions of restricted patients, with this figure being constant over the last decade.⁶⁰ The population of restricted patients has been growing steadily over this century (figure 3). Movement through the system can be delayed by lack of bed availability.

Figure 3: Population of restricted patients in hospital by gender, 2003 to 2020, England and Wales



Source: Ministry of Justice. Please note: the number of restricted patients equates to resident population at year end.

In November 2021, we were signatory to a joint thematic inspection report published by Her Majesty’s Inspectorate of Probation, looking at the criminal justice journey for individuals with mental disorders.⁶¹ This found that while assessment and diversion services have improved, communication across the criminal justice system is patchy. It also highlighted a lack of good-quality mental health care and unacceptable delays in accessing available care. This has worsened during the pandemic with the retraction of many community services.

While further expansion of the forensic sector may be necessary to deal with patient volume, the further development of forensic community services

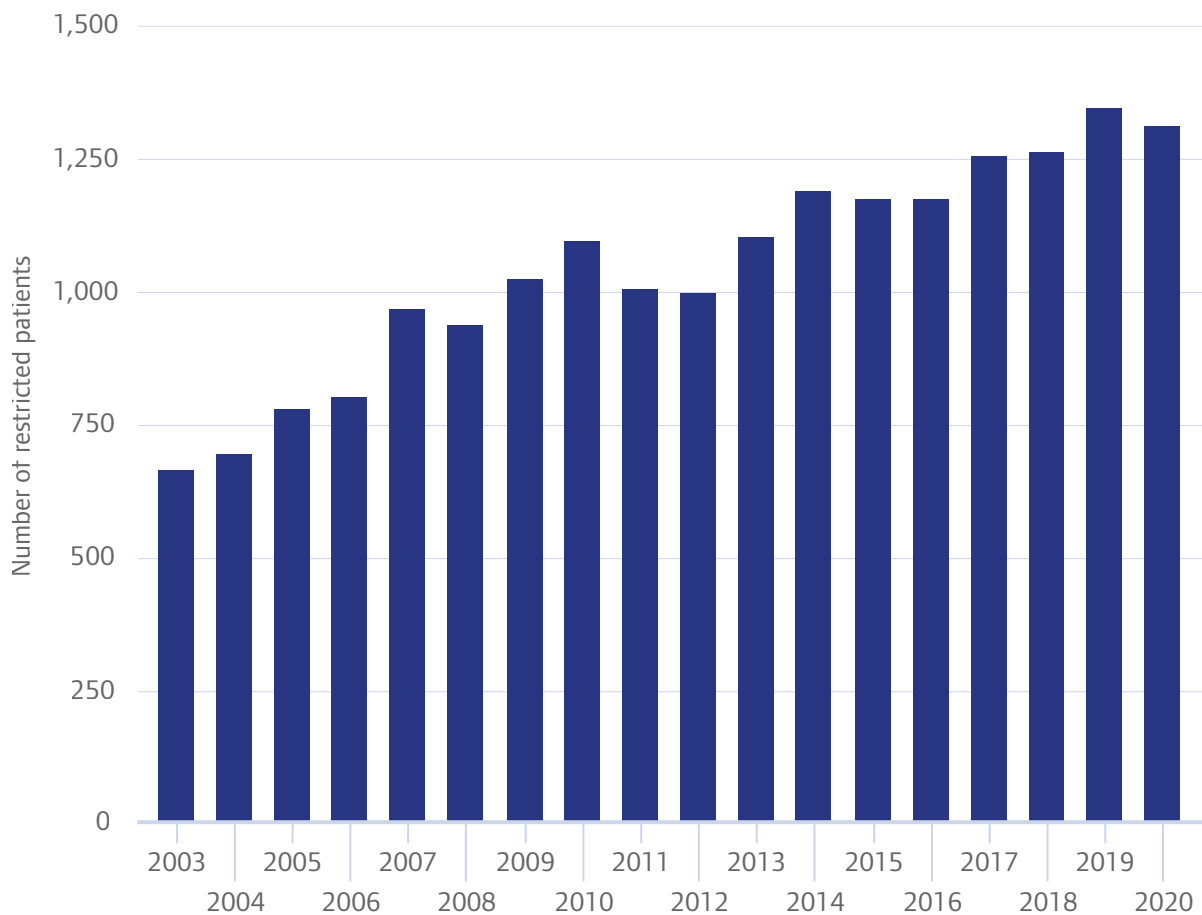
may provide an appropriate less restrictive alternative to hospital care for an increasing number of future patients. There may also be a need for investment in case management at commissioning level, so that existing resources are used more efficiently and in the least restrictive manner possible.

In our response to the White Paper 'Reforming the Mental Health Act', we urged the government to be careful that proposed higher thresholds for civil detention do not have the unintended consequence of pushing more mentally disordered people into the criminal justice system and the forensic sector.

Transfers from prison to hospital

The Department of Health's 'Offender Mental Health Care Pathway', published in January 2005, aimed to realise an ambition that no-one with acute severe mental illness should be in prison.⁶² In the ensuing years there have been considerable improvements in prison health care, and some rise in the population of patients in hospital following transfer from prison (figure 4), but that key ambition seems as far away as ever.

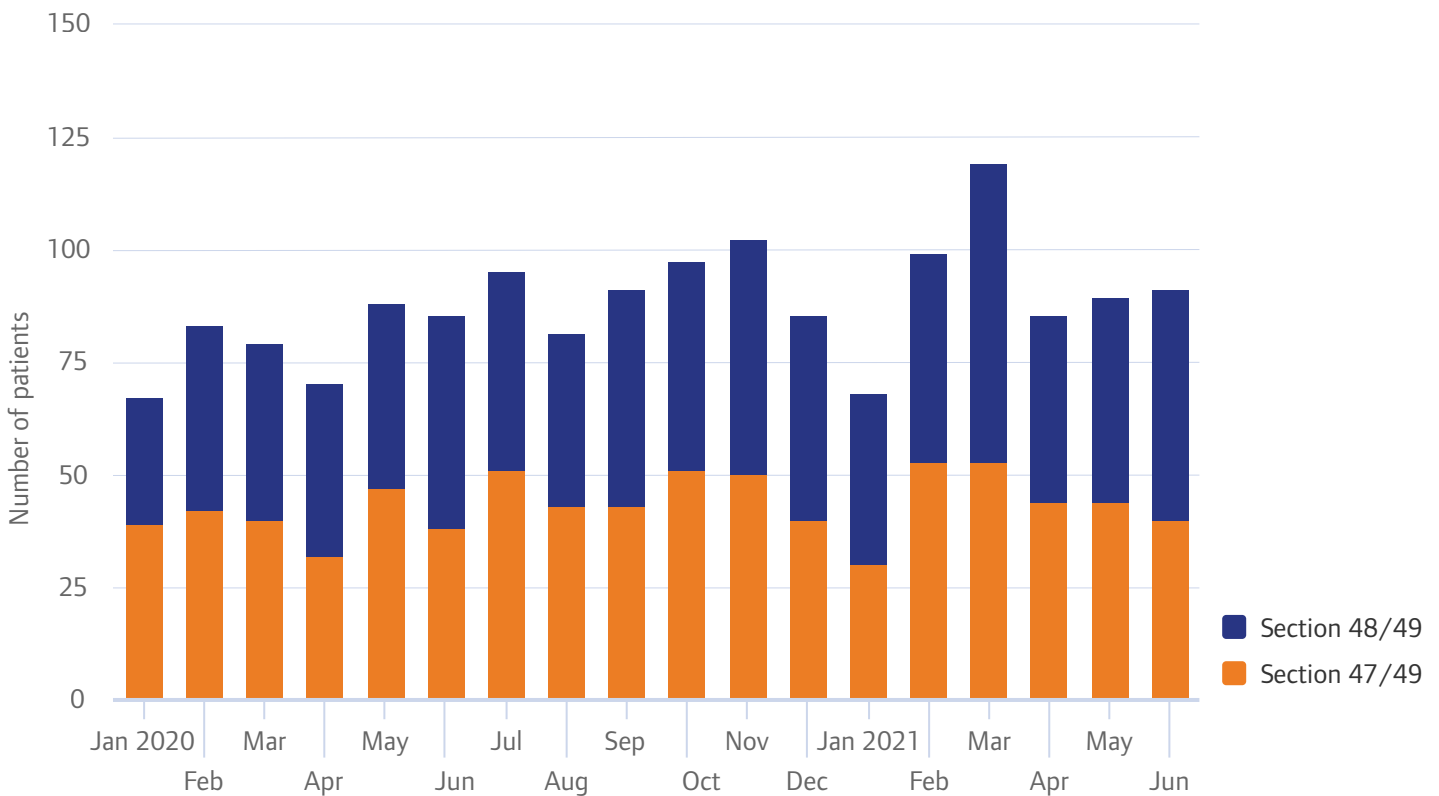
Figure 4: Restricted patients detained in hospital following transfer from prison, 2003 to 2020, England and Wales



Source: Ministry of Justice.

During the pandemic we heard concerns from professionals and patients that mentally disordered offenders were not getting the mental health care they needed because lockdowns were causing delays in transfers. While there was evidence of delays for some inter-hospital transfers, data from the Ministry of Justice suggests that transfers from prison or immigration removal centres continued to be managed at similar levels as before the pandemic (figure 5).

Figure 5: Transfers to hospital from prison or immigration removal centre, January 2020 to June 2021, England and Wales



Source: Ministry of Justice.

Note: Sixteen transferees under section 48/49 in the period are identified in the data as immigration detainees, although twelve of these were transfers from prison or young offender institutions rather than immigration removal centres or other places of detention.

It is welcome that in its review of the MHA, the government has accepted the need to speed up the process of transfer from prison and immigration removal centres to mental health inpatient settings. There can be long delays in the process currently, and some risk that services delay or stagger assessments to avoid breaching current guidelines.

As Black or Black British people are overrepresented both in prison and in secure mental health services, this group is likely to be disproportionately affected by delays in transfer from prison to hospital, or in failure to recognise the need for assessment for possible transfer.

It is not clear whether there are enough beds in the appropriate locations and at the required level of security to enable a statutory time limit for transfers to be effective. We are aware of bottlenecks in secure services, which compound the problem of timely transfer. Also, there are systemic issues in the prison system in terms of lack of suitably qualified and experienced personnel who can identify prisoners who are experiencing mental health problems and refer them on to healthcare resources.

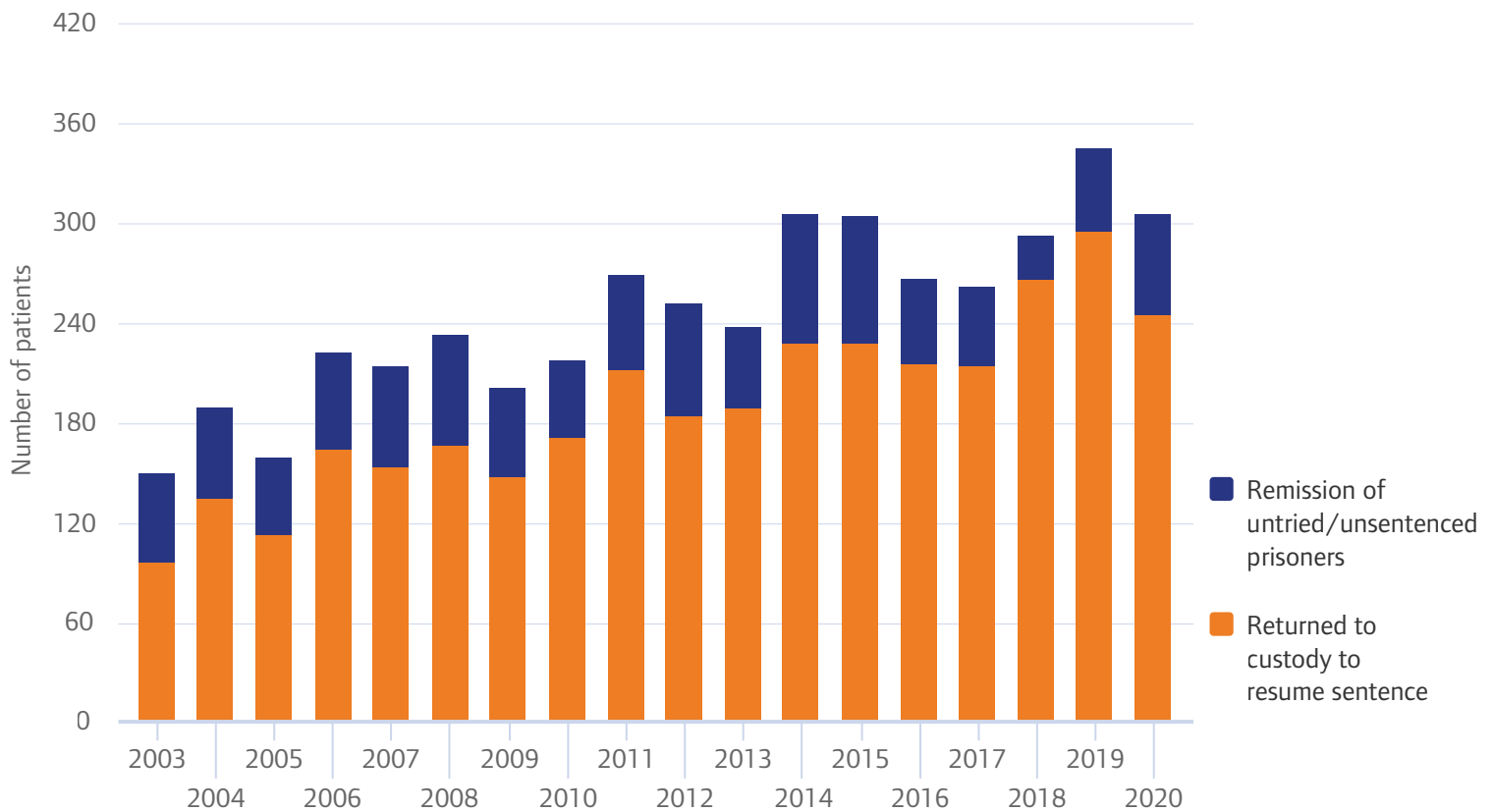
We welcome NHS England and NHS Improvement's actions in commissioning the Centre for Mental Health to conduct a review of mental health care in prisons. Following publication of the initial report, *'The future of prison mental health care in England'*, in June 2021,⁶³ we look forward to the proposed mental health needs analysis across the English prison estate. We hope that this study will be able to quantify the unmet needs in prison.

One question for this review should be whether, in terms of admission to hospital for acute mental health treatment, there is parity between healthcare in prison and the general community. We are concerned that there may not be. If the effective threshold for hospital care is much higher for prisoners than the rest of the population, prisoners may be left to become more and more ill before an effective intervention, which risks inhumane care and will make subsequent interventions all the more difficult.

Returning patients to prison after hospital treatment

Patients who are transferred from prison under a restriction order may be returned there after treatment, provided they are still within their sentence tariff or still subject to remand. In 2020, 306 patients were returned to prison in this way (figure 6).

Figure 6: Restricted patients returned to prison after hospital treatment, 2003 to 2020, England and Wales



Source: Ministry of Justice.

There can be a number of reasons for such returns to prison. In most cases, it will be because the hospital responsible clinician applies to the Secretary of State on the grounds that treatment for mental disorder in hospital is no longer necessary. Sometimes it will be because the patient has challenged the security of the mental health setting, for example by absconding from leave, or because the patient is refusing to engage with treatment. In its *'Guidance on Restricted Patients and The Mental Health Act'*, the Parole Board reported that it is 'not uncommon, especially in the case of personality disorder', that patients have disengaged from treatment in hospital and request remission to prison themselves.⁶⁴

Even considering such cases of non-compliance or treatment failure, it is very concerning that arrangements for continued support and aftercare in prison may be available for only a minority of those returned there.

Research published in 2020 on service transitions, interventions and care pathways found that less than one in five patients returned to prison after transfer to hospital under the MHA had care-plans in place under the Care Programme Approach (CPA). This is despite the fact that they were eligible for CPA, and that services reported prisoners on CPA did better than those who were not.⁶⁵

Although CPA is to be replaced across most mental health services (see section on care planning), the government has stated that it should continue to be used in prisons, and will be included within the planned prison mental health specification review during 2021/22. In its position statement on the care programme approach, NHS England and NHS Improvement also acknowledged that the CPA is used inconsistently in custodial health and justice settings.⁶⁶ Transfer to hospital under the MHA is, of course, the clearest possible marker of eligibility under the terms of the CPA and it is vital what replaces this in forensic hospital services should instigate and align with adequate aftercare arrangements for patients returning to prison.

Sentencing to appropriate settings

In Her Majesty's Inspectorate of Probation's joint thematic review of criminal justice services, judges said that they were frustrated that there were so many individuals with mental health issues in the criminal justice system who they felt should not be there. In some cases, information provided to support sentencing lacked detail and analysis of mental health. This meant that opportunities to send offenders to hospital under MHA powers were lost.⁶⁷

We welcome the introduction of new sentencing guidelines for mentally disordered offenders, published in October 2020. In particular, we welcome the fact that the guidelines recognise the need to consider the implications of culture, ethnicity, and gender when sentencing offenders with mental health needs.

We are aware that there are a significant number of people in prison with mental disorders and impairments, including autism, who could benefit from being moved from prison into the community. The successful appeal of *R v Cleland* in July 2020 is an example of a case where neurodiversity was overlooked at the point of trial.⁶⁸

New guidelines from the Sentencing Council on sentencing offenders with mental disorders, developmental disorders, or neurological impairments highlight the need to consider what community options are available under the MHA, such as probation with mental health treatment or guardianship.⁶⁹ We think that this option is not being used enough for people with a learning disability and autistic people because of a lack of suitable alternatives in the community. We discuss the lack of community options in more detail in our section on Independent Care (Education) and Treatment reviews.

The government has also recognised the unmet needs for neurodivergent offenders. In its 2020 White Paper, '*A Smarter Approach to Sentencing*', it has committed to carrying out a national call for evidence to obtain a clearer picture of prevalence and the current national provision to support offenders with neurodivergent conditions in the criminal justice system.⁷⁰ As part of this exercise, we urge the government to include questions of diversion from the criminal justice system.

Conditional discharge and continued deprivation of liberty

We recognise that there is a small group of patients who on discharge from hospital require continuous supervision in order to protect the public. Following the MM judgment of 2018, restricted patients cannot be conditionally discharged from hospital to continued deprivation of liberty (for example in a residential social care placement) if they have mental capacity to agree to such arrangements, but may be so discharged if they lack capacity to give or withhold consent.⁷¹

The solution to date has been to ‘recall’ such patients (albeit not actually requiring their physical return to hospital) whilst granting them extended leave of absence from hospital. There may be little objective difference between the use of conditional discharge or extended leave in these circumstances, but there is an important subjective difference for patients being granted leave rather than discharged that is recognised in paragraph 27.11 of the MHA Code of Practice.⁷² Furthermore, such leave arrangements are difficult to reconcile with the MHA’s basic criterion that its powers are limited to detention in a hospital.⁷³ This has led the high court to invoke section 3 of the Human Rights Act to declare that where it is necessary to do so in order to avoid a breach of a patient’s Convention rights, that criterion of hospital as a place of detention does not apply.⁷⁴

We welcome proposals to address the current position by creating an explicit ‘supervised discharge’ power. However, this should not become a default discharge route for restricted patients and should be used only when strictly necessary. The grounds for use of ‘supervised discharge’ needs to be clearly drafted to ensure that it is limited to people who would not be able to leave hospital without this new measure.



8. MHA interface with Deprivation of Liberty Safeguards

Key points

- There is still confusion around people's legal rights under the MHA, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), with some services making subjective interpretations of guidelines to deprive someone of their liberty.
- With the introduction of the Liberty Protection Safeguards, we would welcome clearer guidance about which legislation to use and make decisions.

In our 2018/19 report, we highlighted the challenges for professionals and patients in understanding people's legal rights under the MHA, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and how these worked together. In this, we called for the codes of practice of these laws to be updated and to provide clear guidance for professionals on these complex interface issues.

We continue to see situations where services are making subjective interpretations of guidelines to deprive people of their liberty under the MHA and DoLS. For example on one remote visit we heard that patients were initially admitted under the MHA, but then an urgent DoLS application was made as this was felt to be the least restrictive option. However, we heard that after the initial urgent application had expired, DoLS authorisations were rarely completed meaning that people were being deprived of their liberty unlawfully.

You told us that all patients were under the Deprivation of Liberty Safeguards (DoLS) and that patients were often admitted under the MHA, with the section later rescinded by the responsible clinician and a DoLS application made. You told us that it was the view of the clinical team that this was the least restrictive option.

We heard from staff and the MHA legislation lead that following the expiry of the urgent DoLS application and extension after 14 days, the full DoLS assessment for the standard authorisation were rarely, if ever, completed. We were told that patients would then remain on the ward having regular reviews by the clinical team to check for any change in their capacity status. For patients whose presentation changed and became actively wanting to leave the ward or refuse treatment, an MHA assessment would be undertaken and the MHA applied if indicated.

One staff member was unclear about the duration of an urgent DoLS.

Older people's acute ward, March 2021

It is unclear in what sense deprivation of liberty can be less restrictive under one form of legislation than another, although each piece of legislation has different safeguards and rights. In light of the introduction of the Liberty Protection Safeguards, we would welcome clearer guidance about which legislation to use and make decisions that are in the best interests of patients and not for their own convenience.



9. First-Tier Tribunal (Mental Health)

Key points

- During the pandemic, the First-Tier Tribunal (Mental Health) continued to hear cases via remote hearings.
- Changing to remote hearings appears to have had no effect on outcome, with around 30% of restricted patients' appeals resulting in some form of discharge decision.
- Poor internet connection remained a common concern from patients, staff and Tribunal representatives, with concerns around data security and protection.

The First-Tier Tribunal (Mental Health) continued to hear cases throughout the pandemic, using remote hearings. Listings were paused for only six working days for some community patients (CTO or conditional discharge) at the end of March 2020, and have otherwise continued as normal.

Changing to remote hearings appears to have had no effect on outcome, with similar proportions of discharges to hearings in 2020/21 compared to the previous year. In 2020/21 and 2019/20 the Tribunal discharged patients in about 10% of its decisions relating to detention overall. Around 30% of restricted patients' appeals resulted in some form of discharge decision, in most cases using the powers given to the Tribunal to order the conditional discharge of restricted patients. Patients detained under the assessment and treatment power (section 2) were roughly twice as likely to successfully appeal as patients detained under treatment powers (section 3 and unrestricted hospital orders) (figure 7). Appeals against CTOs were in general less successful, with about 4% of decisions ordering discharge (figure 8).

Figure 7: Applications against detention to the First-tier Tribunal (Mental Health) with hearings and outcomes, 2019/20 and 2020/21, England

		2019/20				2020/21			
		Section 2	Other unrestricted	Restricted	All detained patients	Section 2	Other unrestricted	Restricted	All detained patients
Applications and hearings	Applications	10,459	16,662	3,398	30,519	10,361	15,484	3,249	29,094
	Withdrawn applications	1,220	4,578	1,142	6,940	1,119	4,003	1,145	6,267
	Discharges by clinician prior to hearing	4,063	5,526	66	9,655	4,010	5,372	55	9,437
	Heard	6,527	9,103	2,611	18,241	6,542	8,307	2,612	17,461
Decision of MHT	Absolute Discharge	374	369	74	817	297	271	67	634
	Delayed Discharge	214	136	1	351	191	91	0	282
	Conditional Discharge	-	-	404	404	-	-	371	372
	Deferred Conditional Discharge	-	-	162	162	-	-	150	150
	Total discharge by Tribunal	588	505	641	1,734	488	362	588	1,438
	No discharge	4,805	8,637	1,400	14,842	4,953	8,735	1,417	15,105

Source: HM Courts and Tribunal Service, Analysis and Performance Team.

Please note: The number of applications, hearings and outcomes will not match due to outstanding matters at the end of each financial year.

Data from HM Courts and Tribunal Service, Analysis and Performance Team. Data for 2019/20 is shown for comparison, but also as we did not request and publish this in last year's report.

Figure 8: Applications against CTOs to the First-tier Tribunal (Mental Health) with hearings and outcomes, 2019/20 and 2020/21, England

	2019/20	2020/21
Applications	4,270	4,853
Withdrawn applications	780	951
Oral Hearings	3,409	3,869
Paper Reviews (considered on papers and therefore patient not present)	591	616
Discharges by Tribunal	138	113
No discharge by Tribunal	3,128	3,464

Source: HM Courts and Tribunal Service, Analysis and Performance Team.

Please note: The number of applications, hearings and outcomes will not match due to outstanding matters at the end of each financial year.

As highlighted in last year’s report, while some people preferred the use of remote hearings, others felt disadvantaged. This was supported by patient feedback on Tribunal hearings in 2020/21. While some people reported a similar experience to face-to-face hearings, others felt that they were not listened to or felt that they were not able to participate fully.

The MHA administrator told us that they found some patients seemed to prefer the remote [hearings] as they seemed less anxious.

Eating disorder ward, March 2021

One patient had attended a virtual Mental Health Tribunal but told us that they did not like the experience of using video conferencing and that their legal representative “had tried her hardest”.

Acute ward, March 2021

Poor internet connection remained a common concern from patients, staff and Tribunal representatives. For example, on one visit to an acute ward in November 2020, staff told us that they had experienced problems with accessing the Tribunal video link because the trust did not have a compatible web browser. As a result, patients and staff had to use their own devices and data, which could have security and data protection issues.

Tribunals continued to be held remotely. Usually there were no issues but one hearing had to be held on the ward due to individual risk. There were connection problems during the hearing. This forms part of an action [for the service].

Acute ward, March 2021

In our last report we highlighted an example of a tribunal decision being set aside on appeal due to a patient's video-link being muted and her consequently not being able to alert the panel when she could not hear witnesses. In November 2020, we heard of another case that illustrates other potential problems with remote procedures. In this case, the Upper Tribunal set aside a first-tier Tribunal decision on the basis that it had been wrong to proceed in the patient's absence, after the patient declined to take part. The patient had previously been assaulted after other patients discovered his history. He was concerned, in this context, that the hearing might be overheard by another patient with whom he was self-isolating due to coronavirus. The Upper Tribunal found that the Tribunal was wrong to have assumed, without investigation, that closing an internal door was sufficient to ensure that proceedings could not be overheard. It also found that the Tribunal had not considered why the patient was anxious and its impact on his ability to participate. As a result, the Tribunal had wrongly approached the adjournment request as if the patient had been concerned with the mode of hearing (i.e. telephone) rather than the fear of being overheard that day.⁷⁵



10. Restraint, seclusion and segregation and the Independent Care (Education) and Treatment Reviews

Key points

- Between November 2019 and September 2020, 77 Independent Care (Education) and Treatment Reviews were completed for people with a learning disability and autistic people in long-term segregation.
- For most people, little had changed since the publication of our report *Out of sight* to improve their situation, with people in long-term segregation experiencing poor care.
- A lack of community alternatives and poor commissioning decisions had led to people being admitted to hospitals that were a long way from home for prolonged periods of time. Over a third of the IC(E)TR patients we reviewed had been in hospital for between 10 and 30 years.
- Services were generally not very good at listening to patients and families. Patients did not feel that their wishes were taken into consideration when planning their care, with many telling us they were unaware of what was being planned for their future.
- Almost half of the patients we reviewed did not have an exit strategy from long-term segregation or a robust discharge plan. Where discharge plans were in place, almost 20% involved a sideways move to another hospital.
- The system of reviews and scrutiny in place to protect patients were failing them and were not safeguarding patients as they should.

In October 2020, we published the findings of our thematic review into the restraint, seclusion and segregation of autistic people, and people with a learning disability and/or mental health condition. Our report, *Out of Sight – who cares?*, found that people were not getting the right support early on, and that this along with a lack of person-centred care planning could lead to people reaching a ‘crisis point’ and ending up in hospital. We highlighted that, although these environments were not therapeutic and could add to people’s distress, many people did not have a clear care and treatment plan in place that would aid their discharge.⁷⁶

During our thematic review, we highlighted early concerns about a lack of care planning in our interim report.⁷⁷ In this, we recommended that there should be an independent and an in-depth review of the care provided to, and the discharge plan for, each person who is in segregation on a ward for children and young people or on a ward for people with a learning disability and/or autism.

Following our recommendation, in November 2019, the government committed to an urgent programme of Independent Care (Education) and Treatment Reviews (IC(E)TRs) for all people with a learning disability and autistic people who were in long-term segregation in specialist mental health inpatient settings. The aim was to review each person's care and treatment to make recommendations for improvement and identify any barriers to discharge.

The IC(E)TRs provided an in-depth review of the care and treatment for 77 people, revisiting many of the people we had seen in the 'Out of Sight' review. For most people, little had changed to improve their situation and the IC(E)TR process highlighted that people cared for in isolation in hospital often:

- are accommodated in environments that are not suitable (or compliant with the Mental Health Act Code of Practice guidance)
- have not had a full assessment of their needs
- are not being provided with the therapeutic care they need
- are not cared for by a consistent team of staff who have the right skills and have had appropriate training
- do not have a robust discharge plan in place
- are not being protected by the existing mechanisms designed to safeguard them.

A thematic report on these reviews was published by Baroness Hollins in July 2021 in The Oversight panel's interim conclusions and recommendations, which highlighted seven improvement areas for immediate action.

Additionally, Baroness Hollins recommended the continuation of independent case reviews for all people with a learning disability or autistic people in segregation, including those who were in scope of the 2012 to 2020 reviews. These IC(E)TRs restarted in November 2021.

How the reviews took place

Between November 2019 and September 2020, 77 IC(E)TRs were completed. All but one of the people reviewed were detained under the MHA.

Of the people whose care and treatment was reviewed:

- 25 patients were in specialist learning disability or autism assessment and treatment units (ATUs)

- 16 patients were in medium secure units
- 13 patients were in rehabilitation units
- 10 patients were in high secure hospitals
- nine patients were in low secure units
- two patients were on mental health wards
- one patient was on an eating disorder unit
- one patient was in an acquired brain injury unit.

Nine of the patients counted above were in CAMHS facilities. More patients were in NHS facilities (48) than independent hospital settings (29).

In response to the pandemic, from March 2020 reviews were carried out remotely, to be followed up by an on-site review where required as soon as it was safe and sensible to do so. Thirty-four of the 77 IC(E)TRs were completed using the remote methodology, with 22 of these marked as requiring a follow-up on-site visit.

Each IC(E)TR was carried out by an expert panel made up of an independent chair; a service commissioner; clinical expert; expert by experience; and, under a special commissioning arrangement by the Secretary of State, an MHA Reviewer.

For each IC(E)TR, the expert panel spent a full day reviewing the care and treatment of a single patient. This included speaking to the patient and their family (where appropriate), interviewing their care team, commissioner and advocate, reviewing their environment (where an on-site visit took place) and scrutinising their care records. At the end of the review, the chair fed back the panel's findings and recommendations to the care team.

Following each IC(E)TR, MHA Reviewers wrote a summary of the key findings and took part in a debrief session where any safeguarding issues or areas of concern were identified and escalated to local inspection teams. Concerns were escalated in 75% of all cases, with 58 individual cases across 29 locations being escalated to local inspection teams for review. Inspection teams responded immediately, taking a range of actions, such as addressing issues raised in ongoing engagement activity; carrying out focused inspections. In the case of one provider, inspectors included information from IC(E)TRs as evidence to issue a 'notice of proposal' leading to the closure of the service.

Lessons from the IC(E)TRs and thematic reviews

The findings from our thematic reviews and involvement in the IC(E)TR process paint a bleak picture of much of the care and treatment of people who were subject to long-term segregation. In the light of this, admission to hospital for autistic people and people with a learning disability needs to be very carefully considered, as it can have wide reaching and long-term consequences.

Admission to hospital

For some people, being admitted to hospital may be the right treatment decision, particularly where they also have a diagnosis of mental illness. Well-planned admissions with clear goals for discharge can support some patients to stabilise and move forward.

However, people being admitted to hospital from the community because their placement has broken down and not because they need to be in hospital is a widely accepted and ongoing concern.

Through the IC(E)TRs, we have found several cases where people have been admitted to hospital because there were no other credible alternatives in the community. For example, in one case we heard that a patient who had been stable and living in the community for 20 years, was admitted to hospital because the provider failed to follow the care plan for him. The patient was hypersensitive to noise, but a noisy person was accommodated next door to him. He was then taken to a theme park on a Saturday afternoon, which overstimulated and overwhelmed him, resulting in an incident. Following the incident, the provider served notice on him and he was admitted to hospital.

In situations like this one, there was little evidence that community care teams and commissioners had fully explored support options in the community. Often we found that care co-ordinators and commissioners had little or no history or experience of putting bespoke or creative interventions in place. In addition, we found that there is often no clear funding stream for providing bespoke community support, particularly where this support may be required over a longer-term period. There is also a lack of suitably skilled and equipped people to provide such support.

We found that poor commissioning decisions had led to some patients being admitted to hospitals that were a long way from home, often against the wishes of patients, families and carers and beyond the scrutiny of local teams. Admitting vulnerable people, often with limited verbal language or ability to make their distress understood, to unfamiliar and distant facilities increases the risk of a closed culture developing with all the inherent risks that this brings.

Over a third of the IC(E)TR patients we reviewed had been in hospital for between 10 and 30 years. At least half of the patients reviewed had been admitted to their current hospital placement not from the community, but from another hospital. In some cases, the reasons why people were transferred was clear and included, for example, to be moved nearer to home, stepping up or down levels of security, or because their previous hospital had closed. In other cases there was no clear rationale, but this could be due to issues with service provision, a breakdown in the therapeutic relationship, or because they had simply run out of ideas about what to do.

Families and carers of autistic people highlighted the impact that being transferred to a new hospital could have on their relatives. We heard that this could lead to an escalation in patients' distress, especially where staff did not understand the patient or were unable to meet their needs. Care teams then used the evidence of increasingly disturbed behaviour as a justification for

keeping the person in hospital. IC(E)TR panels found that few providers had recognised this or considered how distress could potentially be reduced by transferring people to their own homes.

Care and treatment in hospital

The IC(E)TR panels often found that care for autistic people and people with a learning disability in long-term segregation was poor. These findings repeat those of our thematic review and wider monitoring and inspection work. Some of the issues identified also engage people's human rights.

We found that staff did not always have a good understanding of autism, even in specialist learning disability or autism units. A fundamental lack of essential assessments (such as communication, sensory or cognitive function) meant that in some cases staff did not have even the most basic grasp of the needs of their patients. Many services reported a lack of specialist staff (such as occupational therapists, speech and language therapists and psychologists) to carry out assessments and develop autism informed care plans.

Most staff providing hands-on support were caring and compassionate and felt they were doing their very best with people with very complex needs. However, many staff told the IC(E)TR panels that they had only had a basic level of autism awareness training (often as part of their induction) and felt ill equipped to meet the needs of the patient.

Staff shortages were a common theme across many IC(E)TRs. This is supported by data from NHS Digital which shows that between March 2020 and September 2021, the percentage of registered nursing vacancies increased from 13% to 17%.⁷⁸ This meant that some patients were being cared for by an ever-decreasing pool of familiar, experienced staff. Reliance on agency and bank staff frequently meant that 'hands on' staff were unfamiliar with the triggers for patients' distress behaviour and not clear on how to de-escalate it. This invariably led to increased distressed behaviour by the patient and increased frustration, burnout and vacancies in the staff teams.

Poor quality positive behaviour support (PBS) plans made this problem worse. Some staff lacked confidence in what they were doing, and told the IC(E)TR panels about a trial and error approach to caring for individuals, rather than having a clear plan and listening to family input. Staff were sometimes frightened of patients due to levels of aggression and were not supportive of them receiving more interaction, exiting long-term segregation or working towards discharge.

Some staff demonstrated poor attitudes towards patients, including falling asleep while on observation duties; and abusive attitudes such as provoking or shouting at patients; or imposing punitive sanctions (for example, cancelling leave, removing personal possessions, or not allowing access to the telephone). Staff responsible for the day-to-day care of segregated patients told us that they were frequently excluded from decision-making meetings such as multidisciplinary team and care programme approach (CPA) meetings.

Individual sensory needs and communication issues frequently meant that the kindest way of caring for some people was in a smaller, quieter area of

the ward. However, we saw huge variation in the types of environments patients were being segregated in. Some patients had their own bungalows, apartments, or an entire ward to themselves where attempts to make the environment comfortable and homely were clear. Others were segregated in a single room, which could be either their bedroom or a seclusion room.

We found many examples of patients being cared for in bare rooms, comprising of a mattress on the floor, devoid of any personal possessions or items of comfort. Overall a third of patients were living in environments that were of poor quality, did not meet their needs or were not compliant with the MHA Code of Practice. Some environments were dirty, and some did not have access to other rooms or areas of the ward, or outside space. The IC(E)TRs came across patients who had not had access to fresh air for many months.

In a majority of cases, staff sat outside the long-term segregation area observing the patient, sometimes via CCTV. Some CCTV cameras were trained on the toilet and shower area, with monitors located in areas that could be seen by other patients and staff. Staff had varying degrees of interaction (some very minimal) with the patient. For some, all activity and communication took place through a locked door, with food and other items (such as toilet paper) passed through a hatch. For one patient, this meant kneeling or lying on the floor as he was spoon fed through a hatch in the bottom half of the door.

Cultures of containing and managing risk had emerged so that patients led empty lives with little occupational therapy, activities, structure, or friendships. A third of patients did not have access to appropriate activities or therapies. There was a lack of focus on therapeutic intervention to help patients cope better, improve their communication skills or prepare them for discharge. Activities that were provided were rarely based on individual or personal interests. For example, one patient identified that they would like a punch bag, sensory box, paddling pool and bike, but the hospital said they were unable to provide any of these due to funding issues.

In just over a fifth of cases, we found that there was some dispute over patients' diagnosis. It is not surprising that multidisciplinary teams struggled to care effectively for patients when there was disagreement about diagnosis and approach. Invariably, this led to prolonged admissions, as specialist assessments and support were not sought where there was dispute. Similarly, commissioners reported that this made discharge planning very difficult because it was not clear which pathway or community provider would be the most appropriate for the patient.

Some patients we reviewed had been in these situations for many years. It is difficult to understand how managing people in this way could be considered therapeutic, and impossible to comprehend how patient's behaviour might be expected to improve under such conditions.

Trauma and harm

A number of providers, Independent Mental Health Advocates (IMHAs), families and carers reported that patients' distressed behaviour had got worse since being admitted to hospital. This included some patients who had

become significantly more aggressive, begun to self-harm or whose self-harming had got substantially worse since they were admitted. In one case, a patient described as previously being on track to pass his GCSEs had lost all verbal language since being admitted to hospital and suffered such cognitive decline that he now struggles to understand the written word.

There was clear evidence that some patients required trauma-informed care not just because of the distress they had experienced before being admitted to hospital, but because of the trauma they had suffered in the hospital system. Services were poorly prepared for this and we struggled to find any examples of positive practice.

Where patients were identified as being inappropriately placed or where they were waiting for transfers to a different hospital (usually to one of a higher level of security), providers focused on maintaining the status quo. Some providers spoke candidly about containing patients until they could be moved on and openly agreed that they were no longer trying to improve patient's quality of life or ease restrictions. Often, the provider had given notice to the commissioner in these cases.

During the IC(E)TR process we came across several patients who were detained on forensic sections following criminal proceedings. In some cases, this was for offences committed while in the community, but for a small number it was as a result of assaults carried out on staff or patients while an inpatient. There should be a wider debate about criminalising patients, particularly where it is a failure of services to adequately assess and meet their needs, which may be contributing to the levels of distressed behaviour and then result in an incident. Equally, the practice of prosecuting assaults that happen while a person is being restrained need to be reconsidered. We have found that discharging autistic people who are in long-term segregation is very difficult; for those with forensic backgrounds it is arguably even more so.

Attention to physical healthcare

The IC(E)TRs highlighted a lack of holistic care. Many patients in learning disability or autism specialist units had poor mental health care, while staff caring for autistic people in mental health units did not always fully understand their sensory or communication needs. Neither type of service was particularly adept at identifying, exploring and treating physical health concerns. The IC(E)TR panels found:

- a frequent lack of understanding of how patients articulate pain
- patients' needs in relation to physical health services, such as dentists or opticians, were not always met
- care teams did not always explore or work to reduce physical health conditions in otherwise young healthy people. For example, many patients were seriously overweight and had diabetes and hypertension. One 39-year-old patient had not had the reasons for her incontinence explored.

- a lack of understanding of the impact of antipsychotic medicine on some patients' mental and physical health. In some cases patients were being prescribed antipsychotic medicine without a clear rationale. This did not conform to guidelines around Stopping over medication of people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)
- diagnostic overshadowing in terms of both physical and mental health issues.

Insufficient reviews of care, treatment and restrictive practices

Through the IC(E)TRs, we found that 35% of providers had failed to review long-term segregation in line with the MHA Code of Practice. As a result, in these cases patients were kept under very restrictive regimes for many years, even where providers recognised that patients were getting worse not better. In 30 of their reviews (39%), the IC(E)TRs concluded that patients were subject to overly restrictive care and treatment regimes. Fifteen patients (21%) were subject to prolonged, prone or mechanical restraints such as furniture and other objects being used to block exits, emergency response belts and handcuffs. Some patients' lives were characterised by daily restraint and one patient was regularly restrained for 10 hours a day without a clear plan to reduce or review this.

Some patients had very limited or no contact with an advocate, while some advocates were not able to communicate effectively with patients. We found advocates endorsing practices which the IC(E)TR panel considered to potentially breach patients' human rights

Very few patients understood their situation and how or when they might be discharged, although many were able to tell us they wanted to go home or leave the service. Others no longer sought discharge and had become so institutionalised that they were afraid to leave their long-term segregation area. One such patient refused to consent to any and all reviews of his care, which meant he had not had the benefit of an external care and treatment review.

Listening to patients and their families

Services were generally not very good at listening to patients and families. Patients were seen as "challenging", "complex" and "lacking in communication skills". Patients did not always feel that their wishes were taken into consideration when planning their care. Many patients told us they were unaware of what was being planned for their future.

When families tried to advocate for their relative, they were often seen as "overbearing" and "difficult". As a result, some families felt frightened about criticising care in case there were repercussions for their relatives. A small number of families felt that they had had no choice but to go to the press, social media or their MP in order to get their concerns heard.

Patients were often not supported to keep in contact with families. For example, some families whose relatives had been placed far from home were given little or no support from the hospital, local authority or clinical commissioning group to visit their relative. In some cases, we heard that family relationships had broken down but hospital care teams provided little support to rebuild and improve these relationships. In addition, family members were often unable to have private phone conversations or visits with their loved ones. Providers told the IC(E)TRs that pandemic restrictions or other risk management concerns were the rationale for this, but this did not hold up to closer scrutiny.

Through IC(E)TRs we found that staff often did not have adequate skills to communicate with non-verbal patients or people who had complex communication support needs. Communication assessments were inadequate, and we found that most staff did not have training on Makaton or Picture Exchange Communication (PECS). In one case, the distressed behaviour of one individual had reduced once she was taught how to use PECS. We heard how being able to make her needs understood helped the individual feel less frustrated. As a result, she was self-harming less and was given more access to the garden, which she found calming and enjoyable. Unfortunately, she had been at the service for two years before staff with skills in PECS were available to support her to communicate in this way.

Patients were often being cared for by staff who were unfamiliar to them and, as a result, did not understand the nuances of their behaviour or communication. Some communication passports, which such staff would have to rely on for basic information on how to engage with patients, were of poor quality.

Discharge from hospital

We found significant problems with discharge planning. Almost half of the patients we reviewed did not have an exit strategy from long-term segregation or a robust discharge plan. Where discharge plans were in place, almost 20% involved a sideways move to another hospital, or to an empty ward because there were no other credible alternatives in the community. Some plans involved the transfer of patients to hospitals rated as inadequate by CQC. While families were alarmed by this, commissioners felt that these were appropriate plans.

For many of the patients reviewed, discharge into the community was the only way out of long-term segregation. However, this often appeared to be difficult to achieve as there were frequent disputes about the type of care needed, who would provide it and who would pay for it. This was made worse by the lack of suitable community placements.

We frequently heard that discharge planning did not start when the person was admitted to hospital, and for some patients was only considered after they had been in hospital for years. Once discharge was agreed, it took on average one to two years for a bespoke community placement to be arranged. In the meantime, patients remained in unsuitable hospital environments with poor quality lives, sometimes for years. For example, one patient had been

recommended for discharge by a Mental Health Review Tribunal four years before the IC(E)TR review, without any action being taken. Another had been assessed as ready for discharge for a decade.

In a small number of cases, providers had served notice to commissioners stating that they could not care for the patient and that they needed to be urgently moved. However, again some of these patients had remained in the hospital for months or years after the provider had served notice. When commissioners failed to move the patient, or provide additional support and resources while alternatives were being sought, there did not appear to be a clear escalation process.

Keeping people in hospital often increased in their distressed behaviour, making discharge plans more complex or in some cases no longer viable. Discussions about discharge often seemed focus on how the patient was presenting in hospital, with ongoing distressed behaviour often used as the justification for continuing to keep them in hospital. When families attempted to remind commissioners and care teams of past successes of care in the community, they were seen as being unrealistic and minimising the problem at hand.

Care teams told the IC(E)TR panels that it was difficult to discharge patients to areas without specialist autism community teams. Even where such teams were in place, communication and planning for transition between hospitals and community services was often poor. Communication with families could be even worse, with families reporting that they were not always involved in discharge planning. In some cases, discharge plans that families disagreed with were being pushed forwards.

Discharge plans need to include additional support during the transition period and to anticipate that moving from the hospital to the community is unsettling. They must recognise that this may cause an escalation in distressed behaviour until the patient has a chance to settle. Unfortunately, we saw very few discharge plans with this contingency planning included in them. A small but significant number of patients reviewed in the IC(E)TRs were in hospital because previous discharges had failed very quickly due to poor discharge planning. In some cases, discharges had failed in a matter of days or weeks.

The IC(E)TRs identified particular problems in people transitioning from child and adolescent mental health services (CAMHS) to adult services. Moving from CAMHS to adult services can be a difficult time and risks disrupting any progress made. However, we saw little evidence of forward planning or a drive to discharge the patient before they turn 18.

In one case, a patient remained in a CAMHS service despite turning 21. Due to concerns about having an 'adult' on a children's ward, the patient was only allowed onto the ward area after all the other patients had gone to bed, spending the rest of his time locked in the extra care area. Conversely, we heard of children having to remain in hospital until they became 18 because it was difficult to find placements in Ofsted regulated community services, and that there would be more choice once they had turned 18.^{79,80}

Safeguards failing patients

There is a system of reviews and scrutiny designed to protect vulnerable patients who are admitted to hospital. However, throughout the IC(E)TR process it has become clear that these mechanisms were failing patients and were not safeguarding them as they should.

- **The MHA Code of Practice** provides guidance on long-term segregation, which includes a system of regular reviews to ensure patients are cared for in the least restrictive way for the shortest time possible. However, we found that 16% of providers did not recognise the way they were caring for patients as long-term segregation, and there was some confusion about the difference between long-term segregation and seclusion. What constitutes seclusion and long-term segregation needs to be clarified, as failure to recognise this means that patients are not effectively safeguarded.

We also found that 35% of providers failed to review patient care in line with the MHA Code of Practice. Where they took place, the quality of the external reviews was generally poor and did not offer an in-depth independent scrutiny of the patient's care.⁸¹

Long-term segregation reviews did not attempt to gather information and views of a wider group of people, with IMHAs and commissioners rarely being involved. We found some reviews had been carried out without the external hospital reviewer (independent consultant psychiatrist) meeting the patient.

External reviews were often carried out by consultant psychiatrists who were not specialists in autism or learning disabilities, who worked in the same trust or independent provider, and successive reviews were completed by the same doctor. As a result, very few independent reviews challenged the treatment plan or made any recommendations about how to improve the patient's situation. Where recommendations were made, we did not find evidence that they were followed and there is no follow-up or sanctions imposed where this is the case.

- **Care and treatment reviews (CTRs)** arose as a safeguard under the Transforming Care Agenda and comprise of a panel including an independent clinical expert and an expert by experience, chaired by the commissioner or in secure settings, the commissioning case manager. CTRs provide a regular opportunity for commissioners to review the care and treatment patients receive while in hospital. However, the IC(E)TR programme uncovered evidence that CTRs were not consistently working as effectively as had been expected.

We saw some poor CTR reports with few recommendations in cases where the IC(E)TR panel had grave concerns about the quality of the patient's care. We also saw many examples of providers ignoring recommendations from previous CTRs without any consequence. This included, for example, a recommendation made by a CTR in 2017 that a patient should be stepped down from secure care, for whom no progress had been made in this respect over the intervening three years.

The NHS England and NHS Improvement process for CTRs involves commissioners sending a report with their recommendations to the provider. They told us it is standard practice for this to go to someone who was present at the review, such as a nurse or ward manager. The same process was adopted for the IC(E)TRs, although CQC inspectors found that IC(E)TR reports were often not disseminated more widely than this. This became a problem when inspectors tried to discuss concerns found during the IC(E)TR with senior leadership teams who had no knowledge of the IC(E)TR report. Where multidisciplinary teams did not agree with the recommendations or were defensive about their practice, they were less likely to share CTR reports with senior leadership teams or act on their recommendations, undermining the intention and limiting the impact of the CTR safeguarding process.

However, a more fundamental concern is that many people are in services that cannot meet their needs, are a long way from home or are unable to be discharged due to a lack of community provision. The CTR is chaired by the same person who is responsible for both the inappropriate placement and the failure to commission suitable provision in the community. Under these circumstances, it is clear to see how this safeguard is failing people.

Both the CTR and IC(E)TR processes are dependent on consent, so if patients refuse to take part in a review, providing they have capacity to make such decisions, then they cannot go ahead. We came across a small number of patients who refused to consent to the process including one man who had refused all previous CTRs and as a result had never had his situation exposed to external scrutiny of this kind. This raises some questions about capacity as it is hard to credit that a person with capacity would refuse to participate in a review that would likely improve their quality of life. It suggests a failure to build capacity to make the decision. We found some patients had no ambition to move beyond hospital as they had been there that long it had become home (institutionalisation).

Autistic people find change very difficult and as a result some do not welcome a process that encourages change and discharge. However, we also had concerns about the consent process and concluded that there was a weakness in the system that relies on hospital staff (who may not fully understand the care and treatment review process) to seek the consent of the patient. In one particular case, both the patient and the staff believed that he was deserving of secure care and we questioned how rigorously staff would pursue consent for an external review under these circumstances.

Feedback from stakeholders heralded the IC(E)TR process as being far more robust and helpful in terms of supporting providers and commissioners to get it right. In her July 2021 report, Baroness Hollins recommended the continuation of independent case reviews for all people who are in segregation, including those who were in scope of the 2019 to 2020 reviews and all people who have entered segregation since November 2019 or enter segregation in future.⁸² We are pleased that the government is supporting the continuation of this independent review process, with the reviews restarting in November 2021.⁸³

- **Local authority safeguarding teams.** During the IC(E)TR process, a number of concerns were escalated to the local authority safeguarding teams due to the seriousness of issues. Three safeguarding alerts had been initiated by others immediately before the IC(E)TR (families, providers and other stakeholders), six were made by the chair of the IC(E)TR panel and an additional four safeguarding alerts were made by CQC following discussion with the local inspection team. None of these resulted in the local authority safeguarding teams taking any action. Following their investigation, each safeguarding team concluded that despite concerns with the quality of care, providers were doing what they could in what were difficult circumstances for patients with complex support needs.

The IC(E)TR project team have met with the Chief Social Worker in relation to cases identified in IC(E)TRs where there was an apparent failure of safeguarding teams to take action where required. The Chief Social Worker's Office had already been commissioned to write a Code of Practice in relation to safeguarding concerns under section 42 of the Care Act. Additionally, clear information about what does and does not constitute a safeguarding concern will be issued to ensure referring agents' expectations are commensurate with the powers and duties of safeguarding teams.

- **CQC.** In line with the findings of the thematic review, we found that some of the most distressing cases were in services rated as good or outstanding. This highlights issues we have in our current methodology, that have been recognised in our closed culture programme and strategy development, and form the basis of challenges to CQC from the independent report for Norfolk's Safeguarding Adults Board.

We are improving the way we register, monitor and inspect services for people with a learning disability and autistic people. This includes developing more in-depth inspections to scrutinise services' cultures and understand people's experiences.⁸⁴

Quality of evidence became a key issue throughout the IC(E)TR process. MHA Reviewers were able to present evidence of concern or harm based on what they had observed, the views of the expert IC(E)TR panel and on the accounts of patients and carers. Even with the expert backing of the panel, it could at times be difficult to argue that such evidence of poor cultures and risk of abuse was sufficiently robust to support regulatory action. It seems likely that, in the past, such evidence has not always directly impacted ratings or fed into enforcement action.

The reasons for this are complex, but includes the possibility that the weighting given to a patient's or carer's account is significantly less than that given to the provider's account. This is known as epistemic injustice. Where MHA Reviewers' evidence relied on the testimony of patients and carers, this was seen as less credible testimony than that of the provider. This was even the case when other stakeholder's testimony corroborated the feedback of patients and carers. This provides a challenge to improve the way in which inspectors or inspection methodology understands and responds to concerns raised by MHA Reviewers. There is also a need for MHA Reviewer monitoring methodology to improve the way evidence is collated, to better supports concerns about patient care.



11. Our work in 2020/21

Key points

- Over 2020/21, we carried out 682 MHA monitoring remote reviews of wards. We spoke with 1,895 patients and 1,111 carers.
- SOADs provided second opinions for 14,146 patients, which resulted in changes to 30% of the 1,030 treatment plans for medication relating to detained patients who were refusing consent.
- In 2020/21, we received notifications for 667 incidents of patients absent without leave. This is slightly lower than average (over the last five years, we have received an annual average of 736 notifications).
- We received notifications that 363 people had died between April 2020 and March 2021, while detained under the MHA, which is a rise on the previous year (240 deaths in 2019/20). A large number of these deaths (268 out of 363) were due to natural causes, of which 43% (114) were identified as caused by COVID-19.

Remote review activity

As discussed in last year's report, in response to the restrictions imposed due to the pandemic, at the start of April 2020 MHA monitoring visits were replaced with remote reviews of services. These relied on contact with patients, staff, advocates and carers by telephone or video conference.⁸⁵

Over 2020/21, we carried out 682 MHA monitoring remote reviews of wards. We spoke with 1,895 patients and 1,111 carers. Although we returned to site visits from July 2021, we have retained some aspects of the remote review methodology, in particular continuing to contact carers and advocates by telephone or video link outside of the physical visit. We have found that these contacts increased in remote reviews, and provided a more rounded picture of services.

In addition to the remote reviews, MHA reviewers took part in Independent Care, Education and Treatment Reviews (IC(E)TRs) for 77 patients, discussed in the section on the Independent Care, Education and Treatment reviews.

Complaints and contacts received by CQC

CQC's complaints team and call centre received 2,280 contacts in 2020/21 (compared to 2,231 in 2019/20 and an average of 2,385 over the last five years) from people raising issues concerning the MHA. Ninety-one percent of contacts were by telephone, and 9% were by email or through our website. This picture is largely consistent with the previous year. Most of these contacts will be expressing some complaint or concern, but the vast majority are dealt with through advice or referral to NHS complaints procedures. Half of the contacts opened and resolved in 2020/21 were closed within a month, and three quarters within three months.

Over 2020/21 we opened seven complaints investigations on matters that had not been satisfactorily resolved through local processes. An example of such a complaints investigation is given in the section on aftercare.

The Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (SOAD) service is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion to state the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent. CQC is responsible for the administration of the SOAD service, but SOADs are independent and reach their own conclusions by using their clinical judgment.

In March 2020, the SOAD service moved to a remote-working approach. Using telephone and video conferences, rather than physical visits enabled the second opinion service to continue despite restrictions introduced as a result of the pandemic.

In April 2020, the service introduced the pilot of a new app that enabled SOAD authorisation forms T3 to be created and shared with hospitals. This has now been developed to include other statutory forms and rollout of the app to all SOADs is underway. Results from the pilot showed that 70% of certificates completed by SOAD were accessed by the hospital within 24 hours, and 80% in less than two days, rather than the previous seven. The app was used for 25% of T3s, and 50 providers have received a T3 completed this way.

Following the introduction of the app and remote working more generally, an audit of outputs shows no decline in accuracy or appropriateness of content, and the rate of errors on certificates has fallen. Response time from receipt of request to opinion reduced to an overall average of 12 days in the period, as SOADs initially had greater availability and no longer have to travel to carry out their role. The backlog of second opinions awaiting appointment reduced from 1,200 to less than 50, although there has been an increase again in the latter part of the reporting year as SOADs have returned to other commitments.

Patient experience of the remote SOAD process

We asked patients who have used the remote SOAD service to tell us about their experiences. We are grateful for the considerable help of hospital mental health administrators and legislation leads, which enabled us to gather 75 responses to a short questionnaire, which was created with input from people who use services.

If given a choice whether or not speak with a SOAD at all, only 41% (31) stated a positive wish to do so. Nineteen percent of patients (14) thought they would prefer that the SOAD just read their notes with no personal contact. The rest either had no preference (27%, 20) or were not sure which option to pick (12%, 9). One patient did not provide an answer.

When asked their preferences about the independent doctor (SOAD) review, 21% (16) said they would prefer to see the SOAD in person but maybe wait longer, 28% (21) would prefer to have their treatment quickly but forego the opportunity to see a SOAD, 25% (19) said they had no preference, and 15 (20%) were not able to decide which option to pick. Four (5%) did not answer.

Where meetings with the SOAD could not be in person because of COVID-19 restrictions, 32% (24) would prefer to speak to the doctor by telephone; 31% (23) by video-link. The rest had no preference (20%, 15) or were not able to decide (15%, 11). Two patients (3%) did not provide an answer.

When asked their preferences about changes that might be made in the future, over half (52%, 39) of the patients surveyed would wish to have an opportunity to put their views in writing to contribute to the SOAD process: 32% (24) were happy to do this with help from staff if necessary, and 20% (15) would prefer to be supported by an advocate. Others had no preference (19%, 14) or were unsure which option on the questionnaire reflected their view (28%, 21). One patient did not provide an answer.

At the time of writing, the pandemic and its impact are far from over. There is scope for retaining aspects of the remote working processes to deliver more timely and targeted intervention, to offset delay and geographic factors, and to better respond to patients' wishes. Work on possible models, triage, and prioritisation continues.

Second opinion activity in 2020/21

SOAD reviews are needed to allow the following treatments where consent is not given, except in an emergency:

- medication for mental disorder after three months from first administration when a patient is detained under the MHA
- medication for mental disorder after the first month of a patient being subject to a community treatment order (CTO)
- electroconvulsive therapy (ECT), at any point during the person's detention.

When we receive a request from the provider caring for the patient, we have a duty to appoint a SOAD to assess and discuss the proposed treatment with a minimum of two professionals involved in the patient's care. SOADs can issue certificates to approve treatment plans in whole, in part, or not at all depending on their assessment of the treatment plan in an individual case.

In 2020/21:

- SOADs provided second opinions for 14,146 patients – 117 fewer overall than 2019/20.
- 10,880 SOAD visits were to look at treatment plans for medication, with the rest considering treatment plans for electroconvulsive therapy (ECT) or for medication and ECT.
- 2,028 second opinions were for patients subject to Community Treatment Orders (CTOs) – this is up from 1,039 (7.3%) in 2019/20.

Outcome of SOAD visits

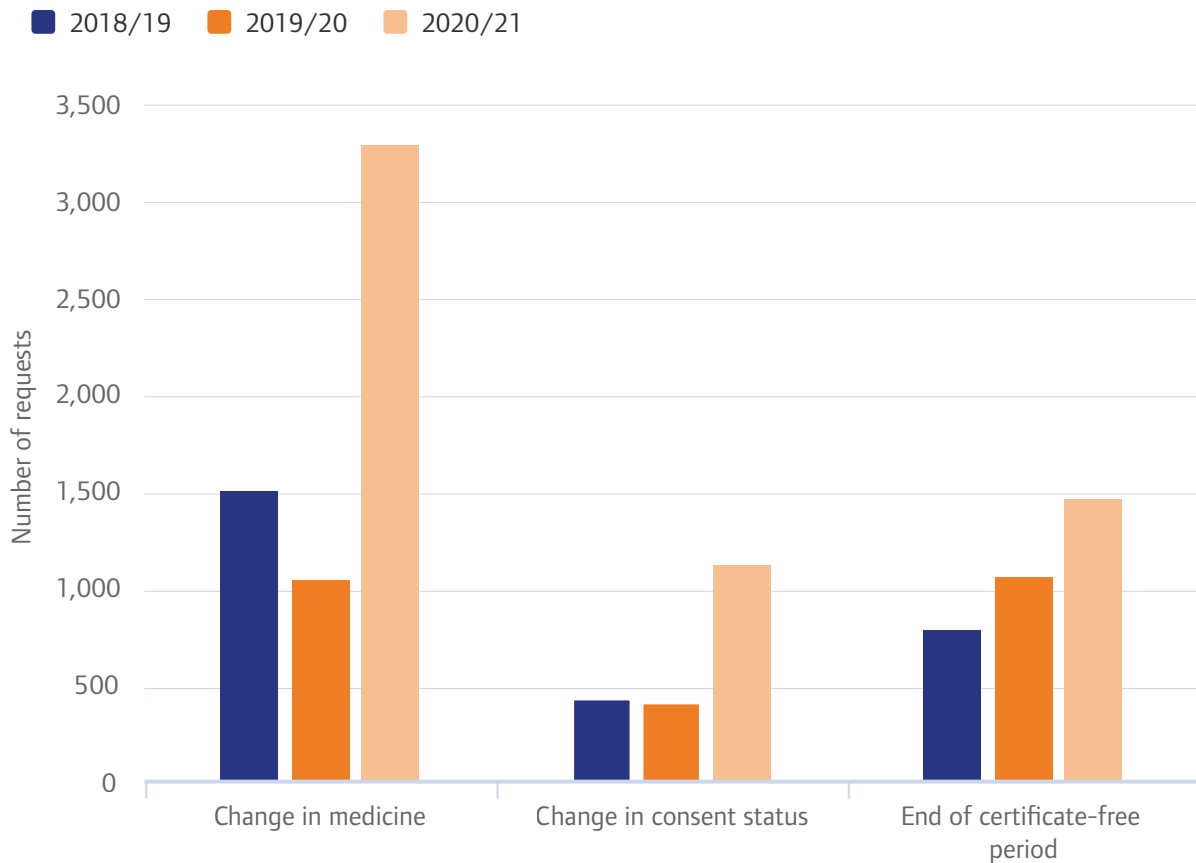
In 2020/21, SOAD review resulted in change to 30% of the 1,030 treatment plans for medication relating to detained patients who were refusing consent, and to 24% of the 11,757 plans considered for treatment with medication of detained patients incapable of consent. Such change commonly reduces the dosage and/or number of medicines proposed.

Treatment plans were changed in 17% of the 1,456 second opinions for ECT, or ECT and medication, compared to 23% in 2019/20.

There was a slight increase in the overall percentage of second opinions resulting in no change to the treatment plan (76%) in 2020/21 compared to 2019/20 (71%). During the pandemic there has also been a fall in the percentage of times where there is discussion between the Approved Clinician in charge of the patient's treatment and SOAD (74% of 100 cases sampled from 2019/20, reducing to 46% from 100 cases sampled from the period after April 2020). Needing to submit written information on treatment plans before the remote visit may be a factor in these changes in practice. Where detailed information is provided in advance, it seems likely that this may increase the quality of proposed plans and reduce the need for further discussion between SOAD and approved clinician.

The use of urgent treatment powers

Figure 9: **Reasons for second opinion requests for medication, where urgent powers had been used, detained and CTO patients, 2018/19 to 2020/21, England**



Source: CQC SOAD data. Please note: Data excludes 233 requests based on 'other' reasons for a second opinion request. 199 of these were recorded in 2020/21, 12 in 2019/20 and 22 in 2018/19.

During 2020/21, the use of urgent treatment powers to give medication before a SOAD visit is requested more than doubled from the previous two years, both in number and as a proportion of all requests relating to treatment with medication. Eighteen percent of all requests for SOAD visits relating to treatment with medication indicated that urgent powers had been used in 2018/19; 17% in 2019/20, and 48% in 2020/21.

Figure 9 shows the most frequent reasons for such second opinion requests, where the submission stated that section 62 powers for urgent treatment had been used.

We cannot be certain whether the rise is a genuine increase in use of urgent powers, or better reporting by provider services in their requests for a second opinion, or a mixture of both. It is plausible that there has been a genuine

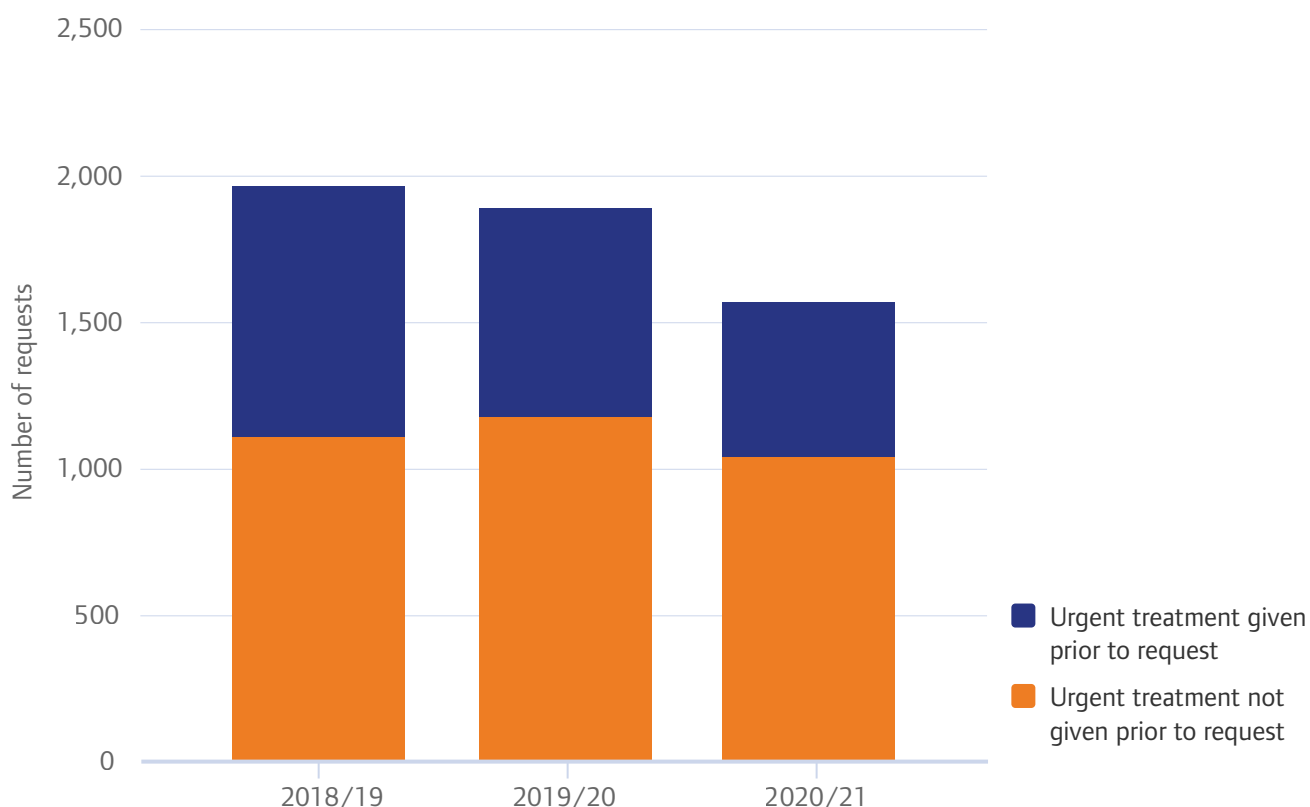
increase during the pandemic. One factor may be stresses on services, including remote working for some clinicians and administrators, and ‘fire-fighting’ by clinical staff at times of staffing pressures. As almost half of all uses of urgent powers to give medication in 2020/21 stemmed from a need to make changes to prescribed medicine, it may be a reflection of additional fluctuation of treatment needs due to the pandemic itself or the measures taken to contain it.

In 2020/21, 19% of requests that report the use of urgent powers were required because the patient had withdrawn consent or become unable to give valid consent due to mental incapacity. Such cases may be seen as a reflection of good clinical practice in having regular discussions with patients over consent, and assessing capacity if it is in doubt.

However, in about one quarter of recorded uses of urgent treatment prior to requests for medication in 2020/21, the underlying reason was the expiry of the three-month period in which treatment can be given without certification by a SOAD (or the one month equivalent for Community Treatment Order patients). This suggests that the request was made very close to or after that expiry date, and had the request been made earlier the use of urgent treatment powers could have been avoided. As such this use of urgent powers should be avoidable and, were this is the case, indicates poor administration by services that denies patients their rights under the Act.

The number of requests to consider treatment with ECT declined in 2020/21 to 1,463 from 1,789 in 2019/20. The proportion where urgent treatment powers had been used before a SOAD is requested also declined from 38% (709) in 2019/20 to 34% (529) in 2020/21 (figure 10). Despite SOAD opinions being easier and quicker to access, we have noted some pockets of increase in use of section 62 in ECT for some providers. We are exploring this further with those providers.

Figure 10: Second opinion requests for ECT and use of urgent treatment powers, 2018/19 to 2020/21, England



Source: CQC SOAD data.

Notifications of absence without leave

Hospitals designated as low or medium security must notify us when any patient liable to be detained under the MHA is absent without leave, if that absence continues past midnight on the day it began.

In 2020/21, we received notifications for 667 incidents. This is slightly lower than average (over the last five years, we have received an annual average of 736 notifications, but the figure fluctuates year-on-year). This may be a reflection of reduced opportunities for leave over the year, due to pandemic restrictions, as four out of five absences happen when the patient is on leave and therefore not on hospital premises. As usual, half of all the absences occurred when patients stayed away longer than had been authorised: such cases may reflect positive risk taking by providers.

In one-third of all cases, the patient returned to hospital voluntarily; another 7% were brought back by family members, and in about 18% hospital staff were involved in the return. Police returned the patient in 28% of cases.

Notifications of deaths of patients under the MHA

Providers have a legal duty to notify us of deaths of people detained, or liable to be detained, under the MHA. In this section, we provide figures for the numbers of people who died while in detention and subject to community treatment orders (CTO). This is based on information included in notifications that providers have sent to us. Figures are based on the date of death unless otherwise stated and exclude deaths of people that were not detained, or liable to be detained at their time of death – that is, people who were removed from section at their time of death.

Data on notifications may be updated over time leading to changes in overall numbers and/or the categorisation of deaths. These updates may relate to data cleaning, delays in notifying CQC of a death of a detained patient or information received through the coroners' courts.

We have also published data on deaths of people under the MHA notified to CQC during 2020/21 in our insight briefings. Our insight briefings provided overall figures for any death notified to CQC through our MHA death notification process based on date of notification so are not directly comparable to the figures included in this report.

We received notifications that 363 people died while detained under the MHA between 1 April 2020 and 31 March 2021, (figure 11), which is a rise on the previous year (240 deaths in 2019/20). A large number of these deaths (268 out of 363) were due to natural causes, of which 43% (114) were identified as caused by COVID-19.

Figure 11: **Deaths of patients in detention, 2016/17 to 2020/21, England**

Type	2016/17	2017/18	2018/19	2019/20	2020/21
Natural causes	186	189	136	143	268
Unnatural causes	54	48	34	32	33
Undetermined	7	10	25	65	62
Total	247	247	195	240	363

Source: CQC notifications.

Unlike deaths of detained patients, providers are not required to notify CQC of deaths of people subject to CTO. As such, data is likely to fall below actual numbers of deaths of CTO patients.

From the notifications we received, we found that 65 people subject to CTO died between April 2020 and March 2021 (figure 12). While numbers are small, we have seen an increase in both natural (27 in 2021/20; 21 in 2019/20) and unnatural (23 in 2021/20; 10 in 2019/20) cause deaths.

As at September 2021, the cause of death of 62 detained patients and 15 deaths of people subject to CTO were still to be determined and requires

further information from care providers and/or coroners. The cause of deaths in detention are usually determined through the coroners' courts, which can lead to a delay for accurate statistical reporting.

Figure 12: Deaths of patients subject to CTO, 2016/17 to 2020/21, England

Type	2016/17	2017/18	2018/19	2019/20	2020/21
Natural causes	29	23	9	21	27
Unnatural causes	12	7	5	10	23
Undetermined	1	4	2	5	15
Total	42	34	16	36	65

Source: CQC notifications.

Figures 13 and 14 present information about the underlying cause of death for those deaths where the cause is known. The coding of the cause of death is undertaken manually based on the free text information included in the death notification, including information provided by coroners' courts. This can involve the application of judgement on the part of the coder to attribute the underlying cause of death and/or requests for expert advice. Contributory causes of death are not recorded as part of this analysis.

Figure 13: Cause of natural deaths as notified to CQC, April 2020 to March 2021, England

Cause of death	Detained Patients	CTO Patients
Aspiration pneumonia	7	1
Cancer	9	2
Chronic Obstructive Pulmonary Disease	7	3
Covid-19	114	5
Heart disease	27	6
Myocardial infarction	12	2
Other	42	6
Pneumonia	20	1
Pulmonary embolism	29	1
Respiratory problems	1	0
Unknown	0	0
Total	268	27

Source: CQC notifications.

Figure 14: Cause of unnatural deaths as notified to CQC, April 2020 to March 2021, England

Cause of death	Detained patients	CTO patients
Accidental	2	2
Another person	1	0
Drowning	0	1
Fire	0	0
Hanging	9	2
Iatrogenic	0	0
Jumped from building	0	1
Jumped in front of vehicle / train	4	0
Method unclear / other	0	1
Self-poisoning	6	16
Self-strangulation / suffocation	8	0
Unsure suicide / accident	3	0
Total	33	23

Source: CQC notifications.

Figure 15 shows age at death of detained and CTO patients where the cause of death is known.

Figure 15: Age at death of detained and CTO patients, for natural and unnatural deaths, April 2020 to March 2021, England

Age	Detained patients		CTO patients	
	Natural causes	Unnatural causes	Natural causes	Unnatural causes
20 and under	1	3	0	0
21 to 30	5	14	0	3
31 to 40	15	9	1	8
41 to 50	16	3	3	5
51 to 60	39	1	6	5
61 to 70	59	3	4	1
71 to 80	67	0	9	0
81 to 90	54	0	4	1
91 and over	11	0	0	0
Unknown DOB	1	0	0	0
Total	268	33	27	23

Source: CQC notifications.

Figure 16 shows the ethnicity of patients who died while in detained hospital or subject to a CTO (where the death was notified to CQC).

Figure 16: Recorded ethnicity of detained and CTO patients at time of death, April 2020 to March 2021, England

Ethnicity	Detained Patients	CTO Patients
White	254	45
BAME	61	12
Not known / not stated	48	8
Total	363	65

Source: CQC notifications.

As highlighted in our January 2022 Insight briefing, we are concerned that poor recording of ethnicity and an overreliance on the categories of 'not known' and 'not stated', including in the recording of deaths, is creating further equality issues.

Appendix A: Monitoring the MHA as a part of the UK's National Preventive Mechanism

The UK ratified the United Nations' *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT) in 2003. In doing so it committed to establish a 'National Preventive Mechanism' (NPM), which is an independent monitoring body to carry out regular visits to places of detention to prevent torture and other ill-treatment. An NPM must have, as a minimum, the powers to:

- regularly examine the treatment of persons deprived of their liberty in all places of detention
- make recommendations to relevant authorities with the aim of improving the treatment and conditions of persons deprived of their liberty
- submit proposals and observations on existing or draft legislation.

The UK NPM, established in 2009, consists of separate statutory bodies that independently monitor places of detention. CQC is the designated NPM for deprivation of liberty in health and social care across England. We operate as an NPM whenever we undertake regulatory or other visiting activity to health and social care providers where people may be deprived of their liberty. A key focus of our NPM visiting role is our activity undertaken in monitoring the MHA.

Being part of the NPM brings both recognition and responsibilities. NPM members' powers to inspect, monitor and visit places of detention are formally recognised as part of the UK's efforts to prevent torture and ill-treatment. At the same time, NPM members have the responsibility to ensure that their working practices are consistent with standards for preventive monitoring established by OPCAT. There is also an expectation that NPMs will cooperate and support each other internationally.

The Association for the Prevention of Torture, an international NGO that works with NPMs across the world, has set out the following main elements an approach that prevents ill-treatment:

- **Proactive rather than reactive:** Preventive visits can take place at any time, even when there is no apparent problem or specific complaints from detainees.
- **Regular rather than one-off:** Preventive detention monitoring is a systematic and ongoing process, which means that visits should occur on a regular basis.

- **Global rather than individual:** Preventive visits focus on analysing the place of detention as a system and assessing all aspects related to the deprivation of liberty, to identify problems that could lead to torture or ill-treatment.
- **Cooperation rather than denunciation:** Preventive visits are part of an ongoing and constructive dialogue with relevant authorities, providing concrete recommendations to improve the detention system over the long term.

The NPM publishes an annual report of its work, which is presented to Parliament by the Lord Chancellor and Secretary of State for Justice. Its website is at <https://www.nationalpreventivemechanism.org.uk/>.

References

1. NHS Digital, *Mental Health Act Statistics, Annual Figures, England, 2020-2021*, 26 October 2021
2. Keown et al, Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study, *BMJ*, 2011, 343:d3736
3. UK Parliament Committees, Expert Panel: evaluation of the Government's commitments in the area of mental health services in England, Non-inquiry session
4. Department of Health and Social Care, *Reforming the Mental Health Act: The Government's response to the consultation, January 2021*, page 104-6
5. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the COVID-19 pandemic*, November 2020, page 16
6. National Institute for Health and Care Excellence, *Shared decision making, NICE guideline [NG197]*, June 2021
7. National Institute for Health and Care Excellence, *Decision-making and mental capacity, NICE guideline [NG108]*, October 2018
8. Mental Health Act 1983, section 132
9. *University Hospitals Dorset NHS Foundation Trust & Anor v Miss K* [2021] EWCOP 40 (10 June 2021)
10. Department of Health and Social Care, *Reforming the Mental Health Act: The Government's response to the consultation, January 2021*, pages 57-60
11. MHA 1983, s.130C(4A)
12. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic*, page 53-54
13. Department of Health and Social Care, *Mental Health Act 1983: Code of Practice*, 2015, paragraph 8.5
14. See also *Progress towards smokefree mental health services. Findings from a survey of mental health trusts in England*. Action on Smoking and Health, October 2019
15. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic*, page 46
16. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic*

17. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic*, page 50-51
18. NHS England and NHS Improvement, *Delivering same-sex accommodation*, September 2019
19. See *Monitoring the MHA in 2019/20*, p.38-9
20. Department of Health and Social Care, *Over £400 million pledged to remove dormitories from mental health facilities*, October 2020
21. NHS England and NHS Improvement, *Delivering same-sex accommodation*, September 2019
22. Care Quality Commission, *Sexual safety on mental health wards*, September 2018
23. Care Quality Commission, *Brief Guide: Assessment of same-sex accommodation*, March 2015
24. NHS England and NHS Improvement and Public Health England *Managing a healthy weight in adult secure services – practice guidance*. Developed through the Adult Secure Clinical Reference Group (NHS England and NHS Improvement) – Managing a Healthy Weight Task and Finish Group, February 2021
25. Department of Health and Social Care, *Report of the independent review of NHS hospital food*, October 2020
26. Department of Health and Social Care, *Policy paper: Health and Care Bill: hospital food*, July 2021
27. Department of Health and Social Care, *Mental Health Act 1983: Code of Practice*, January 2015, para 33.10
28. Care Quality Commission, *Monitoring the Mental Health Act in 2018/19*, February 2020, page 23
29. *Care Programme Approach: NHS England and NHS Improvement position statement*. 1 July 2021, version 1.0
30. NHS England and NHS Improvement, *Care Programme Approach: NHS England and NHS Improvement position statement*, July 2021
31. *Milton Keynes CCG (17 018 823e)*
32. *NHS Guilford and Waverley CCG (18 007 431a)*
33. NHS England, *Who Pays? Determining which NHS commissioner is responsible for making payment to a provider*, August 2020
34. *Mental Health Act 1983*, section 117(4)
35. Department of Health and Social Care, *Care and support statutory guidance*, para 19.64

36. *R (Worcestershire County Council) v Secretary of State for Health and Social Care and Swindon Borough Council* [2021] EWHC 682 (Admin)
37. Department of Health and Social Care, *DHSC's position on the determination of ordinary residence disputes pending the outcome of the Worcestershire case, August 2021*
38. Department of Health and Social Care, *Reforming the Mental Health Act: Government response to consultation, August 2021*
39. Care Quality Commission, *A new strategy for the changing world of health and social care - CQC's strategy from 2021*
40. Care Quality Commission, *Our equality objectives for 2021-2025*
41. Centre for Mental Health, *Mental Health for All? The final report of the Commission for Equality in Mental Health, November 2020*
42. NHS Digital, *Mental Health Act Statistics, Annual Figures, England, 2020-2021, October 2021*
43. NHS Digital, *Mental Health Act Statistics, Annual Figures, England, 2020-2021, October 2021*
44. NHS England, *Advancing mental health equalities strategy, October 2020*
45. Department of Health and Social Care, *Modernising the Mental Health Act – final report from the independent review, December 2018*
46. Norfolk Safeguarding Adults Board, *Safeguarding Adults Review: Joanna, Jon & Ben, September 2021, para 174-5*
47. Norfolk Safeguarding Board, *Seven minute briefing: Managing racial abuse towards staff from people who lack capacity, September 2021*
48. Government Equalities Office, *LGBT Action Plan: Improving the Lives of Lesbian, Gay, Bisexual and Transgender People, July 2018*
49. Care Quality Commission, *The state of health care and adult social care in England 2020/21*
50. Care Quality Commission, *Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021*
51. NHS Confederation, *Reaching the tipping point, August 2021*
52. Children's Commissioner, *Who are they? Where are they? Children locked up, November 2020, page 18*
53. NHS England, *Funding boost for young people's mental health services, June 2021*
54. Department of Health and Social Care, *Reforming the Mental Health Act, January 2021, page 80-83*

55. Department of Health and Social Care, *Reforming the Mental Health Act*, January 2021, page 83
56. Department of Health and Social Care, *The Government Response to the Joint Committee on Human Rights reports on the Detention of Young People with Learning Disabilities and/or Autism and the implications of the Government's COVID-19 response*, October 2020
57. Care Quality Commission, *Out of Sight – Who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition*, December 2020
58. Department of Health and Social Care, *DHSC's response to CQC's 'Out of sight – who cares?: restraint, segregation and seclusion' report*, July 2021
59. Care Quality Commission, *Home For Good: Successful community support for people with a learning disability, a mental health need and autistic people*, September 2021
60. Ministry of Justice, *Restricted Patients 2020 England and Wales: Statistics Bulletin*, April 2021
61. Her Majesty's Inspectorate of Probation, *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*, November 2021
62. Department of Health, *Offender Mental Health Care Pathway*, January 2005, page 2
63. Dr Graham Durcan, *The future of prison mental health care in England*, Centre for Mental Health, June 2021
64. Parole Board, *Guidance on Restricted Patients and the Mental Health Act*, December 2020, paragraph 14.1
65. Leonard S, Webb R and Shaw J, *Service transitions, interventions and care pathways following remittal to prison from medium secure psychiatric services in England and Wales: national cohort study*, *BJPsych Open* 2020 Aug 3;6(5):e80. doi: 10.1192/bjo.2020.62
66. NHS England and NHS Improvement, *Care Programme Approach: NHS England and NHS Improvement position statement*, July 2021, version 1.0
67. Her Majesty's Inspectorate of Probation, *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*, November 2021
68. *R v Cleland* [2020] EWCA Crim 906 (16 July 2020)
69. Sentencing Council, *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*, October 2020
70. Ministry of Justice, *A Smarter Approach to Sentencing*, September 2020

71. *SSJ v MM* [2018] UKSC 60
72. Department of Health, *Mental Health Act 1983: Code of Practice*, para 27.11
73. Mental Health Act 1983, section 72(1)(b)(i)
74. *Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust & Anor v EG* [2021] EWHC 2990 (Fam)
75. *GL v Elysium Healthcare* [2020] UKUT 308 (AAC)
76. Care Quality Commission, *Out of Sight – who cares? Restraint, segregation and seclusion review, October 2020*
77. Care Quality Commission, *Thematic Review of Restraint, Prolonged Seclusion and Segregation*, May 2019
78. NHS Digital, *NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics*, November 2021
79. *Lancashire CC v G (No3) (Continuing Unavailability of Secure Accommodation)* [2020] EWHC 3280 (Fam) (02 December 2020)
80. Children’s Commissioner, *Who are they? Where are they?* November 2020, pages 43-44
81. Department of Health and Social Care, *Mental Health Act 1983: Code of Practice*, January 2015, paragraph 26.156
82. *Baroness Hollins’ letter to the Secretary of State for Health and Social Care about the Independent Care (Education) and Treatment Reviews*, 21 July 2021
83. *Government Responses to the CQC ‘Out of Sight - Who Cares?’ Report and to Baroness Hollins’ Interim Report on Seclusion and Restrictive Practice for People with a Learning Disability and Autistic People*, 21 July 2021
84. Norfolk Safeguarding Adults Board, *Safeguarding Adults Review: Joanna, Jon & Ben*, September 2021, paragraphs 167-70
85. Care Quality Commission, *Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic*, November 2020, page 67-68

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