



**Monitoring the  
Mental Health Act**  
in 2023/24



**Care Quality Commission**

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Mental Health Act  
in 2023/24**

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<b>Foreword</b>	4
<b>Summary</b>	6
<b>CQC and the Mental Health Bill</b>	10
<b>System pressures and the MHA</b>	13
Inpatient admission	15
Discharge planning and support	19
<b>Workforce</b>	22
Recruitment, retention and skill mix	23
Challenges in addressing staffing issues	25
Training for staff	26
Second Opinion Appointed Doctor service	27
The future of the SOAD service	29
<b>Inequalities</b>	31
Discrimination	33
Communication and peoples' rights	35
Meeting patients' needs	36
Care for autistic people and people with a learning disability	38
<b>Children and young people</b>	40
Spotlight on the use of the MHA for children and young people	44
Staffing and quality of care	45
Quality of environments	46
Challenges in transition in care	49
<b>Environment</b>	53
Ward environments	54
Security and privacy	55
Outdoor and kitchen access	56
Restrictive practices	59
Single-sex accommodation	61
<b>Our regulatory activity in 2023/24</b>	63
MHA monitoring visits	63
Second Opinion Appointed Doctor service	63
Absence without leave (AWOL) notifications	65
Complaints data	66
Notification of deaths of detained patients and patients subject to a community treatment order	69
<b>Appendix A</b>	71
First Tier Tribunal data	
<b>Appendix B</b>	74
CQC as a part of the UK National Preventive Mechanism	
<b>References</b>	76

# Foreword

Our report this year highlights the ongoing challenges in mental health care that are compounding the pressures on mental health inpatient services. The issues we raise will be all too familiar to many, including the shortage of staff and staff in post not always having the right training to meet the needs of all of the people they care for. This, combined with a lack of inpatient beds, means that people continue to be detained a long way from home, often in environments that don't meet their needs.

Through our conversations with thousands of patients, carers and staff, we have heard time and again how being detained in a hospital far from home can make people feel isolated from their support network and have a detrimental effect on recovery. Grace's story, told in greater detail in our report, highlights the impact of this, not just on those who are detained but their family and friends too:

*"Being placed so far from home meant that Grace did not have any visitors while she was in hospital... she felt she was taken away from everything she knew and was really scared. Not being able to see Grace had a significant effect on her children. She described how they went to bed crying and when she did see them... it was difficult to interact while they were being monitored."*

Getting the right care, at the right time and in the right place is essential for everyone. However, findings from our Mental Health Act monitoring work reveal how certain groups still face significant barriers in accessing care, particularly people from ethnic minority groups and those living in areas of deprivation.

Our findings also reinforce concerns raised in both last year's report and our 2022/23 State of Care report about the significant and lasting impact that delays can have on children and young people. Without access to good, timely care, children with mental health needs are both at increased risk of harm and of becoming adults with relapsing mental health problems.

It is essential that we view the challenges faced by people in mental health inpatient services in the context of the significant pressures across the entire mental health pathway. We know that a growing number of people are in contact with secondary mental health services, and we have raised concerns in successive reports that community mental health services are struggling to support all the people who need it. We are increasingly concerned that the system is at risk of failing people in need of care, their families and in some cases, the wider society.

In our special review of Nottinghamshire Healthcare NHS Foundation Trust, we found evidence of people having to wait several months and in some cases several years for mental health treatment provided in the community.

We identified systemic issues with community mental health care, including a shortage of mental health staff, and a lack of integration between mental health services and other healthcare, social care, and support services. We warned – and continue to warn – that without action these systemic issues pose an inherent risk to patient and public safety.

In 2023/24, many services told us that detained patients seemed to be more unwell on admission than in the past. This can lead to a prolonged recovery time, which is not only a significant toll on the individual person, but also makes it more difficult for services to admit new patients.

The increase in demand for inpatient beds also heightens the risk that patients will be discharged too soon, without the appropriate support in place, and then need to be readmitted. As a result, they may find themselves being bounced from service to service without ever receiving the level of care that they need.

We welcome the recent focus on improving mental health and learning disability care in the [2025-26 NHS operational planning guidance](#).<sup>1</sup> We are hopeful that the introduction of the Mental Health Bill will strengthen this by bringing about long-awaited, important reforms that will enable the system to improve mental health care. However, we recognise that some of the provisions of the revised Mental Health Act may take years to implement.

We remain concerned about abuse and closed cultures in mental health services and ongoing problems with care pathways and lack of community provision for autistic people and people with a learning disability. We are continuing to embed our enhanced approach to inspecting specialist services and wards for autistic people and people with a learning disability to help us proactively identify potential closed cultures.

We will continue to use the insight and evidence gathered through our monitoring role, as well as our community mental health programme, to support our work in engaging and feeding into any changes in the passage of the Mental Health Bill. We are committed to using this insight and evidence to also help shape any subsequent changes to the Code of Practice and drive the improvements in mental health care across the system and provide better outcomes for patients.

Moving forward, we will ensure changes introduced by the Bill are reflected in our approach to monitoring the MHA. This will allow us to check whether the key aims of the reforms – including enhancing patients’ rights and safeguards, giving them a meaningful voice in their care and treatment and reducing compulsion – are being met.



A handwritten signature in black ink that reads "J Wilkes".

**Jenny Wilkes**

Interim Director of Mental Health

# Summary

This report sets out CQC's activity and findings during 2023/24 from our engagement with people who are subject to the Mental Health Act 1983 (MHA) as well as a review of services registered to assess, treat and care for people detained using the MHA.

The 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.

## 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 who are currently detained in hospital under the MHA, and we require providers to take action when we become aware of concerns or areas that need to improve.

We also have specific duties under the MHA, such as to:

- provide a second opinion appointed doctor (SOAD) service
- review complaints relating to use of the MHA
- make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also highlight practices that could lead to a breach of people's human rights during our MHA visits, and we make recommendations for action to improve. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM regularly visits places of detention to prevent torture, inhuman or degrading treatment. See Appendix B for more information on our role.

## Evidence used in this report

This report is based on the findings from 823 monitoring visits (which covered 870 wards) carried out during 2023/24. This involved speaking with 4,634 patients (3,343 in private interviews and 1,291 in more informal situations) and 1,435 carers. We also spoke with advocates and ward staff. Our MHA reviewers issued 823 monitoring reports during this period. A team of analysts carried out a focused qualitative review on a sample of all monitoring reports (20% of reports from each primary service type). Qualitative findings from this review were appraised and developed further by a series of focus groups with MHA reviewers.

This year, alongside speaking with people during our monitoring visits, we also carried out a series of interviews with people who have lived experience of being detained under the MHA or of caring for someone who has been detained. Their experiences illustrate the effect of detention on patients and

their loved ones, and other issues highlighted in this report. We have used pseudonyms to maintain their anonymity.

We thank 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.

In this report, we also use evidence from a quantitative analysis of statutory notifications submitted by registered providers, and complaints and/or concerns submitted to us about the way providers use their powers or carry out their duties under the Act. We also use information from activity carried out through our second opinion appointed doctor (SOAD) service. This is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion on the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent.

The report also draws on data from NHS England's Mental Health Services Data Set (MHSDS), using both the annual figures from April 2023 to March 2024 and monthly performance statistics files. Figures used in the report relate to the specific data files referenced and were correct at the time of writing.

In addition to the above, we worked with the Strategy Unit (hosted by NHS Midlands and Lancashire), a specialist NHS analytical team, to understand the scale of people attending emergency departments (A&E) because of a mental health crisis and whether this highlighted any inequality.

To do this, the Strategy Unit analysed patient-level data in the Emergency Care Dataset (ECDS), NHS 111 dataset and the MHSDS. They looked at attendance and call rates, and how these varied by characteristics such as age, gender, ethnicity and deprivation. They also examined the characteristics of people's contact with the service, such as the time and mode of arrival, their presenting mental health condition and whether they were already known to mental health services.

Following this work, the Strategy Unit focused on children and young people in 2 ways. The first examined children and young people presenting at urgent and emergency services with mental health needs using the same approach as above. The second piece of work focused on how detentions under the Mental Health Act (MHA) for children and young people (under 25 years old) vary over time and by characteristics such as age, gender, ethnicity and deprivation. They used MHSDS to examine conversions between different sections of the act, length of detention, number of re-detentions and distance from home.

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.

All the data used in the report is quality assured and validated. Some of the data may change over time as it is updated with new information in the live system.

## **Key points**

### **CQC and the Mental Health Bill**

We welcome the Mental Health Bill, which was introduced in the House of Lords in November 2024 and will bring about important reforms to increase the safeguards for people who are detained.

The new statutory principles embedded within the Bill, and accompanying changes to the Code of Practice, will provide for a sharper focus on the rights and experiences of mental health patients, people in custody who have a mental disorder, and people with a learning disability and autistic people.

However, as highlighted in our 2022/23 report, legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.

### **Systems**

We remain concerned that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time. Not being able to access care in a timely way can lead to people's mental health deteriorating while they wait for support.

Through our monitoring activity, we have seen how system pressures mean people are detained far from home or in environments that do not meet their needs. Many services told us that patients seem to be more unwell on admission than in the past.

Services need to balance the increase in demand for inpatient beds with ensuring existing patients are not discharged too soon.

### **Workforce**

In 2023/24 there were continuing problems with workforce retention and staffing shortages, as well as concerns around training and support for staff. Although the mental health workforce has grown by nearly 35% since 2019, shortages in both medical and support roles continue to have a negative impact on patient care.

Shortages of doctors also continue to affect the delivery of our second opinion appointed doctor (SOAD) service. We remain concerned about the long-term sustainability of the service, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions.

### **Inequalities**

We are concerned that some of the key issues we raise in this report, including access to mental health support, are particularly challenging for certain groups

of people, such as people from ethnic minority groups and those living in areas of deprivation.

We identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.

There was variation in how well services met people's needs. While many provided access to spiritual leaders, we remain concerned about gaps in the knowledge of staff around caring for autistic people.

## **Children and young people**

Children and young people continue to face challenges in accessing mental health care. Increasing demand is leading to long waits for beds, and increases the risk of being placed in inappropriate environments and/or being sent to a hospital miles away from home.

Once in hospital, we are concerned that access to specialist staff is being affected by low staffing levels, leading to patients' needs not being met. In addition, the quality of physical environments for children and young people varies; access to food and drink, and food preparation facilities were key issues for many children and young people.

Challenges in transitions of care between children and young people's mental health services and adult mental health services remain, with many young people still falling through the gaps and not getting the care and support they need.

## **Environment**

Through our MHA monitoring visits, we found that the quality of inpatient environments continues to vary. We are concerned about the impact of poor-quality environments on patients and have seen examples of how ageing and poorly-designed facilities affect people's care.

Being able to go outside brings therapeutic benefits for patients, but access to outdoor facilities varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, we also found examples of unwelcoming gardens and at some services, patients' access to outdoor spaces was limited. This issue was also raised by members of our Service User Reference Panel.

# CQC and the Mental Health Bill

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.

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.

While some important amendments were made to extend the rights of people with a mental illness in the [Mental Health Act 2007](#), there are still concerns that much of the current legislation is over 40 years old and does not reflect modern understanding of mental illness.<sup>2</sup>

In 2017, the government commissioned a review of the MHA and how it affects patients, professionals and the public. The independent review, led by Professor Sir Simon Wessley, was the first review of the legislation since the Mental Health Act 2007 changes. The review's [final report](#), published in 2018, identified 4 key principles that should be used as a 'basis for all actions taken under the act' and form the foundation of the 2024 mental health bill:

- choice and autonomy
- least restriction
- therapeutic benefit
- the person as an individual.<sup>3</sup>

We welcome the introduction of the Mental Health Bill, which was introduced in the House of Lords in November 2024 and will bring about important reforms to increase the safeguards for people who are detained. This is a key factor in enabling the system to improve mental health care and provide better outcomes for people, ensuring people are cared for in a way that maximises their choice, control and independence and promotes their dignity, privacy and human rights.

The new statutory principles embedded within the Bill, and accompanying changes to the Code of Practice, will provide for a sharper focus on the rights and experiences of mental health patients, people in custody who have a mental disorder, and autistic people and people with a learning disability.

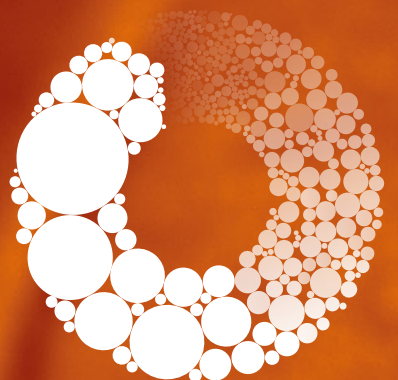
While the Bill is introducing many significant and long-awaited amendments, we will be monitoring a number of areas closely to ensure they translate into positive changes for people:

- **Over-representation of Black people detained under the Mental Health Act and placed on community treatment orders (CTOs).**  
This is a longstanding inequality and everyone involved in the delivery and oversight of mental health services must put measures in place to address it. We welcome the ambitions in the Bill to decrease the overall use of community treatment orders and the racial disparity in their application, but it will be important to keep these reforms under review following implementation to measure their true impact.
- **Ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability.**  
This can lead to them being inappropriately detained in hospital, which can have a devastating impact. We are pleased to see important amendments to the MHA included in this Bill, which will increase the safeguards for people who are detained. However, we are concerned that, even with the changes, there may still be a risk that people may be detained in suboptimal hospital placements. It will therefore be important to monitor implementation to ensure people are safeguarded from unintended consequences.
- **Persisting abusive and closed cultures in too many mental health services.** The likelihood that a service might develop a ‘closed culture’ is higher if an inherent risk factor is present.<sup>4</sup> There are many inherent risk factors such as workforce retention and staffing shortages, which remain one of the greatest challenges for the mental health sector. While we have seen many services challenge and reduce the use of restrictive practices, there is still significant work to be done.
- **Impact on our second opinion appointed doctor (SOAD) service.**  
The SOAD service is an important safeguard for people who are detained under the MHA. While we welcome the increased safeguards included in the Mental Health Bill, we remain concerned about our ability to deliver the service in the longer term. Proposals in the Bill will result in a substantial increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions. Additional funding is needed to deliver the future second opinion service, which the Department of Health and Social Care (DHSC) has accepted in its impact assessment for the Mental Health Bill. However, as we highlight in the section on workforce, ongoing challenges with workforce availability means that additional funding alone will not be enough to address the issues facing the service.

- **Protecting patients’ rights.** Our power to investigate MHA complaints complements our monitoring and regulatory role, as we use the intelligence from MHA complaints to inform wider work and to uphold the rights of people subject to the MHA. Measures in the Bill to improve how providers tell people how to complain will be beneficial to patients in ensuring their rights are protected. We will ensure our MHA complaints process is aligned with the Mental Health Bill in its final and published form after it gains Royal Assent. We commit to working with the Parliamentary and Health Service Ombudsman to direct complainants correctly and consistently to the appropriate oversight body, and ensure our process is accessible and responsive for people using services and their representatives.

Where appropriate, we discuss the Mental Health Bill and anticipated changes in more detail throughout the report in the context of our findings from 2023/24. But, as highlighted in our 2022/23 report, legislation alone won’t bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.

**System pressures and the MHA**



# System pressures and the MHA

## Key points

- We remain concerned that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time.
- Through our monitoring activity, we have seen how system pressures mean people are detained far from home or in environments that do not meet their needs.
- Services need to balance the increase in demand for inpatient beds with ensuring existing patients are not discharged too soon.

Across the mental health system in England, services remain under significant pressure. [A recent report published by Mind](#) describes a mental health crisis, warning that “the scale and severity of mental health need is spiraling” and putting the system “at breaking point”.<sup>5</sup>

Data from the Mental Health Services Data Set (MHSDS) shows that the number of people in contact with secondary mental health services increased by 43% between March 2019 and March 2024, which cannot be accounted for by population growth alone. In successive State of Care reports, we have raised concerns that high demand for community mental health services – without the capacity to meet it – is affecting people’s ability to get the care they need, when they need it.

Our [special review of Nottinghamshire Healthcare NHS Foundation Trust](#) found evidence of people having to wait several months, and in some cases several years, for community mental health treatment. Similarly, an analysis of free text responses to the 2023 NHS Community mental health survey found that people reported significant waits between referral, assessment and treatment.

In our last Monitoring the Mental Health Act report, we highlighted the importance of early intervention in preventing people from reaching a crisis. Getting the right mental health care, as early as possible, can have a significant positive impact on the trajectory and severity of a person’s illness. Not being able to access care in a timely way can lead to people’s mental health deteriorating while they wait for support. The Centre for Mental Health’s recent [Care beyond beds](#) report warns that when there is a delay or complete lack of appropriate intervention, the severity of someone’s mental illness can increase, which can lead to more distress and upheaval, as well as higher costs for services.<sup>6</sup>

Figures from NHS England’s Mental Health Services Data Set (MHSDS) show an 18% increase in the number of adults with a serious mental illness who accessed community mental health services between March 2023 and March

2024. These people may need to access urgent and emergency care services, and research from the Strategy Unit (hosted by NHS Midlands and Lancashire) shows over 80% of patients presenting at emergency departments with mental health needs are known to specialist mental services. The research also highlighted how people with mental health needs access urgent and emergency services differently. These patients use ambulances more, often arrive out of hours and are more likely to wait longer in emergency departments for assessment and treatment than those with physical health conditions. One in 3 people calling NHS 111 who had a primary mental health complaint were referred to an emergency department, compared with only 11% of callers with a physical health complaint.

Data from MHSDS shows that in 2023/24, the number of very urgent adult referrals to crisis teams more than doubled, reaching 3,063 in March 2024. This suggests people are becoming more unwell while waiting for the help they need. Recovery time in hospital may therefore increase, meaning bed occupancy rates remain high.

This puts pressure on inpatient services, with staff needing to balance the pressure to admit new patients with ensuring existing patients get the care they need. It could lead to people being placed on wards that do not meet all of their needs. For example, very unwell patients may be admitted to an acute ward rather than a psychiatric intensive care ward. In services for older adults, we have seen instances of people with dementia or other cognitive impairments who are placed on wards for people with functional mental health conditions because specialist dementia services are full, meaning people are not cared for in the most dementia-friendly environments. This can affect ward communities, as patients with very different needs are being cared for in close proximity.

Being discharged too soon or not getting enough community support after discharge could mean people's mental health deteriorates again. Research from the Strategy Unit showed almost 2,500 patients in England attended emergency or urgent care departments 5 times or more for their mental health in 12 months.

## **Inpatient admissions**

According to NHS England, in 2023/24, 52,458 new detentions under the Mental Health Act were recorded in England. As at March 2024, there were 16,706 patients recorded as being detained in hospital under MHA powers. Many services have told us that patients seem to be more unwell on admission than in the past, suggesting a lack of supportive interventions prior to admission. We have heard this in relation to admissions from the community, and transfers to hospital from prisons. When people are more unwell on admission it can lead to an increase in recovery time, which not only comes at a significant, potentially long-lasting personal cost for individuals, but also makes it more difficult for services to admit new patients. Data shows that bed occupancy figures continued to be much higher than the 85% standard.

A recent [report by LaingBuisson](#) highlights that, while occupancy rates in NHS mental health trusts reached record levels, the independent mental

health hospital sector has continued to grow in value. It identifies high NHS occupancy rates as a driver of supply to the independent sector, and estimates that providing publicly funded care (either from NHS or local authority funding streams) accounts for around 92% of the market value.<sup>7</sup>

### **Amy's story**

We spoke with Amy, who explained how a lack of suitable accommodation affected her when she was detained under the MHA. In early 2024, Amy was initially detained under section 136, which is when police can use emergency powers to take people from a public place to a place of safety, often a section 136 suite.

In Amy's case, there were no section 136 suites available within a 4 hour-radius. Amy therefore spent hours waiting in a police staff room. She was accompanied by 2 police officers but lots of people came in and out of the room, sometimes discussing police matters as they were unaware she was there.

Amy is diabetic, and during her time at the police station, she was not provided with any insulin. Eventually, a 136 suite was found for her, an hour away from the police station. When Amy arrived, staff recognised that she needed medical assistance for her diabetes and an ambulance took her to A&E. Amy's mental health was also assessed and she was then detained under section 2 of the MHA.

Amy returned to the section 136 suite as there were no other beds available. She stayed for 5 days under 2-to-1 observation – not because of her needs, but to follow the trust's policy for anyone in the section 136 suite. The suite had infrared sensitive cameras to help staff monitor patients, which Amy said she was not told about initially, leaving her feeling distressed and paranoid.

Other issues made the section 136 suite unsuitable for Amy. The room could be noisy, and as Amy is autistic, she struggled when she could overhear patients in other rooms. She also described murals on the walls where people had carved messages like "kill me" and said she was unable to look outside because the blind was broken. Staffing issues meant she could not always go outside to smoke when she wanted to, and she was not made aware of activities she could take part in on the ward. She told us she felt like "an animal in a cage".

Amy was disappointed that she was not able to be involved in the ward round and felt excluded from a big conversation about what would happen with her life. The ward manager, who she had not met previously, informed her she was going to be discharged. Amy did not feel ready to leave and told staff she intended to take an overdose. Staff advised they would add this to her notes. Amy felt the service was under pressure to have the section 136 suite back and she was soon discharged.

As Amy had never visited the hospital before, she did not know where she was and was not supported to find her way home. She was distressed and shortly after leaving hospital, took an overdose of insulin. Her mother was concerned about Amy and called the police, who took her to a place of safety once again.

Through our monitoring activity, we also saw patients held in overly restrictive settings as a result of bed shortages. In one instance, a lack of beds on the ward meant seclusion rooms were being used as bedrooms. These spaces are designed to include limited furnishings, and patients may feel unsettled by being put in a space they may have experienced during seclusion. It also prevents the seclusion room from being available for its intended purpose. At another service, we found 16 patients allocated to a 12-bed ward:

*“There were 16 patients allocated to the 12-bed ward. Four informal patients and a detained patient were on overnight leave from the ward. There was only 1 vacant bed available on the ward for a patient to return to if they wished to do so, meaning that 4 patients would have no bed to return to.”*

This demonstrates the impact of bed shortages on patients as, if at any point more than one person needed to return, there would have been no bed readily available for them. In circumstances like this, patients may be moved to another unit or placed in a seclusion room.

We have seen multiple examples of out-of-area placements as result of limited local bed provision, where there was no clinical benefit for the patient to be placed out of area (such as needing support from a specialist service). In 2023/24, NHS Digital data shows there were 5,500 new inappropriate out-of-area placements, a 25% increase on the previous year. In several services, patients were often placed significant distances away from their families and friends. As we highlighted in our last Monitoring the Mental Health Act report, we know that out-of-area placements can make people feel isolated from their support network and this year, some patients told us they missed their families. It can be difficult for families to visit relatives who are placed out of area, for example:

*“The IMHA [Independent Mental Health Advocate] said that they were aware of difficulties for patients caused by them being placed out of area, and that this limited opportunities for families to visit and for home leave. They were aware of 1 patient who had been on the ward for some months and unable to have a visit in that time, due to the distance involved.”*

A recent [report by the Health Services Safety Investigations Body \(HSSIB\)](#) found that out-of-area placements can harm patients, families and carers and increase a person’s length of stay in hospital. It outlined that patients rarely want an out-of-area placement, but their choices and opinions are not always taken into consideration.<sup>8</sup>

To support patients detained far from home, staff at one service offered extra support by driving patients to see their families for regular home visits.

However, offering this to patients relies on having enough staff to cover the ward, which, as we discuss in the workforce section, is not always the case.

### **Grace's story**

Grace, a mother of 2 children, told us about her experience of being admitted to a hospital far away from home, and the effect this had on her family. Grace had been admitted to hospital several times for her mental health, but system pressures and being placed far from home made her most recent admission feel isolating and distressing.

In 2023, Grace was assessed and needed to be admitted to hospital but there were no beds available. During this time, different people from the crisis team visited her at home each day. She wasn't told who would be coming or at what time, which she described as stressful, unsettling and disempowering. Her children witnessed everything and were distressed when their mum could not meet their needs.

After 3 weeks, Grace was told that a bed had become available, 5 hours away from home. Grace's husband was concerned about the prospect of her being so far from the children but knew the current situation was not working. Looking back on her experience, Grace can now see this too.

Being placed so far from home meant that Grace did not have any visitors while she was in hospital. Her husband could not drive, and her children suffer with travel sickness. Grace explained that not seeing her loved ones affected her recovery. She reflected that she wasn't always able to talk on the phone as staff were sometimes too busy, her phone wasn't always charged, or she wasn't always allowed to use the ward phone. This took a significant emotional toll and Grace worried about her children feeling that she did not love them.

After 4 weeks, Grace was moved to a hospital closer to home. However, this was still in a different county, an hour and a half away from her house. Her family took a taxi to visit her, but the journey made the children feel ill.

Grace said the month she spent in the first hospital felt much longer. She felt she was taken away from everything she knew and was really scared. Not being able to see Grace had a significant effect on her children. She described how they went to bed crying and when she did see them at the second hospital, it was difficult to interact while they were being monitored.

Grace did not feel she developed therapeutic relationships with staff when she was detained. She explained that her care co-ordinator, who knew her, was too far away to have meaningful input into her care. When she was preparing to come home, reviews were delayed because staff were not able to join online meetings, often due to issues with technology. This meant Grace's discharge was delayed.

## Discharge planning and support

The increase in demand for inpatient beds and the need to admit more patients raises concerns about other patients being discharged too soon and then needing to be readmitted. Ward managers told us about the pressure to discharge the “least unwell” patients. Carers have also explained instances where, after struggling to get an admission, their loved one seems to leave hospital too soon while still very unwell.

Short admissions can also limit discharge planning, and we remain concerned about community support for people when they are discharged. A member of our Service User Reference Panel (a group of carers and people who are, or have been, detained under the Mental Health Act) explained how a lack of support with their transition back into the community meant that their mental health quickly deteriorated. They reached a crisis and needed to be readmitted as an inpatient once again. Through our monitoring activity, we heard similar concerns from staff:

*“Staff were concerned that the pressure on the ward to admit patients was affecting the ability to ensure that patients were discharged into a setting that supported them to stay in the community long-term. They cited examples of some patients who had repeat admissions because of breakdown of community support.”*

In January 2024, NHS England introduced statutory guidance on [Discharge from mental health inpatient settings](#). This outlines how organisations should work together to ensure effective discharge planning and the best outcomes for people when they are discharged from hospital. The guidance sets out that people should receive a follow up from their community health team, intensive support team or crisis resolution home treatment team within 72 hours of discharge.<sup>9</sup> In 2023/24, 73% of people who were eligible received this type of follow up, down from 76% in 2021/22.

The guidance also says that discharge planning should involve people who use services and their chosen carers, starting before or on admission and continuing throughout a person’s stay in hospital. This aligns with the [MHA Code of Practice](#). In our special review of Nottinghamshire Healthcare NHS Foundation Trust, we found that the discharge planning process across community mental health and crisis services was not robust, with little evidence of discharge planning in care plans.

Patients detained for treatment under the MHA have a legal entitlement to aftercare, and the MHA Code of Practice gives detailed guidance that encourages health and social care bodies to interpret the definition of aftercare broadly. To meet patients' wider social, cultural and spiritual needs, aftercare should encompass:

- health and social care
- employment services
- supported accommodation and services.

However, the reality of aftercare provided is often far less holistic than the Code's guidance suggests.

We welcome the government's intention to require services to jointly notify a patient in writing if and when they decide to terminate aftercare services on the grounds that a patient is no longer in need of their support. This change in law may help patients to challenge such decisions if they feel they are unreasonable, but there remain few levers in the system to ensure that the aftercare initially provided is adequate for its purpose of meeting patients' needs arising from their mental disorder and reducing the risk of readmission to a hospital.

Through our MHA monitoring activity, we found that many mental health services held daily meetings to discuss discharge planning. Services often supported patients and their families or carers to be involved in discussions about discharge. Families and carers who were given opportunities to be involved in and have oversight of discharge planning spoke positively about this. Some patients told us they felt satisfied with their discharge plans, knowing about the support they would receive once discharged.

However, we found instances where it was unclear whether patients and families had been involved in discussions about discharge. Some patients felt unheard by staff and unhappy about their plans. This is concerning as the MHA Code of Practice outlines that, wherever possible, patients should be engaged in decision making that affects their care and treatment.<sup>10</sup>

We found examples of good practice, where services put measures in place to support patients after discharge. These included maintaining support from ward staff and in one example, doctors were able to provide community support to ensure consistency once patients were discharged from the hospital. Another service arranged visits to discharge placements for patients who were anxious about discharge:

*"Some carers spoke with us about the planned discharge of their relative. While they were supportive of the process and felt that their voice had been heard, there was still some anxiety about the discharge placements failing because of the speed of the discharge. However, we heard about an unannounced visit to a potential placement by a patient and relative so that they could see what it was like. We also heard of plans for patients to go for a meal followed by an overnight stay before they were discharged."*

Another service offered 4 weeks of continuity support following discharge to give patients with complex mental health needs the best chance of living independently in the community:

*“Patients at [mental health service] have complex mental health needs and have either been in hospital for many years or have a history of repeated admissions. To give these patients the best possible chance of living more independently in the community, staff invited community providers to build a service around the individual needs of each patient, rather than trying to fit the patient into an existing service. Records showed care co-ordinators attended ward rounds for patients who were preparing for discharge. Staff offered up to 4 weeks support to patients and community placement staff following discharge. This provided patients with continuity during the transition to a new placement. Whenever possible, the unit keeps the patient’s bed open during this period in case they needed to return. For example, a patient had recently returned to the unit because he was unhappy at the community placement.”*

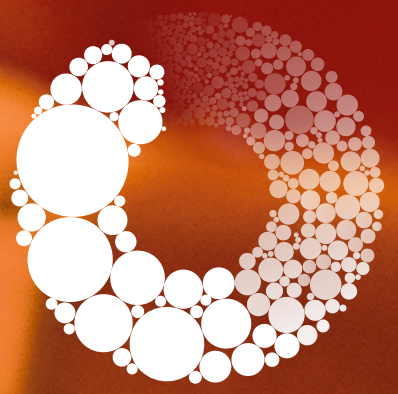
While these examples are encouraging, we remain concerned about the scale of challenges affecting the wider mental health system. The British Medical Association described tension between different parts of the system, with general practice, community mental health, and urgent and emergency care all overstretched.<sup>11</sup> Through our monitoring visits, we heard that most inpatient services experienced some delays discharging patients, primarily associated with external factors such as:

- a lack of specialist services and community resources within the area to meet patients’ needs
- a lack of capacity when a suitable placement is found
- shortages and a high turnover of care co-ordinators in the community, which complicates discharge arrangements, irrespective of the time and effort from mental health services in discharge planning
- difficulties in securing funding packages to meet the cost of the level of care needed for the patient
- referrals being declined by mental health services.

For people who need support, pressures in the wider system contribute to negative outcomes. Delays in accessing care risk people’s mental health deteriorating. In addition, issues around discharge – whether people are discharged too soon or without the support they need – increase the risk of further crises and admissions.



Workforce



# Workforce

## Key points

- Problems with workforce retention and staffing shortages continued in 2023/24. While the mental health workforce has grown by nearly 35% since 2019, we are still seeing a shortage in both medical and support roles, which is negatively affecting patient care.
- We have ongoing concerns around training and support for staff, with evidence of staff not having the specialist training required, particularly in caring for autistic people and people with a learning disability.
- We continue to face challenges in the delivery of our Second Opinion Appointed Doctor (SOAD) service due to the shortage of doctors able to take on the role. The long-term sustainability of the service is a key concern, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while at the same time reducing the timeframes for delivering some second opinions.

In last year's Mental Health Act annual report, we reiterated our concerns around workforce retention and staffing shortages being one of the greatest challenges for the mental health sector. While we continue to see problems with the levels of staffing, patients and carers are generally positive about staff themselves. Patients we spoke with have described feeling safe on the ward and feeling that staff treated them with "dignity and respect". They also spoke of staff as being "reassuring", "considerate", "caring", and "supportive". In addition, patients recognised that existing staff worked hard to try to mitigate any impacts on the patients, even when there were some issues they could not address. For example, at one location carers *"spoke highly of the staff, describing them as 'wonderful'"*.

## Recruitment, retention and skill mix

Recruitment to mental health roles has continued over the last year. However, we still hear that not all vacancies are being filled. As a result, we are seeing a shortage in both medical and support roles, which is negatively affecting patient care.

Between March 2019 and March 2024, the mental health workforce grew by nearly 40,000 full time equivalent (FTE) members of staff (35%). While this is a positive improvement, difficulties in recruiting staff to specific, skilled roles remain. Results from the 2023 NHS staff survey showed that on average 58% of staff working in mental health and learning disability trusts (including those providing other types of community services) reported working unpaid hours on a weekly basis – higher than the national average of 53%.

Problems with staffing and skill mix were key concerns identified through our special review of services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Evidence from our monitoring activity shows that services across the country are currently facing many of the same challenges in recruiting staff, including nurses, psychologists, occupational therapists and consultant psychiatrists.

Issues included:

- Wards without a permanent Responsible Clinician. As a result, in one instance, doctors from another hospital over 40 miles away were covering the ward, and there was not always a doctor available on-site within normal working hours.
- Multiple wards with no occupational therapists available for their patients.
- Instances where services were without a physiotherapist or reported difficulties recruiting tutors for young people of compulsory school age.

A recent report by the King's Fund has also raised concerns around challenges with staffing and skill mix. In its report Mental health 360, the King's Fund described how the recent increases in overall staffing levels has led to a higher proportion of newly qualified staff. This, it highlighted, has changed the level of staff experience and skill mix of services.<sup>12</sup>

As we reported in last year's report, not having the right levels of suitably qualified staff can have a huge impact on the safety of people who use services and the quality of care they receive. This includes affecting patients' access to therapeutic activities, stopping them from taking planned leave, or even preventing them from accessing fresh air.

This year, we continued to see how staff shortages led to activities, such as group excursions, day trips and access to gyms being delayed or cancelled. We heard how not having enough staff can lead to limits being placed on entertainment activities available on the ward or, where patients need to be escorted, stopping them from being able to go outside to get fresh air because there are not enough staff to escort them. For example, one MHA reviewer described how patients at the service they visited, *"had a weekly timetable of activities, but sessions were sometimes cancelled because there were not enough staff"*.

Shortages of staff are also preventing patients from taking leave authorised under section 17 of the MHA. This can delay people's recovery or create unnecessary distress. At one ward, patients told the MHA reviewer that the shortage of staff on the ward *"sometimes meant that section 17 leave was postponed. [The patient] said they were usually given another day or time, but occasionally leave was cancelled altogether."*

We also continue to hear about the impact of problems with workforce retention and staffing shortages on the quality of care for patients detained in the 3 high secure hospitals. Examples include concerns around inappropriate use of confinement of patients during the daytime at Rampton high secure hospital, as raised in our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. In that report, we

highlighted issues with confinement being planned several weeks in advance of known staff shortages, rather than considering less restrictive measures.

## Challenges in addressing staffing issues

To manage gaps in staffing, we heard examples from several hospitals of staff in wards that were already short staffed being moved to provide cover for worse shortages in other wards. For example, on one ward we heard how, *“activities were often cancelled or postponed as activities staff were pulled into numbers to cover shortfalls in staffing across the hospital”*. In hospitals with a range of wards, this can often mean that staff are pulled from rehabilitation wards, or other wards where patients are less unwell, to support the management of acutely ill patients on admission wards. As a result, this can lead to activities being limited. This is particularly damaging to the effectiveness of rehabilitation wards, where this can be a major part of the ward’s therapeutic purpose.

This supports the findings from our inspection of [acute wards for adults of working age and psychiatric intensive care units](#) in October 2023, and our inspection of [wards for older people with mental health problems](#) in November 2023. In both these inspections, we found that the services did not have enough staff to keep people safe. It was also an issue we raised in our [Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust](#), where we highlighted how moving staff around to cover gaps elsewhere increases the risk of harm and compromises the quality of patient care.

To fill vacancies, many services are continuing to use agency and bank staff. As highlighted in our previous reports on [Monitoring the Mental Health Act](#) and our [2022/23 State of Care](#) report, the use of bank and agency staff can prevent meaningful therapeutic relationships from developing between staff and patients. This was supported by feedback from MHA reviewers who described the barriers patients face in building therapeutic relationships. As a result, patients are less likely to engage with treatments and interventions, which can affect their recovery time.

Our analysis of monitoring reports found examples of poor interactions between staff and patients at multiple locations. Some patients stated that there were sometimes problems with *“bank or agency staff not knowing the patient’s needs very well.”* At other services, some patients described agency staff as ‘not friendly’ and ‘less caring’ towards patients, with one patient telling us they saw agency staff speaking to patients in *“an abrupt and harsh tone”*. In this instance, we recommended that the provider take action to ensure agency staff treat patients with respect and dignity. Poor interactions can also lead to communication issues, with a patient on one ward describing how they found it *“difficult to talk to others because they did not know them.”*

Relying on non-permanent staff can also affect the quality of care people receive. For example, in some wards we found that staff shortages and turnover were leading to issues such as patients not having a named nurse. A named nurse should promote patients’ wellbeing, safety and satisfaction, developing therapeutic relationships with patients, families, and carers.

At one clinic, we heard that a patient's "named nurse had left and not been replaced". At a different hospital, patients also claimed that they "did not know who their named nurses were" and this was supported by staff who stated, "they no longer received named nurse days because of staffing issues", which "had a direct and adverse impact on care planning".

Feedback from our MHA reviewers suggests that agency staff are often less familiar with the ward and as a result need to be supervised more. This reflects previous concerns we raised in our [2021/22 Monitoring the Mental Health Act report](#) around issues with inductions for agency staff, and agency staff not always receiving the level of support and supervision they need. This can add to the pressure created by staffing shortages and in turn affect the morale of permanent staff.

Working under this sustained pressure poses a challenge to the safe, effective care of people using mental health services. This is reflected in results of the NHS staff survey which show that, when asked if they would want their friends and relatives to be treated in their organisation, many staff working in mental health and learning disability trusts (including those providing community services) still do not feel the standard of care is high enough (64% in 2023, compared with a high of 70% in 2020).

## **Training for staff**

We have ongoing concerns around training and support for staff. As highlighted in previous Monitoring the Mental Health Act reports, this can be a particular issue for bank and agency staff where, for example, they may not have received even basic induction on the computer systems or have access to all areas of the hospital. Analysis of our monitoring reports has also highlighted how a lack of training may mean that agency staff do not know or follow ward practices.

Broader issues included staff missing required training, such as risk assessment training, and a lack of knowledge and training around record keeping. MHA reviewers often found that clinical records, such as patient care plans, did not record information about patient engagement, or show evidence that the patient's views or wishes had been taken into account. Furthermore, paperwork relating to reviews of medicines, treatment plans, or seclusion were sometimes missing. These findings reflect concerns around risk assessment and inconsistent record keeping that we raised in our [Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust](#).

As we highlight in the inequalities section, we continue to find evidence of staff not having the specialist training required to care for the people, particularly autistic people and people with a learning disability. In more than one location, we found that staff were not trained to support autistic patients and people with protected characteristics. As highlighted in last year's Monitoring the Mental Health Act report, we are concerned that this lack of training can lead to people not receiving the care they need. In addition, poor staff training and supervision, high turnover of staff and consistent staff shortages are all inherent risk factors that lead to services developing a [closed culture](#). We define a closed culture as 'a poor culture that can lead to harm,

including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm.

We also continue to see different interpretations of the interface between the Mental Health Act and the Mental Capacity Act, which the Deprivation of Liberty Safeguards (DoLS) are part of. In recent State of Care reports, we have raised concerns that providers' understanding of DoLS remains varied. This affects how the safeguards are applied and, in some cases, means people may not have a DoLS authorisation in place when they need one.

In the [2018/19 Monitoring the Mental Health Act report](#) we raised our concerns that neither patients nor professionals were likely to be clear on when the MHA or DoLS should be used. This could lead to the safeguards and rights relating to deprivation of liberty being applied inconsistently. We suggested that the government should update the respective codes of practice to reflect evolving case law needs, but this has not happened.

In 2019, the government passed the Mental Capacity (Amendment) Act, which planned to replace the DoLS system with the Liberty Protection Safeguards (LPS). While this has been delayed, the introduction of LPS will not resolve the questions of interface between these systems and the MHA.

We remain concerned that clinicians may not always be considering where the MHA can be used when the DoLS framework is not appropriate and where the patient is objecting to their placement. This concern is heightened by widespread delays in DoLS assessments, which can mean that some patients never receive an independent assessment of their clinician's decision to initiate an urgent deprivation of liberty. When such urgent applications expire, delays in the system mean that patients and clinicians are left in legal limbo, without any effective safeguard or procedure.

In 2024, the High Court decided that such legal limbo excludes patients in independent health providers from the reach of state obligations to its detainees under the Human Rights Act. In other words, the High Court found that, since a DoLS authorisation was not in place, it could not be argued that the functions carried out by the independent health provider were of a public nature. As such, the significant procedural failures in DoLS implementation have the effect of pushing some detained people beyond the reach of the Human Rights Act.

The court also found that neither the joint-funding arrangement under section 117 of the MHA nor CQC regulation could be used as evidence to conclude that the provider in question was delivering functions of a public nature. As a member of the National Preventive Mechanism, we are concerned that failure to close this gap may also have implications for ensuring that people have protections against inhuman or degrading treatment. We note that this issue has been raised in parliament over the passage of the Mental Health Bill and hope that government will want to close this gap in the protection of patients.

## **Second Opinion Appointed Doctor service**

Second Opinion Appointed Doctors (SOADs) are consultant psychiatrists appointed by CQC to deliver the statutory second opinions required to

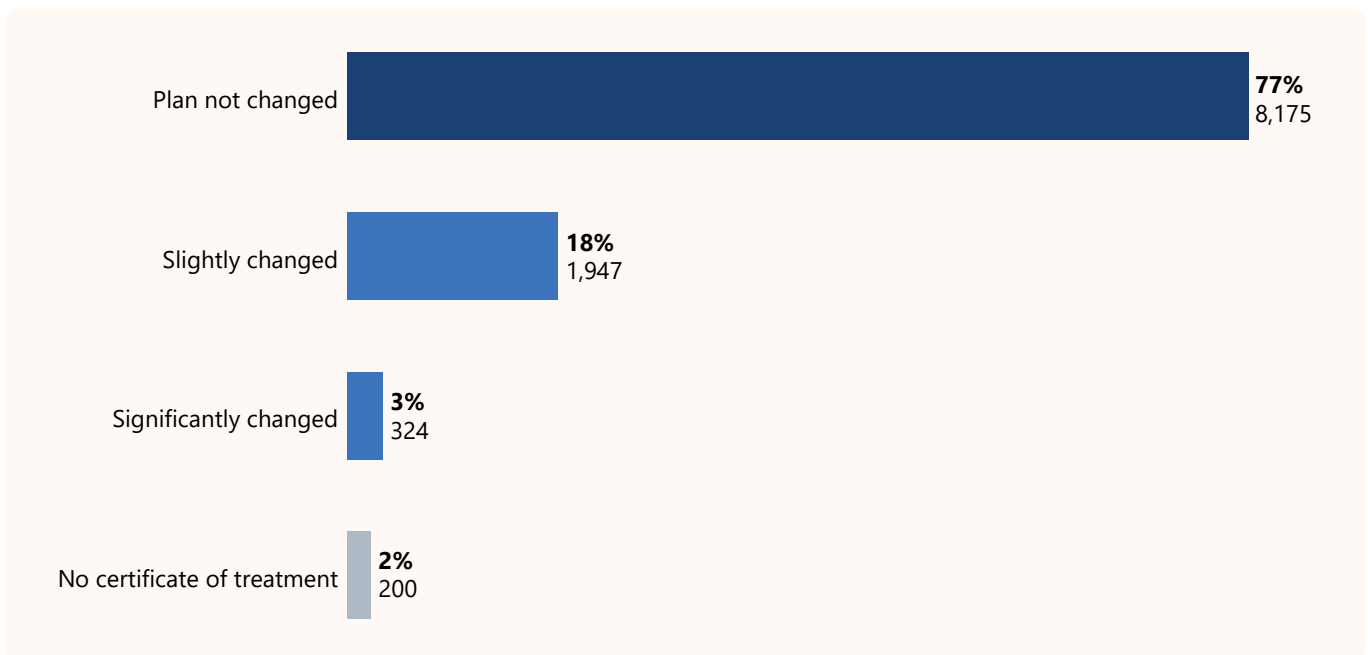
authorise treatment under the MHA in specific circumstances. The SOAD service provides a safeguard for people who do not have capacity to consent to their treatment or who do not consent to their treatment.

Currently, a statutory second opinion to authorise treatment plans that include medication can be requested after a detained person has had 3 months of treatment with medication. For treatment with electroconvulsive therapy (ECT) a second opinion can be requested as soon as a person is detained as there is no 3-month period within which the treatment can be given without consent or a second opinion.

CQC is responsible for administering the SOAD service, but SOADs make independent decisions, reaching their own conclusions by using their clinical judgement. Depending on their assessment, SOADs will issue a certificate to approve treatment plans in whole, in part, or not at all for a person's treatment plans. A SOAD can decide not to certify the proposed treatment if, in their view, this is not appropriate.

In 2023/24, we received 15,698 requests for a second opinion. For most patients (77%), treatment plans were not changed following review by a SOAD (figure 1).

Figure 1: **Outcome of SOAD review, 2023/24**



Source: CQC

Where treatment plans were changed, it was most likely to be changed for detained patients receiving ECT and medication, and for detained patients receiving medication only.

In our last Monitoring the Mental Health Act report, we highlighted our concerns about the long-term sustainability of the SOAD service. We highlighted how, despite additional short-term funding from the Department

of Health and Social Care, we had difficulties in providing the number of second opinions that were requested, within a reasonable timeframe.

Over the last 2 years we have increased the fee paid to SOADs and carried out targeted recruitment to increase the number of SOADs. However, we are still struggling to recruit enough SOADs and have significant shortfalls in the numbers of SOADs needed to deliver our current second opinion duties.

As noted in last year's report, the shortfall affects how quickly SOADs are able to respond to requests for second opinions. We highlighted how we were not keeping pace with demand and, as a result, the length of time between receiving a request for a second opinion and the SOAD certification of the treatment was increasing. Over the last year, we have worked to reduce the backlog of requests. However, there are still significant delays in delivering second opinions and we are continuing to work on improving our processes and recruitment.

Of the second opinion requests received in 2023/24, over a quarter (28%) were cancelled by providers before we could provide the second opinion. The proportion of total requests cancelled has increased year-on-year since 2017/2018. The most common reason for requests being cancelled was because the patient had been discharged.

To be able to carry out their duties, SOADs need access to the relevant patient medical information and consultees (people involved in the patient's care, including the responsible clinician, nurse and another professional involved in the person's care). Good communication and information sharing is important to enable the SOADs to work effectively. In many cases, MHA administrators are good at supporting this process. However, where this does not work well it can lead to additional delays in people receiving a second opinion.

## **The future of the SOAD service**

There are many positive proposals in the Mental Health Bill. The reforms will increase safeguards for people who are detained under the MHA and aim to address many of the issues we have raised in successive Monitoring the Mental Health Act reports.

The Bill puts forward changes that will affect the SOAD service. There are very important changes to reduce the length of time that people who are detained can be treated without their consent before a statutory second opinion is required to authorise the treatment. This will mean there are additional expectations of the SOAD service.

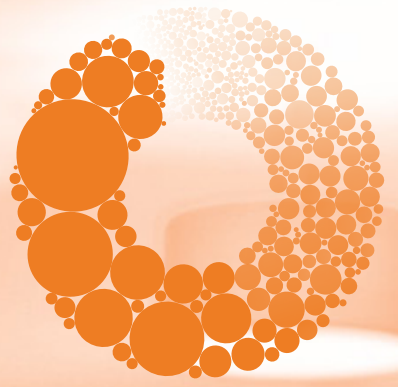
These proposals will increase the numbers of second opinions required and will reduce the timeframes for delivering some second opinions. Our duties under the MHA are funded by grant in aid, and additional funding is needed to deliver the future second opinion service. This has been accepted by the Department of Health and Social Care (DHSC) in its impact assessment for the Mental Health Bill.

However, as we highlight above, ongoing challenges with workforce availability means that additional funding alone will not be enough to address the issues facing the service.

Other changes being introduced by the Bill include:

- **Urgent SOAD certification** – we support increasing protections for patients under urgent electroconvulsive therapy (ECT) procedures. We will need to revise and review our SOAD service processes to establish how we can deliver this reform.
- **Remote technology** – the Bill allows the use of remote technology for urgent ECT second opinions. We think this should also be extended for use in other routine second opinions, where appropriate, to avoid unmanageable cost pressures in an expanded SOAD service and we are in discussions with DHSC about this.

Inequalities



# Inequalities

## Key points

- We are concerned that some of the key issues raised in this report, including access to mental health support, are particularly challenging for certain groups, such as people from ethnic minority groups and those living in areas of deprivation.
- We identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.
- There was variation in how well services met people's needs – many provided access to spiritual leaders, but we remain concerned about gaps in the knowledge of staff around caring for autistic people.

Data shows that access to mental health services is particularly challenging for certain groups of people, such as those living in areas of deprivation, people from ethnic minority groups and young people. This is concerning, given that, as we outline in the [systems](#) section, not getting the right help at the right time can lead to otherwise avoidable admissions as people's health deteriorates.

In our 2023/24 State of Care report, we highlighted that people who live in areas of higher deprivation were more likely to attend urgent and emergency care departments for their mental health needs than those in the least deprived areas. Attendance rates are over 3 times higher, suggesting people in the most deprived areas face significant challenges in accessing support in the community. Data also shows that the most deprived areas have the highest rates of detention. In 2023/24, detention rates in the most deprived areas were 3.5 times higher than in the least deprived areas.

We also have long-standing concerns that not everyone detained under the Mental Health Act is treated equally. In 2023/24, we continued to see how some people face inequalities in care and treatment because of their protected characteristics. We found attempts by services to address these inequalities varied. While some services promoted equality, diversity and inclusion, ward staff were not always able to explain how their service supported people's cultural needs. More work is needed to ensure care is fair for people who are detained under the MHA.

## Discrimination

The MHA Code of Practice is clear that “there must be no unlawful discrimination”.<sup>13</sup> We expect providers to be inclusive and respectful of people’s needs, values and circumstances. This includes taking into account the following protected characteristics, which mean it is against the law to discriminate against people because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

In previous Mental Health Act reports and in our annual State of Care report, we have continued to raise concerns about the over-representation of Black people who are detained under the MHA or placed on community treatment orders. In 2023/24, the detention rate for people from Black or Black British groups was 242 per 100,000 population. This was 3.5 times higher than the rate for people from white ethnic groups (68 per 100,000 population). Detention rates have increased slightly for all groups compared with the previous year.

A report by the [Centre for Mental Health](#) found that experiencing racism increases a person’s chances of having poor mental health and makes it harder for them to get the right support. It highlights that people with mental health needs may be treated less well in society, including in the social security and justice systems, and calls for concerted action to tackle these inequalities and close the health gaps between different groups.<sup>14</sup>

Through our monitoring visits, we found some instances of discrimination, both staff to patient and patient to staff. We heard from our MHA reviewers that racial abuse towards staff is common. For example at one visit we heard that:

*“There were incidents of racial abuse of staff by a patient. This was documented and reported to the police, with support for the staff involved.”*

At another service, we identified culturally insensitive language in patient notes, with one patient’s risk assessment referring to a risk of them making “Islamic comments”. We outlined that the service should address how it ensures all staff follow the principles of anti-discriminatory practice.

We also found examples of services taking steps to tackle racism. This included encouraging patients and staff to create and share anti-racism resources:

*“We saw when we went onto the ward that there was an anti-racism poster. The ward manager told us there had been an anti-racism event several months ago which took place over a whole week, and staff and patients had devised this poster at the time. She told us about how the ward promoted a positive culture.”*

Another service facilitated events to celebrate Black History Month. On 2 wards, patients from ethnic minority groups told our reviewers that they had not experienced discrimination and felt staff understood, respected and supported their cultural and religious needs.

The Patient and Carer Race Equality Framework (PCREF) aims to support NHS trusts to become actively anti-racist organisations. It is NHS England’s first anti-racism framework for mental health trusts and mental health service providers and will be a mandatory requirement from March 2025. PCREF sets out to ensure that trusts and providers co-produce and implement concrete actions to reduce racial inequalities in their services.<sup>15</sup>

In our last Monitoring the Mental Health Act report, we reported on positive initial findings of PCREF pilots and early adopter sites. Since then, these trusts have continued to report positive progress, including:

- focusing on data held in their trust and establishing workstreams to enhance data collection and better understand their populations and where discrimination may be happening
- engaging with a range of local groups and forming local partnerships, including with a local police force, to hear from different groups and develop training
- ensuring that the Board PCREF lead is well-established and the Board are engaged with the framework
- using tools such as Dialog+ to facilitate better co-produced care plans and recruiting community support experts to work with care co-ordinators to bridge the gap between trusts and people who use services.<sup>16</sup>
- updating websites and intranet pages with information on PCREF, explaining its governance structure and opportunities to get involved.

It is not only mental health trusts that have a role to play in PCREF. According to the Mental Health Equalities Programme and the National Institute for Health and Care Research (NIHR) Mental Health Implementation Network (MHIN), system partners will be critical to the effective implementation of the framework. Integrated care boards and partnerships, local authorities, and NHS mental health trusts must work with, and importantly listen to, people from ethnic minority groups to co-produce culturally appropriate care models and ensure accountability at all levels.

We support PCREF as a practical tool to tackle racism and dehumanisation. In the lead-up to March 2025, we have continued to encourage services to embed the approach through our regulatory and monitoring activity. Once mandatory, we will check how services use the framework as evidence to inform our assessments. This includes how mental health services embed equity into their shared vision and ensure equity in experience and outcomes for people from ethnic minority groups.

As a regulator and monitoring body, it is important that we do not hold others to account for actions we are not taking ourselves. We stand against racism, violence, aggression and abuse in all forms. We are currently adopting the [principles for an anti-racist organisation](#) set out by the NHS Race and Health Observatory.<sup>17</sup> Our approach will focus on how we address the effects of structural, institutional, and interpersonal racism. This includes addressing racism in our external regulatory work for people using services and providers, as well as internally for CQC colleagues.

In our last Monitoring the Mental Health Act report, we also discussed the discrimination faced by some lesbian, gay, bisexual, and transgender (LGBT+) people detained under the MHA. We highlighted improved visibility and focus on care for LGBT+ people and in 2023/24, LGBT+ patients we spoke with generally felt supported. However, one patient described being “intermittently misgendered” by staff. While reviewers often have positive conversations with staff about LGBT+ issues, some wards are more confident than others about providing LGBT+ support.

## **Communication and people’s rights**

The MHA places a legal duty on services to provide patients and carers with information about their situation and rights. The [MHA Code of Practice](#) outlines that providers should ensure all relevant information is communicated in a way that the patient understands. It says providers should identify any communication difficulties and everything possible should be done to overcome barriers to effective communication. Throughout our monitoring activity, we identified several issues around people not understanding their rights, including:

- patients not being informed of their rights at admission or significant delays in informing people of their rights after admission
- rights not being repeated regularly
- staff not providing updates to patients on their legal rights when the section of the Act under which they are detained has changed
- our MHA reviewers not being able to ascertain if a person had understood their rights
- patients not being referred to the Independent Mental Health Advocate (IMHA) when they do not understand their rights
- a lack of written information regarding legal rights provided to patients for future reference
- legal rights information not given in a person’s preferred language
- inconsistent approaches to explaining people’s rights.

These issues were echoed by members of our Service User Reference Panel, who described patients' rights as feeling like a "tick box" exercise, with some members feeling that they were not made aware of their rights in a meaningful way. Not explaining people's rights clearly and in a way that the person can understand does not uphold the principles of fairness, respect, equality, dignity or autonomy, and could potentially lead to situations where their human rights are infringed or breached, for example, where understanding rights engages Article 6 the right to a fair trial. We also heard a suggestion from the group that often less experienced staff, such as student nurses, were tasked with ensuring patients were aware of their rights but were not always best-placed to explain them in detail, with examples and context.

We also found issues with communicating and involving patients in important updates about their care plans. This includes copies of care plans not being shared with patients, inconsistent approaches to creating care plans and poor communication about the care planning process, meaning people lacked awareness of what their plan was and how it was completed. However, it was promising to find examples of clinical records that clearly stated patients' preferred pronouns, their wishes regarding their gender identity and how they were to be kept safe on the ward.

Inclusive communication is vital to ensure everyone receives high-quality care. Despite this, we continue to find examples of poor communication with patients detained under the MHA. Although interpreting and translation services were available at many services, we found examples of language barriers for patients who did not speak English as a first language. Often, interpreters were only used for important meetings and did not support people to communicate on a day-to-day basis. Sometimes, this prevented staff from being able to engage with patients, which could make their experience of detention more isolating. For these patients, watching television was sometimes their only form of activity, although this was also in English.

## Meeting patients' needs

The Equality Act requires providers to consider how their policies, programmes and service delivery will affect people with protected characteristics. It places a duty on providers to take positive steps to avoid discrimination through reasonable adjustments. At several services, staff had adapted their wards to support the needs of people with limited mobility.

*"We saw a patient who used a wheelchair had a larger bedroom and shower that accommodated their limited mobility. He told us a staff member had built a ramp so that he could access the gazebo in the ward garden as well as being able to use the other areas of the garden."*

However, we visited a number of wards that were unsuitable for wheelchair users because of their layout and location within the hospital. For example, one first-floor ward had beds fixed in place, no en-suite facilities and no

accessible bathrooms, meaning patients with limited mobility had to be placed elsewhere. At another ward, patients complained about nurse call buttons being out of reach and one person with limited mobility explained having to summon staff by shouting.

Inappropriate ward environments can also have a negative effect on neurodivergent people. At a couple of services, we were concerned about the frequency of alarms going off and noisy leaking gutters, which increase the risk of sensory overload for some patients. As we highlighted in our last Monitoring the Mental Health Act report, services must determine each patient's unique sensory profile and preferences.

How well services met the needs of people with dementia also varied. A lack of signage and consideration about the layout of the ward prevented a couple of services from creating dementia-friendly spaces. However, another service used contrasting colours and picture signs to help patients navigate around the ward. Patients were also encouraged to add a photograph of themselves to their bedroom door to help them to find their own room.

It is also important that mental health services meet people's cultural and religious needs. We were concerned to find instances where this was not the case. This included a lack of Halal options or not catering for vegan or vegetarian diets. We also found examples of male members of staff escorting or observing female patients, despite this being problematic because of the patients' cultural backgrounds.

### **Ali's story**

Ali described his mother as a housewife who is devoted to her family. She is British Pakistani and Ali explained how her experience of detention under the MHA was negatively affected by a lack of access to interpreters and culturally appropriate activities.

Ali's mother has a history of bipolar disorder, severe anxiety and depression. She has been detained numerous times and during a recent hospital admission, Ali was concerned that issues with communication and interpreting meant staff did not explain his mother's rights to her. He requested an interpreter, which the hospital provided, but while they spoke the same language, they did not share the same local dialect. Ali raised the issue with staff but it took 3 days to source an appropriate interpreter.

Ali feels this process could have been quicker and clearer. His mother felt confused, insecure and vulnerable not knowing what was happening to her. Sometimes Ali was left to interpret conversations, which he found draining. He explained wanting to be objective and accurate, but being aware of his own interpretation and judgements.

On the first day of his mother's hospital admission, Ali worked with staff to ensure her cultural requirements were noted in her care plan. He commented that staff were receptive and open to her needs, but he felt her plan was not always put into practice. He explained that the halal food provided by the hospital did not taste authentic to his mother and he started to bring food from home for her. His mother has diabetes and Ali was concerned that a lack

of continuity of care meant she sometimes ate the wrong foods at the wrong times because staff were not familiar with her needs.

Ali felt his mother was indirectly discriminated against as she was often left out of activities on the ward with no one to speak to. He told us that embroidery and cookery classes were often heavily westernised and could have been tailored to his mother's cultural needs (for example, by embroidering a flower rather than a Western holiday motif, or suggesting his mother draws a pumpkin, as she wouldn't understand being asked to paint a picture for Halloween). His mother also must pray each day but with no dedicated prayer room on the ward, she was praying in her bedroom, which further isolated her.

Ali's mother was in hospital for around a month before being discharged. At this point, Ali took over her care.

In contrast, many services had access to a chaplain or other spiritual leader who could provide patients with support and guidance. One service successfully adapted a patient's routine to ensure that mealtimes did not coincide with prayer time. Some services had dedicated multi-faith spaces that allowed patients to practice their chosen faith.

However, these areas were not always fit for purpose and we have seen examples of multi-faith rooms being used as storage areas. At another service, a religious space was moved to the female-only lounge, meaning female patients no longer had access to a single-sex space. We heard how staffing pressures can make it difficult for staff to facilitate patients attending religious services:

*"Two patients told us they attended Chapel on a Wednesday and Sunday but had not been able to go for the past 2 Sundays because of a lack of staff."*

## Care for autistic people and people with a learning disability

At some services, gaps in staff knowledge affected the care provided for autistic people and people with a learning disability. Some staff had not completed mandatory learning disability and autism training, which exists to ensure that staff have the right knowledge and skills to provide safe and informed care. We expect providers to meet the needs of everyone using their service. This includes ensuring staff have the appropriate training to help improve experiences and outcomes for all people who use services.

In last year's report, we outlined our [cross-sector policy position](#) on reducing restrictive practices, which clarifies our expectation of providers.<sup>18</sup> Following this, in our December 2024 blog on [reducing restrictive practices](#), we highlighted that restrictive practices like chemical restraint are inappropriate when they could have been prevented through better person-

centred planning, listening, understanding, skills, support, and system partner collaboration.<sup>19</sup> People must not be unnecessarily sedated, rapidly tranquillised or anaesthetised for communicating an unmet need, emotions, or distress. Wherever we see chemical restraint being used, we will want to understand why and how the decisions have been made about this course of action.

In previous years' Monitoring the Mental Health Act reports we have outlined that a lack of suitable accommodation in the community has led to autistic people and people with a learning disability being unnecessarily detained in hospital. In late 2023, we announced that the Department of Health and Social Care asked us to take a lead on Independent Care (Education) and Treatment Reviews (IC(E)TRs) for 2 years. The focus of our IC(E)TR programme is reviewing people's care and encouraging providers and commissioners to overcome the barriers to support people to move out of long-term segregation into more suitable environments where they can flourish.

Our programme began in May 2024 and we have seen some positive examples among the first group of people to have had a review:

- One person was successfully discharged from long-term segregation in a high-secure setting.
- A young person was successfully moved to more appropriate adult services in a single-person accommodation that better meets their needs.
- Another person was discharged into their own placement in the community.

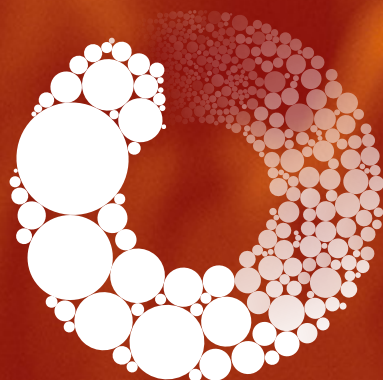
However, we continue to find cases of hospital admissions that could have been avoided altogether. In previous Monitoring the Mental Health Act reports, we have also raised concerns about autistic people and people with a learning disability staying in hospital for prolonged periods when this does not meet their needs. From our monitoring work and our involvement in IC(E) TRs we know that in almost every case, the principal cause is the lack of a practical alternative in the form of resourced community support.

We welcome the ambition to change this situation, which is reflected in the proposals of the Mental Health Bill to exclude learning disability or autism from the scope of civil detention for treatment under the MHA. This means that having a learning disability or being autistic alone cannot be a reason to detain a person. But legislation alone will not bring the changes needed.

Without suitable community-based alternatives there is still a risk that people may be detained in sub-optimal hospital placements under alternative legal powers such as the Deprivation of Liberty Safeguards (DoLS) or its eventual replacement, Liberty Protection Safeguards. Autistic people and people with a learning disability could also become increasingly vulnerable to being drawn into criminal justice measures, such as detention under the criminal justice powers of the MHA, or imprisonment.

It will therefore be essential to ensure that improved community support is in place throughout the country before the reforms are implemented.

Children and young people



# Children and young people

## Key points

- The increasing need for children and young people's mental health services means they continue to face long waits for a bed to become available, risk being placed in inappropriate environments or being sent to a hospital miles away from home.
- Research commissioned from the Strategy Unit on the use of the MHA for children and young people shows variation across integrated care board areas in the use of the act, lengths of stay and the distance of beds from home.
- Many services have specialist staff who are trained to care for children and young people. However, access to specialist staff is being affected by low staffing levels leading to patients' needs not being met.
- The quality of physical environments for children and young people varied, with access to food and drink, and food preparation facilities key issues for many children and young people.
- We continue to hear about challenges in transitions of care between children and young people's mental health services and adult mental health services, with many young people still falling through the gaps and not getting the care and support they need.

As we raised in this year's [State of Care report](#), demand for children and young people's mental health services continues to grow. Data from the Mental Health Services Data Set (MHSDS) shows that in 2023/24, on average each month nearly 560,000 children and young people under 18 were in contact with mental health services. At the same time referrals also rose, with the average number of referrals each month for children and young people increasing by 4% from the previous year.

However, the increasing need for mental health care is not always being met. A recent report published by [Mind](#) warns that children and young people continue to face challenges with their mental health but the NHS and schools cannot cope with the level of need.<sup>20</sup> MHSDS data shows that while the number of children and young people in contact with mental health services increased by 16% from 2022/23 to 2023/24, the number of interactions they had with mental health services only increased by 10%. Evidence from the 2023 Community mental health survey also showed that children and young people continued to face long waiting times at all stages of care from initial assessments, to diagnoses, medicines, and therapies.

## Florence's story

Florence first started struggling with food at the end of 2020. She didn't recognise it as an issue at first, just viewing what she was doing as normal dieting to lose weight. Florence's dieting became gradually more extreme and then escalated in the summer of 2021.

Florence was rapidly losing weight and, when her periods stopped and some of her hair started to fall out, she decided to speak to her mum about what she was going through. Florence visited the GP in October 2021 who made a referral to children and young people's mental health services.

Anticipating a long wait for help from the children and young people's mental health services, Florence accessed support from an eating disorder therapist privately, which she found very helpful. However, Florence and her family still wanted to access family-based therapy and support from a nutritionist through children and young people's mental health services.

Florence waited 7 months for initial contact from children and young people's mental health services. While nutritionist support was put in place quickly, the wait for therapy was another 6 months.

In late 2022, Florence started therapy with an eating disorder specialist from children and young people's mental health services. However, she didn't develop a good relationship with the therapist and felt patronised and misunderstood by a therapist who she believed spoke to her like she was younger and less intelligent than she was. She found these sessions so frustrating that she would regress with her eating because of them, so she decided to discontinue the therapy.

*"This was really upsetting because we've been on a... wait list for a year to receive therapy and now that therapy was doing me more harm than good."*

Florence was still receiving support from her private therapist throughout this time. The therapist advised her to seek some additional support from children and young people's mental health services for underlying depression so a referral to a psychiatrist was made in the summer of 2022.

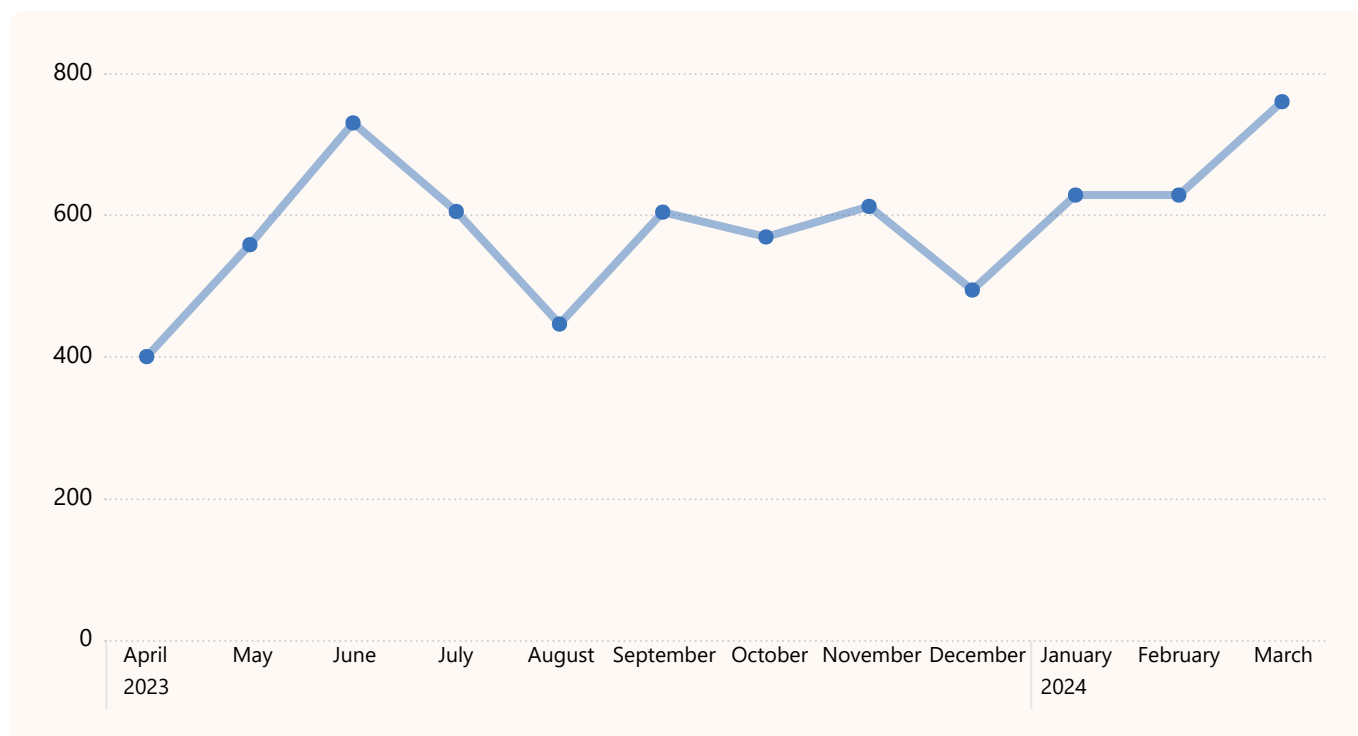
After 8 months of waiting, Florence was given an appointment with a psychiatrist to support with the underlying depression. By this point Florence wasn't struggling with depression anymore so it was decided no further support was required.

Not getting help when they need it can increase the risk of children and young people reaching crisis point. According to MHSDS, in 2023/24, there were over 7,000 very urgent referrals to crisis teams for children and young people under 18. While numbers of referrals vary across the year, we are concerned that services are falling below the expected standard in providing people with care.

Best practice guidelines from the Royal College of Psychiatrists state that crisis teams should see very urgent referrals within 4 hours, and urgent referrals within 24 hours. In April 2023, 47% of the very urgent referrals of very urgent referrals

of children and young people or people under 18 met the time standard of 4 hours. This varied across the year (figure 2), with a low of 33% in March 2024.

**Figure 2: New very urgent referrals of children and young people under 18 to crisis care teams, April 2023 to March 2024**



Source: NHS England, Mental Health Services Data Set

As we described in detail in last year's [Monitoring the Mental Health Act report](#), not getting the right support in the community at the right time can lead to children and young people ending up in inappropriate environments, including urgent and emergency care. This is a particular risk for young people aged 16 to 18 as support from children and young people's mental health services typically ends at 18 years old.

Research from the Strategy Unit found that people aged 18 to 21 consistently have the highest rates of presentation for mental health issues at both emergency departments and urgent care centres. In addition, the research shows that children and young people aged 0 to 17 were the only age group to have an increase in attendance rates at type 1 urgent and emergency services (A&Es) since 2019/20.

In 2023/24, there were around 5 million attendances to emergency departments by children and young people, of which 64,000 had a primary diagnosis of a mental health condition. More than 85% of those children and young people attending emergency departments for a mental health condition were known to mental health services. Data from MHSDS shows the rate of attendance in younger females was substantially higher than for younger males in every year since 2019/20. For example, in 2023/24, the rate in

younger females was 515 per 100,000, whereas in younger males it was 263 per 100,000.

The lack of specialist beds for children and young people can then lead to them facing long waits in urgent and emergency care while they wait for a bed to become available, being placed in inappropriate environments such as adult wards, or being sent to a hospital miles away from home. This can be hugely detrimental to their recovery.

This year, we have continued our work to identify how we can improve our regulation of children who are placed in unsuitable settings. As described in last year's report, as part of this, we are working with internal and external stakeholders to design and implement solutions so that all children will be cared for in placements where they are cared for by staff who can understand, and meet, their needs.

We continue to consider what actions we can take as the regulator to improve the quality of care being provided to children. This has included a number of actions to improve our oversight of where children are being cared for, and to help the public and providers to understand how we work together with other stakeholders and regulators to provide quality regulation of children's services within evolving models of care. In addition, we are continuing to ensure that our regulation, including [the assessment framework](#) and any accompanying guidance or training, are inclusive of children and young people. This includes strengthening our assessment approach for those children and young people who are admitted to unsuitable settings.

## **Spotlight on use of the MHA for children and young people**

It is vital that when children and young people are admitted to hospital for treatment of their mental health condition it is for the shortest time possible.<sup>21</sup> NHS England has recognised that some children and young people may remain in hospital for longer periods than ideal. The reasons for this are varied and may be due to complexities and pressures across the system, increased mental health needs, or a breakdown in a social care placement.<sup>22</sup>

Length of detentions may also be affected by how far away from home children and young people are placed. As we have highlighted in previous Monitoring the Mental Health Act reports, being placed out of area can present challenges when patients are ready to be discharged, such as securing appropriate community support back in the person's local area.

To understand more about the detention of children and young people under the MHA, we commissioned the Strategy Unit to look at how detentions under the MHA for children and young people (covering ages 0 to 24) has varied over the last 5 years.

As part of its research, the Strategy Unit looked at the nature of ‘conversions’ between different sections of the act; lengths of stay; and how far from home patients were admitted to beds. The research found:

- The types of section used to detain children and young people, and how often they were used, varied greatly between integrated care board (ICB) area.
- Between 2019/20 and 2023/24, around 45% of children and young people detained, for a single episode or more than one episode, started off with short-term detentions (sections 136, 4, 5(2) and 5(4)) – the equivalent for adults over the same period is 30%.
- The median length of stay varied by ICB area and has increased over time from 15.3 days in 2019/20 to 21.5 days in 2023/24.
- Of the 11,854 MHA detention spells in 2023/24, 1.65% were longer than 365 days.
- Almost half of all instances where children and young people are detained have at least one period of re-detention within 12 months. Some children and young people may have multiple periods of detention within these numbers.
- There has been a small increase in the mean distance children and young people are admitted from their home.

## **Staffing and quality of care**

Children and young people who are admitted to hospital often have complex and changing needs. The MHA Code of Practice is clear that they should be cared for by staff with the right training, skills and knowledge to understand and address their specific needs.

Through our monitoring activity we have found that children and young people’s mental health services have some specialist staff who are trained to care for children and young people. We found that many services had multidisciplinary teams in place, including occupational therapy, psychiatry, speech and language therapy, dietetics, teaching/education, and social work.

We have also found evidence of multidisciplinary teams and care teams working together to understand the needs of the patients and ensure the least restrictive methods were used. This was supported by feedback from children and young people, and their carers, who were generally positive about staff and described them as attentive, kind and caring, and that they felt supported day-to-day.

However, as described in our section on [workforce](#), concerns around staffing have been raised in some services. This included staff on some wards, particularly agency staff, lacking the knowledge and skills required for the specialist services they were working in. Most staff were trained in verbal de-escalation, physical restraint, chemical restraint and the prevention and management of aggression. However, we heard how some staff members were observed to be using inappropriate language towards already distressed patients. We heard how this could have a negative effect on the recovery of patients.

*“One patient told us that permanent members of staff were always caring and that they would provide reassurance during periods of distress. However, feedback regarding agency staff was not so positive, with patients feeling that they sometimes could not always support them in a person-centred way.”*

In some cases, access to specialist staff was affected by low staffing levels which, MHA reviewers identified, led to patients’ needs not being met. For example, at one service we heard there were not enough doctors available to cover the unit, which meant that patients were not always seeing doctors often enough. The service had also reduced the number of patients it was able to accept as it was not able to open all its beds due to the lack of staff.

*“[The ward] is a 10-bed [children and young people’s mental health ward] for male and female patients. At the time of our visit only 6 beds were open due to staffing issues.”*

As highlighted in previous Monitoring the Mental Health Act reports, access to activities, for example arts and crafts, playing board games, watching TV, and trips out into the community, is important as they give children and young people a sense of purpose, structure to the day and aid their recovery.

While most patients MHA reviewers spoke with said that they had access to a range of activities as a part of their daily routine, we were concerned that low staffing levels were also affecting the availability of activities in some services. This view was shared by some carers we spoke with who told us their relatives did not have enough to do on the ward and that they would like to see more activities available.

Feedback from MHA reviewers also highlighted the significance of access to educational opportunities. They described how these opportunities provided children and young people with structure, specialist support (such as speech and language therapy and trained teachers) and gave them a space to develop life skills.

We found that patients generally had access to schooling and learning, with most services able to provide access to classroom-based learning facilitated by an education professional. However, not all children and young people had equal access to educational opportunities, with some patients saying they had not received any education or had only been offered online modules and non-teacher led sessions (see section on [transition](#)).

## **Quality of environments**

Section 131A of the Mental Health Act is clear that children and young people admitted to hospital for the treatment of mental disorder should be cared for in an environment that is suitable for their age (subject to their needs). This includes having appropriate physical facilities. Getting the right care in a therapeutic environment supports people to get better more quickly

and reduces avoidable time spent in hospital. However, we found that the quality of physical environments for children and young people varied.

The MHA Code of Practice highlights Article 8 of the European Convention on Human Rights (ECHR) as particularly important for people detained under the Act. This requires public authorities to respect a person's right to a private life. Through our MHA monitoring visits we found positive examples of services providing children and young people with their own ensuite bedrooms and supporting them to have some privacy. However, we also found examples of patients having to share washing and toileting facilities. We heard how this could have an impact on admissions.

*"Only 2 bedrooms had an ensuite shower room. This meant the majority of patients had to share communal bathing and toileting facilities. Staff told us that admissions were impacted by this as considerations had to be made for the ratio of male to female patients but also the use of the assisted bathroom."*

When children and young people cannot be admitted to a children's specialist ward, there is an increased risk of them ending up in inappropriate environments, including adult wards. In 2023/24, we were notified of 120 instances where children and young people under 18 years old were admitted to adult wards. While most of these were emergency detentions, 12% were planned admissions and 20% were informal admissions. In addition, we found that admissions of children and young people to adult wards varied across the country. The areas that reported the most notifications were the central and north regions, which accounted for 44% and 33% of total notifications.

We found that some of these admissions were directly supported by children and young people's mental health teams. This would happen when an adult seclusion room was being used due to lack of seclusion space for children on the children's units. In a small but notable number of admissions, the children affected were autistic, had ADHD or were children with a learning disability, but it wasn't clear what considerations were being made for their care. A number of the admissions were due to preference, whether that be clinical, social or legal (for example, if the young person couldn't be placed with other children due to ongoing criminal prosecution), and a small number were due to the child approaching their 18th birthday.

The design of ward environments can also have an impact on patient recovery. We found that wards for children and young people were not always age appropriate. MHA monitoring reports sometimes described wards as "too clinical", and that they did not offer patients a relaxed and comfortable environment. However, MHA Reviewers were often positive about patients' access to services that would support their ongoing recovery and development. These included access to sensory rooms, occupational therapy rooms, classroom environments, and bedrooms fitted with hoists and profiling beds.

Access to food and drink, and food preparation facilities were key issues for many patients. While most services provided patients with access to food and drink preparation facilities and food storage, some patients told MHA reviewers that the food they were provided with was unpleasant and that there was limited choice.

*“Two patients told us the food was not very nice and there was a limited choice. However, they both said there were alternatives to the menu. Patients told us snacks were available, although a patient was unhappy with the limited choice of these.”*

In other cases, patients described needing to get staff permission and/or supervision to access to these facilities.

### **Restrictive practices**

Restrictive practice is defined as “making someone do something they don’t want to do or stopping someone doing something they want to do” (see also section on [environment](#)).<sup>23</sup> Most people recognise restraint, seclusion, and segregation as the more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice that easily become day-to-day normal responses to perceived risk or lack of time. This includes, for example, denying people access to visitors, friends, or food due to a lack of staff or time.

In some services, we found that children and young people had opportunities to exercise independence by having a key to their room and being able to personalise their room the way they wished. However, in others we found that some patients had to ask for permission to access services and facilities, such as toilets, food storage, and outdoor spaces, which had an impact on their personal development and access to independence.

Blanket restrictions and measures were in place in some services, which prevented children and young people from engaging in what may be considered standard day-to-day tasks, such as going outside and making a hot drink.

Access to fresh air and outdoor spaces was a key area of concern for MHA reviewers. While outdoor spaces and fresh air were available to patients most of the time, in many services children and young people had to seek permission or supervision to access otherwise locked outdoor spaces. Some outdoor spaces were also deemed unsafe and therefore access was restricted.

*“Both parents of [the patient] were concerned that their relative was not having access to fresh air. They had been told by their relative that they were not able to access the courtyard because of “trip hazards.” They would like their relative to be able to access fresh air.”*

We also found evidence of blanket restrictions in relation to the use of electronic devices. Not all services allowed the use of electronic devices, resulting in some patients having limited access to the internet and social media. The MHA Code of Practice states that although a policy around mobile phone possession and usage should exist, they should be proportionate to risk and should not seek to impose blanket restrictions on patients.

In many services, restrictions on device use were proportionate and based on individual need. We found that children and young people had access to their own mobile phones or had access to a phone of some sort. Some patients also had access to laptops and tablets. Most services had Wi-Fi or internet access for young people to use. This is in line with the MHA Code of Practice to support patients in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media.

## Challenges in transitions in care

In last year's MHA annual report, we raised concerns about transitions in care between children and young people's mental health services and adult mental health services. We reported the negative impact transitions can have, with young people being moved onto adult wards as soon as they turn 18, or because they are soon to turn 18, and feeling like they are suddenly being expected to act as an adult.

In December 2024, the Healthcare Services Safety Investigation Branch (HSSIB) published its investigation report '[Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services](#).' The findings of this report echo our concerns around the quality of care and support for young people during transition. Key findings from the report include:

- Young people may be discharged from inpatient children and young people's mental health services because they have reached 'transition age' and not because their mental health care needs have changed.
- The criteria of adult mental health services for ongoing care as an 'adult' inpatient may mean young people are discharged from inpatient children and young people's mental health services to an alternative setting that is not suitable to meet their ongoing needs, for example bed and breakfast hostels, with community services providing more limited mental health care and support.
- Health, social care, local authorities and education do not always work together in a consistent and integrated way to support positive outcomes for young people who are transitioning from inpatient children and young people's mental health services to adult mental health services.
- In many children and young people's mental health services, 'blanket' safeguarding measures are implemented overnight for people reaching 18. These measures are not based on a change in individual behaviours or risks. Perceived safeguarding challenges are a driver for rigid aged-based transitions.<sup>24</sup>

But it is not just about transfer of clinical care. Access to educational opportunities is a particular concern for young people when transitioning from children and young people’s mental health services to adult mental health services. In its report, HSSIB found that the education needs of young people approaching 18 who are transitioning from inpatient children and young people’s mental health services are not always being met. Investigators heard about the challenges some young people faced after moving between services, such as not being able to sit exams. This, they heard, could have lifelong impacts on young people and have a negative effect on their outcomes.

Guidance from the National Institute for Health and Care Excellence (NICE) is clear that transition planning should start from year 9 (age 13 or 14). But this needs to be person-centred. As highlighted in our 2014 report, what works for one 14-year-old may not work for another because of developmental maturity and their resulting needs. What matters most is that services must be integrated, and care co-ordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life – whatever their age. However, the recent HSSIB report found that current NHS England service specifications and commissioning guidance for inpatient children and young people’s mental health services do not support needs-based flexible transitions.

In 2019, NHS England outlined plans to redesign the structure of children and young people’s mental health services to create a comprehensive offer for 0 to 25-year-olds that reaches across mental health services for children, young people and adults. This included delivering an integrated approach across health, social care, education and the voluntary sector.<sup>25</sup>

This was supported by the publication of the NHS Mental Health Implementation Plan 2019/20 to 2023/24, which stated how “NHS England and NHS Improvement will document and share learning from areas...so local systems can adapt their models of care. These models will include stretch arrangements and changes in commissioning and service approaches for both children and young people’s mental health services and adult mental health services to ensure young adults receive appropriate support regardless of their age or diagnostic profile.”<sup>26</sup>

## Summer's story

Summer first started experiencing extreme stress and suicidal thoughts when she was at school and starting her GCSEs. She didn't speak to anyone about how she was feeling, but significant changes to her behaviour in school resulted in an admission to hospital, where she stayed under observation for a few days. This was when Summer first had contact with children and young people's mental health services, with support planned to remain in place once she was discharged. However, after discharge, Summer recalls the support from community children and young people's mental health services being withdrawn prematurely and the impact this had on her:

*"I think at the time I was not engaging very well just because of my state at the time and so basically, because I wasn't really talking about things, they just sort of dropped me ... I felt a bit forgotten about and a bit confused because I sort of thought like if they said I needed help, why did they just drop me?"*

Summer looks back on this time as a crucial turning point in her life:

*"And I think if I hadn't been dropped by them and they just gave me a bit of time to get to know them, would I have got into crisis? Would I have come back to hospital? (the second time)"*

Around 18 months later, Summer was in crisis again and was referred to the school nurse, who made a GP appointment for her. The GP referred her to the crisis team and she was admitted to hospital under inpatient children and young people's mental health services initially for 2 weeks. Although Summer agreed to the initial admission, after 2 weeks, healthcare professionals didn't feel she was ready to leave hospital. At this point she was detained under section 2 of the Mental Health Act.

*"I felt like I didn't deserve it and at the time, I felt like I wasn't ill and I didn't need to be sectioned. So, it was really confusing for me. I felt bad because I thought I'm taking up someone else's place in the hospital. And I felt really guilty about that... it was quite a hard time because nothing was really working for me in terms of treatments, and I ended up staying there for about 2 years. I was only discharged because I was 18, not because I was better."*

Summer describes the impact the 2-year stay in hospital had on her life:

*"I didn't do many GCSEs. When I left, I didn't know what to do because I didn't have any GCSEs and I thought no one's gonna want to give me a job and I'm not gonna be able to go to college... I felt like I wasn't a normal person of my age because I was in hospital and I missed out on all the things I thought were normal of people of my age."*

When Summer was admitted to hospital for the second time, she was referred to the Early Intervention Service (EIS). This service will see patients for a maximum of 3 years. Therefore, by the time she was discharged from hospital she only had 6 to 7 months of support left. Summer describes how the withdrawal of that support felt:

*"I felt quite helpless to be honest, I felt uncertain about what was happening... I felt like because I was in hospital I wasn't getting the support from them so I was a bit confused as to why that was included (in the 3 years)... It takes me*

*a while to get to know people and to really want to talk to them. So, it's quite frustrating because I'd only just left hospital. I'd started therapy and then it's just suddenly stopped."*

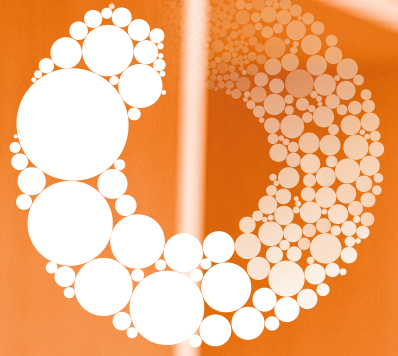
After being discharged from the EIS, Summer was referred to various adult mental health services. She describes being "passed on" from service to service for approximately 1 year before being accepted by an adult mental health team and offered ongoing support. The only support available to Summer during this time was emergency crisis support.

*"I just wanted to feel reassured in terms of, yeah, you're in the right place, we can help here, and like just feel hopeful and encouraged. So, it was quite difficult because I wasn't getting that feeling."*

Summer is now under an adult mental health team and is generally happy with the support she is receiving. She feels like she can request an appointment if she needs one, but also feels that the service isn't always as proactive with contacting her as they should be, and the changeover of staff is high. Since leaving hospital, with support from her family, Summer completed her English GCSE and enrolled in a college course.

*"If I hadn't been to hospital my life would be a lot different now. I probably wouldn't have chosen the degree I've done ... If I hadn't been in hospital some things that are important to me now wouldn't be."*

Environment



# Environment

## Key points

- The quality of inpatient environments continues to vary and we have seen examples of how ageing and poorly designed facilities affected patients' care.
- Being able to go outside brings therapeutic benefits for patients, but outdoor access varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, we also found examples of unwelcoming gardens and at some services, patients' access to outdoor spaces was limited.

The Mental Health Act (MHA) Code of Practice sets out that "patients should be offered treatment and care in environments that are safe for them, staff and any visitors, and are supportive and therapeutic."

However, in our 2023/24 State of Care report, we highlighted how a lack of resources, ageing mental health estates and poorly-designed facilities can lead to issues around privacy and dignity for patients, as well as compromise the safety of both patients and staff. Through our MHA monitoring visits, we found that the quality of inpatient environments continues to vary. We remain concerned about the impact of poor quality environments on patients.

## Ward environments

While we visited many wards that were suitable for patients' needs, we continue to see how issues with ward environments can affect people's care. As we reported last year, in some cases, these issues can lead to blanket restrictions.

We found issues in some older wards owing to the design and layout creating blind spots and ligature risks. To overcome these issues, some services used observation mirrors to cover blind spots.

As we discuss in the [Inequalities](#) section of this report, not all wards were accessible for patients with limited mobility. While a few wards had been adapted to meet the specific needs of individual patients, others had several staircases and out of reach call buttons, which made them unsuitable for wheelchair users.

Patients have a right to a suitable standard of environment, which is emphasised in respect of detained patients under the Standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. We expect inpatient environments to be well-decorated, welcoming, light, airy, clean, and homely, and many meet these expectations to some degree. However, in our 2023/24 State of Care report, we raised concerns about the environment of some mental health wards. These concerns were echoed on some monitoring visits. Where we found

issues with unwelcoming environments, we were concerned about the effect on patients' dignity and safety:

*"During our tour of the ward, in one pod's lounge, we noticed that 4 glass panels in the door leading to the courtyard and a window had been damaged. A safety film had been placed over the damaged glass. We also noticed that one window, opposite the patient's bedroom, had been boarded up. The charge nurse informed us that the damage had occurred in February 2023. The clinical matron said the damaged windows were due to be replaced on 3 May 2023."*

Most inpatient environments had single occupancy bedrooms, although not all dormitories have yet been converted or rebuilt. Nearly all bedrooms were ensuite, with an adjoining bathroom containing a shower, sink, and toilet. In a small number of cases, rooms without an ensuite and dormitory-style bedrooms shared single-sex bathrooms and toilets. Patients often personalised their rooms with decorations, bedding or photographs.

## **Security and privacy**

The MHA Code of Practice states that hospitals should provide adequate storage in lockable facilities for patients' clothing and other possessions. Most wards now have single-occupancy bedrooms that contain a lockable storage space for patients to store valuable and personal items. A few wards have lockers outside of patients' bedrooms. Where services did not offer this facility, many patients always kept their valuable items with them.

*"There was no lockable storage for patients in their bedroom areas. Patients told us they kept valuable items on their person. None of the patients reported items going missing, however most patients were in shared dormitories and felt having a space to lock items away would be helpful."*

Patients often controlled the locking and unlocking of their bedroom door. They were issued with either a wristband, key card, key fob, or key on admission to the ward. These gave patients control over entry to and from their bedroom, while also keeping personal items safe.

However, we found other examples where patients were not able to lock their bedroom doors. In some cases, this was because the same key opened all doors and keys were therefore for staff only. In others, there were no individual risk assessments for keys. Some patients told us about other patients accessing their rooms and items going missing from their bedroom because doors remained unlocked. It is important that services respect patients' privacy, and the MHA Code of Practice outlines that this encompasses the protection of their private property. In other services where

bedroom doors auto-lock on closing, we have seen examples of patients using towels to prop open doors, which can present a fire safety issue.

Many bedroom doors have viewing panels to enable staff observation without opening the door itself. Viewing panels mostly operated from inside patient bedrooms as well as outside, providing patients with privacy. In these cases, staff could override the closing of a blind when necessary. Patients in one ward could state their preference through a notice message on their bedroom door regarding how they wished to be observed. MHA reviewers found another inpatient service using an electronic light system installed outside of patient bedrooms.

*“Viewing panels were kept closed and only opened when completing observations. The ward operated an electronic light system outside each bedroom door, so that if a patient was using the bathroom, staff would know not to open the viewing panel at that time.”*

Some services use contactless monitoring systems that replace the need for physical observation through viewing panels or opening patients’ bedroom doors. This includes those known as ‘vision-based monitoring systems’ (VBMS), which are a type of data-driven digital healthcare monitoring technology. VBMS uses an infrared sensitive camera to allow non-contact monitoring of people’s vital health signs, with some models incorporating a regulated medical device.

Several campaign groups have raised concerns about the use of VBMS, arguing that this can create safeguarding issues, cause people undue emotional distress and exacerbate existing fears, leading to poor care outcomes.

Detention under the MHA provides authority for care and treatment that will, inevitably, be perceived as intrusive. Observation by staff, particularly during the night, is one of the more severe forms of such intrusion. But it is also a necessary aspect of safety on most wards and an expectation of nursing care.

## **Outdoor and kitchen access**

Being able to go outside brings therapeutic benefits for patients, and the MHA Code of Practice is clear that patients should also be able to access secure outdoor areas and a range of activities of interest. Through our monitoring visits, we found nearly all services had outdoor spaces for patients, but access to these areas varied. Outdoor areas and gardens were usually well maintained, with adequate seating, decoration, and plants, shrubs, and flowers.

In some services, patients were supported to gain independence through therapeutic outdoor activities, including growing a range of plants, flowers and vegetables:

*“There is a large allotment attached to the hospital. The [occupational therapist] for the ward co-led on the management of this space with patients. One patient on the ward worked on the allotment daily and has been responsible for many of the new developments. The allotment had a large range of plants growing including flowers and vegetables. It also had a range of animals including rabbits, chickens, birds, and a chameleon. This space expanded the range of activities available to patients to develop their independence.”*

In contrast, we found a few examples of unwelcoming gardens, particularly in high security settings. While these services have high perimeter fencing for safety, we also found insufficient seating for patients to sit outside and unwelcoming courtyards.

*“Patients had supervised access to fresh air in the 2 courtyards, but these were rather bleak and unwelcoming areas.”*

Access to outdoor and garden environments varied between inpatient services. Some inpatient services were found to have direct access to outdoor and garden environments, allowing patients to freely access these spaces at any time. At other services, outdoor space was limited or not provided:

*“The ward was located on the first floor and did not have a garden. Detained patients who did not have authorised section 17 leave had no access to an outside space and fresh air.”*

At another service, doors to outdoors and gardens were frequently locked, requiring staff to open them. Some services restricted access owing to historical safety concerns such as ligature risks and blind spots. At one service where this was the case, we recommended these risks be addressed to enable patients to go outside safely. We also visited a service where staff did not know if outdoor access should be restricted.

*“Staff appeared confused about the access patients had to the ward garden. They were unsure whether the garden door should be locked or not. Patients were unsure whether access was restricted or unrestricted.”*

Limited access to outdoor spaces was also raised as an issue by members of our Service User Reference Panel. Many panel members reported having no or limited access to outside space during their detention. One person spoke about not being allowed to use outside space on wet days, which upset them as they found being outside in the rain very calming.

The way patients spoke about the quality of food and drink, and access to it, was also mixed. At one service, many patients enjoyed the food provided and praised the level of choice and quality. At another, feedback from patients had driven improvements.

*“Patients all commented on the food, with views ranging from “ok” to “pretty good” and “very good.” One patient said that there had recently been some negative feedback about the food in the ward community meeting, but since then, the food quality had improved, with 2 or 3 choices of meals available at each meal.”*

However, several patients told us about limited choice and repetitive meals, which left them feeling hungry. Some patients also reported a lack of hot meals and limited vegetarian options, while others noted ordering takeaway meals because they felt the food provided was bland. Healthy eating is often raised as a problem in inpatient units. It is vital that services offer a range of balanced, appetising meals, not only to promote a healthy diet but also to ensure people who are detained are treated respectfully and offered choice.

Access to food and drink also varied. Services need to balance protecting people’s safety with promoting autonomy, and this variation in access to food and drink partly reflects differences in the needs and acuity of patients across services. Access to hot water must be risk assessed. Where these risk assessments demonstrate access to hot water must be limited, we expect services to ensure they follow the least restrictive approach and regularly review this so that the restrictions remain appropriate for the patient group.

Most services enabled patients to access food and drink independently, with people able to make their own hot and cold drinks throughout the day. Some inpatient environments also encouraged patients to cook for themselves, developing independent living skills in the process. Patients reported how cooking for themselves gave them a sense of pride.

*“The unit was recovery-orientated. One patient said, “The staff encourage people to be independent here.” Patients assisted staff with shopping for, and the preparation of, communal meals. Patients told us proudly how they had learned to cook meals for everyone.”*

However, on some visits we found kitchens were not open to patients and patients had to ask staff for access:

*“The kitchenette was locked, with patients needing to ask to be able to get their own food from the cupboard or ask staff to prepare them a hot drink. The kitchenette had staff tea and coffee making facilities and storage for staff food, which gave the room the feel of being a staff resource rather than a clinical area.”*

## Restrictive practices

In recent Monitoring the Mental Health Act reports, we have highlighted the progress made by some services in reducing unnecessary restrictive practices and creating therapeutic environments for patients. While we continue to find examples of providers reviewing restrictions to ensure they remain necessary for patients’ safety, we remain concerned about the volume of instances where restrictive practices are used.

Mental health inpatient settings report occurrences of restrictive practice through the Mental Health Services Data Set (MHSDS). The level of reporting has increased in inpatient settings, which could reflect better reporting practices across providers. But at the same time, it could reflect that more people are being restrained and more types of restraint are being used. In 2023/24, on average, restrictive practices were reported over 14,200 times per month, a 4% increase from the previous year. Each reported incident could involve a range of restrictive interventions, and an individual might experience multiple interventions per month. On average, each month over 2,900 people were reported to be subject to restrictive interventions.

We recognise that restrictive practices are appropriate in limited, legally justified and ethically sound circumstances in line with people’s human rights. But our expectations are clear: everyone working in health and care has a role to play in reducing the use of restrictive practices. Wherever restraint, seclusion or segregation is perceived to be the only safe option, providers must consider whether the services provided meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point.

Staff in many services were trained in methods of restraint. This included verbal de-escalation, physical restraint, chemical restraint and the prevention and management of aggression. Despite this, some staff members were observed using inappropriate language towards already distressed patients. This may infer a lack of staff training on how to interact with patients.

However, almost all highlighted shortcomings around training for new and permanent staff were already being corrected, with MHA reviewers assured that training was either completed, ongoing, or due to start soon.

Sometimes, issues with ward environments can increase the risk of blanket restrictions, meaning that access to areas is restricted for all patients,

despite not all patients needing this level of restriction to keep them safe. In 2023/24, we found blanket restrictions were uncommon. Staff at most services reviewed restrictions regularly to ensure they remained proportionate.

In many cases, services were able to give us a clear rationale for the restrictions they impose. However, we continue to find examples of unnecessary restrictions and measures that did not support patients to be independent, such as locking doors to certain rooms:

*“At the time of our visit the doors to the sensory room, the therapy kitchen, the laundry room and the garden were all locked and patients could only access these areas under staff supervision. The rationale for these blanket restrictions was not recorded on a restrictions register.”*

The MHA Code of Practice has numerous requirements for seclusion rooms or areas, including:

- allowing for communication with the patient when the patient is in the room and the door is locked, for example, through an intercom
- having limited furnishing, which should include a bed, pillow, mattress and blanket or covering
- having no apparent safety hazards
- having no blind spots
- always having a clock visible to the patient within the room
- providing access to toilet and washing facilities.

Most seclusion rooms within inpatient environments met the MHA Code of Practice guidelines. We sometimes see rooms where furnishings such as the bed have been removed on grounds of safety, leaving just a mattress. Such interventions need to be carefully considered against individual risks, with suitable patient support, and should not become normalised. Some seclusion rooms also needed repair and cleaning. For example, we found instances where rooms had doors that couldn't be locked, hazardous screws not flush with the wall, broken locks and scratched windows, which made observations difficult.

On some visits, services told us they rarely use seclusion as an intervention and one ward won a trust 'Gold Ward' rating for not using seclusion for 2 years and having no instances of restrictive interventions in 2 months.

It was promising to find staff using a range of strategies, including verbal de-escalation and staff support to reduce the need for restrictive interventions.

*“Each patient had an individualised de-escalation ‘grab bag’ which the patient had been involved in creating. The bag included sweets, fidgets and other items that were helpful in calming the patient if they found their levels of agitation or anxiety were increasing.”*

However, some staff lacked training or space to safely restrain patients on the ward. In these environments, patients were transferred off-ward to more restrictive settings. Patients would be returned to the inpatient service when a bed was available.

*“We were informed that staff were not trained in using restraint and there was no space to do so safely. If patients were to become acutely unwell and physically aggressive, they would be transferred to other wards, such as [ward], a more restrictive rehabilitative setting, an acute ward, or psychiatric intensive care ward. Such transfers could be temporary, pending a return to [ward] when a bed was available.”*

## **Single-sex accommodation**

In our 2023/24 State of Care report, we highlighted a concerning rise in the number of mixed sex accommodation breaches, which have safety implications for patients. People affected by mental ill health can sometimes act in disinhibited ways or may lack the mental capacity to make sound decisions about relationships. They may also have experienced abuse in the past, which might have contributed to their mental ill health, and could leave them at risk of being exploited by others.

The Mental Health Act Code of Practice highlights that women-only environments are important because of this increased risk of sexual and physical abuse, and previous trauma. It also states that consideration should be given to the needs of transgender patients.

Although inpatient environments were generally segregated by sex in line with the MHA Code of Practice, often with single-sex areas such as female-only lounges, some wards did not adhere to this requirement. Several services did not provide functioning and accessible women-only spaces. In some cases, single-sex spaces had issues with their locking systems or were used for other purposes. We also heard from some female patients who did not feel safe or supported when staying on mixed-sex wards.

*“When asked if they felt safe on this ward, 2 female patients said that they would have preferred to be on an all-female ward as they said they felt frightened sometimes when male patients were shouting on the ward.”*

At another service, technology was used to ensure sex segregation was maintained, with patients given electronic fobs that allowed them into the relevant corridor.

The NHS Constitution is clear that people admitted to hospital will not have to share sleeping accommodation with patients of the opposite sex. It has been mandatory for providers to report all mixed sex accommodation breaches since 2011.<sup>27</sup> In 2023/24, in all care trusts, community trusts and mental health providers, there were 292 mixed-sex accommodation breaches, compared with 250 breaches in 2022/23.

Alongside this increase, research published in 2024 shows a concerning rise in the number of sexual safety incidents, including sexual assaults, in mental health wards.<sup>28</sup> We have raised concerns about this for a number of years. In 2018, our Sexual safety on mental health wards report warned that people who use mental health inpatient services did not always feel that staff kept them safe from unwanted sexual behaviour. It also found ward environments did not always promote sexual safety for people using services.<sup>29</sup>

# Our regulatory activity in 2023/24

## MHA monitoring visits

We carried out 823 MHA monitoring visits and spoke with 4,634 patients (3,343 in private interviews and 1,291 in more informal situations) and 1,435 carers.

## Second opinion appointed doctor service

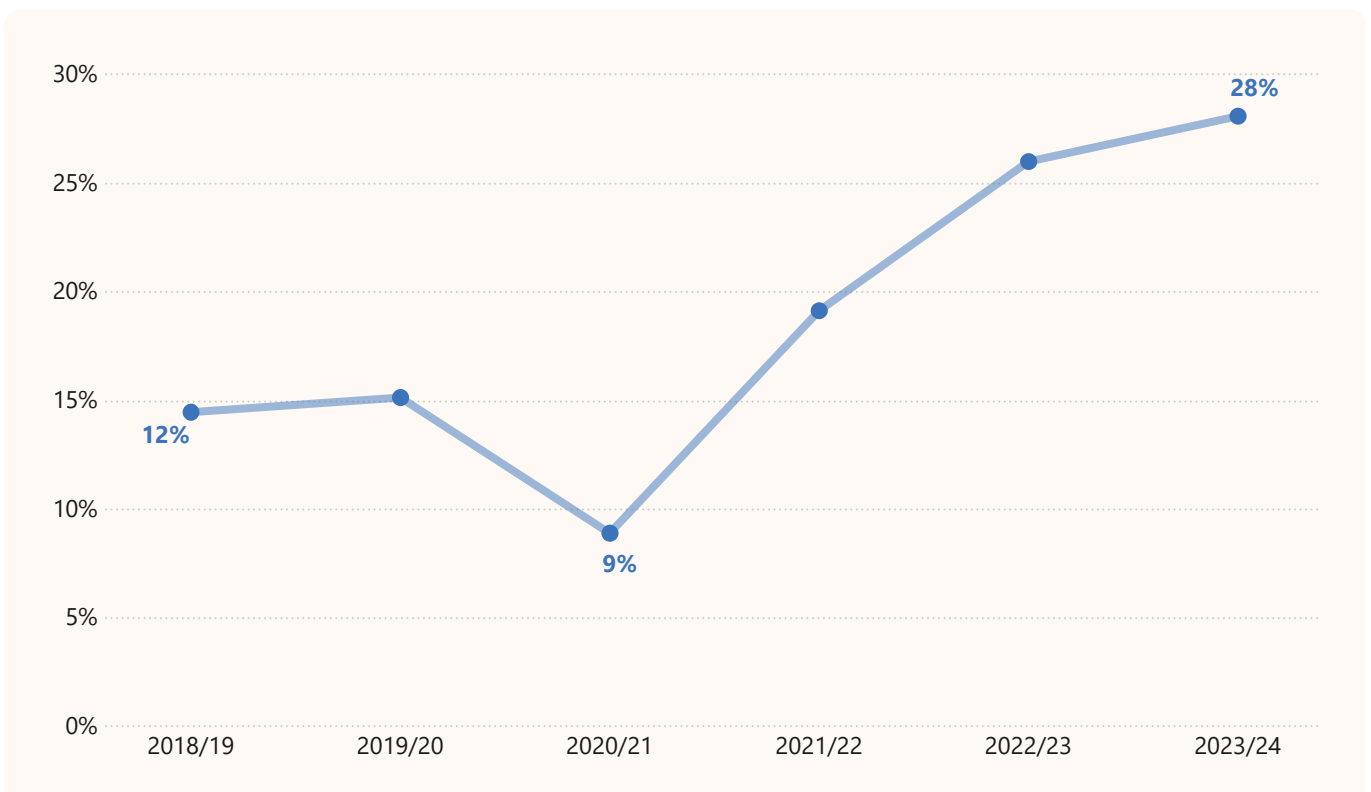
We received 15,698 requests for a second opinion appointed doctor (SOAD), which is similar to volumes received each year since 2020/21. Of the requests, 90% were for patients detained under the MHA.

Just over a quarter of all requests received were subsequently cancelled (28%; 4,402).

The number and proportion of total requests cancelled has generally increased year-on-year since 2017/18 (except for the dip in 2020/21), although the increase from 2022/23 to 2023/24 was much smaller than previous years (figure 3).

The most common reason for cancellation was due to the patient being discharged, which accounted for over a third of all cancellations (36%).

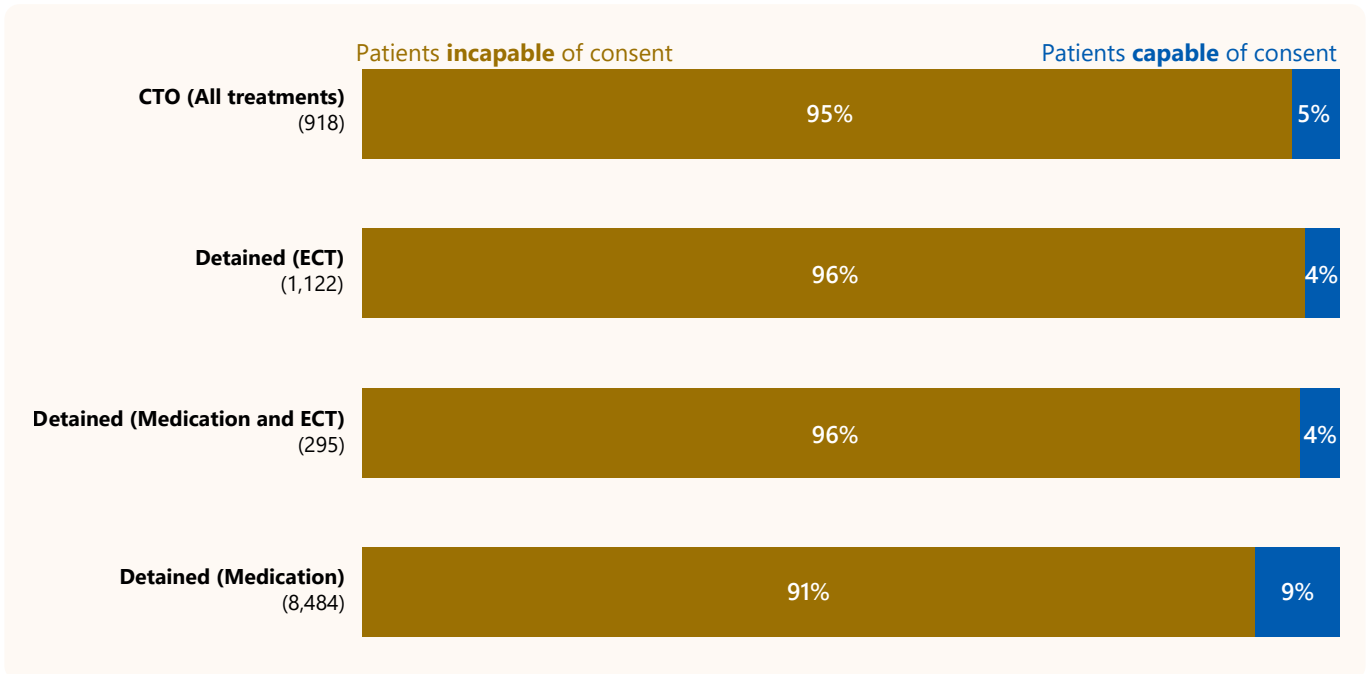
Figure 3: Percentage of total requests cancelled, 2018/19 to 2023/24



Source: CQC

Most requests were made for patients recorded as having no capacity to consent (92%, 9,986). For detained patients on medication, 9% of requests were for patients recorded as being capable of consent and refusing treatment (figure 4).

Figure 4: Patient capacity by treatment type, 2023/24



Source: CQC

Treatment plans are subject to change following review by a SOAD. They 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.

A SOAD can decide not to certify the proposed treatment if, in their view, this is not appropriate. The patient's circumstances may also change before the SOAD has completed their second opinion, meaning their certificate is no longer required, for example if the doctor in charge decides the treatment requiring certification is no longer necessary or the patient is discharged.

In 2023/24, following review of treatment plans by a SOAD:

- 77% were not changed
- 18% were slightly changed
- 3% were significantly changed.

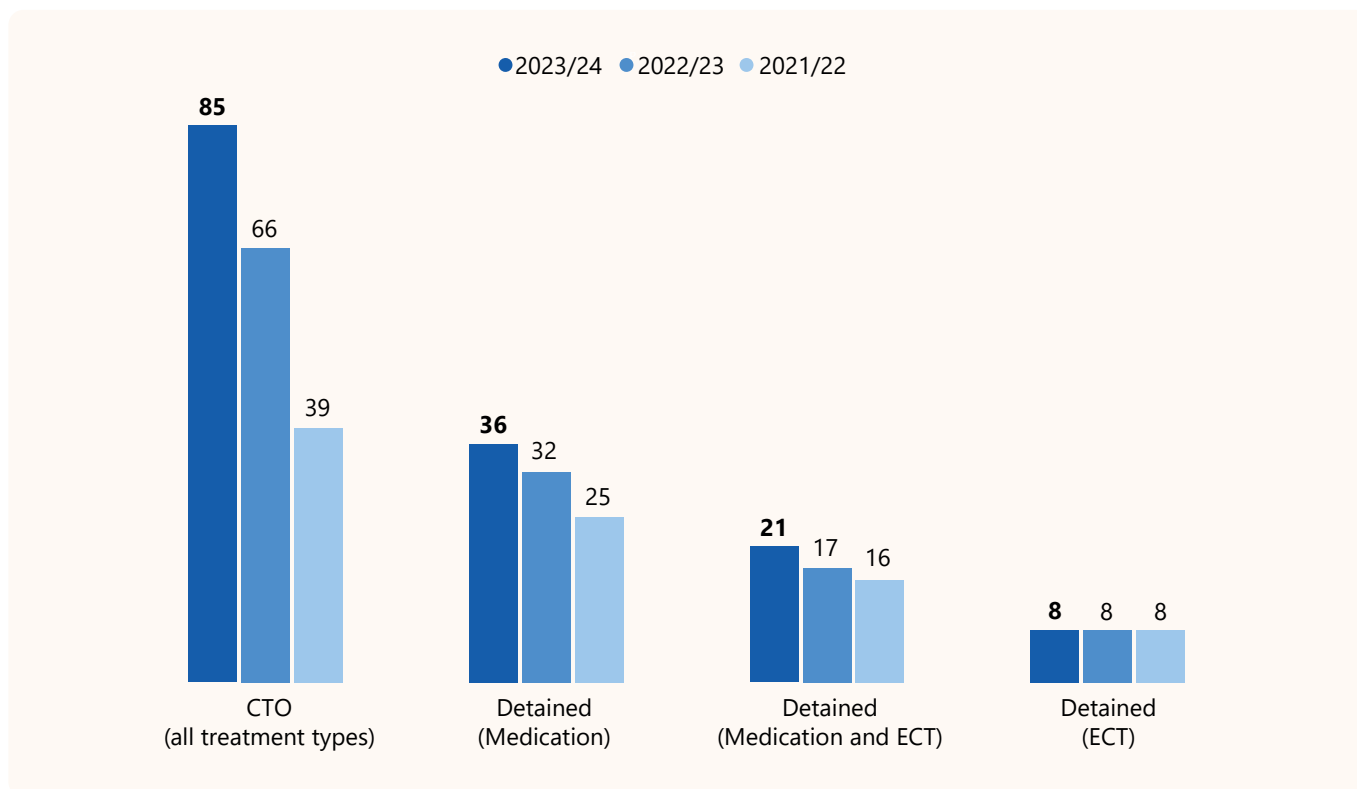
Treatment plans were most likely to change for detained patients receiving medication, either alongside ECT or receiving medication only (see [section on the Second Opinion Appointed Doctor service](#)).

The length of time between receiving a request and the appointed SOAD starting their second opinion continued to increase. The average number of days for both patients subject to a community treatment order (CTO)

and detained patients in 2023/24 was 37 days, compared with 33 days in 2022/23. The most notable increase was for patients subject to a CTO, which saw an increase of 19% compared with 2022/23 (85 days in 2023/24 compared with 66 in 2022/23), (figure 5).

SOADs continue to carry out second opinions both remotely and in person.

**Figure 5: Average number of days to SOAD starting second opinion**



Source: CQC

Note: Figures for 2022/23 in this chart are different to those included in the 2022/23 MHA report, as data has since been updated

## Absence without leave (AWOL) notifications

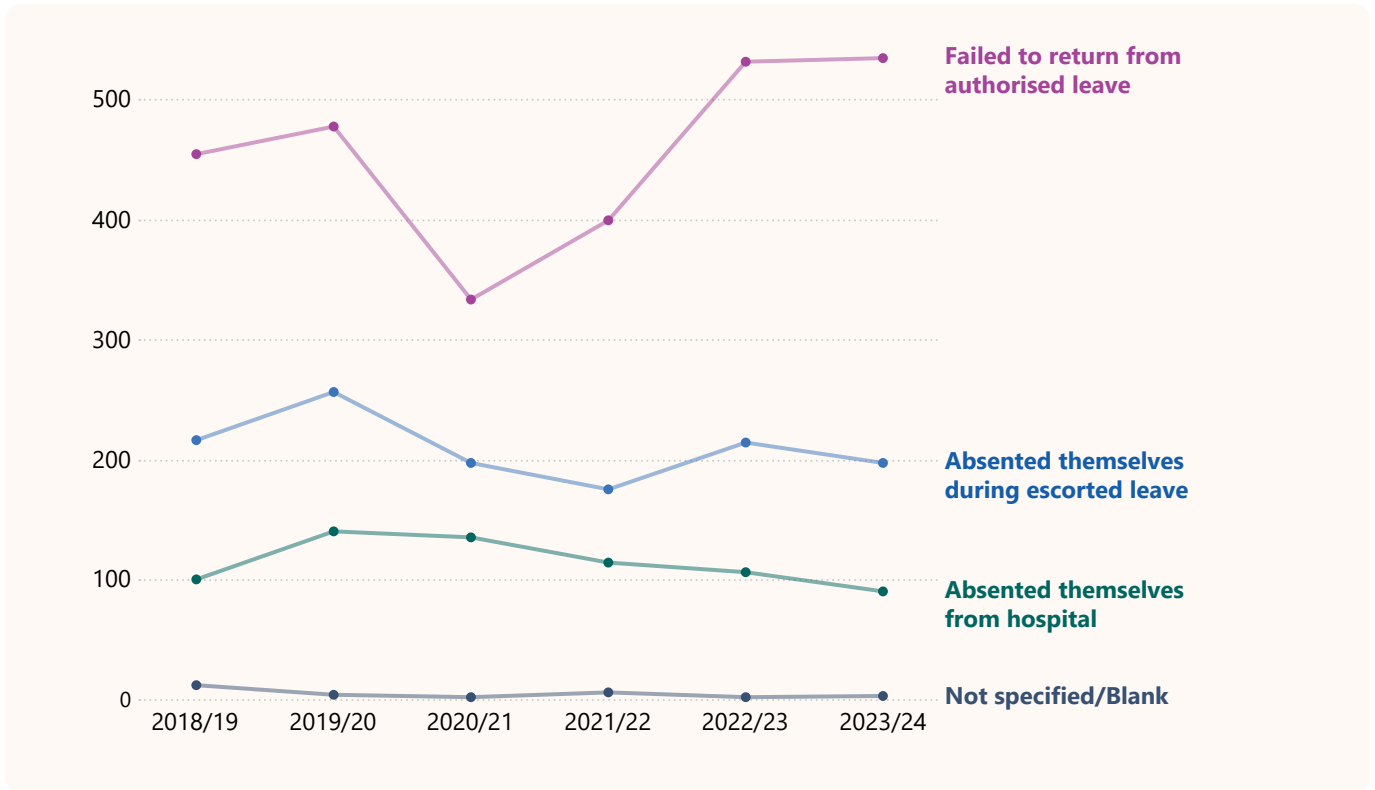
In 2023/24, we were notified of 824 incidents of a detained patient being absent without leave. This was similar to the number of notifications in 2022/23 (853) following a drop in numbers during the pandemic.

### Reason for AWOL notification

The most common reason for AWOL notifications was “Failed to return from authorised leave” (see figure 6). There were fewer notifications with this reason during the pandemic, but numbers have since risen.

For the other reasons provided (“Absented themselves during escorted leave”, and “Absented themselves from hospital”), numbers of notifications have remained more stable.

Figure 6: Reason for AWOL notifications, 2018/19 to 2023/24



Source: CQC AWOL notifications data

Note: The total each year includes patients who were AWOL on more than one occasion.

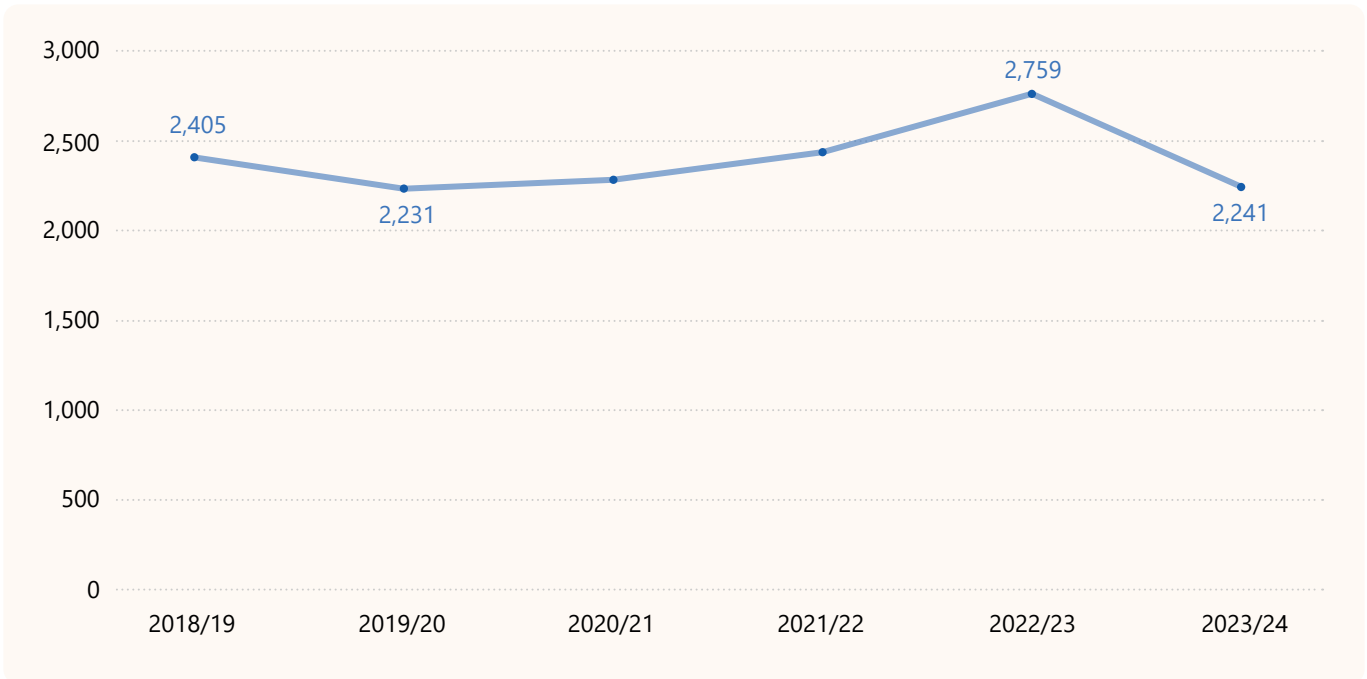
Male patients are more likely than female patients to have an incident of being absent without leave. Of the 824 incidents where a detained patient was absent without leave, 733 notifications recorded the patient’s gender, of these, 79% were males.

### Complaints data

CQC has a discretionary duty under section 120 of the MHA to investigate complaints relating to the care and treatment of people who are, or have been, subject to the formal powers of the Act.

In 2023/24, the number of complaints and contacts received through the MHA complaints system (2,241) reduced by 19% compared with 2022/23. However, this number was comparable with volumes received in previous years, before the increase in 2022/23 (see figure 7).

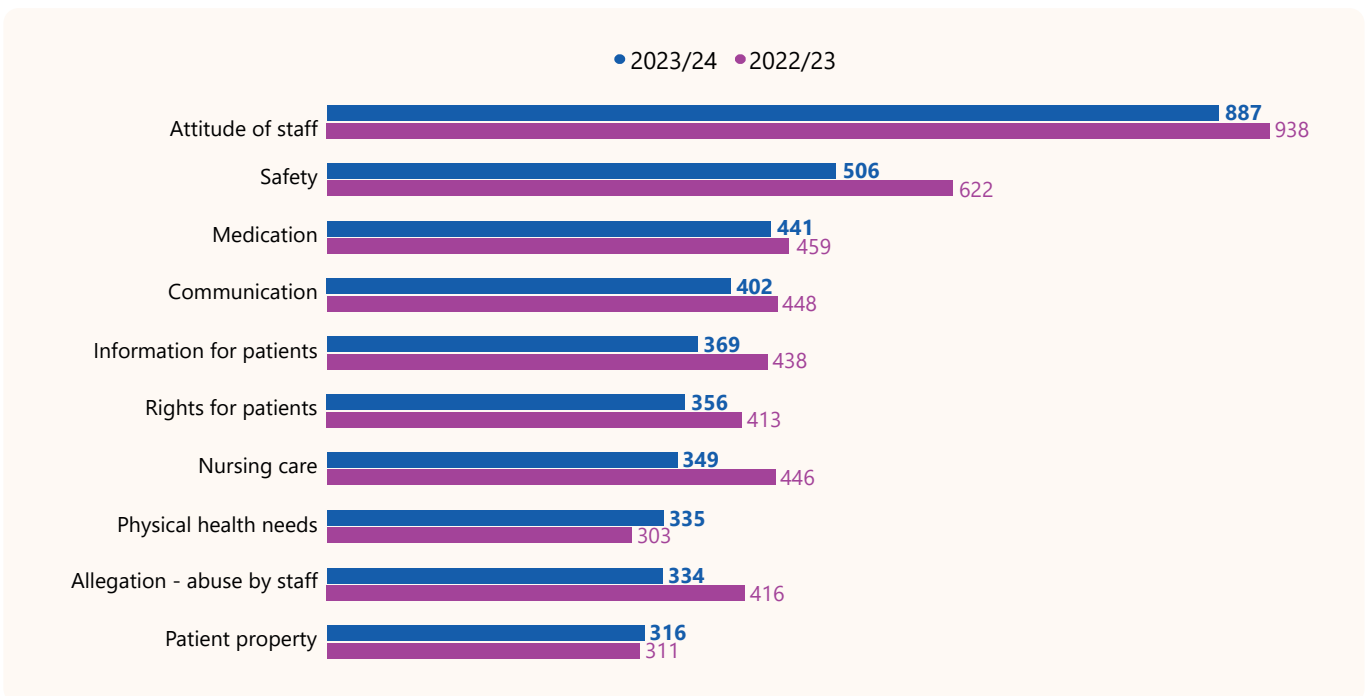
Figure 7: Total complaints received 2018/19 to 2023/24



Source: CQC

The largest proportion of complaints (43%, 887) were in relation to the attitude of staff, followed by safety (25%, 506), (figure 8).

Figure 8: Number of complaints by category



Source: CQC

Note: A single complaint can be assigned to more than one category, therefore the figures above total more than the overall number of individual complaints.

Most complaints and contacts were made by telephone (95%), which was similar to last year (94%).

## Investigations of complaints

We investigated 10 complaints in 2023/24. These in-depth investigations were carried out by MHA reviewers when complainants contacted CQC after they were not satisfied with the responses received from initial complaints investigations by the mental health trust or independent hospital to which they had first complained.

Across the 10 investigations, we looked at 33 concerns raised by complainants. We upheld fully 15 of those concerns raised and partially upheld 10. The concerns we fully upheld included:

- the length of time a provider's complaints handling process took to complete
- inappropriate use of the urgent treatment provisions of the Act (section 62)
- detaining a young person on an adult medical ward for 11 months because a more suitable placement or hospital setting could not be found
- not conducting a MHA assessment appropriately, and not empowering and involving the person in their assessment in a suitable manner
- not providing information to a person detained under the Act and their nearest relative about their legal status and rights as required by section 132 of the Act.

When we uphold complaints, we make recommendations for action that providers should take to learn from the issue and to improve. Following our investigations of complaints during 2023/24, the following are some examples of action taken in response to the recommendations:

- A mental health trust apologised for delays in its complaints investigation process. The trust reviewed and updated its process to bring it in line with new national guidance and to speed up the process.
- A mental health trust reviewed its processes relating to urgent treatment and provided updated guidance to its medical staff.
- Another mental health trust apologised for failing to ensure a young person was cared for in the most suitable environment and subsequently carried out a serious case review following our investigation. In the same case, an acute hospital trust apologised for any distress caused to the young person while being cared for in its hospital. The acute trust took action to improve its care and treatment of young people who have an eating disorder to avoid other patients having a similar experience.
- A local authority, a mental health trust and an acute hospital trust gave an apology for any distress caused by the failure to meet the needs of a person during their MHA assessment. All 3 organisations took action to improve communication and joint working between the liaison psychiatry team, the approved mental health professional team and ward staff of the acute hospital trust.

- Similarly, a mental health trust, a local authority and an acute hospital trust all took action to review and update their policies and practice to ensure people are informed of their rights.

## Notifications of deaths of detained patients and patients subject to a community treatment order

During 2023/24, we were notified of 288 deaths, of these:

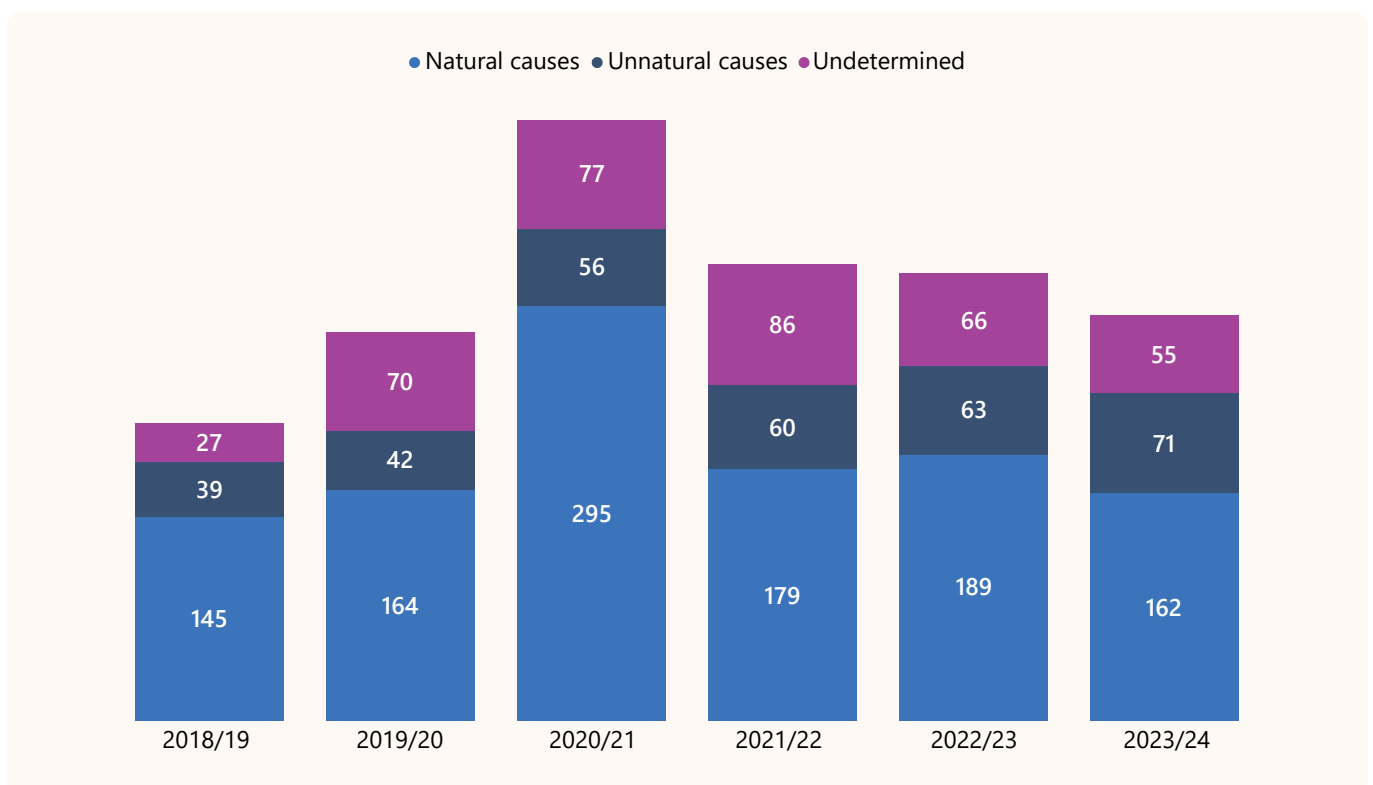
- 225 were detained patients
- 63 patients were subject to a CTO.

Reporting of CTO deaths is not compulsory, therefore figures may be underestimated.

Of the 288 deaths:

- 162 were from natural causes (a result of old age or a disease, which can be expected or unexpected)
- 71 were from unnatural causes (a result of an intentional (harm to self or by another individual) or unintentional (an accident) cause)
- 55 are currently undetermined (the cause of death has not yet been determined by a coroner or CQC does not hold information on cause of death).

Figure 9: Deaths of detained patients and patients subject to a community treatment order, 2018/19 to 2023/24



Source: CQC

For patients in detention and those subject to a CTO in 2023/24:

- of the 162 deaths from natural causes, the most common cause was heart disease (31 deaths)
- of the 71 deaths from unnatural causes, the most common cause involved ligatures (18 deaths).

A higher proportion of patients who died in detention were male (61%), compared with 51% of all people who were detained. Rates of detention were slightly higher for males (91.4 per 100,000 population) than females (83 per 100,000 population).

During the year, 8 young people died while detained. All these deaths were reported to be of unnatural causes except for one person whose cause of death is currently undetermined. Six of these deaths involved ligatures.

Regarding absence without leave or while on leave:

- 11 deaths were reported of detained patients who were absent without leave (AWOL) (5%). Of these deaths, 8 were reported as unnatural causes, 2 of natural causes and one is currently undetermined. Seven people who were absent without leave when they died originally had authorised leave. All but one of these was of unnatural causes, with one currently undetermined.
- 52 deaths were of detained patients who were on leave (23% of deaths of detained patients). Of these deaths, 19 were of unnatural causes.
- 21 deaths were of detained patients who were on escorted leave (9%). Of these deaths, 14 were of natural causes. The purpose of leave for the majority of these 21 patients was being transferred to an acute hospital or emergency department. Only one patient was confirmed to have absconded from their escorted leave before their death.

There were 4 deaths of detained patients who had been secluded (2%). Of these deaths, 3 were of unnatural causes and one is currently undetermined.

There were 13 deaths of detained patients who had experienced control or restraint within 7 days of death (6%). One notification directly described the restraint of a patient prior to their death, which was from natural causes. Six deaths were from unnatural causes.

# Appendix A

## First Tier Tribunal data

The First-Tier Tribunal (Mental Health) has provided its activity and outcome statistics for the year 2023/24. The Tribunal is responsible for handling applications to discharge patients detained in psychiatric hospitals. It also handles applications to change community treatment orders and the conditions placed on a 'conditional discharge' from hospital.

The overall activity of the Tribunal remains relatively constant year on year.

Rates of discharge are consistent with past years. Comparing the data for 'total discharge by Tribunal' against 'no discharge', the Tribunal discharged patients in about 10% of its decisions relating to detention overall. Around 30% of appeals by restricted patients 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. For detentions other than those subject to restriction orders, patients detained under the assessment and treatment power (section 2) continue to be roughly twice as likely to successfully appeal as patients detained under treatment powers (section 3 and unrestricted hospital orders) (figure 10).

Initially in response to Covid-19 restrictions on movement, from 2020 the Tribunal has heard cases primarily using video technology rather than sitting in person at the relevant hospital setting. The use of remote hearings has shown no effect in rates of discharge. There is likely to be a major increase in Tribunal activity as a result of the proposals of the Mental Health Bill 2025, as these reduce the length of time that must pass before a patient can make an application, and will create much more frequent automatic applications for some patients. It is likely that continued and potentially increased use of remote hearings will be key to the Tribunal ever meeting this increased demand, which will enable the Bill's proposals to be implemented.

**Figure 10: Outcomes of applications against detention to the first-tier Tribunal (Mental Health), 2023/24**

		Section 2	Other unrestricted	Restricted	All detained patients
Activity of Mental Health Tribunal	Applications	9,804	15,474	3,079	28,357
	Withdrawn applications	1,155	3,695	1,013	5,863
	Discharges by clinician prior to hearing	3,522	5,649	14	9,185
	Cleared at Hearing <sup>a,b,</sup>	7,054	11,035	2,273	20,362
	Heard <sup>c</sup>	6,472	8,046	2,275	16,793
Decision of Mental Health Tribunal	Absolute Discharge	373	320	84	777
	Delayed Discharge	223	112	1	336
	Conditional Discharge	0	0	364	364
	Deferred Conditional Discharge	0	0	91	91
	Total discharge by Tribunal	596	432	540	1,568
	No Discharge	4,703	8,221	1,260	14,184

- a. The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.
- b. Mental Health Tribunal is unable to distinguish CTO hearings disposed from the total number of other unrestricted hearing disposals.
- c. Includes all cases heard irrespective of outcome including adjourned in the reporting period.
- d. This data is based on all decisions both before and after the hearing.

Source: HM Courts and Tribunal Service

Just under 4% of decisions in relation to CTOs discharge the patient. This is generally less successful than detained patients overall, but only marginally less when compared with the 'other unrestricted' detained group, which may be the most appropriate comparison.

**Figure 11: Outcomes of applications against CTOs to the first-tier Tribunal (Mental Health), 2023/24**

Applications	4,438
Withdrawn applications	827
Hearings	4,168
Oral Hearings <sup>a</sup>	3,616
Paper Reviews (considered on papers and therefore patient not present)	552
Discharges by Tribunal	129
No discharge by Tribunal	3,173

a. The category 'oral hearings' is based on the total number of hearings less the manual count of paper reviews.

Source: HM Courts and Tribunal Service

Note: Although care is taken when processing and analysing the data, this can change over time as the information is taken from a live system.

# Appendix B

## CQC as a part of the UK 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 carry out 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 in monitoring the MHA.

Being part of the NPM brings both recognition and responsibilities. The powers of NPM members 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 co-operate and support each other internationally.

The Association for the Prevention of Torture, an international Non-Governmental Organisation 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.

- Co-operation 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.

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The Care Quality Commission is a member of the UK's National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.



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