Monitoring the Mental Health Act

in 2024/25

Care Quality Commission

Monitoring the Mental Health Act in 2024/25

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Foreword

The Mental Health Act 1983 (amended 2025), which received royal assent in December 2025, marks a significant moment of change in mental health care reform. Many of the issues highlighted in this year's report support the key drivers for change – including poor patient experience, racial disparities in detentions and community treatment orders, and the particular disadvantages felt by autistic people and people with a learning disability.

As an organisation, we remain committed to raising awareness and driving improvements for people detained under the Mental Health Act (MHA). This report is an important vehicle that allows us to amplify the voices of the thousands of patients, family members and carers we engage with during our MHA monitoring work. These conversations, as well as those with advocates and staff, contribute to the improvements we request providers to make for people in their care. In 2024/25 alone we issued well over 3,000 actions.

People who use health and care services need to be empowered to understand their rights. It is also vital that the care they receive is person-centred and that they are given the opportunity to fully participate in decisions about their care and treatment. Sadly, through our monitoring activity, we continue to see examples where people feel their rights were poorly explained or that their individual needs were not considered.

In 2023, we set out our expectations that, in all services, providers promote positive cultures which support recovery, engender trust between patients and staff, and protect the safety and wellbeing of all patients and people who use services. This includes respecting all patients' rights, providing skilled, trauma-informed therapy, that follows the principle of least restriction, and promotes recovery.

Everyone working in health and care has a role to play in reducing the use of restrictive practices. However, the data shared in this report points to a picture of increased use.

The use of restrictive practices continues to be a particular concern for autistic people and people with a learning disability. Findings from our Independent Care (Education) and Treatment Reviews (IC(E)TRs), described in this report, highlight how personalised adjustments have not always been assessed and integrated into people's care to support them to progress out of segregation. We therefore welcome the Department of Health and Social Care's decision to extend this important piece of work until March 2028, enabling us to support more autistic people and people with a learning disability to leave long-term segregation.

This report also highlights our ongoing concerns about systemic inequalities relating to people's ethnicity. In 2024/25, people of Black or Black British ethnicity were over 8 times more likely than those of White British ethnicity to be subject to a community treatment order. People of Black or Black British ethnicity also experienced a 26% increase in community treatment orders between 2023/24 and 2024/25. And the rate of detention for people of Black ethnicity was nearly 4 times the rate for White people, with Black working-age adults experiencing longer inpatient stays compared with White people.

This year, we have continued our work to address these persistent inequalities in mental health care. This includes publishing our guide on how we will assess against the Patient and carer race equality framework (PCREF). This is the first anti-racism framework for mental health trusts and mental health service providers, and forms part of our commitment to tackling inequalities and protecting people's human rights.

However, we are concerned that, even though the framework is now mandatory across NHS mental health trusts and services, awareness appears to be poor. During over 100 of our monitoring visits (to locations and wards) in the first 3 months of 2025, when we asked about PCREF, staff in more than three-quarters (77%) of services said they had not heard of it, and staff in only 8% of these services said they had received specific training, support or information on it since November 2023. We will continue to encourage services to embed PCREF through our regulatory and monitoring activity, and will be checking how services use the framework as evidence to inform our assessments.

The challenges facing people who use mental health inpatient services need to be viewed within the context of wider pressures on the system. As reported previously and reiterated in our 2024/25 State of Care report, demand for mental health services continues to grow. But this year, we have heard from providers how people's needs are also becoming increasingly complex. This, combined with persistent lengthy waits for care, means that patients are often more unwell when they are admitted to hospital.

Ongoing systemic issues with recruitment and retention of mental health staff mean that people are not always getting the person-centred care they need. Patients have told us they see staff who are caring and working hard to keep people safe, but that low staffing levels can prevent staff from being able to carry out their roles, leaving patients feeling unsafe and having a negative effect on their recovery.

Once people are deemed ready to leave hospital, challenges around collaboration and funding and the inconsistent provision of community care can leave them without the proper care and support they need after being discharged from hospital, increasing the risk of being readmitted.

We have a long way to go to meet the needs of people with mental health issues. We remain committed to raising awareness and driving improvements so that everyone can access the care they need. We look forward to continuing to work closely with the government and other stakeholders on the implementation of the Mental Health Act 1983 (amended 2025) to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout their treatment.

Chris Dzikiti
Interim Chief Inspector of Mental Health

Summary

This report presents the findings from CQC's regulatory activity during 2024/25 of our statutory work under the Mental Health Act 1983 (amended 2025). We report on what we found through engaging with people who are subject to the MHA as well as a review of services registered to assess, treat and care for people detained under the MHA.

The MHA is the legal framework that provides authority for hospitals to detain and treat people who have a mental illness and who need protection for their own health or safety, or the safety of other people. The MHA also provides other more limited powers related to community-based care, 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 of their care that need to improve.

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

- providing a second opinion appointed doctor (SOAD) service
- reviewing complaints relating to use of the MHA
- making 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 services to take 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.

Key points

Demand and system pressures

- Demand for mental health care has continued to rise throughout 2024/25, with an average of 453,930 new referrals to secondary mental health services every month.
- Our Mental Health Act (MHA) reviewers are finding that people are becoming more unwell before they are referred for assessments under the MHA, and are also waiting longer to be assessed meaning they are often more unwell when they are admitted to hospital. This can be worse for certain groups of people, such as those living in areas of deprivation.

- Between 2023/24 to 2024/25, we have seen a 17% increase in the use of community treatment orders, compared with an increase of 9% in the previous year.
- On average in 2024/25, the bed occupancy rate (for all mental health overnight beds) has remained above the recommended 85% threshold at 90%. Providers have told us about higher thresholds for admission, delayed discharges and fewer available beds adding to this pressure and the difficulties for people in getting hospital care.
- Inconsistent provision of community care, the need for better funding of mental health services and challenges around collaboration and communication between services can leave people without the proper care and support they need after being discharged from hospital, and can increase the risk of being readmitted.

Staffing pressures and the impact on care

- We are continuing to see systemic challenges in the recruitment and retention of staff, with 9% of roles in mental health trusts in the NHS unfilled in March 2025.
- Recruitment and retention issues are leading to significant challenges around staff experience, skills and competencies, which are exacerbating pressures on services and staff themselves, as they are feeling burnt out and overworked.
- Although some wards have had good levels of staffing with approachable and attentive staff, we have found ongoing challenges around low staffing levels. This can leave people feeling unsafe and have a negative effect on their rehabilitation and recovery.
- Patients often described staff as being caring and working hard to keep everyone safe on the wards. However, our MHA complaints data highlights ongoing concerns around the attitude of some staff, as nearly half of the 2,552 MHA complaints received in 2024/25 included concerns related to the attitudes of staff.

Environment

- We continue to be concerned that pressures in the system and a shortage of beds are leading to people being held for long periods in inappropriate environments such as urgent and emergency care, or being admitted into or kept in services where they experienced more restrictive conditions than they require.
- The number of inappropriate out-of-area placements that were started increased by 5% between 2023/24 and 2024/25. Too many people are still being placed in hospitals far from home, as 5,649 placements started in 2024/25 were out of the patient’s local area.

- While we have seen positive examples of clean, tidy wards that supported people's needs, we continue to see issues in wards on our visits, including problems with the layout, noisy environments and concerns around hygiene and cleanliness.
- Different levels of patient acuity could affect how safe patients felt on the ward, as the presence of patients who were extremely unwell added to the environment feeling busy and unsettling.

Quality and safety of care

- We often saw that staff listened to patients' concerns and involved them in decisions about their care. However, some care plans did not consider the patient's individual needs.
- Although our Independent Care (Education) and Treatment Reviews (IC(E)TRs) highlighted the value of staff who are able to adapt to support people's changing requirements to reduce some of the harm of being in long-term segregation, personalised adjustments were not always assessed and integrated into people's care to support them to progress out of segregation.
- Services that respect human rights are fundamental to good outcomes for people. However, we are concerned that too many people, especially those on wards for older people and those who do not have the capacity to understand their rights, are being unlawfully detained.
- Everyone working in health and care has a role to play in reducing the use of restrictive practices. However, the average number of reported restrictive interventions each month increased between 2023/24 and 2024/25.
- We saw how low levels of staffing on some wards meant that access to areas such as bedrooms, kitchens, gardens, living spaces, and bathrooms was restricted, and patients said this had an impact on their recovery. To reduce restrictive interventions we have seen examples of using technology to keep people safe, while giving people who are sectioned some control over their lives.

Inequalities

- Many services ensured their staff had completed mandatory training in learning disability and autism. However, some staff, especially agency and bank staff, were seen to lack the right skills, as patients reported being unsupported, misunderstood, or spoken to in ways that felt undignified.
- There is still variation across wards in the confidence of providing support to lesbian, gay, bisexual, and transgender patients.
- We continue to be concerned about systemic inequalities relating to people's ethnicity. In 2024/25, people of Black or Black British ethnicity were over 8 times more likely than those of White British ethnicity to be subject to a community treatment order. People of Black or Black British ethnicity also experienced a 26% increase in community treatment orders between 2023/24 and 2024/25.

- The Patient and Carer Race Equality Framework (PCREF) aims to support NHS trusts to become actively anti-racist organisations. It is now mandatory across mental health trusts and providers of mental health services that receive NHS funding. However, during 103 monitoring visits (to locations and wards) between January and March 2025, staff in more than three-quarters (77%) of services said they had not heard of PCREF.
- A continuing concern is that people living in areas of deprivation are more likely to experience inequalities – for example, people living in the most deprived areas were 3.6 times more likely to be detained under the MHA than those in the least deprived areas.
- The number of children and young people (under 18) awaiting a first contact following referral to NHS mental health services increased by 20% between 2023/24 and 2024/25, rising from a monthly average of 237,590 and 285,510 (both values are a 3-month rolling total). Over the same period, the median monthly waiting time increased by 65% from 175 days in April 2023 to 288 days in March 2025.

Evidence used in this report

This report is based on analysis of the findings from 635 MHA monitoring visits carried out during 2024/25. This involved speaking with 3,642 patients (2,771 in private interviews and 871 in more informal situations) and 717 family members or carers. We also spoke with advocates and ward staff.

We also consider the content of 3,248 actions that we requested providers make to improve, based on concerns found on our visits.

Our analysts carried out a focused qualitative review of a sample of all monitoring reports from 2024/25 (40% of reports from each primary type of service). We looked into these findings further through a series of focus groups with MHA reviewers, second opinion appointed doctors, our Service User Reference Panel and our MHA Complaints team.

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 monitor 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 or concerns submitted to us about the way providers use their powers or carry out their duties under the Act. We completed qualitative analysis on a sample of 150 complaints, spread across the 10 most common categories of complaints, to give us a deeper understanding of the concerns people were sharing with us. 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.

In this year's report, we also use evidence from relevant programmes of work within CQC:

- **Independent Care (Education) and Treatment Reviews (IC(E)TRs) programme:** CQC was commissioned by the Department of Health and Social Care to carry out a series of IC(E)TRs, which review the care of autistic people and people with a learning disability who have been detained in long-term segregation. This report includes evidence from qualitative analysis of a sample of 37 IC(E)TR reports (dated May 2024 to May 2025) that look at different areas of

people's care in long-term segregation such as quality of life, future planning, and recommendations for providers and stakeholders involved in a person's care to improve their care and help them to move out of long-term segregation. We also include evidence from a focus group with internal experts.
- **Adult community mental health inspection programme:** This year, we started a comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and health-based places of safety. We have gathered a range of evidence to support us in shaping this programme of work. We use some of this evidence in this report, including 3 provider engagement sessions and focus groups with people with lived experiences, which focused on current challenges and what good care looks like in the community mental health sector. Representatives from 45 providers of community mental health services and crisis care (including health-based places of safety) for adults of working age participated in the provider engagement sessions (November and December 2024). Seventeen Experts by Experience with a range of experiences of using, or supporting those they cared for to use, community mental health or crisis services participated in the focus groups (January 2025).
- **Black men's mental health:** To develop our understanding of how Black men experience mental health care, we commissioned Queen Mary University (QMU) and University College London (UCL) to carry out a rapid review of what 'good' looks like in relation to access, experience and outcomes for Black men. The work included a rapid evidence review and semi-structured interviews with 23 participants, including Black men who use mental health services and their carers and families, providers, mental health advocates and people working in charities. The research team also worked with the Black Men's Health Taskforce (a community engagement group).

The report also draws on data from NHS England's Mental Health Act Statistics, NHS England's Mental Health Services Data Set (MHSDS) and NHS England's Mental Health Bulletin. NHS trusts, independent sector providers and other organisations delivering NHS-funded mental health care submit monthly data to include in the MHSDS. However, not all providers or services submit data, and submissions are only mandatory if care is wholly or partially funded by the NHS. Also, because of quality limitations, certain outputs from MHSDS are not classified as 'official statistics'. Therefore, we advise a cautious approach when interpreting MHSDS in isolation. Where possible, we have triangulated insights from analysis of MHSDS with other evidence sources. For more information, see NHS England's published data quality statement for MHSDS.

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. This ensures 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 data 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.

The Mental Health Act 1983 (amended 2025)

The Mental Health Act 1983 (amended 2025), which was formally introduced to Parliament in the House of Lords as a Bill on 6 November 2024, has received royal assent in the House of Commons.

Rising rates of detention, racial disparities in the use of detention and community treatment orders, and the inappropriate detention of autistic people and people with a learning disability are key drivers for the reformed Act. Importantly, this legislative change seeks to strengthen patients' voices and improve experiences of care and treatment.

We welcome the reform of the previous Mental Health Act (1983) (MHA). We believe the revised legislation will provide a solid foundation to enable greater involvement and control for patients over their care and treatment decisions, and will support the delivery of care and treatment in a way that is less reliant on the use of detention. These are hugely important steps forward.

But the legislation alone will not be enough to achieve this and we therefore look forward to additional measures being taken forward, which were raised during parliamentary debates. We particularly look forward to the provision of suitable community-based services as an alternative to detention, and investment in the sector to grow the workforce. These will be fundamental to fully realising the aims of the Act.

We will work with the Department of Health and Social Care to revise the MHA Code of Practice in 2026. Our aim is to ensure that it has a strong focus on the guiding principles of choice and autonomy, least restriction, therapeutic benefit and treating a person as an individual.

The Act is likely to be implemented over a 10-year period, and we will develop our processes in parallel, so that they enable us to monitor the new provisions in accordance with our statutory roles.

The Act has notable implications for our second opinion appointed doctor (SOAD) service and we anticipate a significant increase in demand for this service. This is because the reforms reduce the length of time a detained patient can be treated without their consent before a second opinion is required. Under the provisions of the Bill, the authorisation by a SOAD for urgent treatment for electroconvulsive therapy (ECT) changes and will increase protection for patients. The Bill states that urgent ECT can only be given to a patient who has capacity but does not consent, or to a patient who currently lacks capacity to consent but has a valid advance decision in place to refuse ECT, if certified by a SOAD. The need for us to provide a SOAD within urgent timescales creates complexities, and we are exploring how we can cater for these changes and the anticipated rise in demand for the SOAD service.

We will continue to work with the Department of Health and Social Care to address the challenges created by the national shortage of consultant psychiatrists, who make up our SOAD service, and current funding arrangements.

The scope and range of our monitoring activities will need to broaden to encompass new legislative provisions. Therefore, we will involve our Experts by Experience and advocacy groups in our updated approach wherever possible. This will enable us to check whether the key aims of the reforms are being met – including enhancing patients' rights and safeguards and giving them a meaningful voice in their care and treatment.

We welcome the government's commitment to monitor and evaluate the impact of the reforms in terms of addressing racial inequalities. We are fully supportive of the Patient and Carer Race Equality Framework, launched in October 2023, which we discuss further in this report, and we will ensure it both informs and shapes our safeguarding of people's rights.

Rising demand and pressures on the system

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Key points

- Demand for mental health care has continued to rise throughout 2024/25 with an average of 453,930 new referrals to secondary mental health services every month.
- Our Mental Health Act (MHA) reviewers are finding that people are becoming more unwell before they are referred for assessments under the MHA, and are also waiting longer to be assessed meaning they are often more unwell when they are admitted to hospital. This can be worse for certain groups of people, such as those living in areas of deprivation.
- Between 2023/24 to 2024/25, we have seen a 17% increase in the use of community treatment orders, compared with an increase of 9% in the previous year.
- On average in 2024/25, the bed occupancy rate (for all mental health overnight beds) has remained above the recommended 85% threshold at 90%. Providers have told us about higher thresholds for admission, delayed discharges and fewer beds are adding to this pressure and the difficulties for people in getting hospital care.
- Inconsistent provision of community care, the need for better funding of mental health services and challenges around collaboration and communication between services can leave people without the proper care and support they need after being discharged and can increase the risk of being readmitted to hospital.

In 2024/25, the rising demand for mental health care has continued to put pressure on mental health services. Data from NHS England shows that during the year there was an average of 453,930 new referrals to secondary mental health services every month – an increase of 15% from 2022/23.

In this context we are continuing to report that people are facing lengthy waits for treatment. A third of respondents (33%) to the 2024 Community mental health survey said they waited 3 months or more, and 40% of respondents said they felt the waiting time between their assessment and first appointment for treatment was too long. This is supported by the findings of the 2024 Independent investigation of the NHS in England, which highlighted how long waits have become normalised.

Our engagement events with mental health service providers were part of our focused review of community mental health services for working-age adults. Through these events, we have also heard how people's needs are becoming increasingly complex.

When people are not able to access the care they need when they need it, it can lead to their conditions worsening and/or reaching crisis point. The feedback from our 2024 Community mental health survey found that the longer people waited, the more they reported that their mental health got worse. For some, this led to them needing urgent and emergency care:

> *"When I get a crisis come on I get unwell very fast and it seems like the help is not accessible at the first instance and it escalates quickly, and I end up having to go to A&E and this was very distressing."*

As we highlighted in last year's report, this can be worse for certain groups of people, such as those living in areas of deprivation. We have again heard this year how socio-economic challenges, such as difficulties finding housing and employment, are exacerbating this.

In July 2023, the previous government published the National Partnership Agreement, which is based on the Right Care Right Person (RCRP) model initiated by Humber Police in 2020. The framework aims to support people in crisis to get compassionate care that meets their needs, and to end cases of inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs. It sets out a national commitment from the Home Office, the Department of Health and Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England. Local areas were tasked with agreeing a joint multi-agency plan for implementing and monitoring the RCRP approach.

The national framework sets out when it is appropriate for police to respond to a mental health-related incident, which can be either:

- to investigate a crime that has occurred or is occurring or
- to protect people when there is a real and immediate risk to the life of a person, or risk of a person being subject to, or at risk of, serious harm.

When this threshold is not met, partners in local areas will agree the best health-based approach to support people in crisis. The aim is to ensure that the right person responds, who has the right skills, training, and experience to best meet the person's needs. However, as previously highlighted by NHS Confederation, this reduction in support from police adds to the already rising demand and pressure on mental health services, increasing the risk of people not receiving the protection, care and support they need and coming to harm themselves or causing harm to another.

In the focus groups, we heard how our MHA reviewers are continuing to see people becoming more unwell before they are referred for assessments under the MHA. They are also waiting longer to be assessed once a MHA assessment has been requested, whether they are in their homes, in health-based places of safety or in emergency departments. As a result, people are more unwell when they are admitted to the wards. As highlighted in last year's report, this can lead to a longer recovery time in hospital, meaning bed occupancy rates remain high.

As we reported in our 2024/25 State of Care report, the number of urgent and very urgent referrals to crisis services has continued to rise over the last 2 years. Data from NHS England's Mental health services data set (MHSDS) shows 77% more very urgent referrals in 2024/25 compared with 2023/24 (rising to 60,935 from 34,455). There are known quality concerns with this data, as a small number of trusts contribute a large proportion of these very urgent referrals. Data quality and reporting will therefore need to improve to give us a confident picture of the pressure on crisis care services.

Feedback from our inspection teams suggests the reasons for this increase are complex and varied. They include issues such as the ongoing impact of the pandemic, long waiting times, lower bed availability and people with more complex needs being cared for by community teams, which all have an impact.

Over the last year, we have seen more people with higher levels of risk being managed in the community. Data from MHSDS shows that the number of people with serious mental illness accessing community services increased by 11% between 2023/24 and 2024/25, rising from a monthly average of 576,081 to 640,619.

We have also seen an increase in the use of community treatment orders (CTOs) or conditional discharge. Figures from NHS England's Mental Health Act statistics show that the number of CTOs increased from 5,618 in 2023/24 to 6,575 in 2024/25, an increase of 17%, compared with an increase of 9% between 2022/23 and 2023/24. These increases follow 2 years of falling rates (including a fall of 7% between 2021/2022 and 2022/23, and a fall of 9% between 2020/21 and 2021/22). Over the same time period, the number of people detained under the MHA (excluding short-term orders) saw a slight rise of 0.5%, increasing from 52,458 to 52,731.

Caution is required when comparing values over time as trend comparisons can be affected by changes in data quality. Again, data quality and reporting will need to improve in order to give us a confident picture of use of the MHA.

Pressures on hospital beds

The pressure on beds in inpatient services continues. On average in 2024/25, the bed occupancy rate (for all mental health overnight beds) was 90%, remaining above the recommended 85% threshold. For services such as acute admission wards, usual occupancy rates are higher than the average.

Through our engagement events with providers, held as part of our focused review of community mental health services for working-age adults, we also heard that higher thresholds for admission, delayed discharges and fewer beds are contributing to difficulties in people getting hospital care.

As we highlighted in our 2021/22 MHA annual report, if people are not admitted to hospital when needed, they can be left in vulnerable and unsafe positions. This can also lead to people being cared for in unsuitable environments, such as health-based places of safety, for prolonged periods.

Under sections 135 and 136 of the MHA, patients may be admitted to a health-based place of safety (HBPoS) for up to 24 hours. However, we are continuing to find evidence of this time limit being breached because of delays in accessing an inpatient bed.

In March 2025, our MHA reviewers visited 6 HBPoS across 2 NHS trusts as part of our comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and HBPoS. We found that both trusts had an average length of stay over 24 hours, and in many cases, people were in the HBPoS for over 72 hours.

One trust was operating a ‘swing-bed’ system, where the HBPoS can be designated as a bed on the neighbouring admission ward. This allowed the trust to formally admit patients to the HBPoS itself under MHA section 2 or section 3 and avoid any gap in formal powers of legal detention. As a result, staff and patients were clear about the legal status of their detention.

While swing-bed arrangements can provide a legal solution to the holding power running out of time, they do not address the underlying problem of delays in access to admission wards and can prevent further admissions to HBPoS. Through our review, we found examples of people being diverted to emergency departments in acute hospitals as the HBPoS were occupied. Services should ensure that bed managers do not de-prioritise patients held under swing-bed arrangements for a ward bed, both in the interests of the patient’s admission experience, and to free up the HBPoS for further use.

Participants in our focus group for our Service User Reference Panel (SURP) discussed the consequence of not being able to get a bed in hospital. One person described how their sibling has often been detained in the emergency department due to a lack of beds. This has created complex situations leading to their sibling not receiving timely care.

Analysis of our MHA monitoring reports shows that pressures on bed availability continue to result in people being placed in a service outside of their local area despite the government's ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020/21. Looking at the data from MHSDS for 2024/25, more people were placed out of area inappropriately: the number of new inappropriate out of area placements increased by 5% from 5,392 in 2023/24 to 5,649 in 2024/25. This is still too high.

As we have highlighted previously, and illustrated by Grace's story in our 2023/24 report, being placed out of area can be isolating and makes it more difficult for people to have regular contact with friends and family, which can have a significant impact on their care and recovery.

As well as being placed far from home, analysis of our MHA monitoring reports also continues to show how a lack of beds is resulting in people – including children and young people – being placed on an inappropriate ward (see also section on children and young people). This can lead to difficulties for patients and staff, as people with different needs are placed together. For example, during our focus groups, a MHA reviewer spoke about how they had seen older patients with dementia being placed on a functional older person's ward. We heard how the environments on these wards can be unsuitable for people with dementia, as there were problems with noise, lighting and high levels of stimulus, which can make people feel unsafe (see also section on inequalities).

On another ward that was over the bed occupancy rate, we found that people who asked to take overnight leave were being told they may not be able to return to the ward due to new admissions. Staff understood that this would be detrimental for some people and could cause a setback in their treatment and recovery. However, they did consider the impact on those who were most unwell and sometimes beds would be reserved.

Another issue resulting from a lack of beds is where people can be admitted into or kept in services where they experienced more restrictive conditions than they required. Examples include a lack of beds in step-down wards or community treatment services, which leads to delays in discharging people from hospital (see section on discharge).

System-wide challenges

Inconsistent provision of community care, the need for better funding of mental health services and the impact they have on people – particularly around discharge – has been a recurring theme across the last 5 Monitoring the Mental Health Act reports. Our MHA monitoring visits continue to illustrate the impact of these shortfalls, with one report highlighting the following example:

> *"One patient told us how cutbacks in community services had contributed to them relapsing, including reduced availability of respite services and the closing of a community hub they used to visit."*
>
> Extract from MHA monitoring visit report

In last year's report, we highlighted new statutory guidance from NHS England that outlines how organisations should work together to ensure effective discharge planning and the best outcomes for people when they are discharged from hospital. However, analysis of our MHA monitoring reports from 2024/25 shows that challenges around collaboration and funding continued to affect people when being discharged from hospital.

The reports showed that for a small number of people, waiting for an assessment or where there was a lack of agreement over who would take on psychiatric and social supervision had prevented them from being discharged when they were ready to leave. However, we did see a few examples where the ward maintained regular contact with both community-based services and trust-wide bed management to obtain updates on proposed discharges and transfers from the ward.

But we also heard how poor communication and collaboration has an impact on people's experience of care, how their care is co-ordinated and their transitions between pathways. For example, participants in our focus group of CQC Experts by Experience, which informed our focused review of community mental health services for working-age adults, described how poor communication could lead to indecisiveness about who would provide care, which could lead them feeling left in limbo.

Through our engagement events with providers, held as part of the same focused review, we heard that good communication was particularly vital when a person is discharged back to primary care. Providers spoke of the need to ensure all discharge notes are available to a person's GP – ideally immediately. They told us this was important to reduce both risk and the potential for people's wellbeing to deteriorate, and possible future hospital admissions or crisis.

We also heard that when discharged back into the community, it can be difficult for people to get the support they need from their GP. Experts by Experience in our focus groups told us that GPs are often happy to take on simple medication regimens, but are less likely to take on complicated medicines, making it much harder to get them changed. We heard how, in some instances, community mental health services had advised GPs not to make any changes to a person's medicines. In other cases, GPs were said to be pushing back on medicines prescribed by community mental health services.

To better understand the challenges for each sector more widely, we held a workshop with GPs and hospital pharmacy leads in February 2025. At the workshop, GPs described how their workload was increasing and how they felt that shared care protocols were often intended for patients with medically complex conditions, which they did not have the knowledge to manage. They were concerned about patient safety and how shared care protocols increase the burden on already stretched resources.

We also heard from providers that information can get lost in transition, and that there were too many handover points. A lack of shared computer systems to store and access information across services added to difficulties in communication and contributed to 'working in a silo'. Another factor from providers was that there are too many IT systems in place that do not 'speak to each other'. This resulted in not being able to produce key data metrics to effectively monitor service delivery and identify risk areas, and staff having to use workarounds to input and extract information, such as flagging when people do not attend appointments.

As highlighted by our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, disengagement with services is common for people with mental health problems. However, not managing people who struggle to engage with services can have serious safety implications.[1]

Staffing pressures and the impact on care

Staffing pressures and the impact on care

Key points

- We are continuing to see systemic challenges with recruitment and retention, with 9% of roles in mental health trusts in the NHS unfilled in March 2025.
- Recruitment and retention issues are leading to significant challenges around staff experience, skills and competencies, which are exacerbating pressures on services and staff themselves, as they are feeling burnt out and overworked.
- While some wards have had good levels of staffing, with approachable and attentive staff, we have found ongoing challenges around low staffing levels. This can leave people feeling unsafe and have a negative effect on their rehabilitation and recovery.
- Patients often described staff as being caring and working hard to keep everyone safe on the wards. However, figures from our MHA complaints data highlight ongoing concerns around the attitude of some staff; nearly half of the 2,552 MHA complaints received in 2024/25 included concerns relating to the attitudes of staff.

Resourcing and capacity challenges

We are continuing to see systemic challenges with recruitment and retention. Despite an increase in the number of staff over the last few years, the size of the mental health workforce has not kept up with the rising demand for mental health care. Data from NHS Vacancy Statistics shows that 9% of roles in mental health trusts in the NHS were unfilled in March 2025. As a result, we have heard from providers how they feel they are not always able to cope with the increasing levels of demand.

Our MHA reviewers described how system pressures are having an impact on staff morale. This included, for example, compassion fatigue among staff because of high acuity levels and the increasing numbers of patients with highly complex needs. The NHS Keeping Well Service describes compassion fatigue as “the ‘emotional cost of caring for others or their emotional pain’, whereby the individual struggles emotionally, physically and psychologically from helping others as a response to prolonged stress or trauma.”

In another example, we heard how in some trusts, staff get moved around constantly between wards to cover absences and gaps in staffing, this can have a significant impact on staff morale, to the point that some staff are leaving because they feel as if they cannot cope with uncertainty. It can also affect the continuity of care people receive and have an impact on the therapeutic relationship between staff and patients.

Recruitment and retention issues are also leading to significant challenges around staff experience, skills and competencies. These gaps in the workforce are exacerbating pressures on services and staff, with staff feeling burnt out and overworked, and that they are constantly ‘firefighting’, with little long-term impact. This is supported by data from the 2024 NHS Staff survey, which shows that for mental health and learning disability trusts, and mental health, learning disability and community trusts:

- less than half (49%) of people felt able to meet all the conflicting demands on their time
- over a third (34%) of people reported always or often finding their work “emotionally exhausting”
- a quarter (26%) of people reported they were always or often feeling “burnt out because of their work”.

Effects of low staffing

Staff have a huge influence on people’s experience of being detained in hospital under the MHA. A positive, therapeutic relationship with staff is a key element of inpatient care and can help patients to engage with treatments and interventions, leading to a better outcome. Therapeutic relationships play an important role in helping to create a culture where people feel psychologically safe, where they feel comfortable expressing themselves.

A fundamental factor in building these supportive and therapeutic relationships is having consistent staffing.

Through our analysis of MHA monitoring reports we found that patients valued having consistent relationships with named staff, which allowed them to be involved in their care and treatment plans. Regular contact with trusted and familiar staff also allowed for better communication and support for individual preferences, including involving family and carers. Some wards that we visited have had good levels of staffing, and in others we’ve heard from patients how, despite being very busy, staff made time for them and remained approachable and attentive.

However, other reports have described challenges around low staffing levels, which can prevent people from developing therapeutic relationships and can leave them feeling unsafe (see also section on demand and system pressures).

As well as vacancies, staffing levels were affected by sickness, incidents requiring staff intervention or staff needing to provide enhanced levels of support and observation for people on the ward with higher acuity levels. For example, we heard how, in some wards, a lot of people were on enhanced observation as they were experiencing considerable levels of distress. As a result, staff were not readily available or were not quick enough to respond. At one ward, almost all patients told us they did not feel safe on the ward. The majority of patients said this was because they felt there were not enough staff around to support them.

Low levels of staffing affected people's rehabilitation and recovery. For example, people were unable to access all areas of the service, such as outdoor environments for fresh air, or they were not able to take a shower as there were not enough staff available to observe them. It could also lead to having to cancel daily activities and section 17 leave. People described how this left them feeling frustrated or that it would negatively affect their level of confidence.

We have seen the effects that low staffing levels could have on people in long-term segregation through our Independent Care (Education) and Treatment Reviews (IC(E)TRs) programme. Being able to spend time outside long-term segregation was important for people because it meant that they could:

- experience reduced restrictions
- practise being in different environments
- connect with peers and family members
- participate in interests and hobbies they enjoyed.

However, we found examples where low numbers of staff meant that people could not spend time outside of long-term segregation because leave could not be facilitated. This seemed to be because more staff or specialist members of staff were needed to facilitate leave but they were not available.

The following experiences highlight this issue:

> *"On the day of our visit...night staff were below planned levels. A patient who had been secluded in their bedroom on [the] ward told us that although they left their bedroom every day for fresh air, due to a shortage in staffing they were not able to spend long outside of their bedroom."*
>
> Extract from MHA monitoring visit report

> *"A patient previously in bedroom seclusion told us they had requested food and drinks from staff. However, there had not been enough staff to open the door to give them the food or drink. They said when their observation levels decreased it had been harder to get staff to support their needs."*
>
> Extract from MHA monitoring visit report

> *“There were current staffing difficulties on the ward, which included a deficit in the availability of allied health professionals. The occupational therapy team told the panel they had plans in place to support the person to spend time out of long-term segregation but were unable to offer this support until at least 3 months after the review date.”*
>
> Extract from IC(E)TR report

As highlighted in this year’s State of Care report, issues with staffing are also leading to significant challenges around staff experience, skills and competencies. Our MHA reviewers described how some wards may appear to have adequate staff numbers, but there was not always the appropriate skill mix and knowledge among staff, which could affect how clearly staff communicated with each other, and this had led to less effective responses to emergencies.

The mix of skills and experience could be a particular problem where bank and agency staff were being used, adding to the pressure placed on staff and the service, and contributing to patients feeling unsafe. Our MHA reviewers described how agency staff are generally unfamiliar with patients, and although they can read the patients’ care plans, they do not always know how to de-escalate patients. They described how agency staff don’t have enough time to build a therapeutic relationship with patients, which can lead to less effective care and patients feeling frustrated.

In services with a high staff turnover, people were reluctant to build rapport with staff because there was “no point” in getting to know them if they would be leaving again.

> *“Patients told us there was a high use of agency staff on the ward. They felt that non-regular agency staff did not know them well. One patient informed us that an agency staff member had restricted their use of toilet paper as they were unsure of the patient’s individual risks. Regular staff intervened and the issue was resolved quickly.”*
>
> Extract from MHA monitoring visit report

This theme was supported by feedback from carers who told us that when they spoke with staff who did not work at the service regularly, they often did not know the patients personally and could not provide updates on their care. We heard how this difference can be more marked during weekends and night shifts, when the use of agency staff can be more common.

The challenges around bank or agency staff were also highlighted in a 2024 report by the Health Services Safety Investigation Branch

(HSSIB), Workforce and patient safety: temporary staff - integration into healthcare providers. The report found that providers often had little information about the bank or agency staff they were employing, which meant they could only give them tasks on the basis of their role, rather than skill or experience. For mental health settings this meant temporary staff were commonly allocated to carry out continuous observation, as this was considered to be a clearly-defined task which was not complex.[2]

To be therapeutic, continuous observation requires staff to build and maintain trust and rapport with the patient. The HSSIB investigation heard of many instances where temporary staff carried out this role for many hours at a time.[3] As we raised in our Monitoring the Mental Health Act annual report 2021/22, enhanced, continuous observation provides an opportunity for prolonged therapeutic engagement. However, it can be difficult and exhausting for both patients and staff. Carrying out continuous observation for many hours on end, particularly with staff unknown to the patient, increases the risk of this becoming a passive activity rather than active therapeutic engagement.

Guidance from NHS England on enhanced therapeutic observation states that, while senior nurses provide overall clinical governance for enhanced therapeutic observation, the nurse in charge on the ward is responsible for allocating ward staff to perform observations, ensuring the skill mix is safe and appropriate for both the ward and patient, and ensuring that staff have regular breaks.[4]

One MHA monitoring report shared similar concerns about bank staff sleeping during night shifts and how this led to patient observations being neglected. When we raised concerns about this, the provider responded by contacting all ward staff to remind them to take care of their wellbeing, while reminding them of the consequences of being found to be sleeping on shift. The ward management team also removed staff from the bank who were found to have been sleeping on shift.

MHA reviewers who took part in our focus groups also told us they had seen examples of agency staff sleeping during night shifts. They explained that because agency staff work at different locations, and sometimes for multiple agencies at the same time, it is harder to have a clear oversight of the hours they work. This means that they might do consecutive shifts and end up exhausted by the time they have night shifts.

Low staffing levels can also affect people's ability to get their care reviewed by a Second Opinion Appointed Doctor (SOAD). As we reported last year, ongoing difficulties with the funding of the service and insufficient numbers of SOADs has led to a backlog of requests and delays in delivering second opinions. While we are working to reduce these backlogs, communication challenges with hospitals can lead to additional delays in people receiving a second opinion. For example, we have heard about SOADs being unable to contact the ward on the phone to book an appointment as phones go unanswered, or staff are unable to book SOADs into the ward because either no staff are available, or the staff member is too junior to have permission to book on the system.

Attitudes of staff

Members of our Service User Reference Panel (SURP) highlighted the importance of patients feeling able to approach staff with their concerns. One SURP member described how approachable staff are conducive to a person's recovery.

This was supported by the findings of our analysis of MHA monitoring reports. Several reports highlighted how staff attitudes were important in making patients feel supported and safe. Patients often described staff as caring and working hard to keep everyone safe on the wards. Some patients described how positive attitudes and behaviours contributed to an overall positive atmosphere on the ward, potentially minimising the incidence of violence.

> *"Patients felt safe. They told us the current patient group got on well together and one patient said, "it's like a second family". We were told that there were sometimes arguments and shouting, but violence on the ward was rare."*
>
> Extract from MHA monitoring visit report

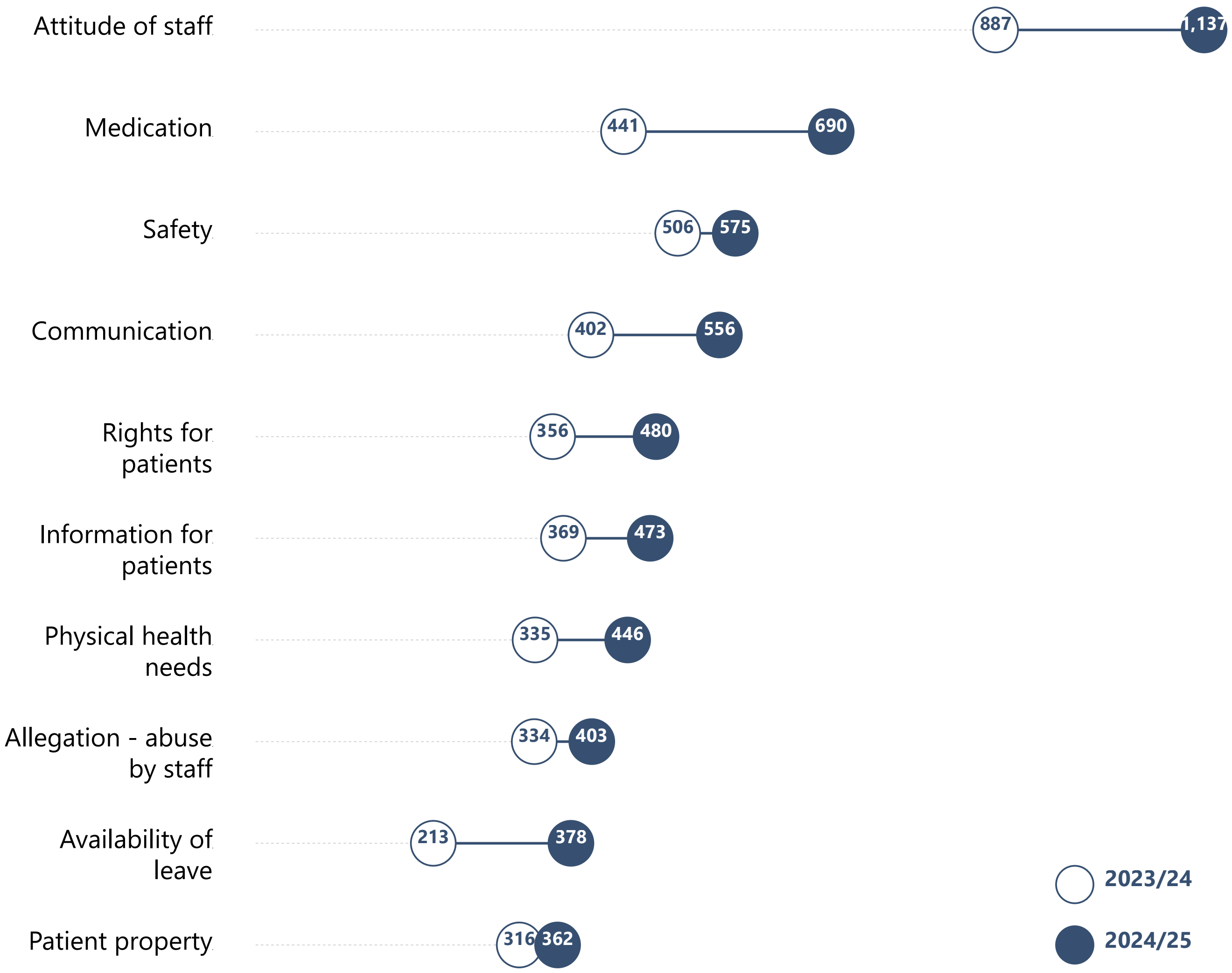
Patients also commented positively on staff who respected their privacy, for example, by knocking on their room doors before entering. One patient highlighted the importance of being treated with respect when in seclusion, to preserve their dignity, for example when showering or using the toilet.

> *"We spoke with a patient in seclusion who told us the observing staff interacted with him and treated him with respect. Male staff completed his observations when he was using the shower and toilet area."*
>
> Extract from MHA monitoring visit report

Analysis of our MHA monitoring reports highlights how patients feel more able to share safety concerns with staff who are friendly, helpful and approachable, which helped them to feel safe on the wards. Feeling that staff listened to their concerns seemed to be particularly important for some of the patients who had previous experience of violent assaults within the wards.

However, figures from our MHA complaints data highlight ongoing concerns around the attitude of some staff. Out of 2,552 MHA complaints received in 2024/25, 45% included concerns about the attitudes of staff, ranging from therapists and nurses being unwelcoming and/or rude, to staff being inattentive (figure 1).

Figure 1: **Number of complaints about use of the MHA by category, 2023/24 and 2024/25**



Source: CQC MHA complaints data

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.

Erin’s story

Erin first began struggling with her mental health as a teenager. She was self-harming and once she’d finished her GCSEs she was doing so more often. By the age of 17, her parents were struggling to take care of her at home and the children and young people’s mental health service admitted her to an acute adult ward at an NHS mental health hospital as there were no beds available in any mental health inpatient units for children and young people.

After an ‘awful’ 4-month cycle of being discharged then readmitted to hospital, Erin was admitted back to the adult NHS ward that she was originally admitted her to, where she was diagnosed with borderline personality disorder (BPD). This began her 9-year journey through the mental health system.

For 6 years, Erin was detained in various independent mental health services, including high dependency units, psychiatric intensive care units and forensic services. During this time, because she was considered such high risk, Erin was frequently held in overly restrictive environments, often in seclusion, with constant observation and, in many cases, a lack of access to therapy or therapeutic activities.

At one service early in her journey, Erin was diagnosed with a schizophrenia spectrum disorder and told that she didn’t have BPD. When she told staff that she didn’t have a schizophrenia spectrum disorder, they described her as ‘treatment-resistant’. She was prescribed clozapine – an antipsychotic medication primarily used to treat treatment-resistant schizophrenia. Erin struggled with being on clozapine, becoming overweight and describing how it made her very sleepy for much of the time she was detained, “I was like a zombie”, she said. “I was just so zoned out and overmedicated”.

Erin also described being on the receiving end of poor staff attitudes. For example, at one service, she was not trusted to use a toothbrush and went months without being able to brush her teeth. As a result, her dental braces disintegrated because they hadn’t been cleaned for so long. She described how the staff bought her an enormous novelty toothbrush ‘because she wouldn’t be able to swallow it’. This was the first time Erin had tried to brush her teeth in months and the staff laughed at her while, desperate for basic dental hygiene, Erin tried to brush her teeth with the novelty toothbrush. She ended up laughing too because she’d normalised being humiliated by this point.

Throughout this period, Erin describes feeling ‘written off’ by staff – at one point staff told her parents, on multiple occasions, that she was ‘never going to get out’.

In 2020, Erin was moved to an NHS medium secure unit, which provided the person-centred care she needed to help her recover. Erin described feeling like she was “viewed as a human being, not as a problem or someone who needed to be kept”, and that staff believed in her, and didn't penalise her for self-harming. For example, she described how the occupational therapist found her a non-swallowable toothbrush with a big handle that she could keep in her room, enabling her to brush her teeth twice a day.

Staff also enabled her to take up art again by providing her with pastels and a bendy pen that was dissolvable if swallowed.

With the support of the staff at the unit, Erin was able to come off her medication and create a tailored care plan that focused on her recovery and discharge back into the community. Erin was discharged from hospital in January 2023 and, with the support of her partner, family and friends, is rebuilding her life. Erin went back to college in 2024 and is now in her first year of university, with the long-term goal of becoming a forensic psychologist.

(From an interview with a member of the public for this report)

Qualitative analysis of these complaints showed allegations of physical and verbal violence, as well as issues that patients raised about staff requiring them to take medicines authorised under the MHA without their consent or with no information about side effects. In some cases, patients described how the care offered to them was not always person-centred, as individual needs and personal history (such as background information, history of self-harm, and past adverse reactions to medicines) were not always taken into consideration.

This was echoed in some of our MHA monitoring visit reports. One report describes the effect of poor attitudes of staff on patients:

> *"Some patients said some staff had poor attitudes, they could be dismissive or ignore them, or showed favouritism to some patients over others. One patient said staff had not been compassionate when removing personal items from their room for safety. Patients said they had heard some staff complaining openly about their working terms and conditions, and the patients felt this was contributing to this concern."*
>
> Extract from MHA monitoring visit report

Another report spoke of how a patient mentioned feeling infantilised when staff spoke to them, while a patient in another ward described staff as "quite scary". We also found examples where staff were not seen as approachable or did not respond to incidents quickly enough, which left patients feeling unsafe. In one ward the behaviour of staff and the response to incidents led to a frightening environment for some patients.

One report suggested a connection between negative staff attitudes – specifically staff being "abrupt and bossy" towards patients, and a high turnover of staff. This reinforces the idea, as highlighted in the section on effects of low staffing, that consistency and regular contact between staff and patients are essential to maintaining positive relationships and ensuring their psychological safety.

Our work on Independent Care (Education) and Treatment Reviews (IC(E)TRs) found concerns around staff in certain roles not understanding, or seeing the need to support people, as part of their job. We found evidence of this lack of responsibility to support and engage with people in reports.

One report stated that "a person and their family told us that staff did not always engage and support them". Similarly, we heard that "sometimes bank staff do not engage with them, just sit and stare at them, which can be triggering". It seemed that some people were paired with staff who may not have viewed engaging and forming meaningful relationships as their responsibility, which has been noted as an important factor in helping people to leave long-term segregation.

This disconnected care for people – with some staff, professionals and services not recognising their responsibility to support people in long-term segregation and to progress out of it – could lead to people's needs not being met and a longer stay in a segregated environment.

Environment

Environment

Key points

- We continue to be concerned that pressures in the system and a lack of beds are leading to people being held for long periods in inappropriate environments, such as in urgent and emergency care, and/or being admitted to or kept in services where they experienced more restrictive conditions than they need.
- The number of inappropriate out-of-area placements that were started increased by 5% between 2023/24 and 2024/25. Too many people are still placed in hospitals far from home; 5,649 placements started in 2024/25 were out of the patient's local area.
- While we have seen positive examples of clean, tidy wards that supported people's needs, through our visits we continue to see issues with wards such as problems with the layout, too much noise and concerns around hygiene and cleanliness.
- Different levels of patient acuity could affect how safe patients felt on the ward, as the presence of patients who were extremely unwell added to the environment feeling busy and unsettling.

Appropriateness of settings

Under the MHA, when a patient needs hospital treatment they should be admitted to a service that is able to provide appropriate treatment in a therapeutic environment. The Mental Health Bill defined 'appropriate treatment' as treatment that has a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment. The revised Code of Practice will provide further guidance on this.

Our analysis of MHA monitoring reports found that the capacity of wards to admit new patients, and whether they are able to offer appropriate treatment, can be affected by the mix of patients and levels of acuity, and whether they have the right levels of experienced staff to manage patients safely. Through our MHA monitoring visits we have seen examples of wards that would consider the suitability of new referrals based on the current ward acuity to avoid inappropriate admissions. This would help to ensure that the service could support a new admission while continuing to support the existing patient group. But where services have been able to manage referrals in this way, it may mean that they have unused beds, which, with the overall lack of beds across mental health services, could cause additional pressures elsewhere in the system.

Pressures in the system and a lack of beds can lead to people being placed in inappropriate wards and/or being admitted to or kept in services where they experienced more restrictive conditions than they needed. See the section on demand and system pressures.

MHA reviewers told us they were particularly concerned about people being detained in acute hospitals and in urgent and emergency care (UEC) departments. As we highlighted in our 2020 report Assessment of mental health services in acute trusts, emergency departments are often not suitable environments for people experiencing a mental health crisis. Emergency departments are not therapeutic for people with mental health needs and can make people's mental and physical health worse.

MHA reviewers raised concerns about the experience of people with mental health needs in acute settings. In particular, MHA reviewers were concerned that acute hospital staff are not necessarily fully aware of the requirements of the Act, Code of Practice or the rights and safeguards for people subject to the formal powers of the Act.

We have particular concerns around the placement of children in inappropriate settings, which we discuss further in the section on children and young people.

Out-of-area placements

We know that out-of-area placements can make people feel isolated from their support network and can have long-term implications for their recovery. To drive improvement, the government made a commitment to end inappropriate out-of-area placements by March 2021.[5] However, a lack of beds and wider system pressures mean that too many people are still being placed a long way from home.

In 2024/25, NHS England's MHSDS reported data showed that 5,649 placements were started out of the patient's local area (a 5% increase from 2023/24). In 2024/25, the rate of new inappropriate out of area placements started ranged from a high of 249 per 1,000,000 of the population to a low of 14 per 1,000,000 of the population. In some cases, this may be because the person needed specialist care that was not available in their area, such as autistic people and people with a learning disability, and people with an eating disorder or disordered eating diagnosis.

As highlighted in our 2021/22 MHA annual report, being placed out of area can increase challenges around communication with community mental health teams and securing appropriate community support back in the person's local area. We reported that this can also lead to issues around which local authority area is responsible for paying for the person's care, and can lead to people staying longer in hospital.

Quality of ward environments

Our analysis of MHA monitoring reports from 2024/25 found positive examples of clean, tidy wards that had been purpose built or recently modified to support people's needs. However, as we highlighted in both our 2023/24 MHA and State of Care reports, we continue to be concerned about the poor quality of many ward environments and impact this is having on the safety, privacy and dignity of patients and staff.

As at November 2025, data from NHS England showed that the estimated cost to eradicate NHS estates backlog maintenance had increased to £15.9 billion, up from £13.8 billion in 2023/24. This is defined as the investment needed to restore buildings to a defined condition based on assessed risk, excluding planned maintenance.[6]

Throughout our visits and from complaints we received from patients detained under the MHA, we have seen issues with wards, including problems with the layout such as uneven flooring and narrow corridors, wards being noisy and concerns around hygiene and cleanliness. For example, on some visits we found that wards were dirty, untidy, smelly and, at times, unsanitary. This extended to outdoor areas – in one ward we found overflowing bins, which could create infection risks. In another example, patients told us about a rodent infestation, which was confirmed by the ward manager. In response, the provider engaged pest control and asked patients and staff for ongoing feedback to confirm that the problem had been dealt with.

Inaya's story

Khadija's daughter, Inaya, started experiencing symptoms of depression while she was at school. Inaya and her family visited A&E on many occasions, particularly in the evenings, when she struggled the most, including with suicidal ideation.

Inaya's mental health team referred her for specialist talking therapy, but she wasn't offered any support while on the waiting list, which lasted for months. When her assessment appointment came around, she was told that her condition wasn't 'serious enough' to be treated with the therapy.

When Inaya was around 20 years old, a member of staff in the A&E department's mental health team decided to send her to hospital. This hadn't happened before, and the staff member didn't explain why this visit resulted in a different outcome.

So, after being told that she could be admitted to 'anywhere in the country' with an available bed, Inaya was admitted to a hospital that was outside her hometown, and a 45-minute drive from home.

Khadija described the environment of the hospital as "awful" and felt "lucky" if she found a "sympathetic nurse". Inaya was offered a 'quiet room' that wasn't actually quiet, as staff were speaking loudly outside and there was a constant noise – possibly coming from a generator.

The room was very brightly lit, and Inaya couldn't control the light settings. There was blood on the walls, and a sectioned-off bathroom and toilet that was so "disgusting" it was "practically unusable".

A screw had come out of one of the plug sockets, leaving it half exposed. Khadija reported this to a nurse, highlighting how it could be unsafe for a patient in that room (particularly if they were experiencing suicidal ideation), but the nurse responded with a derogatory comment.

Inaya stayed in the quiet room overnight, with no bed. When Khadija asked for something for her daughter to sleep on, a staff member gave her a thin, plastic mattress without a pillow or blanket.

Inaya was later admitted to a more pleasant room in an adult ward for around 3 days, where her family visited her twice a day, including in the dark.

The hospital psychiatrist advised that a treatment team near her home would take Inaya's case on, visit her, and support her while she recovered at home.

Although Khadija reported Inaya's suicidal ideation, the team that was closer to their home deemed her condition to not be "serious enough" for further care and they discharged her. The team did not signpost her to any further services.

Khadija, her husband, or Inaya's sister would support her, and they would constantly monitor her condition at home. Her sister quit her university course to support her, and Khadija feels fortunate enough to be able to give up her work to support her too.

Beyond the care from family, Khadija reports that "Everything we've had, we've had to fight for".

(From an interview with a member of the public for this report)

Issues with temperature control and heating could have an additional impact on patients, leading to some wards being too hot, too cold, and/or poorly ventilated. Multiple reports highlighted issues with people being unable to open windows, having to ask staff to have windows opened or windows that needed to be replaced.

"The bedrooms were poorly ventilated. The vents on the windows did not work and staff did not know how to operate them. Patients told us the rooms were extremely warm and this was having a direct impact on their sleep and mood. One patient told us he was experiencing migraines and told us he was worried "he would not make it through the night" due to the heat."

Extract from MHA monitoring visit report

Patients have told us how poor temperature control could cause them distress and discomfort, and stop them from sleeping well, which affected their mood, as well as their physical and mental health. For example, one patient told us that they had been experiencing migraines due to the heat of their room and that they had stopped showering when confined at night due to the heat the shower caused in their room. The provider responded to our call for action by checking the ventilation in all rooms.

A MHA reviewer also told us about the issues with the temperature of the ward they had found during one of their visits:

> *"It was unbearably hot on most of the ward including in patients' rooms. One patient told us that wet towels were their only means of cooling themselves down whilst in bed. One patient slept on the floor in the television lounge which was slightly cooler than the rest of the ward. This interfered with other patients' use of the lounge."*
>
> Extract from MHA monitoring visit report

Several patients also told us about not being given everyday items such as toothpaste or toilet paper, or being offered food they were allergic to, which they felt were violations of their basic human rights as well as their individual needs.

Our analysis of MHA monitoring visit reports highlighted that challenges could be exacerbated for patients with protected equality characteristics. For example, while some services had taken steps to meet the needs of patients with mobility issues by providing accessible rooms, wheelchair ramps and appropriate equipment, concerns were raised regarding uneven surfaces, narrow corridors and inaccessible areas. In one case, this meant a patient in a wheelchair was unable to access the ward's dining room, potentially affecting their dignity and social inclusion.

A participant in our Service User Reference Panel (SURP) focus groups told us there have been occasions where they have been unable to take a shower on the ward due to poor mobility and physical co-morbidities. They described the impact of this, highlighting that the inability to maintain your personal hygiene can have a negative impact on wellbeing and can lead someone to 'spiral downwards'.

MHA reviewers described how wards could be noisy and unsettled, with alarms going off that contributed to a sense of fear among patients. We heard that to address this, some trusts were using silent alarms. These enable staff to be alerted when an incident occurs without unsettling all the ward.

However, we heard how some services have systems for announcements that are louder than alarms, and can potentially upset patients:

> *"There is a hospital which used a female voice that the patients could cope with, but they changed it to a male voice that upset the patients. Some people found it triggering and at nighttime it would wake quite a few patients."*
>
> Extract from MHA reviewer focus group

We are concerned that these environments are not therapeutic for patients and are affecting services' ability to keep people safe. As we highlighted in our last Monitoring the Mental Health Act report, these types of ward environments can be particularly challenging for neurodivergent people and can also increase the risk of sensory overload for some patients. We talk in more detail about the impact of poor environments in our section on autistic people and people with a learning disability.

These findings were supported by feedback from our SURP focus groups. One participant said that, in their experience, wards had been 'incredibly hectic' with bright lights, banging and shouting. This had created a 'frightening' environment for them, that it had 'set [them] back' in their recovery, and their risk levels escalated due to the sensory environment. They reflected that they were discharged in a 'far worse state' than when they were admitted. Focus group participants voiced that addressing some of these issues (for example, quieter doors) would help wards become more sensory friendly as a result. However, as highlighted above, changes may be challenging due to the escalating estates maintenance backlog.

Patient acuity levels could also affect how safe patients felt on the ward. Analysis of our MHA monitoring visit reports found that wards with patients who were extremely unwell could add to the environment feeling busy and unsettling. This was supported by feedback from carers who told us that, on one ward, the environment could be so unsettling and frightening that it led to a patient spending most of their time in their room. The provider responded by reviewing staffing levels and knowledge requirements, and improving community and carers meetings to listen to concerns and take action.

Reports from our MHA monitoring visit showed concerns around the safety of women. The MHA Code of Practice highlights the importance of women-only spaces to reduce the risk of sexual and physical abuse and reduce the risk of trauma for women who have had prior experience of such abuse. This includes being able to access female-only lounges. In addition, all sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms.[7]

Quality and safety of care

Quality and safety of care

Key points

- We often saw that staff listened to patients' concerns and involved them in decisions about their care. However, some care plans did not consider the patient's individual needs.
- Our Independent Care (Education) and Treatment Reviews (IC(E)TRs) highlighted the value of staff who are able to adapt to support people's changing requirements to reduce some of the harm of being in long-term segregation. But personalised adjustments were not always assessed and integrated into people's care to support them to progress out of segregation.
- Services that respect human rights are fundamental to good outcomes for people. However, we are concerned that too many people are being unlawfully detained – especially those on wards for older people and those who do not have the capacity to understand their rights.
- Everyone working in health and care services has a role to play in reducing the use of restrictive practices. However, between 2023/24 and 2024/25 the average number of restrictive interventions each month rose by 24% from 13,240 to 16,462.
- We saw how low staffing levels meant that, on some wards, access to areas like bedrooms, kitchens, gardens, living spaces, and bathrooms was restricted, which patients said affected their recovery. In order to reduce restrictive interventions, we have seen technology being used to keep people safe, while giving people who are sectioned some control over their lives.

Communication and rights

Involving patients in their care

One of the key themes that affected patients' experience was their ability to have a say about their care. Many Mental Health Act (MHA) monitoring reports described staff who listened to patients' concerns and involved them in decisions about their care. For example, some reports described how patients participated in community meetings and had regular one-to-one meetings with named staff – using these occasions to express their views about their care plans and the everyday activities on the ward.

Regular one-to-ones with staff with whom they had built a trusting relationship also gave patients the opportunity to discuss their proposed medication, as well as preferences with contact and involvement of family and carers.

> *“One carer said that the responsible clinician was excellent and had supported them to get physical healthcare treatment, which made a significant difference to their quality of life.”*
>
> Extract from MHA monitoring visit report

However, in our monitoring we have seen instances where care plans lacked detail and did not consider the patient’s individual needs. For example, on one ward, our reviewers felt that care plans did not highlight how patients with specific, identified needs, such as autistic people, would be supported. In this case, the provider responded to our call for action by providing training on person-centred care planning for nurses and introducing a monthly care plan audit. The section in this report on Care for autistic people and people with a learning disability highlights some positive examples of patient-focused care planning.

During another MHA monitoring review, some patients reported that although they were given copies of their care plans, they had not been involved in reviewing them. In response, the service committed to the following actions:

- the ward manager to undertake a review of all care plans
- the ward manager to develop guidance for staff to ensure that care plans are produced collaboratively and when patients’ needs change
- staff to document in electronic care records when a patient refuses a copy of their care plan, saying why and when they will be approached again to encourage collaboration
- the ward manager to continue to carry out a dip sample approach to check on the impact of the above actions and repeat this monthly until assurance on care plan updates has improved.

Our MHA reviewers also noted how the use of peer support workers and family ambassadors on wards can have had a positive impact on the way people engage with services. These roles can support families, friends, and carers to get answers to their questions much more easily and can provide a direct link between the ward and the family.

The importance of communication was also a key theme in our Independent Care (Education) and Treatment Reviews (IC(E)TRs) into the care and treatment of autistic people and people with a learning disability who are in long-term segregation. We discussed the early findings from our IC(E)TRs in our latest State of Care report.[8]

We highlighted instances where clinical teams lacked the knowledge and the expertise to work with autistic people and people with a learning disability, which could be a barrier to them moving out of long-term segregation. Shortfalls included knowing how to support people’s communication requirements and supporting them in trauma-informed and reassuring ways that reduced anxiety around change. By contrast, we also saw successful initiatives where independent stakeholders implemented a human rights-based approach and focused on staff building good relationships with people in long-term segregation to better understand their wishes and requirements.

We found evidence through our IC(E)TRs that the personalised adjustments that some people needed were not always assessed and integrated into care to support them to progress out of long-term segregation. For example, one review report notes that, “It had been long identified that the person needs a speech and language therapist assessment. However, the provider was not able to provide this due to funding”.

However, IC(E)TRs also highlighted that some staff were able to mitigate some of the harms caused by restrictions in long-term segregation by making personalised adjustments to support people’s changing requirements (for example, sensory requirements and preferences, and mealtime preferences).

Supporting patients to understand their rights

Our human rights approach to regulation states that people who use health and care services need to be empowered to understand their rights, and services that respect human rights are fundamental to good outcomes for people.[9]

Our monitoring work continues to reveal that communication about people’s legal rights varies across services. Some services explained rights to people promptly, they documented discussions and reminded them regularly. However, at other services, people felt that their rights were poorly explained or they did not fully understand them. In some cases, patients were not given a new explanation when the legal section under which they were detained changed.

> *“There was no indication, in any records we reviewed, that informal patients had been made aware they could leave. We reviewed several records for detained patients on sections 5(2), 2 and 3 where we could not see any evidence that information had been given to patients about their status under the MHA. The IMHA told us they had to regularly prompt staff to help patients understand their rights.”*
>
> Extract from focussed MHA monitoring visit report

Services have told us how patients are referred to independent mental health advocates (IMHAs) to help them understand their legal rights. We heard positive examples where patients were automatically referred to this service if they did not have capacity to understand these rights and that information on advocacy had been made available in accessible formats. We also heard of advocates being introduced to all patients, always being notified about seclusion, and attending seclusion reviews to support patients’ views. However, in other services patients were unsure about how to access an IMHA or had not been told about the service.

Encouragingly, we have found that services often have good access to interpreters, who have been used to support various activities, such as ward rounds. Importantly, some services had used interpreters to ensure that patients understood their rights under section 132 of the Mental Health Act, where their first language was not English. However, this wasn't always the case, with some wards either unaware of how to arrange interpreters or not using them often.

> *"We spoke with a patient whose first language was not English. They said staff arranged interpreters for admission, ward rounds, or any important meetings, he said he did not feel like he has struggled to communicate or have his wishes known."*
>
> Extract from MHA monitoring visit report

To support better communication, we noted the use of easy read formats or pictures to ensure that important information was accessible to all patients, such as information about rights, searches, medication and sexual safety. However, there were a few occasions where this had not been provided, creating barriers to communication.

De facto detention

Our MHA reviewers expressed their concerns that too many people, especially those on wards for older people, were deprived of their liberty without clear legal authorisation.

They explained that this can happen when a person is kept in hospital while not being formally detained under the Mental Health Act or having a Deprivation of Liberty Safeguards authorisation in place to provide an alternative authority to keep them detained. As discussed in our State of Care report, applications to authorise the deprivation of a person's liberty have increased significantly over the last decade, often resulting in lengthy delays.

MHA reviewers said that this practice has become so common it is "almost normalised". Where patients are deprived of their liberty without a legal authorisation in place, they have no legal framework to use to appeal the deprivation of their liberty or de-facto detention. They also have no right to support from an Independent Mental Health Advocate to help them understand their rights, or to support them in raising concerns about their situation.

Supporting needs and wellbeing

Feeling listened to by staff was one of the most prominent themes from analysis of people's feedback to the 2024 Community Mental Health Survey who had experienced both inpatient and community mental health services.[10] People who felt listened to said staff took the time to listen to them, gave them space to share their concerns, explain things to them, and ensure they understood the process, and what was happening with their care.

Through our MHA monitoring, we saw that personalised care was possible where staff had built a trusting therapeutic relationship and had a good understanding of the person, and the person felt listened to and involved in their care.

Our MHA reviewers observed interactions between staff and patients that were kind, warm, respectful and caring.

> *"Patients spoke in glowing terms about the staff. They said that the nurses, support workers, therapy staff, chef and housekeeping staff were very kind and respectful. One patient said, "The staff here are the most amazing people. They really care. It's not just a job. Nothing is too much trouble for them. I can't fault them." Another said, "If I cry, they help. They are beautiful people. I feel blessed"."*
>
> Extract from MHA monitoring visit report

However, a participant in our focus groups held with people who use services and their families gave an example of a policy in one service that had a negative impact on patients' health and wellbeing. Patients were not allowed access to extra food, such as fresh fruit and vegetables, but could only 'buy in' food from delivery companies. This meant that they were frequently eating fast food, and the participant noticed that their relative had gained weight as a result.

By comparison, our monitoring showed that on some wards, patients were encouraged to prepare their own hot meals in the kitchen, promoting self-sufficiency. We heard how, on a few wards, independent access to food and drink preparation gave patients a sense of confidence and the life skills needed to live independently.

> *"In order to gain independent living skills, staff gave patients a weekly meal budget of £30, which patients used to shop and prepare their own meals. The ward had 2 connecting self-contained flats where patients would gain the confidence and skills to live independently and have support from staff when needed."*
>
> Extract from MHA monitoring visit report

Our MHA reviewers observed variation in how patients' religious, cultural and spiritual needs were met. For example, several services provided access to chaplains and other religious leaders, multifaith spaces, and culturally appropriate food, including halal and kosher options. However, they also observed that some services did not provide a dedicated multifaith room or, if they did, it was ill-equipped or also used for other purposes, like storage or family visits. Lack of an appropriate space meant that some wards struggled to provide adequate chaplaincy services, as there were no quiet spaces to reflect and meet patients' spiritual needs.

> *"The multifaith ward in the wider hospital lacked compass directions meaning that patients, such as those from the Islamic faith, would struggle to identify the correct direction to pray in. The room was also missing a clock and had limited religious material available to patients."*
>
> Extract from MHA monitoring visit report

Several services arranged activities, events and initiatives that celebrated religion and culture, including visiting local churches and mosques, group sessions, visits from external organisations and activities to celebrate religious festivals. Some services had also created activities and initiatives to support people living with dementia.

> *"On the day of the visit we observed a music reminiscence group in progress. The trust had recently commissioned a reminiscence newspaper, 10 copies of which would be delivered daily and were available for patients. Staff told us there was an orientation group each day and the newspaper would form part of that discussion."*
>
> Extract from MHA monitoring visit report

It is important to understand the distinction between religious and cultural needs. Our reviewers have not always found patients' cultural needs being met on the wards, especially regarding hair and skin care – for example, Black women not being given the right hair and skin care to meet their needs. However, patients have also told us about a ward that "had access to a barber who specialised in Afro-Caribbean hair".

Restrictive practices

The Human rights framework for restraint asserts that "Restraint that amounts to inhuman or degrading treatment can never be justified", but that this is "more likely... when it is used on groups who are at particular risk of harm or abuse, such as detainees, children and disabled people."[11]

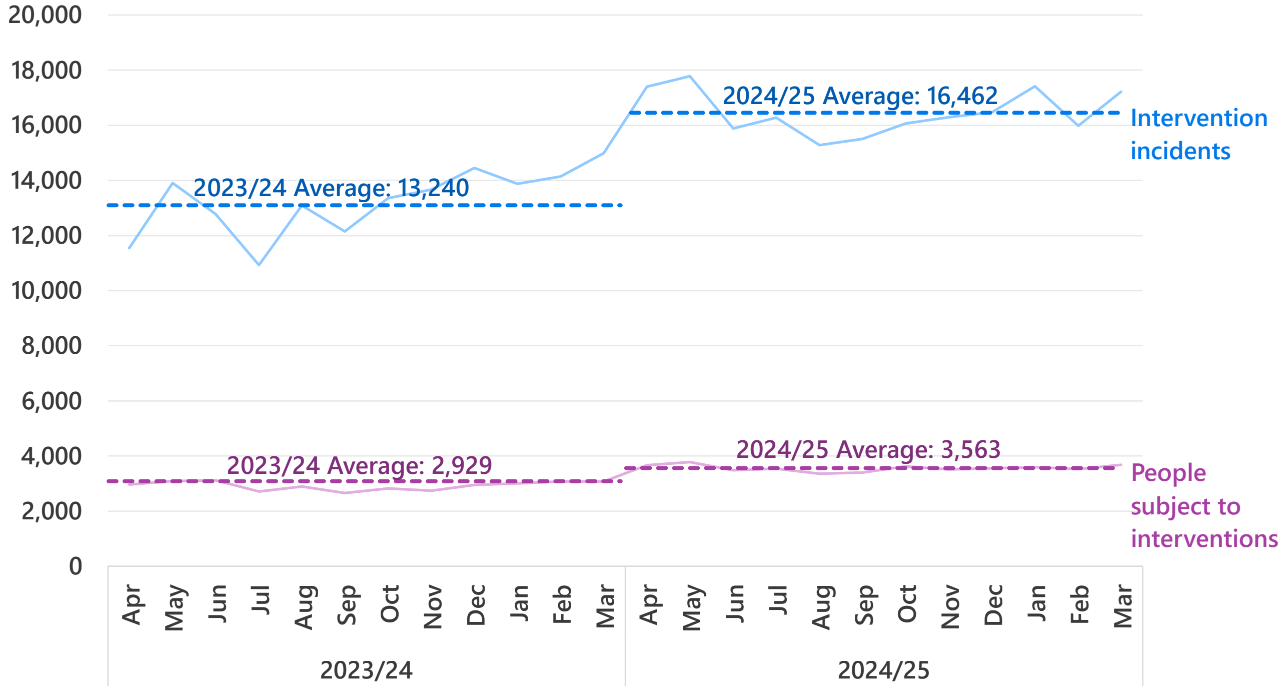
In last year's Monitoring the Mental Health Act report, we affirmed that although restrictive practices are appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights, our expectations are that everyone working in health and care has a role to play in reducing their use.

Through our MHA complaints function, we have received feedback about inappropriate use of restraint, where people told us of staff using excessive force on people, causing bruises, marks, and being left with feelings of "humiliation" and "degradation". Although we have continued to find examples of services that have been able to reduce the use of restrictive interventions, national data shows an increase in the number of reported incidents.

Mental health inpatient settings report occurrences of restrictive practice through the Mental Health Services Data Set (MHSDS). The level of reporting has continued to increase in inpatient settings, which could in part reflect better reporting practices across providers, but analysis of the data suggests that more people were subject to restrictive interventions more often between 2023/24 and 2024/25, with the average number of restrictive interventions each month rising by 24% from 13,240 to 16,462. Also, the average number of people subject to restrictive interventions each month increased by 22% – from 2,929 to 3,563 (figure 2).

This is further supported when looking at the number of restrictive intervention types (such as physical, chemical, or mechanical – use of belts and other restraints, and seclusion). The average monthly number of restrictive intervention types has risen by 26% between 2023/24 and 2024/25.

Figure 2: **Number of restrictive interventions per month, 2023/24 and 2024/25**



Source: NHS England's Mental Health Services Dataset monthly statistics.

Many of the seclusion and segregation rooms we saw met the design requirements of the MHA Code of Practice, and patients were supported appropriately. For example, in one service independent advocates who covered 3 wards told us that when they saw patients in seclusion they were wearing their own clothes and had been given food and drink at regular intervals and on request.

However, some rooms were not meeting requirements. For example, in one room the mattresses were too thin and close to the ground, which could be particularly difficult for patients with impaired mobility. Some seclusion rooms were also in need of a clean and needed repair work to doorframes and paintwork.

> *“The [seclusion] room was not clean and ready for use. There were splashes of what appeared to be bodily fluids on one wall and there were remnants of dried tissue/toilet paper on another.”*
>
> Extract from MHA monitoring visit report

On many wards, staff told us they rarely used the seclusion or segregation room or did not use them at all, and a few wards did not have any seclusion facilities. We heard how this was because they wanted to reduce the use of restrictive practices on the ward, with some wards telling us they used other de-escalation methods in the first instance, such as verbal de-escalation and low-stimulus quiet rooms.

Some services we visited were using bedrooms for seclusion, with one service’s policy stating that “a patient’s bedroom for the purpose of seclusion or other isolation should be based on clinical rationale and not due to a lack of suitable designated seclusion facilities.”

> *“Patients on ward who had experienced bedroom seclusion told us they had not been restrained prior to their period of bedroom seclusion. Two patients said they had felt safe in their bedrooms and were aware of the reasons why they had been secluded. One patient told us there had been no issues staying in touch with family and friends during seclusion and they were able to access fresh air and activities off the ward daily. All patients told us they had access to a television, activities and games in their bedrooms.”*
>
> Extract from MHA monitoring visit report

Patients used our complaints process to tell us about occasions when they believed they had unfair restrictions placed on them. These usually involved leave (both escorted and unescorted) and visits from relatives and loved ones. Restrictions also included policies on personal possessions and everyday items. Patients sometimes felt these restrictions were enforced solely as a way to punish them for behaviour that staff considered unagreeable, rather than to guarantee the safety of the patients themselves. It is important that services are open about their rationale for restrictions wherever possible, to avoid such perceptions.

We saw through our monitoring that, on some wards, access to various rooms was restricted for all patients, including bedrooms, laundry rooms, kitchens, gardens, living spaces, and bathrooms. We mention in this report how this is partly due to low levels of staffing. Some patients said this had an impact on their recovery.

> *"During our visit we saw blanket restrictions where patients were not able to access fresh air or use the laundry room without staff supervision. This was due to these areas needing to be accessed through a locked fire door and were noted on the blanket restriction register. Patients we spoke with said not being able to access fresh air when they wanted was restrictive."*
>
> Extract from MHA monitoring visit report

To reduce restrictive interventions, we have seen services using technology to keep people safe, while giving people who are detained some control over their lives.

> *"Patients had wrist fobs that were programmed according to an individual risk-assessment to allow or restrict patients' access to any room or patient area, and to the outside balcony attached to the ward, so they could go out for fresh air. Access could be programmed to scheduled times, so access was available at some times but not others, based on clinical need and individual risk. This removed the need for blanket restrictions related to locking rooms, enabling a least restrictive approach. The services gave us an example where 2 patients could access the laundry independently using their fobs – but only at alternative times to avoid known potential triggers for conflict."*
>
> Extract from MHA monitoring visit report

In our last MHA monitoring report, we acknowledged that periodic observation by staff during the night, while often necessary, can disturb patients' sleep and be experienced as severely intrusive. We noted that some services have adopted digital contactless patient monitoring technologies in part to lessen this disturbance. Such systems have had a controversial reception from some service user groups, and in 2025 we published guidance on our expectations in relation to practice around these.[12]

Other services are rethinking whether the common practice of regular night-time checks for every patient is necessary or proportionate. The Sleepwell project, initiated by the Positive and Safe Care team at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, used individualised risk-assessment to identify patients who could be allowed a 'protected sleep period' between midnight and 6am, where no checks were carried out. Although this was not suitable for all, for many patients this has been found to be safe and effective, with the added benefit of better sleep helping patients get the most out of their treatment in the daytime. We are pleased to note a number of services are now piloting this scheme with a view to adopting it.[13]

Discharge

In our 2024/25 State of Care report, we highlighted from feedback that the increasing pressure on mental health services is leading to people being discharged from services before they were ready, increasing the risk of relapse or re-admission.

As discussed earlier, our MHA reviewers have raised concerns about a lack of beds in step-down wards, which leads to patients being discharged home inappropriately.

We have also seen through our monitoring that the availability of residential or nursing care homes can cause delays to discharge:

> *"We were told that one current patient had been turned down by [many] care homes on the basis of their complex needs and presentation. In another case, a patient's relatives had been unhappy with the proposed care home but no appropriate placement had been identified. These patients had been admitted to the ward for nearly 1 year instead of the average length of stay of 2-3 months."*
>
> Extract from MHA monitoring visit report

The inability to move into a step-down ward or a place in the community can have a negative impact on people. Delays can keep patients in a ward that is no longer appropriate for them, or where they experienced more restrictive conditions than they needed. One ward told us that some people were re-admitted following discharge because there were either no appropriate placements available or no placement would accept them.

> *"One carer told us that their daughter was preparing to be discharged to supported living but there had been delays. They said they were concerned that their daughter would get discouraged, undoing all the progress that she had made."*
>
> Extract from MHA monitoring visit report

More positively, we have seen through our monitoring where services have taken a joined-up approach to discharge planning:

> *"Staff referred patients prior to discharge to the trust's home treatment and community mental health teams for additional community support. Patients continued to receive interventions post discharge from the same responsible clinician they had on the ward. The hospital's discharge co-ordinator supported the patients and multidisciplinary team with the safe discharge of patients."*
>
> Extract from MHA monitoring visit report

Throughout our IC(E)TR reviews, discharge planning was viewed as an important part of supporting people to leave long-term segregation. Review reports often noted that there was no discharge plan in place and recommended that providers start to create a pathway for people to leave long-term segregation by working with other stakeholders, such as commissioners and local authorities, as well as with the person and those who represent their best interests. Reasons for discharge planning not happening included:

- lack of staff skills and knowledge
- lack of leadership within the clinical team
- lack of understanding of the person's requirements
- disagreement between stakeholders.

Experts involved in the reviews thought this lack of leadership could lead to a culture of 'stuckness' where, although staff might want to support someone to leave, a team might become collectively uncertain about how to do this. In our reviews, we have seen independent stakeholders from external initiatives providing the necessary leadership and direction, often implementing a human rights-based approach and focusing on staff building a good relationship with people in long-term segregation to better understand their wants and requirements.

Inequalities

Inequalities

Key points

- Many services ensured their staff had completed mandatory training in learning disability and autism. However, some staff, especially agency and bank staff, were seen to lack the right skills, as patients reporting being unsupported, misunderstood, or spoken to in ways that felt undignified.
- We continue to see variation in confidence across wards in providing support to lesbian, gay, bisexual, and transgender patients.
- We still have concerns about systemic inequalities relating to people's ethnicity. People of Black or Black British ethnicity were over 8 times more likely than those of White British ethnicity to be subject to a community treatment order in 2024/25.
- The Patient and Carer Race Equality Framework (PCREF) aims to support NHS trusts to become actively anti-racist organisations. It is now mandatory across mental health trusts and providers of mental health services that receive NHS funding. However, during 103 monitoring visits between January and March 2025, staff in more than three-quarters (77%) of these services said they had not heard of PCREF.
- We continue to be concerned that people living in areas of deprivation are more likely to experience inequalities – for example, people living in the most deprived areas were 3.6 times more likely to be detained under the MHA than those in the least deprived areas.
- The number of children and young people (under 18) awaiting a first contact following referral to NHS mental health services increased by 20% between 2023/24 and 2024/25, rising from a monthly average of 237,590 and 285,510 (both values are a 3-month rolling total). Over the same period, the median monthly waiting time increased by 65% from 175 days in April 2023 to 288 days in March 2025.

Care for autistic people and people with a learning disability

Care planning

It is important that services ask patients about their own needs. Our MHA reviews have highlighted services that supported people with a learning disability and autistic people by creating individualised, patient-focused care plans, with input from the patients themselves and their carers. For example, one care plan had ensured that a patient who had a secondary diagnosis of autism was provided with ear defenders, a weighted blanket and access to a sensory room, to help support their individual needs.

Positive Behaviour Support (PBS) plans were also used effectively, incorporating personalised strategies for managing risks and triggers. However, we also saw instances where care plans lacked sufficient detail and failed to address individual needs, including support for autistic people and recognition of religious requirements. This meant that, on occasion, it was not clear how these patients would be supported while on the ward.

We have also seen instances through our Independent Care (Education) and Treatment Reviews (IC(E)TRs) where people's care plans were not up to date with assessments. This meant that care plans for autistic people and people with a learning disability who were in long-term segregation did not always fully reflect their requirements.

Environment and adjustments

Our MHA reviewers are concerned that people with a learning disability and autistic people are admitted into unsuitable environments too often due to pressures on capacity in the system. One reviewer gave an example of people with a learning disability, who may need only a lower level of support for their mental health, being admitted to a psychiatric intensive care unit, despite it being the wrong environment for them. The reviewers explained that this can lead to more incidents, poor experiences and segregation, as patients' sensory needs are not being met.

Our analysis of MHA monitoring reports also found that the suitability of environments for autistic people and people with a learning disability varied between services.

Although some wards were suitable, for example by using pictorial signs and posters or providing quiet rooms, several reports found some ward environments to be unsuitable for autistic people. Issues included loud noises, a lack of low-level lighting, a lack of quiet and sensory spaces and décor that did not support sensory needs. During one visit to a hospital that had seen an increase in admissions of autistic people, staff and patients told us that the ward environment did not meet the therapeutic needs of people with sensory needs, as it could often be loud. We included this in our Provider Action Statement, to which the provider responded by committing to install sound dampening products on both wards.

> *"Staff told us they would try not to admit patients with a learning disability or autism diagnosis due to environmental issues on the ward, such as no low lighting. However, during our visit there were patients detained on [the ward] with a learning disability and autism diagnosis. One patient said the environment was not helpful or beneficial for their recovery. They told us the ward was chaotic and they needed a low stimuli environment."*
>
> Extract from MHA monitoring visit report

A participant in our Service User Reference Panel focus groups, who is autistic, highlighted how what suits one person in terms of a sensory environment may not suit another autistic person. They suggested that wards should offer a variety of spaces, as well as staff who are trained and competent in understanding individual needs, to better support people's individual sensory needs and preferences.

Findings from our IC(E)TR reports highlighted instances where people did not have access to equipment or environments that sufficiently met their requirements. For example, one review report noted that a person's specialised sensory equipment was lost for months, but no action was taken to replace it. Another report implied that someone's living environment was at odds with their requirements as an autistic person with a learning disability, and although there was a potentially less restrictive option for them with "convenient access to fresh air" that was "less noisy", which could aid their sensory requirements, this was not made available.

We also found evidence that some people were not receiving assessments, and that some people's assessments were being carried out in a way that did not properly identify their requirements. These issues meant that adjustments were not always made to enable them to progress out of long-term segregation. For example, for one person, a provider relied on "a sensory profile and communication passport implemented at the former hospital", which needed to be updated. The lack of up-to-date assessments meant the provider was unable to determine whether "sensitivities might also be impacting on the way they experienced the world and others, which might be linked to an increased risk of harm, particularly to others". Given that long-term segregation is a last resort, if valid assessments are not in place for people, services might have missed opportunities to identify alternative, less restrictive ways of caring for people in alternative settings.

Staffing and training

Through our monitoring activity, we have seen many services that ensured their staff had completed mandatory training in learning disability and autism, helping to promote informed and compassionate care. Some wards had dedicated 'green light champions', who received enhanced training to advocate for autistic people and people with a learning disability. Others had specialist teams or access to professionals like occupational therapists and psychologists for sensory assessments.

However, concerns were also raised in MHA monitoring reports about inconsistencies, especially about agency and bank staff, who were sometimes perceived as lacking the skills to support autistic patients effectively. Patients talked about being unsupported, misunderstood, or spoken to in ways that felt undignified.

At one service, an independent mental health advocate said there had been occasions where autistic people had their bedrooms moved without notice and staff did not stick to care plans or agreed routines.

While acknowledging that staff were willing and caring, the advocate felt that staff needed additional training and awareness of autism to understand the need to follow care plans and agreed routines. The provider responded to our call for action by setting up a new training programme to include autism awareness.

Findings from our IC(E)TRs also flagged that staff did not always have the right skills and training. In order to support each person out of long-term segregation, staff need to receive, and be engaged with, the right training so that they can better understand and support autistic people and people with a learning disability.

Care for LGBT+ people

In our previous reports on Monitoring the Mental Health Act, we have noted variation across wards in confidence over providing support to lesbian, gay, bisexual, and transgender (LGBT+) patients. We continue to hear of difficulties. For example, at one service, patients told our MHA reviewers that they had been misgendered by night and bank staff, despite sharing their preferred pronouns during staff handover. They reported that one staff member had rolled their eyes when they were challenged about using an incorrect pronoun, and that another member of staff had used their previous name. The patient told us that these experiences had caused them upset and made it difficult to develop therapeutic relationships with some members of staff. The provider responded to our call to action by mediation with the ward manager to repair the relationship, supporting staff to attend educational sessions on gender identity and booking all nurse leaders on training to support them to challenge direct and indirect discrimination.

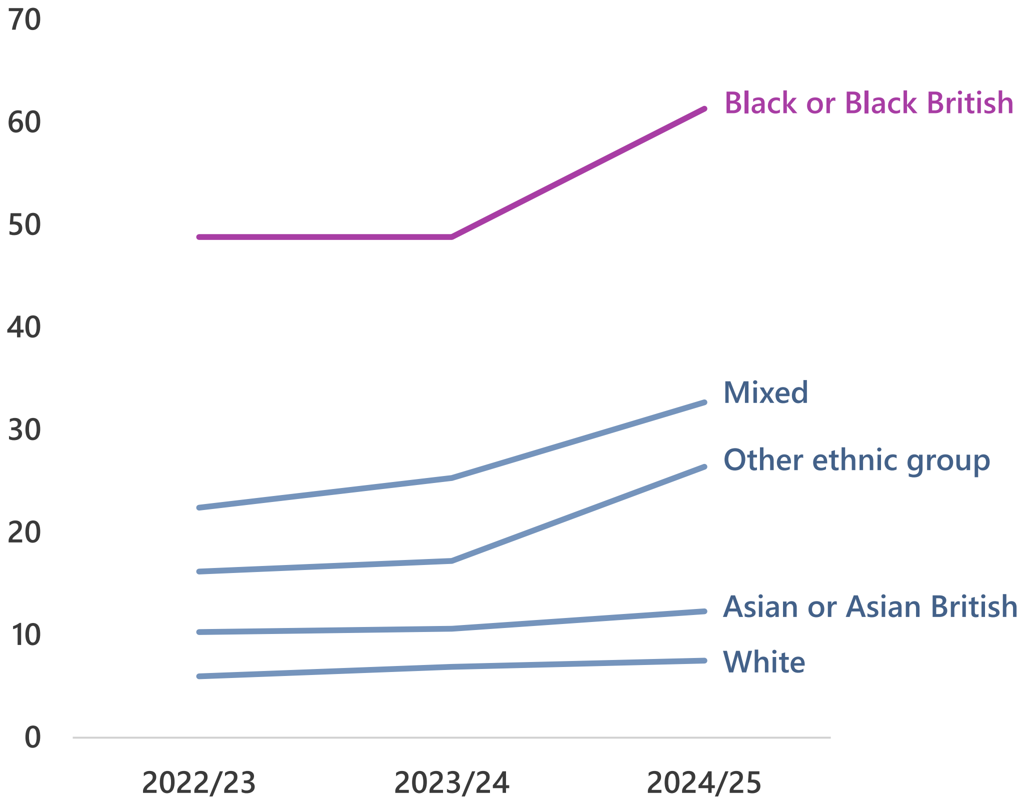
But several services were actively supporting LGBT+ patients. For example, some services have participated in LGBT+ events and initiatives, including day trips to celebrate Pride month. We also saw services making sure transgender people were treated with dignity and respect and received the appropriate support – for example, by allocating bedrooms based on the patient's preference, providing gender neutral bedrooms and ensuring staff used the correct pronouns in both conversation and patient records.

> *"Staff documented specific needs within a care plan relating to this patient's transition [who identified as transgender]. We noted this patient's care plan was written with support from an external agency who supported young people during their transition."*
>
> Extract from MHA monitoring visit report

Ethnicity

We continue to be concerned about systemic inequalities relating to people's ethnicity. Analysis of NHS England's Mental Health Act Statistics found that in 2024/25, people of Black or Black British ethnicity were much more likely than any other group to be subject to a community treatment order (CTO) – over 8 times more likely than those of White British ethnicity. Between 2023/24 and 2024/25, people of Black or Black British ethnicity also experienced a 26% increase in CTOs. People in 'Other ethnic groups' showed the highest increase of 49%, rising from 18 to 26 standardised per 100,000 population between 2023/24 to 2024/25 (figure 3).

Figure 3: **People subject to community treatment orders (standardised per 100,000 population) by ethnicity, 2022/23 to 2024/25**



Source: NHS England's Mental Health Act Statistics.

Data also shows that in 2024/25, the standardised rate of detentions per 100,000 people of Black ethnicity was 262 per 100,000 population compared with 66 per 100,000 for people of White ethnicity. This means the rate of detention for Black people was 4 times the rate for White people.

At 18%, people of Black ethnicity also experienced the highest rate of repeated detentions in 2024/25, compared with 17% for those of Mixed ethnicity and 15% for those of White ethnicity.

Black working-age adults also had longer stays as an inpatient: stays of 60 days or more were almost 4 times higher than for White adults (a crude rate of 113 compared with 29 per 100,000 population).

Black men's mental health

In our latest State of Care report for 2024/25, we highlighted the longstanding inequalities in mental health care that Black men experience.

To develop our understanding of how Black men experience mental health care, we commissioned Queen Mary University (QMU) and University College London (UCL) to carry out a rapid review of what 'good' looks like in relation to access to care, experience of care, and outcomes for Black men. As part of the review, the team carried out a literature review, which showed that Black people (that is, people of Black Caribbean and Black African heritage) continue to face stark and persistent inequalities in mental health care.

The literature review found that not only are Black people 3 to 5 times more likely to be diagnosed and admitted to hospital with schizophrenia compared with all other ethnic groups, they also are less likely to access care early. Inequalities affect Black people along the entire care pathway from access to diagnosis, assessment, treatment and recovery.

Members of the review team spoke with 23 people, including those with lived experience, family, carers, charities and advocacy groups, and providers of services to hear their experiences.

People described stigma as one of the main barriers to accessing mental health services – both in terms of the way communities often viewed mental illness as a sign of weakness or shame, and past experiences that have led to distrust in services.

> *"Stigma around mental health services and fear of dying in services prevents communities from encouraging loved ones to access services. I think when you come from a racialised background, our communities are fearful of stigma and also fearful of the real things that do happen, such as people dying in like mental health services."*
>
> (Person who uses services)

Participants in the research by QMU and UCL described how care that was not holistic and was focused on medication could mean that the causes of the patient's mental health condition were not addressed and would probably continue to be there after the treatment ended.

They also felt that the ability of services to deliver holistic care was also affected by the current fragmentation of the healthcare system, where there were notable gaps in the communication between providers.

> *"You may see a nurse, an [occupational therapist], a psychiatrist, a psychologist…the multidisciplinary team sometimes is more challenging in the way that they communicate to each other. It shouldn't be our responsibility to take bits and pieces [of information] and make sure these are communicated."*
>
> (Family member/carer)

Findings from the literature review show that staff must be properly trained to fight racism and support Black men with respect and understanding, and that services need to be held accountable when they fail to do the right thing.

Patient and Carer Race Equality Framework

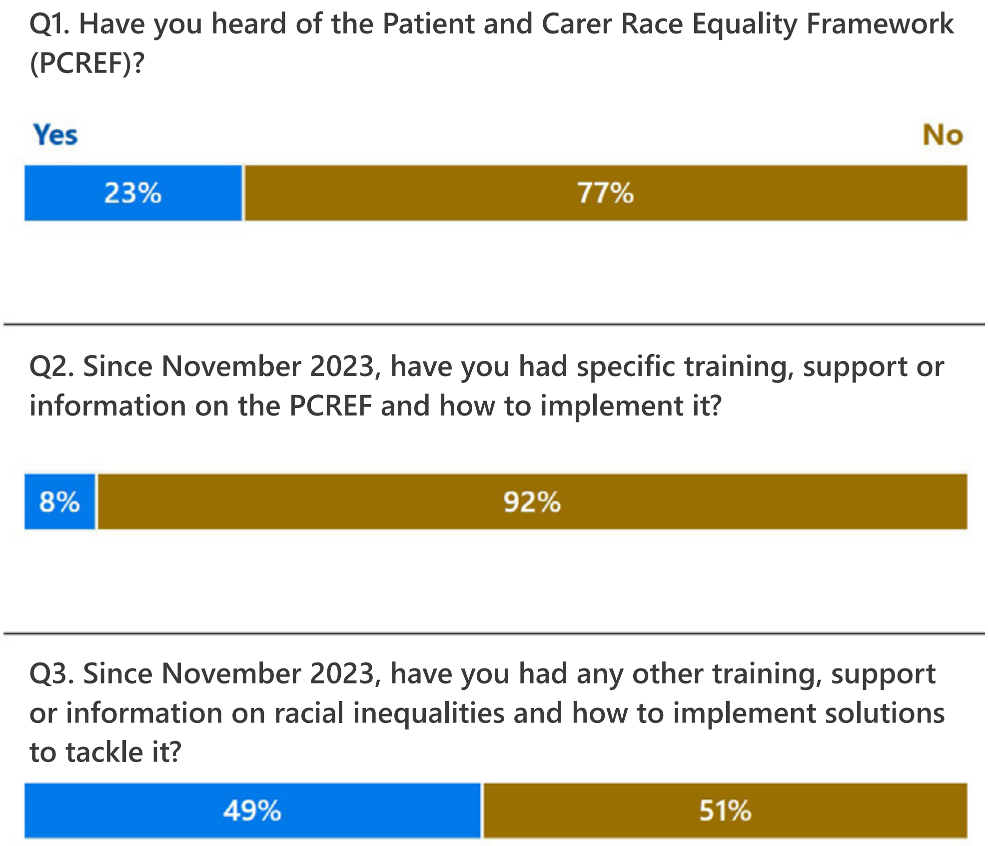
The Patient and Carer Race Equality Framework (PCREF) aims to support NHS trusts to become actively anti-racist organisations. In last year's Monitoring the Mental Health Act report, we reported on continued positive findings of PCREF pilots and early adopter sites.

It is now mandatory across mental health trusts and providers of mental health services that receive NHS funding. In the last quarter of 2024/25, MHA monitoring teams asked focused questions about PCREF on their monitoring visits.

Our MHA reviewers have noted that staff in many wards, including ward managers, seemed to be unaware of PCREF. This is despite it being mandatory for NHS mental health trusts and providers to have the framework in place by the end of 2024/25.[14] One reviewer commented: "every ward I go to, nobody's heard of it". To look into this further, our reviewers asked staff, mainly ward managers, a standard set of questions during 103 monitoring visits between January and March 2025. The results also point to a poor knowledge of PCREF among staff on these wards:

- in more than three-quarters (77%) of services visited, staff said they had not heard of PCREF
- staff in only 8% of these services said they had received specific training, support or information on PCREF and how to implement it since November 2023
- in half (51%) of the services, staff said they had not received any other training, support or information on racial inequalities and how to implement solutions to tackle it since November 2023 (figure 4).

Figure 4: **Patient and Carer Race Equality Framework knowledge and training questions, January to March 2025**



Q1. Have you heard of the Patient and Carer Race Equality Framework (PCREF)?

Q2. Since November 2023, have you had specific training, support or information on the PCREF and how to implement it?

Q3. Since November 2023, have you had any other training, support or information on racial inequalities and how to implement solutions to tackle it?

Source: CQC's own data collected by MHA Reviewers during monitoring visits in final quarter 2024/25.

We support PCREF as a practical tool to tackle racism and dehumanisation. We will continue to encourage services to embed the approach through our regulatory and monitoring activity, and will be checking how services use the framework as evidence to inform our assessments, using our guidance.[15] 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.

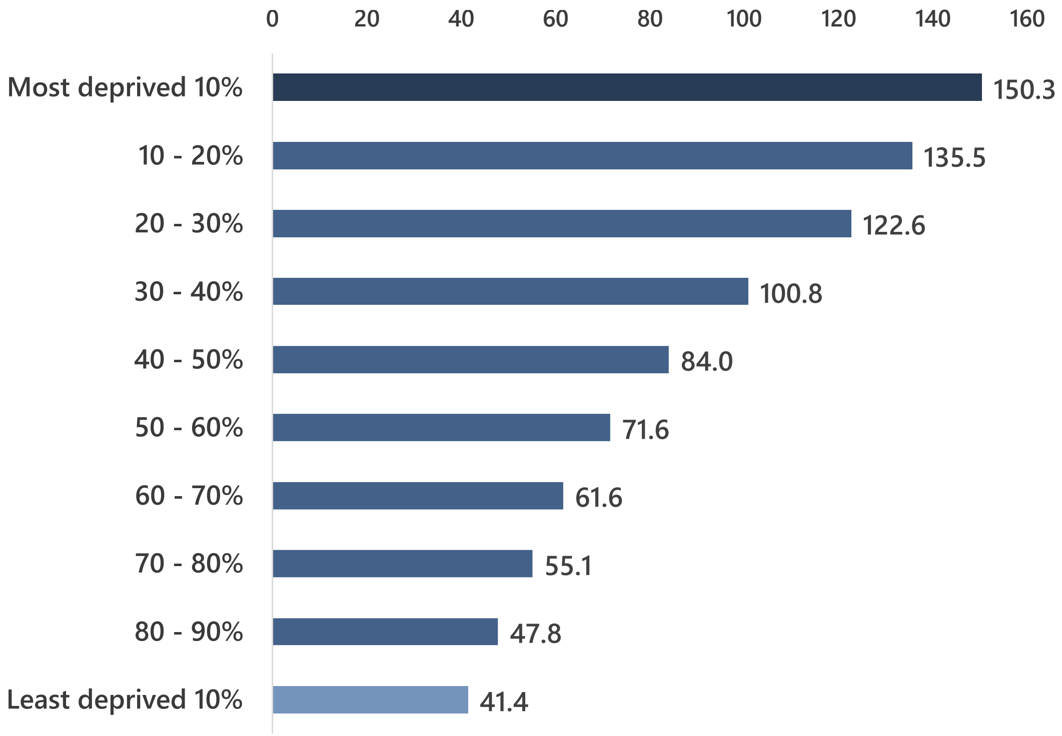
As a regulator and monitoring body, it is important that we do not hold others to account for actions we are not taking ourselves.
We stand against racism, violence, aggression and abuse in all forms. We are currently adopting the principles for an anti-racist organisation set out by the NHS Race and Health Observatory. 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 our colleagues in CQC.

Deprivation

People living in areas of deprivation are more likely to experience inequalities. This is reflected in NHS England's latest survey of mental health and wellbeing, which found that the proportion of adults with common mental health conditions was higher in those living in the most deprived fifth of areas.

Our analysis of Mental Health Act Statistics shows that in 2024/25, people living in the most deprived areas were 3.6 times more likely to be detained under the MHA than those in the least deprived areas (figure 5).

Figure 5: **Crude rate of detention by deprivation decile per 100,000 population, 2024/25**



Source: NHS England's Mental Health Act Statistics.

NHS England's figures also show that people in the most deprived areas were more likely to have longer stays on a mental health ward as an inpatient – particularly for working-age adults. In 2024/25, among adults aged 18 to 64, the crude rate of people staying in hospital for more than 60 days was 75 per 100,000 in the most deprived areas, compared with 17 per 100,000 in the least deprived areas.

A further concern is that in 2024/25, people in the most deprived areas were over 3 times more likely to experience a new out-of-area placement than those in the least deprived areas. An 'out-of-area placement' is a bed in a hospital outside someone's local area, which may mean that they cannot receive regular visits from their care co-ordinator to ensure continuity of care and effective discharge planning, or their family and carers.[16]

Emily's story

Emily, who is working age and lives in a relatively deprived area of England, was diagnosed with depression and anxiety by her GP, who referred her for cognitive behavioural therapy.

When Emily told her GP that the therapy wasn't working for her, her GP offered her 'general' mental health advice (for example, to take walks). She felt that her GP had just become used to seeing her crying her eyes out, and she lost faith in her GP practice, which did not refer her to any more services.

Emily feels that if the GP practice had referred her to a community service, what came next might have been prevented.

As Emily's mental health continued to deteriorate, her mum called the crisis team on multiple occasions but said it wasn't easy to get them on board.

When Emily got to the point where she was physically trying to end her life, the crisis team came out to visit her and called the police and an ambulance.

Emily was panicked and not fully aware of what was happening, she was handcuffed and detained under the Mental Health Act. She didn't know her rights, and her family, who watched in horror as she was taken away, did not know what it meant to be detained. Emily said she felt "almost like a criminal".

Emily was initially taken to a local hospital, which didn't have enough space to accommodate her on a longer-term basis. So, after a couple of weeks, she was taken to a hospital outside of her local area, where she could be more closely supervised.

While the second hospital was clean, Emily said she thought it felt "like prison". She was kept in a small room with a bed, where she couldn't open a window or access electrical equipment. Although Emily later came to understand that these measures were for her safety, she reflected that the room itself looked "miserable". She would have appreciated the opportunity to personalise the space, or to put some colour on the hospital's blank walls.

For the first few weeks, Emily was mainly left alone, without visitors except for staff administering her medication (often with restraints due to Emily's refusals). She called her brother every day, but staff didn't ask if she needed anything and they stayed in their offices. She felt lonely, and she was confined to her room without explanation.

For the first month of her stay, no one explained to Emily what was going to happen to her, what medication she'd be given, or which therapy she could be offered.

A few weeks later, Emily's brother was allowed to start visiting her, and Emily was given access to various therapies, as well as a well-kept outdoor space, and communal rooms for patients (including a games room and a television room). She could be social again and learn about the other patients' journeys into detainment.

Once she'd started to feel a little better, Emily's brother would cook with her, check she was eating properly, and remind her of the world outside of the hospital.

Emily was soon allowed to go outside for supervised walks for up to an hour. However, on returning to the room, she would become upset – especially when realising that she would miss Christmas with her family that year.

During her sixth month, hospital staff described Emily's discharge plan to her and her family, explaining that medical staff would visit her at home to conduct medicine reviews. She was allowed to ask questions about the plan and felt supported after she was discharged.

However, she still believes that if the GP practice and the crisis team had been better co-ordinated, her mental health might not have deteriorated so severely.

(From an interview with a member of the public for this report)

Children and young people

Access

Children and young people are still facing challenges in accessing mental health care.

In our most recent State of Care report, we noted issues with waiting times for community health services. These include community paediatric services, which provide care for children who need diagnostic assessments and initial support for complex and ongoing physical and mental health issues, including neurodivergent conditions, such as attention deficit hyperactivity disorder (ADHD) and autism.

As at December 2024, the majority of people waiting over a year for community health treatment are those waiting for community paediatric services. They make up 85% of the community healthcare waiting list, compared with the next most-awaited service – speech and language therapy – which accounts for 10%.[17]

According to NHS England data, the number of children and young people (under 18) awaiting a first contact following referral to NHS mental health services increased by 20% between 2023/24 and 2024/25, rising from a monthly average of 237,590 to 285,510 (both values are a 3 month rolling total). Over the same period, the median monthly waiting time increased by 65% from 175 days in April 2023 to 288 days in March 2025.

Ethan’s story

When Ethan was 10 years old, he was referred to a community hospital. Following an assessment, he was told that although he closely met many of the criteria for autism, he did not meet the threshold for diagnosis.

His mum, Claire, describes a difficult few years at school where Ethan experienced bullying as others perceived his behaviour as juvenile.

By the time Ethan was 16, he was struggling to read. He worried that he might be unable to pass his GCSEs or A-Levels, or that he’d struggle to build a family or get a job once he left school. He independently booked a telephone consultation with his GP practice, which offered to refer him to cognitive behavioural therapy or to a mental health charity, but doing so would mean Ethan joining a waiting list for up to a year.

From that point on, Ethan’s mental health deteriorated quickly. His school started to phone Claire, asking her to visit the school to provide Ethan with some mental health support because he had been self-harming himself on the premises – a behaviour that Claire later learned might have been Ethan trying to cope with feeling overwhelmed because of his autism.

Claire suggested that Ethan be taken out of school because she didn’t expect it to monitor him continuously. After the school had referred Ethan to a temporary community social worker, Ethan was eventually taken out of school and later expelled before he could start year 13.

Over the next 4 months, Ethan’s mental health spiralled: he carried out 55 suicide attempts, went missing nearly 30 times, and in the space of 1 week Claire took him to A&E 9 times. During that time, Claire thinks the crisis team at the A&E department could have engaged with him better to understand his needs.

After around a year, Ethan’s social worker and GP attended a multidisciplinary meeting, which decided he should be detained under Section 2 of the Mental Health Act, in a psychiatric hospital for young people.

Although the psychiatric hospital verbally explained to him where he was and what was going to happen, Claire thinks Ethan would have better understood what was happening if it had been written down for him instead.

The psychiatric hospital ensured that Ethan didn’t have access to objects that could put his safety at risk – for example, a phone charger, shoes with laces, and a belt. He was given non-slips socks to wear during indoor activities and was only allowed to open his window a small amount. After around 4 weeks, Ethan was allowed to go outside for fresh air while supervised.

He was given access to an indoor gym, TV room, and sensory room, and enjoyed taking part in social activities like quiz nights.

After around 2 weeks of observations, the staff assessed Ethan for autism. Around 8 weeks later, they diagnosed him with autism.

The psychiatric hospital offered Ethan various forms of therapy, including family therapy, systemic therapy, occupational therapy, autism-specific support, counselling, and speech therapy. Ethan did not wish to engage with any of the therapists, but they continued to observe him to understand some of his non-verbal cues and to ensure that his sensory needs were being met.

The ward staff kept Claire updated on Ethan’s condition through online calls, while respecting Ethan’s privacy. Claire also received updates from Ethan’s social worker and spoke to her GP about her own struggles with her mental health – which began to improve once she knew that Ethan was safe, secure, and taken good care of.

Claire was told that if Ethan hadn’t been detained at all, he would still be waiting for a diagnosis, which would have taken ‘a few years’.

(From an interview with a member of the public for this report)

Environment

The challenges for children and young people in accessing mental health care are also due to a lack of specialist inpatient environments. As we reported last year, this means children and young people are often placed out of area, which can increase the risk of them losing contact with friends and family, and disrupting their education.

Our analysis of MHA monitoring reports and our focus groups have shown that children and young people are still being placed in inappropriate settings such as general paediatric wards, rather than on specialist wards for children and young people’s mental health. We have noted issues on visits to general paediatric wards, as the following example shows.

> *“The [Independent Mental Health Advocate (IMHA)] was not sure if the staff were giving patients information about their legal position and rights as staff did not refer any patients to them… They said: “Staff don’t really understand the MHA. They are medically trained and that isn’t their fault. They are not set up for this”.”*
>
> Extract from MHA monitoring visit report

Our analysis of statutory notifications shows that many children and young people are also still being placed on adult wards. In 2024/25 there were 117 notifications of a child placed on an adult ward.

Although it may be necessary to place a young person on an adult ward in some circumstances, we are concerned that staff working on adult or general wards may lack the specialist knowledge and skills required to provide appropriate mental health care for young people. This includes understanding the expected processes, protocols, and safeguarding standards.

We also continue to see children and young people with mental health needs being placed in settings where the provider may deliver mental health support but has not registered with Ofsted. This means the child does not benefit from the protection of a correctly registered provider.

Analysis of Mental Health Services Dataset (MHSDS) data found that, in 2024/25, females aged under 18 were over 3 times more likely than males under 18 to stay on a mental health ward for 60 days or more (a crude rate of 4 for males compared with 14 for females per 100,000 per population). There was a similar pattern for stays of over 90 days (3 for young males compared with 11 for young females per 100,000 per population).

Restrictive interventions

Children and young people aged under 18, and young adults aged between 18 to 24 experienced the highest rates of restrictive interventions of all types in 2024/25, at a monthly average of 375 and 66 per 1,000 occupied hospital bed days, respectively (based on data from MHSDS). For under-18s, the rate of restrictive interventions per 1,000 bed days has more than doubled in the last 2 years.

In 2024/25, children and young people under 18 years old were most likely to be subject to the most restrictive forms of physical intervention compared to other types of restrictive intervention, at an average of 2,992 incidences a month, including prone, supine, side, seated, kneeling restraint. These were followed by other types (‘not listed’) of physical restraint at an average of 2,628 incidences a month.

We need to understand what is driving these higher rates of restrictive interventions in children and young people.

Our regulatory activity in 2024/25

Our regulatory activity in 2024/25

Mental Health Act monitoring visits

We carried out 635 Mental Health Act (MHA) monitoring visits to 710 wards in 2024/25, the large majority of which were unannounced.

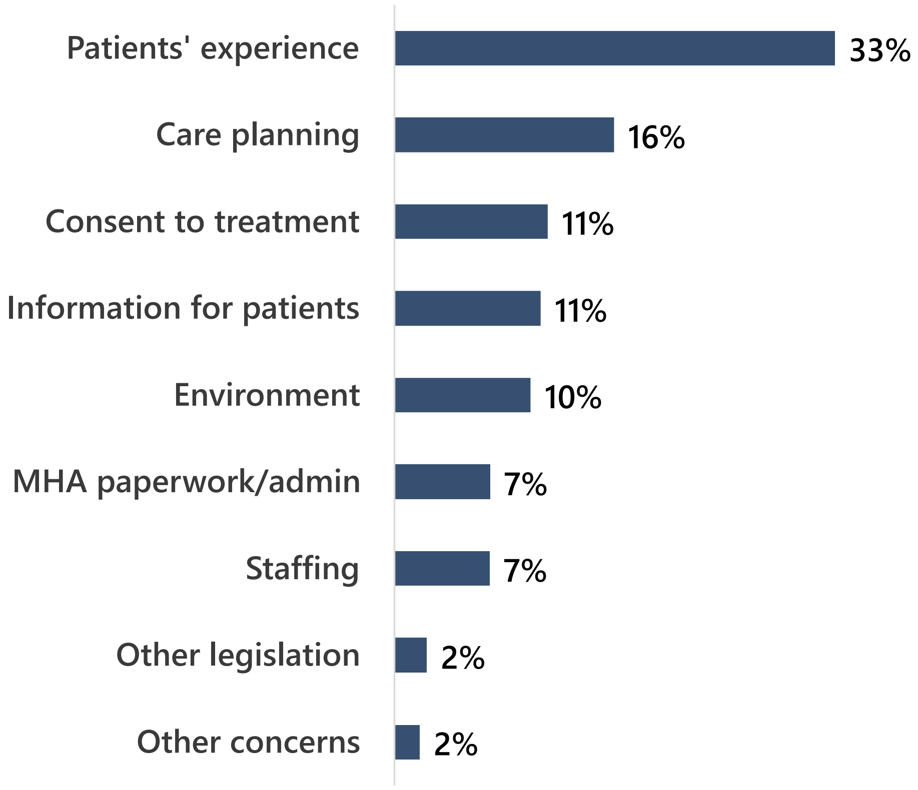
As part of this, we spoke with 3,642 patients (2,771 in private interviews and 871 in more informal situations) and 717 family members or carers.

Most visits were to acute inpatient wards (29%) and forensic wards (23%), followed by older persons wards (13%) and rehabilitation wards (12%).

We requested 3,248 actions from providers to make improvements based on concerns found on our visits. Of the concerns we raised:

- 33% related to patient experience
- 16% related to care planning
- 11% related to consent to treatment (figure 6).

Figure 6: **Themes from concerns raised with providers in Mental Health Act monitoring visits, 2024/25**



Source: MHA activity data. Note: one visit may result in more than one of the same category of concern being raised.

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.

SOAD requests can be made:

- to certify medicine after 3 months from starting treatment for mental disorder after being detained
- when the patient has started a community treatment order (CTO) and it is clear a SOAD will be needed after 1 month
- when the treatment changes significantly
- when electro-convulsive therapy (ECT) is recommended.

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 a person's treatment plans in whole, in part, or not at all. A SOAD can decide not to certify the proposed treatment if, in their view, this is not appropriate.

The majority of SOAD consultations are online, although the proportion of in-person visits has been rising every year for the last 3 years.

Second opinion appointed doctor requests

In 2024/25, we received 15,999 requests for a second opinion appointed doctor (SOAD), which was the highest number since 2019/20.

Most requests (86%) were made for patients recorded as having no capacity to consent (10,055 requests). For detained patients on medication, 4% (405 requests) were for patients recorded as being capable of consent and refusing treatment.

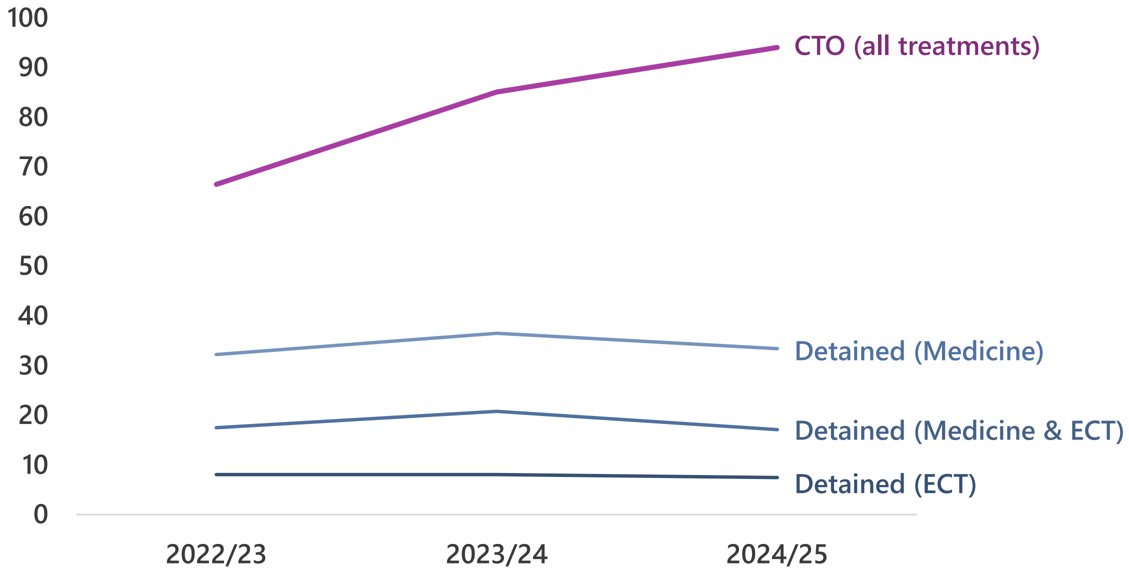
Of all the requests, just over a quarter (27%) were subsequently cancelled (4,351 requests), which is a similar proportion to last year.

Of the 4,351 cancelled requests, 88% were for detained patients. Where a reason for cancellation was recorded, the majority (39%) continued to be because the patient had been discharged from hospital (1,629 cancelled requests). If a patient is discharged before the second opinion takes place, it could mean that for their entire detention period, the patient received treatment to which they did not, or could not consent, and did not receive the statutory safeguard of an independent second opinion to certify the appropriateness of the treatment.

For patients on a community treatment order (CTO), the main reason for cancellation was because the CTO was revoked (32%).

We record the number of days between a request for a SOAD assessment being submitted and the assessment taking place. In 2024/25, this reduced for detained patients for all treatment types compared with the previous year. However, in the context of a year in which the number of reported CTOs increased, the length of waiting time increased by 9 days in 2024/25 to 94 days (figure 7).

Figure 7: **Average number of days from SOAD request submission to second opinion assessment, 2022/23 to 2024/25**



Source: CQC SOAD data.

Where ethnicity was recorded, 71% of completed requests were for White British patients (7,573) and 12% were for Black or Black British patients (1,255). However, Black or Black British patients faced considerably longer waits for SOAD assessments than White British patients – by 5 days on average. The average wait time from submitting a request to a SOAD assessment for White British detained patients was 16 days, compared with 21 days for Black or Black British detained patients. For patients on a CTO, the difference in wait times was even longer – the average wait for Black or Black British patients was 30 days longer than White British patients.

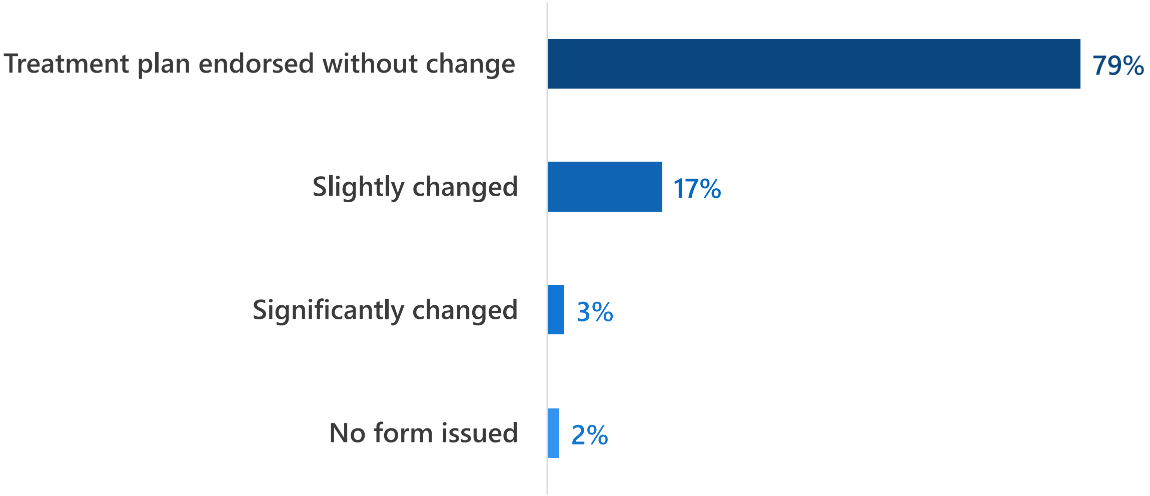
We are taking these differences in waiting times seriously and making it a priority to reduce them. It is particularly important given the systemic inequalities relating to people's ethnicity, including Black or Black British patients, which we discuss throughout this report. We do not yet understand why these differences are happening. Requests for a second opinion are anonymised prior to appointment, so SOADs do not have access to patients' ethnicity information when making decisions about appointments.

To address the differences in waiting times, we are continuing to analyse our data at national, regional and individual provider level to identify any national or local factors, as well as seeing whether there is a link, for example, between waiting times and the complexities of patients' treatment plans. We will continue to monitor and report on the findings of this analysis and the actions we are taking to reduce this inequity.

Outcomes of second opinions

Out of 10,851 completed SOAD requests where an outcome was recorded, 79% of treatment plans were endorsed without change. Around 1 in 5 requests led to some form of change to treatment plan (slightly or significantly) or no certificate issued, which is similar to previous years (figure 8). This highlights the importance of the SOAD service as a safeguard in terms of ensuring that treatment is safe and appropriate for patients.

Figure 8: **Outcomes of SOAD assessments, 2024/25**



Source: CQC SOAD data.

SOADs look at treatment plans that have already been formulated by a primary physician. They will question a treatment plan or modify it if, for example, evidence for its effectiveness to treat the individual patient is weak.

Providers are required under Section 61 of the Mental Health Act to report on treatment that has been certified by a SOAD. These reports are scrutinised by members of a panel of clinicians. If they find any queries or concerns, they raise them with the clinical team to resolve, but it may lead to the withdrawal of the existing SOAD certificate, so that a new SOAD review is required. Examples of these queries include:

- seeking assurance that patients on high-dose antipsychotic medication are receiving the additional physical health monitoring required
- questioning the length of courses of medication used to reduce agitation, given their rapidly decreasing beneficial effect and increased adverse effects, such as increased risk of falls.

Of the 3,758 Section 61 reports received in 2024/25, around 1 in 5 required some sort of follow-up with the provider.

Absence without leave notifications

In 2024/25, we were notified of 644 incidents of detained patients being absent without leave (AWOL). This is lower than last year (824 notifications). Nearly half (45%) of the notifications recorded the patient as being returned by third parties (mainly the police), and a third (35%) returned voluntarily.

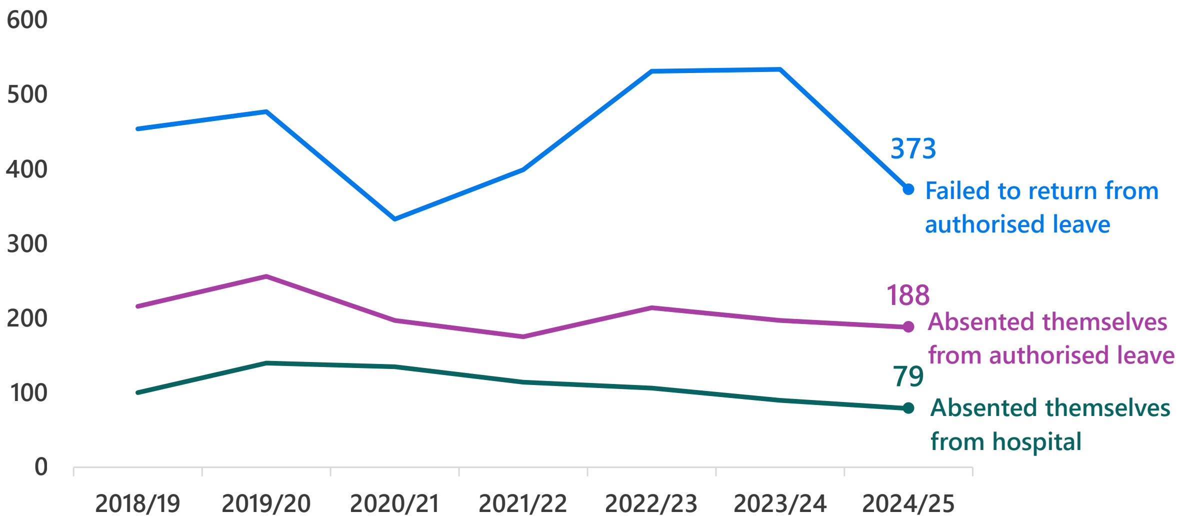
Male patients were more likely than female patients to be AWOL. Of the 633 incidents where gender was recorded, 501 (79%) were males.

Of the 361 notifications that recorded a patient ID, 45 (15%) were AWOL more than once during 2024/25.

Reason for AWOL notification

The overall decrease in the number of AWOL notifications in 2024/25 was mainly because fewer patients failed to return from authorised leave (from 534 in 2023/24 to 373 in 2024/25) (figure 9). Of these, 42% (156) returned voluntarily and 24% (89) were returned by police.

Figure 9: **Reasons for AWOL notification, 2018/19 to 2024/25**



Source: CQC AWOL notifications data.

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

Mental Health Act complaints

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.

During 2024/25, CQC received 2,552 complaints through the MHA complaints system.

Of these, 45% included complaints about ‘Attitude of staff’ (slightly higher than last year at 43%). Complaints about medication (27%), safety (23%) and communication (22%) were the next most common categories assigned (note that a single complaint can be assigned to more than one category).

Telephone calls are still the main channel for receiving complaints (87%). However, there was a notable rise in complaints received by email in 2024/25, to 10% compared with 4% in 2023/24.

Investigations of complaints

If patients, staff or any member of the public are unhappy with the use of powers or how duties have been carried out under the MHA, they can make a complaint to us.

We explained our complaints process and described the nature of the complaints we receive and how they are resolved in a previous Mental Health Act report.[18] For example, people may ask us to investigate concerns that have not yet been considered through a service’s own local complaints resolution processes. In these cases, it is usually appropriate for people to try to get the complaint resolved locally. We will advise them where to look for information and, where appropriate, support them to complain to the service. Once the service has investigated the complaint, we expect them to tell the person making the complaint, and us, about the outcome.

Where local complaints processes have been exhausted, and it is appropriate for us to carry out our own investigation, the complaint will be investigated by a Mental Health Act reviewer.

We investigate when complainants tell us they've not been satisfied with the responses they've received from investigations by their mental health trust or independent hospital.

Our MHA reviewers investigated 8 complaints in 2024/25. Across the 8 investigations, the complaints covered a range of areas of concern. We either partially or fully upheld 7 of these.

The concerns we fully upheld included:

- a patient staying on a ward for 6 weeks without being seen by a consultant
- failure by a hospital to involve a patient's nearest relative in their care
- a patient not receiving a copy of their care plan
- a trust's failure to adhere to its duty of candour policy
- failure to obtain consent for a physical health examination.

When we uphold complaints, we make recommendations for action that providers should take to learn from the issue and to improve. Some examples of action that providers took during 2024/25 included:

- strengthening governance structures around audit processes and safeguarding data
- introducing a new risk assessment and management plans
- improving care plan compliance through oversight meetings
- reviewing documentation and procedures around care planning
- providing workshops on the Mental Capacity Act and consent, and training on investigating complaints to hospital staff.

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

During 2024/25, we were notified of 314 deaths. Of these:

- 253 were detained patients
- 61 were patients subject to a community treatment order (CTO).

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

Of the 314 deaths:

- 174 were from natural causes (a result of old age or a disease, which can be expected or unexpected). The most prominent causes were heart disease (44 deaths) and pneumonia (42 deaths)
- 41 were from unnatural causes (as a result of an intentional cause – harm to self or by another individual, or unintentional cause – an accident). Hanging was the most prominent cause (13 deaths)
- 99 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).

Where gender was recorded for 285 patients who died and were detained or subject to a CTO, 64% were male (182 deaths).

Where ethnicity was recorded for 266 patients who died and were detained or subject to a CTO:

- 81% identified as White British
- 9% identified as Black, African, Caribbean or Black British – an indication of the higher rates of detention under the Mental Health Act for this ethnic group
- 5% identified as Asian and Asian British.

During the year, 6 young people (aged 20 and under) died while detained.

Nearly a quarter of deaths of detained patients were of those on Section 17 leave (72 deaths). Of these:

- 48 patients were on escorted leave when they died
- 11 were absent without leave when they died.

There were 14 deaths of detained patients where it was recorded that the patient died within 7 days of restraint.

Seven patients died during or within 7 days of seclusion or time out.

Appendix A: First-tier Tribunal data

The First-tier Tribunal (Mental Health) has provided its activity and outcome statistics for the year 2024/25. 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 37% 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).

Figure 10: **Outcomes of applications against detention to the First-tier Tribunal (Mental Health), 2024/25**

Activity of Mental Health Tribunal

	Section 2	Other unrestricted	Restricted	All detained patients
Applications	10,326	15,842	3,167	29,335
Withdrawn applications	1,244	3,715	1,010	5,969
Discharges by clinician prior to hearing	3,662	5,652	9	9,323
Cleared at Hearing [1, 2]	7,636	11,457	2,458	21,551
Heard [3]	6,978	8,238	2,461	17,677

Decision of Mental Health Tribunal

	Section 2	Other unrestricted	Restricted	All detained patients
Absolute Discharge	422	301	72	795
Delayed Discharge	199	120	1	320
Conditional Discharge	0	0	438	438
Deferred Conditional Discharge	0	0	78	78
Total discharge by Tribunal	621	421	589	1,631
No Discharge	5,185	8,761	1,380	15,326

Source: HM Courts and Tribunal Service.

1. The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.
2. We are unable to distinguish CTO hearings disposed from the total number of other unrestricted hearing disposals.
3. Includes all cases heard irrespective of outcome including adjourned in the reporting period. Based on decisions both before and after the hearing.

Just over 3% of decisions in relation to CTOs discharge the patient. This is generally less successful than for 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), 2024/25**

Applications	4,869
Withdrawn applications	879
Hearings	4,525
Oral Hearings[4]	3,890
Paper Reviews (considered on papers and therefore patient not present)	635
Discharges by Tribunal	122
No discharge by Tribunal	3,554

Source: HM Courts and Tribunal Service.

4. Oral hearings is based on the total number of hearings less the manual count of paper reviews.

Note: The details are subject to inaccuracies inherent in any large-scale recording system and reflect the best data that is available at the time of publication.

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 of 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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