May 2024

Detailed College response to the 'Independent Care (Education) and Treatment Reviews: final report, 2023, DHSC'

Introduction

Towards the end of 2023 The Rt. Hon. Professor Baroness Hollins published a report on people with an intellectual disability, and autistic people, who are detained in mental health and specialist learning disability hospitals. It was the culmination of the Independent Care (Education) and Treatment Review (IC(E)TR) programme which reviewed the care and treatment of 191 people who were detained in Long Term Segregation (LTS) between November 2019 and March 2023. The Review was commissioned in December 2019 by The Rt. Hon. Matt Hancock MP (the then Secretary of State for Health and Social Care), with Baroness Hollins appointed to oversee the programme.

We welcome this important and timely report which has comprehensively reviewed the use of LTS. We also welcome the Government's response to it. This work applies to England only. We note that policy and practice vary across other UK nations.

We are saddened to hear of the number of distressing experiences of LTS. This must be addressed. We support action to ensure that LTS and other restrictive practices are reduced. They must only be used when necessary and with appropriate safeguards. They must never be used punitively. They should be notifiable events.

Summary

We agree with the following recommendations from Baroness Hollins. In order for them to be implemented in practice, challenges within the system would need to be addressed. We need to see more resources and capacity put into focused and local specialist support, as well as into the wider health and care system.

- **R1: We wholeheartedly agree that all staff working with people with a learning disability and/or autistic people should be delivering therapeutic and human rights-based care. All training for staff must be underpinned by training models that have a proven efficacy for this patient cohort.**
- **R2: We agree that practice leadership should be improved and that commissioners of services for people with learning disability and/or autistic people should therefore undertake appropriate training.**
- **R3: We agree that the assessment and treatment of people with a learning disability and/or autistic people in LTS and seclusion should be informed by good practice. Whilst it is difficult to see how formal**

guidance from professional bodies could add to statutory guidelines within the Mental Health Act (MHA), we welcome the opportunity to share good practice and to engage with Baroness Hollins on this important area, particularly in the context of our support for the updating of the MHA. Given system-level challenges and collective responsibility, clinicians must never be held solely accountable for implementing guidance.

- **R4: We agree that everyone in LTS and seclusion should have access to independent specialist trained advocacy and specialist free legal advice.**
- **R6: We agree that LTS and seclusion should be notifiable events to the CQC and ICB executive lead for learning disability and autism.**
- **R7: We agree that, before admission, clinical contracts must be agreed between commissioners and hospital managers regarding the services being commissioned for people with a learning disability and/or autistic people. As with many of the recommendations listed in the report, translating this recommendation into practice is dependent on workforce and resource challenges across the health care system, including in the community, being addressed.**
- **R8: We agree that to protect those in LTS and seclusion, safeguarding processes must be strengthened. We do not believe, however, that it is possible or advisable to have a blanket rule for 'family members and advocates… to visit those in solitary confinement at any time of day or night if they consider it necessary, in the environment in which they are living'.**
- **R10: We agree that annual reporting is important. Annual reporting should focus on progress towards reducing the use of LTS and seclusion for people with a learning disability and/or autistic people, rather than ending the practices completely.**
- **R11: We agree that action is needed to prevent admission or readmission into hospital at times of acute distress where the community support services do not meet a person's immediate needs.**
- **R12: We agree that DHSC, NHS England, and CQC should commit to funding and delivering interventions to reduce the use of LTS and seclusion and should move people to the least restrictive setting and out of hospital as soon as possible.**
- **R13: We agree with monitoring people who have been in LTS and seclusion to ensure changes are sustainable and they are receiving good community support.**

We do not agree with the following recommendations:

- **R5: We do not agree that 'solitary confinement for people with a learning disability and/or autistic people should become *never events*' for under-18s as well as in the other instances specified.**
- **R9: We do not agree that both long-term segregation and seclusion of people with a learning disability and/or autistic people should be 'renamed solitary confinement'.**

In this response, we welcome many of the recommendations in the report. We set out what is required for these recommendations to be implemented in practice and acknowledge key conclusions and commitments from Government.

As we explain in response to recommendation 5, we are pleased to see that DHSC commit to reducing the use of 'long-term segregation' for people with a learning disability and autistic people. Given that in many ways, LTS (unless grossly misinterpreted) is one of the least restrictive ways to manage risk, the Government should go further and commit to reducing all restrictive practice. At the same time LTS and other restrictive practice must remain available options to be used, when necessary, as part of a carefully considered, multi-disciplinary and co-produced safety plan. The realities of the current situation and lack of suitable alternatives mean that LTS and seclusion each have important functions in the management of risk which is essential for patient and staff safety. We also need to recognise that LTS and seclusion can have roles in best interests plans for patients in the light of realistic alternatives.

In this context, this response also identifies elements of the report that we do not agree with. **We note that the terminology used in the report encompasses within the single term 'solitary confinement' both long-term segregation and seclusion and recommends that this term should inform policy and practice.**

As we set out in response to recommendation 9, whilst definitions do need improvement, we disagree with this approach. Though there are some similarities between LTS and seclusion there should be a recognition of distinct differences which require a separation in terms.

Part of the challenge (and illustrating problems with current definitions) is that the way in which definitions are interpreted and applied in practice varies, with the two terms too often conflated. In this context, it is helpful to recall that the *Mental Health Act: 1983 Code of Practice* (MHA) makes a distinction between the two terms, applying different monitoring and safeguarding protocols to each:

- 'Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'.
- 'Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long-term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm'.

Moreover, the term 'solitary confinement' could be viewed as misleading. We know from the professional practice of our members, including those who work in prisons that solitary confinement usually refers to a practice that involves a person being kept in a locked room. Such rooms might be small and windowless. There can be no obligation for others to interact with the individual, so the person can have little if any contact with others – they are in essence completely alone. This does not correspond to the Mental Health Act specifications for how Long-Term segregation and seclusion should be practised. Patients in Long-Term Segregation and seclusion are monitored by responsive staff and in some cases spend significant periods of the day with others including family members, in activities and through escorted leave.

We recommend instead that seclusion, and Long-Term Segregation are defined separately and in distinction from each other, with thought given to the circumstances of both patients and staff on how the two terms relate to each other. Similarly, a clear distinction should be made between solitary confinement **and** seclusion and LTS. This would support staff to better recognise any deficient practice and would support CQC regulation.

We do recognise, that seclusion, as it is currently defined in the MHA, will always give rise to a state of solitary isolation. Within this context, there may be scope to apply the term 'solitary isolation' to 'seclusion' only. Any changes to definitions would need to be legally codified before implementation.

Given the important roles of both LTS and seclusion, and as we set out in our response to recommendation 5, we do not agree that 'solitary confinement' for people with a learning disability and/or autistic people should become a *never event* for under-18s as well as in the other categories and instances specified.

We note that in their response to the report, DHSC advise that changes to terminology and making 'solitary confinement' a never event would be incompatible with current legislative frameworks. However, we also note that DHSC state that when the *Mental Health Act 1983: Code of Practice* is next reviewed, they will consider a change in terminology and that they may 'consider whether there are further actions [they] can take to include scenarios where long-term segregation is used that falls below the minimum standards as *never events*'. We look forward to further discussion with Baroness Hollins, DHSC and other stakeholders on these points, as well as on the report and its implications more broadly.

It is essential to place the needs of the person, their carers and their families at the centre of this conversation, alongside the expertise of psychiatrists and other healthcare professionals. To help inform this approach we recommend that the raw and anonymised data underpinning the (IC(E)TRs) thematic review is shared with a small number of select stakeholders, including the College.

Report recommendations and College responses, in full

1. *Recommendation 1*

All staff working with people with a learning disability and/or autistic people should be delivering therapeutic and human rights-based care. This should be supported with development opportunities for staff in the community to increase positive risk-taking to help people develop and grow. All staff that use any restrictive practice need to be trained in:

- *law and policy including human rights, and the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child*
- *de-escalation and preventative approaches in accordance with the Restraint Reduction Network Training Standards as legislated in the Mental Health Units (Use of Force) Act 2018*
- *tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the Core Capabilities Frameworks*
- *the HOPE(S) model*

College view

We wholeheartedly agree that all staff working with people with a learning disability and/or autistic people should be delivering therapeutic and human rights-based care.

We are pleased to see that in their response to this recommendation DHSC reaffirm commitments to roll out Oliver McGowan Mandatory training and to develop an associated code of practice. We are also pleased that DHSC state that the HOPES model will be evaluated by an independent research body to assess impact; this is, of course, an imperative prior to its deployment.

All training for relevant staff working with people with learning disability and or/autistic people must be underpinned by training models that have a proven efficacy for this patient cohort. This will require all training models, including those related to Oliver McGowan training, to be regularly monitored and evaluated. Learning will need to be embedded into model refinement and implementation. Evidence bases must be made available to clinicians.

Training in Human Rights must include knowledge of key judgements from the ECHR and the domestic courts. The United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child are framed broadly and are difficult to translate into practical training. They may also contain potential conflicts with domestic law, including the Human Rights Act and ECHR jurisprudence. Domestic law and ECHR jurisprudence are binding and responsive to Parliament.

We must also acknowledge wider system barriers that are likely to make recommendation 1 difficult to deliver in practice.

It is important that staff have the time to access training, which we often hear can be a challenge.

We also need to see investment in high-quality sensory sensitive environments - which by reducing sensory overload have an important role in lessening risk - and in trained multi-disciplinary teams who feel valued and supported in their roles. Clinical teams are highly motivated to provide the best care possible. Services need to be able to support them in this.

It is important to understand that the maintenance of therapeutic environments is reliant on the prioritisation of staff and patient safety, with risks effectively mitigated and services having the capacity to respond rapidly to physical violence (when prevention strategies have been unsuccessful).

No member of staff should be expected to tolerate physical assaults as part of their job, and all patients should feel safe.

2. *Recommendation 2*

Practice leadership should be improved by commissioners of services for people with learning disability and/or autistic people undertaking the following training:

- *tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the Core Capabilities Frameworks*

- *the HOPE(S) model*

DHSC and NHS England should also consider how best to equip commissioners with relevant skills and knowledge to ensure cost effective and humane commissioning, including understanding the legal and policy frameworks relevant to the assessment, planning and delivery of community-based services and support.

College view

We agree that practice leadership should be improved by commissioners of services for people with learning disability and/or autistic people undertaking appropriate training.

See also response to recommendation 1.

It would be useful for commissioners to have experienced practice-based learning in addition to knowledge-based learning. However, to effect change in practice, more would have to be done than training alone, for instance through the specification of provision in clinical contracts.

3. *Recommendation 3*

Professional bodies should issue good practice guidelines on the assessment and treatment of people with a learning disability and/or autistic people in solitary confinement. To help develop those guidelines this should include identifying relevant capabilities from the Core Capabilities Frameworks and training opportunities. These are nationally recognised frameworks that have been developed to capture the skills, knowledge and behaviours needed for staff working across health and social care to support people with a learning disability and/or autistic people.

Clinicians should be held accountable when they fail to follow these good practice guidelines. Examples of failings may include:

- *failing to assess someone in a timely manner*
- *failing to report to commissioners and hospital managers if staff do not have the required skills to deliver recommended treatment*
- *failing to attend C(E)TRs*
- *found to have used punitive measures such as the withholding of section 17 Mental Health Act 1983 leave*
- *failing to develop a clinical environment that does not rely on enforced isolation in solitary confinement*

If someone is admitted to hospital, the referring team in the community should be clear about the goals of admission, and remain involved, seeking to support the person's return home as soon as possible. Their role is firstly relational, building trust, sharing their professional skills, and helping the person to share their story so that their distress can be better understood and seamless, and ongoing care and support provided. Commissioning approaches which favour *episodes of care, where services are commissioned for discrete blocks of time, instead of being outcomes based, are not effective for people with a learning disability and/or autistic people and should be discontinued.*

College view

We agree that the assessment and treatment of people with a learning disability and/or autistic people in LTS and seclusion should be informed by good practice.

We note that in response to this recommendation DHSC state that they are 'supportive of professional bodies issuing guidelines on the assessment and treatment of people with a learning disability and autistic people who are in long-term segregation in a hospital setting'. They further state that these are matters for professional bodies to consider rather than the DHSC themselves.

The Mental Health Act already contains statutory guidelines on the assessment and treatment of people with a learning disability and/or autistic people in LTS and seclusion. Whilst it is difficult to see how formal guidance from professional bodies could add to this at present, we welcome the opportunity to share good practice and to engage with Baroness Hollins on this important area, particularly in the context of our support for the updating of the MHA.

We strongly agree that when someone is admitted to hospital, the referring team in the community should be clear about the goals of admission, and should remain involved with the case, seeking to support the person's return home as soon as possible. We recognise the importance of the care team building mutual trust, sharing their professional skills, and helping the person to share their story so that their distress can be better understood, with seamless and ongoing care and support provided.

Successful implementation of guidance is dependent on factors that are not wholly under the control of staff.

There is a collective responsibility for implementation of guidance and clinicians are often unable to implement good practice guidelines because of challenges within the system.

Responsibility for implementation of guidelines must therefore sit not only with clinicians but also with trusts and commissioners - as well as with the national level decision-makers overseeing the wider system. Clinicians cannot be accountable for the actions of others.

Within this context, it is important to be mindful of the challenges clinicians can face when looking after patients with high-level needs - for instance the needs of patients involved in violence or sexual assault. Our members report that it is becoming increasingly difficult to find placements for complex patients in the face of challenges that include workforce pressures and securing successful police involvement. These challenges must be addressed by Government at a national level.

Whilst LTS and seclusion must never be used punitively, we do not agree that 'withholding Section 17 Leave' should be considered a 'failing' or wholly as a punitive measure, given that reviewing Section 17 leave is an important part of managing patients safely.

Recommendation 4

Everyone in solitary confinement must have access to independent specialist trained advocacy, specialist free legal advice and a redress scheme must be available to them.

College view

We agree that everyone in LTS and seclusion should have access to independent specialist trained advocacy and specialist free legal advice.

We note that in their response to this recommendation, DHSC advise that staff should make patients and their families aware of their rights and resources. To do this effectively staff must have the time and information.

We strongly believe that patients in LTS and seclusion who have faced harm should have access to a redress scheme. Access to a redress scheme should be in accordance with national legislation.

We don't think that a redress scheme should be automatically available to all patients in LTS and seclusion. This would risk creating a culture based on a premise that patients have automatically been treated badly by staff, where clinicians are on the defensive and where clinicians are disincentivised to assess risk with potential adverse consequences on patient and staff safety.

Addressing the legislative system more broadly, we must recognise the responsibility of Courts to reduce the risk of restrictive practice to people when they are ordered to be detained.

5. *Recommendation 5*

Solitary confinement for people with a learning disability and/or autistic people should become 'never events' in the following instances (and see annex C):

- *for children and young people under 18 years of age*
- *where it does not meet minimum standards for adults (see proposed Solitary Confinement Code of Practice Framework, developed by the Oversight Panel)*
- *where it lasts for longer than 15 days*

If solitary confinement is used as a 'never event' it must trigger:

- *a serious investigation as stipulated in NHS England's never event policy*
- *private company directors and senior trust management must be held to account for failing to provide a safe and therapeutic environment.*

The use of other restrictive interventions should be closely monitored to ensure that there is not an increase in their use because of the reduction in solitary confinement.

College view

We very much agree that 'private company directors and senior trust management must be held to account for failing to provide a safe and therapeutic environment'. However, given extensively documented resource problems and lack of suitable alternatives, we don't agree that 'solitary confinement for people with a learning disability and/or autistic people should become *never events*' for under-18s as well as in the other categories and instances specified. Similarly, we do not believe that 'if solitary confinement is used as a *never event* it must trigger a serious investigation as stipulated in NHS England's never event policy'.

Our members report that the realities of the current situation and lack of suitable alternatives mean that for some patients in extreme and rare circumstances - including those under the age of 18 or subject to long-term segregation and seclusion over a period longer than 15 days - long-term segregation and seclusion can be a necessary part of risk management. Risk management is an essential part of ensuring patient and staff safety. We also need to recognise that LTS and seclusion can have roles in best interests plans for patients in the light of realistic alternatives.

The recommended 15-day period is somewhat arbitrary and likely to be rendered unworkable by the ambiguity of current definitions for LTS and seclusion. As set out in our response to recommendation 8 we support the use of and strengthening of safeguarding processes for LTS and seclusion. We are pleased to see that DHSC commit to reducing the use of 'long-term segregation' for people with a learning disability and autistic people. Given that in many ways, LTS (unless grossly misinterpreted) is one of the least restrictive ways to manage risk, the Government should go further and commit to reducing all restrictive practice; we maintain however that LTS and other restrictive practice must remain available options to be used when necessary as part of a carefully considered, multi-disciplinary and co-produced safety plan.

Whilst we largely welcome the proposed minimum standards set out in 'Oversight Panel's solitary confinement code of practice framework', ensuring a 'homely' environment wouldn't be compatible with every aspect of restrictive practice, where there is a need to create a safe and low stimulus environment. Similarly, we are not confident that in practice it would be possible for the 'medical director or an alternative appropriate staff member within the senior leadership team' to sign off 'use of tear-proof clothing or bedding [in an emergency]'.

We note, that in response to this recommendation, DHSC conclude that recommendation 5 would not be workable under the current legislative framework and that in the context of the revision of the Mental Health Act 1983 Code of Practice, they may 'consider whether there are further actions [they] can take to include scenarios where long-term segregation is used that falls below the minimum standards as *never events'*.

We are pleased to see DHSC commit to share and reinforce good practice and quality oversight so that staff working in a mental health inpatient setting can make use of alternatives to restrictive practices.

We would be happy to work with Baroness Hollins, DHSC, NHSE, families and other stakeholders on these issues. We recommend if LTS and seclusion are utilised for any patient they should be subject to stringent checks and balances with a clear rationale given for the intervention and alternatives having been fully considered. They must only be used as a last resort and should not be used for longer than necessary.

6. *Recommendation 6*

Solitary confinement should become a notifiable event to CQC as well as to the ICB executive lead for learning disability and autism and the provider board. The notification should be made within 72 hours of a person entering solitary confinement.

College view

We agree that LTS and seclusion should be notifiable events to the CQC and ICB executive lead for learning disability and autism.

We note that in their response to this recommendation, DHSC advise that they are considering changes to CQC regulations (which would be subject to Parliamentary approval) to improve reporting and notifications by providers to CQC on the use of specified restrictive practices.

We note also the intention that this would provide a better flow of information, supporting CQC to convene an IC(E)TR as soon as possible where someone is moved into long-term segregation, so that recommendations could be made to support safe care and treatment in the least restrictive setting. We would be happy to work with DHSC and the CQC around these issues.

7. *Recommendation 7*

Before admission, clinical contracts must be agreed between commissioners and hospital managers regarding the services for people with a learning disability and/or autistic people being commissioned. These clinical contracts should be outcomes based and include the responsibility of local services, including community clinicians, as well as hospital clinicians, to collaborate to achieve timely discharge.

Key points:

- *clear complaints procedures must be in place to ensure that concerns that an ICB has failed to undertake its commissioning responsibilities appropriately can be investigated thoroughly and in a timely manner. Commissioning should be overseen by the ICB's executive lead for learning disabilities and autism. CQC and NHS England's roles in monitoring effective commissioning should be clarified*
- *commissioners should benchmark their own outcomes and cost effectiveness against best practice in the UK and internationally*
- *boards of private hospital groups and senior management in NHS trusts where crimes are found to have been committed by staff in their hospitals must retain financial and legal accountability*
- *when a person has been detained in solitary confinement, for any length of time, the ICB must ensure:*
  - *the person is offered trauma-informed therapy for as long required*
  - *financial compensation is available and accessible*

College view

We agree that before admission, clinical contracts must be agreed between commissioners and hospital managers regarding the services being commissioned. Contracts should be outcome-based and require local services, including community clinicians, as well as hospital clinicians, to collaborate to achieve timely discharge.

We suggest that ICBs should ensure that the care plan includes clear statements on the discharge pathway. At the time of admission, detail should be given on the model of provision that the person would require in order to leave hospital.

It will be important to establish how contractually based arrangements will help to achieve earlier discharge. (It is important to recognise that if an admission is arranged as an emergency or through the Courts, early discharge may not be possible.) Services would also need to be aware of any consequences that would follow if a contract were breached.

We must also recognise that translating this recommendation into practice and achieving 'timely discharge' is dependent on addressing workforce and resource challenges across the health care system (acute and community). See also responses to recommendations 11 and 12.

We do not agree that financial compensation should be automatically available and accessible. Like points set out in response to recommendation 4, this would risk creating a culture based on a premise that patients have automatically been treated badly by staff, where clinicians are on the defensive and where clinicians are disincentivised to assess risk. Such a culture risks jeopardising patient and staff safety.

Any form of segregation and seclusion must be based on necessity to manage risk. If it is determined that their deployment was necessary to prevent harm this must not result in financial compensation. We note that in their response to this recommendation, DHSC advise that NHSE will continue to consider the outcomes of their 2022 clinical contracts pilot as part of their ongoing work. The College would be happy to engage with DHSC and NHSE on this work.

8. *Recommendation 8*

To protect those in solitary confinement, safeguarding processes must be strengthened by:

- *ensuring that people's, relatives' and staff voices are acted on immediately when a complaint or concern is raised*
- *CQC's 'closed cultures' guidance should be reviewed to see if the guidance remains fit for purpose*
- *family members and advocates should be able to visit those in solitary confinement at any time of day or night if they consider it necessary, in the environment in which they are living*
- *family members need to be provided with information about how to raise a safeguarding or other concern, including having contact details of the responsible commissioner for the hospital placement*
- *current protections for whistle-blowers should be reviewed to ensure protections are adequate and fit for purpose*
- *a safeguarding register should be maintained and shared on an agreed frequency, with CQC documenting indicators of poor care and treatment CQC should make greater use of covert surveillance in a way that does not add to the power imbalance between the staff and patients that already exists. Blanket use of technological surveillance must be regularly reviewed to ensure it continues to meet the principle of least restrictive and remains rights-respecting.*

College view

We welcome most of the recommendation that to protect those in LTS and seclusion, safeguarding processes must be strengthened.

However, we do not believe it is possible or advisable to have a blanket rule for 'family members and advocates … to visit those in solitary confinement at any time of day or night if they consider it necessary, in the environment in which they are living'.

The patient may not wish to receive family/advocate visits; the nature of the relationship with family members could mean that visits could cause further distress and there may already be a policy in place for visits to be restricted – for example for patients in secure care.

There may also be restrictions on hospital visits that arise from the need to maintain safe environments for all. In such cases, we advise that family members should be able to meet their loved ones at mutually agreed times, where this is deemed in the best interest of the person.

Related to 'greater use of covert surveillance in a way that does not add to…power imbalance' and to regular review of blanket surveillance, we emphasise that use of technology should respect the dignity and confidentiality of all people within the unit. We would welcome evaluation of whether surveillance measures are effective at enhancing safeguarding or whether there are unintended harms caused by enhanced surveillance.

We note that in their response to this recommendation, DHSC advise that work is underway to explore how best to prioritise, resource and co-ordinate extensive improvement activity around safeguarding issues related to the CQC – including whistleblowing, closed cultures and related areas. We would welcome the opportunity to engage with the CQC and DHSC on this.

We are also pleased to see DHSC in their response commit to ensuring that all patients, including people with a learning disability and autistic people, receive safe and high-quality care, and to publishing their response to the Rapid review into data on mental health impatient settings (June 2023) . Similarly, we welcome promises that the Health Services Safety Investigations Body (HSSIB) will be 'launching a series of national investigations into mental health inpatient settings as one of its first priorities' to identify and address risks to the safety of patients, making recommendations to facilitate the improvements of systems and practices in the provision of mental health care in England. We look forward to engaging with the HSSIB on this important area of work.

9. *Recommendation 9*

Both long-term segregation and seclusion of people with a learning disability and/or autistic people are renamed ‘solitary confinement’.

College view

We do not agree that both long-term segregation and seclusion of people with a learning disability and/or autistic people should be renamed ‘solitary confinement’.

We agree that current definitions for long-term segregation and seclusion must be improved.

Definitions used by the CQC, Mental Health Act 1983 Code of Practice and local protocols in Trusts vary and do not fully capture how the terms operate in practice. The terms can also be too easily conflated. This is despite there being important differences between the two terms. The Mental Health Act: 1983 Code of Practice makes a distinction,

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long-term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm.

Connected - different monitoring, governance and safeguarding protocols are applied to each practice which must not be conflated and there are important distinctions based on the clinical environment for patients in each setting. Additionally, someone in long term segregation can be granted section 17 leave which isn’t the case for someone in seclusion.

(See also our response to recommendation 5).

We don’t believe that combining the two terms into a single definition is a solution. This could lead to blurred lines between two different kinds of practice.

Moreover, the term ‘solitary confinement’ could be viewed as misleading. We know from the professional practice of our members, including those who work in prisons that solitary confinement usually refers to a practice that involves a person being kept in a locked room. Such rooms might be small and windowless. There can be no obligation for others to interact with the individual, so the person can have little if any contact with others – they are in essence completely alone. This does not correspond to the Mental Health Act specifications for how Long-Term segregation and seclusion should be practised. Patients in Long-Term Segregation and seclusion are monitored by responsive staff and in some cases spend significant periods of the day with others including family members, in activities and through escorted leave.

Instead, we recommend that seclusion and Long-Term Segregation are defined separately and in distinction from each other, with thought given to the circumstances of both patients and staff on how the two terms relate to each other. Similarly, a clear distinction should be made between solitary confinement **and** seclusion and LTS. This would support staff to better recognise any deficient practice and would support CQC regulation.

We do recognise that seclusion, as it is currently defined in the MHA, will always give rise to a state of solitary isolation. Within this context, there may therefore be scope to apply the term 'solitary isolation' to 'seclusion' only. Any changes would need to be legally codified before implementation.

We note that in their response to this recommendation, DHSC advise that changes in terminology would be incompatible with current legislative frameworks, and that instead they will use this recommendation and the rest of Baroness Hollins' report to consider whether a change in terminology should be made when updating the Mental Health Act 1983 Code of Practice when it is next reviewed. We would welcome the opportunity to be involved in discussion around this.

10. *Recommendation 10*

The government must publish an annual report on the progress towards ending the use of solitary confinement for people with a learning disability and/or autistic people. This should outline any learning, with both examples of best practice and areas for improvement. A commissioner to oversee this work should be considered.

College view

We agree that annual reporting is important. Annual reporting should focus on progress towards reducing the use of LTS and seclusion for people with a learning disability and/or autistic people, rather than ending the practices completely. As we have advised in response to recommendation 5 and recommendation 9, there are some circumstances where it might be necessary to use both LTS and seclusion; the term 'solitary confinement' should not be used.

Reports should include data, actions and accounts of lived experience. It will be important to ensure a balance of views from families, clinicians and others involved in the process, including where there is a shared view that the most therapeutic environment and conditions amount to long-term segregation when using the existing definition.

We note that in response to this recommendation DHSC advise that the CQC is taking over implementation of IC(E)TRs and will be considering how to report on progress both to DHSC and nationally. As part of their delivery of IC(E)TRs, CQC will evaluate and identify learning from the programme. We look forward to engaging with the CQC on this work.

11. *Recommendation 11*

To prevent admission or readmission into hospital at times of acute distress where the community support services do not meet a person's immediate needs, we recommend:

- *alternative accommodation to hospital should be available within each ICS area in times of acute distress, or emotional and behavioural crisis, and to facilitate earlier discharge.*
- *commissioners should undertake pilots and evaluate the effectiveness of 'intensive recovery pods' (homely places of safety in the community) which are autism friendly, trauma informed and where the person and those supporting them feel safe.*

Alternative crisis responses and intensive support teams in learning disability and autism services are being developed in some places but are not universally available. Consistent, more reliable, robust and familiar multi-disciplinary community mental health support involving teamwork between the person themselves, their family and/or advocate is required. Integrated support from specialist practitioners in occupational therapy, speech and language therapy, specialist nurses, psychology, psychiatry and psychotherapy is essential.

College view

We agree that action is needed to prevent admission or readmission into hospital at times of acute distress where the community support services do not meet a person's immediate needs. We are supportive of the ways in which recommendation 11 recommends this could be done.

It is crucial that 'intensive recovery pods' are not expected to perform the same function as hospitals, without the same safeguards and legal protocols. **These are essential to protect a patient's human rights and welfare.**

Clear guidance for clinicians on hospital alternatives should also be developed. The guidance should relate to the legal frameworks which should be considered and to the measures appropriate to safeguard both staff and patients from the risk of violence. Provision of any hospital alternatives must be informed by evidence on what both patients and staff require.

It is essential that there is sufficient capacity in the community as well as elsewhere in the system to support implementation of these recommendations. Our members report that without this and without viable options for community discharge it is more likely for avoidable restrictive practice to be used and for longer. We are pleased to see that DHSC to some extent recognises this in their response to this recommendation, referencing previous commitments to spending, the 2023 NHSE Long Term Workforce Plan and the 2022 Action Plan for 'Building the right support for people with a learning disability and autistic people'. These plans must be fully resourced, implemented and built upon. We look forward to working with DHSC, NHSE and other stakeholders on this critical work.

12. *Recommendation 12*

DHSC, NHS England and CQC should commit to funding and delivering interventions to reduce the use of solitary confinement and move people to the least restrictive setting and out of hospital as soon as possible. These interventions include IC(E)TRs, senior intervenors, the HOPE(S) programme, and ensuring each person in solitary confinement has an independent advocate. There should also be the introduction of a discharge co-ordinator who should be allocated to people with a learning disability and/or autistic people who enter solitary confinement to help monitor the implementation of their therapeutic plan and manage both their discharge out of hospital and their rehabilitation in the community.

College view

We agree that DHSC, NHS England and CQC should commit to funding and delivering interventions to reduce the use of LTS and seclusion and to a policy of moving people to the least restrictive setting and out of hospital as soon as possible.

All interventions used for patients must be well evidenced, with evidence available to clinicians. Interventions must have a proven efficacy for meeting the specific needs of people with a learning disability and/or autism.

We support the idea to introduce discharge co coordinators. To be workable, the role would need to be clearly defined and resourced. Clarity would be needed on how the role related to Senior Intervenors, the clinical MDT and RC within inpatient settings.

There should always be a considered balance between integrating patients into the community (including through encouraging social engagement) and providing patients with care away from others to ensure safety for all.

We note that in their response to this recommendation DHSC,

- Reiterate their response to recommendation 10: the CQC will be taking over responsibility for delivering IC(E)TRs. This will be for a 2-year period and with support from NHSE. The CQC is to adopt learning from the programme to date, including improvements to the approach, in order to ensure that the care of people with a learning disability and/or autistic people in long-term segregation will continue to be scrutinised. CQC will report on the programme and gather feedback from people who receive an IC(E)TR and from their families.

- Reiterate commitments for the HOPE(S) model to be independently evaluated as well as consider findings from The Senior Intervenor pilot evaluation as part of ongoing work.

- State that they are working with NHS England and other system partners to develop guidance for discharge from mental health, learning disability and autism inpatient settings. This will set out how NHS bodies and local authorities can work together to support the discharge process for people and to ensure the right support in the community, including for people with a learning disability and autistic people. Learnings will be considered as part of future work to support people out of long-term segregation and towards discharge.

It will be important that this activity engages professional bodies effectively. The College would welcome the opportunity to be involved with DHSC, the CQC and NHSE on this work. To benefit both patients and staff, IC(E)TRs should support the development of recommendations that enable good governance, regulation, and clinical effectiveness.

13. *Recommendation 13*

Anyone who has been in solitary confinement should be monitored for 2 years following discharge from hospital to ensure changes are sustainable and they are receiving good community support. It is important they are receiving the correct therapeutic support to address the difficulties that may have arisen as a result of the trauma associated with solitary confinement.

To assist with this, the keyworker scheme for children and young people should be expanded in each ICS so that a named keyworker is provided for adults on the dynamic support register, or where there are similar identified needs. This role has a broader remit than the discharge co-ordinator role in recommendation 12 and is responsible for working with people to avert distress and family breakdown.

College view

We agree with monitoring people who have been in LTS and seclusion to ensure changes are sustainable and that they are receiving good community support.

In practice, it is likely that this proposal would be difficult to implement. It may require legislative change and would need ring-fenced resource.

We also suggest that monitoring should be for five years, rather than two. The two-year period is too short to make judgments concerning recovery from the long-term experience the person would have had. Given that there may be a perception that the person only requires care packages for the period they are being monitored, a longer monitoring period would also help to guarantee longer packages of care. This would improve the likelihood of the person doing well in the community and would strengthen risk prevention.

In addition to key worker expansion, we advise that consideration should be given to developing and piloting a community rehabilitation model to support people who have been in hospital long-term. This would help to monitor and reduce potential for 'revolving door' admissions.

People who have been in LTS and seclusion should remain on the Dynamic Support Register in their locality. When people are discharged to a placement away from their originating service, they should be entered on the register of the host ICB.

We note that in their response, DHSC state that responsibility to monitor the wellbeing of individuals sits with local ICBs, with ICBs encouraged to share themes and learning to enable NHSE to support change on a wider scale. ICBs must have the infrastructure and capacity to this effectively and this is a responsibility of government.

College action

The College will be addressing the post-report policy landscape in multiple ways.

We welcome and will take advantage of opportunities to work with DHSC, the CQC, HSSIB, NHSE, and families and other important stakeholders. We will continue to work with current and future Governments on the reform of the MHA and MCA. We will continue to call for investment in alternatives to restrictive practice, including within therapeutic environments and within the community.

We will continue to promote learning from the RCPsych 'Reducing Restrictive Practice' programme.

We will continue to work with NHS England to deliver the National Autism Training programme for psychiatrists. The programme provides in depth training for psychiatrists who wish to specialise in autism and neurodiversity, thus supporting the development of a future pipeline of clinical leaders for specialist autism services.

We will also work through the College's Centre for Quality Improvement (CCQI) to ensure our outputs carefully consider the report and its recommendations. The CCQI develops standards to promote high quality mental health care and reduce variation in service delivery. A set of core standards outlines the fundamentals of all service provision across inpatient and community care, with specialist standards developed for specific service settings.

The CCQI's core standards are being revised and updated this year which will involve reviewing all new and updated guidance. The report's recommendations will be reviewed as part of this process.

The ongoing work of the CCQI will also consider the recommendations across several of its quality networks:

- The Quality Network for Learning Disabilities inpatient standards revision process is underway. It will take the Hollins recommendations into consideration and include strengthening the standards around family involvement, training requirements, access to advocacy and legal help.
- The Quality Network for Learning Disabilities rehabilitation standards are in their first year of implementation and will be reviewed in summer 2024.
- The Quality Network for Learning Disabilities community standards are due for revision in 2025.
- The network is also planning to host a learning event focusing on legal challenges to discharge planning. The event will address long-term segregation and take place in 2024.
- There have been initial discussions within the College about the development of a new network to ensure the quality of specialist services. External funding would be required for the development of a new network.