# Oversight Panel’s solitary confinement code of practice framework

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## Guidelines for interpreting the framework

This document has been developed by Baroness Hollins and the IC(E)TR Oversight Panel and serves as a framework for a solitary confinement code of practice. The aim of this framework is for the content and proposals to inform a finalised and operational code of practice. The intention behind the code of practice is to set out the standards expected to be met when a person is placed in solitary confinement.

The 3 central chapters in this code of practice framework each feature the following sections:

* rationale section
* proposed content section
* areas for further development section

The purpose of each of these sections is as follows:

* rationale: to outline the importance of the chapter and the purpose it serves as a feature of the code of practice
* proposed content: to outline the content that should be included in this section
* areas for further development: to outline the content which, while necessary to include in the chapter, requires further development

## Defining solitary confinement

### Defining solitary confinement: rationale

The use of solitary confinement for people with a learning disability and autistic people has the potential to cause significant harm to the physical, emotional and psychological wellbeing of those persons. Despite this, providers still adopt methods of solitary confinement in an attempt to manage distressed behaviour, where the self or others may be at risk of harm, and reduce perceived harm.

Solitary confinement may be referred to as ‘seclusion’, ‘segregation’, ‘isolation’, ‘time out’, among others. These terms are often used interchangeably. Regardless of the term used, the phenomenon remains the same: people are denied meaningful human contact and are isolated from their peers. There is evident need for an umbrella term which encompasses this phenomenon, which may facilitate better identification and reduce the likelihood of discrepancies in levels of restriction and safeguards in place.

Rationale for using ‘solitary confinement’ to refer to enforced isolation from meaningful contact with peers:

* improve therapeutic options for people in distress and reduce the use of solitary confinement
* reduce segregation inequalities, for example people with a learning disability and autistic people are more likely to be isolated from peers
* create a single definition to reduce misunderstandings about what constitutes solitary confinement, thereby increasing identification and enabling a reduction strategy
* create dissonance in the system, acknowledging the harms caused and instilling aspiration and imperative for reduction
* enable agile and effective reduction strategies, for example HOPE(S) practitioners
* ensure minimum standards for solitary confinement spaces
* reduce the legacy of harm caused to people by confinement, for example ‘social death’

#### The impact of solitary confinement

Research demonstrates that solitary confinement cannot be considered therapeutic and that the benefits do not outweigh the impact of its use. (See [Solitary confinement: effects, practices, and pathways toward reform](https://academic.oup.com/book/35060), and [Chapter 8, Solitary confinement, loneliness, and psychological harm](https://academic.oup.com/book/35060/chapter-abstract/298994915?redirectedFrom=fulltext).) Solitary confinement can lead to increased social, mental health and physical health difficulties and can result in further social exclusion and secondary symptoms which emerge as a consequence of isolation.

Furthermore, there are features of solitary confinement that may serve to inadvertently maintain a cycle of the use of such restrictive measures, for example when people adapt to the practice.

While some implementing solitary confinement argue that a person’s rights to life and health are protected in solitary confinement, others argue convincingly that a person’s health is seriously compromised, and solitary confinement breaches people’s right to be free from inhumane and degrading treatment.

#### The importance of having a clear definition

Key points:

* discrepancies between definitions of solitary confinement leads to incorrect recognition, reporting, monitoring and treatment.  Development of a clear and focused definition should improve recording and monitoring
* the aim is to remove any ambiguity and ensure that people who are separated from their peers receive the safeguards set out in the [Mental Health Act 1983: Code of Practice 2015 (‘the MHA Code’)](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) together with any additional protections that may be developed, and that they are protected from harm by strict limits on the duration they are confined by means of solitary confinement
* the definition describes the ‘what’ of solitary confinement and does not include its purpose or justification. This allows the application of the definition to different settings and populations while ensuring its recognition and that such actions need to be justified

### Defining solitary confinement: proposed content

Solitary confinement is the enforced isolation from meaningful human contact with peers which includes all practices that deny people meaningful human contact, including those currently referred to as seclusion, time-out or long-term segregation.

Solitary confinement also refers to practices where people are detained in individual bespoke flats or housing and where there is enforced denial of meaningful human contact with peers. It would not constitute solitary confinement if a person were detained alone and meaningful human contact was unrestricted, for example, the person was free to engage face to face with friends, family and peers at their will.

In the case where a person is detained in their own living space in hospital, regular monitoring and safeguards akin to those used for persons identified as being in solitary confinement should remain in place to ensure the care does not meet the threshold for solitary confinement and for their equal protection due to their vulnerability to potential closed cultures.

This definition ensures there is no longer a distinction between seclusion and long-term segregation - they should have the same meaning and the term ‘solitary confinement’ should be used to describe both.

1. Definition: meaningful human contact
2. Contact that involves being face to face with a loved one, friend or significant other who provides empathic, warm and nurturing interpersonal communication and who helps you to feel safe. It includes having a community presence and relationships, recognising that some people will not have relationships with family or lack close friends. Meaningful human contact does not include being with staff in institutions or talking to people through medical necessity.
3. Definition: peers
4. Non-paid people such as family, friends and other patients and members of the community.

Further details on the use of solitary confinement:

* solitary confinement, due to the established harmful impacts it poses to people, should only be used as an exceptional intervention. Staff should have assessed alternative, less restrictive interventions and subsequently concluded that this risk cannot be managed by alternative means. There should be an immediate plan which details how the solitary confinement will end at the earliest opportunity
* solitary confinement of a person as a consequence of a services failure to meet a person’s needs for safety, communication and sensory requirements also meets the definition of solitary confinement and should be subject to the same scrutiny as solitary confinement for other reasons
* this definition would include services in its scope that have developed individual living areas or community-based care (usually for populations with sensory and neurodevelopmental needs), even if they have a social and relational model underpinning them. If a person is isolated from their peers in a service, this constitutes solitary confinement
* the assumption should be that anyone who is in total isolation is likely to have suffered harm because of exposure to solitary confinement. Exposure to solitary confinement has the potential to bias a person’s perception of threat, diminish social confidence and possibly exacerbate mental disorders which could affect the person’s ability to decide to leave solitary confinement.  For example, a person who is aware that they need to consent to something in order to end a toxic stimulus isn’t really giving free consent
* solitary confinement should never be used to support a person whose risk relates to self-harming behaviours and any de facto arrangements should be ended immediately
* the use of solitary confinement for children (under 18 years) must comply with [article 37 of the United Nations Convention on the Rights of the Child 1989.](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child) To this end, it should only be adopted as a last resort and should be discontinued after a maximum of 15 days due to its harmful impact
* solitary confinement should be discontinued after a maximum of 15 days due to its harmful and devastating impact

### Defining solitary confinement: areas for further development

Key points:

* the chosen term and definition of solitary confinement needs to be agreed and developed further - including fully working through any impacts of the proposed definition
* the key elements which need to be present to confirm that the definition of solitary confinement is met need to be further developed and defined. Time-based definitions should also be further developed if appropriate
* further work to define and clarify what is meant by terms such as ‘exceptional circumstances’ in which solitary confinement may be used as an intervention, and the ‘shortest time possible’ should be undertaken

## Standards for solitary confinement

### Standards for solitary confinement: rationale

Key points:

* providers should have and adhere to clear policies in relation to reducing all restrictive interventions and practice.  The principles of least restrictive and proportionality should be demonstrated at all times
* where solitary confinement is used, it is important that it is done in a way that ensures physical safety and minimises the risk of psychological harm to the person
* all decisions in relation to solitary confinement should uphold people’s human rights as a priority. It is recognised that a person in solitary confinement is vulnerable to harm and to human rights breaches and therefore staff should review any interference to the person’s rights as a matter of urgency

### Standards for solitary confinement: proposed content

Providers should:

* have clear policies regarding primary and secondary preventative strategies to avoid solitary confinement
* adopt a personalised, trauma-informed approach to care
* ensure that people are cared for in the least restrictive environment, while ensuring appropriate levels of security and safety
* consider alternative strategies to enable people to self-regulate to prevent the risk of solitary confinement
* ensure that staff can seek advice from services who provide models of care that prevent and reduce the use of solitary confinement
* ensure they are compliant with the [Mental Health Units (Use of Force) Act 2018](https://www.legislation.gov.uk/ukpga/2018/27/enacted) including by providing information to those using services and training for staff to recognise acts of force and how to reduce them
* ensure that they are compliant with article 37 of the United Nations Convention on the Rights of the Child 1989

#### Accommodation

Providers should:

* ensure that the solitary confinement environment is safe, dignified, well-maintained, calm, homely and complies with the minimum accommodation standards set out below
* adhere to specialist advice on neurodevelopmental building design and include all technological advances, especially when designing a new environment
* reduce potential safety hazards posed to the person in solitary confinement. CCTV, or video surveillance, should not be used as a replacement for in-person observation as a means of monitoring people in solitary confinement. The use of any CCTV should respect the privacy of the person and be reviewed regularly to ensure it remains the least restrictive means by which to maintain the person’s safety. Where a person experiences its use as an infringement of their right to privacy, it should be reviewed with a view to its removal

Minimum requirements for an environment used for solitary confinement:

* a bedroom with ligature free ensuite shower and toilet facilities
* washing facilities and toilets should be separate to the bedroom, with a dividing wall to ensure privacy and dignity is maintained, in line with [relevant guidance on minimum standards for psychiatric intensive care](https://napicu.org.uk/publications/national-minimum-standards/)
* ensure that the environment is considered in line with each person’s need and adjusted and personalised where possible. For example, the use of light levels and temperature should be adjusted in line with the person’s sensory needs and preferences
* there should be a means of communication and summoning assistance when the door is locked with the person inside, and the person should have regular opportunities to communicate through an open door. Staff should be able to respond to the feedback and needs of the person. People in solitary confinement should be able to see the person communicating with them therefore the button for the intercom should be close to the communication viewing panel
* people in solitary confinement should not be deprived of access to their own clothing or bedding. If required as an emergency due to ongoing risks of self-harm, use of tear-proof clothing or bedding should be signed off by the medical director or an alternative appropriate staff member within the senior leadership team. This should be regularly reviewed and reduced as soon as possible. The individualised care plan should clearly state when items should be restricted

Any room facilitating solitary confinement should:

* have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
* have a door or doors which open outwards
* afford some privacy and be situated on a ward with those of the same gender
* be decorated and furnished in a calming manner, in line with best practice for those with neurodevelopmental disorders, where appropriate
* not have blind spots, and alternate viewing panels should be available where required
* have a facility to monitor the person’s vital signs without entering the room (this should only be used where necessary and not be used as an alternative to communicating with the person)
* have locally, externally controlled lighting, including a main light and subdued lighting for night-time. Lighting should be adjusted to suit the person’s needs
* have locally, externally controlled room temperature, which enables those observing the person to monitor the temperature
* have a clock which is visible to the person from within the room and the type should be in line for those with neurodevelopmental disorders
* include furnishings which as a minimum should include a bed, pillow, mattress and blanket or covering

#### Access to social contact, outside space and activities

The person in solitary confinement should be provided with access to a risk-free quiet comfortable lounge, a place to sit and eat and a place to do activities.

The person should have access to fresh air and outside space that is pleasant and secure. Ideally this should be directly accessible from the room. The garden should not overlook environments that are over-stimulating (for example, providers should consider specialist fencing with calming images).

The person should have access to digital technologies, including television, radio, telephone, tablets and other digital technologies, and this should be facilitated unless there is a cogent reason to limit access.

Access to activities such as games, at developmentally appropriate levels, should be facilitated for both adults and children.

To reduce the psychological harm of solitary confinement, the person should be provided access to social contact that is safe, compassionate, reciprocal, meaningful and respectful.

##### Activities

The person should also be provided access to:

* occupational therapy which assesses meaningful activities that the person is interested and wishes to participate in. These activities should be developmentally appropriate
* entertainment facilities in the outside space and bedroom, for example sports equipment, games and art materials. Careful consideration of risk of items should be balanced against the need to provide meaningful activity at a developmentally appropriate level, and alternatives should be provided if the requested resources are judged inappropriate

#### Adjustments and provisions for people in solitary confinement

##### Communication-based adjustments

A speech and language therapy (SaLT) assessment is essential to facilitate appropriate communication with the person at all times to communicate daily issues, guidance, important choices or decision-making. Recommendations from SaLT assessments should be fully embedded in care plans.

Communication passports which outline the person’s most effective and desired means of communication are essential.

Sensory assessments are required to enable services to meet the person’s sensory needs. Recommendations from these assessments should be fully embedded in care plans.

Access to interpreters, easy read or word-free audio and video materials and other appropriate communication provisions in line with the person’s needs should be facilitated and available when required. Such appropriate provisions should be embedded and outlined in care plans.

##### Physical health

Promotion of healthy lifestyles should continue while the person is in solitary confinement. This should include consideration of the following:

* access to a dietician for advice on nutrition and weight; this should be tailored to age, gender and ethnic background
* access to physiotherapy. If a person is held in solitary confinement with limited movement and restricted levels of activity, there may be a particular need for physiotherapy interventions
* physical health monitoring as physical health can impact on a person’s distress as well as their health. Providers should follow national guidance on physical health screening and intervening, including for cardiometabolic syndrome, common when prescribed antipsychotic medication
* physical activity. Providers should facilitate means for physical activity which align with current [NHS exercise guidelines](https://www.nhs.uk/live-well/exercise/exercise-guidelines/)
* during and after any physical restraint, the physical condition of the person (including vital signs and airway status) should be monitored and recorded, and any deterioration responded to

##### Education and training

There should be a continued right to and facilitation of educational provisions for persons under 25 years of age during any periods of solitary confinement.

Providers should carefully consider what education and training can be offered to those not in receipt of an [education, health and care (EHC) plan](https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help#:~:text=An%20education%2C%20health%20and%20care,support%20to%20meet%20those%20needs.).

Education sessions should be interactive and tailored to meet the persons learning style and abilities.

##### Information for people in solitary confinement

People in solitary confinement should have access to information about what they should expect and the care and treatment they should receive.

Staff must ensure they provide information for those in solitary confinement, including on their rights and legal position under the Mental Health Act 1983 as per section 132 of the act.

Staff should also provide information on:

* complaints procedures
* Mental Health Units (Use of Force) Act 2018

#### Interactions with staff

People in solitary confinement rely on staff for all their basic needs, wants and to protect their privacy and dignity as far as humanly possible. Providers should ensure that staff observing have an established relationship with the person.

Only agency staff who know the person should observe them. A one-page pen profile could be used to provide information about the person, important people in their life, past achievements, their interests and needs, including their sensory and communication needs. People in solitary confinement should not be isolated from the staff who are supporting them; face-to-face contact is essential. Observing staff should be able to make decisions about care.

As is already a legal requirement for all qualifying patients under the Mental Health Act 1983 (section 130A, in relation to England), people in solitary confinement should have access to advocacy services, particularly an independent mental health advocate and their legal advisors.

Providers and local authorities should ensure that advocates are appropriately trained to understand the rights of patients and the questions and challenges they need to ask the provider. Advocates should understand the neurodevelopmental disorder the person has and be able to communicate effectively with them to understand their wishes in whatever communication tool they need. This will include Makaton, British Sign Language, Talking Mats, and so on.

The involvement of safeguarding teams should be increased. In the current Mental Health Act 1983: Code of Practice 2015, providers should inform the local safeguarding team if a person is placed into solitary confinement. The local authority safeguarding team should observe and continuously and regularly review the person in solitary confinement.

Internal multidisciplinary oversight provided should include medical and nursing disciplines, and at least one member from an alternative discipline such as psychology, occupational therapy, and speech and language therapy. The independent mental health advocate, legal representative and family where involved should be included.

#### Interactions with family and friends

It is important that care is planned and delivered in line with people’s right to receive dignified and respectful care. At the heart of this is ensuring people have contact with family members and that they are given privacy.

When someone is admitted to solitary confinement, next of kin and other closely involved family or intimate others should be informed. It is not acceptable to do this by voicemail or similar message, as the person being contacted should have an opportunity to ask questions, to be involved in discussing what next or to express concerns.

People in solitary confinement should be granted access to means of digital technology to enable them to keep in contact with family and friends.

Visits from family and friends are a vital part of recovery and therefore should not be restricted in any way unless there is clear evidence of risk to that member of the family or friend which is impractical to mitigate against.

Any restriction should be fully documented in the medical notes and reviewed on at least a weekly basis, and the person should have a right to appeal if access to family members is unjustifiably restricted.

#### Training of staff and quality of care

All staff working with people with neurodevelopmental disorders should be adequately trained to enable good practice relating to the relevant specialism including autism and children.

Existing training requirements which staff should be trained in:

1. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that staff employed by service providers in the provision of a regulated activity ‘must be given appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform’.
2. Section 181 of the Health and Care Act 2022 inserted section 20(5ZA) into the Health and Social Care Act 2008, which imposes a new duty on the Secretary of State to make regulations requiring service providers to ensure that their staff receive training on learning disability and autism which is appropriate to their role. This training requirement came into force immediately (in advance of such regulations being made) by virtue of section 181(7) of the Health and Care Act 2022.
3. Adopting models of best practice that enable systemic culture change. Offer alternative strategies for managing distress, make use of lived experience narratives and train staff in compassionate interventions based on the principles of the least restriction (for example, HOPE(S) diploma and certificate).

The models staff are trained in should:

* be based on a human rights approach
* be based on collaboration and practice leadership
* use a standard template, assessment or checklist to ask themselves pertinent questions as to reasons for this serious impact on the person’s liberty that will inform the strategies the team will employ, for example the barriers to change checklist (see [page 8, HOPE(S): clinical model of care to reduce long term segregation (PDF 778KB)](https://restraintreductionnetwork.org/wp-content/uploads/2019/11/Danny-Angus.pdf))
* use trauma-informed approaches to care and treatment
* use relational approaches to care, which include recognising the importance of relationships when providing care and treatment, understanding the importance of continuity of staff and patient relationships and their important role in supporting and sustaining relationships with family members and friends
* follow relevant guidance with respect to prescribing and administering medication to autistic people or people with a learning disability, for example [STOMP and STAMP guidance](https://www.england.nhs.uk/learning-disabilities/improving-health/stamp/)

##### Provider governance

The provider should have a policy on the monitoring of the use of solitary confinement which is compliant with relevant guidance (see [Mental Health Units (Use of Force) Act 2018, 2018 chapter 27](https://www.legislation.gov.uk/ukpga/2018/27/enacted)).

CQC should be notified when solitary confinement is used.

Providers should ensure that the provider board keeps under review and is informed of use, trends and patterns of use of solitary confinement. A member of the board should be informed whenever solitary confinement is used and should visit a person in solitary confinement within 72 hours of its initiation. This should occur even if the episode has been terminated. The board member should feed back to the board regarding whether the environment in which the person was being held in solitary confinement was therapeutic and appropriate.

A non-executive director or hospital manager should visit and speak with the person and their next of kin or advocate and raise any issues at board level.

#### Commencing solitary confinement

Only a senior nurse in conjunction with the person’s named nurse and the doctor on duty should make the decision to place a person in solitary confinement, provided they have clear evidence that this is the least restrictive and only option available to manage the level of risk. They should have conducted a robust assessment of the person and the situation immediately prior to the commencement of solitary confinement and have used all the alternative strategies in place for that person before doing so.

There should be clear care plans in place detailing alternative strategies deemed appropriate for the person that may be adopted to avoid the use of solitary confinement.

Staff can decide what a person can take into solitary confinement, but the principles of support and opportunity for coping and self-soothing should be considered in these decisions. Care plans should clearly set out what coping strategies the person needs to self-sooth during stressful times.

Observations should be completed by a suitably qualified person who has an established relationship with the person. Consideration should be given to the most appropriate observer, based on the person’s preferences and trauma history.

There should be a solitary confinement plan (see [Brief guide: Long-Term Segregation (PDF 174KB)](https://www.cqc.org.uk/sites/default/files/20200824_9001307_brief-guide_long-term-segregation_v3_0.pdf)) in place for people in solitary confinement. The aim of care plans is to move the person out of solitary confinement and support them to reduce potential risks and increase positive coping. Care plans should be individualised, contain information surrounding early warning signs and triggers, and include defined goals for the person. Providers should assist the person to use advance statements to identify their wishes and feelings. If there is a risk the person may be confined again then an advanced care plan should be made with the person to reduce the likelihood of this course of action.

Consent for recording the person on the local dynamic support register, on admission, should be sought.

#### Ending solitary confinement

The ending of solitary confinement can be carried out by the nurse in charge, doctor carrying out the medical review, multidisciplinary team, or member of the senior leadership team who has reviewed the person.

The person in question, and separately their family and/or advocate should be given a debrief in which they are asked about their experience of solitary confinement and providers should use this feedback to focus on improving the experiences of those in solitary confinement.

#### Reviews

Each provider should be encouraged to use their provider collaborative and other resources to set up a network of specifically qualified reviewers.

External reviewers should have specific knowledge and experience in the diagnosis of the person in solitary confinement.  An external reviewer should be qualified in the appropriate specialism. They should not be in any way involved in the care, treatment or in funding of the care of the person, in order to remain independent.

The external review team should be multi-disciplinary in membership and as a minimum requirement consist of one responsible clinician (or non-medical approved clinician) and a registered mental health nurse (who is a band 8a or above) with the option of an additional mental health practitioner with relative experience. The panel should also involve an independent mental health advocate and an NHS England commissioner independent of the hospital to provide an additional level of objectivity to the review process.

#### Single person settings

While adhering to the standards previously outlined, providers should consider support and regulation for those people who are in single person settings; these can be inpatient or community placements.

People in single person settings should have a social worker, discharge co-ordinator and a fully trained advocate to ensure that their human rights are protected.

When it is necessary for a person to be in a single person setting, to meet the person’s sensory and social needs there needs to be a sustained focus on community presence and meaningful peer relationships. Opportunities for meaningful contact should be regularly reviewed, to reduce the risk of closed cultures and to ensure the person is not being denied peer and family relationships.

An external review should take place every 3 months to ensure that the person’s needs are being fully met. The review should make recommendations as to further needs and ensure that the wishes of those using the services are taken into consideration. If there are instances where it has not been possible to meet the person’s wishes safely, this should be fully documented and reviewed during each review. The person should have the support of an advocate, family and/or friends during those reviews.

#### Safeguarding register

A safeguarding register should be maintained and shared on an agreed frequency with CQC documenting indicators of poor care and treatment, including but not only:

* access for relatives and advocates to where the person they are concerned about is living
* the ratio of registered health and care staff to untrained staff on duty in any 24-hour period
* lack of identified advocate or no advocate visit for a person in previous 28 days
* complaints and concerns raised by the person detained, and/or relatives, advocates and staff, in relation to the use of solitary confinement - including complaints and concerns about ward culture, relationships and feelings of fear
* the person’s treatment and activity programme are lacking essential elements
* the person does not have a personalised care and treatment plan with a detailed past medical or social history
* unfulfilled recommendations from safe and wellbeing reviews, C(E)TRs and IC(E)TRs
* absence of [STOMP](https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/) medication reviews and reviews of physical health

### Standards for solitary confinement: areas for further development

Staff training:

* building on the training previously outlined, it will be important to expand on the training for staff managing and interacting with people in solitary confinement; this should be further defined

Internal and external reviews:

* a standard template for reviews of the care of people in solitary confinement should be developed, ensuring more consultation with advocacy, families and carers when undertaking reviews
* what is considered ‘relative experience’ in relation to the additional mental health practitioner should be further defined

## Discharge pathways

### Discharge pathways: rationale

This chapter has been written to guide commissioners, care managers and multi-disciplinary staff in hospital and the community. It should also be shared with the person, family members and advocates, who can use it as a resource to state what should be expected as part of the discharge planning process.

Discharge planning is a key area of focus and is essential to ensure that people who are in solitary confinement, and indeed anyone leaving hospital, are properly supported to move into their community with the right support. Part of the challenge is to ensure that this happens in a timely way, ensuring that the needs and aspirations of the person are central to personalised plans. It should be remembered that, as the Mental Health Act 1983: Code of Practice 2015 emphasises, the planning for after-care ‘needs to start as soon as the person is admitted to hospital’.

Planning needs to be undertaken recognising the legal framework, upholding the human rights of the person, with all involved ensuring that they understand and apply the relevant legislation, throughout the whole process.

Previous work has been undertaken as part of [Transforming Care](https://www.england.nhs.uk/learning-disabilities/care/) and adopted within the [NHS Long Term plan (2019)](https://www.longtermplan.nhs.uk/) outlining a 12-point discharge plan.

1. 3.36 . . . all areas of the country will implement and be monitored against a 12-point discharge plan to ensure discharges are timely and effective. We will review and look to strengthen the existing C(E)TR and care and treatment review policies, in partnership with people with a learning disability, autistic people or both, families and clinicians, to assess their effectiveness in preventing and supporting discharge planning.

The 12-point plan has been reviewed by members of the Oversight Panel in the light of learning and the changes that have taken place as part of the IC(E)TR process, and have been updated and included in this chapter.

The following sections outline the actions that need to be undertaken as part of discharge planning. Although it is helpful to consider a sensible ‘ordering’ of activity, some key considerations are required to be at the forefront of thinking.

There are several essential areas of law that need to be considered before, during and after discharge planning. Please note that all the points in the discharge plan are listed with the understanding that these key legislative considerations have been understood and enacted fully as part of the discharge planning process.

An essential part of the planning and implementation of a person’s discharge is ensuring that actions taken are lawful, which includes compliance with duties to promote and respect the person’s human rights and equality. This requires an understanding of the differing legal frameworks and how they apply to the person concerned.

### Discharge pathways, 12-point plan: proposed content

#### 1. The person is in active treatment and active person-centred planning starts

Discharge planning ideally starts on admission, with a documented, shared, broad hypothesis on where the person will need to be after a stay in hospital. The referring clinician and commissioner have a key role in outlining their aspirations for the person’s discharge.

In order to understand the person and their journey before their admission to hospital (including the decision that hospital admission was required), 2 key things need to be established and written down:

* a full chronology of events leading up to admission. This will include the person’s early history, their history of diagnosis (and when and where this took place), key events in their life, family and/or support arrangements, current treatment, and the triggers and events that led to the application for admission
* a document that describes who the person is and what matters to them. This must include what they love doing, their skills, gifts and strengths, the key people that matter to them, how best to communicate with the person, and their hopes and dreams for the future

These documents need to be read and understood by anyone who will work with the person during their time in hospital.

The professional who has requested that hospital admission be considered should ensure that these 2 documents are prepared and up to date.

##### Discharge co-ordinator

A person whose role is to co-ordinate the discharge of a person in solitary confinement should be allocated. There should be a discharge co-ordinator for each person in solitary confinement and each co-ordinator should have a manageable number of people to support. For example, key workers for children support 10 to 15 people at any one time.

The discharge co-ordinator should have a role outside of the hospital multidisciplinary team and should be based in the geographical area in which the person has been deemed to be ordinarily resident. The discharge co-ordinator needs to have the relevant skills, knowledge and authority to arrange regular meetings for planning every month during the period that person is in hospital and operationalise the plan through the co-ordinated efforts of key organisations. Actions agreed following clinical reviews and assessments should inform these discussions; the framework for progression is the 12-point discharge plan.

Documents required for a personalised discharge plan:

1. A person-centred plan, sometimes called a ‘life plan’ needs to be developed after admission if one is not in place (or updated). This should be based on and developed from a ‘What matters to you?’ conversation and should outline what is required to support the person to meet their needs and aspirations. It should clearly state what support the person needs to keep them and others safe and enable the person to live a good life in the community.  The person should be able to choose who they want to be involved in this conversation.
2. A support plan, sometimes called a ‘working policy’, should be developed to describe how the person should be supported (in line with their wishes and preferences). It should be a dynamic document that changes after new learning takes place - this could be after goals are reached or any incidents take place. This plan should also include how risks are identified and managed.
3. A housing specification should be developed (for example [a home identification form (PDF, 720KB)](http://hsa.learningdisabilityengland.org.uk/Home%20identification%20form%20final-documentresourceid=620.pdf) could be used to help people develop a specification for accommodation) and discussions on what type of housing arrangements (for example tenancy or shared ownership) need to take place to meet the person’s individual and specific housing needs. The discussions will also consider whether the person will be able to return to their own home and whether this would be possible if adaptations were made. This should include considerations identified in any sensory, occupational therapy and environmental assessments. Housing arrangements should be made early in the process to avoid delays. Housing options that support stability and are separate from support facilities should be chosen. This is so that if the provider changes in the future, the housing option does not have to change. The [National Development Team for Inclusion (NDTI)](https://www.ndti.org.uk/change-and-development/housing-choices2) have information concerning checking tenancies.

Commissioners should ensure that specifications for support are able to accommodate the needs of the person, both for a direct provider of support, but also for those universal and targeted community services that the person will need to use.

Most people will be eligible to be offered a personal health budget, or integrated budget, because they will be required to have aftercare under section 117 of the Mental Health Act 1983. Discharge co-ordinators should consider how people might be supported to exercise their choice and control through a direct payment, or through an individual service fund (ISF).

Any person in solitary confinement in any setting and whether detained under any part of the Mental Health Act 1983 or detained under the [Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents) should have an ISF or other ring-fenced budget allocated that includes funding for community care, therapeutic care and trauma-informed care as well as to meet any additional housing needs.

##### People involved

Representatives involved in discharge should have the authority to make relevant and efficient decisions on behalf of their organisations. Individuals involved would typically include:

* the person and their family
* advocates
* discharge co-ordinator
* social worker and other representatives of the responsible bodies, for example local authority (adult social care/children’s services) and/or the local integrated care board (note: the local authority and integrated care board have a joint responsibility to provide aftercare under section 117 of the Mental Health Act 1983)
* housing co-ordinators
* education specialists (these should be involved for children and young people with special educational needs)
* planning facilitator
* community provider
* members of the community multi-disciplinary team alongside those who have been supporting the person in hospital

##### Legal status of people in solitary confinement

The legal status of a person should determine any specific processes which may need to be followed as part of discharge planning. Specifically, these will include:

* people detained under forensic sections (with or without restrictions); this is relevant because they may be subject to specific constraints related to their choices about where they live, and who they can contact (for example, chapter 40 of the Mental Health Act 1983 relates to preventing a person contacting relevant victims of crime)
* people eligible for section 117 aftercare (for example people detained under section 3 of the Mental Health Act 1983 and certain Part III patients); this is relevant because the relevant authorities (the relevant local authority and relevant integrated care board (ICB) or NHS England) should be engaged from the outset of the planning process. Also, section 117, eligible individuals will have a ‘right to have’ a personal health budget. This also applies if they have [continuing healthcare needs](https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/) or use a wheelchair irrespective of any Mental Health Act 1983 status
* people who have had a previous criminal conviction; this is relevant because they may find it difficult to secure employment or get a mortgage
* children and young people; this is relevant because they will have specific relevant educational requirements that need to be considered, and/or specific planning related to preparing for adulthood. (The [Children and Families Act 2014](https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted) and [Special Educational Needs and Disabilities (SEND) regulations](https://www.legislation.gov.uk/uksi/2014/1530/contents/made) will therefore apply.)

#### 2. Preparing for discharge

As noted above, planning for discharge should start on admission. When an appropriate treatment review identifies that a person is ready for discharge, the treatment review panel will complete a key lines of enquiry (KLOE) document which indicates a discharge date and specific, measurable, achievable, relevant and time bound (SMART) actions which specific individuals are responsible for.

It is critical that people undertake the actions allocated to them by the panel as a minimum. Failure to act within timescales should be escalated appropriately.

Where people may have communication or cognitive needs, providers should ensure that plans are fully understood by the person in question. For example, engaging speech and language therapists may be helpful to facilitate this.

People involved:

* the person, their family and advocate
* multi-disciplinary teams
* review panel and leads for actions
* commissioners
* social workers
* discharge co-ordinator

#### Further considerations for providers when considering discharge preparation

Under the Mental Capacity Act 2005 all people aged 16 and over are to be assumed to have capacity to make decisions for themselves unless evidence shows otherwise.

It is important that if there are concerns that the person is not able to make specific decision(s) relevant to the discharge planning that a mental capacity assessment in relation to such decision(s) is undertaken in accordance with the Mental Capacity Act 2005. This requires careful planning including the timing of such assessments and ensuring that those undertaking the assessments have the necessary training and skills to do so. It is important to consider how this can be incorporated at the earliest opportunity in the discharge planning.  If a person has registered a lasting power of attorney (LPA) for health and care and/or for property and finance, or has a deputy appointed by the Court of Protection, their attorney or deputy must be involved.

For cases where the person is assessed to lack capacity to make the decision in question, the actions or decisions taken as part of the discharge plan must be in the person’s best interests. Such decisions require consideration of the person’s wishes and feelings, beliefs and values. These considerations will be key throughout the discharge planning process and planning undertaken accordingly.

When considering the person’s needs and wants, and the key actions to be taken, there must be consideration of implementation and responsibility. For example, considering whether the person has capacity to sign a tenancy agreement in relation to housing preparations.

If the care arrangements for the person will amount to a deprivation of liberty, consideration must be given as to how this will be authorised. There should be careful consideration of how care arrangements align with the Mental Health Act 1983 powers.

For example, if a tribunal is likely to order conditional discharge there will need to be an application for an authority for the deprivation of liberty so that it can sit alongside the conditional discharge.

These considerations are of high importance and therefore should be addressed imminently during discharge planning. Failure to do so may cause delays to discharge.

The prospective provider once identified will need to be alerted about the potential impact of the person’s legal status at the earliest stage. They could find helpful solutions to make plans work practically, as well as being put fully in the picture about any constraints and opportunities that exist.

#### 3. Identifying the legal frameworks relevant to the person’s discharge planning

Those co-ordinating discharge must ensure that all involved in a person’s discharge process fully understand the relevant legal frameworks that are applied. This includes throughout the admission period and in preparation for discharge.

This will include the Mental Capacity Act 2005, including LPAs or deputyships, and mechanisms for authorising any required deprivation of liberty (for example [deprivation of liberty (DoL) safeguards 2015](https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance)). This will need to be co-ordinated with the tribunal’s decision-making.

The Mental Health Act 1983 provides statutory requirements that relate to preparations for discharge (section 117). The Mental Health Act 1983: Code of Practice 2015 includes guidance on discharge planning.

All stages of discharge planning should hold the person’s human rights as an overarching priority.

Responsibilities under the [Care Act 2014](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted) should be enacted.

People involved:

* the person and their family
* responsible clinician
* approved mental health professional
* social worker
* advocate
* case manager
* legal representative at the person’s tribunal
* attorney or deputy
* discharge co-ordinator

Discharge planners must consider how planning is influenced by relevant legal processes. For example, progressing an appropriate plan for aftercare may influence whether the tribunal is going to discharge or conditionally discharge a person. See, for example, the Mental Health Act 1983: Code of Practice 2015, 33.12:

"Where a tribunal or hospital managers’ hearing has been arranged for a patient who might be entitled to after-care under section 117 of the Act, the hospital managers should ensure that the relevant Clinical Commissioning Group (CCG)[note] and local authority have been informed. The CCG and local authority should consider putting practical preparations in hand for after-care in every case but should in particular consider doing so where there is a strong possibility that the patient will be discharged if appropriate after-care can be arranged. Where the tribunal has provisionally decided to give a restricted patient a conditional discharge, the CCG and local authority should do their best to put after-care in place which would allow that discharge to take place."

Note: CCGs are now integrated care systems (ICSs), which became legally established in the Health and Care Act 2022.

#### 4. Decision-making and participation

It will be important to ensure that the relevant bodies that are responsible for the person’s aftercare are identified. If disputes over responsibility arise, relevant bodies should seek an agreement regarding how to proceed. For each of the responsible bodies, a named contact person should be identified.

For those who are entitled to section 117 services on their discharge from hospital, an important question will be whether their accommodation needs fall under section 117 (the first question being is whether the accommodation services are to meet a need arising from or related to their mental disorder) or fall outside section 117 (and if falling outside, the legal powers and duties relevant to the provision of accommodation).

#### 5. A risk assessment and dynamic support plans are commenced

Risk plans, which are increasingly called dynamic support plans, should include how distressed behaviours can be avoided and supported. Feeling safe is a basic human right and it is critical that risk plans have the person’s human rights at the forefront of thinking. Discharge coordinators and external reviewers must be alert to risk averse attitudes among the wider decision-making stakeholder group.

Risk assessment and planning may need to anticipate potential risks associated with distress and any risks associated with restrictive practice and outline risk-reducing actions in the case of sudden dilemmas and emergencies. Dynamic support plans should cover positive risk related assessment and actions designed to enhance the confidence, competence, wellbeing and safety of people and those supporting them.

There should be a review of the dynamic support plan and related planning once the provider, and accommodation, is identified. A conversation needs to take place between the agencies involved and should focus on risk tolerance levels among the differing agencies involved, and how to reconvene to learn from any incidents or significant successes and amend support plans accordingly based on new learning. Flexibility of funding post-discharge needs to be considered as part of this discussion and could include pre agreed contingency funds held with the provider, that they can access if the need arises.

It should be highlighted that if restrictions will be needed to keep the person safe as part of planning, the question as to whether this may give rise to a deprivation of liberty must be considered. If it is thought that a deprivation of liberty might arise, legal authority for this must be sought (legal advisers will identity the correct legal procedures for doing so).

A risk plan should be a dynamic document and should be updated as environments and people around the person change and risks change. Risk taking is part of life - most of us learn new things by trying them first.  Everyone needs to feel safe and well supported to take risks.

People involved:

* the person and their family
* an advocate
* commissioner
* social worker or discharge co-ordinator
* community multidisciplinary team
* local authority representatives

Points for further consideration:

* how people in an inpatient unit are likely to be very different to how they are in their own home in the community. Things that people react to will change as their environment changes, and how the people around them respond. Therefore, this part of planning must be kept dynamic; it will be ever changing, needing constant review well beyond the person going to their home
* having a structured and consistent human rights focus is essential
* a proactive and preventative approach can be useful. This involves imagining a course of desired action, and then thinking about what could go wrong, and then planning together to mitigate or illuminate anything that could decrease or increase the chance of the best hoped-for outcomes

#### 6. A specification is completed

It is likely that commissioners would need to tender for provision of care if it is not already established in the right locality for the person. It will need to include all the learning concerning the person’s needs in planning. People with lived experience and families should be included in the selection processes of the care provisions where possible.

Funding the necessary support will require a local funding decision on care and support provision to be undertaken in principle.

In addition to direct support, the local specialist community multi-disciplinary team and other specialist providers of therapy and care will need to know about the person and what they need to do to help the person. A good handover between hospital and community staff is important, and it is critical that a responsible clinician in the community is identified, and fully engaged.

People involved:

* the person and their family
* an advocate
* people with lived experience may be part of wider selection processes
* commissioner
* social worker or discharge co-ordinator
* community multidisciplinary team
* responsible clinician
* local authority representatives

#### Trauma-informed commissioning

People leaving solitary confinement will have experienced high levels of personal stress. Trauma-informed commissioning requires that any known triggers for trauma, related to a person, are fully understood by the commissioner and care managers, and that they are considered as part of any planning. Exposing anyone to services or experiences that could trigger a traumatic response is always unacceptable. For example, if someone feels unsafe or is triggered by the unpredictable behaviours of others around them, or by high levels of noise or other sensory stimulus, it is inappropriate to expose a person to an environment where this is likely to be the case.

#### 7. Procurement processes are completed if required

Note: some commissioners may have support already set up, or people may have identified a provider or other support utilising their own funding (for example personal budget or personal health budget or resources).

The process for allocating the costs and funding should be undertaken and decided upon in a timely manner. Integrated care boards are expected to have joint policies in place on how funding for section 117 aftercare services is allocated. Where the person is not entitled to section 117 aftercare, or has needs that fall outside section 117, the relevant funding assessments will need to be completed including continuing health care and social care funding where applicable.

Including options for personal budgets should always be a constant consideration and fully supported with good available advice and brokerage.

People involved:

* commissioners
* social worker
* contracting and procurement leads
* (if the person has their own budget) brokerage support and their family or advocate, and attorney or deputy, as appropriate
* relevant skilled and suitable providers of support

Key considerations for procurement processes:

* does the local area have enough of the right kind of provider to meet the needs of this person, and indeed others? If not, is there a need to bring in or build support providers locally?
* what is the local pay like for skilled support staff - is the payment to providers enough to attract and maintain good support staff in their work?
* is there enough community infrastructure, like affordable housing and transport, for support staff?
* is the local multi-disciplinary team skilled to support the person as well as offering guidance to support staff?

#### 8. Accommodation and a provider of support are identified

Key points:

* identification of housing, which crucially involves the person and their family or other members of the person’s support network who know them best, needs to take place as soon as possible after admission so that any needed adaptations are made in good time
* national and local housing leads can provide good advice and information about funding that is specifically available to people, authorities and housing associations, for securing accommodation, or making adaptations
* providers should work to understand the kind of staff that could best support the person, using information in the personalised plans. In order to do this, they will need to get to know the person and also to develop their own assessment, which means having agreed and supported access to the person and those who know them well
* visits from the person, their family and professionals will be needed to assess and advise on any adaptations. This may include a sensory and environmental assessment as well as considering any risks that can be managed through environmental changes. Housing agreements will need to be signed (for example, a tenancy agreement)
* adaptations or any changes to the home will need to take place, and be quality checked before the person moves in
* recruitment and training of care staff (involving the person and their family and/or those who know the person best) needs to take place. Staff should be ‘matched’ to the person, depending on their relevant skills, attributes, and interests
* once a provider has been identified, if traditional contracting is to be used, contracts will need to be signed. For small or new providers, some adjustments may be required to provide extra support, including enabling payment schedules that help with cash flow to pay staff

People involved:

* the person and their family
* an advocate
* discharge coordinator
* support provider
* housing officer
* community multidisciplinary team (for example occupational therapists)

#### 9. Funding is confirmed

Funding needs to be confirmed for care and support along with any other elements. This may include contingency funding in some cases, whereby having resources on hand to use to avert crisis may be required.

There may be some additional capital costs for equipment or specific therapy-related costs also that need to be met.

People involved:

* local finance teams
* funding panels
* case manager and/or discharge co-ordinator

#### 10. Monitoring progress

Throughout this process, all involved need to be aware of the legal requirements and how these impact practical planning. It may be that there are delays with this part of the process, therefore pursuing decisions may be required to make sure that discharge happens in a timely way. Delays will have an effect for everyone ready and waiting for the move; this might affect people emotionally or financially.

People involved:

* responsible clinician
* discharge coordinator
* approved mental health professional
* social worker
* advocate

#### 11. A transition is planned and underway

A transition plan for leaving hospital needs to be discussed with everyone involved and subsequently agreed. This should include section 17 leave arrangements and funding for staff to enable this.

It can be an exciting time and should be a great opportunity for the person to get to know new staff and to visit their new home. It is important that the new provider has regular access to the person, simply because they will need time to build a good relationship.

A discharge meeting should be held to ensure that contingency and follow up plans are in place including how extra help can be sought if needed.

At this point a C(E)TR may be helpful to ensure that the discharge package is robust.

People involved:

* the person and their family
* an advocate
* discharge coordinator
* agreed lead clinician for ongoing support

Considerations for transitioning periods:

* transport costs may be significant where the persons hospital is a long way from their home. Funding needs should be agreed early in the process
* similarly, new staff and the person will need to get to know each other before the move. This will need careful planning and may include accommodation costs for new staff if the hospital is far away and there is a need to shadow on the ward or unit
* the type and means of transport will need to be carefully planned

#### 12. The person is discharged

Following discharge, follow-up review meetings should be planned; the first meeting between the discharge co-ordinator and relevant staff should take place within 4 weeks, and the date should be decided as soon as possible.

The community multi-disciplinary team follow-up contact should occur within one week of discharge, and an agreed level of follow up and support for the provider must be agreed and confirmed. This will include what happens in the event of a crisis, or concerns that a crisis may be imminent.

Regular communication should be arranged to ensure that support is there for all parties. This should happen monthly at a minimum. These meetings should be scheduled for at least 2 years while the person settles in. They can be extended if required.

People involved:

* the person and their family
* an advocate
* care manager
* responsible clinician
* support provider
* commissioner
* any related hosing representatives if required

#### Considerations for crisis plans

Crisis plans should include what to do in the event of support breaking down, or if staying in the identified accommodation may be untenable, using local identified alternative accommodation. Use of pre-agreed contingency funding is advised.

Local commissioners should have crisis accommodation such as intensive support pods, and/or means of short-term emergency support developed as part of their local offer.

C(E)TRs are helpful to steer a path. If there are any setbacks, it is important to use events as learning opportunities, so they can be put right together, using reflection, discussion and new ideas.

### Discharge pathways: areas for further development

#### Preparation of documents relating to discharge

Further clarification is required regarding which members of the multi-disciplinary team are responsible for preparing documents relevant to discharge planning.

#### Discharge co-ordinator role

The role of the discharge co-ordinator in the discharge plan is a pivotal one. An appropriate job description requires further development and [may be based on the role descriptions from NHS England’s key workers for children](https://www.england.nhs.uk/learning-disabilities/care/children-young-people/keyworkers/#:~:text=Keyworkers%20work%20with%20children%20and,in%20a%20co%2Dordinated%20way.).

#### Resolving disputes over discharge planning

It is recommended that there is a person responsible, and a pathway agreed, for resolving disputes relating to discharge planning. This should subsequently be developed, with consideration given to how this interacts with existing programmes of work such as the Senior Intervenor pilot programme.

It is recommended that there should be a dispute resolution process families can follow easily, for example, using [Ask Listen Do](https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/). The NHS England learning disability and autism quality concerns can facilitate the concerns escalation process.

Further consideration should be given to how [NHS England’s March 2022 position statement on the Care Programme Approach](https://www.england.nhs.uk/publication/care-programme-approach-position-statement/#:~:text=It%20enables%20services%20to%20shift,need%20of%20community%20mental%20healthcare.) may relate to and/or impact discharge.

#### Accountability

Accountability processes need to be developed which outline appropriate pathways and necessary actions to be taken in the event of individuals responsible for care failing to meet expectations.

The discharge co-ordinator may have an important part to play in facilitating such accountability.

#### Tribunal

Consideration should be given regarding how tribunal’s decision-making might be co-ordinated with authoritative decisions regarding deprivations of liberty. Appropriate and relevant guidance should be sought to support this.

#### Dynamic support registers

Consideration should be given as to how risk plans relate to dynamic support registers.

## Examples of best practice

The following section will outline initiatives and actions which have been considered examples of best practice, and tools that are available.

### Independent oversight - Independent Care (Education) and Treatment Reviews (IC(E)TRs)

IC(E)TRs are C(E)TRs chaired by independent professionals and involve an independent CQC mental health act reviewer.

The aim of IC(E)TRs is to ensure that every effort is being made to provide people with care that meets their individual needs and decisive care planning, so that they can be discharged to the least restrictive setting as soon as possible.

Baroness Hollins chaired an independent Oversight Panel from November 2019 to March 2023 to review the findings from this work.

### Independent interventions - senior intervenors

Senior intervenors are independent experts of health and social care practice who worked with people and systems on a case-by-case basis to help move people in the most restrictive settings towards discharge. This pilot was funded until March 2023 and is currently being evaluated.

### Good practice examples: facilitating better situations for people in hospital

#### HOPE(S) model

NHS England has commissioned the [HOPE(S) training model](https://www.merseycare.nhs.uk/hopes-model) which is being delivered to embed good practice across inpatient services to reduce the use of long-term segregation and restrictive practices for people with a learning disability and autistic people.

HOPE(S) provides practice leadership, training and direct support to the person, their families, clinical teams and organisations. It is a human rights-based approach which uses an assessment and SMART intervention targets to effect change.

#### National Development Team for Inclusion (NDTi) - sensory environment checks of inpatient units

The [NDTi](https://www.ndti.org.uk/) conducts sensory environment checks in hospitals. This assessment of the sensory environment focuses on practical changes that could be made to improve the building; recommendations made will reduce the sensory load that inpatients may experience.

#### Studio 3 - low arousal approach

Teams within [Studio 3](https://www.studio3.org/) work with the person and staff team to provide therapeutic support and create a low-arousal environment.

Good practice examples: supporting people in solitary confinement to move back into the community.

#### Helping People Thrive

[Helping People Thrive](https://www.bild.org.uk/helpingpeoplethrive/) contains stories from autistic people and people with a learning disability who were in Assessment and Treatment Units (ATUs) for years, often segregated from others. They are now thriving, living in their own homes, in their own communities.

These stories detail instances where Building the Right Support has worked and good commissioning systems, clinicians, care organisations, self-advocates and families have made good things happen.

#### Respond

Founded in 1991, [Respond](https://respond.org.uk/) is a national charity providing therapy and specialist support services to autistic people and people with a learning disability who have experienced abuse, violence or trauma.

Respond will work with people in long-term segregation and their families, commissioners and hospitals to support people to move on. The process is based on a trauma-informed approach (see Mary’s story in the book [Helping People Thrive: stories and lessons in transforming care](https://www.bild.org.uk/helpingpeoplethrive/)).

#### NDTi: small supports

NDTi teams work with commissioners to set up small local organisations which support people who have histories of being in long-term segregation.

#### AT-Autism

[AT-Autism](https://www.atautism.org/) provides independent consultancy and support regarding service design and helping people move on.

#### I’m Out of Here - life planning

[I’m Out of Here](http://www.imoutofhere.org.uk/) facilitates planning for people (children, young people and adults) and their families to help them get great lives.

Life planning helps the person find purpose through:

* their gifts: have faith in their unique gifts, finding ways to share them
* their resources: make the best of everything the person has got to offer
* their people: the people who believe in them and can help them find their way
* their community: find meaning by joining in with things that matter to them
* hope: follow their dreams and not playing safe - life is for living!

#### Cubbies

[Personalised Sensory Regulation (PSR)](https://cubbie.ie/personalised-sensory-regulation/) is a new and effective way to support autistic people and their sensory needs. It is distinguished from traditional analogue solutions by being an easy-to-use, immersive, safe, personal space of sound and vision. It is free of disruptions and driven by software that is regularly and automatically updated. Outcomes are predictable and reliable, achieved in 5-, 10- or 15-minute time periods spent in a ‘cubbie’.

## Resources: guidance and legislation

[Brief guide: Long-Term Segregation (PDF, 174KB)](https://www.cqc.org.uk/sites/default/files/20200824_9001307_brief-guide_long-term-segregation_v3_0.pdf). CQC, 2020

[Brief guide: seclusion rooms (PDF, 115KB)](https://www.cqc.org.uk/sites/default/files/Brief_guide_Seclusion_Rooms.pdf). CQC, 2020

[Care Act 2014](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

[Care Programme Approach: NHS England position statement (PDF, 185KB)](https://www.england.nhs.uk/wp-content/uploads/2021/07/B0526-care-programme-approach-position-statement-v2.pdf). 2022

[Children Act 1989](https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted)

[Children and Families Act 2014](https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted)

[How CQC identifies and responds to closed cultures](https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures)

[Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents)

[High security psychiatric services directions 2013: arrangements for visits by children](https://www.gov.uk/government/publications/high-security-psychiatric-services-directions)

[Human Rights Act 1998](https://www.legislation.gov.uk/ukpga/1998/42/contents)

[Keeping Me Safe and Well: Risk Assessment Screen (PDF, 1.11MB)](http://www.ewin.nhs.uk/sites/default/files/eWIN%20Case%20Study%20-%20e552_Keeping_Me_Safe_and_Well_Screen%20477.pdf). Mersey Care NHS Trust, 2011

[Liberty Protection Safeguards: what they are](https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are#:~:text=The%20Liberty%20Protection%20Safeguards%20will,to%20consent%20to%20their%20arrangements.)

[Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents)

[Deprivation of liberty safeguards: resources](https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance)

[Code of Practice: Mental Health Act 1983](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983). 2015

[Mental Health Units (Use of Force) Act 2018](https://www.legislation.gov.uk/ukpga/2018/27/enacted#:~:text=An%20Act%20to%20make%20provision,units%3B%20and%20for%20connected%20purposes.)

[Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England and police forces in England and Wales - draft for consulation](https://www.gov.uk/government/consultations/mental-health-units-use-of-force-act-2018-statutory-guidance/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales-draft-for-co). 2021

[National framework for NHS continuing healthcare and NHS-funded nursing care](https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care)

[National Minimum Standards for Psychiatric Intensive Care in General Adult Services](https://napicu.org.uk/publications/national-minimum-standards/). National Association of Psychiatric Intensive Care, 2014

[National Minimum Standards for Psychiatric Intensive Care Units for Young People](https://napicu.org.uk/national-minimum-standards-for-young-people-2015/). National Association of Psychiatric Intensive Care, 2015

[NHS exercise guidelines](https://www.nhs.uk/live-well/exercise/exercise-guidelines/)

[Stopping over-medication of people with a learning disability (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)](https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/). 2020

Shavon Shalev. [The Istanbul Statement on the Use and Effects of Solitary Confinement](https://www.solitaryconfinement.org/istanbul). 2007

[The United Nations Convention on the Rights of the Child](https://www.unicef.org.uk/what-we-do/un-convention-child-rights/). UNICEF, 1990

## Further information

[Annual health checks and people with learning disabilities](https://www.gov.uk/government/publications/annual-health-checks-and-people-with-learning-disabilities/annual-health-checks-and-people-with-learning-disabilities)

[Capital investment and property business case approval guidance for NHS trusts and foundation trusts](https://www.england.nhs.uk/financial-accounting-and-reporting/capital-investment-and-property-business-case-approval-guidance-for-nhs-trusts-and-foundation-trusts/)

[Care, Education and Treatment Reviews (CETRs)](https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/)

[Disabled Facilities Grants](https://www.gov.uk/disabled-facilities-grants)

[What is an education, health and care (EHC) plan?](https://educationadvocacy.co.uk/what-is-a-ehcp/) Education Advocacy, 2020

[My health passport](https://www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport). National Autistic Society, 2020

[Home ownership for people with long-term disabilities (HOLD): Factbook (PDF, 176KB)](https://www.local.gov.uk/sites/default/files/documents/HOLD%20and%20shared%20ownership%20and%20step%20by%20step%20guide_FINAL.pdf). Local Government Association, 2018

[Home identification form](http://hsa.learningdisabilityengland.org.uk/Home%20identification%20form%20final-documentresourceid=620.pdf)

[Independent Care (Education) and Treatment Reviews (IC(E)TRs)](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews)

[Independent Mental Health Advocacy (IMHA)](https://www.pohwer.net/independent-mental-health-advocacy-imha). POhWER

[What are ISFs?](https://www.cambridgeshire.gov.uk/residents/adults/organising-care-and-support/paying-for-care/individual-service-funds) Cambridgeshire County Council

[Personalised care and support planning](https://www.england.nhs.uk/personalisedcare/pcsp/)

[Personalised Care Institute](https://www.personalisedcareinstitute.org.uk/)

[Alert Card Schemes](https://www.npaa.org.uk/alert-card-schemes/). National Police Autism Association

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