# Baroness Hollins' letter to the Secretary of State for Health and Social Care about the Independent Care (Education) and Treatment Reviews

Published 8 November 2023

Contents

[Background of IC(E)TRs and Oversight Panel 2](#_Toc151709727)

[Number of people still in long-term segregation - moving in and out 3](#_Toc151709728)

[Recommendations 4](#_Toc151709729)

[Wider considerations 7](#_Toc151709730)

[Conclusion 7](#_Toc151709731)

This letter concerns the conclusion of the programme of independent reviews of those in long-term segregation. It is from Baroness Hollins, Chairperson of the Independent Care (Education) and Treatment Review (IC(E)TR) programme for people with a learning disability and autistic people in inpatient settings. It is addressed to the Secretary of State for Health and Social Care and dated 17 July 2023.

The Rt Hon Steve Barclay MP
Secretary of State for Health and Social Care
Department of Health and Social Care

17 July 2023

Dear Secretary of State

I am writing to you following the conclusion of a piece of work I agreed to undertake for one of your predecessors. The programme of independent reviews I oversaw was intended to improve the quality of care for people with a learning disability and/or autistic people detained under the [Mental Health Act 1983](https://www.legislation.gov.uk/ukpga/1983/20/contents) in long-term segregation, and to support them towards discharge. These reviews have had limited success.

## Background of IC(E)TRs and Oversight Panel

The interim report of the Care Quality Commission’s (CQC) thematic review on restraint, prolonged seclusion and segregation, [Out of sight - who cares?](https://www.cqc.org.uk/publications/themed-work/rssreview), was published on 21 May 2019 and showed distressing examples of people with a learning disability and autistic people being detained in what amounted to solitary confinement. CQC’s report recommended that there should be an independent review of the care provided to, and the discharge plan for, each person who is in long-term segregation and has a learning disability and/or is an autistic person.

In December 2019, the then Secretary of State for Health and Social Care commissioned me to oversee the implementation of a programme of Department of Health and Social Care (DHSC) managed, independently chaired Care, (Education) and Treatment Reviews. My task was to oversee the Independent Care (Education) and Treatment Reviews (IC(E)TR) programme, derive learning and identify what needs to change to facilitate effective discharges of people to less restrictive environments. I recruited a multidisciplinary oversight panel comprising ‘experts by experience’ and health, care and legal professionals to assist me. I am grateful for their help.

In my role as chair of the IC(E)TR Oversight Panel, I have been a member of your department’s Building the Right Support Delivery Board chaired by the Parliamentary Under-Secretary of State for Mental Health and Women’s Health Strategy. As a crossbench peer, I represented the House of Lords on the joint committee on the Draft Mental Health Bill which had proposed changes to the Mental Health Act 1983 for people with a learning disability and/or autistic people.

In July 2021 my [letter to the then Secretary of State for Health and Social Care](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/baroness-hollins-letter-to-the-secretary-of-state-for-health-and-social-care-about-the-independent-care-education-and-treatment-reviews) and the [Oversight Panel’s Thematic Review](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/thematic-review-of-the-independent-care-education-and-treatment-reviews) and [recommendations following the first phase of IC(E)TRs](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/the-oversight-panels-interim-conclusions-and-recommendations) were published alongside the [government’s response](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-government-response).

This is my final report and recommendations, following the completion of the second phase of reviews. I would welcome a formal response from the government preferably to be published simultaneously with the publication of my report.

Throughout this letter and my report, I will use ‘solitary confinement’ as an umbrella term to refer to long-term segregation and seclusion. This is because Oversight Panel members and I consider that solitary confinement is the best descriptor of the enforced social isolation described in the independent reports for the 114 individuals reviewed in this second phase of IC(E)TRs. Some stakeholders consider that the term solitary confinement suggests a punitive approach, which is at odds with professional practice, the requirements of the [Mental Health Act 1983: Code of Practice 2015](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) and CQC regulations. Where I have used the phrase ‘long-term segregation’ this is because it refers to those who met the criterion for an IC(E)TR as defined for this particular programme.

## Number of people still in long-term segregation - moving in and out

Two phases of the IC(E)TR programme have taken place since November 2019, and the programme continued, despite considerable difficulties, even at the height of the COVID-19 pandemic. Altogether, between November 2019 and March 2023, 191 IC(E)TRs have taken place. Of the 114 people who received an IC(E)TR in the second phase, which ran between November 2021 and March 2023, we have been informed by NHS England that only 48 have been moved out of long-term segregation and only 7 people have been discharged from hospital.

During this time other interventions have been running alongside the IC(E)TR programme, including [HOPE(S)](https://www.merseycare.nhs.uk/hopes-model) (a human-rights based clinical model designed to reduce the use of long-term segregation), safe and wellbeing reviews and a Senior Intervenor pilot which was developed by NHS England following a recommendation from the Oversight Panel’s original report to pilot bespoke and intensive case management. These interventions are being evaluated to assess their effectiveness, but interim feedback suggests that success is most likely to be seen when these interventions are used in conjunction with each other, and when the interventions offered are tailored to each person’s individual circumstances. I welcome these innovations.

Despite these programmes of work, the number of people with a learning disability and/or autistic people detained in long-term segregation has remained around 115 at any one time, as it appears that when someone is discharged, another person moves into their space in long-term segregation.

When I was appointed, I cautioned that discharging people is only one side of the problem and that, as important as it is to support people out of solitary confinement, we must also prevent people moving into it.

The IC(E)TR programme has confirmed to me that too often solitary confinement is used as a means to contain people with a learning disability and/or autistic people who have been failed because of inappropriate care and treatment earlier in their pathway of care. The Oversight Panel does not consider there to be any therapeutic benefit to this practice and recommend that solitary confinement and any other uses of restrictive practices that isolate people from meaningful human contact, should be severely curtailed as soon as possible.

## Recommendations

I have worked with the members of the Oversight Panel to produce a series of recommendations aimed at severely curtailing the practice of solitary confinement for people with a learning disability and/or autistic people and improving their life chances. These can be found in my report.

I have highlighted some urgent starting points below, but all the recommendations in my report are critically important. Focusing on one or two recommendations will not achieve the desired transformation of the support needed to achieve the ‘gloriously ordinary lives’ envisioned in the [recent report from the House of Lords Adult Social Care Committee](https://committees.parliament.uk/publications/31917/documents/193737/default/). In our view, system wide failings are at the root of the reliance on solitary confinement to ‘warehouse’ troubled and traumatised people. The responsibility cannot all be put on individual commissioners, hospital managers and clinicians, although they have key parts to play.

1. Solitary confinement involves the use of enforced social isolation and forcibly denying people meaningful human contact. Therefore, I recommend that both long-term segregation and seclusion of people with a learning disability and/or autistic people are renamed solitary confinement.
2. I recommend that solitary confinement for people with a learning disability and/or autistic people become NHS England registered [never events](https://www.england.nhs.uk/publication/never-events/) in the following instances:
* for children and young people under 18 years of age. This will bring us into line with international practice (see [annex D to my report](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023) - where it does not meet new minimum standards for adults (see accompanying document for a [proposed solitary confinement code of practice framework](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023) which Oversight Panel members have helped to develop)
* where it lasts longer than 15 days
1. All instances of solitary confinement must be notifiable to provider boards, commissioners and to CQC. It is imperative that people are not put at risk of other restrictive interventions and that the practice does not go ‘underground’.
2. 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.
3. 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. To assist with this, the keyworker scheme for children and young people should be expanded in each integrated care system (ICS) so that a named keyworker is provided for adults on the dynamic support register, or where there are similar identified needs.
4. 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.
5. The Oversight Panel have helped to develop a [solitary confinement code of practice framework (see accompanying document alongside the report)](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023) which proposes minimum standards to be implemented for all uses of solitary confinement for people with a learning disability and/or autistic people. Minimum standards, informed by the Oversight Panel’s code of practice framework and recommendations, should be introduced as soon as possible through an amended Mental Health Act 1983: Code of Practice 2015. Any instances of solitary confinement that do not meet these minimum standards should trigger a never event and those responsible must be held accountable. We consider that the minimum standards need to include:
* no instance of solitary confinement should last longer than 15 days
* family members and advocates must have unrestricted visitation access to people detained in solitary confinement
* access to independent specialist advocacy as recommended in the soon to be published NHS England report on advocacy and to specialist legal advice
* all staff working with people in solitary confinement in hospital settings should be trained in therapeutic and human-rights based approaches to care; in law and policy and in de-escalation, and preventative approaches in accordance with the [Restraint Reduction Network Training Standards](https://restraintreductionnetwork.org/know-the-standard/) as legislated in the [Mental Health Units (Use of Force) Act: 2018](https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018).
* specialist trauma-informed therapy must be commissioned and provided for people who have been traumatised by the use of restrictive practices
* minimum standards for all solitary confinement areas must include:
* activity
* an eating area/furniture
* a separate toilet/bathing room
* direct access to outside space
* natural light
* a clock
* digital and communication technology
* all services using restrictive practices including solitary confinement should have regard to [CQC’s closed cultures guidance](https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures) which should be reviewed to see if the guidance remains fit for purpose

It is also important that these minimum standards sit alongside my other recommendations, including the following ones which I wish to draw particular attention to:

* private company and trust managers must be held to account for failure to provide a safe and therapeutic environment
* 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, with clinicians held to account if they fail to meet these
* people with a learning disability and/or autistic people in solitary confinement must have access to free specialist legal advice and a redress scheme should be available to them
* safeguarding register should be maintained and shared by providers on an agreed frequency with CQC documenting indicators of poor care and treatment

## Wider considerations

There are some wider considerations that cannot be ignored if any of the learning from this programme of work has any chance of achieving the changes that people deserve. Some key recommendations to highlight are:

* alternative accommodation must be readily available within each ICS area in times of acute distress, or emotional and behavioural crisis; for when community support services are not able to meet the person’s immediate needs or keep them and their support network safe; and to avoid hospital admission
* health and social care providers must pool their budgets to provide improved, integrated services. From the evidence I have reviewed, there is little evidence of this being adopted, either widely or efficiently for people who were or are at risk of being placed in long-term segregation
* there is an urgent need for radical reform to address the crisis in care for disabled adults of working age
* the key role of education in preventing admission, for example, by adopting zero exclusion policies, and supporting discharge, must be recognised and addressed through more joined up working with the Department for Education
* the clear expectation of multiagency planning and co-operation and funding needs to be strengthened

## Conclusion

Interventions have been developed which can effectively support people out of solitary confinement, and yet this harmful practice continues to be used routinely as a so-called ‘last resort’. The lack of expertise in units adopting this approach is unacceptable.

I have found no evidence from IC(E)TR reports of any therapeutic benefit to patients from solitary confinement. I urge the practice to be curtailed due to the magnitude and severity of the harm caused, which outweighs any possible benefit. The use of solitary confinement for most of the people reviewed followed an admission to hospital because of a breakdown in community support including education.

People admitted in these circumstances need to instead be supported in the community, close to family and friends in a setting where they feel safe. Environmental failings require environmental solutions, hospitals are for active treatment for identified and treatable conditions. This is why I have recommended that solitary confinement becomes a never event for children and young people who have a learning disability and/or are autistic. I have also recommended an end to all instances of solitary confinement for adults who have a learning disability and/or are autistic which do not meet the minimum standards proposed in my report. I strongly urge the government to act swiftly on my recommendations.

With kind regards

Professor Sheila the Baroness Hollins
Chair, Oversight Panel to review IC(E)TR programme for people in long-term segregation

© Crown copyright 2023

[www.gov.uk/dhsc](https://www.gov.uk/dhsc)

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3/).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

