# Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people

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## Introduction

### Summary

This report focuses on people with a learning disability and/or autistic people who are detained in mental health and specialist learning disability hospitals.

The Independent Care (Education) and Treatment Review (IC(E)TR) programme reviewed the care and treatment of 191 people who were detained in long-term segregation between November 2019 and March 2023. The programme was established because of serious concerns about the use of long-term segregation, and in particular about lengthy stays and difficulties in discharging people from long-term segregation. The aim was to identify the blocks to discharge and to assess whether independently chaired Care (Education) and Treatment Reviews (C(E)TRs) would be more effective than commissioner chaired C(E)TRs in developing the right support for each person detained in long-term segregation.

[Safe and wellbeing reviews](https://www.england.nhs.uk/learning-disabilities/care/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/) set up after the Cawston Park Hospital Inquiry assisted in identifying people in long-term segregation. At the start of the second phase of the programme there were 115 people in long-term segregation and a similar number were in long-term segregation at the end. At the time of writing, of the 114 people who received an IC(E)TR in the second phase, 48 had moved out of long-term segregation, including 7 people who had been discharged from hospital.

The data collected by NHS England does not measure the numbers of people who have had an IC(E)TR, remain in hospital and have been moved to conditions of higher security. Robust information is also not available about whether any of the 191 people who received an IC(E)TR review have since died, due to inconsistencies in reporting by providers. This information is critically important and should be considered by NHS England and the Care Quality Commission (CQC) for future work in this area. I am pleased to hear that CQC are beginning to address this through improvements to their notifications system.

During this period some additional interventions were established in an attempt to improve individual outcomes. A [Senior Intervenors pilot](https://www.england.nhs.uk/learning-disabilities/about/reducing-long-term-segregation/) which supported 17 people (but ended in March 2023 pending evaluation of its effectiveness), and the [HOPE(S)](https://www.merseycare.nhs.uk/hopes-model) practice leadership and culture change programme (funded until 2024) were both commissioned by NHS England. These interventions, working alongside IC(E)TRs, have helped to achieve the outcomes obtained so far.

The Oversight Panel found a lack of urgency in addressing the many systemic issues that were identified through the IC(E)TR reviews.

International consensus across various sectors and disciplines on the harms caused by enforced isolation are scientifically evidenced and compelling, and the consensus is that enforced isolation has no therapeutic benefit.

Members are unanimous in recommending that all instances of enforced social isolation, including seclusion and long-term segregation, should be renamed ‘solitary confinement’. The panel recommends that its use with children and young people under the age of 18 should be ended with immediate effect, and that the use of solitary confinement for people with a learning disability and/or autistic people should be severely curtailed and time limited. Minimum standards for the use of solitary confinement should be introduced urgently through amendments to the [Mental Health Act 1983: Code of Practice](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983).

### Definitions

Terms for enforced isolation include ‘seclusion’, ‘long-term segregation’, ‘isolation’, ‘time out’, ‘individualised package of care’ and ‘solitary confinement’, among others. These terms are often used interchangeably. An overarching term to describe the common experience of enforced isolation where people are denied meaningful human contact is required. This will improve recognition, monitoring, intervention and safeguards for all uses of enforced isolation.

To determine who should receive an IC(E)TR, the definition of long-term segregation that CQC used in their [Thematic Review of the use of restraint, prolonged seclusion and segregation for people with mental health problems, a learning disability and/or autism (PDF, 333KB)](https://www.cqc.org.uk/sites/default/files/20181203_restraint-thematic_tor.pdf) was applied:

"Nursing or caring for a person in enforced isolation, regardless of whether the procedures and requirements of the Mental Health Act 1983: Code of Practice for long-term segregation are met.

The enforced isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers."

This differs from the definition of long-term segregation used in the Mental Health Act 1983: Code of Practice, which is:

"A situation where, to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.

In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm."

CQC’s definition was used in the IC(E)TR programme to include people who are segregated for reasons other than a risk of harm to others.

‘Solitary confinement’ is used in this report as an umbrella term to mean:

"Enforced isolation from meaningful human contact with peers which includes all practices that deny people meaningful contact with other people, including but not only, 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 and/or housing and where there is enforced denial of meaningful human contact with peers. It does not constitute solitary confinement if a person is living alone and meaningful human contact is unrestricted, for example the person is free to engage face to face with friends, family and peers, and so on, at their will. In the case where a person is detained in their own living space, regular monitoring and safeguards comparable to those used for persons identified as being in solitary confinement should remain in place. This will ensure the care does not meet the threshold for solitary confinement and afford equal protection and safeguards due to their vulnerability to the development of closed cultures."

1. Meaningful human contact: definition
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 a person 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. Peers: definition
4. Non-paid people such as family, friends, other patients and members of the community.

### Background

This background briefly sets the context for the work of the Oversight Panel for the IC(E)TR programme and explains where the programme sits in relation to the government’s [Building the Right Support Action Plan](https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people/building-the-right-support-action-plan), published in July 2022. It also takes note of the independent review of the [Mental Health Act 1983](https://www.legislation.gov.uk/ukpga/1983/20/contents), the [draft Mental Health Bill 2022](https://www.gov.uk/government/publications/draft-mental-health-bill-2022) and [the report of the pre-legislative Joint Committee on the Draft Mental Health Bill](https://committees.parliament.uk/committee/605/joint-committee-on-the-draft-mental-health-bill/), of which I was a member.

Alexis Quinn, manager of the Restraint Reduction Network, and an Oversight Panel member, shared her reflections on her experiences in an extract from her book, [Unbroken](https://books.google.co.uk/books/about/Unbroken.html?id=48MyuQEACAAJ&redir_esc=y), which details the lasting impact of time in various forms of solitary confinement.

"In my memoir, ‘Unbroken’, details of my confinement illustrate that the single most important interventions to improve wellbeing are not the costliest. One time, after being mechanically restrained, a nurse entered solitary confinement. She removed the handcuffs and leg straps, and she held me. This staff member and a handful of others refused to extend the narrative of my badness and chose instead to enter into a relationship, building upon my inherent goodness by connecting to my humanity. In her arms, she single-handedly combatted the legacy of isolation, reawakening within me feelings of acceptance, care and love. Feelings I had not felt for many years. The legacy of solitary confinement extends beyond the person leaving the space. I remain affected in deep and devastating ways. Each day I wake up to the dull, enduring pain of isolation and aloneness. Emotional flatness, a difficulty in establishing meaningful contact with others, an oversensitivity to sensory and emotional stimuli, a distrust of people and regular flashbacks are but a few symptoms I still experience. Every staff member should feel empowered to reduce this impact by connecting deeply with the person."

This narrative demonstrates the importance of a commitment to prevent and reduce solitary confinement as a clinical practice. It highlights that systemic and practice change is required at all levels to achieve this goal.

People do better in life when their uniqueness as human beings is recognised, valued and supported, and when they live a meaningful life in a place that they call home. Some need regular, personalised support to live what the recent House of Lords Adult Social Care Select Committee called [‘a gloriously ordinary life’ in their report](https://publications.parliament.uk/pa/ld5803/ldselect/ldadultsoc/99/9902.htm). Some just need timely support in a crisis. To achieve this requires good planning and a local commitment to ensure each person experiences the best health, care, education and support.

Investment in community-based provision for people with a learning disability and/or autistic people, including the engagement of experienced, community-based providers offers the possibility of reduced support over time should the person’s level of distress diminish, as it often does with good, personalised community support. This requires crisis support, the possibility of a graded introduction to the community, as well as flexible support offers. This is further referenced in recommendations 3 and 11.

It is hoped that the introduction of training for staff in relation to learning disabilities and autism (see the [Oliver McGowan Mandatory Training on Learning Disability and Autism programme](https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism)), will contribute to improving the capabilities and competencies of staff throughout the system and facilitate a wider understanding of autistic people and how best to assess and support their personalised needs. This should benefit the health and care of people both at home and when admitted to hospital and will play an important part in reducing restrictive practices in the future.

The [Building the Right Support Action Plan](https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people/building-the-right-support-action-plan) is widely welcomed, as are changes to integrated care system (ICS) responsibilities in the [Health and Care Act 2022](https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) including the introduction of executive leads for learning disability and autism. But it is hard to see how implementing the action plan will turn things around for those people who are currently being failed, given the deficit in funded social care and the lack of universal specialist community mental health support. These gaps in service provision too often lead to crisis admissions to hospital for people whose life stories describe a seemingly irreversible pathway to a traumatic detention. People who may then be further failed with lengthy detentions in hospital, including periods of what is currently called long-term segregation. People who, in some hospital settings, are experiencing what we considered to be poor, punitive or even abusive care, which only adds to their trauma.

We cannot legislate our way out of these difficulties without more resources in the wider health and care system as well as in focused and local specialist support. The Oversight Panel has concluded that solitary confinement is inhumane and creates long-lasting problems for the person, their families and carers. For the health and care system, this practice adds to the many difficulties staff and services experience, rather than solving any problems.

As this report shows, culture change is needed throughout the whole health and care system if the aspirations set out in the action plan are to be achieved for everyone.

The Oversight Panel’s remit is at first sight much narrower than the [Transforming Care Programme](https://www.england.nhs.uk/learning-disabilities/care/) and the Building the Right Support Action Plan, but in trying to understand why a small but significant number of people are still being detained in long-term segregation (re-named solitary confinement in this report), the Oversight Panel re-looked at some of the systemic issues at play.

1. We examined the systemic issues involved by considering the baseline situation (the diagnosis) and the context.
2. We oversaw the introduction and implementation of a new intervention (IC(E)TRs).
3. We recommended improvements to the intervention in the light of experience.
4. We examined the IC(E)TR reports - and related outputs such as any escalation of safeguarding concerns.
5. We reviewed agency responses to these outputs and their impact on people’s lives.
6. Finally, we considered whether the inputs were contributing to the systemic change that stakeholders were expecting.

### Evidence examined

Following each IC(E)TR, independent chairs produced an anonymised summary report of their findings. The reports focused on:

* why people were being cared for away from others
* how long segregation had lasted
* how it was affecting them
* their relationships with others
* what people involved believed should change about a person’s care

These anonymised reports were shared with me, and in some cases with Oversight Panel members. In addition to the summary reports, the Oversight Panel were also presented with anonymised data on people who had received, or met the criteria for, an IC(E)TR. This allowed us to draw conclusions relating to the care of people with a learning disability and/or autistic people in long-term segregation. This, along with the existing expertise and experience of Oversight Panel members, informed this final report, recommendations and framework for the Mental Health Act 1983: Code of Practice revision.

## Independent Care and (Education) Treatment Reviews

### The introduction and implementation of the new intervention (IC(E)TRs)

In 2020, at my request, the Department of Health and Social Care (DHSC) commissioned Alicia Wood to assist me with a [Thematic Review](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews) of the first 26 IC(E)TRs, and this report informed the discussions of the Oversight Panel appointed to assist my enquiries (see annex E for membership). The Thematic Review highlighted common themes and findings and identified issues that needed to be addressed urgently.

The most shocking finding was that very little seemed to have improved for the 26 people reviewed. This outcome was despite the best efforts of the work by NHS England to implement the Building the Right Support model. For most of those 26 people, their care was consistent with that reported numerous times in previous inquiries and exposés. Similar themes also ran through many of the second round of IC(E)TR reviews which were completed by the end of March 2023. However, in these reviews it was also good to see the early impact of the practice leadership and culture change programme, HOPE(S), which has been introduced by NHS England in hospital settings, in helping to reduce the use of restrictive practices and supporting teams to address solitary confinement.

Social media comment, submissions to the [Select Committee for Pre-legislative Scrutiny of the Draft Mental Health Bill](https://publications.parliament.uk/pa/jt5803/jtselect/jtmentalhealth/696/report.html), recent television documentaries, research papers, reports by the [Joint Committee on Human Rights](https://committees.parliament.uk/committee/93/human-rights-joint-committee) and the [Health and Social Care Select Committee](https://committees.parliament.uk/committee/81/health-and-social-care-committee/) all point to the continuing failures of current health and social care provision to offer meaningful mental health support for all in the community. It has been shown that this remains the case even when family or personal life events could have been anticipated and better supported. The consequence is that when crises happen, instead of a friendly, homely and trauma-informed environment to help the person process what is happening in their lives, some people may be admitted to hospital.

Some end up being detained under the Mental Health Act 1983, and some placed in solitary confinement, and further traumatised by the social and sensory deprivation they experience during lengthy periods of enforced isolation, as well as by the hospital routine and environment. We have heard that some previously law-abiding citizens have been criminalised for expressions of their distress during foreseeable, regime induced overwhelming behaviours of distress. This is very concerning because it’s known that having a criminal record can have long-term effects on a person’s prospects, for example employment opportunities and home ownership. A minority are then transferred to conditions of higher security due to the application of a forensic lens to interpret their distressed behaviours, and if the support they need is considered to require this.

The Oversight Panel’s more detailed discussion of what is wrong with the use of solitary confinement for people with a learning disability and/or autistic people is set out in annex B and careful reading is recommended. It describes some of the lessons from the IC(E)TR programme, including the financial and personal costs of solitary confinement and the need for minimum standards for its use. Examples of how some services have improved clinical effectiveness are explored, and the importance of research and specialist training for staff emphasised.

### The IC(E)TR intervention and commissioner responses to IC(E)TR reports

The IC(E)TR programme has had 2 phases: the first ran between November 2019 and August 2020 and reviewed the care of 77 people; the second ran between November 2021 and March 2023 and reviewed the care of 114 people detained in long-term segregation.

The IC(E)TR programme planned to offer an IC(E)TR to every person with a learning disability and/or autistic person in long-term segregation. However, due to the continuing influx of people moving into long-term segregation, and some practical challenges including a shortage of independent chairs, it was not possible to reach every person by 31 March 2023. NHS England conducted a prioritisation exercise, to ensure those who were the highest priority for an IC(E)TR were offered one.

Alexis Quinn, in her capacity as an expert by experience and member of the Oversight Panel, jointly interviewed prospective independent chairs of IC(E)TRs with Baroness Hollins. The quality and comprehensiveness of their reports were overall good, but in any future model of IC(E)TRS ongoing peer support and supervision is recommended as this is harrowing work. For more details of the IC(E)TR process, see annex A.

### Changes introduced to IC(E)TRs in light of experience

One early lesson from the reviews was that commissioners and clinicians lacked confidence in making arrangements to support the discharge of people from solitary confinement. Often a move to a less restrictive setting is needed before people are moved into the community, dependent on a person’s circumstances. We know that discharge planning requires engagement from different council and NHS teams, including housing, community based multi-disciplinary teams, finance, legal and other staff. We found that too often the discharge process was poorly led and co-ordinated.

An early workshop, held on 13 February 2020, with ‘experts by experience’ and a range of commissioners and providers focused on looking at the delivery of personalised services to people who had got stuck in the system. This led to publication of an illustrated guide called [Helping People Thrive](https://www.bild.org.uk/helpingpeoplethrive/) which summarised stories of people moving back into their own homes in the community. The aim was to provide those responsible with some examples of people who had made the transition successfully. One of those is Mr Wonderful.

#### Mr Wonderful’s story

Mr Wonderful lived in a hospital for 20 years, much of that time in solitary confinement. He got his life back and lived happily in his own home until his sad death last year. There is a long story about what happened to get Mr Wonderful back into his home and community but what is important is that he was a person who was thought to be ‘too difficult’ to live in his community and the opposite was proved to be the case.

To cut a long story short, Mr Wonderful was able to get his life back because of the following:

* a passionate commissioner driving it who used procurement laws in a better way to meet local needs
* thorough clinical formulation leading to an effective therapeutic plan
* skilled and experienced care provider with well trained staff
* Individual Service Fund and flexibility with funding
* £60,000 transition and crisis fund for 12 months
* NHS England Capital Fund for housing
* shared risk between all involved
* pro-active plan to avoid re-admission

This is what people need, not solitary confinement.

People like Mr Wonderful, who had been detained under a forensic section of the Mental Health Act 1983, often cause anxiety and despondency among clinicians because it seems so hard to find pathways out of long-term segregation. His story is offered as a story of hope and possibilities for everyone.

At the end of the first year of the IC(E)TR programme, despite delays caused by the pandemic and difficulties in conducting the reviews, I advised the then Secretary of State for Health and Social Care to offer independent case management to everyone in long-term segregation. The response by NHS England was to introduce a pilot Senior Intervenor programme for 17 adults with a learning disability and/or autistic adults. This pilot was funded until March 2023, with the commitment to continue to fund those already allocated a senior intervenor through to their discharge, and is currently being evaluated.

I remain concerned that this was short-term funding for a crucial intervention and from my perspective less than the full case management approach I had proposed. Senior intervenors are appointed to facilitate discharge planning but were not intended to oversee the decision making and project management of a person’s discharge and reintegration into their home community. I understand that in practice they have usually remained involved during the transition and helped to reassure family and providers by sharing any perceived risk.

The completion of Safe and Wellbeing Reviews by NHS England has helped to identify people in long-term segregation and to refer people for IC(E)TRs. CQC has worked closely with the Oversight Panel, with the role of Mental Health Act 1983 reviewers in IC(E)TRs being critical to their success.

### What still needs to change

Oversight Panel members are particularly concerned about the following findings from consideration of the reports of the IC(E)TRs undertaken through this programme:

1. We found no therapeutic benefit to solitary confinement. This is a restrictive practice used for containment. The resulting sensory and social isolation is invariably harmful leading to far-reaching difficulties in any rehabilitation from the confinement, such as the ability to re-establish meaningful relational connections when released.
2. Further iatrogenic harm is being caused when psychotropic medication is used without therapeutic intention, and by the inappropriate use of other restrictive practices, including physical interventions.
3. Diagnostic overshadowing contributes to a lack of therapeutic benefit when the presence of a learning disability or autism is seen as a sufficient reason for detention without any curiosity about why this person is in this crisis, at this time, in this environment, with these carers.
4. Traumatised people are further traumatised by inappropriate hospital environments which do not make provision for their sensory and communication needs.
5. Families and friends are too often denied access to their relative in solitary confinement and are excluded from treatment and care decisions. In some cases, they report being penalised or simply not believed when they raise concerns.

## Recommendations

The Oversight Panel members are unanimous in recommending that the use of solitary confinement should be severely curtailed, but not by increasing the use of other restrictive interventions. There are many ways in which this situation could be radically transformed. We make 13 recommendations organised around 3 main themes which require urgent action by the Secretary of State for Health and Social Care, NHS England, CQC, integrated care boards (ICBs) and hospital/trust boards.

### Improving care and support for people with a learning disability and/or autistic people detained in solitary confinement

### Recommendation 1

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

* law and policy including human rights, and the [United Nations Convention on the Rights of Persons with Disabilities](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html) and the [United Nations Convention on the Rights of the Child](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child)
* 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)
* tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the [Core Capabilities Frameworks](https://www.hee.nhs.uk/sites/default/files/documents/ACP%2520Primary%2520Care%2520Nurse%2520Fwk%25202020.pdf)
* the HOPE(S) model

### Recommendation 2

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

* tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the Core Capabilities Frameworks
* the HOPE(S) model
* DHSC and NHS England should also consider how best to equip commissioners with relevant skills and knowledge to ensure cost effective and humane commissioning, including understanding the legal and policy frameworks relevant to the assessment, planning and delivery of community-based services and support.

### Recommendation 3

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

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

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

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

### Recommendation 4

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

### Improving accountability and visibility when solitary confinement is used

### Recommendation 5

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

* for children and young people under 18 years of age
* where it does not meet minimum standards for adults (see proposed [Solitary Confinement code of practice framework](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023), developed by the Oversight Panel)
* where it lasts for longer than 15 days

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

* a serious investigation as stipulated in [NHS England’s never event policy](https://www.england.nhs.uk/publication/never-events/)
* private company directors and senior trust management must be held to account for failing to provide a safe and therapeutic environment

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

### Recommendation 6

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

### Recommendation 7

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

Key points:

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

### Recommendation 8

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

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

### Moving people out of solitary confinement and preventing future use of solitary confinement for people with a learning disability and/or autistic people

### Recommendation 9

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

### Recommendation 10

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

### Recommendation 11

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

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

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

### Recommendation 12

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

### Recommendation 13

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

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

## Conclusion

My heart breaks that after such a long period of work, the care and outcomes for people with a learning disability and autistic people are still so poor, and the very initiatives which are improving their situations are yet to secure the essential funding required to continue this important work.

There are 3 key principles with which I conclude my investigation. The first is that all support needs to be based in relationships. Professional risk assessments and risk plans do not meet people’s needs without ongoing meaningful and supportive relationships with health, social care and education professionals.

Secondly, when things go wrong at home, or in the community, they need to be sorted out at home. People with a learning disability and/or autistic people need effective, accessible support. Trying to mend environmental pressures in hospital never works. It just adds new environmental pressures. Hospitals are for clinical interventions that can only be delivered in hospital.

Thirdly, trauma is usually at the root of the exclusions that eventually lead to hospital admission, and for too many people, to solitary confinement. Trauma-informed environments are essential but responding early to adverse childhood experiences to pre-empt a lifetime of repeated exclusions is humane and cost effective.

The humanity of people in solitary confinement gets forgotten. Their life story remains unknown. The use of solitary confinement affects the person’s identity to such an extent it causes what could be described as a ‘social death’. The panel are unanimous in recommending that the use of solitary confinement should be severely curtailed for people with a learning disability and/or autistic people in the ways outlined above.

"Social Anthropologist, Dr Jane Hubert who spent 350 hours observing life in a locked ward, wrote in her first days’ ‘field’ notes: ‘I was alone in the ward’, when the nurses closed the door behind her and left her alone with 16 men some of whom were regularly placed in solitary confinement. She recognised that their humanity had been forgotten, and began to make relationships with the men, reconstructing their life stories with the help of their families and trying to counter the dehumanising culture that she had found. She told David, who was thought to be non-verbal, that his parents loved him, and he replied: ‘Bless you.’"

Extract from [Men with severe learning disabilities and challenging behaviour in long-stay hospital care](https://www.proquest.com/docview/2315618707?accountid=145313)

The Oversight Panel members have recommended measures that could impact on these widespread systemic failures and, working with stakeholders, has helped to draft a framework code of practice for the use of solitary confinement, which DHSC is urged to fully consider. The draft code defines and sets out guidance on the use of solitary confinement and includes modifications to the existing 12-point discharge protocol. The panel’s key recommendations have been suggested for inclusion wherever possible in the Mental Health Act 1983: Code of Practice when this is next revised, and I advise that this should be implemented as soon as possible. These include that:

* solitary confinement should become an NHS England ‘never event’ for all children and young people under 18 years of age with a learning disability and/or who are autistic (in line with international practice - see annex D)
* minimum standards for the use of solitary confinement for adults with a learning disability and/or autistic people should be introduced as soon as possible, through an amended Mental Health Act 1983: Code of Practice which should be informed by the Oversight Panel’s solitary confinement code of practice framework. Until this happens, and to ensure the standards are followed sooner, the Oversight Panel’s solitary confinement code of practice framework should be developed fully and incorporated as an annex to the Mental Health Act 1983: Code of Practice
* it should be discontinued after a maximum of 15 days due to its harmful and devastating impact (in line with international evidence, see annex D)
* mandatory reporting of all and every use of solitary confinement should be introduced

The introduction of IC(E)TRs in 2019 and the addition of a Senior Intervenors pilot in 2021 are beginning to show an impact with respect to supporting people’s discharge to less restrictive environments, albeit much more slowly than originally hoped. Safe and wellbeing reviews, completed by NHS England after the Cawston Park Hospital [Safeguarding Adults Review](https://www.norfolksafeguardingadultsboard.info/publications-info-resources/safeguarding-adults-reviews/joanna-jon-and-ben-published-september-2021/), helped to identify people in solitary confinement and referred them for an IC(E)TR but have now concluded. The end of the safe and wellbeing reviews programme may mean that the true extent of the use of solitary confinement will again be overlooked.

The addition of the clinically based HOPE(S) model last year has complemented the use of IC(E)TRs and the senior intervenor role, and it is hoped that this 3-pronged approach to tackle solitary confinement will be more effective over time. This is because this approach entails review, clinical support and system navigation and unblocking, which together might reduce the paralysis in the system and promote increased progression and discharge.

The panel has concluded that IC(E)TRs are valuable while recognising that some administrative improvements are needed to ensure the right people are present and able to contribute, that the findings are communicated in a timely manner, that recommendations that emerge from these reviews are followed up and that the recommendations have some force. Repeat IC(E)TRs should, where possible, involve continuity in panel membership. I have been contacted by several families personally to thank DHSC and the Oversight Panel for the impact an IC(E)TR has had on the care of their family member.

As both phases of the IC(E)TR programme have come to an end, an urgent decision from DHSC is needed about who should be asked to manage an IC(E)TR programme in the future rather than DHSC. An enhanced role for Mental Health Act reviewers would be helpful.

However, without a discharge co-ordinator, people will remain stuck in an unwieldy and inflexible system. Just as in my [first-year report](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews), I now repeat my recommendation that everyone detained in solitary confinement must be allocated a discharge co-ordinator to project manage their discharge and rehabilitation in the community. People leaving hospital should have their progress carefully monitored by their discharge co-ordinator in conjunction with a keyworker for at least 2 years to ensure that measures put in place for successful community living prove sustainable.

For some individuals, a senior intervenor will also be required when systemic changes are needed. This NHS England programme’s scalability will require more senior intervenors to be recruited. I note with considerable concern that at the time of writing, none of these initiatives have any ongoing government funding commitment. This is unacceptable, and I ask for an urgent commitment to be made to fund these programmes.

The number of people still being held in long-term segregation is similar to the number in January 2020. The clear conclusion must be that if solitary confinement facilities are available, clinicians will use them.

The 2022 House of Lords Adult Social Care Select Committee report, [A ‘gloriously ordinary life’: spotlight on adult social care](https://publications.parliament.uk/pa/ld5803/ldselect/ldadultsoc/99/9902.htm), raises aspirations for the lives of all disabled adults and its recommendations are very timely, chiming as they do with our deliberations.

Legislative changes, including those proposed in the [draft Mental Health Bill 2022](https://www.gov.uk/government/publications/draft-mental-health-bill-2022), cannot replace chronic and serious under funding, poorly informed and unaccountable commissioning and a widespread lack of skills in social care and therapeutic support. The most important changes must be a change of culture to one of kindness, and continuity in helping people’s relationships develop and thrive.

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

July 2023

## Annex A: Independent Care (Education) and Treatment Review process

IC(E)TRs are independently chaired reviews for people with a learning disability and/or autistic people who are detained in long-term segregation in hospital. They are modelled on [Care, (Education) and Treatment Reviews (C(E)TRs)](https://www.england.nhs.uk/learning-disabilities/care/ctr__trashed/care-education-and-treatment-reviews/).

C(E)TRs are part of [NHS England’s commitment to improve the care of people with a learning disability and/or autistic people](https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/). They have the aim of reducing admissions and unnecessarily lengthy stays in hospitals by ensuring that a plan is in place to move people to less restrictive settings and, ultimately, to discharge. They are a person centred, independent process carried out by an independent panel of people, who ask key questions and make recommendations that lead to improvements in safety, care and treatment, and future planning, asking whether this person needs to be in hospital for their care and treatment, and taking a solution-focused approach. C(E)TRs have been found to improve the quality of care people receive in hospital and have helped to reduce the number of people being admitted to hospital.

The main purpose of IC(E)TRs is to improve outcomes, improve the quality of life and reduce the use of long-term segregation for people with a learning disability and/or autistic people who are detained in long-term segregation, as quickly and safely as possible. As with C(E)TRs, the IC(E)TRs review the individual’s care to ensure they are receiving safe and effective care and treatment in the least restrictive setting and that there is a clear plan for discharge and future care.

Working with the independent chair, the IC(E)TR panel reviews how individuals care, health and support needs are being provided based on the 4 key elements of all C(E)TRs:

* am I safe?
* am I getting good care now?
* what are my plans for the future?
* can my care and treatment be provided for the future?

In addition, there is a very specific focus on assessing:

* whether standards of care (including the use of long-term segregation) are being met
* that the provider is following care protocols
* the person’s quality of life and physical health care
* plans to move people into less restrictive settings
* the changes that are needed to improve care and support step down or discharge for each individual

Although IC(E)TRs are modelled on C(E)TRs, there are some key differences:

* unlike C(E)TRs, IC(E)TRs are chaired by an independent chair, and a Mental Health Act 1983 reviewer (provided by CQC) sits on the panel
* IC(E)TRs are only offered to people with a learning disability and/or autistic people in long-term segregation
* although IC(E)TRs follow the same process as a C(E)TR and use the same [key lines of enquiry](https://www.england.nhs.uk/publication/care-and-treatment-review-key-lines-of-enquiry/), the key lines of enquiry are supplemented by questions specific to segregation and restrictive practice
* IC(E)TRs provide additional focus on what needs to happen to support a move to less restrictive care in as ordinary a home environment as possible and monitoring of actions to achieve that
* summary information regarding IC(E)TRs was reported to the Oversight Panel, chaired by Baroness Hollins, to identify themes and support action

## Annex B: lessons the Oversight Panel learned from the IC(E)TR programme

The use of solitary confinement signifies a 4-stage failure, of which it is the third stage.

1. The first is that community-based support, including education, have been insufficient to prevent a person being removed from school or their family or other home, and being admitted to hospital.
2. The second stage is the failure to provide learning disability and autism friendly, skilled and person-centred support in hospital, resulting in further trauma and further restriction on top of the person’s removal from their community, their family and their friends.
3. The third stage is the use of restrictive practices, including solitary confinement.
4. The fourth stage is the lack of clarity about whose responsibility it is to commission and fund skilled support in the community and the lack of any effective project or case management of discharge planning.

A person who was traumatised in the community becomes further traumatised in hospital, and the power dynamic massively increases the harm they experience.

Julie Newcombe, Oversight Panel member and co-founder of [Rightful Lives](http://rightfullives.org.uk/), said:

"Solitary confinement is, for many, the end of a long journey of failure by services. An IC(E)TR is needed because the [C(E)TR](https://www.england.nhs.uk/learning-disabilities/care/ctr__trashed/care-education-and-treatment-reviews/) process failed the person, and the C(E)TR process was needed because the [Education, health and care plan](https://educationadvocacy.co.uk/what-is-a-ehcp/) process failed the person first."

Some of the lessons outlined below which we have seen through the IC(E)TR programme, relate to these stages of failure.

### Number 1: on the costs of solitary confinement

Long-term segregation can be a significant interference with a person’s human rights. It involves social isolation and enforced separation from one’s peers. It may be experienced as punitive by the person themselves, is frequently traumatic and does not provide any therapeutic benefit. Being socially isolated is likely to increase anxiety and contribute to an increase in mental distress and behaviour that challenges both the person themselves and others, making rehabilitation more difficult.

The Oversight Panel members strongly recommend that long-term segregation should be renamed ‘solitary confinement’. The use of this emotive but accurate term will be uncomfortable and may be felt as a criticism by clinical staff who are working to support people in a fragmented clinical and social care pathway that we consider inappropriately and insufficiently resourced. The use of the term will help to challenge an observed tendency to desensitisation and complacency associated with the use of long-term segregation. It is, however, a criticism of any hospital boards and managers who market a service as a specialist treatment resource when they lack the real estate and the specialist skills to be able to deliver such a service safely. It is also a criticism of any commissioners who purchase the wrong service for a person for whom they have responsibility. The argument that such services are often bought as a last resort for people who are at risk of harming either themselves or others is not valid. A failure to plan for the low volume of high risk ‘patients’ who may need a bespoke and intensive community response is inexcusable.

When taking a population-based approach to commissioning, psychiatric hospital admission may seem a financially ‘cheaper’ option for commissioners when a particular person and their family and/or carers reach crisis point. However, this is poor planning and personally costly for the individuals concerned. This will show up as real costs and missed opportunities to create local resources and to build the skills and capabilities required in the local workforce. For example, paying for care outside of the local area leaches resources from that area that could otherwise benefit from the multiplier effect of that spending.

The impact on the health and wellbeing of families is also likely to be a cost. Poor planning leaves people to struggle on at home without the skilled help they need to prevent a crisis becoming unmanageable. In such instances family cohesion can break down thus reducing the ease of individuals returning to their family home after admission. The resulting trauma can be long lasting both for the person and their families.

Commissioners and the organisations they work for should be held accountable for poor use of public money - especially where their spending decisions result in human rights abuses and other unlawful actions by public bodies, such as failing to uphold the [Care Act 2014](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted).

Ill-informed commissioning does nothing to create more stable futures for people admitted to inpatient settings, to prepare the way for them to be discharged nor to prevent future admissions. It certainly doesn’t pave the way for an ordinary life. The introduction of dynamic support registers and using them as a resource for planning future care may help commissioners to get it right more often. To this end, it is hoped that commissioners will choose to do more than the minimum requirements stipulated in NHS England’s [Dynamic support register Care (Education) and Treatment Review policy and guidance](https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/) which includes that people who are in hospital must also be added to the dynamic support register. I recommend a named keyworker is identified by the commissioner to be responsible for helping to avoid unnecessary admissions to mental health hospitals by ensuring the person and their families get the right support in the community at the right time ([keyworkers are currently only available to children and young people](https://www.england.nhs.uk/learning-disabilities/care/children-young-people/keyworkers/)).

Shortage of appropriate community-based provision leading to admission to hospital as an alternative solution perpetuates an inadequate and damaging cycle. Hospital placements are expensive and too often do not meet people’s needs, or cause them harm. Local authorities frequently struggle or are slow to fund the care costs of people for whom the NHS is currently paying. Too little is yet being done to integrate services effectively, and this is a major obstacle for many people in hospital. Integrated care boards (ICBs) and local authorities must continue to strive to integrate their services. Commissioners for community and hospital services for people with a learning disability and/or autistic people should have to demonstrate specialist expertise in learning disabilities and autism. An independent regulator could be created for commissioners that sets standards and requirements for on-going training, with a duty to enforce compliance through disciplinary action. While CQC can monitor their progress they currently have no enforcement powers - however, it is worth noting that under the Health and Care Act 2022, since May this year, CQC has responsibility to assess how the ICS as a whole is meeting their Care Act 2014 responsibilities, not just the ICB.

We noted that at interview many candidates for the role of independent IC(E)TR chair said that their motivation for applying to be an independent chair was influenced by their experience of commissioning failings. This concern was borne out by the unresponsiveness of some commissioners to so many of the IC(E)TR recommendations. It is of note that families have reported coming up against a ‘commissioning brick wall’ when trying to get appropriate and timely care and support for their family member who is in solitary confinement. People using services and their families and advocate should know exactly what is being purchased, and they should be given contact details of the commissioner to raise any concerns that arise in relation to service level delivery. When concerns are raised, commissioners should meet with families, record their concerns and act on them. We have found that families who remain concerned have had a good response from [Ask Listen Do](https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/) where the NHS England Learning Disability and Autism quality concerns team can facilitate the concerns escalation process.

### Number 2: need for minimum standards

Too many of the IC(E)TR reports that I have read tell a story of very basic seclusion rooms: often with no access to private toilet and bathing facilities; with no natural light or fresh air; of staff who lack knowledge about learning disabilities and autism; of no communication and sensory assessments having been done; no clinical formulation, no training and no discharge plan; no continuity of care between the hospital and the community clinical team.

Concerns about the extreme poverty of many of the rooms being used to confine people led to recommendations such as:

“Review the seclusion facility to ensure that they have appropriate furniture to safely eat their meals.”

Or for another person:

“To review the concerns of the Mental Health Act 1983 reviewer regarding the room they are in, and either undertake adaptations to improve privacy and dignity, lighting and furniture or to consider if there is an alternative room(s) that is more suitable for long-term segregation.”

Or, “to clarify the rationale of why there is no furniture”.

One argument used when the standard of accommodation provided includes at least a bedroom and a bathroom, somewhere to spend the day and access to fresh air, is that the harms of social isolation may be reduced. The Oversight Panel believe that a ‘gilded cage’ is still a cage and that the psychological damage caused by such instances of social isolation are in fact just as real. The research suggests that the harms of confinement are ‘dose dependent’, and that harm is likely to be caused even after a short time in a seclusion room. Such harm may be seen in the form of isolation panic (see [Mosaic of despair: human breakdowns in prison](https://psycnet.apa.org/record/1993-98827-000)).

However, the longer the denial of meaningful human contact continues, the worse things get. One implication of this research is that bespoke flats within the hospital may not provide a safer environment if it means that the person’s confinement lasts longer unless this arrangement allows greater contact with family and peers.

The Oversight Panel recommends that minimum standards for all solitary confinement areas (including what are currently known as seclusion rooms) should include:

* furniture/area for activities and eating
* a separate toilet/bathing room
* direct access to outside space
* natural light (for example, a window)
* a clock
* digital and communication technology

### Number 3: need for specialist training for staff

IC(E)TR chairs reported that people’s life stories were not always known to the inpatient team including knowledge of the person’s strengths, interests and abilities. Some admitting clinical teams had low therapeutic aspirations and were risk-averse; others lacked the skills and resources needed to make timely assessments. We found that people with a learning disability and/or autistic people admitted to psychiatric units too rarely gained any therapeutic benefit, whether a psychiatric illness had been diagnosed or not.

It seems that when an admission traumatises or re-traumatises people who are already distressed and frightened to the point that their behaviour changes, staff may think they have no alternative to using seclusion or segregation as well as other restrictive practices. Elspeth Bradley and Marika Korossy explain that:

"Feeling unsafe activates the autonomic nervous system, causing disruption in body homeostasis and consequent physical ill health and mental suffering. Feeling safe promotes health. Ensuring people with disabilities feel safe is treatment."

See [Are difficult behaviours described in intellectual and developmental disabilities and autism actually adaptive responses to feeling unsafe? (PDF, 1.26MB)](https://oadd.org/wp-content/uploads/2022/09/V27-N3-JoDD-22-390-Bradley-and-Korossy-v3.pdf)

There were innumerable concerns about the lack of staff training and the lack of a stable staff group who knew the people in their care. For example:

"It’s imperative that models of staffing are reviewed and that all staff working with Y receive training and support based on the recommendations of these assessments including an understanding of autism."

An advocate described a visit to a young person in an assessment and treatment unit:

"I was just finding a way of connecting with them. They had started to lift their head, look at me and show interest. Then there was shouting and banging from the ward. We heard the staff rushing towards the commotion. The worker the person trusted left saying they couldn’t leave me on my own with them, so 2 staff, in black uniforms, came in. I invited them to sit down but they just stood in the corner.

I was very aware that the person’s anxiety was heightened, they covered their ears and started rocking. Having the 2 staff staring at them didn’t help! We carried on the conversation for a little while but the noise in the ward escalated as did the person’s anxiety. I managed to support them until they felt more settled and said goodbye.

I refer to the 2 people in black uniforms as bodyguards . . . they were agency staff ‘supporting’ on the ward that day. Two of 8 agency staff on the ward with only 3 regular staff present. Eight agency staff who didn’t know the people staying on the ward that day.

As I was leaving an experienced nurse came and sat with me. With tears in her eyes, she said how helpless she feels. ‘How can you support people well when you have 8 strangers on the ward who just don’t understand how to support each person?’

Some well-meaning staff teams are segregating autistic people because they believe that they prefer it or that they will feel safer. If the person is distressed due to overwhelming sensory stimuli and emotional overload in the ward, solitary confinement may have the benefit of immediate sensory deprivation thereby reducing behaviours of concern in the short term. But people adapt to this poverty of environment in ways that create greater psychological distress. This can lead to a legacy of relational harms when the person’s need for safe, caring and consistent staff to accompany them when they are distressed is not met.

We noted in many cases the impact of social ‘death’ and its far-reaching consequences and urge clinical teams not to use solitary confinement for the purpose of reducing overload, but instead to prioritise relational working, and to use recommended techniques and strategies for reducing sensory overload in the ward, as identified in the [National Development Team for Inclusion report, ‘It’s Not Rocket Science’](https://www.ndti.org.uk/resources/publication/its-not-rocket-science)."

### Number 4: some evidence of good practice

Some reports commended the staff team. For example, one IC(E)TR report praised the support being given to an autistic person with a moderate learning disability and a history of depression and aggressive behaviour who was being treated in a single person flat in the hospital with 2-to-1 support:

"The approach of a core team at the current placement has worked well and the person has had a consistent staff team who clearly know them well and what they like to do. They can identify early warning signs of mood change and can divert them to minimise the risk of escalation. Their family member has visited them every day. A property close to their family is being adapted for them. Funding has been agreed for a one-year transition plan to enable the staff team from the community provider to work alongside the multi-disciplinary team and develop the required level of understanding and trust with them.

Their parents said that the person receives excellent care and they have trust in the core team and the approach they take with the person to meet their needs, give them an active day, and respond to changes in behaviour."

Another report spoke about the comprehensive assessment and treatment provided for a young autistic person with a moderate learning disability and trauma related anxiety in their own flat within the hospital:

"A formulation and a framework for providing positive behaviour support including a positive support behaviour plan has been compiled and implemented. The HOPE(S) model is being utilised and barriers to change have been identified. The psychologist is helping the person cope with the voices they hear and a trauma-informed approach is being taken. The occupational therapist is assessing their level of functioning to inform their discharge plan. They go out on section 17 leave every day with their core team of staff who they know well but are their only source of socialising."

A report about a young person with a moderate learning disability (and a long history of family bereavements, exclusion from school and foster care) explained that the multi-disciplinary team decided that they would be ‘less anxious’ in seclusion and more likely to co-operate with the care plan:

"The person was nursed in long-term segregation to facilitate a low stimulus environment, to reduce the risk of assaults on both staff and peers, to help them to engage in care plans so that staff can better support their mental state, to encourage them to use the garden for fresh air. They are tolerating staff in their flat for longer periods to complete activities. The close working between hospital and community staff was commended."

But the lack of any other social engagement with family or peers remains concerning in all these examples.

An example of good practice across the country where people are being given community support to avoid hospital admittance, is described below by Wendy Ewins, Head of Commissioning, Case Management and Keyworking (Learning Disabilities and Autism) at [Black Country Healthcare NHS Foundation Trust](https://www.blackcountryhealthcare.nhs.uk/). Wendy has been instrumental in supporting the Black Country to reduce its over-reliance on inpatient models of care and develop sustainable alternatives in the local community that support people to live well.

"Noticing that Black Country citizens were often being admitted for distressed and risky behaviours at the point of crisis, Black Country Healthcare NHS Foundation Trust commissioned an emergency response team. This is a service commissioned with a local social care provider; the aim is that they have an immediate and skilled social care response team available 24/7 and commit to being with the person within 2 hours from point of contact (it is often within the hour). They go to wherever the person is (at home, in the Emergency Department, in custody, in an ambulance and so on) and their role is to join the team to see whether their service could support the person safely in their usual living environment. They can stay with the person 24/7 until usual services can assess and support. Often this means they can develop a safe relationship with the person and their family, give the family a break, support a social care provider who feels like they have run out of options, or support an ambulance crew or emergency department team who might not have much training in learning disabilities or autism to think about the interplay of communication, physical health symptoms and emotional distress.

In 2022 to 2023 our emergency response team supported 51 citizens and cost a similar amount to what a single assessment and treatment bed would cost for a year.

It has been so successful we are now piloting a specialist children’s emergency response team - early indicators are that this is reducing our reliance on inpatient care for children and young people, supporting earlier discharge, and enabling shorter lengths of stay in emergency departments and acute hospital settings."

The Oversight Panel considers that positive approaches such as those outlined above should be made more widely available at the earliest opportunity.

### Number 5: clinical concerns

Clinical effectiveness is a concern. Sadly, the following quote was not untypical when I asked clinicians for examples of an effective and timely admission:

"I don’t have any examples of effective admissions. My inpatient experience as a senior psychiatry trainee was largely spent working with people who had entered hospital because of failings by social care providers and were then stuck on noisy, cramped wards or subject to restrictive interventions."

A worrying development highlighted by IC(E)TR chairs and by my own observations at one IC(E)TR I attended in person, is that in some hospitals the multi-disciplinary team members are not present on site. They may be independent contractors who come in for a specified assessment task rather than being part of a comprehensive multi-disciplinary team that can develop a timely formulation and oversee a comprehensive treatment plan. We have observed clinical services being mainly provided by the nursing team, including healthcare assistants, and during current workforce shortages many of these are short term agency staff.

In some of these services, the responsible clinician attends meetings online and supervises the ward doctor online, rarely being present in the ward. Nor does it seem routine practice for the referring community psychiatrist to visit the person whilst they are in hospital, to meet or liaise closely with the responsible clinician or to attend nursing or multi-disciplinary team meetings, even online. No wonder it so often takes more than 28 days to complete an assessment (there is a 28-day limit for section 2 of the Mental Health Act 1983 whereas section 3 is for up to 6 months and can be renewed).

Long drawn-out assessments add to the person’s distress at being in hospital, away from everything and everyone familiar to them. Repeated changes of hospitals, even before any assessment had taken place, was a common finding, and some people in solitary confinement were still awaiting a full assessment and plan after months or even years, which also impacts the quality of the assessment as the added stress gives a skewed picture of the person and their needs.

The [START (Systemic, Therapeutic, Assessment, Resources and Treatment) programme](http://thenadd.org/wp-content/uploads/2017/10/START-Overview_2017.pdf#:~:text=The%2520START%2520%2528Systemic%252C%2520Therapeutic%252C%2520Assessment%252C%2520Resources%252C%2520and%2520Treatment%2529,for%2520individuals%2520with%2520IDD%2520and%2520behavioral%2520health%2520needs) in the USA has successfully shifted the focus to preventative services and shorter hospital admissions with a mix of high-level case management, targeted funding towards community responses and sanctions for hospitals and commissioners, where necessary.

Research by START in the USA reported that the average time for an inpatient multi-disciplinary team assessment for a similar cohort was much shorter, perhaps because of the continuity built into their protocols and because of their tertiary level crisis response teams. START also reported the challenge of meeting poorly understood and under researched needs and described the dilemma for multi-disciplinary teams of inadequately developed assessment and treatment pathways.

START clinical teams provide 24-hour mobile crisis prevention and intervention services. The primary tool to assist caregivers and first responders is the START Cross System Crisis Prevention and Intervention Plan. This is an individualised written plan of response to provide a clear, concise and realistic set of supportive interventions to prevent or de-escalate a crisis. The goal of the plan is to build the capacity of primary caregivers to address vulnerabilities in the person’s setting through the identification of individual character strengths and effective strategies in early stages of difficulty. The plan offers a tertiary level of response that ranges from early intervention to assisting during an acute crisis.

## Annex C: research into the psychological harms of ‘enforced isolation’

Humans are wired to connect[[footnote 1]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:1) and therefore it is essential to wellbeing that meaningful social connections are made and sustained. People need opportunities to express and receive empathy, form intimate relationships, and have outlets to discuss, share and have their distress acknowledged, and so on[[footnote 1]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:1). Confinement, for any length and in any setting, exposes people to psychologically painful experiences which undermine their “sense of belonging, control, self-esteem, and meaningfulness, reduces pro-social behaviour, and impairs self-regulation”[[footnote 2]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:2). Research into the impact of seclusion, long-term segregation and solitary confinement across health, prison environments and education has shown that these practices can be damaging and cause iatrogenic trauma to service users and staff[[footnote 3]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:3)[[footnote 4]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:4). Studies examining the impact on people confined highlight that confinement induces shame, severe distress, powerlessness and humiliation[[footnote 5]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:5)[[footnote 6]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:6) [[footnote 7]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:7)[[footnote 8]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:8). There is a well-established relationship between distressed behaviours and solitary confinement which negatively impacts on people’s experience of care, increasing their length of stay and the levels of restrictions, as well as reducing the person’s engagement in their care.

Solitary confinement has been shown to deprive individuals of social skills, sensory input, activity and the necessary cognitive and psychological stimulation required. As a result of these deprivations, people may experience increased anxiety, paranoia and depression. In addition, there is a reduction in collaboration, social tolerance and daily living skills. It is recognised that the detrimental impact of segregation is likely to be even greater on young people than adults[[footnote 9]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:9)[[footnote 10]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:10).

### The severity of harms caused by confinement are dose dependent

Adverse effects, including the significant and severe psychological impact of solitary confinement, are well researched in scientific literature across sectors and international borders[[footnote 11]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:11). The negative consequences of isolating people from meaningful human contact are “dose dependent”[[footnote 11]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:11). This means that the longer the isolation, the greater the harm. That said, people report having immediate aversive reactions. “Isolation panic”, for instance, is suffered at the time or shortly after being placed in confinement and includes experiences of rage, loss of control, breakdowns in wellbeing, psychological regression and increases in self-harm[[footnote 12]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:12).

Longer confinement results in numerous psychological symptoms including anxiety, fear, panic, a sense of emotional impending doom, hypersensitivity, irritability, aggression, rage, ruminations, paranoia, hallucinations, cognitive dysfunction, loss of emotional control, mood swings, hopelessness, depression, social withdrawal, self-harm and suicidal ideation and behaviour[[footnote 13]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:13)[[footnote 14]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:14)[[footnote 15]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:15)[[footnote 16]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:16)[[footnote 17]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:17)[[footnote 18]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:18).

Additionally, [suicide and self-harm are more likely to occur in confinement and the immediate period after confinement is often a stressful and high-risk period](https://www.researchgate.net/publication/26859621_The_Distillation_of_VISCI_Towards_a_Better_Identification_of_Suicidal_Inmates). The findings of these studies are consistent with the anecdotal experiences of people in inpatient units in the UK that are being supported by HOPE(S) practitioners.

Social isolation is a clearly evidenced stressor, which is compounded by the lack of physical, perceptual, and psychological stimulation and the inability to move freely and exercise. Therefore, in addition to impacting on mental health as described above there are significant impacts on the persons physical health and neurobiology. When used for extensive periods of time it leads to biological stress that may cause serious and disabling neuropsychological damage. The impoverished environment, and the poor access to natural light, increase the likelihood of [vitamin D deficiency and can lead to health issues such as obesity.](https://pubmed.ncbi.nlm.nih.gov/15600381/) Strong and others (2020) reported that [solitary confinement caused an increase in skin irritations, pain and musculo-skeletal problems](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7546459/). Prolonged and enforced isolation has also been shown to contribute to hypertension, chronic cardiovascular disorder, and overall early mortality rates[[footnote 19]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:19).

### Legacy of harm, including social death

The stressfulness and painfulness of confinement results in people altering their relational patterns to adjust to isolation. This can create and sustain risks of psychological and interpersonal harm, reflected in the difficulty of moving people out of solitary confinement.

To cope with the painful, asocial nature of confinement, people paradoxically create more distance between themselves and others, convincing themselves they do not need people. People may demonstrate a fear of human contact, becoming increasingly unfamiliar and uncomfortable with social interaction. These relational patterns are termed [‘chronic strategies of disconnection’](https://www.researchgate.net/publication/318023193_Therapists%27_self-reported_chronic_strategies_of_disconnection_in_everyday_life_and_in_counselling_and_psychotherapy_an_exploratory_study) which endure long after the threat of relational harm has passed, interfering with the ability to lead a fulfilling social life. This is particularly problematic for autistic people whose adaptive behaviour is then seen as a symptom of their disorder. The absence of meaningful contact has been described as a dull ache that never goes away - feelings of closeness can never be rekindled[[footnote 11]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:11).

Severe and enduring relational harms occur in confinement and have been termed ‘[social death](https://www.upress.umn.edu/book-division/books/solitary-confinement)’. UK based author Alexis Quinn describes an inability to perceive herself in confinement due to not being perceived by another. Unable to determine her existence, Alexis would throw herself at hard surfaces to gain feedback of aliveness. Many people subject to isolation develop an inability to feel deep positive emotion for people, having lost the capacity to connect deeply with others[[footnote 11]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:11). Alexis grieves relationships, a sense of who she once was and knows this is unlikely ever to be regained[[footnote 20]](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an#fn:20). Her experience is consistent with that described by Lisa Guenther as ‘social death’.

## Annex D: international practice

The following suggest or mandate that children and young people as well as mentally ill people should never suffer confinement, underscoring the widespread recognition that it is a psychologically painful and potentially very harmful environment:

* The [National Commission on Correctional Health Care (NCCHC) position statement (2016)](https://www.ncchc.org/position-statements/)
* [Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2011).](https://www.ohchr.org/en/special-procedures/sr-torture) See the ‘2022 Committee Annual Report’ at the bottom of the page.
* [American Academy of Child and Adolescent Psychiatry](https://www.aacap.org/)
* [United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990)](https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-rules-protection-juveniles-deprived-their-liberty)
* [American Psychological Association (2016), Committee on Children, Youth, and Families](https://www.apa.org/pi/families/committee)

The United Nations Convention on the Rights of the Child (UNCRC) adopted in 1990 also makes clear that solitary confinement must be used only in exceptional circumstances. See article 37 (inhuman treatment and detention) which states that:

Children must not be tortured, sentenced to the death penalty, or suffer other cruel or degrading treatment or punishment. Children should be arrested, detained or imprisoned only as a last resort and for the shortest time possible. They must be treated with respect and care and be able to keep in contact with their family. Children must not be put in prison with adults.

The [American Psychiatric Association (2012), reference 50,](https://jaapl.org/content/43/4/406#ref-50) recommends that “prolonged segregation” (which it defines as segregation lasting longer than 4 weeks) of adult people with serious mental illness, “with rare exceptions, should be avoided due to the potential for harm.”

Similarly, [Mental Health America’s (2011) position on seclusion and restraints](https://www.mhanational.org/issues/position-statement-24-seclusion-and-restraints#:~:text=Therefore%252C%2520as%2520a%2520matter%2520of%2520fundamental%2520policy%252C%2520Mental,only%2520when%2520necessary%2520to%2520prevent%2520imminent%2520physical%2520harm) included that they urge “the abolition of the use of seclusion . . . to control symptoms of mental illnesses.”

The [National Alliance on Mental Illness (2016) statement](https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Solitary-Confinement) “opposes the use of solitary confinement and equivalent forms of extended administrative segregation for persons with mental illnesses.”

The [American Public Health Association (2013)](https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue) observed that mentally ill people are at risk of being “placed in segregation as punishment for behavior that is a product of their illness,” and may “deteriorate and experience an exacerbation of symptoms” if they are subject to confinement.

Finally, the [National Science Foundation](https://nap.nationalacademies.org/catalog/18613/the-growth-of-incarceration-in-the-united-states-exploring-causes) concluded that “long-term segregation is not an appropriate setting for seriously mentally ill”.

### Mandela rules

The [Mandela Rules](https://www.un.org/en/events/mandeladay/mandela_rules.shtml), approved by the [Commission on Crime Prevention and Criminal Justice (2015) (PDF, 2,424KB)](https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/draft_reports/E-2015-30-E-CN.15-2015-19/E2015_30_ECN152015_19_ADVANCE_UNEDITED.pdf), contain several provisions that are explicitly designed to significantly regulate and limit the use of solitary confinement.

Specifically, rule 45.2 prohibits its use entirely “in the case of people with mental or physical disabilities when their conditions would be exacerbated by such measures.” The Commission on Crime Prevention and Criminal Justice standard minimum rules for the treatment of prisoners, passed by the United Nations, defined “prolonged solitary confinement” as lasting “for a time period in excess of 15 consecutive days” and mandated that such prolonged confinement “shall be prohibited” (Rules 43.1 and 44).

### Solitary confinement must be limited to very short periods

Widespread professional consensus suggests that isolation must be limited to very short periods, due to the likely increase in risks of psychological and/or physical harm increasing with length of confinement. (See [The psychological effects of solitary confinement: a systematic critique](https://www.journals.uchicago.edu/doi/abs/10.1086/696041).) It is therefore suggested that solitary confinement should be limited to the briefest amount of time possible.

[The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2011)](https://www.ohchr.org/en/special-procedures/sr-torture) for the United Nations wrote that in his opinion confinement lasting more than 15 days constitutes “torture”.

The [American Bar Association Standards for Criminal Justice (PDF, 2.18MB)](https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/treatment_of_prisoners.pdf) hold that “segregated housing should be for the briefest term and under the least restrictive conditions practicable”. (See Standard 23–2.6(a).)

The [New York State Bar Association](https://nysba.org/NYSBA/Practice%2520Resources/Substantive%2520Reports/PDF/SolitaryConfinementReport_0413.pdf) called on state officials to significantly limit the use of solitary confinement and recommended that solitary confinement for longer than 15 days be prohibited.

[NCCHC’s position statement](https://www.ncchc.org/position-statements/solitary-confinement-isolation-2016/) specified that solitary confinement of longer than 15 days constitutes “cruel, inhumane, or degrading treatment of inmates” and that correctional health professionals should not employ it.

#### Northern Ireland Department of Health policy

In March 2023, the Northern Ireland Department of Health published new [departmental policy on restrictive practices, restraint and seclusion](https://www.health-ni.gov.uk/publications/regional-policy-use-restrictive-practices-health-and-social-care-settings-public-consultation) which says that children and young people should never be shut in a room alone and prevented from leaving.

The new Department of Health policy does not apply to schools but includes the treatment of children and young people, as well as adults, in health and social care. It defines restrictive practices as those that “limit a person’s movement, day-to-day activity or function”. That includes physical or mechanical restraint, where someone is prevented from moving or part of their body is restrained. Restrictive practice can also include psychological measures like depriving someone of choice or withholding food or drink. Seclusion, meanwhile, is defined as “the confinement of a person in a room or area from which free exit is prevented”.

The Department of Health policy states that while restrictive practice or seclusion “may be necessary on occasion”, they “should only be used as last resort”. “There must be a real possibility of imminent harm to the person or to staff, the public or others if no action is undertaken,” the policy states. But it says, “children and young people should never be subject to seclusion”. “Worldwide evidence provides no definitive conclusion that the use of seclusion has a therapeutic benefit,” the policy continues. “It can be seen as punitive and can cause psychological harm.”

The policy says that the use of restraint and seclusion also risks causing a patient trauma and could hinder their recovery. “Restrictive interventions, restraint and seclusion should not be used for reasons related to disability,” it states. “Restrictive interventions, restraint or seclusion must never be used as discipline, to inflict pain or humiliation, or a substitute for the provision of proper, person-centred care.”

The policy was developed following consultation with a range of organisations, including the Police Service of Northern Ireland, Royal College of Nursing, Northern Ireland Commissioner for Children and Young People, and the Education Authority.

## Annex E: membership of the IC(E)TR Oversight Panel

The Oversight Panel is comprised of experts by experience, clinicians, people with backgrounds in housing, commissioning and service provision.

Professor Sheila the Baroness Hollins, Chair
Crossbench member, House of Lords Emeritus Professor of Psychiatry of Learning Disability, St George’s, University of London

Julie Beadle-Brown (until July 2022), member
(At time of membership) Professor in Intellectual and Developmental Disabilities, Tizard Centre, University of Kent

Jennifer Kilcoyne, member
Clinical Director Centre for Perfect Care, Director for National HOPE(S) NHS England Collaborative

Julie Newcombe, member
Mother of an autistic man and co-founder of [Rightful Lives](http://rightfullives.org.uk/)

Camilla Parker, KC (Hon), member
Legal and policy consultant, Just Equality

Alexis Quinn, member
Restraint Reduction Network Manager

Salim Razak, member
Consultant in the Psychiatry of Intellectual Disability and Associate Clinical Director for Neurodevelopmental Services, Avon and Wiltshire Mental Health Partnership NHS Trust

Bob Tindall, member
Social care consultant

Helen Toker-Lester, member
Former joint commissioner and provider of services, former clinical nurse specialist and currently an independent consultant in the field of health and social care

Alicia Wood, member
CEO Books Beyond Words, policy expert in housing and community care and co-founder of Learning Disability England

Anne Worrall-Davies, member
(At time of membership) Senior Psychiatrist Lead (Children and Young People), Learning Disability and Autism Programme - NHS England, former IC(E)TR chair

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