Environment

Key points

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

Appropriateness of settings

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

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

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

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

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

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

Out-of-area placements

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

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

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

Quality of ward environments

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

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

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

Inaya's story

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> "The bedrooms were poorly ventilated. The vents on the windows did not work and staff did not know how to operate them. Patients told us the rooms were extremely warm and this was having a direct impact on their sleep and mood.

> One patient told us he was experiencing migraines and told us he was worried "he would not make it through the night" due to the heat."

Extract from MHA monitoring visit report

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

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

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

Extract from MHA monitoring visit report

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

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

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

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

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

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

Extract from MHA reviewer focus group

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

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

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

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