Evidence used in this report

This report is based on analysis of the findings from 635 MHA monitoring visits carried out during 2024/25.

This involved speaking with 3,642 patients (2,771 in private interviews and 871 in more informal situations) and 717 family members or carers. We also spoke with advocates and ward staff.

We also consider the content of 3,248 actions that we requested providers make to improve, based on concerns found on our visits.

Our analysts carried out a focused qualitative review of a sample of all monitoring reports from 2024/25 (40% of reports from each primary type of service). We looked into these findings further through a series of focus groups with MHA reviewers, second opinion appointed doctors, our Service User Reference Panel and our MHA Complaints team.

This year, alongside speaking with people during our monitoring visits, we also carried out a series of interviews with people who have lived experience of being detained under the MHA or of caring for someone who has been detained. Their experiences illustrate the effect of detention on patients and their loved ones, and other issues highlighted in this report. We have used pseudonyms to maintain their anonymity.

We thank all these people, especially people detained under the Act and their families, who have shared their experiences with us. This enables us to do our job to monitor how services across England are applying the MHA and to make sure people's rights are protected.

In this report, we also use evidence from a quantitative analysis of statutory notifications submitted by registered providers, and complaints or concerns submitted to us about the way providers use their powers or carry out their duties under the Act. We completed qualitative analysis on a sample of 150 complaints, spread across the 10 most common categories of complaints, to give us a deeper understanding of the concerns people were sharing with us. We also use information from activity carried out through our second opinion appointed doctor (SOAD) service. This is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion on the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent.

In this year's report, we also use evidence from relevant programmes of work within CQC:

Independent Care (Education) and Treatment Reviews (IC(E)TRs) programme

CQC was commissioned by the Department of Health and Social Care to carry out a series of IC(E)TRs, which review the care of autistic people and people with a learning disability who have been detained in long-term segregation. This report includes evidence from qualitative analysis of a sample of 37 IC(E)TR reports (dated May 2024 to May 2025) that look at different areas of people's care in long-term segregation such as quality of life, future planning, and recommendations for providers and stakeholders involved in a person's care to improve their care and help them to move out of long-term segregation. We also include evidence from a focus group with internal experts.

Adult community mental health inspection programme

This year, we started a comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and health-based places of safety. We have gathered a range of evidence to support us in shaping this programme of work. We use some of this evidence in this report, including 3 provider engagement sessions and focus groups with people with lived experiences, which focused on current challenges and what good care looks like in the community mental health sector. Representatives from 45 providers of community mental health services and crisis care (including health-based places of safety) for adults of working age participated in the provider engagement sessions (November and December 2024). Seventeen Experts by Experience with a range of experiences of using, or supporting those they cared for to use, community mental health or crisis services participated in the focus groups (January 2025).

Black men's mental health

To develop our understanding of how Black men experience mental health care, we commissioned Queen Mary University (QMU) and University College London (UCL) to carry out a rapid review of what 'good' looks like in relation to access, experience and outcomes for Black men. The work included a rapid evidence review and semi-structured interviews with 23 participants, including Black men who use mental health services and their carers and families, providers, mental health advocates and people working in charities. The research team also worked with the Black Men's Health Taskforce (a community engagement group).

The report also draws on data from NHS England's Mental Health Act Statistics, NHS England's Mental Health Services Data Set (MHSDS) and NHS England's Mental Health Bulletin. NHS trusts, independent sector providers and other organisations delivering NHS-funded mental health care submit monthly data to include in the MHSDS. However, not all providers or services submit data, and submissions are only mandatory if care is wholly or partially funded by the NHS. Also, because of quality limitations, certain outputs from MHSDS are not classified as 'official statistics'. Therefore, we advise a cautious approach when interpreting MHSDS in isolation. Where possible, we have triangulated insights from analysis of MHSDS with other evidence sources. For more information, see NHS England's published data quality statement for MHSDS.

The evidence in this report has also been corroborated, and in some cases supplemented, with expert input from our subject matter experts and specialist MHA reviewers. This ensures that the report represents what we are seeing in our regulatory activity. Where we have used other data, we reference this in the report.

All data in the report is quality assured and validated. Some of the data may change over time as it is updated with new information in the live system.