Inequalities

Key points:

- We continue to have concerns around long-standing inequalities in mental health care. While we have seen examples of trusts making progress in tackling inequality over the last year, more is needed to address the over-representation of Black people who are detained under the MHA and placed on community treatment orders.
- We are concerned that local care pathways are not meeting the needs of people who need specialist support. In many cases, this is leading to prolonged detention in hospital, which has a detrimental impact on people's health and wellbeing. We are clear that there is still an urgent need to improve the provision of community care.
- We welcome the NHS national roll-out of the Patient and Carer Race Equality Framework (PCREF), which sets out to improve access, experience and outcomes, and meet the needs of people from ethnic minority groups. In line with our commitment to tackling inequality, we will be assessing the PCREF through our new assessment framework.
- We have seen positive examples of staff celebrating and understanding diverse cultural perspectives. However, we are concerned that people may be at risk of direct or indirect discrimination in services where staff do not recognise and respect people's protected characteristics as defined by the Equality Act 2010.

In our last report, we highlighted that inequalities in mental health care are systemic issues needing a system-wide response, but that change also needs to be driven at a local level by integrated care systems and providers.

Since our report, the architecture for the way our health and care services are delivered in England has changed, with integrated care systems and their respective boards gaining legal status in July 2022. In line with these changes, we are changing the way we do things at CQC, including our new responsibility to assess whether different parts of a system are working together and meeting the needs of their local populations. This includes assessing whether integrated care systems are developing and implementing an effective strategy that addresses health inequalities within the population.

Over the last year, we have seen examples of NHS trusts making progress in tackling inequality and improving the experiences of people with protected characteristics who are detained under the MHA. But we remain concerned that more needs to be done across the mental health sector to reduce inequalities and prevent discrimination. As reported in our State of Care report, while we have found a strong intention and commitment to address inequalities and act on issues, few integrated care systems have demonstrated an urgency to act on this area.

Racial inequality

Our last report highlighted long-standing concerns that not everyone detained under the MHA is treated equally. We particularly called for urgent action to tackle the over-representation of Black people detained under the MHA and those on community treatment orders (CTOs).

Data from NHS England continues to show that:

- detention rates for Black or Black British people are over 3 and a half times higher than for people in White ethnic groups (227.9 detentions per 100,000 population compared with 64.1 detentions per 100,000 population).
- the use of CTOs is over 8 times higher for Black or Black British people than for people in White ethnic groups (48.8 uses per 100,000 population compared with 6.0 uses per 100,000 population).

Through our engagement and monitoring activities, people from ethnic minority groups have told us about their negative experiences of detention and the impact this has had on them. For example, in one of our interviews with people with lived experience, Jennifer, who has bipolar disorder, described feeling like she was treated differently because of her ethnicity:

> "I think being a Black woman on the wards, you are seen as more of a threat as someone with a mental health condition. You need to be expressive but if you are you are seen as a 'nutter'."

Interview with person with lived experience

At another service we visited, we heard about several incidents of patients making racially abusive comments to other patients. In this case, staff were robust in dealing with these incidents of racial abuse and escalated them to the police:

> "Recently there were several incidents of patients making racially abusive comments. Staff got the trust's security lead and the police involved. A police officer came onto the ward and spoke to the specific patients about their behaviour and potential consequences. This was done sensitively given the patients' mental state, but it was successful in addressing these patients' behaviour."

Psychiatric intensive care unit (PICU) for men and women, September 2022

These examples highlight the need for change. The racial inequalities faced by people from ethnic minority groups when detained under the MHA are ongoing and need addressing. People from ethnic minority communities in the UK are more likely to experience mental illness, but are less likely to receive the mental health care support they need.

One of our key strategic priorities is to consider what more we can do through our statutory regulatory and monitoring roles under both the Health and Social Care Act and the MHA to improve the experiences of Black men when using mental health services. We want to raise public awareness and encourage local integrated care systems, local authorities and services to work together to take responsibility for identifying and addressing the long-standing inequalities in mental health care.

Tackling inequality is also a key feature of the NHS Long Term Plan. However, we know that poor-quality recording of ethnicity data is making it more difficult for organisations to effectively monitor and detect inequalities in access to services, and ensure they are meeting the needs of individual people.

In 2022, our focused review of ethnicity data recording in mental health services found that recording of ethnicity varied between systems, and that the ethnicity of nearly 1 in 6 patients was recorded as 'not known' and 'not stated'. In this report, we highlighted that systems with higher rates of not known and not stated ethnicity will not be able to effectively understand and, in turn, address inequalities in the care being provided.

Improving the quality of recording is essential to enable services to understand variation in referrals, treatments and deaths by ethnicity. The importance of good data remains a key area of focus and was recognised in a recent Lords debate on discussions around the reform of the MHA.

We welcomed the principles of the draft Mental Health Bill, which proposed to amend the MHA to increase the safeguards for people who are detained and reduce the over-representation of people from Black and ethnic minority groups. The bill also set out ambitions to decrease the overall use of CTOs and the racial disparity in their application. However, we are concerned that it is not clear how changes to the criteria for the application of CTO would achieve this aim.

Justification for using CTOs is still a matter of debate across professionals and groups of people who use services. However, we accept that a CTO may provide a less restrictive alternative way of managing a perceived risk. The draft bill proposed to tighten the criteria for CTOs and we supported the intention to make sure that CTOs are used 'only where there is a strong justification'. We also welcomed plans for a future review of CTOs following the proposed changes in the bill.

While we welcomed the ambition of the new bill, changes to legislation alone are not enough. The causes of racial inequality are multifactorial and need additional community resources, including outreach to minority groups.

We were disappointed that the bill was not included in His Majesty's speech in November 2023. However, we are pleased that non-legislative action continues, such as the Patient and Carer Race Equalities Framework (PCREF), and that the government remains committed to reform.

Improving patient experience

After a series of pilots, NHS England formally rolled out the PCREF in November 2023 – the first ever anti-racism framework for mental health trusts and mental health service providers. The PCREF is a mandatory requirement that sets out to improve access, experience and outcomes for people from ethnic minority groups.

There is expected to be an embedding and maturing period while the PCREF is adopted nationally. NHS mental health trusts and mental health care providers will be required to have a PCREF in place by the 31 March 2025.

Reflecting on the findings of its pilot and early adopter sites, in its publication of the PCREF, NHS England highlighted evidence of the positive impact of the new framework:

> "... these pilot trusts have shown us what is possible when we listen to local communities and work with them to deliver care that is culturally appropriate, trustworthy and meets their needs. Inaction in the face of need is a clear indicator of systemic racism in operation and our pilot trusts and early adopter sites have been proactive in naming racism, identifying how it is operating across their services and the anti-racism framework (PCREF) has served to focus attention on strategies and actionable insights to counter."

We welcome the national roll out of PCREF and will continue to work with NHS England as trusts embed the framework. We are also supportive of the recent Royal College of Psychiatrists 'Act Against Racism' campaign, which aims to help mental health employers tackle racism in the workplace. The guidance contains 15 actions to help organisations in the UK to tackle racism at a strategic and systemic level, and employers in the sector can sign up to a network committed to this objective.

As an organisation, we're committed to tackling inequality, with one of our core ambitions focused on regulating to advance equality and protect people's human rights. In December 2023, we published our updated human rights approach. This is integral to our new assessment framework and regulatory approach. It means we have a stronger focus on protecting and promoting people's rights when they use services, and we can act more quickly to protect people when their rights are at risk. This revised approach describes how we will influence change. It includes commitments for CQC to support this shift and the opportunities available to realise them.

Our role is to make sure people have safe, high-quality care. Care that doesn't protect and promote human rights is neither safe nor good quality. But a focus on human rights helps ensure people receive good care.

As part of our new assessment framework, we will be assessing the PCREF under the quality statement Equity in experiences and outcomes. We will look at this area in all planned regulatory assessments in NHS-funded mental health services. We expect providers to actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. Care, support and treatment should be tailored in response to this.

Mental health trusts are required to implement the PCREF, and we will assess this using the well-led framework under the quality statement Shared direction and culture. We expect providers to have a shared vision, strategy and culture. This should be based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

We plan to incorporate assessment of the PCREF into our MHA monitoring activity as we develop our approach.

In our last Monitoring the Mental Health Act report, we also highlighted how a lack of cultural understanding can negatively affect the outcomes of people from ethnic minority groups. Advocacy can help patients to be involved in their care, but it needs to be adaptable and responsive to an individual person's culture. We reported on a government-funded programme of pilots to test different models of culturally appropriate advocacy in both inpatient and community mental health settings.

The first phase has been successfully completed and the Department of Health and Social Care has reported a better understanding of barriers and enablers to implementing culturally appropriate advocacy models. It is hoped that culturally appropriate advocacy initiatives can potentially increase the uptake of advocacy and help to ensure people from ethnic minority backgrounds who use mental health services have better access to justice.

Preventing discrimination

The MHA Code of Practice guiding principle on respect and dignity states that 'there must be no unlawful discrimination' and that providers must be inclusive and respectful of people's individual needs, values and circumstances. This includes:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race, religion or belief
- sex and sexual orientation
- culture.

Through our monitoring activity this year, we have seen positive examples of staff celebrating diversity and understanding different cultural perspectives.

> "Staff told us they celebrated different cultures on the ward and had recently promoted Black history awareness. They told us they would provide different types of food such as Jamaican dishes to embrace diverse cultures."

Dalston Ward (low secure ward for adult male patients who have an acquired brain injury), St Mary's Hospital, Elysium Healthcare, November 2022

We also found positive examples, including at St Mary's Hospital, where staff had supported people to ensure they could practise their faith:

> "There was a multi-faith room in the hospital. Staff told us they were able to support patients to visit different religious facilities in the community. They told us they were also able to arrange different religious representatives to visit the ward at a patient's request."

Dalston Ward (low secure ward for adult male patients who have an acquired brain injury), St Mary's Hospital, Elysium Healthcare, November 2022

> "We were told that on Fridays the staff team arranged for a member of staff who shared their faith to work on shift with them; this meant they could be supported to attend the local mosque for Friday prayers."

Hopton Ward (rehabilitation service for male patients), Wickham Unit Avon and Wiltshire Mental Health Partnership NHS Trust, November 2022

However, we also saw evidence of providers not enabling a culture where staff recognised and respected people's protected characteristics as defined by the Equality Act 2010. We are concerned that this may increase the risk of direct or indirect discrimination against people. For example, at one service we found that staff were unaware of how to provide patients with access to religious support:

> "The hospital had no access to spiritual care or access to religious support. Staff were not aware as to how to access this, if required."

Mixed-gender child and adolescent (CAMHS) psychiatric intensive care unit (PICU), December 2022

Last year we reported that there was greater visibility and focus on care for lesbian, gay, bisexual and transgender (LGBT+) people as an equality issue. This is important as LGBT+ people have a higher risk of having mental health issues, with research from Stonewall showing that half of LGBT+ people had experienced depression, and 3 in 5 had experienced anxiety.

We expect all providers to respect the rights and needs of patients to avoid unlawful discrimination. At one trust we observed this in action where people were being well supported by the gender identity team:

> "Staff were sensitively [supporting] one patient who wanted to be referred to as female. They were being supported by a peer support worker from the gender identity team within the trust."

Additional support unit (ASU) Whipton Hospital, Exeter, Devon Partnership NHS Trust, August 2022

At another trust, we were encouraged to see that a patient's correct pronouns were used in all records at one service:

> "The patient's correct pronoun was used within all records we read... He said at present, staff treated him with respect and understanding. He had not experienced discrimination related to his gender from other patients and felt safe."

Silverstone Ward (specialist dialectic behavioural therapy rehabilitation ward), St Andrew's Hospital, January 2023

However, as highlighted in our previous report, further work is needed to ensure people feel respected and safe. This is supported by data from the Mental Health Foundation, which shows that around 1 in 8 LGBT+ people have experienced unequal treatment from healthcare staff because they are LGBT+. One in 7 people have avoided treatment for fear of discrimination.

During our visits, we have seen examples of a lack of respect for LGBT+ patients, for example services not respecting patients' choice of pronoun. At one service, we were particularly concerned that a patient was not taken seriously when correcting staff on their chosen pronouns:

> "Patient C informed us that some staff had not respected their chosen pronouns when they were in a crisis. When they informed staff of this, they told them; to 'get over it' and 'deal with it' and that they were 'overreacting'."

Psychiatric intensive care unit for men and women, June 2022

Using wrong pronouns and names (or making assumptions) can make people feel unsafe or untrusting of staff, and have a detrimental effect on their care. Guidance for the Health and Social Care Act is clear that people using services should be addressed in the way they prefer, and all communication must be respectful. Providers must have due regard to the protected characteristics and provide care in a way that ensures people's dignity at all times.

Inclusive communication

Effective communication is essential to ensure that patients are respected and cared for in a way that meets their individual needs. The MHA Code of Practice is clear that it's the provider's responsibility to make sure patients are given information about how the Act applies to them, and to identify and address the individual communication needs of each person.

Since August 2016, all providers have had a duty to meet the Accessible Information Standard. This sets out requirements for all providers of NHS care and/or publicly-funded adult social care to identify, record, flag, share and meet the information and communication needs of people with a disability, impairment or sensory loss. As part of our monitoring activity, we look to ensure providers are communicating with patients and carers in ways that suit their needs.

During 2022/23, we saw positive examples of patients being given information in an accessible way, and providers using appropriate language about people's protected characteristics. This helped promote an inclusive and respectful culture where people could engage with staff.

However, we also found examples where providers did not consider inclusive ways of communicating with people with protected characteristics as defined by the Equality Act 2010, which negatively affected their health and wellbeing, as the following example shows:

> "A patient's carer told us that their relative had a hearing impairment and needed to be able to lip read to fully understand what was being said. We were told that the responsible clinician refused to move their face mask when speaking with the patient, leaving the patient distressed and uncertain about what had been said."

Ward for older people with functional mental health problems, September 2022

Following our visit, we instructed the provider to address the issue and they agreed to make clear face masks available to staff to use as appropriate.

At another ward, we saw a cleaner being asked to interpret for a patient, which meant that they could not engage with staff when the cleaner was not there. Not being able to engage with people on the ward creates barriers and we were concerned that staff did not recognise the impact of this.

The MHA Code of Practice is clear that this is not good practice and that interpreters need to be skilled and experienced in medical or health-related interpreting. It also states that interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement. Asking people who do not have this training to fulfil this role can be a risk to patient confidentiality and care, with the potential for misinterpretation.

We've seen some examples of good practice in this area, with interpreters available for all meetings and to translate documents, and staff using immediate voice translator technology. However, we are concerned that this is not always the case and sometimes people are left with no meaningful way to communicate with staff.

Supporting people's physical needs

Services must make sure they are meeting people's individual needs and that care is person-centred. Our reviewers found several examples where providers had not done this, which risked putting people with a physical disability at a disadvantage. For example, at one service the reviewer noted:

> "One patient informed us that equipment provided was unsuitable for her and the bed was extremely uncomfortable and unsafe. We discussed this with the ward manager who told us that all patients with disabilities on the ward were given pressure mattresses despite this being unsuitable for the patient we spoke with."

Acute admission ward for female patients, January 2023

At another service, a bathroom had not been adapted for a patient who used a wheelchair, which led to their dignity being compromised:

> "Staff supported a patient to use the toilet and undertake personal care. The patient was a wheelchair user and the toilet used was not large enough for the patient,

> equipment, and staff. The toilet was near the main entrance of the hospital. Staff used a temporary screen to try to maintain the patient's dignity."

Rehabilitation hospital for men, March 2023

Our updated human rights approach is based on the FREDA principles (fairness, respect, equality, dignity and autonomy). It clearly states that there can be no good care without this rights-respecting care.

Not making reasonable adjustments to meet people's individual needs suggests a lack of person-centred care planning and can put disabled people at a substantial disadvantage. We continue to raise actions with providers when we see that reasonable adjustments have not been made.

Lack of specialist support

We are concerned that local care pathways are not meeting the needs of people who require specialist support. In many cases, this is leading to prolonged detention in hospital, which has a detrimental impact on people's health and wellbeing. For example, at one ward for Deaf/deaf men we reported that:

> "Many of the patients had been detained under the MHA either on the ward, or at other facilities, for many years. Staff told us that a number of patients no longer required detention on a secure ward and could have been discharged if suitable aftercare provision was available in the community."

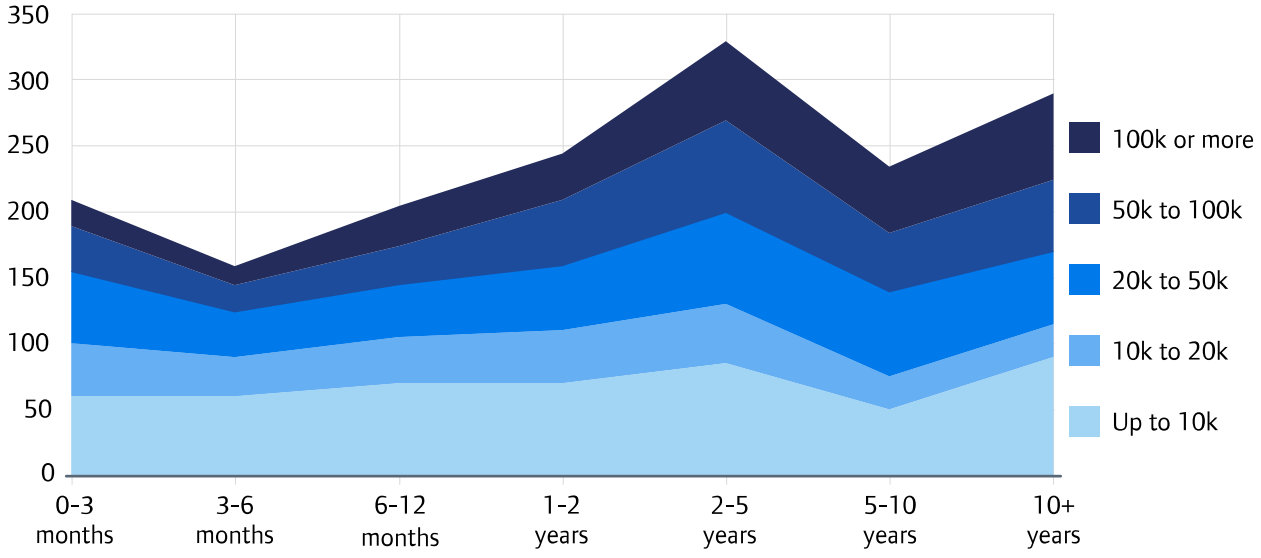
Low secure mental health service for Deaf/deaf men, January 2023

In particular, we remain concerned about ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability. At the end of October 2023, 2,035 inpatients were autistic people or people with a learning disability. Of these, 92% (1,880) were subject to the MHA.

Information about how far away patients were placed from their home was known for 1,675 of the 2,035 patients. Of these, around half (855) had been in hospital for over 2 years (total length of stay is the time since the date of first admission to any hospital as part of this continuous period of inpatient care).

Figure 3 shows how far away from home autistic people or people with a learning disability were placed in hospital, and how long they spent in hospital.

Figure 3: Distance away from home that autistic people or people with a learning disability were placed, over time (as of end of October 2023)



Source: NHS England, Learning disability services monthly statistics
Note: Approximate figures based on sums of rounded published figures

Too often, this lack of community-based options of care means people find themselves in the wrong setting for their needs and/or with inappropriately trained staff or staff shortages.

We have been reporting on these concerns for many years. In 2020, our thematic review on restraint, seclusion and segregation highlighted the devastating impact of inappropriately detaining autistic people and people with a learning disability in hospital. In our final report, Out of sight – who cares?, we reported how a lack of care planning was leading to too many people ending up in seclusion and segregation in hospital for prolonged periods.

Our interim report, published in 2019, recommended that there should be an independent in-depth review of the care provided to each person who is in segregation on a ward for children and young people or on a ward for people with a learning disability, including their discharge plan.

Following our recommendation, in November 2019, the government committed to an urgent programme of Independent Care (Education) and Treatment Reviews (IC(E)TRs) for all people with a learning disability and autistic people who were in long-term segregation in specialist mental health inpatient settings. Led by Baroness Hollins, the aim was to review each person's care and treatment to make recommendations for improvement and identify any barriers to discharge.

As reported in our 2020/21 annual report, phase one of the review found that little had changed since the publication of our Out of sight report to improve the situation of autistic people and people with a learning disability.

In November 2023, Baroness Hollins published her final report. Figures show that as at May 2023, of the 114 people who received an IC(E)TR in the second phase, which ran between November 2021 and March 2023, 48 had been moved out of long-term segregation and only 7 people had been discharged from hospital. In her letter to the Secretary of State for Health and Social Care, Baroness Hollins described how autistic people and people with a learning disability have been "failed because of inappropriate care and treatment earlier in their pathway of care".

We hope that Baroness Hollins's report will act as a driver to help eliminate long-term segregation for autistic people and people with a learning disability. We expect care to be person-centred and providers to promote a culture that supports recovery, builds trust, and protects the safety and wellbeing of all people using services.

Following the publication of Baroness Hollins's report, the Department of Health and Social Care asked CQC to take the lead on IC(E)TRs for the next 2 years. In the first year, we will be working alongside NHS England. We are pleased to begin this work and will report further when we are able to.

For autistic people and people with a learning disability, long-term detention under the MHA does not often meet their needs. We supported the ambition of the draft Mental Health Bill to prevent inappropriate detention for autistic people and people with a learning disability. However, we have raised our concerns about some potential unintended consequences in the wording of the current draft bill. This includes concerns that autistic people and people with a learning disability could be:

- subject to the criminal justice powers of the MHA because the bill was only changing the civil detention criteria and not the criminal detention criteria
- admitted under Deprivation of Liberty Safeguards (DoLS) instead of the MHA
- re-diagnosed with a concurrent psychiatric disorder so they meet the new criteria (for example, depression resulting from a placement that doesn't meet their individualised needs).

We are also clear that changes to legislation are not enough, and there remains an urgent need to improve community care. Having access to high-quality community-based services and support enables people to get the care they need in their local area. This is vital in providing early interventions before people reach crisis point, as well as avoiding unnecessary hospital admissions or delayed discharges. However, although the draft bill provided a welcome spotlight and sense of urgency to this issue, we are disappointed the bill isn't being progressed in this parliamentary session.