Addressing inequalities and cultural needs

This is the 2021/22 edition of Monitoring the Mental Health Act

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Key points:

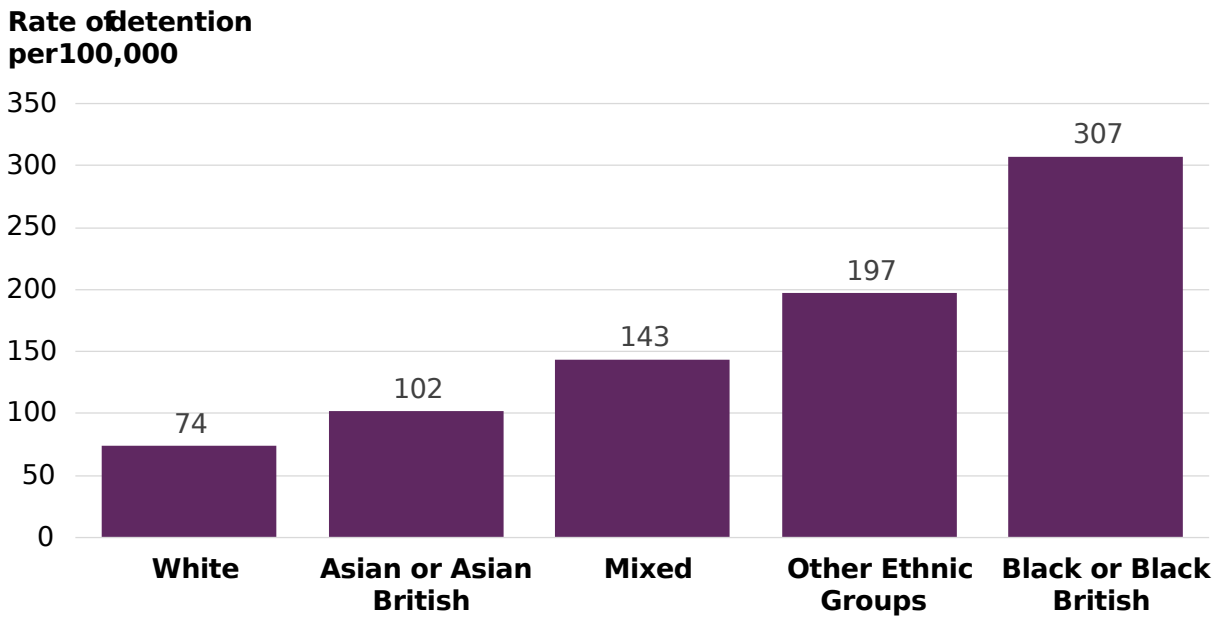
- Urgent action is needed to tackle the over-representation of people from some ethnic minority groups and, in particular, the over-representation of Black people detained in hospital or on community treatment orders.
- Providers and integrated care systems must take responsibility for addressing health inequalities at a local level. The Advancing Mental Health Equalities Strategy and Patient and Carers Race Equalities Framework (PCREF) provide national support to enable services to do this effectively.

- Some services are taking a positive approach to addressing inequalities. This includes services identifying members of the staff team to take a leading role for diversity, promoting an equalities approach across wards and supporting staff and patients.
- More widely, we have frequently heard ward managers and others describe their service as a safe space for lesbian, gay, bisexual and transgender (LGBT+) people, and such greater visibility and focus on LGBT+ as an equality issue is a very welcome development. However, further work is needed to ensure people feel respected and safe.

Over-representation of people from some ethnic minority groups

In last year's report, we highlighted the longstanding concerns that not everyone detained under the MHA is treated equally. In particular, we raised our ongoing concerns that Black people are more likely to be detained under the MHA, spend longer in hospital and have more subsequent re-admissions than White people. Figure 2 demonstrates this trend continues, with Black people 4 times more likely to be detained than White people.

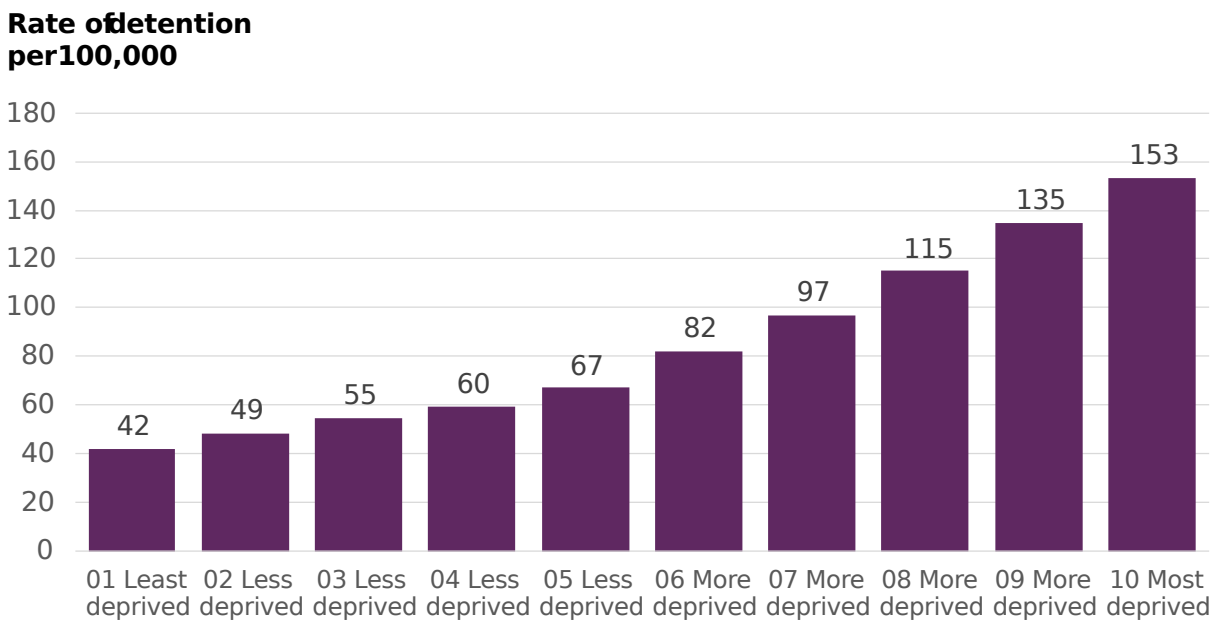
Figure 2: Rate of MHA detention per 100,000 population, by broad ethnic categories, England, 2021/22



Source: NHS Digital, Mental Health Act Statistics, Annual Figures – 2021-22

We know that MHA detention rates vary across England, with figures from NHS Digital showing that people living in the most deprived areas are at a much greater risk of being detained under the MHA (figure 3)

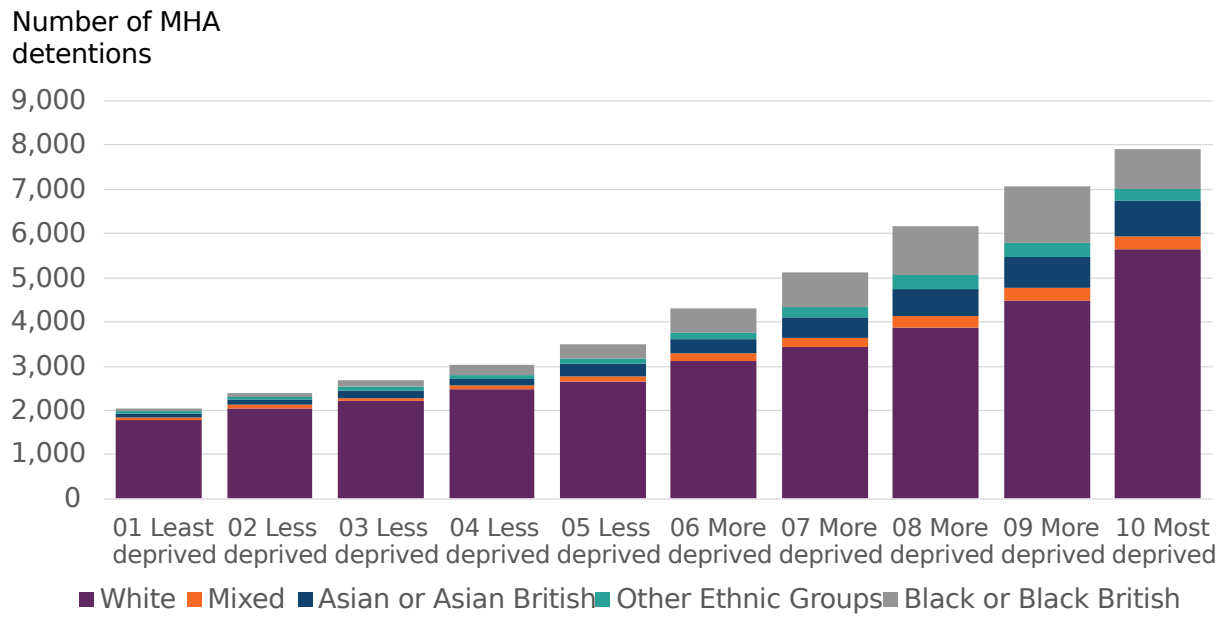
Figure 3: Rate of MHA detention per 100,000 population, by index of multiple deprivation (IMD) decile, 2021/22



Source: NHS Digital, Mental Health Act Statistics, Annual Figures - 2021-22

When ethnicity and deprivation are mapped together it demonstrates these risks are inter-related (figure 4).

Figure 4: Detentions under the MHA recorded in MHSDS, by index of multiple deprivation (IMD) decile and broad ethnic categories, 2020/21



Source: [NHS Digital, Mental Health Act Statistics, Annual Figures – 2021-22]

A report from [Account], a community interest company highlighted the impact of this on Black men detained under the MHA, based on a series of focus groups in secure hospitals. Participants of the focus groups described the inherent socioeconomic inequalities and racism they face as Black men from deprived areas.

> Participants were very aware of social inequalities and unfairness across the journey. Some pointed to racism which they saw as the bedrock on which society was built. They described being taught they were inferior to others from a young age and had experienced racism from individuals and agencies long before experiencing any mental ill health symptoms.

There was a sense that racism in society was repeated along with structural inequalities in areas such as housing, education and employment. Along with these, participants felt the impact of racial stereotypes which expected and suspected them of being criminals. Participants also talked about struggling against internalising these negative social expectations.

Black men's experiences of the secure care pathway

A particular area of concern is the disproportionate use of community treatment orders (CTOs) for Black people. Figures from this year's Mental Health Services Data Set (MHSDS) suggest that rates of CTO use for the 'Black or Black British' group are over 11 times the rate for the White group.

Our review of CTO use in London, published in November 2022, found that in most boroughs the ethnicity for about half of patients on CTOs was recorded as Black, despite the proportion of Black people living in the borough being lower. In one borough, we were told that Black patients were consistently over-represented among CTO patients by a factor of 6 to 7 based on the population data.

"I have been on a CTO for over two years. I had been discharged for a year previously and I was fine until I came into contact with the police and they delivered me back to psychiatric services. You cannot escape if you are mixed race. I have had too many appointments. They are always wanting to see me and this has made me suicidal. I want to be discharged and to have nothing to do with services and not to take medication because I am not mentally ill. I have no faith in the system and no faith in tribunals. All White panels, and especially White judges, will never take my word against that of the treating team."

Community patient, quoted in Mental Health Act community treatments orders (CTO) – focused visits report

The government has stated that it wants to see a decrease in the overall use of CTOs, especially the disproportionate use of CTOs for Black people. While we welcome the government's objective to reduce the disproportionate use of CTOs for people from some ethnic minority groups, we are concerned about how this will be achieved as the causes underlying this are multifactorial. We will continue to evaluate whether the opportunities provided by a revised MHA and a new code of practice will improve this situation. However, as highlighted in the foreword, we also want to work with stakeholders, including people who have experienced mental health services and their carers and families, to build on existing research to drive real change.

As highlighted in last year's report, we welcome NHS England's commitment to reducing mental health inequalities through the Advancing Mental Health Equalities Strategy and the development of a Patient and Carer Race Equality Framework (PCREF). The government has committed to working with patients, carers, health system leaders and key stakeholders to develop the PCREF, with the goal of improving access, experience and outcomes for people from ethnic minority groups by supporting, incentivising and assuring targeted, localised actions in local health systems.

Over the last year, the PCREF has been piloted at a number of sites including South London and Maudsley Foundation NHS Trust. As part of the pilot, the trust has been working with Black Thrive Lambeth and Croydon BME Forum and has co-produced practical projects to test and learn if improvements are being made in key areas including:

- service use
- diagnosis of psychotic spectrum disorders

- use of medication for Black people with a diagnosis of psychotic spectrum disorders
- the use of detention
- the use of seclusion and restraint.

We look forward to developments in the PCREF model and are working to reflect its expectations as we develop our approach to regulation and monitoring.

Alongside efforts to tackle racism, services need to ensure that they are being inclusive of patient needs. This includes, for example, care plans being translated into languages other than English and meeting people's religious and cultural needs. Not meeting these needs can have a negative impact on people's experiences. This year, we have seen some services struggling in this area.

Some patients did not have care plans to meet their needs. This included patients from ethnic minority groups and those with physical disabilities. For example:

- some patients from ethnic minority groups had care plans to meet their needs but others did not
- care plans did not routinely consider patient's cultural or religious dietary preferences
- specific diversity care plans did not consider the possibility of abuse, bullying or harassment.

Some patients said staff did not treat them with respect because they were from an ethnic minority group. This is a serious concern, particularly in the light of poor care planning around patients' equality and diversity needs.

Rehabilitation wards, June 2021

However, we have also seen some examples of good practice with staff being inclusive of people's needs. In addition, many services have identified a lead for promoting equality and diversity across wards, and taking responsibility for supporting staff and patients.

> Six patients on the ward were observing Ramadan last month and the ward made arrangements for patient meals and medication times to be outside of their fasting times. The ward staff worked closely with the Imam who supplied them with timetables for prayer and meal times. In addition, the hospital organised a celebratory meal for Eid, for all patients on the ward. This was very well received by all patients on the ward and positive feedback was given by the patients.
>
> **Medium dependency ward, Ashworth Hospital, Mersey Care NHS Foundation Trust**, May 2021

> The ward had a diversity lead in the staff team. One patient had been supported to use the multi faith room, take leave in a local mosque and the team had requested an Imam visit the patient on the ward. Two patients were being supported to attend a local LGBTQ+ event.
>
> **Fern ward (rehabilitation ward for women with personality disorders), Cheadle Royal Hospital, Affinity Healthcare,** June 2021

Culturally appropriate advocacy

A lack of cultural understanding can negatively affect the outcomes of people from ethnic minority groups. Although advocacy can help patients to be involved in their care, it does not always meet people's specific needs and may be seen as less available or attractive to people from ethnic minority groups.

In our review of CTO use in London, we found that people on a CTO, many of whom were people from ethnic minority groups, were generally not accessing independent mental health advocacy and did not always know where to go for support.

Culturally appropriate advocacy should be adaptable and responsive to an individual's culture. This includes, for example, supporting people with advocates of the same ethnicity, understanding the importance of culture, cross-cultural relations and cultural difference, and adapting practice to meet culturally unique needs.

While larger advocacy services may be better able to meet contract requirements, they are not always best placed to support people from ethnic minority groups in the way that smaller advocacy and community organisations can. These smaller organisations are often more ethnically representative of communities they serve and have local experience of working with people from ethnic minority groups. Commissioning and supporting this type of culturally appropriate advocacy could help in addressing mental health inequalities.

Since 2021, a government-funded programme of pilots have been testing different models of culturally appropriate advocacy in both inpatient and community settings. The 3 pilots that ran as part of the first phase are as follows:

- In Manchester, advocacy provider Gaddum and the local community organisation African and Caribbean Mental Health Services piloted culturally appropriate advocacy in inpatient and community settings in areas with a high number of people from ethnic minority groups who are detained under the MHA.
- In London, Black Thrive provided culturally appropriate advocacy in a similar context, and also used an innovative 'living room' concept to create a more homely community space where both scheduled and drop-in advocacy sessions could take place.
- In the West Midlands and Oxfordshire, Pohwer piloted culturally appropriate advocacy in inpatient and community settings in areas with a low number of people from ethnic minority groups who are detained under the MHA.

We look forward to seeing the results of these pilots and hope that continued funding will be made available to strengthen the evidence base and inform the design of longer-term pilots, as was suggested at the start of the programme.

Inpatient services as a safe space for LGBT+ people

In last year's report, we highlighted some examples of excellent care we had seen for lesbian, gay, bisexual and transgender (LGBT+) people. We are encouraged that this year, ward managers and others have frequently described their service as a safe space for LGBT+ people.

> The ward was a safe place for LGBT patients. An LGBT patient we spoke with confirmed this and told us staff were very welcoming to his husband and they felt valued as a couple. A staff member told us that all staff had diversity training. The unit also had diversity champions.
>
> **Avalon Centre, Swindon, Elysium Neurological Science (Badby) Ltd**, January 2022

We are encouraged that, where staff or patients have told us that they were less confident over the ward culture being an LGBT+ safe space, staff have generally been keen to address this and to consider what practical measures can be taken. This has included obtaining and displaying information for LGBT+ support and services contacts, and discussion at patients and staff meetings.

Following discussion with the ward team we were provided with information on how they can promote a culture of LGBT+. The Rainbow Badge initiative has been introduced enabling staff to endorse non-judgemental and inclusive care for those who identify as LGBT. Wearing the Rainbow Badge provides a visual symbol for others to identify individuals who can be approached to feel comfortable talking about issues related to sexuality or gender. Ward staff have been provided with details of how to access the online training course to obtain the badge. In addition, ward staff have been asked to nominate themselves as ward champions to promote this initiative.

Response to visit letter, **acute ward for men and women**, June 2021

People who are detained under the MHA have, by definition, not chosen to come into hospital, and the experience can be frightening and upsetting for anyone. Many mental health services have been organised on the basis of binary gender separation. The elimination of mixed-sex accommodation (where accommodation is defined in terms of sleeping areas) and the creation of women-only safe spaces is an important aspect of ensuring that women are and feel safe from sexual threat on wards. We have seen many examples of services successfully providing LGBT+ safe spaces in this context.

The transgender patient was keen to point out that staff do not discriminate against transgender people and are really good at accepting people as they are. They are exemplary in this respect. The ward manager takes issues raised, such as hate speech, seriously.

Low secure rehabilitation ward for women, Oxleas NHS Foundation Trust, May 2021

Other units, for example some units for children and young people, have told us about the flexible approach they take to meeting people's needs. This includes ensuring they have single-gendered spaces if they are required, and that services ensure patient safety and security in the alternative arrangements.

> Quiet rooms were no longer gendered, and staff told us that this was to reflect the gender fluid culture more appropriate to the young patients. Bedrooms had en suite shower and toilet facilities and the ward was not separated into gendered areas. Staff told us that this worked well, although patients were moved around according to risk assessments.
>
> We were told that all staff were able to take a LGBT+ electronic learning questionnaire which would then allow them to wear a rainbow lanyard and support the promotion of an inclusive ward environment. One member of staff had done this.
>
> We observed that the bedroom corridors and quiet rooms were no longer segregated by gender. Staff told us that patients had asked for gender specific signs to be removed from the quiet rooms and bedroom allocation was more fluid to respond to the ongoing range of risks, of which gender and sexual safety was considered.
>
> **Coral Ward for children and adolescents, Bowmere Hospital, Cheshire & Wirral Foundation Trust**, August 2021

It is important to note that alongside evidence of good practice, we continue to find examples of poorer practice. For example, feedback from our MHA reviewers suggests that some transgender and non-binary patients are still not having their gender or pronoun preference acknowledged, with staff sometimes referring to a transgender or non-binary person by a name they used before transitioning. Work needs to continue to ensure LGBT+ people feel respected and safe.