Inequalities

Key points

- We are concerned that some of the key issues raised in this report, including access to mental health support, are particularly challenging for certain groups, such as people from ethnic minority groups and those living in areas of deprivation.
- We identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.
- There was variation in how well services met people's needs– many provided access to spiritual leaders, but we remain concerned about gaps in the knowledge of staff around caring for autistic people.

Data shows that access to mental health services is particularly challenging for certain groups of people, such as those living in areas of deprivation, people from ethnic minority groups and young people. This is concerning, given that, as we outline in the systems section, not getting the right help at the right time can lead to otherwise avoidable admissions as people's health deteriorates.

In our 2023/24 State of Care report, we highlighted that people who live in areas of higher deprivation were more likely to attend urgent and emergency care departments for their mental health needs than those in the least deprived areas. Attendance rates are over 3 times higher, suggesting people in the most deprived areas face significant challenges in accessing support in the community. Data also shows that the most deprived areas have the highest rates of detention. In 2023/24, detention rates in the most deprived areas were 3.5 times higher than in the least deprived areas.

We also have long-standing concerns that not everyone detained under the Mental Health Act is treated equally. In 2023/24, we continued to see how some people face inequalities in care and treatment because of their protected characteristics. We found attempts by services to address these inequalities varied. While some services promoted equality, diversity and inclusion, ward staff were not always able to explain how their service supported people's cultural needs. More work is needed to ensure care is fair for people who are detained under the MHA.

Discrimination

The MHA Code of Practice is clear that "there must be no unlawful discrimination". We expect providers to be inclusive and respectful of people's needs, values and circumstances. This includes taking into account the following protected characteristics, which mean it is against the law to discriminate against people because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin

- religion or belief
- sex
- sexual orientation

In previous Mental Health Act reports and in our annual State of Care report, we have continued to raise concerns about the over-representation of Black people who are detained under the MHA or placed on community treatment orders. In 2023/24, the detention rate for people from Black or Black British groups was 242 per 100,000 population. This was 3.5 times higher than the rate for people from white ethnic groups (68). Detention rates have increased slightly for all groups compared with the previous year.

A report by the Centre for Mental Health found that experiencing racism increases a person's chances of having poor mental health and makes it harder for them to get the right support. It highlights that people with mental health needs may be treated less well in society, including in the social security and justice systems, and calls for concerted action to tackle these inequalities and close the health gaps between different groups.

Through our monitoring visits, we found some instances of discrimination, both staff to patient and patient to staff. We heard from our MHA reviewers that racial abuse towards staff is common. For example at one visit we heard that:

> “There were incidents of racial abuse of staff by a patient. This was documented and reported to the police, with support for the staff involved.”

At another service, we identified culturally insensitive language in patient notes, with one patient’s risk assessment referring to a risk of them making “Islamic comments”. We outlined that the service should address how it ensures all staff follow the principles of anti-discriminatory practice.

We also found examples of services taking steps to tackle racism. This included encouraging patients and staff to create and share anti-racism resources:

> “We saw when we went onto the ward that there was an anti-racism poster. The ward manager told us there had been an anti-racism event several months ago which took place over a whole week, and staff and patients had devised this poster at the time. She told us about how the ward promoted a positive culture.”

Another service facilitated events to celebrate Black History Month. On 2 wards, patients from ethnic minority groups told our reviewers that they had not experienced discrimination and felt staff understood, respected and supported their cultural and religious needs.

The Patient and Carer Race Equality Framework (PCREF) aims to support NHS trusts to become actively anti-racist organisations. It is NHS England’s first anti-racism framework for mental health trusts and mental health service providers and will be a mandatory requirement from March 2025. PCREF sets out to ensure that trusts and providers co-produce and implement concrete actions to reduce racial inequalities in their services.

In our last Monitoring the Mental Health Act report, we reported on positive initial findings of PCREF pilots and early adopter sites. Since then, these trusts have continued to report positive progress, including:

- focusing on data held in their trust and establishing workstreams to enhance data collection and better understand their populations and where discrimination may be happening
- engaging with a range of local groups and forming local partnerships, including with a local police force, to hear from different groups and develop training
- ensuring that the Board PCREF lead is well-established and the Board are engaged with the framework

- using tools such as Dialog+ to facilitate better co-produced care plans and recruiting community support experts to work with care co-ordinators to bridge the gap between trusts and people who use services
- updating websites and intranet pages with information on PCREF, explaining its governance structure and opportunities to get involved.

It is not only mental health trusts that have a role to play in PCREF. According to the Mental Health Equalities Programme and the National Institute for Health and Care Research (NIHR) Mental Health Implementation Network (MHIN), system partners will be critical to the effective implementation of the framework. Integrated care boards and partnerships, local authorities, and NHS mental health trusts must work with, and importantly listen to, people from ethnic minority groups to co-produce culturally appropriate care models and ensure accountability at all levels.

We support PCREF as a practical tool to tackle racism and dehumanisation. In the lead-up to March 2025, we have continued to encourage services to embed the approach through our regulatory and monitoring activity. Once mandatory, we will check how services use the framework as evidence to inform our assessments. This includes how mental health services embed equity into their shared vision and ensure equity in experience and outcomes for people from ethnic minority groups.

As a regulator and monitoring body, it is important that we do not hold others to account for actions we are not taking ourselves. We stand against racism, violence, aggression and abuse in all forms. We are currently adopting the principles for an anti-racist organisation set out by the NHS Race and Health Observatory. Our approach will focus on how we address the effects of structural, institutional, and interpersonal racism. This includes addressing racism in our external regulatory work for people using services and providers, as well as internally for CQC colleagues.

In our last Monitoring the Mental Health Act report, we also discussed the discrimination faced by some lesbian, gay, bisexual, and transgender (LGBT+) people detained under the MHA. We highlighted improved visibility and focus on care for LGBT+ people and in 2023/24, LGBT+ patients we spoke with generally felt supported. However, one patient described being “intermittently misgendered” by staff. While reviewers often have positive conversations with staff about LGBT+ issues, some wards are more confident than others about providing LGBT+ support.

Communication and people’s rights

The MHA places a legal duty on services to provide patients and carers with information about their situation and rights. The MHA Code of Practice outlines that providers should ensure all relevant information is communicated in a way that the patient understands. It says providers should identify any communication difficulties and everything possible should be done to overcome barriers to effective communication. Throughout our monitoring activity, we identified several issues around people not understanding their rights, including:

- patients not being informed of their rights at admission or significant delays in informing people of their rights after admission
- rights not being repeated regularly
- staff not providing updates to patients on their legal rights when the section of the Act under which they are detained has changed
- our MHA reviewers not being able to ascertain if a person had understood their rights
- patients not being referred to the Independent Mental Health Advocate (IMHA) when they do not understand their rights
- a lack of written information regarding legal rights provided to patients for future reference

- legal rights information not given in a person’s preferred language
- inconsistent approaches to explaining people’s rights.

These issues were echoed by members of our Service User Reference Panel, who described patients’ rights as feeling like a “tick box” exercise, with some members feeling that they were not made aware of their rights in a meaningful way. Not explaining people’s rights clearly and in a way that the person can understand does not uphold the principles of fairness, respect, equality, dignity or autonomy, and could potentially lead to situations where their human rights are infringed or breached, for example, where understanding rights engages Article 6 the right to a fair trial. We also heard a suggestion from the group that often less experienced staff, such as student nurses, were tasked with ensuring patients were aware of their rights but were not always best-placed to explain them in detail, with examples and context.

We also found issues with communicating and involving patients in important updates about their care plans. This includes copies of care plans not being shared with patients, inconsistent approaches to creating care plans and poor communication about the care planning process, meaning people lacked awareness of what their plan was and how it was completed. However, it was promising to find examples of clinical records that clearly stated patients’ preferred pronouns, their wishes regarding their gender identity and how they were to be kept safe on the ward.

Inclusive communication is vital to ensure everyone receives high-quality care. Despite this, we continue to find examples of poor communication with patients detained under the MHA. Although interpreting and translation services were available at many services, we found examples of language barriers for patients who did not speak English as a first language. Often, interpreters were only used for important meetings and did not support people to communicate on a day-to-day basis. Sometimes, this prevented staff from being able to engage with patients, which could make their experience of detention more isolating. For these patients, watching television was sometimes their only form of activity, although this was also in English.

Meeting patients’ needs

The Equality Act requires providers to consider how their policies, programmes and service delivery will affect people with protected characteristics. It places a duty on providers to take positive steps to avoid discrimination through reasonable adjustments. At several services, staff had adapted their wards to support the needs of people with limited mobility.

> “We saw a patient who used a wheelchair had a larger bedroom and shower that accommodated their limited mobility. He told us a staff member had built a ramp so that he could access the gazebo in the ward garden as well as being able to use the other areas of the garden.”

However, we visited a number of wards that were unsuitable for wheelchair users because of their layout and location within the hospital. For example, one first-floor ward had beds fixed in place, no en-suite facilities and no accessible bathrooms, meaning patients with limited mobility had to be placed elsewhere. At another ward, patients complained about nurse call buttons being out of reach and one person with limited mobility explained having to summon staff by shouting.

Inappropriate ward environments can also have a negative effect on neurodivergent people. At a couple of services, we were concerned about the frequency of alarms going off and noisy leaking gutters, which increase the risk of sensory overload for some patients. As we highlighted in our last Monitoring the Mental Health Act report, services must determine each patient’s unique sensory profile and preferences.

How well services met the needs of people with dementia also varied. A lack of signage and consideration about the layout of the ward prevented a couple of services from creating dementia-friendly spaces. However, another service used contrasting colours and picture signs to help patients navigate around the ward. Patients were also encouraged to add a photograph of themselves to their bedroom door to help them to find their own room.

It is also important that mental health services meet people's cultural and religious needs. We were concerned to find instances where this was not the case. This included a lack of Halal options or not catering for vegan or vegetarian diets. We also found examples of male members of staff escorting or observing female patients, despite this being problematic because of the patients' cultural backgrounds.

Ali's story

Ali described his mother as a housewife who is devoted to her family. She is British Pakistani and Ali explained how her experience of detention under the MHA was negatively affected by a lack of access to interpreters and culturally appropriate activities.

Ali's mother has a history of bipolar disorder, severe anxiety and depression. She has been detained numerous times and during a recent hospital admission, Ali was concerned that issues with communication and interpreting meant staff did not explain his mother's rights to her. He requested an interpreter, which the hospital provided, but while they spoke the same language, they did not share the same local dialect. Ali raised the issue with staff but it took 3 days to source an appropriate interpreter.

Ali feels this process could have been quicker and clearer. His mother felt confused, insecure and vulnerable not knowing what was happening to her. Sometimes Ali was left to interpret conversations, which he found draining. He explained wanting to be objective and accurate, but being aware of his own interpretation and judgements.

On the first day of his mother's hospital admission, Ali worked with staff to ensure her cultural requirements were noted in her care plan. He commented that staff were receptive and open to her needs, but he felt her plan was not always put into practice. He explained that the halal food provided by the hospital did not taste authentic to his mother and he started to bring food from home for her. His mother has diabetes and Ali was concerned that a lack of continuity of care meant she sometimes ate the wrong foods at the wrong times because staff were not familiar with her needs.

Ali felt his mother was indirectly discriminated against as she was often left out of activities on the ward with no one to speak to. He told us that embroidery and cookery classes were often heavily westernised and could have been tailored to his mother's cultural needs (for example, by embroidering a flower rather than a Western holiday motif, or suggesting his mother draws a pumpkin, as she wouldn't understand being asked to paint a picture for Halloween). His mother also must pray each day but with no dedicated prayer room on the ward, she was praying in her bedroom, which further isolated her.

Ali's mother was in hospital for around a month before being discharged. At this point, Ali took over her care.

In contrast, many services had access to a chaplain or other spiritual leader who could provide patients with support and guidance. One service successfully adapted a patient's routine to ensure that mealtimes did not coincide with prayer time. Some services had dedicated multi-faith spaces that allowed patients to practice their chosen faith.

However, these areas were not always fit for purpose and we have seen examples of multi-faith rooms being used as storage areas. At another service, a religious space was moved to the female-only lounge, meaning female patients no longer had access to a single-sex space. We heard how staffing pressures can make it difficult for staff to facilitate patients attending religious services:

> "Two patients told us they attended Chapel on a Wednesday and Sunday but had not been able to go for the past 2 Sundays because of a lack of staff."

Care for autistic people and people with a learning disability

At some services, gaps in staff knowledge affected the care provided for autistic people and people with a learning disability. Some staff had not completed mandatory learning disability and autism training, which exists to ensure that staff have the right knowledge and skills to provide safe and informed care. We expect providers to meet the needs of everyone using their service. This includes ensuring staff have the appropriate training to help improve experiences and outcomes for all people who use services.

In last year's report, we outlined our cross-sector policy position on reducing restrictive practices, which clarifies our expectation of providers. Following this, in our December 2024 blog on reducing restrictive practices, we highlighted that restrictive practices like chemical restraint are inappropriate when they could have been prevented through better person-centred planning, listening, understanding, skills, support, and system partner collaboration. People must not be unnecessarily sedated, rapidly tranquillised or anaesthetised for communicating an unmet need, emotions, or distress. Wherever we see chemical restraint being used, we will want to understand why and how the decisions have been made about this course of action.

In previous years' Monitoring the Mental Health Act reports we have outlined that a lack of suitable accommodation in the community has led to autistic people and people with a learning disability being unnecessarily detained in hospital. In late 2023, we announced that the Department of Health and Social Care asked us to take a lead on Independent Care (Education) and Treatment Reviews (IC(E)TRs) for 2 years. The focus of our IC(E)TR programme is reviewing people's care and encouraging providers and commissioners to overcome the barriers to support people to move out of long-term segregation into more suitable environments where they can flourish.

Our programme began in May 2024 and we have seen some positive examples among the first group of people to have had a review:

- One person was successfully discharged from long-term segregation in a high-secure setting
- A young person was successfully moved to more appropriate adult services in a single-person accommodation that better meets their needs
- Another person was discharged into their own placement in the community.

However, we continue to find cases of hospital admissions that could have been avoided altogether. In previous Monitoring the Mental Health Act reports, we have also raised concerns about autistic people and people with a learning disability staying in hospital for prolonged periods when this does not meet their needs. From our monitoring work and our involvement in IC(E)TRs we know that in almost every case, the principal cause is the lack of a practical alternative in the form of resourced community support.

We welcome the ambition to change this situation, which is reflected in the proposals of the Mental Health Bill to exclude learning disability or autism from the scope of civil detention for treatment under the MHA. This means that having a learning disability or being autistic alone cannot be a reason to detain a person. But legislation alone will not bring the changes needed.

Without suitable community-based alternatives there is still a risk that people may be detained in sub-optimal hospital placements under alternative legal powers such as the Deprivation of Liberty Safeguards (DoLS) or its eventual replacement, Liberty Protection Safeguards. Autistic people and people with a learning disability could also become increasingly vulnerable to being drawn into criminal justice measures, such as detention under the criminal justice powers of the MHA, or imprisonment.

It will therefore be essential to ensure that improved community support is in place throughout the country before the reforms are implemented.