Foreword: Chris Dzikiti

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

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Over the previous two Monitoring the Mental Health Act reports, we have recognised the huge impact of the pandemic on inpatient mental health services and the extreme pressure that staff have been under.

This year is no different – the effects of the pandemic continue to be felt, with increasing demand for services.

As stated in our 2021-22 State of care report, workforce issues and staffing shortages remain the greatest challenge for the sector. Not having the right staff levels and skill mix can prevent people from receiving the care and treatment they need, when they need it, and in the right environments. This can also have a detrimental effect on staff, with patients themselves telling us that they are concerned about staff wellbeing and the pressure they are under due to unmanaged workloads. Despite this, bright spots of good practice are to be found where services strive to be creative and flexible in a challenging environment.

Gaps in community care are adding to the pressure on mental health inpatient services, with many inpatient services struggling to provide appropriate places for people to receive inpatient care and treatment. As well as improving support in the community, more needs to be done to increase the availability of inpatient beds to ensure people who need treatment in hospital have access to the care they need. Currently, some areas do not have enough beds to meet this need, increasing the risk of people ending up in inappropriate environments. This continues to be a particular challenge for children and young people's mental health services with data from CQC notifications showing a 30% increase in the number of under 18s admitted to adult psychiatric wards in 2021/22 compared to 2020/21.

Where people need treatment in hospital, they should be able to access the inpatient services they need, for the shortest time possible, in a therapeutic environment close to home. Too many people, particularly people with a learning disability and autistic people, continued to be cared for in hospital settings far from home. As we have highlighted in other reports, people being placed in hospitals far from home and away from friends and family can increase the risk of closed cultures developing.

A closed culture is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm. Closed cultures, and the possibility of breaches of human rights, may occur across a wide range of health and social care settings. The knock on effect of staff shortages, including the use of agency staff and the lack of continuity of care, are inherent risk factors in the development of closed cultures. However, we are particularly aware of the increased risk in services that care for people with a learning disability and people with a mental health condition.

Too many closed and abusive cultures persist. The light shone on people's poor experiences in recent media coverage should be the spur that leaders and stakeholders right across the board need to work promptly, transparently and jointly, to prioritise the rights of people to be cared for in a safe environment that upholds and respects their dignity.

Yet again we are calling for urgent action to tackle the over-representation of people from some ethnic minority groups who are detained under the mental health act, in particular the over-representation of Black people on a community treatment order.

It is now 20 years since the publication of Breaking the Circles of Fear, but progress in tackling long-standing inequalities in mental health care is woefully inadequate. We know from this and numerous other reports that the inequality faced by some people from ethnic minority groups is not just a result of current legislation, but is inexorably linked with wider personal experiences of racism, access to opportunities and socioeconomic circumstances. We want to work with stakeholders, including people who have experienced mental health services and their carers and families, to build on this research and drive real change.

As evidenced by NHS England's Advancing Mental Health Equalities Strategy, work is underway at a national level to build racial equality into mental health services. Despite this and proposals set out in the draft Mental Health Bill to address racial inequalities in mental health care, we are concerned about how these proposals will improve the care for people from ethnic minority groups, without measures such as investment in community services and culturally appropriate advocacy.

While these are systemic issues needing a system-wide response, change also needs to be driven at a practical level, between commissioning bodies and providers. For example, at a local level integrated care systems and services need to work together to take responsibility for identifying and addressing health inequalities. A key part of this will be improving how data to monitor equalities is captured and used.

We will continue to monitor how these challenges are being addressed, particularly in relation to inequalities.

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