Department
of Health

Equality for all: Mental Health Act 1983: Code of Practice 2015

Equality Analysis

Title:
Equality for all: Mental Health Act 1983: Code of Practice 2015: Equality Analysis

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Equality Analysis

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Target audience:
Executive directors of health and social care provider organisations; service managers, governance leads and executive quality leads in health and social care services; staff working in health and social care services; enforcement and inspection staff; chairs (and members) of local safeguarding adults boards; lecturers and those who deliver professional training and training in positive behaviour support (or equivalent) and the use of restrictive interventions; academic and research staff; people who use services, family members, carers and parents of people receiving services; independent advocates and organisations; police and people working in criminal justice settings; people supporting victims, professional regulatory bodies; Tribunal staff, local authorities; legal representatives; security staff working in health and social care settings; commissioners of health and social care services.

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Equality Analysis

Contents

Executive summary

1.1 This Equality Analysis (EA) accompanies and informs the new 2015 Mental Health Act 1983: Code of Practice ('the Code'). The EA is divided into 11 main chapters, including this executive summary.

1.2 Chapter 2 sets the scope and structure of the EA, and introduces the Equality Act 2010, including the protected characteristics and the three limbs of the Public Sector Equality Duty (PSED).

1.3 Chapter 3 introduces the Mental Health Act 1983 ('the Act') and the purpose of the revisions to update the Code. Of particular importance in doing this was the need to address equality concerns, especially for individuals from black and minority ethnic (BME) backgrounds, those with a learning disability or autism or those who do not speak English or English as a first language, and to ensure that all patients and, as appropriate, family and carers were involved in discussions about care and treatment under the Act. The Code was last updated in 2008 and since then there have been changes in legislation, case law, professional practice and policy that need to be addressed. *Closing the Gap* and *Transforming Care*,[1] and other reports and studies, identified concerns with current inpatient mental healthcare that needed to be addressed. The update of the Code works within the current legislative framework and is concerned with providing additional or clarifying existing guidance in relation to how the Act should be applied in practice.

1.4 Chapter 4 sets out who is affected by the Code, and the relevance of the protected characteristics. In 2013/14 there were over 50,000 detentions.

1.5 Chapter 5 sets out what data has been collected, tested and analysed in developing this EA. This included data and reports from a literature review of publicly available information and anecdotal feedback during the review, in particular the public consultation. Considerable limitations, gaps and constraints were identified in the information available. This has been highlighted as it impacts on the quality of the analysis.

1.6 Chapter 6 sets out the engagement and involvement undertaken in revising the Code. This includes testing both the data provided and the revised policy. The Department of Health (DH) was supported by two active and influential groups: a steering group of professionals including doctors, nurses, social workers, advocacy/support staff, hospital managers and policymakers, and an expert reference group of patients, former patients, carers and an independent mental health advocate (IMHA). The Department of Health also tested the policy and the emerging data during the public consultation, including a dedicated event on equality.

1.7 Chapter 7 analyses the main impacts identified. These are set out by issue so that readers can see what the data indicated and what has been done in the revised Code to address these issues. The main impacts considered are:

- Police powers and places of safety (chapters 16 and 19)
- Rates of detention and community treatment orders (chapters 2, 14, 15, 19, 20 and 29)
- Length of detention (particularly chapters 32 and 38 but also throughout under the least restrictive option and maximising independence guiding principle)

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[1] Department of Health. *Closing the Gap: Priorities for essential change in mental health*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf. Department of Health. Transforming care: A national response to Winterbourne View Hospital. Department of Health Review. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf.

- Location of placement (chapters 14 and 11)
- When to use the Mental Health Act, when to use the Mental Capacity Act 2005 (MCA) and how these work together (chapter 13)
- Use of restrictive interventions (chapters 26 and 24)
- Medication, including over-medication and inappropriate prescribing (chapters 1, 23, 24 and 26)
- Lack of involvement in discussions/choices about care and treatment and not communicating in a way that the person understands, for example in their first language (throughout the Code, including especially the empowerment and involvement guiding principle in chapter 1)
- Poorer health outcomes and lower life expectancy (chapter 24)
- Lack of cultural understanding and ensuring services take account of cultural, ethnic and religious diversity (throughout, and chapters 1, 3, 26 and 34)
- Nearest relative (chapter 5 and throughout)
- Use of blanket restrictive practices, including blanket locked doors (chapter 8)
- Restrictions on the right to a family life (for family and carers, mothers and babies – chapters 8, 11 and 14)
- Use of appropriate washing and sleeping facilities (chapters 8and 19)
- Lack of staff skills, knowledge and understanding (throughout, including chapters 1, 6, 12, 19, 20 and 38)
- Concerns about lack of attention to human rights (chapters 1 and 3)
- Preventing victimisation, bullying, harassment and abuse (chapter 3 especially)
- Specific guidance to prevent unfavourable treatment for people from particular groups, such as BME communities, those with learning disabilities, autism, dementia, or who do not speak English (chapters 3, 14, 20, 22 and 23)
- Case studies and good practice guidance (accompanying resources)

1.8 Chapter 8 considers the impacts identified by the three limbs. Figure 1 indicates how we think the policy as set out in the Code will help to eliminate discrimination, advance equality of opportunity and foster good relations.

1.9 Chapter 9 considers the impact by the protected characteristics. Figure 2 sets out mitigations to address impacts identified. It links this to the respective chapters or sections in the Code or additional actions, which are included in the action plan (chapter 10).

1.10 Chapter 10 is an action plan of further actions we consider are necessary, besides the revisions to the Code, to further mitigate some of the concerns identified, and further discharge the PSED. Actions set out in figure 3, in relation to improving the quality and quantity of data that is collected, monitored, reported and acted on, include ways of promoting equality further, for example through our Accessibility and Awareness project and a commitment to consider potential changes in primary legislation at the next opportunity.

1.11 Finally a collection of appendices, listed by protected characteristic, plus a consideration of carers, lays out the data collected that has formed the basis of this analysis. This includes quantitative data and qualitative data, as well as feedback during the public consultation.

2. Background and context

Scope of Equality Analysis (EA)

2.1 This EA accompanies and informs the revised Mental Health Act 1983: Code of Practice ('the Code') published in Parliament on 13 January 2015 and due to come into force, subject to Parliamentary approval, on 1 April 2015.

2.2 The EA analyses the potential impact of the revised Code on the advancement of equality of opportunity, the fostering of good relationships and the elimination of discrimination, harassment and victimisation that is prohibited under the Equality Act 2010. It is designed to ensure that the Secretary of State for Health (and where appropriate, the Secretary of State for Justice) has proper regard to these aims in accordance with the Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010 (see EA paragraphs 2.11–2.17 below).

2.3 This EA has been informed by feedback we received to our consultation document *Stronger Code: Better Care*,[2] which set out proposed changes to the Code and secondary legislation. It builds on the consultation stage EA[3] that accompanied that consultation document and the Impact Assessment undertaken 2006–2008.[4]

2.4 This EA should be read alongside the revised Code and the Government response document.[5] Also of relevance to the context for this EA is the wider work being undertaken, including changes to the reference guide[6] (equivalent to an explanatory note), the awareness and accessibility project, changes to secondary legislation and development of a new web resource, as part of our proposals to ensure successful implementation (promoting awareness of the new Code, training the relevant professionals and ensuring the changes are complied with and the benefits for patients realised). The contents of this EA will be re-visited and updated as necessary as part of that work.

2.5 This EA supersedes both the initial consultation stage EA, the Race Equality Impact Assessment (REIA) undertaken to support passage of the Mental Health Act 2007, and the Equality Impact Assessment to support preparation of the existing Code published in

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[2] Department of Health. *Mental Health Act 1983: Draft Code of Practice for consultation*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/329778/DoH_Code_of_Practice_accessible.pdf. Department of Health. *Stronger Code: Better Care. Consultation on proposed changes to the Code of Practice: Mental Health Act 1983*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/327653/Doh_Consultation_for_web.pdf.

[3] Department of Health. *Consultation Stage Impact Assessment, section 7 Equality Analysis*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/330710/MHA_CoP_Impact__Equality_Assessment.pdf.

[4] Department of Health. *Mental Health Bill 2006 – Race Equality Impact Assessment*. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062695. Department of Health. *Code of Practice: Mental Health Act 1983 – Equality Impact Assessment*. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597.

[5] Department of Health. *Mental Health Act 1983: Code of Practice. 2015*. www.gov.uk/government/publications/code-of-practice-mental-health-act-1983. Department of Health. Stronger Code: Better Care. Government response to the consultation on the Mental Health Act 1983 Code of Practice. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[6] Department of Health. *Reference Guide to the Mental Health Act 1983*. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088163.pdf. Department of Health. *Reference Guide to the Mental Health Act 1983*. 2015. www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983.

2008.[7] The evidence indicates that, while many issues identified by this 2008 analysis were addressed, more actions can be taken to further eliminate discrimination, advance equality of opportunity and foster good relations in discharging the Public Sector Equality Duty (PSED) in section 149 of the Equality Act 2010.

Structure of EA

2.6 The EA starts by setting out the background and context as to why it was considered necessary and desirable to update the Code. This includes concerns about equality that we wished to address.

2.7 The EA then sets out the evidence considered, and the stakeholders engaged with in both collecting and testing data and testing policy proposals.

2.8 The EA then summarises the main identified issues relating to equality, setting out how these have been addressed in the Code or by other means or, alternatively, it explains where this has not been done and why, for example because it would require a change to the primary legislation which is beyond the scope of the project to review and revise the Code. Figure 2 and the appendices summarise the impacts and mitigations by the protected characteristics in the Equality Act 2010. Carers have also been considered.

2.9 The analysis then includes a summary of the changes in relation to the three limbs in the PSED (figure 1).

2.10 An action plan (figure 3) outlines further action that we are taking to support the work already done in the Code, to address and mitigate equality impacts.

Public Sector Equality Duty (PSED)

2.11 As a ‘public authority’ for the purposes of Schedule 19 to the Equality Act 2010, the Secretary of State for Health (SofS) has a duty under the Equality Act 2010 to have due regard to the following matters in the exercise of the Secretary of State’s functions:

- the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act;
- the need to advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- the need to foster good relations between people who share a protected characteristic and people who do not share it.

2.12 The protected characteristics for the purposes of the PSED are: (i) age; (ii) disability; (iii) gender reassignment; (iv) marriage and civil partnership; (v) pregnancy and maternity; (vi) race; (vii) religion or belief; (viii) sex; and (ix) sexual orientation. The duty only applies to marriage and civil partnership as regards the first aim of the need to eliminate unlawful discrimination.

2.13 Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

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[7] Department of Health. *Mental Health Bill 2006 – Race Equality Impact Assessment*. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062695. Department of Health. *Code of Practice: Mental Health Act 1983 – Equality Impact Assessment*. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597.

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and
- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

2.14 The steps involved in meeting the needs of disabled people that are different from the needs of people who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

2.15 Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to: tackle prejudice, and promote understanding.

2.16 Compliance with the duties may involve treating some persons more favourably than others (though this is not to be taken as permitting conduct that would otherwise be prohibited under the Act).

2.17 This EA shows the steps that have been taken to assess the impact of the Code for the purposes of the PSED, and where relevant how this has influenced the content of the Code.

3. Purpose: intended outcomes of the new Code

3.1 People with mental health problems can be particularly vulnerable to abuse of their human rights and discrimination in the allocation of resources, service provision and professional practice. People with mental health problems who have one or more protected characteristics under the Equality Act 2010 may experience direct or indirect discrimination in the way that services are provided to them, or the benefits they receive from services. This is particularly true for patients subject to the Mental Health Act 1983 ('the Act')[8] who have been detained for treatment in hospital or who are in the community. One of the major objectives of the revisions to the Code is to advance equality of opportunity and eliminate discrimination, harassment and victimisation.

3.2 The Code provides guidance to professionals on how to undertake their roles and responsibilities under the Act, to ensure that patients receive high-quality and safe care. It gives guidance to patients, their families and carers on their rights under the Act.

3.3 The Code was last published in 2008. Since 2008, there have been changes in primary and secondary legislation, policy, case law and professional practice that need to be reflected in the Code. This updated Code and its accompanying reference guide ensure that they are up to date, fit for purpose and continue to make real differences to the care and treatment of patients suffering from severe mental disorder. The updated Code and the reference guide will work together better so that professionals and others can more clearly see the related guidance.

3.4 **In particular, the revised Code aims to:**

- ensure patients, and their carers, are involved in discussions about their care and treatment;
- focus on personalised care and minimise the use of inappropriate blanket restrictions;
- support the delivery of a number of actions in *Closing the Gap: Priorities for essential change in mental health*[9] (2014), including particularly to:
  - promote high-quality services focused on recovery;
  - radically reduce the use of all restrictive interventions and take action to end the use of high-risk restraint, including face-down restraint;
  - ensure carers are better supported and more closely involved in decisions;
  - ensure mental healthcare and physical healthcare are better integrated;
  - eliminate discrimination and stigma around mental health;
- embed policy developments in the areas of use of restraint and seclusion, use of sections 135 and 136 by the police, independent mental health advocates (IMHAs), and the use of community treatment orders (CTOs);
- clarify the interaction between the Act and the Mental Capacity Act 2005 (MCA), particularly the Deprivation of Liberty Safeguards (DoLS);

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[8] Mental Health Act 1983. www.legislation.gov.uk/ukpga/1983/20/contents.

[9] Department of Health. *Closing the Gap: Priorities for essential change in mental health*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf.

- reflect changes resulting from the Health and Social Care Acts 2008 and 2012, and the Care Act 2014;[10]
- address relevant recommendations from the annual reports of the Care Quality Commission (CQC) about the use of the Act, for example about blanket restrictions;[11]
- consider issues raised by the Health Select Committee report on the post-legislative scrutiny of the Mental Health Act 2007, Her Majesty's Inspectorate of Constabulary/CQC report on the use of section 136, and the recent Home Office/Department of Health section 135 and 136 review;[12] and
- tackle relevant issues arising from the serious case review into Winterbourne View and subsequent investigations and reports by the CQC.[13]

3.5 Of particular importance to this analysis are the objectives to advance equality of opportunity and eliminate discrimination. This reflects the feedback received from individuals, groups and representative organisations who perceive that the Act has disproportionate impacts on some groups (e.g. BME groups, people with a learning disability, individuals with autism and/or behaviour people may consider challenging, people who do not speak English or English as a first language). In particular, concerns have been raised in relation to higher levels of detention in some groups with a protected characteristic than would be expected compared with the general population, with longer periods of detention after use of police powers and disproportionate impacts on overall health outcomes, such as being more likely to be subject to restraint, seclusion or segregation while in hospital, poorer health outcomes and lower life expectancy. A key objective of the work to update the Code was to address these concerns.

3.6 Much data is anecdotal, with data on some of the protected characteristics being particularly weak, both in terms of quantity and quality. A primary objective of the Department of Health is to improve the data foundation and to better understand the potential drivers for some of these impacts, including where potential drivers and characteristics may interact where inter-sectionality occurs. Additions or amendments to guidance in the Code have been included where appropriate to address these and other concerns.

Scope of the programme

3.7 The programme to update the Code did not intend to and was not able to address all the issues related to equality or discrimination within the wider mental health system. This analysis focuses on those issues which relate to how the Act is applied in practice and that we were able to consider as part of the project on updating the Code that applies in England.

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[10] Health and Social Care Act 2008. www.legislation.gov.uk/ukpga/2008/14/contents. Health and Social Care Act 2012. www.legislation.gov.uk/ukpga/2012/7/contents/enacted. Care Act 2014. www.legislation.gov.uk/ukpga/2014/23/contents/enacted.

[11] Care Quality Commission. Annual reports. www.cqc.org.uk/taxonomy/term/49.

[12] House of Commons Health Committee. *Post-legislative scrutiny of the Mental Health Act 2007. First Report of Session 2013–14*. 2013. www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf. Her Majesty's Inspectorate of Constabulary/Care Quality Commission. *A Criminal Use of Police Cells?* 2013. www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf. Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983*. 2014. www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act.

[13] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review*. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse.

3.8 For example, some of the concerns raised related to the provisions in the Act itself rather than how the Act was being applied in practice. Other concerns related to other parts of the health and care system, including lack of preventative and integrative services, cultural bias or lack of understanding. These issues could result in people being more likely to present for diagnosis later, when their symptoms are more acute and fewer treatment options are available. While the Department of Health has considered these wider impacts, and where appropriate offered guidance in the Code or an action to address these, some of these are outside the scope of the current project and revisions. The Code is only able to offer guidance for people in relation to the Act. Where these issues relate to the Act we have commented on these and recommended that they should be considered as part of any review of the Act.

4. Who is affected

4.1 The Act only affects those patients receiving assessment, care and treatment under the provisions of the Act, plus people supporting them or carrying out duties, roles and responsibilities under it. This includes families, carers, advocates and professionals. People with mental health conditions more broadly are not covered by the legislation. People with other disabilities or physical health conditions are only covered for their treatment for their mental health condition under the Act. In this EA, as in the Code, people subject to the Act are referred to as 'patients'.

4.2 **In 2013/14 there were 53,176 detentions under the Act, an increase of 5% (2,768) since 2012/13:**[14]

Detention:	**Total**
On admission	34,806
Subsequent to admission	14,087
Following use of section 136	2,882
Following revocation of a CTO	1,401
In addition, in 2013/14 there were 4,434 new CTOs and 287 new uses of guardianship.	

4.3 The Act covers England and Wales, but this Code relates to the application of the Act in England only. There is a separate Code of Practice for Wales.[15] This Code does cover Welsh patients treated in England, and gives guidance about the Mental Health (Wales) Measure 2010 as it applies to English patients treated in Wales and Welsh patients treated in England. Some mental health hospitals provide specialist services that are not available in other parts of the United Kingdom, for example due to the small number of patients who require a particular treatment or specialist type of care. Patients from Scotland, Northern Ireland, the Channel Islands and Isle of Man may be transferred to England to be detained under the Act (e.g. where suitable provision is not available in their own countries) and the Code will therefore also apply to these patients.

4.4 As previously set out, there are nine protected characteristics under the Equality Act 2010: age, disability, gender reassignment, marriage and civil partnership,[16] pregnancy and maternity, race, religion or belief, sex, and sexual orientation. It is also important to consider the interplay between different characteristics. In addition, we sought evidence in relation to carers, homelessness, socio-economic group and geographic location, to determine any differential impacts experienced.

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[14] Health and Social Care Information Centre (HSCIC). *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England 2013/14.* 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. Esp. pp.6, 16–17, 24–32. Please note: These figures refer to 'long-term hospital orders' which last longer than 72 hours. It excludes the users of 'short-term orders' under sections 4, 5(2), 5(4), 135 or 136 or patients subject to guardianship. On 31 March 2014 23,431 people were subject to the Act (18,166 on long-term hospital orders and 5,365 were being treated on CTOs). At the end of 2013/14, 5,365 people were reported to be subject to a CTO but this was smaller than the total calculated as being in place.

[15] Welsh Assembly Government. *Mental Health Act 1983: Code of Practice for Wales*. 2008. www.wales.nhs.uk/sites3/documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf. This Code is currently being reviewed and a revised Code for Wales is due to be published later in 2015.

[16] Marriage and civil partnership is only relevant to the first limb on eliminating discrimination.

4.5 The Code is the key source of guidance for professionals in respect of the use of the Act. It is helpful to individuals subject to the Act (e.g. those detained for assessment or treatment, on a CTO or subject to guardianship) or who are otherwise being treated for mental disorder (e.g. informal patients) and their families/carers, as it explains how the Act should be applied. We know that approved mental health professionals (AMHPs), independent mental health advocates (IMHAs), responsible clinicians, hospital managers and other health and social care professionals consult it on a daily basis to inform their exercise of powers and duties under the Act and clinical practice. The Code is the key document that professionals use to ensure patients' rights are protected and that their practice is consistent with the law.

4.6 The Code is statutory guidance, made under section 118 of the Act, for registered medical practitioners, approved clinicians, managers and staff of hospitals and care homes, AMHPs in relation to the admission of patients under the Act, and to other registered medical practitioners in relation to the medical treatment of patients suffering from mental disorder. As a matter of law, the Code must be followed by those for whom it is statutory guidance, unless there are cogent reasons for not doing so (*R (Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58).[17] If such professionals' use of the Act is legally challenged, the guidance given in the Code will be relevant in determining the challenge. It is also statutory guidance to local authorities under section 7 of the Local Authority Social Services Act 1970. The guidance may also be useful to others, such as the police and ambulance staff, who need to ensure that the Act is used appropriately.

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[17] Regina v Ashworth Hospital Authority (now Mersey Care NHS Trust) (Appellants) *ex parte* Munjaz (FC) (Respondent). 2005. UKHL 58. www.bailii.org/uk/cases/UKHL/2005/58.html.

5. Evidence

What data has been considered

5.1 We have considered primary data, secondary reports and surveys, and gathered our own primary data, including particularly the views of patients, former patients, families and carers and professionals. This has taken place over a sustained period from November 2013 to December 2014, in particular during the formal consultation from July to September 2014.[18] We have referenced publicly available data but have not referenced specific individual consultation comments or other verbal, written and anecdotal feedback provided during the review and update of the Code.

5.2 In preparing the Code we have:

- requested evidence from professionals, providers, commissioners and other stakeholders;
- consulted CQC and utilised the evidence in their annual reports on the use of the Act, consulted data by the Health and Social Care Information Centre (HSCIC) such as the Mental Health and Learning Disabilities Data Set (MHLDDS) and Hospital Episode Statistics (HES), the recent *Learning Disabilities Census* and other publications such as *The Right to Be Heard* and the AMEND study[19] that have considered the operation of parts of the Act;
- held pre-consultation engagement events with professionals and practitioners;
- established an expert reference group of patients and carers with recent or current experience of detention under the Act;
- commissioned the University of Birmingham to work with the Department of Health to undertake a literature and data review of the impact of the Act in relation to both equality and human rights. This identified issues related to all the protected characteristics, especially age, disability, sex, religion or belief and race, and in particular the interplay of characteristics;
- sought views from specific stakeholders via our steering group and experts by experience, professionals and representative bodies, including the Mental Health Alliance; and
- publicly consulted on the proposed changes to the Code.

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[18] Department of Health. *Mental Health Act 1983: Draft Code of Practice for consultation*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/329778/DoH_Code_of_Practice_accessible.pdf. Department of Health. *Stronger Code: Better Care. Consultation on proposed changes to the Code of Practice: Mental Health Act 1983*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/327653/Doh_Consultation_for_web.pdf.

[19] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213. HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September 2013*. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf. Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D. et al. *The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England. Research Report*. Preston: UCLan. 2012. www.uclan.ac.uk/research/explore/projects/the_right_to_be_heard.php. For a consideration of the AMEND study (please note the study is not published), see Singh, S.P., Burns, T., Tyrer, P., Islam, Z., Parsons, H., Crawford, M.J. et al. Ethnicity as a predictor of detention under the Mental Health Act. Psychological Medicine (2014), 44(5). pp.997–1,004. http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9184145&fileId=S003329171300086X.

Consultation

5.3 We asked questions in the consultation document to explore the equality impact of the changes proposed in the revised Code, including the new dedicated chapter on human rights (chapter 3: Human rights, equality and health inequalities), and whether equality and human rights are adequately protected, and if not, what changes could be made. We also asked whether the Code provides sufficient information in relation to individuals where additional safeguards or considerations may be required, for example due to age or disability. We produced an easy read version of the consultation document, response document and summary material, and alternative formats on request to enable patients to respond.

5.4 We received 344 written responses to the consultation, of which 100 commented on equality. The responses to the public consultation were independently analysed and key themes and issues highlighted. The overarching themes were shared with our steering group and expert reference group who provided further comments/insights.

5.5 As part of the consultation we held a dedicated consultation event on equality (31 July 2014), and a range of events targeting people with particular characteristics (e.g. children and young people under 18, deaf patients, female patients, patients with a learning disability, and carers). This included holding open consultation events, dedicated events in community settings and events on inpatient wards (see EA paragraph 5.7 below). One event was organised jointly with Black Mental Health UK and focused on the views and experiences of the black African-Caribbean community. They gave feedback of their negative experiences in relation to the operation of the Act in practice.

5.6 These events were crucial in getting the views of the widest range of patients possible, including those currently detained, those who have no or limited access to the internet, or who are unable to read and write. This emphasised that feedback was not being routinely gathered from all patients, and underlined the need for all patients' views to be routinely sought and recorded and, where that is not possible, for the views of IMHAs and advocates, families and carers to be sought and recorded. The Department of Health gained valuable insights into how to engage with patients, former patients and their representatives and seek their views, and this consultation process itself advanced equality of opportunity and fostered good relations between groups. We gained knowledge about the gaps in information streams and sources; these gaps are discussed later in this EA and addressed as recommendations in the action plan at the end of this EA (figure 3).

5.7 **Code of Practice consultation and engagement events:**

Date	Event	Location
7 July	Regional public consultation event	Leeds
16 July	Regional public consultation event	Birmingham
22 July	Service users and carers consultation event	Leeds
25 July	College of Social Work event	London
28 July	Regional public consultation event	Taunton
30 July	Service users and carers consultation event	London
30 July	CQC's Service User Reference Panel	London

Date	Event	Location
31 July	Equality public consultation event	London
5 August AM	Regional public consultation event	London
5 August PM	Regional public consultation event	London
12 August	Inpatient event	Calderstones Partnership NHS Foundation Trust
August	*Community Care* magazine podcast	Online
26 August	Inpatient event	East London NHS Foundation Trust
28 August	Regional public consultation event	London
29 August	Inpatient event	St Andrew's Healthcare, Northampton
3 September	Inpatient event	West London Mental Health NHS Trust, Broadmoor Hospital
3 September	Royal College of Psychiatrists event	London
4 September	Justice and probation stakeholders event	London and Leeds
5 September	Inpatient event	Partnerships in Care, Manchester
5 September	Inpatient event	Mersey Care NHS Trust, Ashworth Hospital
8 September	Standing Commission on Carers event	London
12 September	4 inpatient events and 1 professionals event	Nottinghamshire Healthcare NHS Trust, Rampton Hospital
13 September	Carers consultation event	Nottinghamshire Healthcare NHS Trust, Wathwood Hospital, Rotherham
17 September	Community consultation event with Black Mental Health UK	London
20 September	Carers consultation event	Nottinghamshire Healthcare NHS Trust, Rampton Hospital
22 September	Webchat	WeNurses online
7 October	Children and young people inpatient event	South London and Maudsley NHS Foundation Trust

5.8 Alongside the consultation document, we published an initial EA in an attempt to quantify the impact of the changes proposed in the Code in order to advance equality of opportunity and eliminate discrimination, including minimising any potential disadvantages for people with protected characteristics.

Responses to the public consultation

5.9 The responses to the consultation were independently analysed for the Department of Health by the Evidence Centre, to ensure that the analysis was independent and objective.[20] There was mixed feedback from consultation responses over whether the Code adequately protected and promoted equality and human rights. Of the 100 responses on equality, 58 responses to the consultation (17% of the total received) explicitly commented about whether the proposed Code adequately addressed and protected equalities and human rights issues. Of these responses, 46% stated that the Code was adequate in this regard and 54% did not think this was the case. Responses from patients and carers were more likely than those from individual health and social care professionals and managers or organisational responses to state that there was room for improvement.

5.10 Of the 100 responses on equality, 63 responses (18% of the total received) made specific comments with regards to how the Code could be strengthened to further protect equalities and human rights. The main suggestions can be grouped as follows:

- providing information for patients and appropriate staff training (11 comments – some repeated from the same respondents);
- providing services and support for specific groups (69 comments – these numbers do not synchronise as some people provided more than one suggestion/comment on an area or in relation to different ‘specific groups’);
- providing more/better examples of good practice (5 comments – some repeated from the same respondents);
- monitoring and complaints (13 comments – some repeated from the same respondents); and
- linking the Code to other related guidance and material (22 comments – some repeated from the same respondents).

5.11 There were few comments received in relation to the impacts of the Code regarding: gender reassignment, sexual orientation, marriage and civil partnership, pregnancy and maternity, religion or belief, socio-economic group, geographic location, carers or homelessness.

5.12 The level of comments may reflect the lack of trust that was conveyed by several stakeholders. Some expressed the concern that nothing changes after consultation and that continuing to say the same things is wasting their time and raising expectations. Some stakeholder organisations stated that the communities that they represent expressed discomfort at responding to a formal consultation. However, our experience was that, although individuals may not respond formally (linked to their lack of trust in the outcomes), when the Department engaged them in community settings, or in an environment familiar to them, they were confident enough to attend, engage and be forthcoming with comments and suggestions. Some offered positive comments about their individual experience. Others pointed to the disempowering and distressing nature of detention under the Act, which reduces the effectiveness of being made subject to the Act. When approached directly for comments, two organisations (one dealing mainly with ethnicity issues and the other with issues around transgender and sexual orientation) said that the reason for not engaging more

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[20] The Evidence Centre. Equality Feedback Report: Feedback about equalities and human rights issues from the consultation about revising the Mental Health Act (1983) Code of Practice. 2014. Unpublished. Please note: This document was commissioned to aid analysis of the consultation responses and development of this EA (hereafter called ‘Equality Feedback Report’).

fully with the consultation was that they were experiencing consultation overload and it was not always clear what they should be prioritising. There could also be impacts from detention that reduced patients' response to the consultation; the inpatient events held could only partly mitigate this.

Literature review

5.13 A literature review of publicly available data, reports, studies and reviews was undertaken by the University of Birmingham on behalf of the Department of Health.[21] Department staff also directly considered reports and studies. This review reflected the data that is available for specific protected characteristics and did not, in any way, imply that the other protected characteristics were less important. The majority of papers reviewed specifically related to England and Wales, with the remainder either relevant to a global context[22] or groups where the literature appeared sparse (e.g. in relation to people with learning disabilities subject to compulsion[23]) or where interesting conceptual points were being made.[24] The majority of papers related to empirical studies and nearly half explicitly considered ethnicity.

5.14 This review only partly offset the gaps in the primary data collection and responses heard during the consultation and anecdotally throughout the review, for example no papers in relation to sexual orientation or religion and faith were identified. This points to a significant gap in knowledge. While this reflects the interests of researchers, it also highlights how the Act is being monitored in terms of the requirements of equality legislation.

Data limitations, gaps and constraints

5.15 There remain concerns with the amount and robustness of available data, especially numerical data. All the data sources have some limitations:

- None of the data sources covers all the protected characteristics. The greatest information relates to age, sex and race or belief. Data on learning disability is stronger than that on other disabilities, although the lessons can be used more widely. This level of data collection should be considered good practice for other characteristics.
- Much data is about mental health more generally rather than specifically about the Act, although this can help with seeing some generic trends.
- The quality of the data is affected by missing data (for some providers or characteristics or practice, e.g. lack of data on use of restraint) or the limitations of what it contains (e.g. some disabilities are not specifically listed so that the impact may be different for people with a particular condition or disability).

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[21] Newbigging, K. Human Rights and Equality and the revised Code of Practice: Rapid appraisal of the evidence. University of Birmingham. 2014. Unpublished. Please note: This report was commissioned to aid the development of this EA (hereafter called 'Literature Review').

[22] See: Wildeman, S. Protecting rights and building capacities: challenges to global mental health policy in light of the Convention on the Rights of Persons with Disabilities. *The Journal of Law, Medicine and Ethics* (2013), 41(1). pp.48–73.

[23] For example: Evans, E. Service development for intellectual disability mental health: a human rights approach. *Journal of Intellectual Disability Research* (2012), 56(1). pp.1,098–1,109.

[24] See: Pelto-Piri, V., Engström, K. and Engström, I. Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care. *BMC Medical Ethics* (2013), 14(1). p.49. Wildeman, S. Protecting rights and building capacities: challenges to global mental health policy in light of the Convention on the Rights of Persons with Disabilities. *The Journal of Law, Medicine and Ethics* (2013), 41(1). pp.48–73.

- Some protected characteristics only affect a very small number of people, for example transgender people. Disclosure of data by providers in respect of patients with these characteristics, even if anonymised, could have raised Data Protection Act 1998 confidentiality and privacy issues.
- Much data is qualitative, anecdotal or based on stories or experiences from individuals or a small number of cases. This raises a number of concerns, for example some of the stories conflict, it has proven difficult to determine how widespread the experiences are, it has proven difficult to identify the specific drivers or causes (especially where there are competing considerations due to different protected characteristics being relevant) and/or it has proven difficult to differentiate perception from reality.
- Under-representation of certain groups among those detained under the Act could be as much of an issue as over-representation. This may be caused by a stigma about mental health and could lead to conditions being undiagnosed and/or not effectively treated.
- In some organisations, there seems to be a lack of understanding of the requirements of the Equality Act and reporting is inaccurate, incomplete or not undertaken.
- It has been difficult to get 'quality of care' data about patient and carer experiences on either an individual or a group basis. The costs of doing this at scale, or in order to achieve a representative sample, are prohibitive. Reports and studies have generally relied on anecdotal feedback from a small number of respondents. Likewise, we estimate that during the consultation we directly spoke with over 1,000 people, including patients, former patients, carers and professionals. While important, these views only represent a small number of the total detentions, or numbers of people affected by the Act in other ways (e.g. as a member of staff or a family member or carer of someone subject to it).
- Stakeholders, including during the consultation, struggled to differentiate between evidence related to the Act and other health and social care or public services, and in particular issues that were relevant to the scope of the project and could be addressed in the Code. This meant that some very valuable comments could not be addressed via this project, although relevant colleagues were advised if comments related to other work being undertaken, for example the review of sections 135 and 136.
- It was difficult to identify major common themes, issues or impacts to be mitigated due to the relatively low number of responses in relation to equality, and that some points were by single consultees of very individual experiences.

5.16 CQC reports have consistently noted that the gender and ethnicity of people subject to the Act is not being monitored. This suggests that other characteristics are not being considered for routine monitoring by NHS providers, for example in relation to sexual orientation or religion and belief, although these may be looked at during CQC visits.[25] The way in which these protected characteristics intersect in the context of the Act is also poorly understood.

5.17 Significantly, CQC noted that many service providers did not collect data that would have permitted it to monitor equality and anti-discriminatory compliance.[26] This has, consequently, limited the impact of strategies designed to reduce inequality, eliminate discrimination and advance the equality of opportunity.

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[25] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213. Literature Review, esp. p.9.

[26] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213.

5.18 The data that allows us to map trends over a number of years shows changing patterns and trends. It is therefore crucial that the data is periodically reviewed to ensure that the impacts are correctly identified and addressed. For example, it was commented that while there was a current concern about the high number of detentions for African-Caribbean people, it is unclear whether race is a determining factor or whether other cross-cultural and cross-racial factors, including but not limited to age profile, personal experiences or other such factors, are relevant. With the migration of people from post-conflict states in the Middle East and North Africa, it may be that we see new trends in relation to ethnic groups. It was important to ensure that the Code revisions addressed a range of factors, especially when the reasons for current trends were complex or not clear.

5.19 It is important that data is routinely collected to correctly identify and address the impacts and that any guidance is future-proofed as far as possible and not overly prescriptive so as to avoid inadvertently excluding people.

6. Engagement and involvement

6.1 A key focus of the work in updating the Code has been engagement with patients, former patients, carers and professionals. We were particularly keen to hear the views of patients (including those currently detained) due to the difficulties we know they have in giving input, especially to a formal consultation process. We held engagement events in community settings and in hospitals to get as wide a number of views as possible. While the numbers of people we directly met with or responded to in writing are still small in relation to all those detained under the Act, we think that this engagement was particularly valuable and insightful. It raised a number of significant impacts that had not been identified in other ways. Given the resources and time available, we prioritised key characteristics (age, sex, race and disability including learning disability, personality disorder and deafness) and ensured that we got feedback from individuals who had these characteristics.

6.2 **Engagement activity included:**

- September 2013 onwards – monthly steering group including a range of professional groups, providers, commissioners, local authorities and support and advocacy organisations;
- September–October 2013 – recruitment of patients and carers to be part of expert reference group, with a national appeal for representatives to be on the group; nine patients/former patients and six carers were selected from over 60 applications;
- October–November 2014 – call for evidence, with a range of individuals and organisations suggesting changes to the Act;
- 4 November and 3 December 2013 – pre-consultation engagement events with professionals involved over 60 professionals from across health and social care sectors, including AMHPs, responsible clinicians, section 12 doctors, Mental Health Act commissioners, service commissioners, providers and legal and academic specialists;
- November 2013 onwards – six meetings of expert reference group of patients and carers, including meeting directly with the Minister for Care and Support;
- attendance at briefing and engagement meetings with a range of stakeholders, including Mental Health Alliance, CQC Patient Reference Panel and College of Social Work AMHP network;
- exchanges (by email, by telephone and in person) with a range of stakeholders on the whole Code or specific chapters; and
- public consultation July-September 2014, including the event on 31 July 2014 dedicated to consideration of equality.

How have stakeholders been involved in gathering or testing available evidence?

6.3 We have engaged a range of stakeholders in gathering and testing the evidence, including:

- commissioning the University of Birmingham to work with the Department of Health to undertake a literature review and analysis of publicly available data, for example in the NMHMDS and CQC's annual reports into the use of the Act;

- employing Inclusion North CIC, a not-for-profit organisation that supports inclusion, to lead a partnership of former patients, carers and support and advocacy organisations, to consider levels of awareness of the Code and to review existing materials on the Act and Code that are made available to patients and their families and carers, in order to identify gaps and areas for improvement and to develop an action plan to increase awareness and understanding of the Code and safeguards under the Act;
- seeking views from patients, recent patients, their carers and families on their experiences of the Act, in particular via our expert reference group, which has met on seven occasions, and by employing a carer and recent patient to comment on the proposed changes to the Code; the expert reference group have considered the EA and provided feedback on the main themes;
- seeking views and evidence from professionals working in health and social care and support and advocacy organisations; our steering group has considered the EA and given feedback on the data collected, the gaps, limitations and concerns; members included a range of health and social care professionals (psychiatrists, hospital managers, social workers, nurses, advocates) and academics specialising in the area of equality, including in relation to the Act; and
- we tested the findings of our initial EA and invited open comment via the consultation, including at a dedicated public consultation event on 31 July 2014.

How have stakeholders been involved in testing the policy or programme proposals?

6.4 We have actively collaborated with a range of stakeholders, including professionals, patients and carers contributing to and leading on the drafting and development of policy in key areas of the Code.

6.5 We convened an active expert reference group consisting of individuals currently detained, recently detained or carers of individuals currently or recently detained and an independent mental health advocate (IMHA). We held a monthly steering group, which also provided detailed comments by email, of professionals from across the health and social care system, including a range of specialist professionals, providers, commissioners, local authorities, and support and advocacy organisations. The steering group included professionals with expert knowledge in, and experience of, the Act as it applied to children and young people and the Act's interface with the Mental Capacity Act 2005.

6.6 Some chapters were drafted collaboratively with experts by experience or professionals, or with a high level of input or oversight from experts by experience or professionals, for example the guiding principles in chapter 1, and chapters 37 and 38 on hospital managers.

6.7 Individual policy and chapter leads took forward specific engagement and testing with relevant stakeholders. This included individuals and organisations with experience of how the Act applied to children and young people, individuals with legal expertise including counsel, section 12 approved doctors,[27] and professionals in the criminal justice system and police who exercise holding powers and operate places of safety under the Act.

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[27] A doctor who has been approved under the Act by the Secretary of State for Health as having special experience in the diagnosis or treatment of mental disorder, or by a body which the Secretary of State has authorised to exercise the approval function under the Act, or by Welsh Ministers. Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. (Doctors who are approved clinicians are automatically treated as though they have been approved under section 12.) See Annex A to the Code.

7. Analysis of impacts identified

7.1 The analysis sets out major changes to the Code overall and then considers specific areas where equality impacts were identified.

7.2 This analysis has been difficult, not least because of the paucity of robust data. Where data does exist, upon analysis it is not clear what the explanation is for the differences in detention rates or lengths of stay. That said, the data does not support the conclusion that the Act in itself discriminates against people with a protected characteristic. What the data does show is that sometimes it is how the Act is applied in practice that may disproportionately affect some groups or might directly or indirectly discriminate, or that people perceive it as doing so. It is clear from our analysis, especially the feedback we have received from patients, former patients and their representatives, that perceptions can be as important as reality, not least because they influence how people feel and behave, including patients or people being assessed.

7.3 While acknowledging the limitations with the data collected (both in terms of quantity and quality), and that factors outside the scope of the new Code are also important, the Government is nevertheless confident that the revised Code goes as far as it can to address the concerns that have been raised in relation to advancing equality and fostering good relations, where this is possible, and that it has been future-proofed as much as possible. The Secretary of State is satisfied that the revised Code does not give rise to conditions that could lead to any individual group sharing a protected characteristic or dual/multiple characteristics from being unlawfully discriminated against, or suffering any other conduct prohibited by the Equality Act. A considerable number of recommendations for further and additional actions have been included in this EA to address, insofar as it is possible, specific factors that are outside the scope of the Code review project, but that nevertheless have equality impacts for those subject to the Act.

7.4 The new Code embeds guiding principles that promote equality and human rights and works towards eliminating discrimination, and provides guidance throughout to reduce concerns or promote good practice at specific points. In particular, guidance is included throughout the Code to address concerns and potential concerns in relation to equality issues. The guiding principle on respect and dignity (chapter 1), supported by chapter 3 (Human rights, equality and health inequalities), strengthens the basis of equality and human rights as a central tenet to the delivery of care, support and treatment under the Act. Individual chapters provide more detailed guidance to address particular equality issues and highlight relevant human rights, and give good practice guidance. The 2008 Code already included a number of chapters and sections providing additional and specific guidance in relation to individuals with some of the protected characteristics: children and young people, learning disabilities and/or autistic spectrum conditions and people who are deaf. The 2015 Code strengthens these chapters in a number of ways and addresses some of the concerns and issues raised by stakeholders.

7.5 Throughout the Code the importance of person-centred care and patient involvement in care planning is emphasised. Such an approach should enable services to challenge blanket rules and practices that may be inadvertently discriminatory, and promote a culture of human rights and recovery in hospital environments and in the wider healthcare field.

New chapter: Human rights, equality and health inequalities (chapter 3)

7.6 The Code includes a new chapter called Human rights, equality and health inequalities (chapter 3) to address a range of concerns raised in relation to equality. Additionally, specific guidance is also included where relevant throughout the revised Code. Stakeholders indicated that they would appreciate greater clarity on the applicable legislation. Responses to the consultation generally supported the principles of the new chapter and the increased focus on equality and human rights, while also pointing out further areas where additional information would be advisable. Most respondents were, however, unable to specify what the additional guidance should be or provide examples of good practice.

7.7 This chapter builds on information provided elsewhere in the Code to:

- explain the relevant human rights and equalities legislation, including in relation to reasonable adjustments and health inequalities; and
- include a new requirement that all commissioners and providers must have a human rights and equality policy to monitor compliance with human rights and equality legislation, which must be reviewed at Board level at least annually. The Code sets out the framework for the policy, but it is for commissioners, providers and local authorities at a local level to determine what should be included in the policy and how any specific issues identified should be addressed.

7.8 These additional requirements aim to ensure that all commissioners and providers understand fully what is required of them in relation to equality and human rights legislation, and that Boards are accountable for reviewing implementation and addressing any concerns or issues that may arise. We believe that this will prove a significant driver in advancing equality, eliminating any direct and indirect discrimination that may exist in practice, tackling prejudice and promoting greater understanding of mental illness. In particular, applying a human rights and equality-based approach in the care and treatment commissioned from and provided by health and social care services to people with mental health problems will contribute to greater equality in people's access to treatment and their outcomes.

Specific impacts on equality

7.9 This section sets out impacts that were identified on particular issues and for specific groups or for people with a protected characteristic, and what new guidance is included in the Code to enhance equality and eliminate discrimination through practice. This is not an exhaustive list but represents the major issues identified and our response.

Police powers and places of safety (chapters 16 and 19)

7.10 Data has indicated a large increase in the use of section 136 (an increase of 315% or 12,902 more uses per annum between 2003/04 and 2013/14). In 2013/14, 74% of recorded places of safety (17,008) were in hospital. There were 307 reported uses of section 135 in 2013/14. In 2013/14, 2,882 uses of section 136 resulted in subsequent detention under other provisions of the Act.[28] It has proven difficult to get reliable information by protected characteristic of the use of sections 135 and 136, although it appears that they are more likely

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[28] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14. 2014*. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. pp.33–38. The HSCIC calls these other provisions 'long-term orders'.

to be used on men (59% of the uses of section 136 and 57% of the uses of section 135) and that BME groups, especially black African-Caribbean men, were over-represented.[29] The typical age range of section 136 detentions was reported as being 32–42 years, with some variation between ethnic groups. Black people were generally younger and white people older. Data indicated that people as young as 11 and as old as 90+ had been detained using these powers, with estimates of approximately 250 people under 18 years being detained in police cells.[30] There was little data on gender reassignment, sexual orientation, religion or belief, or pregnancy and maternity.

7.11 Feedback from stakeholders and during the consultation supported the data and literature review, particularly in relation to the increased use of police powers (especially section 136), and concerns were expressed about the majority of these people not then being detained under sections 2 or 3 of the Mental Health Act, although that could be explained by the different requirements for detention. In particular, people from BME communities, especially the black African-Caribbean community, identified concerns about over-use of police powers and the use of police cells as places of safety. There were concerns that there is disproportionate use of section 136 in respect of black and African-Caribbean people, especially young black men. There were also concerns that language and cultural barriers could mean that situations were misinterpreted or behaviours and responses were not understood or unnecessarily escalated, with police powers under section 136 being used too quickly or alternatives to police cells not being considered sufficiently. It reflected perceptions about 'racism' by parts of the system, on the part of people from the groups disproportionately affected. These views were supported both by consultation responses and in our event with the black African-Caribbean community.[31] These concerns were also highlighted in the joint Department of Health and Home Office review of sections 135 and 136.[32]

7.12 Concerns were raised during the consultation (in both events and written responses) about using police cells as a place of safety for children and young people under the age of 18, under any circumstances. This was largely due to the negative impact that these experiences can have on children and young people, due to their development maturity. These concerns were also highlighted in the joint Department of Health and Home Office review of sections 135 and 136.[33] Similar concerns were fed back in relation to people with a learning disability, autism or dementia, who may have difficulties communicating. Comments were also received, in part related to race, about health and care services and the police

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[29] Keown 2013, cited in: Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: A Literature Review*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389254/Literature_Review_S135_and_S136_of_the_Mental_Health_Act_1983.pdf. HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. pp.33–38. Care Quality Commission and National Mental Health Development Unit. *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. 2011. www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf. Literature Review, esp. pp.10–12. Appendix F.

[30] Borschmann, R.D., Gillard, S., Turner, K., Chambers, M and O'Brien, A. Section 136 of the Mental Health Act: a new literature review. *Medicine, Science and the Law* (2010), 50. pp.34–39. Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: A Literature Review*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389254/Literature_Review_S135_and_S136_of_the_Mental_Health_Act_1983.pdf.

[31] Written evidence submitted by Black Mental Health UK [IPCC 23]. 2013. www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/494we06.htm. Equality Feedback Report. Appendix F.

[32] Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf.

[33] Ibid. Equality Feedback Report. Appendix A.

not understanding religion or belief (especially as practised in some minority or immigrant communities in England) and that this misunderstanding may make use of police powers more likely.

7.13 The Code has been revised to reflect these concerns in relation to sections 135 and 136 generally (chapter 16) and children and young people specifically (paragraph 19.104) insofar as it is possible to do so. In relation to race, disability and religion or belief, significant revisions to chapter 16 have been made to promote the reduction in the use of these powers for all people, including those currently disproportionately affected. These revisions also seek to avoid unnecessarily 'criminalising' people subject to section 135 or 136 powers, and to reduce the need to detain people in police cells or, where police cells need to be used, to encourage the earlier involvement of health and care professionals. In relation to children and young people, disadvantages should be reduced as the revised Code makes it clearer that a child or young person should not be taken into police custody as a place of safety unless, having regard to the best interests of the child or young person, there is no suitable alternative.

7.14 Combined, these changes should enhance equality, promote better relations between groups, including people who share a protected characteristic and those who do not share it, and between those with the characteristic and statutory services especially the police, and reduce disproportionate use of sections 135 or 136 for some groups.

7.15 As well as the revisions to the Code, other work is underway to address the concerns raised in relation to police powers and places of safety. These include the recent review of sections 135 and 136, which made a number of legislative and non-legislative recommendations, and the full implementation of the *Mental Health Crisis Care Concordat* across England.[34] The implementation of the Concordat, and further initiatives proposed by the review of sections 135 and 136, should lead to improvements in the operation of section 136 and increase collaborative working that reduces the need for the use of such powers. This should further promote equality. Ending the use of police cells for under-18s would require a change in primary legislation.

Rates of detention and community treatment orders (chapters 2, 14, 15, 19, 20 and 29)

7.16 Evidence indicates that some people with certain characteristics are more likely to be detained or put on a community treatment order (CTO) relative to their corresponding proportions in the population. These characteristics include age, sex (especially for part 3 patients) and race (see appendices A, F and H), with black African-Caribbean men being particularly over-represented. In 2013/14, 10% of all detentions were from people in the black or black British categories. The largest single group is the white ethnic group (72%).[35] The data does not indicate reasons for these higher detention rates, and many suggestions have been made including lack of cultural awareness, 'racism' or other prejudice, poor clinical judgment, and stigma in communities so that people present later or when more unwell.

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[34] Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf. Department of Health. *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf.

[35] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. esp. p.23.

The relevant appendices include information on some of the hypotheses that have been put forward.[36]

7.17 Data does not appear to support that decisions to detain individuals with a learning disability under the Act are made disproportionately to their percentage in the population (0.2% of people with a learning disability are detained in relation to 0.3% in the general population).[37] This does not include individuals with a learning disability who may be otherwise detained, for example, under the Deprivation of Liberty Safeguards.[38] In 2013/14, 8% of patients (1,405) detained in hospital under part 2 of the Act had a 'learning disability' cited as the primary reason, while the *Learning Disabilities Census* showed that, of 3,250 patients in England in hospital, 78% (2,528) were subject to the Act. This indicates that about half of the patients with a learning disability that are subject to the Act are subject for reasons other than their learning disability (e.g. part 3 admission or admission for reasons other than under learning disability qualification).[39] It was felt by some stakeholders that people with a learning disability were subject to a lower test for admission and that some professionals were not stringently applying the learning disability qualification, making poor clinical decisions in relation to whether someone is being 'seriously irresponsible' or 'abnormally aggressive'.[40]

7.18 It is considered that the requirement for three different professionals to be involved in any decision to admit someone under part 2 of the Act is a strong and rigorous test that provides sufficient safeguards. The Act itself does not appear discriminatory in this regard; in addition any changes to the Act itself would require primary legislation and are outside the scope of the new Code project. Additional guidance is included to encourage professionals to take into account the least restrictive option and the maximising independence guiding principle to ensure that alternatives to detention are considered. Guidance is also included to ensure that staff have sufficient skills, knowledge and understanding or can acquire it, including in relation to the specific needs of people from certain backgrounds or with certain religious beliefs when making a decision to detain someone or not.

7.19 In addition, guidance in relation to the learning disability qualification has been clarified (chapters 2 and 20) to ensure that clinicians are making appropriate decisions for individuals with a learning disability. We consider that this should significantly reduce any potential discrimination for this group.

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[36] Appendices A, F and H. For a consideration of the AMEND study (please note the study is not published), see Singh, S.P., Burns, T., Tyrer, P., Islam, Z., Parsons, H., Crawford, M.J. et al. Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine* (2014), 44(5). pp.997–1,004.

[37] Care Quality Commission. *Annex A: Review of the Mental Health Act 1983 Code of Practice. Consultation response from CQC*. 2014. www.cqc.org.uk/sites/default/files/20140911_mental_health_act_code_of_practice_detailed_consultation_return_1.pdf. p.23. HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September 2013*. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf
Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213.

[38] Care Quality Commission and National Mental Health Development Unit. *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. 2011. www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf. HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September* 2013. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf. Transforming Care and Commissioning Steering Group. *Winterbourne View – Time for Change: Transforming the commissioning of services for people with learning disabilities and/or autism*. 2014. www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf.

[39] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. Esp. p.15. HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September 2013*. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf.

[40] Mental Health Act 1983. www.legislation.gov.uk/ukpga/1983/20/contents. Appendix B.

7.20 It may be that further action is needed in practice, rather than additional guidance in the Code, to assist in this area. To accurately determine this, more analysis and research is needed to ascertain the drivers for disproportionate rates of detention, but if the Act and Code are properly being followed, then they would not give rise to discrimination and should not prejudice particular groups.

Length of detention (particularly chapters 32 and 38 but also throughout under the least restrictive option and maximising independence guiding principle)

7.21 Accurate data regarding length of detention is thin, although the recent *Learning Disabilities Census* provides valuable information in relation to individuals with a learning disability.[41] Anecdotal evidence from stakeholders indicates a perceived disparity between length of detention by certain characteristics (race, age and disability, e.g. learning disability or deafness which requires specialist placements). More widely, concerns were raised about the lack of safeguards in relation to review and discharge, including the prominence of the responsible clinician and the lack of transparency and scrutiny of their decisions, and the lack of effective involvement of patients and their carers in hospital managers' panels and Tribunals. It was felt that this has the potential to lead to discrimination, especially in relation to individuals who lacked capacity to make particular decisions or had difficulty communicating, for example due to dementia, learning disabilities, autism, sensory impairment, race (e.g. individuals for whom English was not the first language) and age (e.g. children or older people). In some cases, there is evidence of the Act and Code not being complied with at all and review not taking place, for example at Winterbourne View.[42]

7.22 Some of these concerns relate to the primary legislation and are therefore outside the scope of the Code revisions, and some relate to what happens in practice that is not compliant with the Code/Act.

7.23 Within the Code we have clarified and strengthened guidance in relation to involvement of patients, nearest relatives and carers in the process. This includes ensuring materials are available in formats that they understand, ensuring that staff on Tribunals, hospital managers' panels and those representing patients (e.g. IMHAs, legal representatives) have sufficient training and skills to enable them to participate fully, and providing additional guidance on uncontested renewal decisions to assist patients that do not fully understand renewal decisions or the impact of these. This additional guidance across chapters 32 and 38 should provide additional safeguards, promote equality and considerably reduce any discrimination that does exist in practice.

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[41] HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September 2013*. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf. Care Quality Commission and National Mental Health Development Unit. *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. 2011. www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf. Care Quality Commission and The Challenging Behaviour Foundation. *3 Lives: What have we learned, what we need to do*. 2014. www.cqc.org.uk/sites/default/files/2014%2006%2017%20Three%20Lives%20report%20FINAL.pdf.

[42] Appendices B and F. South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review*. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse.

Location of placement (chapters 14 and 11)

7.24 We know that where a person is located can have a significant impact on their recovery and their ability to maintain relationships with family, friends and carers (which in itself can be a major factor in how long it takes someone to recover – there is often a link between distance and length of stay). This is a particular concern for individuals who may be detained for a considerable period. This can have a negative impact on their family and friends, due to the costs and time that it takes to visit.

7.25 In chapter 14 we have included additional guidance to encourage commissioners to take patient and carer views into account and, as far as possible, to make decisions about where to locate patients in accordance with their wishes, allowing for cases where this may not be possible (e.g. specialist treatment that is only available in particular locations, or high secure services). Chapter 11 includes guidance indicating that, where a patient is placed out of area, it is good practice to consider the needs of family and carers who have to travel in order to visit. The response to consultation states that the NHS Commissioning Board (NHS England) and the Department of Health will explore developing additional guidance to more fully address this particular problem.

When to use the Mental Health Act, when to use the Mental Capacity Act (MCA) and how these work together (chapter 13)

7.26 Feedback from stakeholders indicated that there was confusion about when to use the Act and when to use the MCA and how the two worked together. This led to concerns that people who lacked capacity to make particular decisions might be over-represented in terms of numbers detained, when they could be treated in alternative settings under the MCA, for example care homes. There were also concerns in relation to treatment for physical healthcare, which is not related to the patient's mental disorder, where a detained patient can still make decisions if they have the capacity to do so. Also, the requirement in the MCA that patients should be assumed to have capacity unless it is established otherwise applies to capacity decisions taken under the Act.

7.27 A new chapter 13 has been included, with flowcharts and case study examples to give additional clarity to support decision-making about which piece of legislation to use and how these work together. The chapter makes clear that decisions should be based on individual circumstances and that clinicians are best placed to make these decisions. We have therefore not provided definitive guidance on which Act to use when there is a choice.

Use of restrictive interventions (chapters 26 and 24)

7.28 A range of stakeholders have expressed concern about the excessive use of restrictive interventions (including physical and mechanical restraint, rapid tranquilisation, seclusion, and long-term segregation).[43] While the empirical data on each of these is slim, as providers

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[43] Mind. *Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England*. 2013. www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf. NHS National Patient Safety Agency. *Understanding the patient safety issues for people with learning disabilities*. 2004. www.nrls.npsa.nhs.uk/resources/?EntryId45=92328. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review.* 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse. Written evidence submitted by Black Mental Health UK [IPCC 23]. 2012. www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/494we06.htm. Challenging Behaviour Foundation. *Physical Interventions for Challenging Behaviour Information Sheet*. 2008. www.challengingbehaviour.org.uk/learning-disability-files/04_PhysicalInterventions.pdf. Equality Feedback Report.

currently only need to report on the use of 'inappropriate restraint', feedback indicates that individuals with communication difficulties (e.g. those associated with a learning disability or autism), and potentially individuals from BME backgrounds, are more likely to be given rapid tranquilisation, to be restrained or secluded. In addition, some of these people are restrained or secluded for lengthy periods of time and are more likely to be harmed during the application of restraint.[44] It is apparent that units and services for ostensibly identical patient populations can show vastly discrepant rates of use of restrictive interventions; this suggests that there remains considerable scope for improvement. There is good evidence that effective governance in the form of a restrictive intervention reduction programme can reduce the incidence of restrictive interventions and also bring about reductions in staff sickness and injuries to staff and patients alike. Feedback indicates that staff often do not understand how to communicate with or address the concerns of these individuals, increasing the likelihood of people becoming distressed and challenging services with their behaviour where their needs are not adequately addressed. Person-centred planning, staff training on how to de-escalate behaviour, the use of therapy, structured days and routine, as well as flexibility and compassion as part of daily routines, have all been shown to be important in reducing the use of restrictive interventions.[45] Discrepancies in the use of restrictive interventions may mean that these have a disproportionate effect on some people.

7.29 Building on the guidance in *Positive and Proactive Care* and the wider Positive and Safe programme,[46] chapter 26 emphasises that for all patients the use of any restrictive intervention should be a last resort, for the minimum time necessary and should not be used for the sole intention of inflicting pain, suffering or humiliation. It promotes the use of preventative strategies, such as positive behaviour support and de-escalation, in order to ensure that restrictive interventions are truly used as a last resort. It stresses the need for training in positive approaches and de-escalation techniques, so that staff are more aware of what can trigger a response and ways to address such responses. It encourages greater engagement with families and discussion with patients when they are well so that care plans can identify alternative approaches. More broadly, the focus throughout the Code on additional staff training and skills includes addressing equality issues and providing individualised support to meet the needs of particular patients (for example by making reasonable adjustments to care pathways). This, and the increased focus on involving patients and their carers in discussions about care and treatment, should help to reduce the need for restrictive interventions and will enable staff to be equipped with more information and skills to utilise if such situations arise. This guidance should be beneficial in, reducing potential discrimination, promoting greater equality of opportunity and improving relations between patients and staff.

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[44] Mind. *Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England.* 2013. www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf. NHS National Patient Safety Agency. Understanding the patient safety issues for people with learning disabilities. 2004. www.nrls.npsa.nhs.uk/resources/?EntryId45=92328.

[45] See for example: Ashcraft, L., and Anthony, W. Eliminating seclusion and restraint in recovery oriented crisis services. *Psychiatric Services* (2008), 59(10). pp.1,198–1,202. Huckshorn, K.A. Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services* (2004), 42(9). p.22. Le Bel, J. and Goldstein, R. The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination. *Psychiatric Services* (2005), 56(9). pp.1,109–1,115. Roles, S. and Gouge, A.P. Restraint Reduction Task Force. *Mental Health Nursing Interest Group* 2014. http://mhnig.rnao.ca/content/restraint-reduction-task-force. Wale, J.B., Belkin, G.S., and Moon, R. Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services: Improving patient-centered care. *The Permanente Journal* (2011), 15(2). pp.57–62. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140751/.

[46] Further work is underway more generally as part of the *Positive and Safe* programme to address concerns about the use of restraint, especially physical restraint. See: Department of Health. *Positive and Proactive Care: reducing the need for restrictive interventions*. 2014. www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions.

Medication, including over-medication and inappropriate prescribing (chapters 1, 23, 24 and 26)

7.30 There has been concern expressed about over-prescribing, or differences in what is diagnosed/prescribed, for people with a learning disability or autism and for people from a BME background.

7.31 Chapter 1 includes a new guiding principle on purpose and effectiveness, which highlights that all treatment must be focused on recovery and be therapeutic, and chapter 23 states that treatment must be appropriate (e.g. specific guidance to support patients with dementia). Chapter 24 has included new guidance providing that, in the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that exceed the maximum dosage listed in current good practice, for example the British National Formulary (BNF),[47] or where multiple medications are used to treat a patient. Chapter 26 requires caution around the prescribing of rapid tranquilisation and emphasises that prescriptions should be in accordance with both National Institute for Health and Care Excellence (NICE) and General Medical Council guidance. If relevant to their organisation, providers should seek to address this in their human rights and equality monitoring and compliance policy (chapter 3), and greater patient involvement generally should assist. Patients and their families highlighted the importance of getting people's views on what works for them and what they would agree for them. The accessibility project promotes advance statements (chapter 9) to support this.

7.32 Care and treatment should be personalised and focused on the individual. Decisions about medication are clinical decisions and should be taken on a case-by-case basis, and in some cases higher doses than recommended might be appropriate. What is considered good practice changes over time. We have therefore not considered it appropriate to suggest absolute limits.

7.33 Chapter 24 also highlights the importance of treatment for physical healthcare, good diet and nutrition, and chapter 1 that a range of treatments may be considered therapeutic. This full range of considerations must be taken into account when determining what medication to prescribe and the dose.

Lack of involvement in discussions/choices about care and treatment and not communicating in a way that the person understands, for example in their first language (throughout the Code, including especially the empowerment and involvement guiding principle in chapter 1)

7.34 Feedback regarding exclusion from making choices, lack of involvement and lack of communication came from people from different cultural and racial backgrounds, people with learning disabilities and autism, and from children and elderly people. It arose persistently and worryingly as a communication issue.

7.35 People who had difficulty communicating included disabled people, for whom reasonable adjustments should be in place as well as person-centred planning. People who do not speak English or have English as a first language reported experiencing problems. This

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[47] The British National Formulary is available at: www.medicinescomplete.com/about/subscribe.htm. See also: Royal College of Psychiatrists. *Consensus statement on high-dose antipsychotic medication*. CR190. 2014. www.rcpsych.ac.uk/files/pdfversion/CR190.pdf.

took the form of non-engagement, having relatives asked to translate personal information and information that would routinely be confidential, not having their needs met, having their needs misunderstood, causing additional stress and distress which led to punitive actions from staff or longer durations in the facility. This related to not being able to communicate effectively, not having information or supporters (e.g. an IMHA available in a format or language they could understand) and professionals not taking appropriate steps to support these individuals.

7.36 A failure to provide information and a way of communicating in the person's first language may mean patients are unable to meaningfully participate in decisions about their care and treatment. This includes a person who uses British Sign Language as their first language who may need an interpreter to understand what is happening to them and what rights they have. The Code already included information about the need to ensure that such patients were provided with an interpreter and could communicate in their first language but evidence suggests that this does not always happen. Stakeholder feedback indicated that there are often difficulties in securing these services and that this can have a significant impact on decisions about care and treatment, including detention, discharge and the use of CTOs.[48]

7.37 Guidance has been included throughout the Code to address these concerns, in particular in the guiding principles, especially the one about empowerment and involvement (chapter 1), in chapter 4 on involving patients, in other chapters at particular points in the care pathway (e.g. IMHAs in chapter 6, hospital managers' panels in chapter 38 and Tribunals in chapter 12) and in relation to specific patients (chapter 20 for those with learning disabilities and autism, chapter 19 for children and young people under 18). There is also new guidance in relation to supporting people with dementia (paragraphs 14.120–14.125) and in relation to immigration detainees (paragraphs 14.126–14.129). It was considered critically important that appropriate interpretation services or other kinds of advocacy/assistance are readily accessible to patients subject to the Act, including those who lack capacity, those for whom English is not their first language or those who have difficulty communicating for other reasons. Interpreters need to be skilled and experienced in medical or health-related interpreting. To deal with patients who lack capacity to decide whether they want an IMHA, we have included guidance providing that, if a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly (paragraph 6.16). The use of family members, particularly children under the age of 16, is not considered good practice and we recommend that this should be avoided (paragraph 4.6).[49]

7.38 Combined, we consider that these changes will have a significant impact in promoting equality of opportunity and eliminating any discrimination that might exist in practice for the patients affected. The changes are also likely to have considerable benefit in reducing tensions with other groups, including staff members, which may in turn reduce the need for the use of restraint and seclusion (see EA paragraphs 7.27–7.30 above). Guidance on supporting individuals to complain and the importance of listening to them, particularly when there may be capacity issues or communication difficulties, is highlighted in chapter 4. This

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[48] See, for example, appendices B and F.

[49] Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D. et al. *The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England. Research Report*. Preston: University of Central Lancashire. 2012. www.uclan.ac.uk/research/explore/projects/the_right_to_be_heard.php.

may help to address the particular concerns identified by reports into Winterbourne View that people lacking capacity 'don't make good witnesses' and 'can't be believed'.[50]

7.39 In addition, our wider Accessibility and Awareness project and new web resource will provide more information and advice, such as short pamphlets or video clips on particular key points in the patient care pathway (point of detention, going to the Tribunal) to assist patients and their families and carers to effectively support them. This will increase patients' awareness of their rights under the Act, in ways that they understand, and should also reduce any disproportionate impact in this area. For more information, the Accessibility and Awareness project is described in further detail at EA paragraph 10.5 below.

Poorer health outcomes and lower life expectancy (chapter 24)

7.40 Relative to the wider population (data is not available to differentiate between different characteristics of inpatients or to compare detained with non-detained) all mental health inpatients, including patients detained under the Act, experience significantly reduced health outcomes, especially in relation to their physical health and a lower life expectancy. It is widely recognised that some of this is due to a mental health diagnosis 'over-shadowing' physical symptoms and a lack of attention given to the physical health of mental health inpatients, with increasing impact with longer lengths of stay. This means that physical conditions often get diagnosed later, and further concerns about poor diet and nutrition and lack of exercise mean that some of these patients are overweight or have co-morbidities that can also affect life expectancy. Some medications to promote mental health and wellbeing also have side-effects that impact on physical health. This was considered a major equality and health inequality issue that we wished to address. The Royal College of Psychiatrists published in 2010 a paper on public mental health, *No health without public mental health*,[51] which included a summary of the research evidence demonstrating the links between mental health and physical health.

7.41 The revised Code helps to deal with this by emphasising the importance of holistic and joined-up approaches to care, including mental, physical and social care, with the respective statutory agencies working together to provide support for the whole person (the guiding principle on purpose and effectiveness in chapter 1). Additional guidance is included in chapter 24 about the need to consider co-morbidities and responsibilities, including in relation to smoking, diet, nutrition and physical activity.

Lack of cultural understanding and ensuring services take account of cultural, ethnic and religious diversity (throughout, and chapters 1, 3, 26 and 34)

7.42 Stakeholders from BME communities, non-English speaking communities and people with particular religious observances reported concerns in relation to both race, and religion or belief, about the perceived discrimination they faced because of a lack of cultural understanding by professionals. There were concerns about a perceived in-built bias or prejudice against particular groups and the impact that this can have on decisions made

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[50] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review.* 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review.* 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse.

[51] Royal College of Psychiatrists. *No health without public mental health.* 2010. www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf. Appendix B.

under the Act. One of the impacts of this lack of understanding was a difficulty for certain groups in accessing specialist services such as Improving Access to Psychological Therapies (IAPT), for example based on language barriers or a failure to take into account cultural diversity and the needs of different faiths. This may affect the quality of the service received and impact on recovery as it means preventative tier 3 strategies are not available, which in turn increases the likelihood of detention and, when detained, increases the length of recovery and can increase the length of stay.[52]

7.43 In the guiding principle on respect and dignity (chapter 1) we have included guidance that people taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture. We have emphasised the need for appropriate training, for the use of interpreters or members of the individual's community and the need for person-centred care planning (see especially chapter 34). The human rights and equality policy (chapter 3) should set out how staff will be provided with learning, development and training on human rights legislation and the Equalities Act. Combined, it is hoped that this additional guidance will help to deal with any issues that are arising in practice. By reducing any perceived discrimination too, this should also help to foster good relations between groups, for example between different communities or faiths or between particular patients and staff.

Nearest relative (chapter 5 and throughout)

7.44 Section 26 of the Act identifies, through a hierarchical list, who is the patient's 'nearest relative' for the purposes of the Act. Section 26(2) provides that unmarried fathers will only be treated as the child or young person's 'father' for the purpose of being identified as the nearest relative if they have obtained 'parental responsibility'. Parental responsibility may be acquired through a number of routes, such as a parental responsibility agreement, subsequent marriage to the mother of the child or young person or by obtaining a residence order. Since 1 December 2003, unmarried fathers of children under the age of 18 have been able to acquire parental responsibility for their children born after this date by registering themselves as the father on their child's birth certificate. The requirement for unmarried fathers of patients under the age of 18 to obtain parental responsibility may be perceived as discriminating against unmarried fathers. Guidance incorporated in the Code (chapter 5) clarifies that the requirement to establish parental responsibility applies only in respect of patients under the age of 18, not born to parents who are married or in a civil partnership.

7.45 As parental responsibility applies only with respect to those under the age of 18, unmarried fathers of adult patients cannot obtain parental responsibility in these ways. We have heard of feedback where this has caused difficulties in practice when the unmarried father is the main care giver. A review of section 26 could include how it applies to unmarried fathers of adult patients. Section 26 has also been criticised for failing to take account of modern caring relationships, and not allowing the carer to displace the nearest relative if these differ; for example a mother who is the main carer for her son and who is divorced from her former husband (the father of her son), who has not seen his son in ten years, yet as the father is older than the mother, the father will be the son's nearest relative unless he is displaced as nearest relative in the mother's favour or delegates his functions to her. Changes to section 26 would require primary legislation – see action included in the action plan (figure 3) to consider these issues at the next opportunity.[53]

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[52] *Quarterly Improving Access to Psychological Therapies Data Set Reports, England, Final Q1 2014/15*. 2014. www.hscic.gov.uk/searchcatalogue?productid=16203&topics=0%2fMental+health&sort=Relevance&size=10&page=2#top.

[53] See, for example, appendices D and J.

Use of blanket restrictive practices, including blanket locked doors (chapter 8)

7.46 CQC has consistently shown that many blanket restrictions, including blanket locked door policies, can often not be justified and have discriminatory effects in practice.[54] For example, restricting access to outside space, the kitchen or the fridge because of concerns for one patient on a ward, including for a medical condition, has an impact on other patients who do not need the safeguard and would appear a disproportionate response. Use of blanket restrictions is also considered a contributory factor in delaying recovery or triggering negative reactions as patients feel that they are unfair.

7.47 New guidance in chapter 8 has been inserted to address these concerns. While some restrictions covering all patients can be justified at ward or hospital level, these need to be documented, justified and explained to patients. Otherwise, decisions should be taken in accordance with the best interests of an individual patient. We consider that this new clarifying guidance, combined with CQC's new inspection methodology, should significantly reduce any adverse effects on some people in this area and promote equality between different groups.

Restrictions on the right to a family life (for family and carers, mothers and babies – chapters 8, 11 and 14)

7.48 Evidence under pregnancy and maternity, marriage and civil partnership, age and disability identified particularly negative impacts for familial relationships, especially for mothers of new babies or parents of young children or where an individual is located far from their home or family (e.g. their spouses or civil partners, parents, children).

7.49 We have included additional guidance at a number of points in the Code to address some of these points, for example to consider patients' circumstances when making arrangements for accommodation, including the support mothers/babies require after pregnancy (chapter 8) and in relation to placements and maintaining family contact (chapters 14 and 11). We will work with the NHS Commissioning Board to develop further guidance on the matters that commissioners should consider when making decisions about placements and intend to include the impact on the family and familial relationships as one of these considerations. See above on location of placement (EA paragraphs 7.24 and 7.25).

Use of appropriate washing and sleeping facilities (chapters 8 and 19)

7.50 Data from CQC indicates that many providers are still not consistently providing single-sex accommodation and are not always able to accommodate other needs. This relates to the characteristics of sex, religion or belief, age for children and young people, and also gender reassignment, sexual orientation, and pregnancy and maternity.[55] Studies have noted that CQC visits may not identify dignity and respect issues. Other studies have highlighted the particular need for verbal patient feedback and conversations about this, and the need for other mechanisms to identify concerns (e.g. carer involvement, advocacy and staff

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[54] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213.

[55] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213.

feedback).[56] Some consultation responses suggested that this was now a lesser issue due to en-suite facilities in many hospitals; however, where these are not provided, this remains a particular concern and there are other reasons for single-sex accommodation being required.

7.51 Of particular importance to patients is the provision of sex-specific accommodation for disabled people, including separate washing and sleeping facilities, recognising that women are at risk of sexual and physical abuse and may have prior experience of this, such that admission to hospital in a mixed-gender environment can lead to traumatisation. This risk needs to be considered in the general ward environment as well. Provision of single-sex sleeping accommodation may be required on the basis of cultural traditions and for transgender patients. There also needs to be specific provision for mothers and babies to be accommodated appropriately and for children and young people under 18 years, to promote equality of opportunity in this area.[57]

7.52 There was already guidance on this in the 2008 Code. Guidance in chapter 8 on privacy and dignity has been strengthened to reflect current policy and guidance, including in relation to the particular needs for transgender patients. This additional guidance will help to address some of the negative impacts we have heard about, regarding how this has been applied, and, in turn, help to reduce the negative impact that this can have on a person's mental health. Providers should ensure they are compliant with the additional guidance and reporting on single sex accommodation.[58] Providers and commissioners should ensure that all patients are treated with dignity and respect (paragraphs 1.13–1.14). Providers and commissioners could include in their human rights and equality policy (chapter 3) how any identified gaps will be addressed. Guidance is also included in chapter 19 in relation to children and young people. CQC commits to publishing relevant equality information in the 2015/16 annual report on the Act and will continue to develop the reporting in later years. CQC has committed to use the Code as 'good practice' and to monitor against this (introduction). Combined this should eliminate any discrimination and promote equality of opportunity.

Lack of staff skills, knowledge and understanding (throughout including chapters 1, 6, 12, 19, 20 and 38)

7.53 Evidence indicated that a lack of specialist skills, knowledge and understanding among professionals meant that some patients received more negative outcomes, such as longer lengths of stay, different or higher rates of medication, decisions that were not appropriate given their cultural, religious or ethnic background, and a lack of involvement in decisions about their care and treatment.

7.54 Guidance has been included on this in the guiding principles (chapter 1) and throughout the Code (e.g. on IMHAs in chapter 6, on the Tribunal in chapter 12, and hospital managers' panels in chapter 38) to ensure that commissioners, providers, local authorities and other organisations have the right skills or understanding to treat patients. This should promote equality for patients affected and foster improved relations between groups.

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[56] See: Russo, J. and Rose, D. 'But what if nobody's going to sit down and have a real conversation with you?' Service user/survivor perspectives on human rights. J*ournal of Public Mental Health* (2013), 12(4). pp.184–192. Lawlor, C., Johnson, S., Cole, L. and Howard, L.M. Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry* (2012), 58(1). pp.3–15.

[57] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213. See, for example, appendices A, C, D, G, H and I.

[58] Eliminating Mixed Sex Accommodation. Department of Health. 2009. PL/CNO/2009/2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200215/CNO_note_dh_098893.pdf. Eliminating Mixed Sex Accommodation. Department of Health. 2010. PL/CNO/2010/3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf.

Concerns about lack of attention to human rights (chapters 1 and 3)

7.55 Some evidence suggested that human rights issues are not always explicitly considered and may be less likely to be captured in monitoring visits by CQC or commissioners.[59] These concerns relate to patients generally detained under the Act and in particular to transgender people, lesbian, gay and bisexual (LGB) people, black and minority ethnic (BME) people and those with strong religious faith or belief.

7.56 For this reason, we introduced a new guiding principle on respect and dignity, which focuses on promoting both equality and human rights (chapter 1), and strengthened other principles, such as the one promoting empowerment and involvement (chapter 1). The guiding principles should inform any decision made under the Act. We specifically stated that 'All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010' (chapter 1) and introduced a human rights and equality policy (chapter 3). This should help to ensure that there is no discrimination or disproportionate impact in practice.

Preventing victimisation, bullying, harassment and abuse (chapter 3 especially)

7.57 Stakeholder feedback indicates that inpatients with protected characteristics may be vulnerable to harassment, bullying or abuse from other patients, for example homophobic bullying, racist comments or sexual harassment. Data indicates that some providers have been unable to ensure a culture of zero tolerance and/or do not have clear policies in place to prevent and manage such behaviour. It has been suggested that this may be a particular issue for individuals who are gay, lesbian or bisexual (sexual orientation) or transgender (gender reassignment) and/or who are Muslim (religion and belief).[60]

7.58 The Code states that providers and commissioners should have in place a human rights and equality policy, which should set out how they will comply with legislation and address any concerns raised. This policy is to be reviewed at least annually at Board level or equivalent. This will assist in reducing unlawful discrimination and advance equality of opportunity in practice.

7.59 Evidence from Winterbourne View clearly identified that the patients there with a learning disability were subject to abuse and degrading treatment.[61] This treatment was unlawful, and the reasons for the failure to prevent or stop it go beyond what the Code can address. However, we have made reference to this and highlighted ways in which patients, carers and staff can make complaints, raise safeguarding concerns and use whistleblowing procedures. We have stressed that it is important that any issues raised are listened to and taken seriously, and carers may need support in being able to do this, especially where an individual may lack capacity, has difficulty communicating or does not have English as their first language. Other work is being taken forward more widely as part of the post-Winterbourne View *Transforming Care* programme to address other concerns raised, including failings across the health and care system.[62]

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[59] Literature Review, p.8.

[60] Literature Review, esp. p.13. Appendices, esp. appendices C, G and I.

[61] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review*. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf.

[62] Department of Health. Transforming care: *A national response to Winterbourne View Hospital. Department of Health Review*. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf.

Specific support or guidance to prevent unfavourable treatment for people from particular groups, such as BME communities, those with learning disabilities and autism, older people with dementia, or those who do not have English as a first language (chapters 3, 14, 20, 22 and 23)

7.60 Studies indicate[63] that people from BME communities, particularly men of African, Caribbean or mixed heritage, may receive less favourable care, support and treatment than patients from other ethnic backgrounds (race). Similar concerns have been raised in relation to individuals who lack capacity (disability) and for whom English is not a first language, especially immigration detainees (race). The consequences of this can be far reaching and appear to influence both the length of detention and the use of police powers and/or restraint. These views were also expressed during the consultation.

7.61 We were keen to address these concerns but also to future-proof any guidance in case the impact on people changes. For example, some people asserted that new groups of migrants may be likely to experience higher detention rates and more negative outcomes in the future. The guidance is therefore drafted broadly to focus on equality issues rather than a particular community or communities and reflects that immigration detainees may be particularly vulnerable and require additional support (chapters 14 and 22). In chapter 3, guidance has been included that requires providers and commissioners to have an equality and human rights policy, which ensures monitoring of equalities issues to allow local solutions to meet the needs of their patients (chapter 3). Additional guidance has been included in relation to learning disability and autism (chapter 20) and on dementia (chapters 14 and 23) to ensure good practice. This should foster good relations between patients and staff and different groups of patients. It should also reduce any discrimination that may exist in practice and the impacts of this on health outcomes.

Case studies and good practice guidance

7.62 A number of stakeholders indicated that it would be helpful to include case studies or good practice about particular issues to do with equality and how to eliminate discrimination, promote equality and foster good relations. This is not an issue related to a particular characteristic or number of characteristics, although a particular case study or good practice example could cover one or more particular characteristics.

7.63 Generally, the professionals working at the time are best placed to make decisions in relation to a particular patient, and this includes any considerations to do with equality. Any case studies in the Code would need to be high level. We therefore think (as set out in our response to consultation generally) that it is more beneficial to include case studies or good practice material on the new web space that is being developed to coincide with the launch of the new Code. This means that the material can be reviewed and updated more regularly and that we can include some of the more difficult situations that represent the realities for those who work with the Act and those who are the subject of the provisions of the Act. We think that this alternative approach will be more effective in promoting equality and reducing any discrimination in practice.

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[63] Literature Review, pp.10–12. Appendix F.

8. Impacts by the three limbs of the Public Sector Equality Duty (PSED)

8.1 People subject to the Act will be very likely to have the protected characteristic of disability and will have other protected characteristics too. The purpose of the Code is to ensure that such persons are adequately protected under the Act. It offers good practice guidance, which seeks to ensure the fullest protection in practice. The revised Code will increase awareness and understanding of the Act and the safeguards provided by the Act and Code. The revised Code will assist in eliminating unlawful discrimination in practice, advancing equality and promoting good relations. These have been objectives in the revisions that have been proposed – particularly in respect of advancing equality between individuals who have mental disorder (of a nature that is a disability under the Equality Act) and those who do not.

8.2 This analysis is set out by each of the three limbs of the PSED:

- eliminating unlawful discrimination;
- advancing equality of opportunity; and
- fostering good relations.

8.3 Figure 1 highlights some of the steps that we have taken to meet our duties under the three limbs of the PSED. Some issues are covered by more than one of the three limbs or the different aspects of the advancing equality of opportunity limb.

Figure 1: Mitigations taken in the Code, separated under the three limbs

Eliminate discrimination	**Specialist skills to promote inclusion of individuals discriminated against due to capacity or communication difficulties (chapters 6, 12 and 38)** Guidance (paragraph 6.7) has been provided for local authorities on the commissioning of IMHAs who understand equality issues, to ensure that there are sufficient numbers of IMHAs with a specialised understanding of the specific needs of particular groups (e.g. patients with a learning disability or autism) and that IMHAs can communicate effectively with them. Similar guidance has been included in relation to staff working for Tribunals (chapter 12) and hospital managers' panels (chapter 38). Combined, this guidance will reduce any direct or indirect discrimination that may exist in practice and promote equality for those that lack the ability to independently communicate and understand the conversations around their care and treatment.
	Eliminating the inappropriate use of blanket restrictions and blanket locked door policies (chapter 8) CQC reports consistently showed that the use of blanket restrictions could often not be justified and was often discriminatory. By including guidance on when, where and how they may be used, and ensuring sufficient scrutiny by organisations, we have provided greater protection to patients from discrimination and provided the CQC benchmarks against which to inspect.

Eliminate discrimination	**Reducing the disproportionate use of restraint and seclusion (chapters 26 and 1)** Anecdotal evidence on the use of restraint indicates that this is used disproportionately on people from BME communities and/or those that lack capacity or have trouble communicating, for example because of autism, learning disabilities or deafness, and about the negative impacts on these individuals, for example the injury and death rate for individuals from BME communities. The Code makes clear that decisions need to be based on the least restrictive option and maximising independence guiding principle (revised principle from 2008 Code), and provides additional guidance on the use of preventative and de-escalation strategies, including positive behaviour support planning or equivalent, and ensuring that staff have skills to support these individuals, including in de-escalation techniques. Other chapters (such as chapter 20 on learning disabilities and autism) provide further guidance. Combined, this guidance should reduce any discrimination that may occur in practice.
	Concerns about the rate and length of detention and CTO Consideration of the least restrictive option and maximising independence guiding principle (chapter 1) and additional guidance in relation to the learning disability qualification (chapters 2 and 20) have been included to address concerns related to age, disability and sex. Generally, it is considered that the requirement for three different professionals to be involved in decisions to admit under part 2 of the Act is a strong and rigorous safeguard. Additional guidance is included in chapters 32 and 38 to provide greater transparency, accountability and scrutiny in review and discharge decisions, and to facilitate greater involvement of the patients, and their nearest relative and carers. This includes in uncontested cases.
	Concerns about the use of sections 135 and 136 Guidance provided in chapter 16 on the use of sections 135 and 136, combined with further initiatives, including particularly the combined effect of implementation of the *Mental Health Crisis Care Concordat*, the review of sections 135 and 136, and the Children and Young People's Mental Health and Wellbeing Taskforce,[64] should reduce disproportionate use of section 135 or 136 for affected groups. This should address the concerns about the use of police cells for children and young people.

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[64] Department of Health. *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf. Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf.

Eliminate discrimination	**Greater clarity on the relationship between the Act and the Mental Capacity Act 2005 (chapter 13)** The new chapter 13 makes it clearer when the different pieces of legislation can be used. This should reduce the use of the Act with respect to people for whom the MCA or a less restrictive option may be possible.
	Expanded guidance in relation to the provision of single-sex and age-appropriate accommodation (chapters 1, 3, 8 and 19) Expanded guidance in chapters 8 and 19, combined with local human rights and equality policies (chapter 3), should ensure that concerns raised, for example on religious or cultural grounds, in relation to transgender patients, or children and young people under the age of 18, are addressed. The guiding principle on empowerment and involvement should also ensure that the patients' wishes, and their carers' as appropriate, are taken into consideration, further reducing any potential discrimination. Providers and commissioners should ensure that all patients are treated with dignity and respect (paragraphs 1.13–1.14). Providers and commissioners could include in their human rights and equality policy (chapter 3) how any identified gaps will be addressed.
Advance equality of opportunity	**In terms of removing or minimising disadvantages suffered by a person with a protected characteristic:**
	Additional guidance on human rights and equality (chapter 3) There is a new chapter on Human rights, equality and health inequalities (chapter 3), which highlights compliance with the Equality Act 2010, including the Public Sector Equality Duty (PSED), and further guidance throughout the Code. This includes establishing a local human rights and equality policy to collect, monitor and address any negative trends that are identified.
	Promoting of physical and mental health (chapters 1 and 24) A new guiding principle on efficiency and equity provides that providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of a high quality and are given equal priority to physical health and social care services. Chapter 24 includes guidance on promoting physical health, including diet and nutrition and support for co-morbidities. This addresses major concerns about the lower health outcomes and lower life expectancy of people with mental health conditions, relative to other people.
	Five new guiding principles (chapter 1) The new guiding principles, especially those on empowerment and involvement, and respect and dignity, and the Code's overall focus on ensuring that people are treated as individuals and that care is personalised, therapeutic and focused on recovery should, in practice, promote the needs of all persons with a protected characteristic, as it means care is tailored and specific to their needs, preferences and circumstances.

Advance equality of opportunity	**Promoting use of advance statements (chapter 9)** Advance statements were included in the previous 2008 Code, but the work via the Accessibility and Awareness project to promote these should ensure that patients are able to express their wishes when they are well, and still be involved in decisions about care and treatment.
	Specialist skills to promote inclusion of individuals discriminated against due to capacity or communication difficulties (chapters 6, 12 and 38) Guidance (paragraph 6.7) has been provided for local authorities on the commissioning of IMHAs that understand equality issues, to ensure that there are sufficient numbers of IMHAs with a specialised understanding of the specific needs of particular groups (e.g. patients with a learning disability or autism) and that IMHAs can communicate effectively with them. Similar guidance has been included in relation to staff working for Tribunals (chapter 12) and hospital managers' panels (chapter 38). This will reduce any direct or indirect discrimination and promote equality for those that lack the ability to independently communicate and understand the conversations around their care and treatment.
	Accessibility and Awareness project In 2014/15 our work to promote awareness of the Code and to make materials more accessible to people subject to the Act, their families and carers focused on two groups that we have identified as requiring specific, different or tailored information and support, due to the lower experiences of services being reported: people from BME backgrounds and people with a learning disability/autism. Combined with general guidance in the Code, providing information in alternative formats (e.g. easy read, video clips, plainer English) should enable these patients and their representatives to better understand what is happening and more fully participate, removing some of the (perceived) disadvantages they currently face.
	In terms of taking steps to meet the different needs of a person with a protected characteristic:
	Providing information in suitable formats The Code strengthens requirements to ensure patients are given information about the Code and the Act in a language and format they can understand (chapter 1, guiding principle on empowerment and involvement). Guidance is included at relevant points in the Code to support this. The wider accessibility project will increase awareness and understanding of the safeguards in the Act.

Advance equality of opportunity	**Specialist skills to promote inclusion of individuals discriminated against due to capacity or communication difficulties (chapters 6, 12 and 38)** Guidance (paragraph 6.7) has been provided for local authorities on the commissioning of IMHAs that understand equality issues, to ensure that there are sufficient numbers of IMHAs with a specialised understanding of the specific needs of particular groups (e.g. patients with a learning disability or autism) and that IMHAs can communicate effectively with them. Similar guidance has been included in relation to staff working for Tribunals (chapter 12) and hospital managers' panels (chapter 38).
	Provision of reasonable adjustments (chapter 3) Chapter 3 includes examples of a range of reasonable adjustments that may be required in respect of a patient's impairment which constitutes a disability under the Equality Act. Further examples are included at particular points in the Code (e.g. paragraph 20.31 for individuals with a learning disability).
	Strengthens guidance in relation to IMHAs (chapter 6) There is strengthened guidance in relation to IMHAs, including guidance in relation to patients who lack capacity to decide whether or not to appoint an IMHA.
	Additional guidance in relation to specific patients The Code includes new or updated chapters or sections that encourage providers and commissioners to take steps to meet the needs of patient groups with particular characteristics. This includes chapters on children and young people (chapter 19), patients with a learning disability or autism (chapter 20) and patients with a personality disorder (chapter 21). It includes sections on supporting people who are deaf (chapter 14), patients with dementia (chapters 14 and 23), immigration detainees (chapters 14 and 22) and support for physical healthcare conditions and co-morbidities (chapter 24). Overall the Code's focus on ensuring that people are treated as individuals and that care is personalised, therapeutic and focused on recovery should, in practice, promote the needs of all persons with a protected characteristic, as it means care is tailored and specific to their needs, preferences and circumstances.

Advance equality of opportunity	**Minimising disadvantages for individuals with a learning disability, autism and/or challenging behaviour (chapter 20)** Chapter 20 provides additional information to support people who have a learning disability, autism and/or challenging behaviour. This chapter has been significantly rewritten to meet the needs of people with these conditions, including reflecting the feedback from stakeholders and the findings regarding Winterbourne View Hospital. Further guidance is provided in other chapters (e.g. chapters 6, 12 and 38) and guidance in relation to patients with a disability more generally, or patients who lack capacity or who have difficulties communicating for other reasons, is often relevant. Examples of guidance which is particularly relevant includes: • the specific updated guidance on supporting individuals with learning disabilities and autism (chapter 20), including: paragraphs 20.31 on reasonable adjustments, 20.32 on examination and assessment, 20.35 on 'hospitals not being homes' and the additional support that may be required, 20.45 on understanding the role and process of the Tribunal and helping individuals with a learning disability to participate, and 20.41 on staff training in preventative and de-escalation strategies such as the use of positive behaviour support planning; • the updated guidance on the learning disability qualification (chapters 2 and 20); and • ensuring patients can be more involved in decisions that affect them, including having information in formats that they understand (e.g. easy read), having access to independent mental health advocates (IMHAs), ensuring staff, including IMHAs, those on Tribunals and on hospital managers' panels, are trained in supporting individuals with a learning disability, autism or behaviour that can be considered challenging (chapters 6, 12 and 38). This is further supported by the work of the Accessibility and Awareness project and. the wider work of the Post-Winterbourne View programme.
	Minimising disadvantages for individuals from BME communities Throughout the Code guidance has been incorporated to address the concerns raised in relation to people from black and minority ethnic communities, including those regarding both race and religion/belief. Examples of guidance that is particularly relevant include: • guidance on the use of sections 135 and 136 and the use of police cells as places of safety (chapter 16); and

Advance equality of opportunity	• guidance on support for immigration detainees (chapters 14 and 22), many of whom are from countries that in England constitute black and minority ethnic communities (e.g. post-conflict states in Africa and the Middle East), and, as set out in the accompanying response to consultation, are exploring developing more specific and tailored guidance to support these people. This is further supported by the work of the Accessibility and Awareness project, and in the *Mental Health Crisis Care Concordat* and the review of sections 135 and 136.[65] Combined, this guidance and other activities should take steps to meet the needs of people sharing these protected characteristics and minimise disadvantages experienced by people from BME background, whether related to the protected characteristics of race or religion/belief.
	In terms of encouraging persons who share a relevant protected characteristic to participate in public life, or any other activity in which participation by such persons is disproportionately low:
	Empowerment and involvement guiding principle (chapters 1 and 4) The new empowerment and involvement guiding principle (chapter 1), and accompanying guidance throughout the Code (especially chapter 4) promoting the involvement of patients, and as appropriate their families and carers, in decisions about care and treatment should foster good relations between patients generally and particular groups of patients, carers and professionals. Guidance is also provided on the use of professionals having or being able to acquire specialist skills, for example to support patients who lack capacity, who have difficulty communicating due to a disability or because they do not speak English or English is not a first language, further supports this (e.g. chapters 6, 12 and 38).
	Access to family, friends and community (chapter 8) The Code includes specific guidance on access to the internet while in hospital and promotes maintaining relationships with patients' family, friends and local community. This should help patients to maintain support and have access to more information than they might otherwise be able to. It should also promote their re-integration into wider society, which should help to foster good relations, when they are able to progress back into community-based settings (chapter 8, including paragraphs 8.7 and 8.21 on the internet).

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[65] Department of Health. *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf. Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf.

Advance equality of opportunity	**Process of developing the Code** The Code includes a foreword by experts by experience (patients, former patients and carers). The expert reference group and consultation events have ensured significant involvement by patients and carers, including those representing a range of different protected characteristics in the work of developing the revised Code.
	Improving data collection, including qualitative data collection Chapter 3 of the Code requires commissioners and providers to have a human rights and equality policy, which ensures that there is robust monitoring of equalities and that details of any action that will be taken in light of the information collected is made available.
Foster good relations	**In terms of fostering good relations between groups:**
	New guiding principles (chapter 1) The new guiding principles overall, but especially the one on empowerment and involvement, promote the involvement of the patient, their family and carers. The respect and dignity guiding principle helps to ensure that everyone is treated with respect and dignity, while the purpose and effectiveness principle encourages a joined-up and holistic approach to care with patients, commissioners, professionals and providers all working together. Combined, and with the associated guidance to support them, these changes should improve relationships between patients, carers and/or professionals.
	Strengthened involvement of carers (chapters 1, 4 and throughout) The changes strengthen requirements to involve carers, family members and advocates in the patient's treatment and care. This should improve relationships between patients (who possess at least one protected characteristic) and other patients, carers and/or professionals.
	Improving awareness and accessibility The changes to the Code, and accompanying steps to promote awareness and understanding of it, should improve the relationship between patients (those who possess at least one of the protected characteristics and other patients), carers, other supporters and professionals across the health and social care system. This should enable improved care and treatment and reduced inpatient stays, and promote recovery.

Foster good relations	**Access to family, friends and community (chapter 8)** There is specific guidance in relation to access to the internet while in hospital, and the promotion of maintaining relationships with a patient's family, friends and local community. This should help patients to maintain support and have access to more information than they might otherwise be able to. It should also promote their re-integration into wider society, which should help to foster good relations, when they are able to progress back into community-based settings (chapter 8, including paragraphs 8.7 and 8.21 on the internet).

9. Mitigating equality impacts

9.1 Figure 2 sets out the equality impacts that have been identified by reference to each protected characteristic, as well as the mitigations that have been included in the new Code to address these. It sets out which chapter or paragraphs of the Code these changes relate to, so that readers can clearly see the link between the issue and the action taken. Appendices A–J set out a summary of the data collected by the respective characteristics.

9.2 The mitigating actions can be grouped into six key areas that are relevant across all the protected characteristics:

- **person-centred and involved assessment and care/treatment planning** with due regard to the empowerment and involvement guiding principle, focusing on 'What do I need to know about you in order to treat you well?';
- **data** – increase the amount and quality of both quantitative and qualitative data to assess, monitor and promote change;
- **equal access to treatment, therapies and outcomes** for patients;
- **improve staff knowledge, attitudes, behaviour and training;**
- care in line with the **guiding principles** (i.e. least restrictive, involves patients and, as appropriate, their carers, and promotes privacy, dignity and respect); and
- **effective communication and representation** so that the patient has information to make decisions in formats they understand and can be represented effectively through interpreters, IMHAs and legal representatives.

Figure 2: Mitigations by protected characteristic and carers of issues identified

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Age	Information provided to patients is often not age appropriate, meaning that children and young people do not understand and are not able to participate effectively.	Information should be appropriate to the patient's age, culture and communication needs, and, as appropriate, their family and carers' needs.	Chapters 19, 4 and 1,
	Age-appropriate beds are not always available for children and young people or older people within a reasonable distance or timeframe of family. This can result in them being placed a long way from family or on wards with patients of a different age; and they may be particularly vulnerable to abuse, bullying or harassment.	Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify their local authority of arrangements that are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18. The Children and Young People's Mental Health and Wellbeing Taskforce is due to publish a report in Spring 2015 and may suggest further mitigations.	Chapters 14 and 19, esp. 19.90–19.104
	During the (separate) review of sections 135/136 of the Mental Health Act and the consultation on the Code it was highlighted that there is some evidence that children and young people are more likely to be held in police cells than adults because some health-based places of safety do not accept under-18s.	The Code now makes it clearer that a child or young person should not be taken to a place of safety in a police station unless, having regard to the best interests of the child or young person, there is no suitable alternative available. The Code continues to clarify that, if this occurs, consideration should also be given to using a different part of a police station or other place under the supervision of a police officer and not a police custody suite. Additionally, the review of sections 135 and 136 makes recommendations for legislative change specifically on this issue of children and young people being detained in police cells, which will be taken forward and developed further.	Paragraph 16.44
	There are high rates of detention for older people, especially very old, and there is a need for age-appropriate services to support people while they are in hospital.	Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify their local authority of arrangements that are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18.	Chapter 14, and 19, esp. 19.90–19.104

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Age	Children's human rights as reflected in the UN Convention on the Rights of the Child (UNCRC) reflect the particular circumstances, needs and vulnerabilities of children. Evidence suggested that providers needed to do more to ensure compliance with this.	Chapter 19 provides that those responsible for the care of children and young people in hospital should be aware of the UNCRC and keep up to date with relevant case law and guidance.	Paragraph 19.4
	Ensuring age-appropriate assessments for children, young people and adults, including adults of different ages.	Making sure that assessments of a child or young person, including of their capacity (16 and 17 year olds) or competence (under 16 year olds), are undertaken by professionals who can demonstrate competencies in working with children and young people and who understand child development. Children and young people should not be considered 'small adults' in terms of equality.	Chapter 19, esp. 19.24–37, 19.73–74
	Transition from children's to adult's services can be difficult due to young people not being prepared for these changes	The Code makes clear that treatment should be appropriate, focused on recovery and be therapeutic. Care plans should be personalised to the individual. Chapter 19 provides specific guidance in relation to transition to support improvements in practice. In addition, *Closing the Gap*[66] sets out the Government's commitment to make progress in this area – this applies to mental health services generally. The NHS Commissioning Board is developing a new service specification for transition. The Children and Young People's Mental Health and Wellbeing Taskforce is considering how to improve transition services and will report in spring 2015.	Chapters 1 and 19

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[66] Department of Health. *Closing the Gap: Priorities for essential change in mental health*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf.

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Disability	There is a paucity of numerical data on any part of this protected characteristic, excepting some on learning disability (post-Winterbourne). This must be addressed for ensuring good commissioning and therefore quality experiences and outcomes that are equal to those for non-disabled people.	Local human rights and equality policies should set out what data should be collected to measure equality impacts, how this should be monitored and what mitigation actions should be taken to address negative trends. The action plan includes actions to improve data collection and monitoring, at local and national level. This includes the Health and Social Care Information Centre (HSCIC) continuing to publish data on the use of the Act, using the Mental Health and Learning Disabilities Data Set (MHLDDS) and CQC publishing information on equality impacts as part of their annual report on the application of the Act. The Department of Health is working with the HSCIC on ways to improve current data sets, including adding inclusion of protected characteristics to the Maintenance Plan for MHLDDS. This will include exploring the feasibility of publishing data by additional protected characteristics, which are already collected for patients subject to the Mental Health Act. The Equality and Diversity Council, members of which include the national health and care bodies, are overseeing a programme of work to improve equality monitoring across the NHS, which will include the development of equality data monitoring information standards for the wider system.	Chapter 3 Action plan (figure 3)
	Life and support needs not being met.	The anticipatory duty to have reasonable adjustments in place is highlighted in chapters 3 and 20. Chapter 24 sets out the need to provide physical and mental health treatment. Chapter 3 provides details of the Equality Act 2010 and reasonable adjustments. Specific guidance is included in the Code (e.g. to support people who are deaf, who have a learning disability or autism, a personality disorder or dementia).	Chapters 3, 14, 20, 21 and 24
	Boredom and lack of physical activity that leads to challenging behaviours, over-eating, lack of exercise and poor diet, and can lead to lower life expectancy and poorer health outcomes.	Chapter 24 sets out the need to provide physical and mental health treatment. It includes guidance on activities, diet and nutrition to address concerns about obesity, co-morbidities and lower life expectancy. Local human rights and equality policies could require provision of meaningful daily activities to reduce boredom and enhance self-esteem, particularly for people with learning disabilities.	Chapters 3, 20 and 24

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Disability	There is anecdotal evidence that patients with learning disabilities, autism or dementia are potentially more likely to be restrained or secluded for longer, and experience longer rates of detention, often a considerable distance from home.	The empowerment and involvement guiding principle and the promotion of advance statements in the Code means that patients will be encouraged to contribute fully, particularly when they are well and have capacity to express their views about where to be placed, what may trigger challenging behaviour and what should be done to de-escalate if their behaviour becomes challenging. The Code encourages: greater involvement of carers in discussions about care and treatment, including location of placement; increased access to information and advocacy services that are appropriate to the needs of these individuals, so that views can be more easily considered; and use of positive behaviour support or equivalents to reduce the likelihood of triggers that may prompt restraint. Chapter 2 gives further guidance in relation to the learning disability qualification, chapter 20 on support for individuals with a learning disability, and there is guidance throughout on ensuring information is in suitable formats (e.g. chapters 6, 12 and 38). Clarification of guidance on the interpretation of the learning disability qualification has been added in chapter 20, to ensure that detention is only where appropriate and people who should not be detained are not. Local authorities and commissioners should work to explore alternatives in the community and focus on prevention.	Chapters 1, 2, 3, 4, 6, 9, 11, 12, 14, 20, 26 and 38

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Disability	Communication impacts for patients with particular communication needs or difficulties (e.g. people with a learning disability, autism, dementia and people who are deaf), as well as people with physical impairments that impede communication (e.g. head injuries and some neurological conditions).	Accessible information and other communication should be made available, as well as the English spoken word (e.g. BSL, Makaton, Moon, sign boards, easy read, large formats, videos, CDs, advocates, interpreters, translators and speech and language therapists). The empowerment and involvement guiding principle establishes the need to involve people, including in ways they can understand, and further guidance is provided at points throughout the Code, for example in relation to IMHAs (chapter 6), the Tribunal (chapter 12) and hospital managers' panels (chapter 38). IMHAs and other professionals to have specialist training to support individuals appropriately. Accessibility and Awareness project to promote awareness of the Code and rights under the Act and provide information in alternative formats. Changes to the Code to make it more user-friendly in response to feedback from patients, former patients and carers. New empowerment and involvement guiding principle to ensure that patients are involved in their care and treatment, and strengthen involvement of carers in the care pathway.	Chapters 1, 6, 12, 34 and 38 Accessibility and Awareness project Action plan (figure 3)
	Loss of/no access to personal auxiliary aids	Care plans should form an intrinsic part of the assessment process and be followed as closely as possible. The Code includes guiding principles on dignity and respect and highlights the importance of supporting physical healthcare needs.	Chapters 1, 34 and 24
	Personal healthcare plans interrupted, changed, not asked for or not followed	Care plans should form an intrinsic part of the assessment process and be followed as closely as possible. The Code includes guiding principles on dignity and respect and highlights the importance of supporting physical healthcare needs.	Chapters 1, 34 and 24

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Disability	Bullying and harassment of patients with additional disabilities (e.g. learning disability, autism, sensory impairment, physical disability).	Local human rights and equality policies could set out how bullying and harassment will be prevented and addressed. The respect and dignity guiding principle sets out that all people should be treated with respect and dignity. The Code also sets out the need to comply with the Equality Act 2010 including, where applicable, the Public Sector Equality Duty (PSED). Chapter 8 provides further guidance on treating people with respect and dignity. Care plans should identify risks to the patient, and include strategies to prevent bullying and harassment and protect the patient. Chapter 4 and the introduction provide advice in relation to making a complaint if standards are not being met, including in relation to safeguarding and whistleblowing.	Chapters 1, 3, 4, 8, 34, and introduction
	Post-Winterbourne focus on learning disability may unintentionally favour those patients with a learning disability, autism or challenging behaviour.	Guidance on equality covers all patients. Specific guidance also included for people who are deaf (chapter 14) or have dementia (chapters 14 and 23) or a personality disorder (chapter 21). The increased data and guidance in relation to individuals with a learning disability can be seen as good practice and organisations should consider the learning from this in relation to people without a learning disability too.	Chapters 3, 14, 21 and 23
	Suitably skilled, trained and supported advocates being more routinely available.	Chapter 6 includes new guidance clarifying that local authorities must commission sufficient IMHAs to meet the needs of patients in their areas who qualify for IMHA services. Local authorities are required to commission IMHA services to reflect the diversity of the local populations, including sufficient numbers of IMHAs with a specialised understanding of the specific needs of patients with physical impairments, sensory impairments, learning disabilities and/or autistic spectrum disorders, and that IMHAs can communicate effectively with them.	Paragraph 6.7

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Disability	During the (separate) review of sections 135/136 of the Mental Health Act and the consultation on the Code concerns were raised that section 136 as a whole stigmatises people with mental health conditions through police involvement and the use of police cells as a place of safety for people with mental health problems who have not committed a criminal offence. There were also concerns that the police sometimes misused section 136 by persuading a person in a private home to go outside so they could be detained and removed to a place of safety.	Chapter 16 states that, wherever practicable, detention in a police station under section 136 should not exceed a maximum period of 24 hours. This will help to minimise the impact on the person and encourage a prompt assessment from a health professional, who is more likely to understand their needs. Chapter 16 also provides guidance that seeks to reduce the level of police involvement, including taking people to a health-based place of safety rather than a police station and using methods of transport other than a police car, to help reduce stigma. It is also made clear in this chapter that persuading a person in a private home to go outside so they can be detained and removed to a place of safety is not appropriate.	Chapter 16
Gender reassignment and transsexuality	There is limited available data on the numbers of transgender people detained, the length of their detention and the use of restraint/ seclusion.	Providers should aim to collect the information under their local human rights and equality policy. Due to the very small numbers of transgender people actually detained or on CTOs, organisations should be particularly sensitive to ensure that any identifiable data is recorded lawfully.	Chapter 3
	There are concerns that hormone therapy, which is the cornerstone of treatment for many transgender people, is not always continued, or it may be delayed, or denied, to those who are in secure accommodation, sometimes even when they have a diagnosis of gender dysphoria.	Chapter 1 (especially 1.17) highlights that physical healthcare needs should be addressed as well as mental healthcare needs. Access to all healthcare that is specific to gender dysphoria should be available without prejudice, as with any other required treatment not related to the mental health condition. The Code says that consideration should be given to the particular needs of transgender patients. Chapter 24 sets out that physical healthcare needs to be supported and appropriate medical treatment provided.	Chapters 1 and 24

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Gender reassignment and transsexuality	Some professionals raised concerns about what accommodation to provide for transgender people (especially those who have not undergone gender reassignment surgery), while meeting the requirements for single-sex accommodation.	Consideration should be given to the particular needs of transgender patients. The Code sets out guidance in relation to sleeping and bathroom areas. 'The Related Material' section to chapter 8 provides further information.	Chapter 8
	Transgender people may be susceptible to bullying and harassment from staff, patients and their families/visitors.	Local human rights and equality policies could set out how bullying and harassment will be prevented and addressed. The respect and dignity guiding principle sets out that all people should be treated with respect and dignity. The Code also sets out the need to comply with the Equality Act 2010 including, where applicable, the Public Sector Equality Duty (PSED). Chapter 8 provides further guidance on treating people with respect and dignity.	Chapters 1, 3 and 8
	Staff require training and increased awareness of needs and how to support transgender people if they are to support them effectively and not inadvertently discriminate. This includes training to address cultural and religious objections to gender nonconformity that may arise among other patients, their families, clinicians and staff.	Local human rights and equality policies could set out how staff who may come into contact with a transgender patient should have training on those issues that are specific to the right, dignity and wellbeing of transgender and non-binary people (people who do not self-identify as either gender). The respect and dignity guiding principle sets out that all people should be treated with respect and dignity. The Code also sets out the need to comply with the Equality Act 2010 including, where applicable, the PSED. Chapter 8 provides further guidance on treating people with respect and dignity.	Chapters 1, 3 and 8
Marriage and civil partnership	Patients reported discrimination and people, including staff, being judgmental about relationships, especially when these may not seem to conform to cultural norms. This intersects with sexual orientation, race and religion or belief.	Local human rights and equality policies should set out how the organisation complies with applicable human rights and equality legislation. Commissioners, providers and local authorities should ensure that staff have appropriate training and access to support to deliver services in a way that complies with equality legislation.	Chapters 1, 3, esp. 3.15 on training, and 34

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Marriage and civil partnership	Concerns that the nearest relative definition (section 26 of the Act) may discriminate against unmarried fathers, and does not reflect many modern caring relationships by not allowing the main care giver to displace the nearest relative if these differ. This is an issue for fathers in both same-sex and different-sex relationships.	Guidance incorporated in the Code (chapter 5) clarifies that the requirement to establish parental responsibility applies only in respect of patients under the age of 18 who are not born to parents who are married or in a civil partnership. Further changes would require primary legislation – action is included in the action plan to consider these issues at the next opportunity. This includes in relation to clarifying section 26 in respect of unmarried fathers of adult patients and non-traditional family relationships.	Chapter 5 Action plan (figure 3)
Pregnancy and maternity	Safety related to pregnancy, including fear of how and where to give birth, privacy and nursing arrangements.	Person-centred care planning should ensure that any restrictions are the least restrictive option and that the mother is involved in discussions about care and treatment. Chapter 8 gives guidance on ensuring that accommodation is appropriate, including mother and baby units with suitably qualified staff, continuance of pre-natal care. Chapter 24 provides guidance on ensuring physical healthcare is also supported, including co-morbidities, diet and nutrition. Providers' local human rights and equality policies could set out local birthing arrangements that can safely deliver on the mother's preferred birthing option/s.	Chapter 1, esp. paragraphs 1.2–1.12, 3, 8 and 24
	Bonding arrangements and whole family experience.	Chapters 11 and 14 include guidance on supporting families to visit and maintain contact.	Chapters 11 and 14
Race	Recovery rates are poorer in people from BME groups, leading to longer periods in hospital or on CTO.	Cultural and ethnic considerations are taken into account in determining what is appropriate medical treatment, including medication. The efficiency and equity guiding principle in chapter 1 sets out that commissioners should commission services that meet the needs of their populations. Local human rights and equality policies should set out what data should be collected to measure equality impacts, how this should be monitored and what mitigation actions should be taken to address negative trends.	Chapter 1 and paragraphs 3.15, 23.9 and 23.12

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Race	During the (separate) review of sections 135 and 136 of the Mental Health Act, data was obtained indicating that BME groups were over-represented in section 136 detentions (and for mental health services/detentions more generally) compared with the general population. Concerns were also raised, in particular from the black African-Caribbean communities, who felt that police use section 136 powers disproportionately on young black men.	A number of changes in the Code seek to reduce the numbers of people detained under section 136 or, where detention is necessary, to ensure that wherever possible places of safety other than police stations are used. By reducing the number of section 136 detentions in police custody, this will improve the situation for all persons detained under these powers. The revised Code also provides guidance that, prior to making use of section 136 powers, consideration should be given to less restrictive alternatives and police should work with health and/or social care professionals to identify other options and inform the decision as to whether detention is in fact necessary. This will help the police to come to a more informed decision and introduce an additional health or care-based perspective into the process. Additionally, where a person is detained in a police cell, the strengthened guidance on appropriate timescales for assessment and detention should also help to encourage a more prompt assessment and the involvement of health professionals at an earlier stage.	Chapter 16, esp. paragraphs 16.21–16.22, 16.36–16.44
	There is a perception that seclusion and restraint are disproportionately used for some people from BME backgrounds, such as black African-Caribbean men and South Asian women.	The respect and dignity guiding principle sets out that everyone should be treated with respect and dignity and chapter 3 requires all commissioners and providers to have a human rights and equality policy. Chapter 26 includes guidance on ensuring staff are culturally sensitive and take into account different cultural backgrounds and preferences to ensure culturally sensitive services and value-based training with zero tolerance on racial discrimination. The Code promotes person-centred planning that focuses, as with all people, on 'what do I need to know about you in order to treat/manage you well'.	Chapters 1, 26, esp. paragraphs 26.10, 26.15, 26.17 and 26.164, and 34

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Race	BME groups are disproportionately represented in the detained inpatient population.	Assessment staff (AMHPs and section 12 doctors) should be trained in delivering care that takes into account specific cultural needs. Chapters 24 and 1 highlight the importance of physical healthcare and promoting recovery, and the need for commissioners to understand the needs of their populations. Chapters 6, 12 and 38 include guidance on IMHAs, Tribunal staff and hospital managers having sufficient knowledge and skills. New guidance has been provided in relation to immigration detainees (chapters 14 and 22). Further guidance in relation to support for immigration detainees is being considered.	Chapters 1, 3, 5, 8, 12, 14, 22, 24 and 34 Action plan in response to consultation
	Suitably skilled, trained and supported advocates being routinely available for people from BME communities as well as majority communities – lack of appropriate and culturally competent advocates leading to less representation and poorer outcomes.	Chapter 6 includes new guidance clarifying that local authorities must commission sufficient IMHAs to meet the needs of their patients in their area who qualify for IMHA services. Local authorities are required to commission IMHA services reflecting the diversity of the local inpatient population. Local authorities should ensure that there are sufficient numbers of IMHAs with a specialised understanding of the specific needs of patients from minority cultural and ethnic backgrounds and that IMHAs can communicate with them. This could include ensuring IMHAs have cultural diversity training and/or access to specialist advice/support should a patient require this.	Chapters 1 and 6
	People may be more susceptible to bullying, harassment and victimisation due to their race.	Local human rights and equality policies could set out requirements for appropriate staff training, zero tolerance and individual and group care planning, in line with the respect and dignity guiding principle. Chapter 8 and the respect and dignity guiding principle set out that everyone should be treated with dignity and respect and kept safe.	Chapters 1, 3, 8 and 34
	Immigration detainees may be particularly vulnerable and may require additional support.	Additional guidance is included in the Code on supporting patients who are immigration detainees. The Department of Health and Home Office are exploring whether further additional guidance would be helpful.	Chapters 14 and 22 Action plan in response to consultation

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Race	Communication needs, in particular but not limited to people whose first language is not English, are not met. (This is included under race in relation to those people of different races who do not speak English.)	The empowerment and involvement guiding principle (chapter 1) sets out that information and communication should be provided in ways that people understand. Further guidance is included in other chapters (e.g. chapters 6, 12 and 38). Local human rights and equality policies could set out how this will be done. Local policies could provide for: • routinely available access to information in patients' and families' first language; • interpreters being routinely available 24/7; • staff confirming that the person is fully informed before they make decisions; • staff being trained in delivering care that takes into account specific cultural needs, such as skin care, higher rates of diabetes in some communities, bias towards alternative healthcare. Chapters 14 and 22 include guidance in relation to immigration detainees.	Chapters 1, 3, 6,12, 14, 22 and 38
	Physical health needs being ignored or inappropriately addressed, leading to lower health outcomes and lower life expectancy.	Chapters 1, 3 and 24 include guidance on ensuring that physical and mental healthcare needs are addressed and health inequalities decreased. The guiding principles on purpose and effectiveness, and efficiency and equity, set out the need for a holistic approach, focused on the whole person and equivalent consideration of physical and mental health needs. Person-centred planning that focuses, as with all people, on 'what do I need to know about you in order to treat/manage you well'. Guidance is included in chapters 1 and 34, and at other places in the Code.	Chapter 1, 3, 24, 34

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Race		Local human rights and equality policies should set out how this will be done and could provide for: • staff being trained in delivering care that takes into account specific physical healthcare needs in some ethnic groups, such as skin care, higher rates of diabetes in some communities, or preference for alternative healthcare; and • focus on culturally sensitive services and value-based training with zero tolerance on racial discrimination.	
	Inter-sectional issues (e.g. inter-relationship between LGBT and religion, non-religion and disability)	Person-centred planning that focuses, as with all people, on 'what do I need to know about you in order to treat/manage you well'. Patients involved in their care planning as set out by the empowerment and involvement guiding principle and chapter 34 on care planning.	Chapters 1 and 34
Religion or belief (including non-belief)	There is a paucity of data on this issue, which makes it difficult to quantify impacts and appropriate responses.	Local human rights and equality policies should set out what data should be collected to measure equality impacts, how this should be monitored and what mitigation actions should be taken to address negative trends. Local policies for commissioners and providers could include requirements for: • staff training to collect data on religious identity; • commissioning of services that uphold and actively engage with people's religious identities and beliefs; and • providers to deliver services that actively uphold and support people's religious identities and beliefs.	Chapter 3
	People may be more susceptible to bullying, harassment and victimisation due to belief or non-belief.	Local human rights and equality policies could set out requirements for appropriate staff training, zero tolerance and individual and group care planning, in line with the respect and dignity guiding principle. Chapter 8 and the respect and dignity guiding principle set out that everyone should be treated with dignity and respect and kept safe.	Chapter 1 3, 8 and 34

Protected characteristic	**Equality impact identified**	**Mitigation to address concern or opportunity to promote (in Code or elsewhere)**	**Code chapter/para (if relevant)**
Religion or belief (including non-belief)	Little referencing to the importance of religion and belief systems in promoting health, access to services and recovery. Some patients and their families suggested that this is often ignored or ridiculed, when it can be an important part of recovery.	Promotion of a holistic approach to care, support and treatment, considering the whole person's needs and taking account of their views about what may help. The patients and their family are key partners in this as well as professionals. The purpose and effectiveness guiding principle focuses on recovery, and treatment must be provided that is appropriate for both mental and physical healthcare. The full range of potential treatments for the patient should be considered. The respect and dignity guiding principle sets out that patients should be treated with dignity and respect. The empowerment and involvement guiding principle sets out that they, and as appropriate their carers, should be involved in discussion about care and treatment.	Chapters 1, 23 and 24
	Need for appropriate washing facilities to comply with religious observance. These are not always available, especially where single-sex accommodation is not provided or washing facilities are not separate.	Guidance is included on the need for appropriate accommodation arrangements. One reason for this is to consider religious preferences. The human rights and equality policy could set this out if providers felt it was necessary.	Chapter 1, Paragraph 8.27
	Ignorance on the different aspects of people's faith and what this means in terms of managing people in detention, e.g. Ramadan and key festivals and celebrations ignored or aspects of faith not being able to be observed	The Code promotes staff sensitivity to cultural needs including in carrying out detention, treatment and care planning and ensuring patients are treated with dignity and respect. The Code includes guidance on commissioners (chapter 1), IMHAs (chapter 6), Tribunal staff (chapter 12) and hospital managers' panels (chapter 38) having sufficient skills or being able to acquire specialist knowledge and expertise. Local human rights and equality policies should set out how staff will be provided with learning, development and training on human rights legislation and the Equality Act.	Chapters 1, 3 esp. paragraph 3.15 on training, 6, 12, 26, 34 and 38
Sex	Detained women are highly vulnerable to sexual harassment or assault.	Local human rights and equality policies could set out how staff should be trained in how to identify harassment and how this can lead to assault, how care planning can be used to prevent assault situations arising, and how these risks should be managed, including at night and in seclusion. This is in line with the respect and dignity guiding principle and the seclusion policy.	Chapters 1, 3, 8 and 26

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Sex	Female patients may feel uncomfortable and compromised when observed by male staff. Some say they find it degrading, others (especially those who have been subjected to sexual or other violence) say it triggers flashbacks.	Person-centred care planning should focus on the individual, including privacy needs. Local human rights and equality policies could set out how this issue should be managed, including at night and in seclusion. This is in line with the respect and dignity guiding principle and the seclusion policy.	Chapters 1, 3 8, 26 and 34
	Women reported concerns with privacy and dignity in care provision, including related to suitable underwear and sanitary protection.	Providers and commissioners should ensure that all patients are treated with dignity and respect (paragraphs 1.13–1.14). Providers and commissioners could include in their human rights and equality policy (chapter 3) how any identified gaps will be addressed. The respect and dignity guiding principle and chapter 8 provide guidance on ensuring people are treated with respect and dignity. This is supported through person-centred care planning, which should include consideration of dignity.	Chapters 1, 3, 8 and 34
	Men are more likely to spend time in hospital either as an informal patient or subject to the Act, especially as a part 3 patient (although the proportion of male part 3 patients reflects the proportion of males in offender population generally).	Local human rights and equality policies should ensure data is collected and any negative trends analysed and the drivers addressed.	Chapter 3
Sexual orientation	Lack of data is an issue as it prevents real consideration of the impacts and how these could be addressed.	Local human rights and equality policies should collect data, monitor and address any negative trends. The action plan includes action on collection of data at a national level.	Chapter 3, esp. 3.15 on training Action plan (figure 3)
	Gay, lesbian and bisexual people may be more susceptible to bullying, harassment and victimisation.	Local human rights and equality policies could set out requirements for appropriate staff training, zero tolerance and individual and group care planning, in line with the respect and dignity guiding principle. Chapter 8 and the respect and dignity guiding principle set out that everyone should be treated with dignity and respect and kept safe.	Chapters 1, 3, 8 and 34

Protected characteristic	Equality impact identified	Mitigation to address concern or opportunity to promote (in Code or elsewhere)	Code chapter/para (if relevant)
Sexual orientation	Concerns that the nearest relative definition (section 26 of the Act) may discriminate against unmarried fathers, and does not reflect many modern caring relationships by not allowing the main care giver to displace the nearest relative if these differ. This is an issue for fathers in both same-sex and different-sex relationships.	Guidance incorporated in the Code (chapter 5) clarifies that the requirement to establish parental responsibility applies only in respect of patients under the age of 18 who are not born to parents who are married or in a civil partnership. Further changes would require primary legislation – action is included in the action plan to consider these issues at the next opportunity. This includes in relation to clarifying section 26 in respect of unmarried fathers with adult children and in non-traditional family relationships.	Chapter 5 Action plan (figure 3)
	Reports suggest an increased risk of self-harm and suicide from LGB patients.	Local human rights and equality policies should set out what data should be collected to measure equality impacts, how this should be monitored and what mitigation actions should be taken to address negative trends. Local policy could set out training requirements, which could include specific mitigations related to preventing suicide and self-harm; zero tolerance of bullying and harassment; and individual and group care planning.	Chapter 3, esp. 3.15 on training
Carers (not a protected characteristic, but relevant to issues raised above)	Prominence of nearest relative (as defined by section 26 of the Act) is not reflective of many caring relationships. This may mean that the patient may suffer as the person best placed to be involved is not legally able to do so.	Guidance is included in chapter 5 in relation to nearest relatives and under-18s. The empowerment and involvement guiding principle encourages the involvement of carers, and further guidance throughout the Code supports this (including, where appropriate, involving carers). The Code promotes the involvement of carers throughout. Further changes would require primary legislation – action is included in the action plan to consider issues at the next opportunity.	Chapters 5 and 1, and references throughout the Code to increased role and involvement of carers. Action plan (figure 3)

10. Action planning for improvement

10.1 This analysis sets out that new guidance in the Code can only go some way to addressing the equality impacts identified.

10.2 In preparing this EA, concern has been raised that there are significant data gaps regarding equality impacts in the application of the Act, which is adversely affecting how compliance with the Equality Act can be monitored.[67] The CQC has consistently reported that equality impacts in relation to certain protected characteristics are not being systematically and routinely monitored by providers, although these and the other characteristics may be inspected during CQC monitoring visits.[68]

10.3 In particular, improving the quality of data and information management would ensure that any discrimination in practice can be identified and addressed. This relates to both the paucity of numerical data and the lack of evidence from patients, the public and families and carers about their experiences. It is not possible to disaggregate the available data by protected characteristic and much is not collected or published. The Department of Health (DH) is working with the Health and Social Care Information Centre (HSCIC) on ways to improve current data sets. This includes exploring the feasibility of publishing data by additional protected characteristics which is already collected. The Department and CQC will use this data to continually inform understanding of the impacts of the Act and Code in practice. We will use this to inform policy design and good practice guidance including future revisions to the Code.

10.4 The Code gives guidance that requires commissioners and providers to ensure robust monitoring of equalities, so that commissioners and providers can better understand how people with protected characteristics are affected by the Act (chapter 3). The Code sets out an overarching framework for the human rights and equality policy and leaves it to local policies to determine what should be included and how this should operate. The policies could include both quantitative data and qualitative information about patients' and their families' experience of outcomes and using services.

Arrangements for making information accessible to staff, patients and the public

10.5 The Department of Health in conjunction with Inclusion North and other partners is taking forward an **Accessibility and Awareness project** over the course of 2014/15. This was supported by a number of consultation responses. This project aims to address concerns about the awareness of patients and carers of the Act and Code, particularly patients who lack capacity, do not speak English, have a learning disability, autism, a physical disability or communication difficulties such as a speech impediment. Indications were that many patients, their families and carers were unaware of the Code, the safeguards of the Act, how to be involved in discussion about care and treatment and how to seek redress if the relevant safeguards were not being appropriately applied. This project seeks to increase awareness and understanding of the Code by patients, their families and carers, but also by professionals, including GPs, social care staff and advocacy services, so that patients can be better supported while subject to the Act. This should also help patients and others

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[67] Literature Review, p.9.

[68] Ibid.

to raise any concerns they have about how the Act has been applied, thereby ensuring commissioners and providers are held to account.

10.6 The Accessibility and Awareness project involves:

- **colour-coding the Code**, to make it easier to navigate, to identify relevant information and, in particular, to highlight the information most relevant to patients, their families and carers;
- **producing supporting material in alternative formats**, for example shorter pamphlets on key issues, video clips and stories of key episodes, so that individuals can better understand what will happen at significant points in the care pathway (e.g. at admission or at the Tribunal, including where possible when they are well), and enabling materials in alternative languages/pictures to be available in both hard copy and electronic formats; this was considered key as some people reported finding it difficult to understand written material about what support they could get, especially when they are unwell; and
- **promoting awareness of and access to** the Code and supporting materials to patients, prospective patients, families, carers, voluntary and community organisations and a range of health and social care professionals.

10.7 More generally, NHS England is developing a new 'accessible information standard'. The accessible information standard will provide clear guidance to health and adult social care organisations as to the steps they must take to ensure that disabled patients, carers and service users receive information in appropriate formats and communication support if they need it. The standard will provide specific direction to organisations around identifying, recording, 'flagging' and sharing patients', service users' and carers' information and communication support needs, and the actions that must be taken to meet those needs. It is anticipated that the standard will particularly affect people who are deaf, blind or deafblind, have some hearing or visual loss, and/or a learning disability. It is also anticipated that the standard will support people with aphasia, autism and/or a mental health condition that affects their ability to communicate.

10.8 The accessible information standard is currently partway through the developmental phase. It is following a formal process to become an information standard, which has a number of stages and milestones. It is anticipated that the standard will be finalised – and published – in spring 2015. It is currently proposed that organisations would then have up to 12 months to comply, meaning that they will be required to have implemented the standard by summer 2016. Further information about the standard is available at www.england.nhs.uk/accessibleinfo.

10.9 Figure 3 captures the key actions that we have determined are required in order to address some of the equality issues identified. Some of these are for the Department of Health (DH) to take forward, other actions have been agreed by DH and system partners to be progressed by partners, such as the (HSCIC, the CQC, the NHS Commissioning Board (NHS England), and some are recommendations for commissioners and providers.

Figure 3: Action plan for improvement

Category	Actions	Target date	Responsibility
Plans already under way or in development to address the challenges and priorities identified	**Accessibility and Awareness project:** The Department of Health in conjunction with Inclusion North and other partners is undertaking an Accessibility and Awareness project. This aims to address concerns about the lack of awareness of the Act and Code, among patients and carers, particularly patients who lack capacity, do not speak English, have a learning disability, autism, are deaf, have a physical impairment, or communication difficulties such as a speech impediment.	April 2015	DH
	NHS England's accessible information standard will provide clear guidance to health and adult social care organisations as to steps they must take to ensure that disabled patients, carers and service users receive information in appropriate formats, as well as communication support if they need it.	Summer 2016	NHS England
Arrangements for continued engagement of stakeholders	**Mental Health Systems Board (MHSB):** The MHSB, which includes all the major system partners in mental health, will continue to provide strategic oversight to mental health.	Already established: ongoing engagement	MHSB
Arrangements for continued monitoring and evaluation of the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)	**Monitoring of data at a local level:** Commissioners and providers should ensure robust monitoring of equality data, including collection of qualitative data, as part of their human rights and equality policy (in accordance with paragraph 3.15).	April 2016	All providers and commissioners (including NHS England)
	Monitoring of data at a national level: CQC will monitor compliance with the Act and Code via CQC inspections and annual reports.	Ongoing	CQC
	The Health and Social Care Information Centre will continue to publish data on use of the Act, using the Mental Health and Learning Disabilities Data Set (MHLDDS).	Ongoing	HSCIC
	DH is working with the Health and Social Care Information Centre on ways to improve current data sets, including adding inclusion of protected characteristics to the Maintenance Plan for MHLDDS. This will include exploring the feasibility of publishing data by additional protected characteristics, which is already collected for patients subject to the Mental Health Act.	2016/17	HSCIC/DH
	The Equality and Diversity Council, members of which include the national health and care bodies, are overseeing a programme of work to improve equality monitoring across the NHS, which will include the development of equality data monitoring information standards for the wider system.	Already established: ongoing monitoring	NHS England

Category	Actions	Target date	Responsibility
	Mental Health Systems Board (MHSB): The MHSB, which includes all the major system partners in mental health, will continue to provide strategic oversight to mental health, including the application of the Act and the Code.	Already established: ongoing monitoring	MHSB
Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results	This **EA will be published** alongside the Code in January 2015. Stakeholders will be made aware of the new Code and EA. From this point it will become a publicly available document and hosted on the www.gov.uk website.	January 2015	DH
Arrangements for making information accessible to staff, patients and the public	**Accessibility and Awareness project:** The Department of Health in conjunction with Inclusion North and other partners is undertaking an Accessibility and Awareness project. This aims to address concerns about the lack of awareness of the Act and Code, among patients and carers, particularly patients who lack capacity, do not speak English, have a learning disability, autism, are deaf, have a physical impairment, or communication difficulties such as a speech impediment.	April 2015	DH
Arrangements to make sure the EA contributes to reviews of DH strategic equality objectives	**[1] Share findings with DH Equality Team:** ensuring that the findings of the analysis is cascaded across the wider Department of Health in order to advance equality.	January 2015	DH
	[2] Propose amending Act: Consider changes to definition of nearest relative and learning disability qualification.	Exploration of amendments to Act at suitable opportunity. Date TBC	DH
Arrangements for embedding findings of the EA assessment within the wider system, other Government Departments, other agencies, local service providers and regulatory bodies	**Embedding findings of EA** Commissioners and providers should ensure that there is **robust monitoring of equality**, so that they can better understand how people with protected characteristics are affected by the Act, via their local human rights and equality policies.	April 2016	All providers and Commissioners (including NHS England)
	CQC to use the Code as the basis for 'what a good rating is' in inspection of mental health hospitals.	April 2015 ongoing	CQC
	CQC commits to **publishing relevant equality information** in the 2015/16 report on the Act and will continue to develop the reporting in later years.	CQC will inspect against new Code from April 2015 and report on findings in the 2015/16 annual report	CQC

Appendices – Summary data collected by protected characteristic

A.0. The appendices include data by protected characteristic, and carers. This includes quantitative published data and qualitative and quantitative data in surveys and reports in our literature review. It also includes qualitative or anecdotal feedback provided during the review (November 2013–December 2014), especially during the public consultation (July–September 2014).

Appendix A: Age

A.1. The protected characteristic of age covers people of all ages. People of a particular chronological age group (whether a particular age or a range of ages) share this protected characteristic.

Data and literature review

A.2. Recent evidence from the NMHMDS does tend to indicate difference by age group, including between men and women in different age groups.

A.3. Males aged 18–35 were the most numerous group detained under the Act in hospital, while 36–64 year olds represented by far the largest age group (59%) on CTOs and the over-65s were a very low proportion of those on CTOs. This suggests that age may be important in influencing professionals' decisions about the level of restriction someone should be subjected to.

A.4. Generally, more men than women are subject to detention under part 2 of the Act; however, in the 65 and over age group, more women than men were detained under part 2. This may reflect their longer life expectancy.

A.5. Fewer than 80 people under the age of 18 were detained under part 2; this was evenly split between males and females.[69]

A.6. There were also reported differences in the age profile of patients in NHS trusts and foundation trusts and independent sector providers, with the independent sector tending to have a lower age profile.[70]

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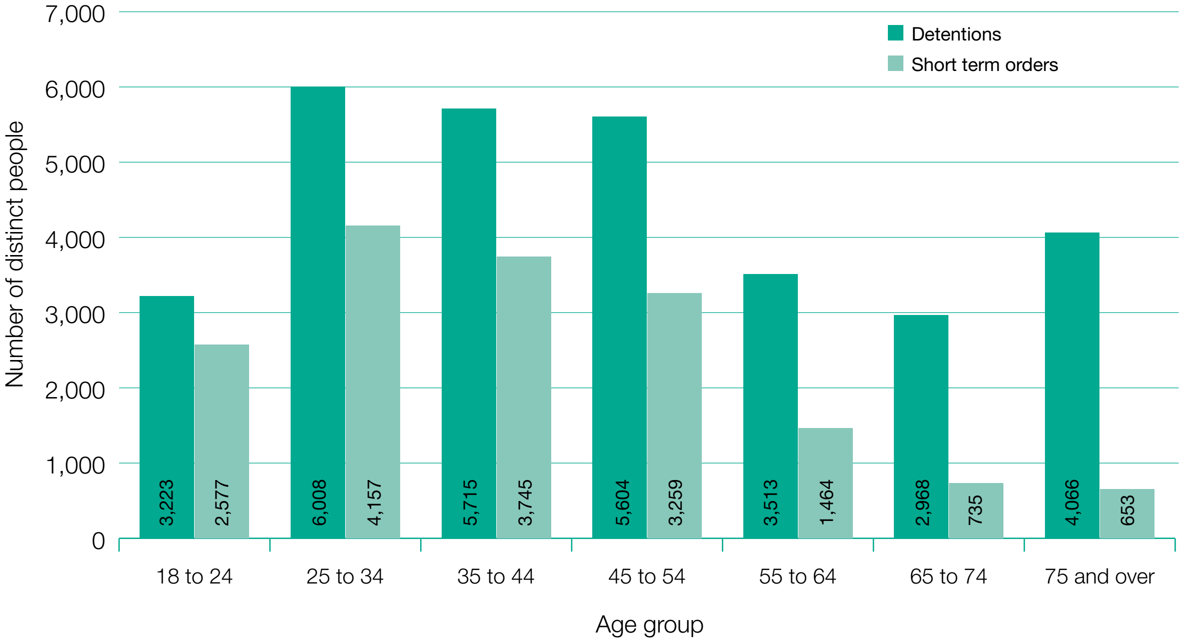
[69] HSCIC. *Mental Health Bulletin: Annual report from MHMDS returns – England 2012/13*. 2013. www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf. pp.5, 10, 15–16.

[70] Ibid. p.30.

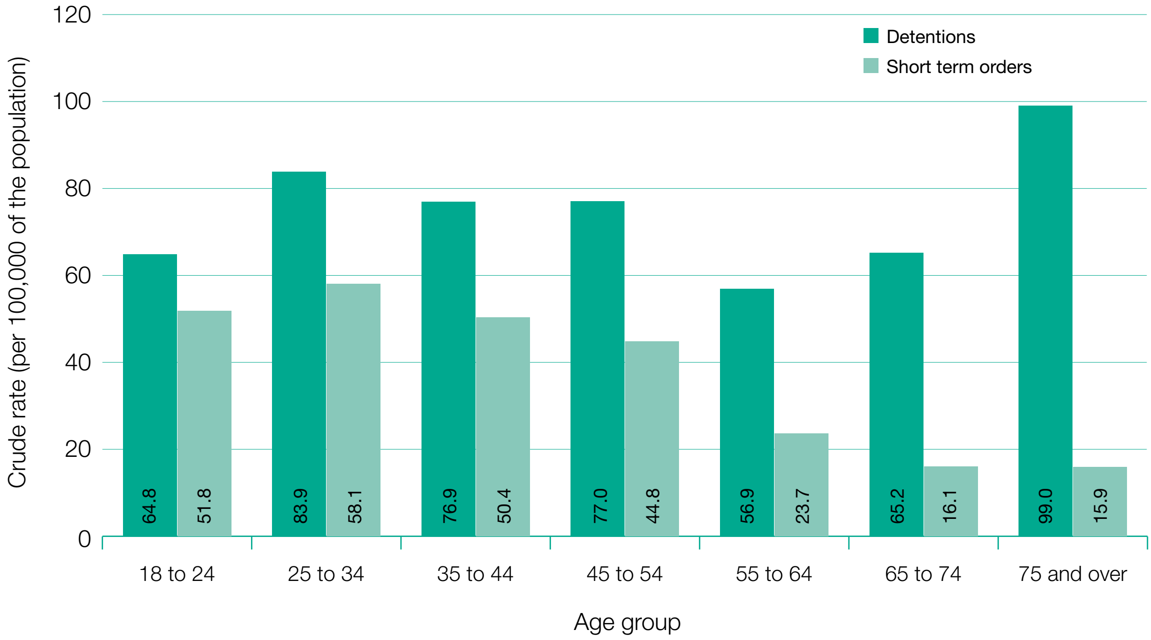
A.7. The information available from HSCIC on the absolute numbers of detention decisions under the Act indicates that the group subject to the most detentions is the 25–34-year-old age group with 6,008 detentions during 2012/13 (see figure 4 below).[71]

Figure 4: Number of people subject to detentions and short-term orders by age group 2012/13



A.8. When one analyses the figures on a head of population basis (by the proportion of people in the population in each age group), over 75 year olds are disproportionately represented in the detention statistics.[72]

Figure 5: Number of detentions and short terms orders by age group in 2013/14 per 100,000 people in the population



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[71] *Monthly Report: A special feature: Experimental analysis about uses of the Mental Health Act in adult mental health services*. 2014. http://www.hscic.gov.uk/catalogue/PUB14125/mha-spec-fea-rep-1213.pdf. See also: HSCIC. Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014, Annual figures. 2014. http://www.hscic.gov.uk/catalogue/PUB15812. Short-term orders refers to sections 4, 5(2), 5(4), 135 and 136. Patients under 18 years are not included.

[72] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf. Short-term orders refers to sections 4, 5(2), 5(4), 135 and 136. Patients under 18 years are not included.

Children and young people

A.9. Children and young people under the age of 18 (both part 2 and part 3 admissions) are a very small percentage of total detentions (178 in 2013/14, a decrease of 5 people or 3%).[73] We received a large number of consultation responses in relation to the need for further guidance on supporting children and young people.

Consultation responses and feedback

A.10. Responses in relation to children and young people under the age of 18 included:

- Assessments were not always considered to be age appropriate. In order to eliminate discrimination and advance equality of opportunity, providers must ensure that children and young people and those with specific needs such as learning disabilities or hearing impairments are assessed by appropriately skilled professionals.
- Suggestions relating to capacity, competence and decision-making among children and young people included stating that capacity applies to over-16s; involving children and young people in decisions that affect them as much as possible, ensuring that safeguards apply to ensure that they have the support to do so; explicitly stating the legal position at the time when the young person has yet to make a decision with regards to admission to hospital; rewording so it is easier for children, young people and their families to understand; including clear examples where a child or young person has been found to have capacity but is deemed to be unable to make a decision; and making clear that the consent, wishes and feelings of the child should be sought in circumstances that allow the child to express their views freely. For example, the child should be spoken to alone if there is a chance that their views may differ from those of their parents.
- Suggestions included that the Code should make it clearer that, when the child has capacity or competence to consent to treatment and objects to the treatment, including informal admission and treatment, most of the interventions envisaged would be so intrusive that it would be inappropriate to rely on parental consent.
- CQC suggested that the Code in respect of the duty in section 140 of the Act should define responsibilities for: commissioning and providing arrangements for the reception of urgent cases, including for people under the age of 18 and identifying and agreeing the arrangements in local areas, including contingency arrangements for those cases where the hospitals named in the policy are not available. This should ensure that local agency boundaries are not an over-riding constraint, and that there are arrangements to ensure children and young people can be admitted in special urgency.
- Comments in relation to crisis care and places of safety included the need for it to be clearer in the Code that an appropriate adult (who is required to attend a police station to assist a person in police custody) should not be called if someone is detained in a police station as a place of safety under the Act and that this should instead be an IMHA.

Transition

A.11. Respondents including patients and national bodies mentioned that the transition from child and adolescent mental health services to adult psychiatric services needs to improve, with considerable changes in practice required. The transition between child/adolescent and adult services is traumatic for many people. There appears to be wide variation in the quality of planning transition in services across England.

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[73] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf.

Older people

A.12. The literature review in relation to older adults identified few empirical studies. CQC reports highlight that women begin to outnumber men in older age bands (i.e. over the age of 65).[74] Some studies have highlighted specific points in relation to old age and very old patients, for example the need to restrain appropriately taking account of physical status and frailty, and the misuse of medication as a particular risk. Deterioration in ability, reflecting the aging process, needs to be carefully considered and attention paid to making reasonable adjustments to ensure that older people have the same access as younger people to information, activities and opportunities to protect their rights and promote their wellbeing.[75]

Consultation responses and feedback

A.13. Some responses commented on older people; however, given the relatively higher rates of detention for older adults relative to their proportion in the general population, the number of comments was lower than might have been expected. Comments related to conditions that are more prevalent in older people including dementia and frailty. In relation to older adults, a number of respondents considered that more specific guidance was required, including specific guidance on supporting older people detained who also had dementia, especially given the increasing numbers of people being detained with dementia.

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[74] Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213 (hereafter called 'CQC 2014').

[75] Literature Review, p.9. Care Quality Commission. *Monitoring the Mental Health Act in 2009/10*. 2010. www.cqc.org.uk/sites/default/files/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf (hereafter called 'CQC 2010'). Care Quality Commission. *Monitoring the Mental Health Act in 2010/11*. 2011. www.cqc.org.uk/sites/default/files/documents/cqc_mha_report_2011_main_final.pdf (hereafter called 'CQC 2011'). Care Quality Commission. *Monitoring the Mental Health Act in 2011/12*. 2012. www.cqc.org.uk/content/mental-health-act-annual-report-201112 (hereafter called 'CQC 2012'). CQC 2014.

Appendix B: Disability

B.1. A person has this protected characteristic if they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

Data and literature review

B.2. The CQC has highlighted the lower life expectancy for people with a serious mental illness, noting that the average life expectancy is now 83 for women and 79 for men but for those with serious mental illnesses it is significantly lower: 69.9 for women and 64.5 for men.[76] One study in Australia highlighted two main reasons for this: clinical barriers to physical care and attitudinal barriers to physical care.[77] Detention under the Mental Health Act provides a window of opportunity to address this and to include physical healthcare as part of an overall plan.

B.3. A person with poor mental health that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities has this protected characteristic. A person detained under the Act is likely to have this protected characteristic for at least the period in which the person is subject to the Act.

B.4. People detained under the Act are disadvantaged in their access to physical healthcare compared with the general population. CQC highlighted the need for the physical health needs of patients detained under the Act to be a priority. Of the 595 deaths of people subject to the Act that were notified to CQC in 2011/12–2012/13, one-third of the people were under the age of 60. This confirms that patients detained under the Act show a similar reduction in life expectancy to people with severe mental illness.[78]

B.5. A study has shown that the experience of detention was often found to be profoundly disempowering, confirming the need for independent mental health advocates (IMHAs) and other forms of advocacy.[79] At the time of the study IMHA access varied considerably and was more problematic for people with needs relating to ethnicity, age or disability. Uptake of IMHA services was influenced by the effectiveness of IMHA provision. The IMHA role was generally valued by patients, with satisfaction mostly reported in terms of positive experiences of the process of advocacy rather than tangible impacts on care and treatment under the Act. However, the understanding by IMHA services of measures to promote equality and diversity was often limited.[80] Following this report the Department of Health has funded a programme to support improved commissioning of IMHA services, including improvement in reflecting the diverse needs of the local population of qualifying patients. Further guidance is forthcoming in 2015.

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[76] CQC 2014. p.72.

[77] Nankivell, J., Platania-Phung, C., Happell, B. and Scott, D. Access to physical health care for people with serious mental illness: a nursing perspective and a human rights perspective – common ground? *Issues in mental health nursing* (2013), 34(6). pp.442–450.

[78] CQC 2014. pp.3–4, 79.

[79] Najim, H. and Shaik, R. *A Critical Review of Patients under Section 5 (2) of the Mental Health Act of 1983*. 2013. Literature Review, pp.9–10.

[80] Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D. et al. *The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England. Research Report*. Preston: UCLan. 2012. www.uclan.ac.uk/research/explore/projects/the_right_to_be_heard.php.

B.6. One study has shown that organisational and ward culture plays an important role in determining the therapeutic milieu for detained patients, including camaraderie with other patients and helpfulness of staff.[81] A lack of activity, boredom, being forced to live with seriously unwell people in cramped and mixed wards, and poor staff attitudes were associated with negative perceptions of detention.[82]

Consultation responses and feedback

B.7. In general people responding to the consultation said they considered that the Code should include more guidance about how services should notify people of their rights and train staff. Suggestions included recommending that services provide information in a short, user-friendly form for patients and carers, such as having a one-page list of people's rights in paper form that should be given out to every patient, and emphasising that information and leaflets should be provided in many formats and languages, including sign language.

B.8. Some comments, while submitted in relation to people with additional or specific disabilities, were also relevant to detained patients more generally (e.g. comments on reasonable adjustments under learning disability and autism).

Learning disability and autism

Data and literature review

B.9. There is better quality data on people subject to the Act who have a learning disability, autism or behaviour that can be considered challenging, compared with data on people subject to the Act who have protected characteristics other than disability. This analysis therefore includes quite a detailed consideration of learning disabilities. This should be seen as good practice relative to other characteristics.

B.10. The Learning Disabilities Census has provided more information about people with a learning disability detained under the Act. This showed that:

- the primary reason for admission under the Act was 'learning disability' under the learning disability qualification;
- 20.3% of people were subject to greater restrictions on census day than on admission; and
- 41.3% of people detained who have a learning disability are detained under part 3 of the Act.[83]

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[81] Ridley, J. and Hunter, S. Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. *Health and Social Care in the Community* (2013), 21(5). pp.509–518.

[82] Literature Review, p. 4.

[83] HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September 2013*. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf. pp.24–31.

B.11. The need for specialist knowledge of learning disabilities and autism has been highlighted by CQC and others.[84] At Winterbourne View concerns were raised about the lack of proper reviews and that individuals who raised complaints were not listened to.[85]

B.12. More generally individuals with a learning disability have significantly lower health outcomes than those without learning disabilities: men with learning disabilities die on average 13 years earlier, and women with learning disabilities 20 years earlier. Of people with learning disabilities, 22% were under 50 when they died, compared with 9% of people without learning disabilities.[86]

B.13. The National Development Team for Inclusion has published guidance on the reasonable adjustments that services need to make for people with learning disabilities or autism and mental health problems to ensure that they are not disadvantaged in accessing appropriate support.[87]

Consultation responses and feedback

B.14. Consultation responses suggested that fully documented account should be taken of a person's learning disability/autistic spectrum disorder and appropriate specialist services should be actively involved. It was suggested that people need training in capacity issues and in being able to identify which decisions a person with a learning disability or autism has capacity to make. Scenarios could be provided, such as people with Asperger's syndrome who appear to have capacity to make certain decisions when in fact they do not.

B.15. It was suggested that the needs of people with learning disabilities at the point of assessment is a concern, and guidance on assessment of patients with learning disabilities or challenging behaviour could be developed and incorporated at a later stage into the Code. It was suggested that there should be better recognition of learning disabilities and autism, and that this should be covered in staff training.

B.16. The CQC, Mencap and the Challenging Behaviour Foundation in their consultation responses and in other places highlighted the need for staff such as IMHAs to have specialist knowledge of learning disabilities and autism. It was suggested that inspection of services by the CQC should include evidence of specific training for staff working with that patient group, of ward regimes being specifically adapted to their needs, and of consideration being given to the appropriate or inappropriate mixing of patient groups given the specific needs and vulnerabilities of these patients.

B.17. Advocacy is needed as individuals are routinely in need of this facility when receiving interventions from public services and continuity of advocacy and initiation of advocacy is essential as an offer for safety. Advocates need to have an awareness of learning disabilities and autism. It was suggested in consultation that advocacy services should always be available and appropriate to the person, including patients with a learning disability, sensory loss, autism or with other cultural or communication difficulties or considerations.

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[84] Literature Review, p.10. Care Quality Commission. *Monitoring the Mental Health Act in 2012/13*. 2014. www.cqc.org.uk/content/mental-health-act-annual-report-201213.

[85] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Care Quality Commission. Review of compliance: Castlebeck Care (Teesdale) Ltd. 2011. www.cqc.org.uk/content/cqc-report-winterbourne-view-confirms-its-owners-failed-protect-people-abuse. Department of Health. *Transforming care: A national response to Winterbourne View Hospital. Department of Health Review*. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf.

[86] Heslop, P., Blair, P., Fleming P., Houghton, M., Marriott, A. and Russ, L. *Confidential Inquiry into premature deaths of people with learning disabilities* (CIPOLD). 2013. www.bris.ac.uk/cipold/reports/fullfinalreport.pdf.

[87] National Development Team for Inclusion. *Reasonably Adjusted? Mental Health Services and Support for People with Autism and People with Learning Disabilities*. 2012. www.ndti.org.uk/uploads/files/NHS_Confederation_report_Submitted_version.pdf.

B.18. It was suggested that reasonable adjustments need to be in place or easily and readily accessed for people with learning disabilities or autism who need them, and that further work should be carried out to identify the reasonable adjustments that need to be made to mental health services to enable people with autism and people with learning disabilities to receive effective treatment, such as holding meetings at a time when the patient is able to participate most fully (people taking antipsychotic medication may not be at their best first thing in the morning), and using natural light and room layout to minimise the patient's anxiety and feeling of being shut in. (These reasonable adjustments were suggested in relation to patients with a learning disability and/or autism but could be applied to people generally.)

B.19. There is a need identified by patients for all mental health services to have service provision for people with autism and learning disabilities. Specialist learning disability and mental health services should also facilitate access to mainstream services.

B.20. Service providers suggested that mention of the UN Convention on the Rights of Persons with Disabilities (CRPD) in the Code would be helpful. The consultation raised that there should be an introduction to the Mental Capacity Act and Equalities Act in relation to people with developmental disabilities.

Physical disabilities

B.21. The protected characteristic includes mobility issues, chronic pain and other physical impairments that make daily activities difficult to manage without the support of equipment. Concerns were expressed during the consultation that people's own aids and equipment were not being made available while they were detained and reasonable adjustments not then being made in hospital.

Appendix C: Gender reassignment and transsexuality (including gender non-conformity)

C.1. A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing, or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. 'Gender reassignment' explicitly covers transsexual people, but the Equality Act 2010 may offer broader protection to people who wish to present their gender differently to that of their birth, e.g. non-binary people (people who do not define themselves as a particular gender).

Data and literature review

C.2. We have not identified data indicating disparity in the use of the Act for these groups compared with others who do not share this characteristic, although stakeholders have fed back concerns.

Consultation responses and feedback

C.3. Anecdotal evidence of patients' experiences does indicate that individuals in this group are susceptible to high levels of discrimination and bullying, including in healthcare settings. They have greater difficulty in obtaining appropriate services, and in making complaints when services are lacking or delivered disrespectfully. Meanwhile, some professionals have indicated difficulties in making adjustments to fully support these individuals and that this may bring a provider into conflict with other inpatients and their families, for example placing a transgender patient on a single-sex ward can be objected to by other patients or their relatives.

C.4. There were concerns that hormone therapy, which is the cornerstone of treatment for many transgender people, is not always continued, or it may be delayed, or denied, to those who are in secure accommodation, sometimes even when they have a diagnosis of gender dysphoria.

Appendix D: Marriage and civil partnership

D.1. A person has this protected characteristic only if they are married or are a civil partner.

Data and literature review

D.2. No studies focusing on these issues were identified.

Consultation responses and feedback

D.3. People fed back concerns about the difficulties that can arise when the patient's main carer is different from the person identified by section 26 of the Act to be the patient's nearest relative. For example, where the main carer is the patient's divorced mother who is younger than the father, or is the patient's father who is not married or in a civil partnership (and has not obtained parental responsibility for the patient).

D.4. As parental responsibility applies only with respect to those under the age of 18, unmarried fathers of adult patients cannot obtain parental responsibility in these ways. We have heard of feedback where this has caused difficulties in practice when the unmarried father is the main care giver. This relates to concerns from both same-sex and different-sex fathers.

Appendix E: Pregnancy and maternity

E.1 Pregnancy means being pregnant or expecting a baby. Maternity refers to the period after birth. For general purposes (not work related), protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Data and literature review

E.2 Two important issues are highlighted, particularly in CQC reports relevant to pregnancy and maternity:[88]

- the first is access to specialist mother and baby units (MBUs) so that women are able to receive safe, effective and appropriate treatment. One study[89] found that the provision of MBUs was inequitable and that they varied in the services offered to women, with nearly half not offering psychological therapies, and
- the second issue reflects the article 8 right to family life and the recognition that mothers, and to some extent fathers and other children, are particularly disadvantaged by being placed in units out of area, and blanket rules that restrict contact (e.g. that prohibit the use of mobile phones etc).

E.3 Hospitalisation may have long-term repercussions not only for the mother but the whole family.[90] Useful resources produced by the Social Care Institute for Excellence (SCIE) and Barnados' outline good practice for parents with mental health problems, including the provision of family-friendly environments and approaches.[91]

Consultation responses and feedback

E.4 The Royal College of Psychiatrists in their consultation response raised concerns, including that in cases of late pregnancy or within the first year postpartum, services should have 24/7 access to a specialist MBU, and women within the first year postpartum should be admitted to the MBU unless there are exceptional reasons not to do so.

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[88] Literature Review, pp.9-10. CQC 2010. CQC 2011. CQC 2012. CQC 2014.

[89] Elkin, A. A national survey of psychiatric mother and baby units in England. *Psychiatric Services* (2009), 60(5). pp.629–633.

[90] Robinson, B. and Scott, S. Parents in hospital: How mental health services can best promote family contact when a parent is in hospital. Barnados. 2007. Available at: www.barnardos.org.uk/resources/research_and_publications/parents-in-hospital-how-mental-health-services-can-best-promote-family-contact-when-a-parent-is-in-hospital/publication-view.jsp?pid=PUB-1393.

[91] Social Care Institute for Excellence. Think child, think parent, think family: a guide to parental mental health and child welfare. 2014. http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf. Barnardos. Family Minded: Supporting children in families affected by mental illness. 2008. http://www.barnardos.org.uk/family_minded_report.pdf. Robinson, B. and Scott, S. Parents in hospital: How mental health services can best promote family contact when a parent is in hospital. Barnados. 2007. Available at: www.barnardos.org.uk/resources/research_and_publications/parents-in-hospital-how-mental-health-services-can-best-promote-family-contact-when-a-parent-is-in-hospital/publication-view.jsp?pid=PUB-1393.

Appendix F: Race

F.1 The protected characteristic of race includes colour, nationality, and ethnic or national origin.

Data and literature review

F.2 The 2008 Equality Impact Assessment and 2006 Race Impact Assessment conducted before the enactment of the Mental Health Act 2007 both identified that certain ethnic and racial groups were more likely to be detained under the Act.[92] While the total number of detentions (72% in 2013/14) are for people who are ethnically white, recent data supports the earlier analysis in the 2008 and 2006 assessments. Data indicates that individuals from black and minority ethnic (BME) backgrounds, especially black African, black Caribbean, and other black groups, are more likely to be detained under the Act, to be detained under the Act for longer periods and to be subject to a CTO. Black or black British people represented 16.2% of all CTOs in 2012/13.[93] The reasons for this over-representation appear complex, with some studies suggesting that figures need to be adjusted to reflect the age profiles and geographical distribution of different ethnic groups.

F.3 In the literature review,[94] the majority of the literature identified related to ethnicity, confirming significant variation in rates of admission and detention both for adults and adolescents in England and Wales.[95] This was a focus for the annual census (Count me in), with data collected over five years from 2005–2010. In its final report, comparisons were drawn between the 2010 data and the 2005 baseline.[96] Examples include:

- Admission rates for many ethnic groups show relatively little change since 2005, the rate for the other black group is considerably lower in 2010 (six times higher than average) compared with 2005 (12 times higher than average). Rates for the other black and white/black/mixed groups show small increases.
- Rates of referral from GPs and community mental health teams were lower than average among some black and white/black groups, and referral from the criminal justice system was higher. Patterns were less consistent for other minority ethnic groups.
- Detention rates have been higher than average among the black Caribbean, black African and other black groups in all six censuses, and almost consistently higher in

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[92] Department of Health. *Mental Health Bill 2006 – Race Equality Impact Assessment*. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062695. Department of Health. *Code of Practice: Mental Health Act 1983 – Equality Impact Assessment*. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597.

[93] CQC 2014. HSCIC. *Mental Health Bulletin: Annual report from MHMDS returns – England 2012/13*. 2013. www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf. pp. 23–26. HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England 2013/14. 2014*. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf.

[94] Literature Review, esp. pp.10–12.

[95] Corrigal, R. and Bhugra, D. The role of ethnicity and diagnosis in rates of adolescent psychiatric admission and compulsory detention: a longitudinal case-note study. *Journal of the Royal Society of Medicine* (2013), 106(5). pp.190–195. Saltus, R., Downes, C. and Jarvis, P. Inpatients from black and minority ethnic backgrounds mental health services in Wales: a secondary analysis from the Count Me In census, 2005–2010. *Diversity and Equality in Health and Care* (2013), 10(3). pp.165–176.

[96] Care Quality Commission and National Mental Health Development Unit. *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. 2011. www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf.

the white/black Caribbean mixed and other white groups. Rates have been average for other minority ethnic groups. Detention rates were particularly high for black African (2.2 times higher), black Caribbean (4.2 times higher), other black (6.6 times higher) and other groups (2.1 times higher).

- A consistent pattern was the higher than average detention rate under section 37/41 for black Caribbean and other black groups.
- Although there have been annual fluctuations in seclusion rates, they have been higher than average for the black and white/black/mixed groups, and the other white group, in at least three of the six censuses. Other minority ethnic groups did not show high rates.
- Black or black British ethnic groups had the lowest percentage of recorded episodes where patients were made subject to the care programme approach (CPA) on detention.
- Minority ethnic groups do not compare unfavourably for other incidents. Rates of self-harm have consistently been lower than average among the black and South Asian groups. Very few ethnic differences in hands-on restraint, physical assault and accidents were observed across the different censuses, and they did not show a consistent pattern.
- Length of stay is longest for patients from the black Caribbean and white/black Caribbean mixed groups, and shortest for patients from the Chinese and Bangladeshi groups.
- There are higher than average rates for the use of CTOs for black and black British groups, and these patterns are evident for both men and women across age groups.[97]

F.4 Detention rates as detailed in the annual census (Count me in) have been higher than average for the six years from 2005–2010 (inclusive), among black Caribbean, black African and other black groups.[98] The reasons for these patterns are contested, with one Department of Health-funded study[99] finding no evidence to support claims of the existence of discrimination on the basis of ethnicity at the point of assessment for detention under the Act.

F.5 Studies also found that individuals from BME groups, especially black people, in contact with mental health services also have poorer health outcomes, lower life expectancy, and report lower satisfaction levels. Black and black British ethnic groups were least likely to be put on the care programme approach (CPA) during detention. In particular, it has been noted that people from specific BME groups are more likely to have adverse pathways into services.[100] One study, for example, identified marked ethnic inequities between white British women and black women and white other women, with white British women more likely to be admitted to a crisis house and black African and black other groups more likely to have had contact with the police.[101] There is some data that people from BME communities

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[97] CQC 2014.

[98] *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. 2011. www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf. HSCIC. *Learning Disabilities Census Report – Further analysis, England, 30 September* 2013. 2014. www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf.

[99] Singh, S.P., Greenwood, N.A.N., White, S. and Churchill, R. Ethnicity and the Mental Health Act 1983. *The British Journal of Psychiatry* (2007), 191(2). pp.99–105. Literature Review, pp.10–12.

[100] CQC 2014.

[101] Lawlor, C., Johnson, S., Cole, L. and Howard, L.M. Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry* (2012), 58(1). pp.3–15.

are less satisfied with treatment, particularly medication, than other ethnic groups, and black Caribbean groups are more likely to doubt the treatment that they were receiving.[102] The reasons for these patterns are contested with some studies rejecting explanations of discrimination on the basis of ethnicity at the point of assessment.[103]

F.6 Some data suggests that non-white women, especially black women, are treated differently to white women when using mental health services, and are 20% more likely to receive a psychosis diagnosis compared with white women (who are likely to be diagnosed with a personality disorder when exhibiting the same symptoms).[104] Data indicates that black women are less likely than white women to display symptoms of postnatal depression and GPs are less likely to recognise any symptoms or signs of a mental health concern.

F.7 There appears to be a perception among black Caribbean and black African patients that the mental health system is institutionally racist, due to their members being disproportionately represented among the detained population. The issue of over-representation cannot be analysed in isolation from the wider socio-economic factors and experiences of these communities. The evidence indicates that members of these communities have poor access to preventive and community services, poor experience of services, and are more likely to enter services via the justice system.[105] This may have unintended consequences, including delaying the point at which people from these communities approach services, and may in part explain the higher level of detention, as interventions at an earlier stage are no longer viable. Other studies have pointed to the importance of local context as an explanation,[106] reinforcing the need for robust information and governance in relation to potential disadvantage on the basis of ethnicity, and arguably other protected characteristics. There is agreement that strategies to improve communication and to develop culturally appropriate and responsive services, particularly early intervention services,[107] are needed. One study crucially highlights the importance of belief and trust in treatment and reinforces the importance of active participation in care planning and decision-making.[108] IMHA services clearly have an important role to play in this regard and, therefore, it is important that these are culturally appropriate and responsive; the Mental Health Alliance, among others, highlighted the importance of BME organisations being commissioned to provide this.[109]

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[102] Boydell, J. et al. Satisfaction with inpatient treatment for first-episode psychosis among different ethnic groups: a report from the UK AeSOP study. *The International Journal of Social Psychiatry* (2012), 58(1). pp.98–105.

[103] Singh, S.P., Greenwood, N.A.N., White, S. and Churchill, R. Ethnicity and the Mental Health Act 1983. *The British Journal of Psychiatry* (2007), 191(2). pp.99–105. Singh, S., Islam, Z. and Brown, L. Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *Programme Grants for Applied Research* (2013), 1(3).

[104] Lawlor, C., Johnson, S., Cole, L. and Howard, L.M. Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry* (2012), 58(1). pp.3–15.

[105] CQC 2014. Literature Review, p.12.

[106] Patel, M.X., Matonhodze, J., Baig, M.K., Gilleen, J., Boydell, J., Holloway, F. and David, A.S. Increased use of antipsychotic long-acting injections with community treatment orders. *Therapeutic Advances in Psychopharmacology* (2011), 1(2). pp.37–45.

[107] Singh, S., Islam, Z. and Brown, L. Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *Programme Grants for Applied Research* (2013), 1(3).

[108] Boydell, J. et al. Satisfaction with inpatient treatment for first-episode psychosis among different ethnic groups: a report from the UK AeSOP study. *The International Journal of Social Psychiatry* (2012), 58(1). pp.98–105.

[109] Jackson, C. and the Mental Health Alliance. *The Mental Health Act 2007: a review of its implementation*. 2012. www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf. Literature Review, esp. pp.10–12.

Consultation responses and feedback

F.8 Some consultation responses called for the Code to encourage increased provision of mental health services and IMHA services tailored to meet the needs of BME groups. Some of the feedback we heard related to perceptions of differing diagnoses or about professionals not understanding different cultures and accounting for this in their diagnosis.

F.9 The need for 'cultural competence', understanding and sensitivity featured in both written responses and verbal comments received during the consultation. Patients suggested that all professionals dealing with people receiving care and treatment under the Act (detained or otherwise), should be aware of the 'cultural norms and practices' of the people with whom they deal. This is to avoid the negative consequence of professionals projecting their own conscious or unconscious cultural biases into the process of care and treatment, thereby potentially distorting and in some cases aggravating the diagnosis. Use of interpreters, community leaders, engagement with local communities and training of staff to understand the local community they are serving were all cited as major ways that this could be addressed.

F.10 A number of consultation responses called for specific aspects of the law to be changed (restrictions on prescribing medication; introducing 'tighter' criteria for detention) that fall outside of the scope of this consultation and revision of the Code. Concerns were cited about the different medications prescribed for different ethnic groups and the different dosages prescribed, and also that sometimes people received different diagnoses. Concerns about dosage amounts, and the combining of multiple prescription medications for an individual patient, were also raised by respondents, specifically Black Mental Health UK and the African Health Policy Network.

F.11 Consultation responses supported the view that that there were believed to be differences in diagnosis and treatment for black and white women.

F.12 Five consultation responses expressed concern that immigration detainees were not directly addressed in the Code. In general, these pointed to perceived inadequacies in the recognition and treatment of mental illness in immigration detainees.

Appendix G: Religion or belief

G.1. This protected characteristic covers any religion (including a lack of religion) and any religious or philosophical belief (including a lack of belief).

Data and literature review

G.2. The literature tells us several things of importance for consideration when preparing this EA and action plan (figure 3). No specific studies on the Act in relation to religion or belief were identified, although CQC have identified concerns. CQC observed instances where there was a failure to make suitable provision for patients' cultural or religious needs, for example not providing halal food or not having arrangements in place so that Ramadan could be observed.[110] These concerns were supported by views expressed during the consultation, including especially in relation to Christian and Islamic observance and rituals.

G.3. Four related studies on the beliefs and clinical practices of psychiatrists in the UK, Canada and the USA have examined representative samples that are of use for this review. One study of British psychiatrists[111] surveyed 231 psychiatrists at general and psychiatric hospitals in London and found that:

- three-quarters (73%) of psychiatrists reported no religious affiliation (50% atheist or agnostic), 28% believed in God, and 22% attended religious services at least once a month;
- 42% believed religiousness could lead to mental illness, 61% said that it could protect against mental illness; and
- with regard to psychiatrists' practices, 48% said that they often or always asked about the religious beliefs of patients, but two-thirds (66%) rarely or never made referrals to clergy.

G.4. A second and more recent study of British psychiatrists[112] focused on those working in old age psychiatry. Asked if they had religious affiliations, 58% replied affirmatively, a figure that is much higher than that for general psychiatrists. Of these, 73% said they were Christian, followed by Hindu, Muslim, Sikh, Jewish and Jain in that order. The majority (92%) recognised the importance of spiritual dimensions in their patients' lives and a quarter considered referral to the chaplaincy service, but more complete integration of spiritual advisors into the assessment and management of individual cases was rare.

Consultation responses and feedback

G.5. A number of respondents, and from a variety of different religions, were supportive of the benefits that religion and spiritual support can have in patients' recovery and the importance of this being enabled while they are in hospital. There were criticisms that professionals often did not understand a particular religious belief, and that this could be an important factor in deciding to detain, when alternatives to detention may have been more appropriate, or that it could lead to a failure to recognise the religion or belief's therapeutic

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[110] Literature Review, p.12. CQC 2014.

[111] Neeleman, J. and King, M.B. Psychiatrists' religious attitudes in relation to their clinical practice: a survey of 231 psychiatrists. 1993, 88(6). pp.420–424. Koenig, H. Religion and mental health: what should psychiatrists do? *Acta Psychiatrica Scandinavica* (1993). http://pb.rcpsych.org/content/32/6/201.full

[112] Curlin, F. A., Lawrence, R. E. et al. Religion, spirituality, and medicine: Psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *American Journal of Psychiatry* (2007), 164(12). pp.1,825–1,831.

value (potentially greater than more traditional therapies) and that professionals should be open to the full range of possible treatments. There were also some suggestions that it was important that religious rituals, rites and festivals could be fully observed and that people should be supported to do so.

Appendix H: Sex (gender)

H.1. This protected characteristic applies to men and women of any age.

Data and literature review

H.2. Data indicates some differences in relation to detention rates for men and women and in the use of community treatment orders (CTOs), although some of these are also related to different age profiles. Men are more likely to spend time in hospital, either as an informal patient or subject to the Act, and be subject to higher levels of restriction using the HSCIC categorisation of sections of the Act that a patient can be detained under. In particular, men were five times more likely than women to be subject to court and prison disposals (part 3 patients). This difference accounts for the largest area of difference in the figures between men and women. Men were also more likely to spend longer in hospital subject to the Act or as an informal patient.[113]

H.3. Data by sex is subdivided by age so please see additional discussion under age in appendix A. In 2013/14, 16,380 people detained on admission to hospital were male, and 14,194 female. On 31 March 2014, of people on CTOs 3,489 were male and 1,876 were female (total 5,365).[114]

H.4. Data indicates that many providers are still not consistently providing single-sex accommodation and are not always able to accommodate other needs. For example, a 2011 study found that: 'The unit is mixed and there were times when the Mental Health Act Commissioner saw female patients on their own with all male staff and patients. There is no gender separation apart from bedrooms. There was no evidence to suggest that women had their individual needs met. There was no evidence that vulnerable women were identified and thought about in the day-to-day running of the unit. There was no evidence that staff were trained to think about women's issues.'[115]

H.5. Although more men than women are subject to detention overall, the following issues were identified by the literature review, and focus on privacy, dignity and safety issues for women:[116]

- Women may be subject to harassment and exposed to men who may take advantage of them, including in child and adolescent mental health services and in gender-specific wards, with continued breaches in terms of mixed-sex accommodation.[117]
- Gender-specific accommodation for sleeping, toileting, washing and during the daytime is an important measure in ensuring the privacy, dignity and safety of women but inappropriate use of mixed-sex wards in emergency situations has been noted.[118]

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[113] HSCIC. *Mental Health Bulletin: Annual report from MHMDS returns – England 2012/13*. 2013. www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf. pp.5, 10, 14, 16, 29. HSCIC has a scale of restrictiveness for different sections of the Act.

[114] HSCIC. *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf.

[115] CQC 2012

[116] Literature Review, esp. pp.12–13. The Mental Health Act Commission. *Thirteenth Biennial Report 2007–2009: Coercion and consent – Monitoring the Mental Health Act 2007–2009*. 2009. www.cqc.org.uk/sites/default/files/documents/mhac_biennial_report_0709_final.pdf (hereafter called 'MHAC 2009'). CQC 2010. CQC 2011. CQC 2012. CQC 2014.

[117] MHAC 2009. CQC 2010. CQC 2011. CQC 2014.

[118] CQC 2011.

- Treatment regimes in some eating disorders units appeared to restrict personal liberty more than would be the case in most other types of psychiatric unit, and this will affect women more than men.[119]
- Gender differences were seen in the use of ECT, being used more often with women, which may reflect longevity, clinical presentation or unhelpful stereotypes.[120]
- Gender differences in presentation which require a different approach, for example women with psychosis are more likely to present having self-harmed, having difficulty with relationships or having a history of abuse.[121]
- Male staff were inappropriately assigned to women patients, for example during night-time observation, bathing and toileting.[122]
- Use of blanket rules that restrict the enjoyment of family life may affect women more than men, as they are more likely to be the primary care giver for children.[123]
- There was a lack of training for staff in relation to women's issues and an associated failure to properly consider the needs of vulnerable women.[124]

H.6. This data needs to be located in an analysis of the gendered expectations and experiences in the life course of men and women, which come to be expressed differently as mental health problems, and are reflected in different preferences for treatment and support.[125] Guidance has previously been produced by the Care Services Improvement Partnership (CSIP)[126] providing a useful resource for how mental health services can incorporate gender-sensitive practice. This includes understanding the realities of women's lives, and in particular ensuring that service provision takes account of the experience of violence and abuse, and creates an environment of relative security, as well as providing therapeutic interventions to address histories of violence and abuse.

Consultation responses and feedback

During the consultation we heard from women about the difficulties experienced during detainment of obtaining suitable underwear, especially bras, and other forms of clothing, and on a smaller number of occasions access to preferred sanitary products. Women reported feeling uncomfortable; this potentially had a negative impact on their recovery, and did not always appear to be in line with the respect and dignity guiding principle. It was considered particularly important to ensure that dignity was maintained while in seclusion or segregation.

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[119] CQC 2010.

[120] MHAC 2009. CQC 2010.

[121] MHAC 2009.

[122] CQC 2010.

[123] Newbigging, K, Paul, J., Waterhouse, S. and Freese, C. *Working towards Women's Well-being: Unfinished business*. London: NMHDU. 2010. www.hsconsultancy.org.uk/system/resources/2/working-towards-womens-wellbeing-unfinished-business.pdf?1302161290.

[124] CQC 2014.

[125] See, for example: McNeish, D. and Scott, S. *Women and girls at risk: Evidence across the life course*. 2014. www.lankellychase.org.uk/assets/0000/2675/Women___Girls_at_Risk_-_Evidence_Review_040814.pdf. Newbigging, K, Paul, J., Waterhouse, S. and Freese, C. *Working towards Women's Well-being: Unfinished business*. London: NMHDU. 2010. www.hsconsultancy.org.uk/system/resources/2/working-towards-womens-wellbeing-unfinished-business.pdf?1302161290.

[126] See: Williams, J. and Paul, J. *Informed Gender Practice. Mental health acute care that works for women*. National Institute for Mental Health in England. 2008.

Appendix I: Sexual orientation

I.1. This protected characteristic means a person's sexual orientation toward persons of the same sex, persons of the opposite sex, or persons of either sex. Sexual orientation relates to a person's sexual attraction as well as their behaviour.

Data and literature review

I.2. Although the majority of lesbian, gay and bisexual (LGB) people do not experience poor mental health, evidence indicates that the increased risk of mental disorder in LGB people is linked to experiences of discrimination. Evidence indicates that LGB people are more likely than people in other groups to experience mental health problems, although the lack of data means that it is not possible to state how this relates to detentions under the Act.[127]

I.3. One study highlighted a range of issues experienced by LGB people.[128] These include: higher risks of mental health problems, suicidal behaviour and substance abuse; a greater likelihood of experiencing physical abuse or verbal intimidation than heterosexual people; and a link between discrimination and increased risk of self-harm. Given the observations about monitoring of protected characteristics, it is highly likely that the experience of LGB people is under the radar and considerations should be given to this in the Code, for example in the context of gender-specific accommodation that may adversely impact upon gay men.[129]

I.4. LGB people are also more likely to report both daily and lifetime discrimination than heterosexual people. Stonewall has also indicated that there is discrimination in the NHS in relation to LGB people. Many LGB people have reported experiencing:[130]

- hostility or rejection from family, parents and friends
- bullying and name-calling at school
- rejection by most mainstream religions
- danger of violence in public places
- harassment from neighbours and other tenants
- casual homophobic comments on an everyday basis
- embarrassed responses (and occasionally prejudice) from professionals, such as GPs
- no protection against discrimination at work, and
- negative portrayal of gay people in the media.

I.5. The 'real' picture is uncertain because of the reluctance of some patients to disclose their sexuality, and some healthcare staff feeling uncomfortable asking the question.

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[127] Warner, J., McKeown, E., Griffin, M., Johnson, K. et al. Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. Results from a survey based in England and Wales. *British Journal of Psychiatry* (2004), 185. pp. 479–485. Care Service Improvement Partnership/National Institute for Mental Health in England. *Mental Disorders, suicide and deliberate self-harm in lesbian gay and bisexual people*. 2007.

[128] Fish, J. *Mental health issues within lesbian, gay and bisexual communities*. 2007.

[129] Literature Review, p.13.

[130] www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx. Stonewall. *Being the Gay One*. 2007.

Gay men

I.6. A UK study[131] found that:

- Twice as many gay and bisexual men report moderate to severe levels of depression and/or anxiety compared with men in general.
- 21% of MSM (men who have sex with men) report feeling recently unhappy or depressed compared with 12% among heterosexual men.

I.7. A government report on preventing suicide[132] found that gay and bisexual men have a particularly high prevalence of self-harm. One in ten gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year.[133]

Lesbians

I.8. A Stonewall report[134] found that:

- One in five lesbian and bisexual women had deliberately harmed themselves in the last year, compared with 0.4% of the general population.
- Half of lesbian and bisexual women under the age of 20 have self-harmed, compared with one in 15 teenagers generally.
- 16% of lesbian and bisexual women under the age of 20 have attempted to take their life at least once, and 5% in the last year, compared with ChildLine estimates that 0.12% of people under the age of 18 have attempted suicide.
- One in five lesbians and bisexual women say they have an eating disorder, compared with one in 20 of the general population.

Bisexuals

I.9. It is usually the practice that bisexual individuals are included with gay and lesbian people. It is clear that, while there are many shared experiences, the needs of the bisexual community are qualitatively different from the lesbian and gay community. Not only can bisexual people appear ‘invisible’ to services, but also people face hostility from the gay and lesbian community and gay and lesbian services are not always appropriate for bisexual individuals.

I.10. A UK report on bisexuality[135] found that, of all the common sexual identity groups, bisexual people most frequently have mental health problems, including depression, anxiety, self-harm and suicidal tendencies. This has been found both internationally and in the UK specifically, and has been linked to experiences of biphobia and bisexual invisibility.

I.11. The key UK Mind report on the mental health and wellbeing of LGB people in England and Wales found that bisexual men and women were less at ease about their sexuality than

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[131] Public Health England. *Promoting the health and wellbeing of gay, bisexual and other men who have sex with men. Initial findings*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/339041/MSM_Initial_Findings__GW2014194.pdf.

[132] HM Government. *Preventing suicide in England: A cross-government outcomes strategy to save lives*. 2012. www.gov.uk/government/publications/suicide-prevention-strategy-launched.

[133] Stonewall. *Gay and Bisexual Men’s Health Survey*. 2011. www.stonewall.org.uk/documents/stonewall_gay_mens_health_final.pdf.

[134] Stonewall. *Prescription for Change: Lesbian and bisexual women’s health check*. 2008. www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3101.asp.

[135] The Open University. *The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity*. 2012. www.open.ac.uk/ccig/files/ccig/The%20BisexualityReport%20Feb.2012.pdf.

lesbian and gay people. The report found that bisexual people were also less likely than their lesbian and gay counterparts to be out to their family, friends, colleagues, general practitioners and mental health professionals, which has clear implications for developing services that are inclusive. Further, bisexual women were found to be less likely than lesbians to have received positive responses to their sexual identity from siblings. Bisexual men, in particular, were found to experience more psychological distress than gay men.[136]

I.12. Research also found that bisexual people had had negative experiences with health professionals, both in the wider context of LGB experience, and in particular. For example, one US study found that over one-quarter of therapists seen by bisexual clients erroneously assumed that sexual identity was relevant to the goal of therapy when the client didn't agree, around one-sixth saw bisexuality as being part of an illness, 7% attempted conversion to heterosexuality and 4% to being lesbian or gay. Many therapists were openly uncomfortable about bisexuality.[137] The UK Mind study suggests that the situation may well be similar in the UK. It found that one-third of bisexual men reported that health professionals had made a link between their sexuality and a mental health problem.[138]

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[136] King, M., McKeown, E. et al. *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales. A summary of findings*. 2003. www.mindout.org.uk/wp-content/uploads/2012/06/SummaryfindingsofLGBreport.pdf.

[137] https://www.tumblr.com/search/Bi+Magazine

[138] King, M., McKeown, E. et al. *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales. A summary of findings*. 2003. www.mindout.org.uk/wp-content/uploads/2012/06/SummaryfindingsofLGBreport.pdf.

Appendix J: Carers

J.1. We have considered carers as a specific group. Our intention in the revisions to the Code is to promote and increase carers' involvement in discussions in care and treatment.

Consultation responses and feedback

J.2. Anecdotal evidence has indicated that an individual without a known nearest relative or carer may experience poorer health outcomes and may stay in inpatient care longer, especially individuals who lack capacity.

J.3. Feedback received indicated problems when the nearest relative, as identified by section 26 of the Act, is not the patient's carer or involved in the patient's life, and does not agree to delegate their functions to the carer/s.

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