NHS South East Mental Health services: Collecting protected characteristics data

Clinical case: Evidence of health inequalities across priority characteristics

February 2023

Executive Summary

Why do we need to collect protected characteristics data?

Indicative national evidence in this report shows that **inequalities do exist** across protected characteristics and other vulnerable groups, in terms of patient **access**, **experience** and **outcomes.** However, there is a lot that we do not know or cannot examine due to the limited data available, especially for the South East.

We need significantly more data to understand these health inequalities, especially at the regional level, as this could **enable providers to advance equality** across the system.

Illustrative best practice case studies highlight how localised interventions can materially reduce mental health inequalities for these priority characteristics. However, to deliver these interventions in the South East, higher coverage and quality of data is needed to understand the exact needs of specific groups.

The priority characteristics being considered in this regional piece of work include:

Disability (Slides 11-14)	**Ethnicity** (Slides 15-18)	**Gender identity & sexual orientation** (Slides 19-22)	**Accommodation status*** (Slides 23-26)

*not a protected characteristic under the Equality Act 2010, although a key vulnerable population / inclusion health group associated with significant mental health inequalities, and a national priority area for health systems

Why do we need to collect protected characteristics data?

Why should clinicians and support staff on the frontline be onboard?

Better outcomes & lower acuity

Some groups experience higher rates of mental illness, limited access to services and poorer health outcomes. Improving access to care and outcomes early on may lead to **fewer acutely unwell patients**[1] requiring mental health services, at a time when services are particularly stretched.

A&E demand

Evidence shows a clear link between high intensity use of A&Es and wider inequalities across issues such as mental health conditions, homelessness, and other issues. Reducing access and treatment inequalities could **reduce high intensity use of A&E services.**

Cost savings

Evidence shows there are substantial cost burdens associated with mental health inequalities. Improving access and outcomes early on and reducing utilisation of costly health services may **deliver cost savings** for providers.

Funding opportunities

In 2019, the Long Term Plan (LTP) set out stronger health equality targets. To reduce inequalities:

- NHSEI gave £2.7m to innovative ICS schemes[2]
- NICR awarded £50m to 13 councils for research[3]

With the LTP refresh & Mental Health 10Y Plan in 23/24, there may be **extra funding pots** we could access.

1: Fair Society, Healthy Lives (The Marmot Review) – Economic Analysis. (2010). Institute of Health Equity. Available at: https://www.instituteofhealthequity.org/file-manager/FSHLrelateddocs/economic-analysis-fshl.pdf
2: Schemes to improve health equality given £2.7m. (2021). NHSE. Available at: https://www.england.nhs.uk/integratedcare/resources/case-studies/schemes-to-improve-health-equality-given-2-7million/
3: Press release: £50 million to tackle health inequalities through research. (2022). GOV.UK. Available at: https://www.gov.uk/government/news/50-million-to-tackle-health-inequalities-through-research

Context and definitions of protected and other characteristics

What are protected characteristics?

As outlined in the Equality Act 2010, it is illegal to discriminate against anyone based on **9** '**protected characteristics**:

1. Age
2. Disability
3. Gender reassignment
4. Pregnancy and maternity
5. Race (i.e. colour, ethnic or national origins, nationality)
6. Religion or belief
7. Sex
8. Sexual orientation
9. Marriage or civil partnership

As part of the general public sector Equality Duty, NHS England is required to 'have due regard to the need to' address 3 equality aims around eliminating discrimination, advancing equality of opportunity and fostering good relations.

However, there are also **other vulnerable groups** which experience health inequalities; many of these are recognised in other legal frameworks, e.g. Armed Forces Act 2021, Children Act 2004, etc. The NHS Long Term Plan has set a clear strategic direction to reduce inequalities for groups across these characteristics too:

1. Accommodation type (e.g. rough sleeping)
2. Ex-British Armed Forces
3. Looked After Child status
4. Deprivation

Which characteristics are a priority for the South East?

1. There is a **clear opportunity** for the South East (SE) to improve data quality and coverage for these characteristics.
2. The national dataset shows that the **SE is significantly lower than the national level,** in the accuracy of data for patients accessing mental health services, for nearly all priority characteristics.
3. The SE is **not a national frontrunner** for any of the priority characteristics.

Mental Health Services Data Set (MHSDS) for South East (SE), October 2022[1]

Priority characteristic	SE accuracy	National accuracy	Best region accuracy
Ethnicity	**64%**	78%	86%
Disability type	**1%**	9%	16%
Gender identity code	**33%**	54%	77%
Gender identity - same at birth	**1%**	10%	29%
Sexual orientation	**1%**	16%	30%
Accommodation type	**27%**	31%	41%

'Accuracy': the proportion of people where the data item has been completed with a valid and useful code, i.e. not marked as other/unknown/not stated

Why are these characteristics a 'priority' for improving data quality?

1) Currently **low data quality** nationally in the MHSDS

2) NHSE have set these as a **high national priority** based on the populations most at risk of mental health inequalities.

1: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023. Available at: https://app.powerbi.com/view?r=eyJrIjoiZGRjZmIyZDEtZGUyOC00YWI2LWJkNGUtNmYyYmJiODQ2MDkwIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

Definitions of priority characteristics

1. **There are varying definitions and categorisations of the priority characteristics** across legal frameworks, the Office for National Statistics (ONS) guidance, and MHSDS.
2. Some providers, such as Sussex Partnership NHS Foundation Trust (SPFT), have spent time reviewing these individually and **agreeing the appropriate categorisation locally**.
3. Providers aiming to improve data quality may need to follow a similar process **to ensure consistency** in coding**.**

Characteristic	MHSDS definition in latest specification[1]	How does MHSDS data model vary from ONS?
Ethnicity	"The ethnicity of a person, as specified by the person."	ONS has some additional ethnic categories (20) compared to MHSDS (16).
Disability type	"The disability of a person. This could be where: the person has been diagnosed as disabled or the person considers themself to be disabled."	MHSDS includes more detailed categories than ONS; Some providers, e.g. SPFT have used an alternative, inclusive classification which maps onto MHSDS/ONS.
Gender identity & reassignment	"The gender identity of a person as stated by the person. An indication of whether the patient's gender identity is the same as their gender assigned at birth."	MHSDS offers a more detailed categorisation (with 2 questions) than ONS. Some providers, e.g. SPFT, have adopted a mix of both, distinct from question on sex.
Sexual orientation	"The SNOMED CT* concept ID which is used to identify a Social and Personal Circumstance for a person."	ONS and MHSDS options are identical.
Accommodation status	"An indication of the type of accommodation that a patient currently has. This should be based on the patient's main or permanent residence."	Options only available in MHSDS; not included in ONS guidance and does not currently have a legal framework.

*SNOMED CT refers to a structured clinical vocabulary, recognised and used in electronic health records internationally, and across providers and NHS organisations in all care sectors.

1: MHSDS V5.0 Technical Output Specification. Available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

Upcoming Patient and Carer Race Equality Framework (PCREF)

Why is the collection of this data particularly important?

The upcoming, refreshed Patient and Carer Race Equality Framework (PCREF) set by NHSE will outline expectations for Mental Health Trusts' strategies to reduce the mental health inequalities faced by racialised and ethnic minority communities[1].

1. Trusts will be expected to**:**

    i. **Record and monitor data by ethnicity.** At a minimum**,** this is likely to include a number of **mandatory metrics** that will be confirmed in the final framework**.**

    ii. **Routinely publish this data** to the Mental Health Services Data Set (MHSDS).

2. By the **end of 2023/24**, Trusts will be required to have developed and published a **localised PCREF plan**.

3. Once rolled out, the PCREF will be **considered** in **CQC assessments.**

4. By improving the collection of this data, **Trusts will be able comply** with the data requirements that underpin the PCREF.

Likely mandatory metrics:

1. Access and outcome measures
2. Detentions under the Mental Health Act
3. Use of Force/restrictive practice data
4. Other inequalities metrics agreed to be relevant to each Trust

1: Patient and Carer Race Equality Framework. (2022). Dr Jacqui Dyer and Husnara Malik. Available at https://www.swlstg.nhs.uk/images/SWLStG_Annual_Public_Meeting_2022.pdf pg. 36-43

Evidence of health inequalities and clinical case for improving data quality, by priority characteristic

Evidence base for inequalities

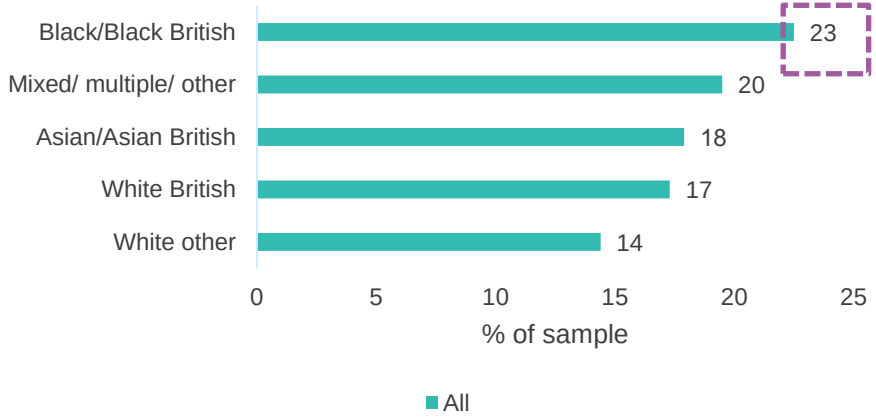
For each priority characteristic, we have outlined evidence for the following areas:

1	**Prevalence of disorders**	There are major disparities in prevalence of mental health conditions between groups; social, economic and environmental determinants may be driving inequalities – **we need to know how.**
2	**Access to services**	Even where the population suffers from mental health conditions, there are various barriers to actually accessing healthcare services for diagnosis and treatment – **we need to know where.**
3	**Experiences & outcomes**	Patients from different characteristic groups are accessing services, and yet systematically having very different experiences, interventions, and even health outcomes – **we need to know why.**
4	**Best practice case studies**	In order to improve data quality and reduce health inequalities in the South East, we can draw from initiatives and lessons learned by other health providers – **we need to know who.**

Why do we need to collect ethnicity data?

Ethnicity: Evidence indicates that there is varying **prevalence** of specific mental health disorders and issues across ethnic minorities. The sources of these disparities are complex and are rooted in historic and contemporary inequities.[1]

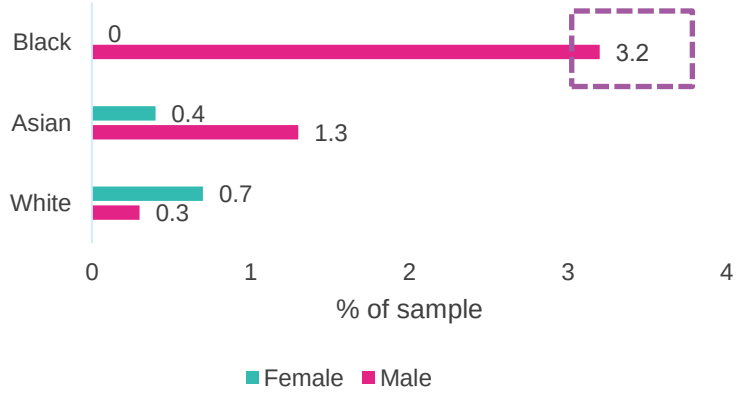
Percentage of adults who experienced a **Common Mental Disorder (CMD)** in the past week by sex and ethnicity [2]



Indicative national data previously showed that those **identifying as Black were more likely than average to have experienced a CMD** in the last week, than those who identified as **White**.

This sample also shows a materially **higher number of Black men being diagnosed with psychosis** in England

Percentage of people aged 16 years and over who screened positive for a **psychotic disorder** in the past year by ethnicity and sex [3]



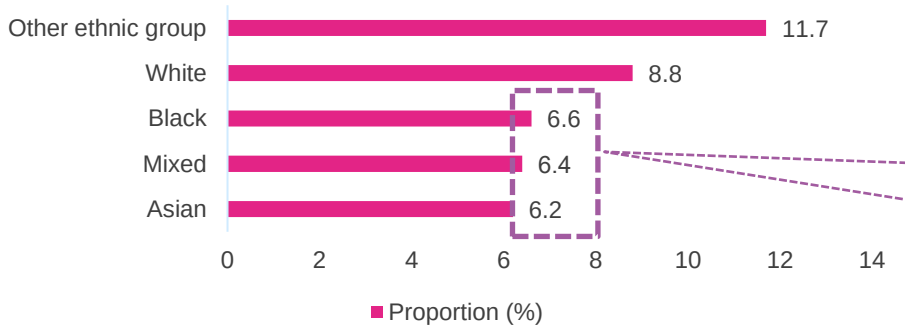
Better understanding of these inequalities would enable providers in the South East to **understand the root causes** driving variation in prevalence**,** and identify drivers that may also be **relevant to delivering high quality care to specific ethnic minority groups** with higher prevalence**.**

1: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). NCBI. Available at: https://www.ncbi.nlm.nih.gov/books/NBK220366/
2: Mental health statistics (England). (2021). Baker, House of Commons Library. Available at: https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf
3: Outcomes for treatment for anxiety and depression. (2021). GOV.UK. Available at: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/outcomes-for-treatment-for-anxiety-and-depression/latest

Why do we need to collect ethnicity data?

Ethnicity: When controlling for varying prevalence of mental health disorders, disparities in **access** to mental health services for diagnosis and treatment across primary and secondary care remain. As with prevalence, these are complex; recent evidence in the South East shows that there are **perceived barriers** to accessing mental health services, particularly among black and minority ethnic (BME) communities[1].

Proportion of people with Common Mental Disorder (CMD) **who received treatment** through Improving Access of Psychological Therapies (IAPT), England, 1 April 2017 to 31 March 2018 [2]



There is evidence of ethnic minorities having potentially higher levels of **undiagnosed CMDs** and **lower levels of screening in primary care**, in studied areas.

Ethnic minorities, especially the **Asian ethnic group**, saw **lower access to IAPT treatment** for CMDs.

Using electronic GP record data, a study of **9000** women in Bradford estimated the proportion of **missed** cases of pre-birth common mental disorders in the population.[3]

Minority ethnic women had **2x** the rate of **potentially missed cases** and **50%** the **volume of screening records** compared to white women.

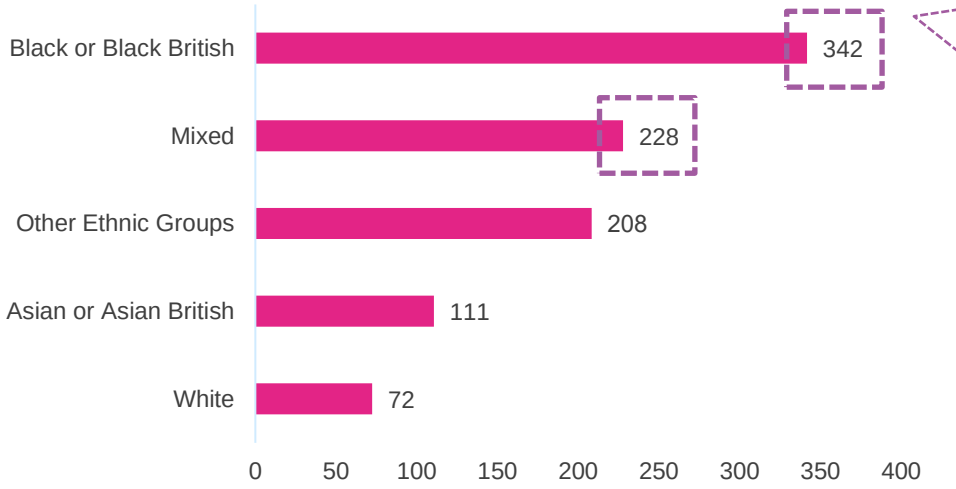
Better understanding of these inequalities would empower providers in the South East to **tailor accessibility of services to specific ethnic groups** and **target current barriers or obstacles** that are leading to high levels of undiagnosed and untreated issues in population cohorts.

1: Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. (2016). Memon A, Taylor K, Mohebati LM, et al. Available at: https://bmjopen.bmj.com/content/6/11/e012337
2: Mental health statistics (England). (2021). Baker, House of Commons Library. Available at: https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf
3: Evaluation of ethnic disparities in detection of depression and anxiety in primary care during the maternal period: combined analysis of routine and cohort data. (2016) Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4853643/

Why do we need to collect ethnicity data?

Ethnicity: There are significant disparities in **patient experiences and outcomes** for ethnic minorities accessing mental health services in England. There are various reasons for this, concerning involve individuals at several levels, including health and social care systems (and their administrative processes), health and social care professionals and patients.[1]

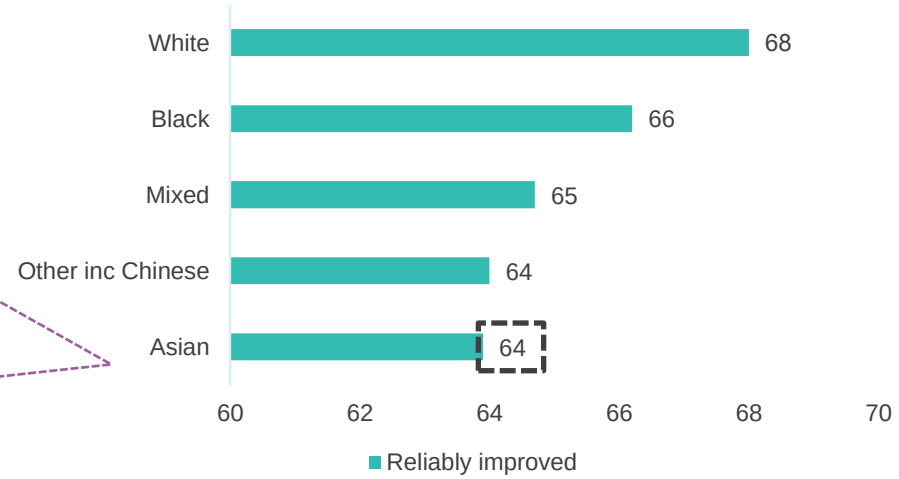
Detentions under the Mental Health Act 1983, by ethnicity, 2021-22 [2]



Evidence shows that Black and Mixed ethnic groups have a **substantially higher rate of detentions** for mental health patients.

The **impact of certain mental health treatments** also varies between ethnic groups, with **Bangladeshi patients seeing materially lower improvement** than White patients

Percentage of patients **showing improvement** following therapy for anxiety or depression, by ethnicity [3]



The actual **delivery of mental health care** and its **impact** on specific ethnic groups could be **significantly improved** with a better understanding of what is driving variation in patient experience and outcomes.

1: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). NCBI. Available at: https://www.ncbi.nlm.nih.gov/books/NBK220366/
2: Mental Health Act Statistics, Annual Figures - 2020-21 (2021). NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures
3: Outcomes for treatment for anxiety and depression. (2021). GOV.UK Ethnicity facts and figures. Available at: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/outcomes-for-treatment-for-anxiety-and-depression/latest

Case studies on using ethnicity data

Case study: Culturally-adapted Family Intervention (CaFI) in the North West[1]

Background

- **Family Intervention (FI)** is a psychosocial intervention approved by NICE, who highlight the urgent need to develop culturally-informed talking therapies.
- **Afro-Caribbean people** in the UK experience the highest incidence of schizophrenia and the greatest inequity in mental health care. Evidence is lacking for this group in particular.
- **Piloted in Manchester** with Afro-Caribbean-origin families cross 2013-17

What did they do?

- **Extant FI model** was culturally adapted using a framework (CaFI)
- Aspects of the therapy designed to maximise its utility and acceptability:
  - **Culturally-informed** explanations of mental health problems (e.g. religion)
  - Improving CaFI therapists' **cultural competency**
- **2 mental health Trusts** in the North West saw 10 CaFI sessions offered to service users and associated families.

What did they achieve?

- **92%** of family units completed all 10 sessions.
- **>80%** of service users agreed they learned something new during CaFI, knew more about how to get information, had a better relationship with their relatives and were more able to say what their needs were.
- Secured **£2.5m NIHR funding** to further refine and evaluate CaFI with people from Sub-Saharan Afro-Caribbean backgrounds. This includes evaluating clinical and cost-effectiveness in an RCT.

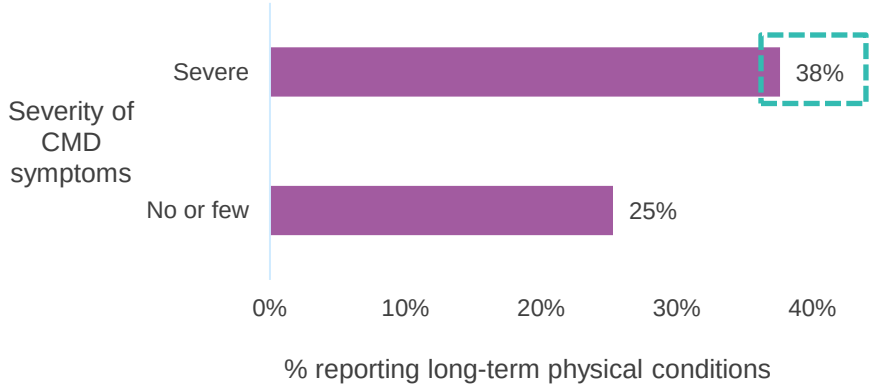
What does this mean for the South East? There has been a recent push to improve ethnicity data across England, catalysed by recent national inquiries into racial inequalities around COVID-19 and maternal mortality. While there are more case studies on targeted physical health-related interventions to reduce inequalities, the volume of best practice for mental health remains limited. **There is an opportunity for the South East to get ahead and target groups that currently see higher prevalence, limited accessibility to services, and poorer experiences & outcomes.**

1: Culturally-Adapted Family Intervention Study (CaFI) – About CaFI. (2022). The University of Manchester. Available at: https://sites.manchester.ac.uk/cafi/about-cafi/

Why do we need to collect disabilities data?

Disability: The South East region is home to some of the highest numbers of disabled people. More than 15.7% people in the South East live with a disability[1], with an estimated 179,000 having complex disabilities[2]. Research evidence highlights the relationship between disabilities & long-term conditions, and **greater prevalence of mental health problems** – this includes physical disabilities.

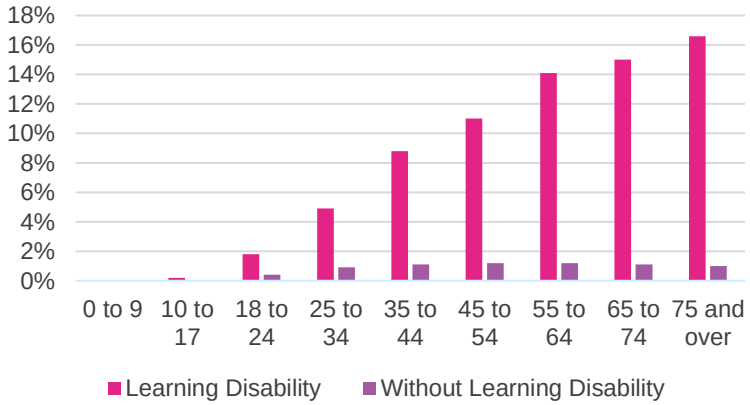
% of people with varying severity of Common Mental Disorders (CMDs) also reporting long-term physical conditions [3]



National data highlights that for patients with CMDs, there is a **higher likelihood of individuals suffering from a long-term chronic physical condition**, if they have severe mental health symptoms.

Partial South-East data indicates that there may be a **significantly higher prevalence of SMIs amongst people with learning disabilities**, compared to those without learning disabilities.

Percentage of patients in the South East with a diagnosis of Severe Mental Illness as at 31 March, age band, 2021-22 [4]



Improved data coverage would allow providers to better **understand the complex relationship** between physical and mental disabilities and mental health problems. This could enable improvements to both mental health services and the delivery of other care for patient groups with specific disabilities.

1: Mapping Disability: the facts (2016). Sports England. Available at: https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/mapping-disability-the-facts.pdf.
2 Complex disabilities in England (2022) Sense. Available at: https://www.sense.org.uk/about-us/statistics/complex-disabilities-in-england/#:~:text=3%2C622-,South%20East,living%20in%20the%20South%20East.
3: Comorbidity in mental and physical illness (2014) CORE. Adult Psychiatric Morbidity Survey. Available at: https://core.ac.uk/download/pdf/287022207.pdf.
4: Comorbidity in mental and physical illness (2014) CORE. Adult Psychiatric Morbidity Survey. Available at: https://core.ac.uk/download/pdf/287022207.pdf.

Why do we need to collect disabilities data?

Disability: There is **limited quantitative evidence on current or historical access** to mental health services for those with physical or mental disabilities – there is a clear opportunity to improve our national understanding in this area. However, qualitative studies have highlighted significant barriers and challenges to accessing mental health services for these groups.

"Access to specialist Learning Disability units **may preclude people** from using other specialised services in the UK"[1]

"People with **dual diagnosis may experience difficulties / delays** in accessing appropriate services because they do not fit specific social or health service criteria"[1]

"Studies found a **lack of awareness** by healthcare providers about the range of communication issues faced by people with intellectual disabilities and/or autism when accessing and attending primary and acute healthcare settings"

"Improving these issues could help **alleviate some of the fears** reported by service users, which represent another reported barrier"[2]

"**Organisational** barriers, **lack of services**, and poor-quality services related to **deficits in knowledge** were among the barriers"[3]

"Many **older adults** with chronic diseases have **difficulties knowing when to seek help**" – 51.9% of respondents in this study.[4]

Better data could **transform the experiences** of patients with disabilities, including long term conditions, chronic diseases, and those with learning disabilities & autism. Providers in the South East could provide more **integrated physical & mental health services** to patients; we need data to identify these exact opportunities.

1: Mental health services for adults with mild intellectual disability (2020). RCPsych. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr226.pdf?sfvrsn=8220109f_2.
2: Barriers and facilitators to primary health care for people with intellectual disabilities and/or autism: an integrative review (2020). Doherty et al. Available at: https://bjgpopen.org/content/4/3/bjgpopen20X101030
3: Barriers and Enablers to Accessing Mental Health Services for People With Intellectual Disability: A Scoping Review (2017). Whittle et al. Available at: https://www.tandfonline.com/doi/abs/10.1080/19315864.2017.1408724
4: Barriers to seeking professional mental health support among older adults with chronic diseases. (2022). Adams et al. Available at: https://assets.researchsquare.com/files/rs-2109770/v1/a479c13f-8919-421a-b3c5-28d647b0cdb0.pdf?c=1664392990

Why do we need to collect disabilities data?

Disability: There is growing research into current **treatments, experiences and outcomes** for patients with disabilities, ranging from learning disabilities to chronic health problems, in relation to mental health**.** This shows the health-related and financial impacts from untreated mental health problems for patients – however there continues to be **limited data** on these trends at the regional level.

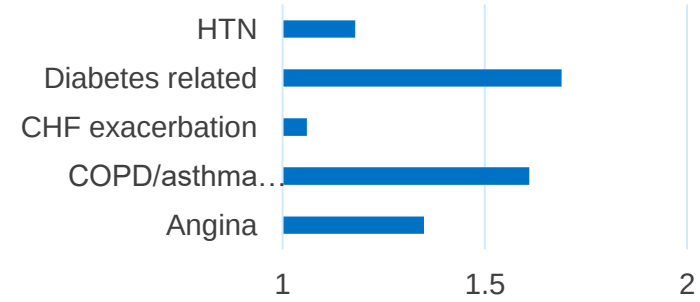
12-18% of all expenditure on long-term conditions is linked to poor mental health and wellbeing.[1] This equates to above **£1 in every £8**

35,000 adults with a learning disability are being prescribed an antipsychotic, antidepressant or both without appropriate clinical justification[2]

73% of people with a learning disability in inpatient settings received antipsychotic medication[2]

Research indicates that there is **higher risk of hospitalisation** for chronic Ambulatory Care-Sensitive Conditions (ACSCs)*, when patients also have depression. Such findings could support better treatment and outcomes for patients in the South East.

The risk of hospitalisations for chronic ACSCs associated with depression compared to individuals without depression [3]



Local South East data on outcomes for mental health patients with disabilities could be integral to better understanding what integrated care in the future should look like. There is an opportunity to reduce the current burden, delivering improvements in terms of patient experience, long-term health and possible system savings.

***Ambulatory care-sensitive conditions (ACSCs):** Group of chronic and acute illnesses considered not to require inpatient treatment if timely and appropriate ambulatory care is received

1: Bringing together physical and mental health: A new frontier for integrated care. (2016). Naylor et al. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf
2: People with learning disabilities routinely inappropriately prescribed antipsychotics, report finds. (2015). BJFM. Available at: https://www.bjfm.co.uk/people-with-learning-disabilities-routinely-inappropriately-prescribed-antipsychotics-report-finds
3: Depression and risk of hospitalisations and rehospitalisations for ambulatory care-sensitive conditions in Denmark: a population-based cohort study. (2013). Davydow et al. Available at: https://bmjopen.bmj.com/content/5/12/e009878

Case study

Case studies on using disabilities data

Case study: Greater Manchester integrated mental and physical health care[1]

Background

- **36 GP practices** in North West England took part in a cluster randomised controlled trial.
- Tested the effectiveness of an **integrated collaborative care model** for people with long term physical conditions and depression
- This care model is an evidence-based approach **recommended by NICE** (NICE 2009a) which has not yet become routine practice

What did they do?

- Provided collaborative care to patients with long term physical conditions, including patient preferences for:
  - Behavioural activation
  - Cognitive restructuring
  - Graded exposure
  - Lifestyle advice
  - Managing drug treatment
  - Prevention of relapse
- Up to **8 sessions of psychological treatment** were delivered by NHS IAPT service clinicians.
- Integration of care was enhanced by 2 **treatment sessions, delivered jointly** with the practice nurse.

What did they achieve?

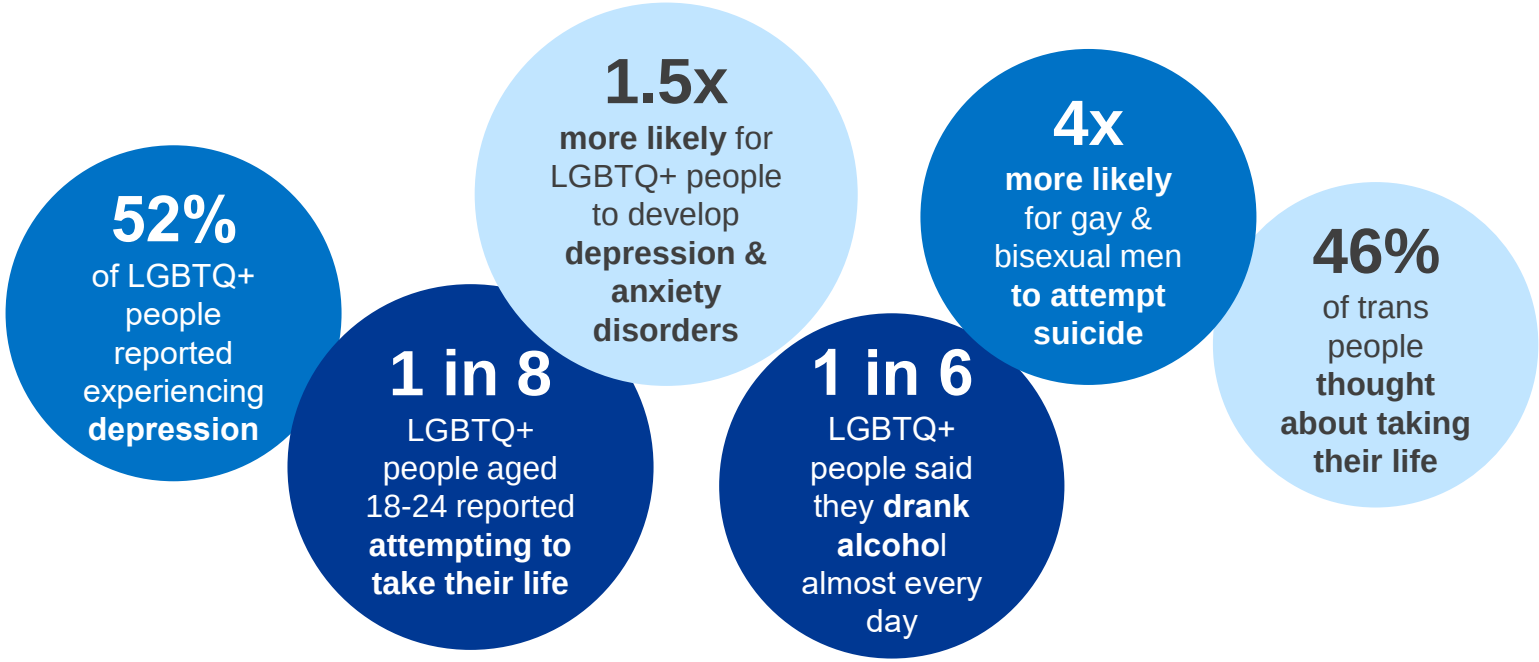
- **Reduction in mean depressive scores** across the 191 patients treated with collaborative care
- Patients reported:
  - Better **self management** of long term physical condition
  - More **patient-centred** care
  - Higher **satisfaction** with care

What does this mean for the South East? NICE guidelines recommend collaborative approaches that consider both mental and physical health care – yet there are very few case studies of new initiatives driven by data on disabilities for mental health patients. **There is a clear opportunity for the South East to be a national leader in this space – better data will be needed to bring providers and clinicians on board, and to attract funding for reducing inequalities.**

1: Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. (2015).Coventry et al. Available at: https://pubmed.ncbi.nlm.nih.gov/25687344/

Why do we need to collect gender identity and sexuality data?

Gender identity and sexuality: The rates of depression, anxiety and other mental health disorders amongst LGBTQ+ people is often higher than for the rest of the population. Evidence shows that this higher risk of poor mental health is often driven by difficult experiences with prejudice and discrimination. It is important to note there is variation in prevalence and experiences between different gender identity and sexuality groups.



Better understanding of these inequalities would enable the South East to **understand the levels of prevalence of different LGBTQ+ groups** and consider how mental health **services could be transformed** to provide support to patients, including through preventative care.

1: Sexual orientation health inequality: Evidence from *Understanding Society*, the UK Longitudinal Household Study. (2017). Booker, Rieger and Unger. Available at: https://www.sciencedirect.com/science/article/pii/S0091743517302141
2: Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations (2011). Haas et al. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662085/
3: Trans people's experiences of mental health and gender identity services: A UK study. (2015). Ellis, Bailey and McNeil. Available at: https://www.tandfonline.com/doi/abs/10.1080/19359705.2014.960990

Why do we need to collect gender identity and sexuality data?

Gender identity and sexuality: Recent academic evidence shows that there is limited UK research examining LGBTQ+ health inequality in mental health services[1]. Within the existing research, there is evidence that these groups are facing difficulties in accessing mental health care.

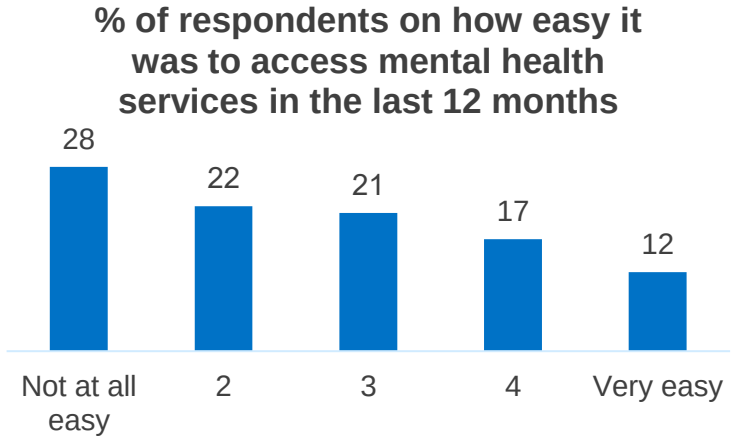
8% of respondents had tried to access mental health services but had been unsuccessful (NIESR)[2]

1 in 7 LGBTQ+ people avoided treatment for fear of discrimination (Stonewall)[3]

28% of respondents who accessed mental health services said it was not easy at all (NIESR)[2].

72% said this difficulty concerned long waiting lists.

22% said that their GP was not supportive.



The South East would benefit from understanding **how access to mental health services varies** between LGBTQ+ groups and the rest of the population. Given the level of indicative evidence that there are difficulties in accessing this care nationally, this data could **support initiatives to improve accessibility** for all groups.

1: The Politics of LGBT+ Health Inequality: Conclusions from a UK Scoping Review. (2021). McDermott, Nelson, Weeks. Available at: https://www.tandfonline.com/doi/abs/10.1080/19359705.2014.960990
2: National LGBT Survey: Summary Report. (2018). Government Equalities Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722314/GEO-LGBT-Survey-Report.pdf
3: Stonewall report reveals impact of discrimination on health of LGBT people. (2018). Available at: https://www.stonewall.org.uk/about-us/media-releases/stonewall-report-reveals-impact-discrimination-health-lgbt-people

Why do we need to collect gender identity and sexuality data?

Gender identity and sexuality: Qualitative research highlights the material numbers of poor patient experiences and outcomes for LGBTQ+ groups accessing mental health services, especially for trans and non-binary patients[1]. However, there is limited systematic, quantitative research on outcomes compared to the rest of the population.

28%
of trans and non-binary respondents said they were **not treated with dignity and respect during labour and birth** compared to just 2% of the MSS sample.[2]

18%
higher likelihood at 'Pride in Practice' registered GP practices of LGBTQ+ people saying GP met their needs[3]

<50%
of the trans and non-binary respondents felt that their **decisions around feeding their baby were always respected by midwives**, compared to 85% of the MSS sample.[2]

Lower
Likelihood of younger LGBTQ+ people being **registered at primary care services** than older LGBTQ+ people[4]

Better understanding of the **experiences of different LGBTQ+ groups** could inform future work in the South East to **reduce inequalities in patient outcomes**, particularly as LGBTQ+ may need mental health care with greater awareness of their identity and personal requirements.

1: National LGBT Survey: Summary Report. (2018). Government Equalities Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722314/GEO-LGBT-Survey-Report.pdf
2: Revealed: Improving Trans and Non-binary Experiences of Maternity Services report. (2022). LGBT Foundation. Available at: https://lgbt.foundation/news/revealed-improving-trans-and-non-binary-experiences-of-maternity-services-items-report/475
3: Pride in Practice LGBT Patient Experience Survey 2021. (2022). Available at: https://lgbt.foundation/news/pride-in-practice-lgbt-patient-experience-survey-2021/476
4: Inequalities in older LGBT people's health and care needs in the United Kingdom: a systematic scoping review. (2019). Kneale et al. Available at: https://pubmed.ncbi.nlm.nih.gov/34531622/

Case studies on using gender and sexuality data

Case study: MindOut voluntary community mental health service, Brighton and Hove[1]

Background

- **MindOut** is a specialist charity providing a mental health service for LGBTQ+ adults, aimed at reducing mental health inequalities for LGBTQ+ groups
- **50%** increase in counselling clients from 20/21 to 21/22
- MindOut uses **voluntary fundraising** to provide its services, despite fulfilling a clear mental health demand which also fills within the NHS remit as a provider of mental health services

What did they do?

- **2,010 people supported** in the area.
- Support included **counselling**, as well as **peer support groups** and targeted support for people **aged 50+.** The broader remit also included advocacy support, training and events relevant to LGBTQ+ groups' mental health.
- Support is **limited by volunteer counsellor training** level – patients experiencing psychosis, mania, complex PTSD, and other serious SMIs often may not be able to receive support.

What did they achieve?[2]

- **Over 97%** of evaluation respondents provided positive feedback.
- **100%** of evaluation respondents said they would recommend the service.
- More than **1440 counselling sessions** were offered to more than **150 individual clients** by a team of 28 volunteer counsellors.

What does this mean for the South East? There is an absence of strong, evidence-based case studies where regions have tackled the inequalities around mental health services for LGBTQ+ patients, although the number of pilot schemes being mobilised and inquiries in this area have been growing in recent years. **There is a significant opportunity for the South East to be the national frontrunner in this area – although data will be needed to understand the exact local needs for interventions targeting LGBTQ+ mental health inequalities in the region.**

1: Mind Out LGBTQ mental health service website. (2022). MindOut. Available at: https://mindout.org.uk/
2: Mind Out Annual Report 2021-2022. (2022). MindOut. Available at: https://mindout.org.uk/wp-content/uploads/2022/12/MindOut-Annual-report-2021-2-final.pdf

Why do we need to collect accommodation status data?

Accommodation status: Evidence indicates that housing pressures and status have a direct relationship with mental health problems, as well as other related physical issues, e.g. substance abuse. In particular, there is significantly higher prevalence of mental health problems, including Serious Mental Illnesses, amongst the homeless and rough sleeping populations.

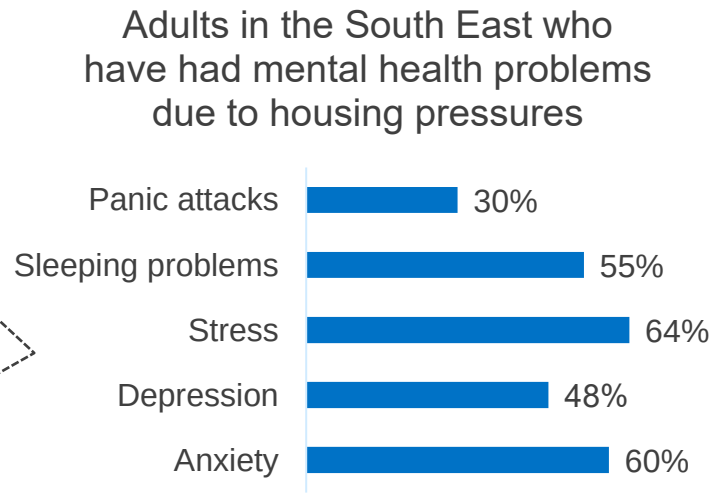
80% of homeless people in England reported mental health issues[1]

45% of homeless people in England had been diagnosed with a mental health condition[1]

8 in 10 People who are sleeping rough have been diagnosed with a mental health condition[2]

25-30% of homeless people estimated to have an SMI, e.g. schizophrenia[3]

There is evidence that accommodation status can be a contributing factor to mental health problems, as well as a consequence[4]

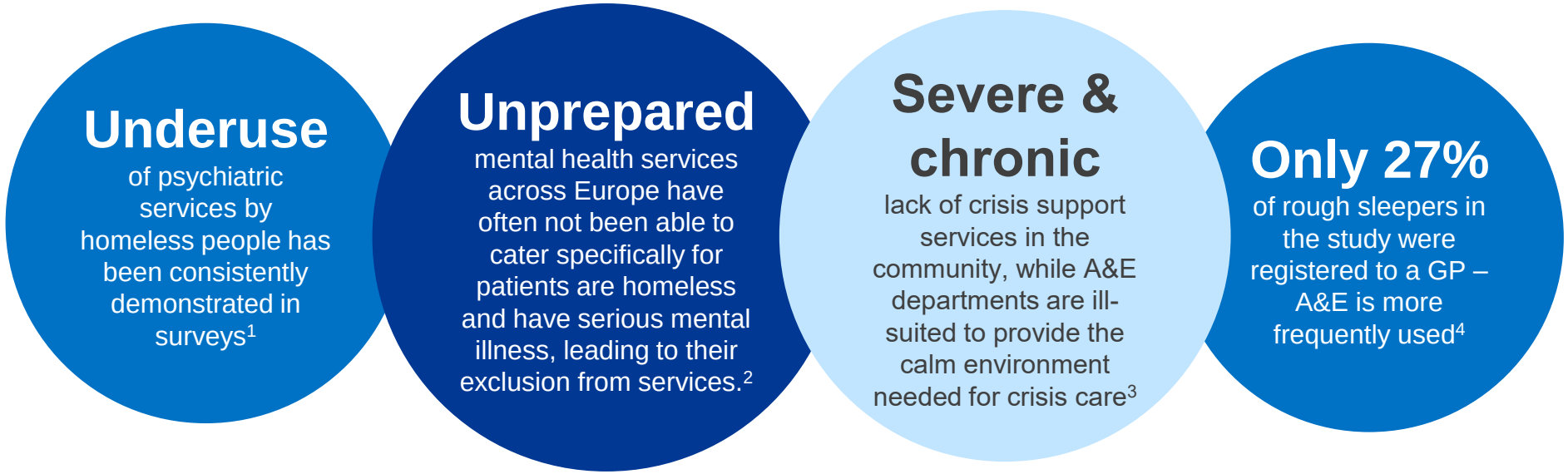


Better understanding of inequalities would enable the South East to **understand the levels of prevalence amongst groups with varying accommodation statuses** and consider how mental health **services could be transformed** to provide better support, especially for those who are homeless or rough sleeping.

1: Homelessness: statistics. (2022). Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/homelessness-statistics
2: Homelessness and mental health: Crisis UK. (2022). Crisis UK. Available at: https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/mental-health/
3: Homelessness, housing instability and mental health: making the connections. (2020). Padgett. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7525583/
4: The impact of housing problems on mental health. (2017). Shelter. Available at: https://england.shelter.org.uk/professional_resources/housing_and_mental_health

Why do we need to collect accommodation status data?

Accommodation status: There are significant barriers to accessing mental health services for those with certain accommodation statuses, e.g. homeless or rough sleeping. In addition to stigma and cultural factors, many people in this group do not have access to primary care, are unable to rely on crisis support services in the community, and face secondary services that aren't well-suited to them. There is a clear opportunity to improve services for vulnerable groups.

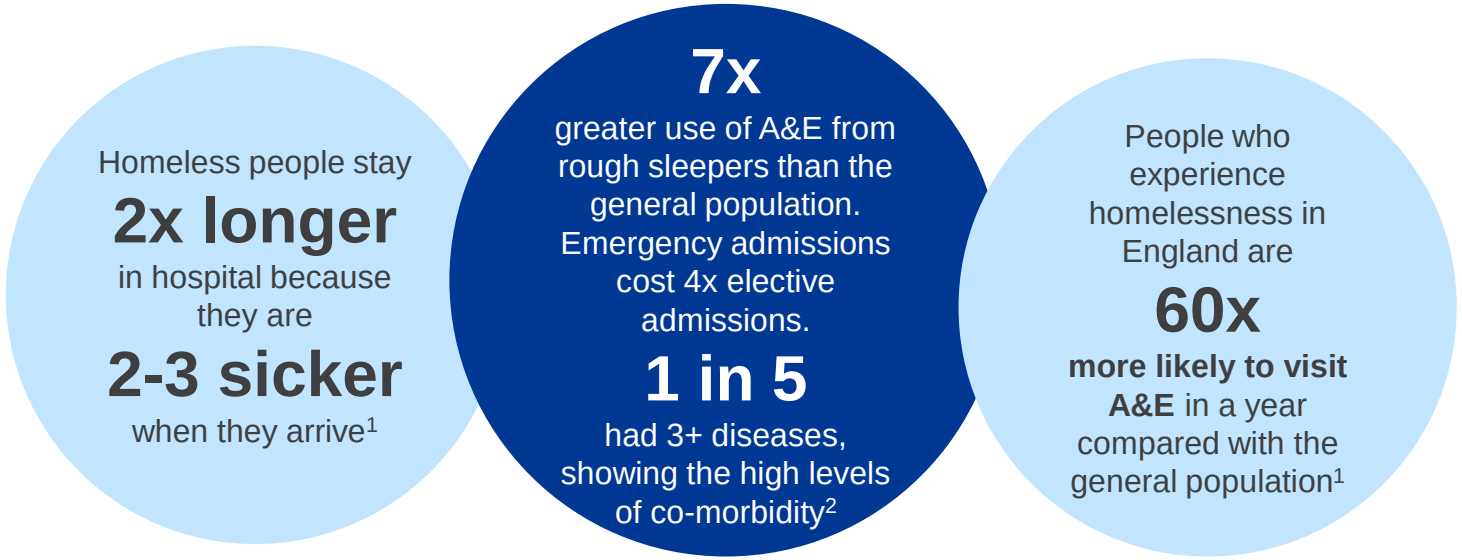


The South East would benefit from **understand the local obstacles** for homeless people, rough sleepers and other vulnerable groups, to access mental health services across primary and secondary care. There could be a significant **opportunity to transform** services and **reduce reliance on crisis services**.

1: Mental health services for single homeless people. (2020). Timms and Drife. Available at: https://psycnet.apa.org/record/2021-19608-011
2: Access to services by people with severe Mental Health Problems who are homeless. (2013). Mental Health Europe. Available at: https://www.mhe-sme.org/access-to-services-by-people-with-severe-mental-health-problems-who-are-homeless/
3: Lost in Crisis. (2017). Healthwatch Manchester. https://www.healthwatchmanchester.co.uk/sites/healthwatchmanchester.co.uk/files/Lost-in-Crisis-HWM-Review-Homeless-Access-to-MH-Services.pdf
4: Rough sleepers: health and healthcare. (2013). NHS North West London. https://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

Why do we need to collect accommodation status data?

Accommodation status: Homeless people and rough sleepers form a large proportion of high-intensity usage in Accident & Emergency services in England, face higher rates of emergency inpatient admissions, and experience longer lengths of stay[1]. The stark contrast in outcomes and experiences to the general population signals that this is an area of concern for health systems, requiring better data and understanding to tackle problems in this area.



There is a clear opportunity to reduce reliance on **much costlier crisis services**, i.e. A&E and emergency secondary care, and **improve access to earlier intervention and treatment** in primary care or the community. These may offer **better environments and experiences**, and could be more catered to homeless people than A&E for example.

1: Nowhere else to turn: Exploring high intensity use of Accident & Emergency Services. (2021). British Red Cross. Available at: https://www.redcross.org.uk/-/media/documents/about-us/hiu_report_nov2021_aw2.pdf?la=en&hash=16A7EF0183AF82614147C3CB1117396C8C18CBC5#:~:text=High%20intensity%20use%20is%20greatest,and%20loneliness%20and%20social%20isolation
2: Rough sleepers: health and healthcare. (2013). NHS North West London. https://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

Case studies on using accommodation status data

Case study: The Rough Sleeping and Mental Health Programme (RAMHP), Imperial College Health Partners[1]

Background

- The Rough Sleeping and Mental Health Programme (RAMHP) is a **two-year pilot** programme which aims to support increased access to mental health services for people sleeping rough in **16 London boroughs and 4 Trusts.**
- The RAMHP is funded by the Mayor of London and the MHCLG Ministry, who are **giving £2.35m** for the programme.

What did they do?

- Four Mental Health Trusts in London have **built specialist teams** with this funding, working with local Street Outreach Teams (SORT).
- Representatives from 16 councils have helped design the shape and roles of these teams, as have **outreach teams from charities**, inc. St Mungo's, and Single Homeless Project.
- The programme is guided by people with **lived experience**, and the Making Every Adult Matter coalition of charities.

What did they achieve?

- **90%** of clients experienced an improvement in their health and wellbeing at the point of discharge in the first 9 months. **90%** of clients also had a care plan complete.[2]
- **50%** of clients have accessed and maintained accommodation after discharge from the service.[2]
- The pilot won an accolade at the Mental Health Awards 2022, for: **Improving Inequalities in Mental Health and for Specialist Services[3]**

What does this mean for the South East? There is a growing number of pilot schemes being mobilised to tackle issues around rough sleeping and homelessness, some of which are related to provision of mental health services. However, the accommodation status underpinning these schemes is limited and complex. **There is an opportunity for the South East to build on the current momentum and reduce inequalities for these vulnerable groups, delivering substantial benefit to health and care systems.**

1: Improving access to mental health services for people sleeping rough. (2020). Imperial College Health Partners. Available at: https://imperialcollegehealthpartners.com/portfolio/ramhp/
2 Homelessness and Rough Sleeping Sub-Committee Report: Mental Health and Rough Sleeping. (2020). City of London Council. Available at: https://democracy.cityoflondon.gov.uk/documents/s143748/Mental%20Health%20and%20Rough%20Sleeping.pdf
3: ELFT Mental Health Projects Given Highly Commended Accolade. (2022). NHS East London NHS Foundation Trust. Available at: https://www.elft.nhs.uk/news/elft-mental-health-projects-given-highly-commended-accolade

Case studies on using protected characteristics data

Day opportunities, Minstead Trust[1]

The Minstead Trust host all-day **activities** at their sites across **Hampshire** for individuals with **learning disabilities**. Day opportunities teach participants work and life skills, and encourage socialising.

The activities support the **mental and physical health** of participants. In 2021-2022, **152 people** took part in day opportunities.

Rethink Sahayak, Rethink Mental Illness[2]

Rethink Sahayak is a mental health service for the **Asian Community** in **Kent and West Sussex**. Their telephone helpline offers **support and information** about local mental health services. Callers can speak in Gujarati, Punjabi, Hindu, Urdu or English.

They also host a peer **support group** to combat **social isolation**.

The BeYou Project, Porchlight and Kent & Medway ICS[3]

The BeYou Project provides one-to-one support and group sessions for **LGBT young people** in **Kent and Medway.** The sessions provide a safe space for individuals to socialise and share experiences.

In 2021/22, The BeYou Project supported **451 young people** and ran **156 group sessions**

Discharge to Assess, Southdown and Sussex Partnership Foundation Trust[4]

Discharge to Assess supports individuals with the **transition into the community** following discharge from acute mental health wards.

Short-term accommodation is provided, and those who are at **risk of homelessness** are assisted in finding a **longer-term residence.**

1: Trust Annual Summary 2021-2022. (2022). Minstead Trust. Available at https://www.minsteadtrust.org.uk/app/uploads/2023/01/Annual-Report-Short-2022_v6_Digital.pdf
2: Rethink Sahayak Asian Mental Health Helpline. (2022). Rethink Mental Illness. Available at https://www.rethink.org/help-in-your-area/services/advice-and-helplines/rethink-sahayak-asian-mental-health-helpline/
3: Trustees Report 2021-2022 (2022). Porchlight. Available at https://www.porchlight.org.uk/downloads/attachments/Trustees-report-2021-22_web.pdf
4: Discharge to Assess (2022). Southdown, Available at https://www.southdown.org/services/discharge-to-assess-brighton-hove/

What have we found?

1. There is **strong evidence that mental health inequalities exist** across all our priority characteristics, both in academic research and national findings in England.

2. These **inequalities exist across**: prevalence of conditions, access to mental health services, and patient experiences & outcomes. The South East currently has a limited regional view of these inequalities, partly due to the **poor data coverage**.

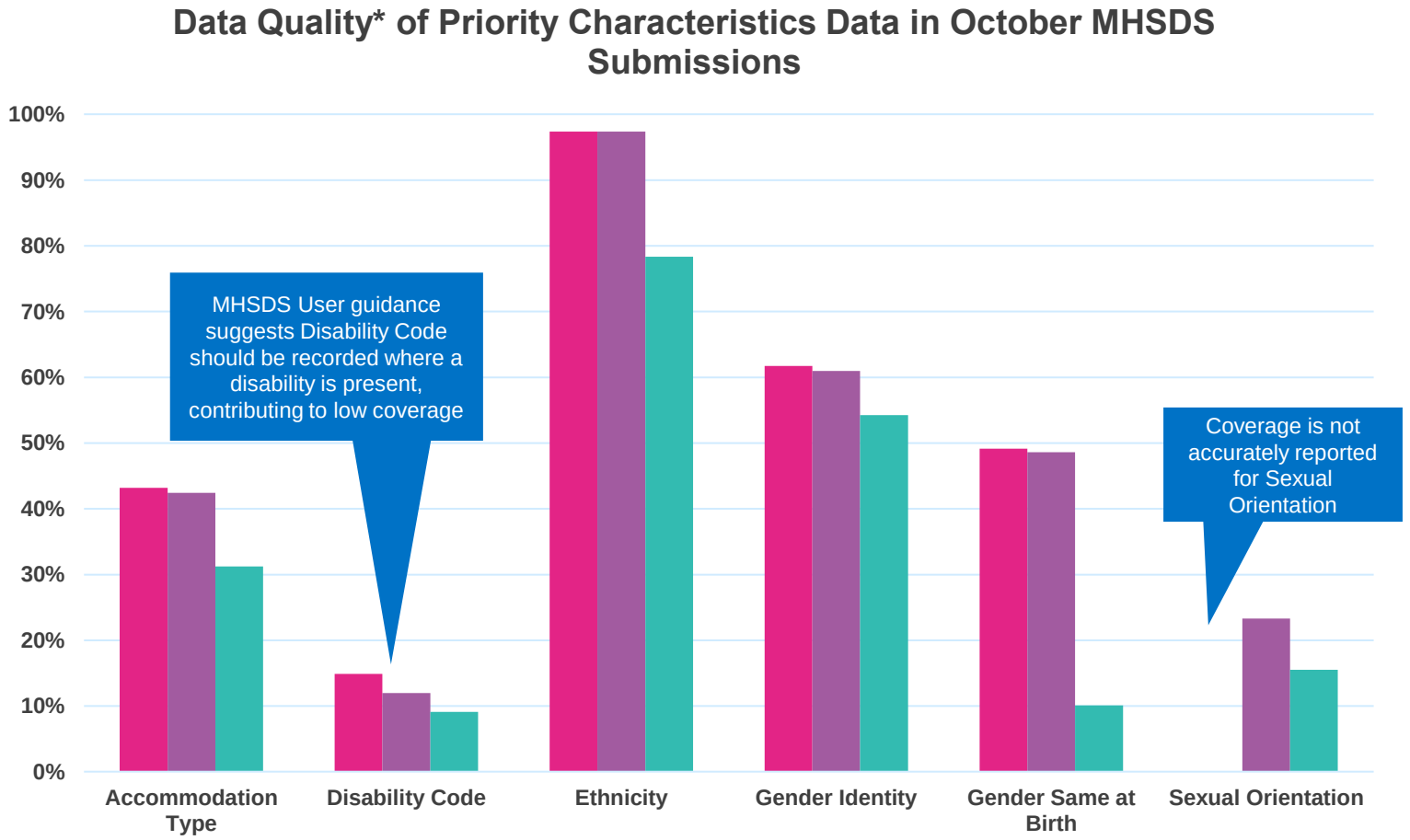
3. Despite growing evidence and calls to act on inequalities in England, there are **few case studies** which illustrate regions making strong progress towards using data on inequalities to inform more targeted interventions for reducing inequalities.

There is a clear clinical case for South East providers to improve data coverage and quality for these priority characteristics, to inform evidence-based interventions for reducing mental health inequalities

MHSDS Priority Characteristics Data Coverage in the South East

Priority Characteristics data quality across all providers in England

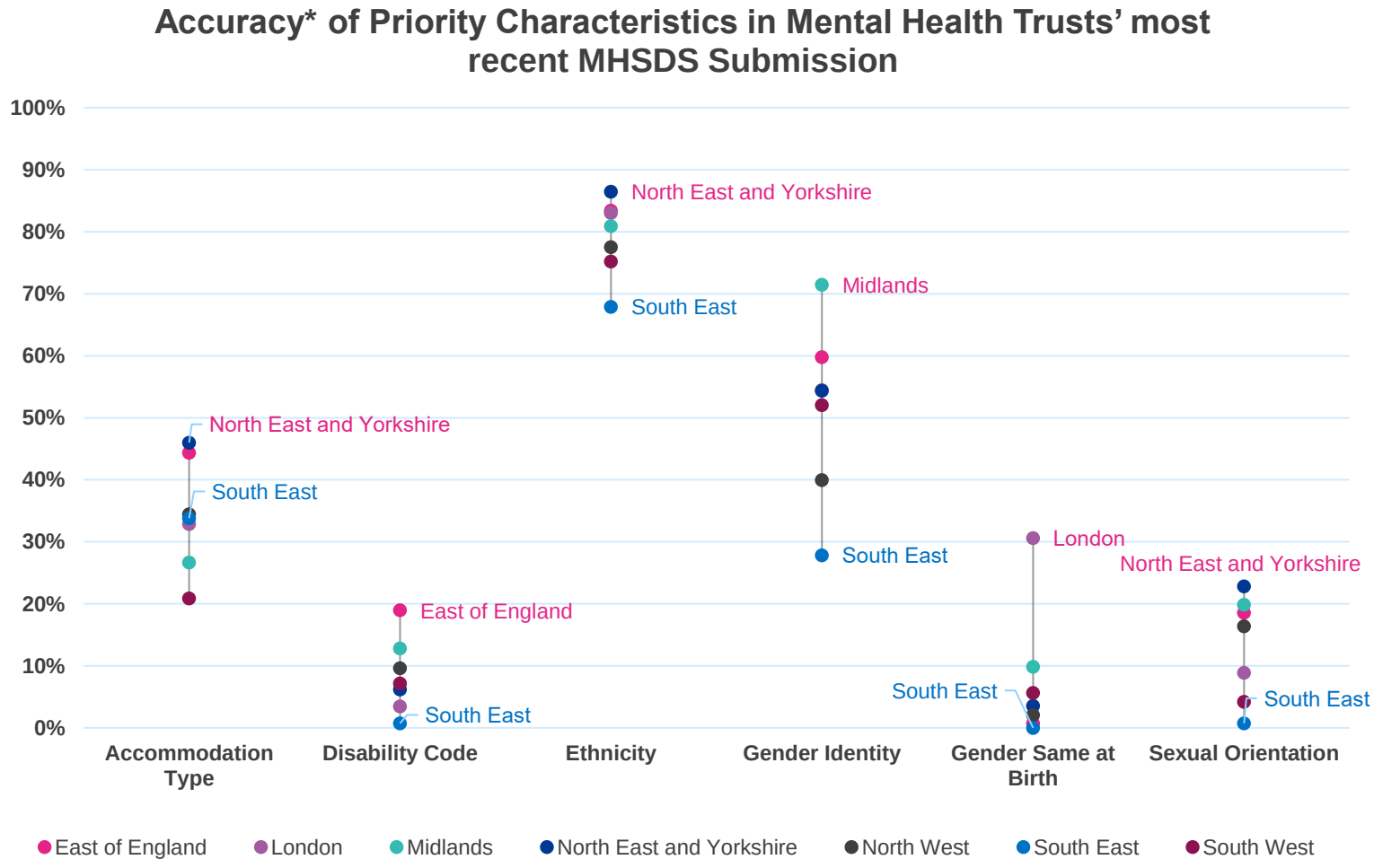
- There is **significant scope** to **improve data quality** across characteristics, **especially** with regards to **accuracy.**
- **Small gaps between coverage and validity** across most characteristics suggests **providers** are largely **using codes defined** in the MHSDS.
- **Ethnicity and Gender-related codes** are recorded in **mandatory tables,** contributing to **higher coverage** (even if the data item itself is not mandatory).



Note: This analysis considers all providers that submit to the MHSDS. Some trusts have failed to submit data since July 2022 due to a cyber attack. Raw data has been suppressed so 0% means <5 records have been recorded.
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023

Accuracy of Priority Characteristics data across regions

- When looking at **Mental Health Trusts**, there is **substantial variation** in accuracy across England, with **different regions performing** well in **different characteristics.**
- **Regions** are largely experiencing **accuracy issues** in the **same priority characteristics.**
- The **South East** has the **lowest** accuracy in **Ethnicity**, **Gender Identity**, **Disability**, **Gender Same at Birth**, and **Sexual Orientation.**



*Accuracy is defined as the proportion of patients where the data item has been completed with a valid and useful code i.e. not marked as other/unknown/not stated.

Note: This analysis considers only Mental Health Trusts, not other providers who submit to MHSDS. Most recent submission used as some Trusts have failed to submit data since July 2022 due to a cyber attack. Raw data has been suppressed so 0% means <5 records have been recorded. Rotherham Doncaster and South Humber NHS Foundation Trust removed from Sexual Orientation calculations for the North East and Yorkshire as reporting errors mean they report >100% accuracy.
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023.
List of Mental Health Trusts Source: Royal College of Psychiatrists.

Regional rankings of Priority Characteristics data accuracy

Across priority characteristics, the **South East ranks lower** in **accuracy** compared to other regions.

	Accommodation Type	Disability Code	Ethnicity	Gender Identity	Gender Same at Birth	Sexual Orientation	Total
East of England	2	1	2	2	6	3	16
London	5	6	3	3	1	5	23
Midlands	6	2	4	1	2	2	17
North East and Yorkshire	1	5	1	4	4	1	16
North West	3	3	5	6	5	4	26
South East	4	7	7	7	7	7	39
South West	7	4	6	5	3	6	31

Key:

Highest Accuracy

Lowest Accuracy

Note: Rotherham Doncaster and South Humber NHS Foundation Trust has been removed from Sexual Orientation calculations for the North East and Yorkshire as reporting errors mean they report >100% accuracy.
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023.

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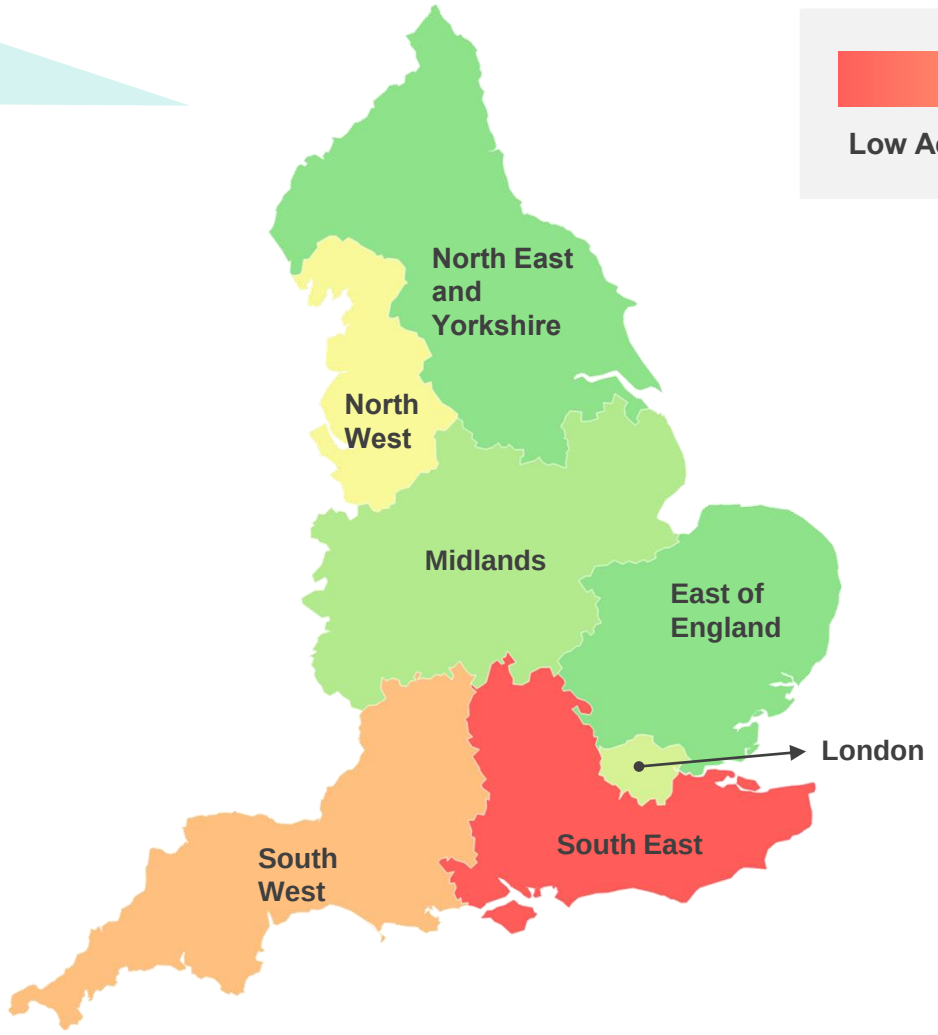
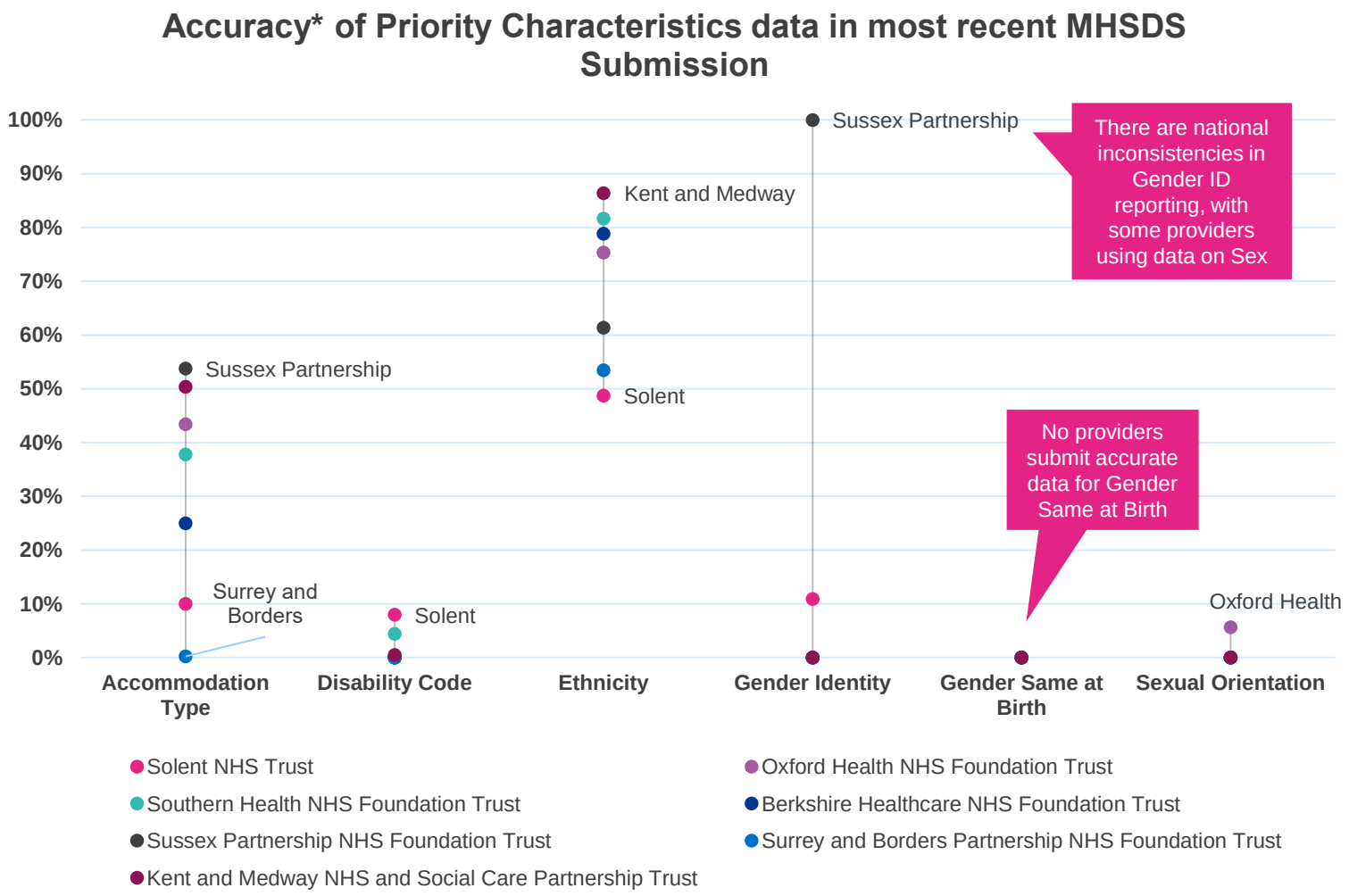


Map data: © Crown copyright and database right 2020 – Created with Datawrapper
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023.

Accuracy of Priority Characteristics data from SE providers

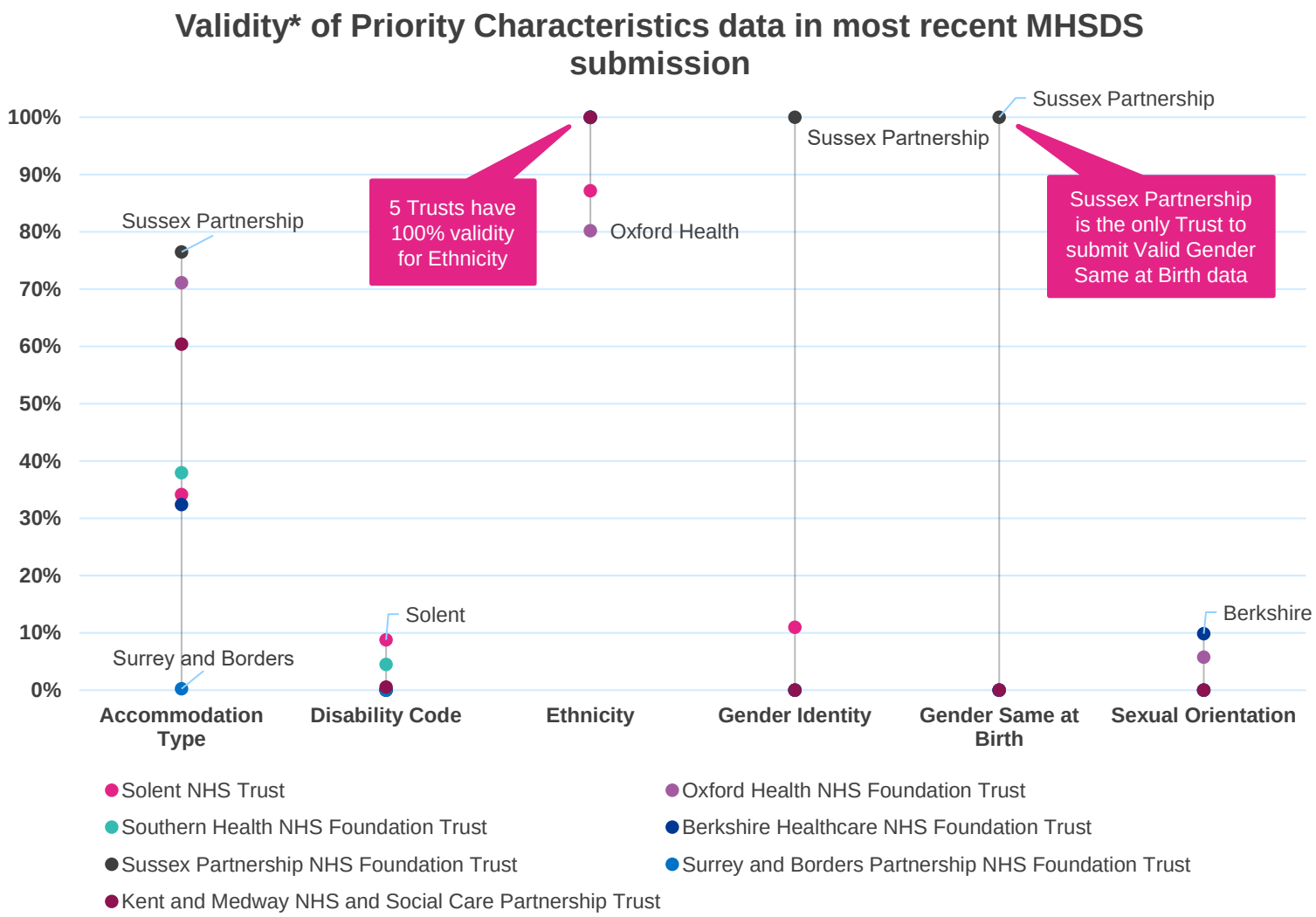


- The **accuracy** of MHSDS priority characteristics data is **low across the South East,** so there is significant **scope for improvement across the region.**
- **Ethnic Category** is the protected characteristic with the **highest accuracy.**
- There are **discrepancies** regarding which **characteristics providers submit data for** (e.g., SPFT report Gender Identity whereas SABP do not).

*Accuracy is defined as the proportion of patients where the data item has been completed with a valid and useful code i.e. not marked as other/unknown/not stated..

Note: Most recent submission used as Oxford Health have failed to submit data since July 2022 due to a cyber attack. Raw data has been suppressed so 0% means <5 records have been recorded.
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023.

Validity of Priority Characteristics data from SE providers



- **Higher validity** compared to accuracy for **Accommodation Type** and **Ethnicity** suggests a **substantial number of 'Unknown', 'Other' and 'Not stated'** codes are being used for these fields.
- For the **other characteristics**, issues surrounding data quality are largely related to the **failure to submit any valid data.**

*Validity is defined as the proportion of patients where the data item has been completed with a valid and useful code i.e. not marked as other/unknown/not stated.

Note: Most recent submission used as Oxford Health have failed to submit data since July 2022 due to a cyber attack. Raw data has been suppressed so 0% means <5 records have been recorded.
Data Source: NHSE Mental Health Services Data Set (MHSDS), Accessed January 2023.