Culture of Care

Intersectionality in inpatient mental health care

A comprehensive guide for the Culture of Care programme

Preface

To deliver truly inclusive, person-centred care, we, people who work in inpatient mental health care, must do more than recognise difference – we must act on it. An intersectional approach asks us to see the whole person, to understand how overlapping identities and experiences shape every interaction, and to respond with empathy, equity and intent.

This guidance is more than a resource – it is a **call to action**. It challenges us to rethink, reshape and reimagine care so that equity is not merely an aspiration, but a lived reality for every individual in our inpatient mental health, learning disability and autism settings.

Grounded in the 12 Culture of care standards for mental health inpatient services, this guide equips people who provide inpatient mental health care to embed intersectionality into everyday practice, and monitor your progress. Our **Top Ten Tips** (Appendix A) offer easy-to-use, practical steps to bring these principles to life, while our **comparative vignette** (Appendix B) illustrates how an intersectional lens transforms care – from understanding lived experiences to shaping compassionate, effective practice. Then we guide you from **principles to practice** (Appendix C) by describing how to facilitate intersectional co-production within care. Lastly, we outline how to meaningfully embed intersectional co-production within mental health services using systems thinking (Appendix D). You can jump to each appendix, and other sections of this guidance, using the side-pane navigation on the right.

This is your opportunity to lead with purpose. To transform cultures. To transform care and to ensure every person receives the support they deserve.

Together, let's make it happen.

Mark, Olivia, Tom and Sal

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1. Intersectionality defined and why it matters

Intersectionality is a term coined by scholar Kimberlé Crenshaw, an American civil rights advocate and scholar of critical race theory. It is a critical framework that recognises how people's experiences are profoundly shaped by the interplay of their multiple social identities (such as race, gender, class, sexuality, disability, age, religion and geographical location) and the intersecting systems of oppression[a] and privilege associated with these identities.

In the context of mental health care, this means understanding that disparities in access, experience and outcomes are not caused only by a single aspect of a person's identity. Instead, they arise from the compounded impact of multiple, overlapping forms of marginalisations. Traditional approaches to equality often fall short for highly marginalised groups because they tend to treat everyone the same or focus on single identity categories in isolation.

Intersectionality, by contrast, centres the lived experiences of people who are most marginalised, highlights inherent power dynamics within society and healthcare systems, and actively promotes equitable,[b] inclusive and truly patient-centred support.

Mark Farmer, a National Advisor on the Culture of Care Programme reflects,

"I am a disabled, gay man with neurodiversity, and navigating life sometimes feels overwhelmingly challenging. When I seek mental health care, I often feel misunderstood – my clinicians seem to miss the full picture of who I am. Beyond my clinical symptoms, I am someone who has been bullied for being gay, who struggles to fit into the LGBTQ Plus community because of my weight, my disability and being middle-aged, and who has experienced a lifetime of trauma. I need care that recognises and supports every aspect of my identity."

This honest reflection underscores the importance of a truly comprehensive approach to mental health care – one that sees and values every layer of the person behind the diagnosis. Therefore, when working with people, we must consciously recognise the complex social and structural factors that perpetuate health inequalities. These factors are not abstract: they manifest in the daily lives and mental health journeys of the people we support.

a A system of oppression refers to institutionalised structures, policies, and cultural norms that unfairly disadvantage certain groups while maintaining privilege and control for others, often based on race, gender, class or other identities.

b Actively promoting equity means intentionally creating fair opportunities, dismantling barriers and ensuring that all individuals, regardless of background, have access to the resources and support that they need to thrive.

1.1 The Wheel of Power, Privilege and Marginalisation

The Wheel of Power, Privilege and Marginalisation (Figure 1)is as a visual aid that was developed in Canada, which helps us understand some of the determinants of power and privilege within UK society. It illustrates how the social identities closer to the centre of the wheel typically hold more power and privilege, while those further from the centre often experience greater marginalisation and oppression. Reflecting on this wheel can help us identify our own positions of privilege, and how they might influence our interactions and perceptions when providing care. The range of colours that are used highlight the complexity of social identity, emphasising that no single factor defines a person's lived experience – rather, it is the intersection of multiple elements that shapes individual realities.

Figure 1: 'Wheel of Power, Privilege, and Marginalization', by Sylvia Duckworth. Used by permission. This version adapted for: A-L Riitaoja, A Virtanen, N Reiman, T Lehtonen, M Yli-Jokipii, T Udd, L Peniche-Ferreira. Migrants at the university doorstep: How we unfairly deny access and what we could (should) do now. Apples – Journal of Applied Language Studies. 2022;16: 121–45. doi: 10.47862/apples.112578. Original version from the Canadian Council of Refugees, https://ccrweb.ca/en/anti-oppression.

The categories in the Wheel of Power, Privilege and Marginalisation are as follows, from the outer edge of the wheel (less power and privilege, more marginalised) to the centre (more power and privilege, less marginalised):

- **Skin colour**: People with darker skin tones are placed at the outer edge of the wheel, while lighter-skinned people are positioned centrally.
- **Education**: People who have reached elementary education (12–14 years old) are on the outer edge, while those with post-secondary education (18+ years old) are at the centre.
- **Ability**: People with significant disabilities are placed on the edge, while able-bodied people are central.
- **Sexuality**: Lesbian, gay, bisexual, transgender, queer and other (LGBTQ+) identities – including pansexual and asexual – are on the edge, while heterosexuality is centred.
- **Neurodiversity**: People with neurodivergence are on the edge, while neurotypical people are in the middle.
- **Mental health**: Vulnerability in mental health is on the outer edge, while robust mental wellbeing is at the centre.
- **Body size**: Larger body sizes are on the edge, while slimmer bodies are positioned centrally.
- **Housing**: People who are homeless are placed at the outer edge, while property owners are central.
- **Wealth**: People with lower incomes are at the edge, while the wealthy are in the centre.
- **Language**: Non-English monolingual people are positioned on the edge, while English speakers are central.
- **Gender**: Transgender, intersex and non-binary people are on the edge, while cisgender people are at the centre.
- **Citizenship**: Undocumented people are on the outer edge, while citizens are in the centre.

Syliva Duckworth, who created the Wheel of Power, Privilege and Marginalisation, said, 'Intersectionality is a lens through which you can see where power comes and collides, where it locks and intersects. It is the acknowledgement that everyone has their own unique experiences of discrimination and privilege.'

1.2 Intersectionality and mental health disparities

Adopting an intersectional lens gives us a crucial opportunity to explore health inequalities with greater nuance. Broad categories often used in healthcare, such as 'BAME' (Black, Asian and minority ethnic), 'LGBTQ+' or 'disabled', can inadvertently mask significant variations and diverse experiences within these groups.

Consider the experience of a woman with a mental health diagnosis. Now, what if she is a Black woman? And further still, what if she is a Black, autistic woman who is living in poverty, has caring responsibilities and is an asylum seeker? Each additional layer of identity and social context introduces new dimensions of potential discrimination, systemic barriers and stressors. Disparities in access to care, the quality of care received and ultimate mental health outcomes can all be significantly compounded when people face multiple forms of marginalisation.

1.3 An obligation to address inequities in mental health care

We must continue to work to address the stark statistics that paint a picture of profound inequity within the UK mental health system. These disparities are often compounded for people who navigate multiple systems of oppression simultaneously. For example, research indicates that racially minoritised LGBTQIA+ young people often face particular additional challenges within educational and support systems, due to intersecting forms of marginalisation and a lack of culturally sensitive, affirming support.

Some of the mental health disparities that people from intersectional communities face are described in Table 1. After considering those disparities, the practical question then becomes: How might we integrate the understanding of these mental health disparities into our daily practice to genuinely improve people's experience of care in inpatient settings?

Intersectional group	Key mental health disparities
Black men	Have higher rates of detention under the Mental Health Act; are more likely to be subjected to restrictive interventions (NHS Digital, 2024; NHS Digital, 2024; Pedersen ML, 2023).
Black women	Are more likely to experience a common mental health problem (29%) compared with White British women (21%) (NHS Digital, 2017 [updated 2020]).
LGBTQ+ youth	Over half (58%) have seriously considered suicide in the past year; 70% have reported recent anxiety symptoms; face discrimination impacting mental health (The Trevor Project, 2024).
Transgender and non-binary youth	Experience worse mental health outcomes and higher rates of victimisation and discrimination (The Trevor Project, 2024).
LGBTQ+ asylum seekers	Experience extremely high prevalence of PTSD (70–100%), depression (76–93%) and suicidality (56–72%) (White LC, 2019; Blackmore R, 2020).
Racially minoritised LGBTQ+ youth	Face additional challenges from intersecting forms of marginalisation and lack of culturally sensitive support (The Trevor Project, 2024; Bachmann CL, 2018).
Autistic adults	Only 31% are employed in the UK; 65% fear discrimination from management if they disclose their neurodivergence (Zaidi K, 2025; Birkbeck, University of London, 2023).
People in lower-income groups	Are up to three times more likely to experience mental health problems than those with higher incomes (Mental Health Foundation, 2025; Public Health England, 2018).
Ethnic minorities (general)	Black adults have the lowest mental health treatment rate (6% versus 13% for White British) (NHS Digital, 2017 [updated 2021]).
Mixed White and Black Caribbean people (service use)	Have the highest rates of using NHS mental health, learning disability and autism services (excluding 'other' categories) (NHS Digital, 2024).

Table 1: Intersectional groups and the key mental health disparities they face

Also see Appendix B for our comparative vignette of intersectional experiences in inpatient care

2. Intersectionality in practice in the Culture of Care programme

The framework of the Culture of Care programme inherently requires an intersectional lens to be fully realised for all patients. Without such a lens, there is a risk that broad principles such as 'equality' or 'safety' could be applied in a generalised manner, which may inadvertently overlook or inadequately address the needs of people who hold multiple marginalised identities. For instance, the concept of safety can differ profoundly for people based on their intersecting identities; what constitutes a safe environment for one person may not feel safe for another, particularly if they have experiences of discrimination or trauma linked to their identity not being considered.

The very existence and mandate of frameworks like the Patient and Carer Race Equality Framework, designed to tackle racial disparities within the broader mental health system, highlights the recognition that universal approaches often fall short for specific communities.

2.1 Mapping intersectionality to the NHS Culture of Care core standards

To support understanding of the Culture of care standards for mental health inpatient services, Leanne Walker (lived experience advisor at NHS England and the Royal College of Psychiatrists) developed the visual representation of the reimagined vision of care (Figure 2). This illustration depicts the 12 core standards and their underpinning principles in the form of a house, symbolising the establishment of a strong foundation for safe, compassionate and supportive care.

- The archway to the house's garden bears the statement, '12 core commitments – creating conditions where everyone can flourish.'
- At the roof of the house lie the vision and values that provide containment and direction for high-quality care:
    - **Vision**: People can consistently access a choice of therapeutic support and feel safe.
    - **True co-production**: Staff, patients and carers collaborate as equal partners in all aspects of care. Collaborative practice is embedded in every aspect of care delivery and service design.
    - **Always compassionate**: Compassion forms the foundation of all interactions and decisions.
    - **Citizenship**: People are recognised and treated as equal members of the community.
- Further overarching principles of providing good care are represented around the building:
    - **All care is trauma-informed, autism-informed and culturally competent**.
    - **Respect for intersectionality**: Care is there for everyone according to their needs.
    - **Each person has the power to make a difference**: The principle that each individual has the power and capacity to make a meaningful difference.
- The garden path and outdoor and green spaces extend the metaphor, symbolising the importance of therapeutic environments and maintaining links with family, community and local services. They signify that healing and recovery are supported by connection and inclusion beyond the inpatient setting.
    - Welcoming environment, with open access to outdoor and green spaces.
    - Connection with life outside hospital, support networks, local services.

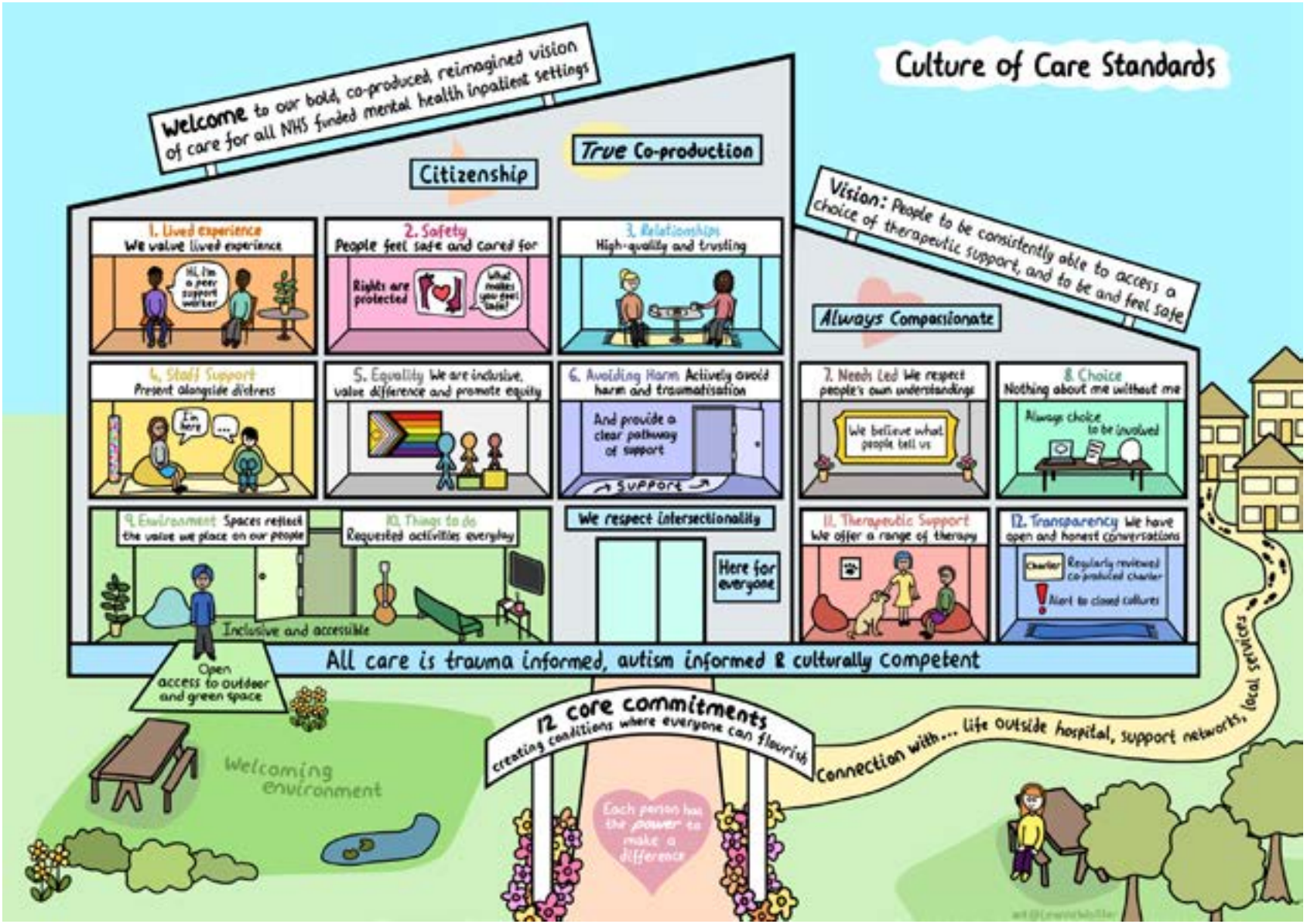


Figure 2: Intersectionality mapped onto the NHS Culture of Care core standards. By Leanne Walker

2.1.1 Applying an intersectional lens

We will now take an intersectional lens to Figure 2.

Table 2 lays out how staff can enhance each of the 12 overarching core commitments of the NHS Culture of Care standards for mental health inpatient services by applying an intersectional lens. Integrating an intersectional approach requires a conscious shift in our clinical and relational practices across all aspects of inpatient mental health care.

Table 2: NHS Culture of Care core standards and how they can be enhanced with an intersectional lens

Core commitment	Enhance with an intersectional lens by:
1. Lived experience 	• **Actively seeking out, amplifying and equitably compensating** the voices and expertise of people with multiple and specific intersecting marginalised identities, who are often the most silenced or overlooked. • **Ensuring that peer support workers and lived experience leadership roles reflect this rich diversity**, and are equipped to support people who have intersectional needs. • **Recognising that lived experience varies greatly** from person to person.
2. Safety 	• **Moving beyond generalised safety protocols**, to understand and address what creates safety or triggers feelings of unsafety for people based on their unique intersecting identities. ▸ For example, consider the specific safety needs of: • a Black transgender woman (e.g., protection from misgendering, racism, transphobic remarks/violence) • an autistic person of colour (e.g., sensory sensitivities compounded by potential racial bias in interpreting behaviour) • or an older person with dementia from an ethnic minority background whose first language is not English (e.g., communication barriers, culturally unfamiliar environment, potential for isolation). ▸ **This includes psychological, cultural and spiritual safety** alongside physical safety.

Core commitment	Enhance with an intersectional lens by:
3. Relationships 	• **Training staff to build trusting, therapeutic relationships** that are attuned to how intersecting identities shape communication styles, trust levels and past experiences with authority or healthcare systems. • **Acknowledging and addressing potential biases held by staff** that could impede relationship-building with certain groups. • **Recognising that relational security is co-created** and means different things to different people.
4. Staff support 	• **Providing tailored support for staff from diverse and intersecting backgrounds**, recognising that they may face specific workplace stressors, including microaggressions, bias and discrimination. • **Ensuring that reflective practice and supervision explicitly create safe spaces** to explore how staff members' intersecting identities influence their wellbeing, professional relationships and approaches to care. • **Acknowledge and address emotional labour**, particularly the additional burden often carried by staff from marginalised or underrepresented groups, and ensure that people's labour is recognised and they are supported. • **Offer targeted wellbeing initiatives and support networks** for staff from diverse communities and backgrounds, co-designed with those they aim to serve. • **Develop and implement tailored workplace adjustments** that respond to the individual needs of staff – including flexible working, reasonable adjustments, and culturally or identity-sensitive support mechanisms.

Table 2 continued

Table 2 continued

Core commitment	Enhance with an intersectional lens by:
5. Equality 	• **Providing genuinely equitable care** that recognises, values and responds to different needs, strengths and vulnerabilities arising from intersecting identities (therefore, shifting from a focus on treating everyone equally). ▸ This involves proactively identifying and dismantling systemic barriers that disadvantage specific intersectional groups in accessing care, experiencing positive interactions and achieving good outcomes. • **Understanding local population demographics through an intersectional lens**. ▸ See the 2019 NCCMH resource, Advancing Mental Health Equity (formerly Equality).
6. Avoiding harm 	• **Recognising that people with certain intersecting identities (e.g., racialised people, LGBTQ+ people, people with trauma histories, neurodivergent people) are at greater risk of experiencing iatrogenic harm**, including re-traumatisation, discrimination and the disproportionate use of restrictive practices. • **Implementing proactive strategies to mitigate these risks** of iatrogenic harm. • **Ensuring complaints and redress mechanisms are accessible and sensitive** to intersectional experiences of harm.
7. Needs-led 	• **Supporting people to articulate their needs** from their own personal intersectional perspective. • **Validating how cultural background, gender identity, disability, socioeconomic status and so on intersect** to shape a person's understanding of their distress, their coping mechanisms and what constitutes meaningful support for them.

Table 2 continued

Core commitment	Enhance with an intersectional lens by:
8. Choice 	• **Understanding that a person's ability to exercise meaningful choice can be significantly constrained** by past experiences of discrimination, systemic barriers, or a lack of culturally appropriate or affirming options. • **Actively exploring what constitutes meaningful choice for diverse people and work to expand those choices** wherever possible, particularly for those whose autonomy has been historically undermined.
9. Environment 	• **Co-designing inpatient environments with people from a wide spectrum of intersecting identities**, to ensure that spaces are not only physically safe and clean but also psychologically, culturally and sensorily affirming and accessible. This includes considerations for: ▸ privacy ▸ religious or spiritual practices ▸ gender-neutral facilities ▸ sensory rooms ▸ visual cues that reflect diversity and promote belonging.
10. Things to do 	• **Ensuring that the range of activities offered is genuinely co-produced** with patients, and that the activities reflect diverse intersectional interests, cultural backgrounds, physical abilities and therapeutic needs. • **Moving beyond generic activities to offer meaningful and engaging options** for different specific groups, and that avoid assumptions or stereotypes.

Table 2 continued

Core commitment	Enhance with an intersectional lens by:
11. Therapeutic support 	• **Offering a range of evidence-based therapeutic interventions that are culturally adapted, trauma-responsive and affirming of diverse identities** (e.g., gender-affirming care or therapies that address racial trauma). • **Ensuring that therapists are skilled in working with intersectional complexities** and can tailor approaches accordingly. • **Addressing barriers to accessing specific therapies** for certain groups.
12. Transparency 	• **Communicating about care decisions, rights and ward procedures in ways that are accessible and understandable** to people with diverse communication needs and literacy levels, taking language, culture and cognitive differences into consideration. • **Being transparent about how intersectional factors are considered in care planning and decision-making**. • **Ensuring that complaints processes are easily navigable and culturally safe** for people from all backgrounds.

More information on the NHS England Culture of Care standards can be found here:

Culture of care standards for mental health inpatient services (NHS England)

2.1.2 Assessment: A holistic and contextual understanding

Assessments should move beyond a clinical formulation[c] to include a comprehensive exploration of the social determinants of mental health, identity-related experiences of discrimination, cultural context, and individual and community strengths.

See also Appendix A, Top Ten Tips 1 & 2, on conducting holistic and contextual assessments and developing intersectional formulations.

c The term 'clinical formulation' can be problematic for some people with lived experience, because it can be experienced as reducing complex, deeply personal narratives into oversimplified clinical categories that leave little room for the nuanced, emotional and multifaceted aspects of their lives.

Practical considerations:

- **Expand social history:** Go beyond basic demographics. Explore how race, gender, class, sexuality, disability, migration status and other identities have shaped their life experiences, access to resources and encounters with discrimination.
- **Trauma-informed approach:** Recognise that experiences of discrimination and oppression are often traumatic. Ask about these experiences sensitively and how they might impact their mental health and engagement with services.
- **Cultural formulation:** Utilise cultural formulation frameworks (for example, from the DSM-5 Cultural Formulation Interview – a structured tool that guides clinicians in systematically exploring how cultural factors influence a person's experience of symptoms, beliefs about illness and overall care needs), to understand the person's explanatory models of illness, cultural idioms of distress, and the role of family and community.
- **Language and communication:** Assess language preferences and provide interpreters if needed. Consider communication styles that may differ across cultures or for people with neurodiversity
- **Strengths-based perspective:** Identify and document the person's and their family's resilience, coping strategies, cultural strengths, friendships and community supports.
- **Ask open-ended questions:** Encourage narratives that allow people to share their unique stories and how their identities intersect. Examples:
    - How has your background and identity shaped your experiences with mental health services?
    - Are there any cultural or spiritual practices that are important to you in your recovery?
    - Have you experienced any discrimination or unfair treatment that has impacted your mental wellbeing?

2.1.3 Personalised care planning: An intersectional narrative

Personalised care planning should evolve into an intersectional narrative that explicitly highlights systemic factors and power dynamics, and identifies intersectionally informed needs. This approach will empower patients and people in their support networks (family, friends or carers) by validating their experiences and co-creating solutions that address root causes.

Practical considerations:

- **Connect symptoms to context**: Explicitly link presenting symptoms and difficulties to broader social, economic and political contexts. For example, anxiety might be linked to experiences of racism or precarious housing (when people face unstable, unaffordable or substandard accommodation that leaves them on the brink of homelessness or experiencing significant insecurity in their everyday lives) rather than only on a person's pathology.
- **Identify systemic barriers**: Document how institutional racism, sexism, ableism or other forms of discrimination have acted as barriers to help-seeking, effective treatment or recovery.
- **Name power dynamics**: Discuss how power imbalances within society, and within the therapeutic relationship or ward environment, might be impacting the person's mental health and their ability to engage with care.
- **Collaborative care planning**: Develop the personalised care plan collaboratively with the person and people from their support network (such as family, friends and carers), ensuring their voice and perspective are central.
- **Intersectional needs:** Clearly articulate needs that are specific to the person's intersecting identities. For example, a need for culturally specific therapeutic modalities, advocacy against discrimination or support navigating social welfare systems.
- **Empowerment focus**: Frame the care plan in a way that empowers the person, highlighting their agency and resilience in the face of adversity.

2.1.4 Therapy and support: Culturally adapted and social justice-oriented

The therapy and support offered must be culturally adapted, identity-affirming and, where appropriate, social justice-oriented. This means moving beyond a 'one-size-fits-all' model.

Practical considerations:

- **Culturally adapted interventions**: Be aware of and utilise therapeutic approaches that have been adapted for specific cultural contexts. This might involve incorporating traditional healing practices, family-centred approaches or different communication styles.
- **Identity-affirming care:** Actively affirm and validate a person's identities. For LGBTQ+ people, this means respecting their preferred pronouns and names; for racialised groups, it means acknowledging and validating experiences of racism.
- **Practice cultural humility**: Clinicians should practice cultural humility, Practicing cultural humility involves ongoing self-reflection, openness and a willingness to learn from others. Unlike cultural competence, which focuses on acquiring knowledge about different cultures, cultural humility emphasises self-awareness, recognising power imbalances and fostering respectful relationships.
- **Advocacy and systemic change**: Where appropriate, support people in advocating for themselves against discrimination or systemic barriers. This might involve signposting to advocacy services or supporting them to make complaints.
- **Consider using group work:** Offer identity-specific or affinity-based groups in which people can share experiences with others who have similar intersecting identities. This can help build community and peer-supported connections.
- **Use a wide range of therapeutic modalities**: Ensure that there are a range of therapeutic options, which can be tailored to individual needs, wants and cultural backgrounds. Discuss the options as part of a person (and people from their support networks) planning their care with the clinical team.

See also Appendix A, Top Ten Tip 3, on offering culturally adapted and identity-affirming therapy.

2.1.5 Ward environment: Intentionally inclusive

The ward environment itself must be intentionally inclusive, fostering a sense of safety, belonging and respect for all. This extends to staff diversity, physical space, communication and responses to discrimination.

Practical considerations:

- **Diverse and culturally competent staff**:
  - **Actively recruit and retain** staff from diverse backgrounds.
  - **Provide ongoing training** in cultural competence, anti-racism, anti-oppression and intersectionality for all staff.
- **Culturally sensitive physical space**:
  - **Food**: Offer diverse food options that cater to various dietary requirements (for example, vegetarian, vegan, halal, kosher) and cultural preferences.
  - **Religious/spiritual needs**: Provide quiet spaces for prayer or reflection and facilitate access to spiritual leaders or resources.
  - **Visuals**: Display diverse imagery, artwork and literature that reflect the patient population and promote inclusivity.
- **Active responses to microaggressions**:
  - **Implement clear policies and training** for staff to identify, challenge and respond effectively to microaggressions,[d] discrimination and prejudice among patients and staff.
  - **Create a culture in which reporting such incidents is safe** and encouraged.
  - **Accessible communication**: Ensure all information (written and verbal) is accessible, considering different languages, literacy levels and communication needs (for example, for people with sensory impairments or learning disabilities).
- **Respect for diverse practices**: Respect and accommodate diverse cultural practices, traditions and family structures.
- **Lived experience co-production**: Meaningfully involve people with lived experience from diverse backgrounds in the design, delivery and evaluation of services and the ward environment. Their insights are invaluable. We have developed a guide to co-production and intersectional considerations here.

d Microaggressions are subtle, often unintentional, forms of discrimination that occur in everyday interactions. They can be verbal, behavioural, or environmental and typically target marginalised groups. While they may seem minor or harmless to the person delivering them, they can reinforce stereotypes and contribute to feelings of exclusion or invalidation.

See also Appendix A, Top Ten Tip 4, on creating an intentionally inclusive ward environment.

See also Appendix A, Top Ten Tips 5 & 6, on actively responding to microaggressions and discrimination and ensuring accessible communication.

See also Appendix A, Top Ten Tips 7 & 8, on respecting diverse practices and involving lived experience in co-production.

3. Monitoring and evaluation for equity: Data-driven improvement

Embedding intersectionality within the Culture of Care standards requires an ongoing commitment to learning, reflection and accountability. Monitoring and evaluation are not just technical exercises – they are expressions of organisational values, demonstrating whether equity and inclusion are truly being lived out in practice.

3.1 Building a culture of psychological safety

For people to feel comfortable sharing aspects of their identity, we must first build a culture of psychological safety, trust and transparency.

Data is not just about numbers – it' is about people's lived realities. Before asking for information, services must show through action that this information will be treated with **respect, confidentiality and purpose**.

By gathering and analysing data in ways that honour people's experiences, we move beyond compliance to genuine understanding – using evidence to inform compassionate, equitable and person-centred care.

3.2 Data collection

While maintaining ethical standards and protecting data privacy, **services should strive to develop systems that allow for more nuanced, intersectional analysis**. This may involve:

- improving how data categories are used
- exploring opportunities for **linking datasets** (with appropriate safeguards)
- developing **more inclusive and flexible data categories** that better reflect the diversity and complexity of identity.

Equally, **qualitative data** – stories, narratives and lived experience accounts – must be recognised as a crucial form of evidence alongside quantitative data.

Data collection within health systems often lacks the granularity needed to capture the realities of intersectional experiences. As a result, the specific needs and outcomes of people who experience multiple – and, often, less visible – marginalisations can be obscured at a systemic level.

3.3 Creating the conditions for trust and disclosure

Building **cultures of trust and psychological safety** is a necessary foundation for meaningful monitoring and evaluation. That is because collecting intersectional data is only meaningful when people feel safe and respected in sharing it. Many individuals – especially those with intersecting marginalised identities – may hesitate to disclose personal information due to fear of stigma, discrimination or misuse.

People will share their information when they believe their stories matter, that they are safe in your hands, and that their information will be used to make things better.

To foster openness and participation:

- **Be transparent about purpose and use:** Clearly explain why the data is being collected, how it will be used and what protections are in place. People need to be able to see how sharing their information leads to understanding and improvement, not judgement or harm.
- **Make disclosure optional, meaningful and safe:** Allow for self-identification using inclusive, plain-language questions, and respect 'prefer not to say' responses without pressure.
- **Model inclusion through leadership and staff behaviour:** When leaders and staff demonstrate openness and allyship, it helps to normalise conversations about identity and belonging.
- **Co-produce data approaches with communities:** Involve service users, carers and staff with lived experience in designing data forms, categories and feedback mechanisms, to ensure that the language and framing feel authentic and culturally appropriate.
- **Embed psychological safety in feedback mechanisms:** Offer anonymous, peer-led or facilitated channels (such as digital platforms or reflective focus groups) to encourage honest sharing without fear of repercussion.
- **Close the feedback loop:** Communicate clearly how feedback and identity data have led to visible service improvements. Demonstrating the impact reinforces trust and encourages continued participation.

Practical considerations

- **Disaggregate data by intersecting identities:** To reveal hidden disparities:
  - Move beyond broad single categories
  - Collect and analyse data on access, experience and outcomes by multiple intersecting identities (for example, Black women, disabled LGBTQ+ people, older Asian men).
- **Utilise qualitative data:**
  - Supplement quantitative data with qualitative insights, through focus groups, interviews and narrative-based feedback sessions with people from diverse intersectional backgrounds.
- **Focus patient feedback on equity:**
  - Design patient and carer feedback tools that specifically ask about experiences of inclusion, discrimination and cultural sensitivity within the ward environment and care pathway.
- **Measure outcomes relevant to marginalised groups:**
  - *Safety:* Do people feel safe from discrimination and harm?
  - *Belonging:* Do people feel accepted and valued on the ward?
  - *Empowerment:* Do people feel involved and respected in care decisions and recovery?
  - Cultural responsiveness: Are services experienced as relevant, affirming and accessible?
- **Use data for continuous improvement:** Apply both disaggregated data and qualitative insights to drive iterative cycles of improvement.
  - Identify disparities, co-design targeted interventions and evaluate their impact.
  - Regularly review and update policies, procedures and training, based on the findings

See also Appendix A, Top Ten Tip 9, on disaggregating data by intersecting identities.

See also Appendix A, Top Ten Tip 10, on measuring outcomes relevant to marginalised groups.

Measuring outcomes: The Culture of Care patient experience

The Culture of Care patient and carer survey includes the following questions that covers these topics listed above. Because this survey collects demographic data, it's possible to interrogate the differences in experiences for marginalised groups:

1. How often do staff help you feel safer on the ward? (Including physically, emotionally and relationally)?
2. Do you feel you have ever been treated badly because of your ethnicity, age, disability, sex, gender, sexuality, neurotype or diagnosis?
3. How often are you involved as an equal in the decisions made about your care and treatment?
4. Does the ward feel like a place that supports you to get better (including the food, physical spaces and amenities provided)?

4. Intersectionality and the workforce

The emphasis within the Culture of Care programme on ensuring that 'staff feel cared for' also has a crucial intersectional dimension concerning the workforce itself. A diverse mental health workforce will experience the workplace differently than one that is not diverse, based on their own intersecting identities.

A positive and supportive culture of care must therefore proactively address potential internal biases, microaggressions and systemic discrimination that may affect staff members.

If staff from marginalised groups do not feel safe, respected, valued and supported, their capacity to deliver care that is compassionate, empathetic and intersectionally aware will inevitably be diminished. This creates a detrimental cycle: poor staff experience can translate into suboptimal patient care, particularly for patients who may share similar marginalised identities and are thus more likely to perceive subtle biases or a lack of genuine understanding from staff. The Patient and Carer Race Equality Framework acknowledges this by including provisions around workforce diversity and the promotion of anti-racist approaches for and by staff.

Training must be ever evolving, being co-designed and co-delivered by people with diverse lived intersectional experiences. Training should move beyond basic awareness to cover:

- unconscious bias
- power dynamics
- cultural humility
- structural competency
- the specific needs and strengths of diverse intersectional groups.

Intersectionality should be a core component of reflective practice sessions and clinical supervision, allowing staff to explore complex cases and their own responses through this lens.

5. Systemic integration

Embedding intersectionality requires changes at multiple levels of the organisation:

- **Policy and procedure review:** All relevant organisational policies and clinical procedures (for example, admissions, risk assessment, care planning, consent, restraint, seclusion, complaints handling) must be systematically reviewed through an intersectional lens. The aim is to identify and proactively amend or remove any elements that may, overtly or inadvertently, perpetuate bias, create discriminatory barriers or lead to inequitable outcomes for certain groups.
- **Service design and environment:** The principles of co-design, with meaningful involvement of diverse service users, must be applied to the ongoing development and adaptation of mental health services and the physical environments in which they are delivered. This ensures that services are welcoming, accessible, affirming and responsive to a wide range of needs, including specific sensory considerations for neurodivergent people and cultural or spiritual requirements.
- **Leadership and accountability:** Sustained and visible leadership commitment is paramount for fostering an anti-racist, anti-discriminatory and intersectionally aware organisational culture. This includes:
    - establishing clear lines of accountability for advancing health equity
    - setting measurable objectives related to intersectional practice
    - ensuring that progress is regularly monitored and reported at senior levels.

See also Appendix D, on embedding intersectional co-production using a nested systems approach.

6. Conclusion

In conclusion, intersectionality is not just a concept. It is a vital framework for transforming inpatient mental health care. Embracing intersectionality moves care toward genuine equity and social justice. It requires a fundamental shift in how we understand mental health: through a lens that recognises power, identity and the complex social contexts that shape people's experiences.

By embedding intersectional principles into every aspect of the Culture of Care programme, from assessment to evaluation, we can build inpatient wards that are safe and equitable, and foster a genuine sense of belonging for all. This is not a one-time initiative, but rather an ongoing commitment that demands continuous effort, critical reflection and steadfast collaboration at every level of the service.

Appendix A. Top ten tips

Here are the top ten tips from this guidance for embedding intersectionality in inpatient mental health care:

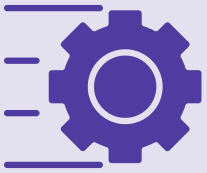
1. **Conduct holistic and contextual assessments:** Go beyond basic demographics to explore how a person's race, gender, class, sexuality, disability, migration status and other identities have shaped their life experiences, access to resources and encounters with discrimination. Use open-ended questions to encourage people to share their unique stories. Plan the person's care in partnership with them and people from their support networks.

2. **Develop intersectional formulations:** Explicitly link presenting symptoms and difficulties to broader social, economic and political contexts. Identify systemic barriers like institutional racism or sexism that have impacted help-seeking or treatment, and name power dynamics within society and healthcare.

3. **Offer culturally adapted and identity-affirming therapy:** Move beyond a 'one-size-fits-all' model. Utilise therapeutic approaches adapted for specific cultural contexts, actively affirm and validate a person's identities (for example, using correct pronouns for LGBTQ+ people, acknowledging experiences of racism for racialised groups) and practice cultural humility.

4. **Create an intentionally inclusive ward environment:** Actively recruit diverse staff and provide ongoing training in cultural competence and anti-oppression. Offer diverse food options (for example, vegetarian, vegan, halal, kosher), provide quiet spaces for prayer and display diverse imagery.

5. **Actively respond to microaggressions and discrimination:** Implement clear policies and training for staff to identify, challenge and effectively respond to microaggressions, discrimination and prejudice among patients and staff. Foster a culture in which reporting such incidents is safe and encouraged.

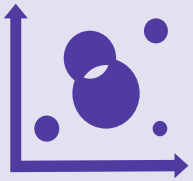


6. **Ensure accessible communication:** Make sure all information, both written and verbal, is accessible. Consider different languages, literacy levels and communication needs for people with sensory impairments or learning disabilities.

7. **Respect diverse practices:** Respect and accommodate diverse cultural practices, traditions and family structures, provided they do not compromise safety.

8. **Involve lived experience co-production:** Meaningfully involve people with lived experience from diverse backgrounds in the design, delivery and evaluation of services and the ward environment. Their insights are invaluable for ensuring genuine equity.

9. **Disaggregate data by intersecting identities**: Move beyond broad categories when monitoring and evaluating services. Collect and analyse data on access, treatment and outcomes disaggregated by multiple intersecting identities (for example, Black women, disabled LGBTQ+ people, older Asian men) to reveal hidden disparities.



10. **Measure outcomes relevant to marginalised groups:** Beyond standard clinical outcomes, measure indicators such as whether people feel safe from discrimination and harm, experience a sense of belonging and empowerment in their care decisions, and perceive services as culturally relevant and affirming.

Appendix B. A comparative vignette of intersectional experiences in inpatient care

We present vignettes of two people with intersectional characteristics and their experiences in inpatient settings, with comparisons made between them and their treatment on the ward.

Marcus and Ella

Marcus, a 45-year-old Black Jamaican cisgender gay man, and Ella, an 18-year-old White British transgender woman, are both autistic adults admitted to mental health inpatient settings in crisis. Yet their experiences unfold differently – shaped by intersecting identities, histories of trauma and how staff interpret their behaviours.

Marcus

Marcus received an autism diagnosis in adulthood after decades of misdiagnosis linked to racialised and classed assumptions. He speaks Jamaican Patois as his first language and has lived through family rejection, housing instability and homophobic bullying. On the ward, his mannerisms are mocked as 'effeminate' by cleaning staff in non-English languages. When another patient translates the homophobic slurs, Marcus is triggered and lashes out – an act of trauma re-enactment misread by staff as aggression. He is restrained and placed in seclusion, which paradoxically offers him relief: the sensory minimalism and solitude free him from the need to mask or perform masculinity. However, when he returns to the main ward, the same pressures resurface. He withdraws, and is labelled 'non-compliant' and 'sullen'.

Ella

Ella, diagnosed in childhood, has a mild learning disability and relies on a text-to-speech app during situational mutism. On her psychiatric intensive care unit (PICU), a blanket phone ban strips her of this communication aid – removing her voice, and affirming reminders of her gender identity. Staff misinterpret her silence as refusal to engage, they deadname or misgender her, and they ask invasive questions under the guise of clinical curiosity. Her non-verbal communication is dismissed as regression, and while visual supports are suggested, they are not implemented promptly. She isolates, becoming more anxious and feeling more unheard, and is recorded by staff as 'resistant' and 'unmotivated'.

While Marcus faces racialised and queer-coded pathologisation,[e] Ella is disempowered by cis-sexist,[f] ableist interpretations of mutism and identity. For both of them, their distress is filtered through institutional norms that frame difference as deviance and silence as defiance.

Reflective questions for ward staff and management

Marcus

1. How do Marcus' race, sexuality, class and mannerisms influence how staff interpret his behaviour?
2. Could Marcus' outburst reflect trauma rather than aggression, shaped by past experiences of homophobia and racism?
3. Why might seclusion feel safer for Marcus than the main ward, and what does this reveal about ward culture?

Ella

1. How do assumptions about Ella's gender, age and learning disability shape perceptions of her mutism and communication?
2. Are gender-affirming and multimodal communication practices consistently embedded in Ella's care?
3. How might Ella's withdrawal reflect autistic overwhelm rather than disengagement, and what support is offered in response?

Collaborative

1. How do intersecting identities shape how distress is interpreted and responded to across the ward?
2. How are staff adapting routines, spaces and language to meet diverse sensory, communicative and identity-based needs?
3. If Marcus and Ella co-produced ward improvements, what would they name as barriers to safety, dignity and participation?

e Racialised and queer-coded pathologisation refers to the ways behaviours or traits of people who are both racially minoritised and queer can be misinterpreted as symptoms of mental illness, shaped by intersecting stereotypes about race, gender and sexuality that distort clinical judgement and reinforce systemic bias.

f Cis-sexist refers to attitudes, behaviours or systems which assume that cisgender identities (where a person's gender matches the sex they were assigned at birth) are more valid or normal than transgender, nonbinary or gender-diverse identities, often leading to discrimination or exclusion of transgender people.

Appendix C. From principles to practice: How to facilitate intersectional co-production across five pillars of care

Following the vignettes in Appendix B, here we share guidance for facilitating intersectional co-production in the areas of equality, safety, relationships, needs-led practice and lived experience.

1. Equality

To address how intersecting identities (such as race, gender, class, sexuality and ability) shape perceptions and outcomes:

- **Diversify co-production spaces** by actively recruiting people with intersecting minoritised identities, and valuing their perspectives as essential rather than supplementary.
- **Use intersectional access audits** (for example, sensory, linguistic, cultural and gender audits) co-designed with patients like Marcus and Ella to identify systemic barriers within the ward.
- **Create intersectional reflection forums** in which staff and patients explore how biases might influence care interpretations and decision-making.

2. Safety

To ensure all patients feel safe emotionally, culturally, physically and sensorily:

- **Redesign safety protocols** (for example, seclusion, phone bans, observation) in collaboration with lived experience advisors to differentiate between control and care, and between containment and comfort.
- **Use trauma-informed, identity-conscious debriefs** following incidents like Marcus's outburst or Ella's mutism episodes, to understand root causes rather than only recording behavioural outcomes.

3. Relationships

To foster relational safety and trust in cross-difference interactions:

- **Facilitate storytelling or empathy workshops**, co-led by Marcus- or Ella-like figures, using narrative practice to shift staff attitudes and increase humanising responses to non-normative expressions.

4. Needs-led practice

To prioritise individual access needs over standardised routines:

- **Train staff in multimodal communication**: as a rights-based practice that is essential for dignity and inclusion, not just as a technical skill.

5. Lived experience

To ensure co-production isn't tokenistic but transformative:

- **Involve people like Marcus and Ella in policy review boards** as decision-makers with veto power over proposals that may harm people with similar life experiences, not only as consultees.

Appendix D. Embedding intersectional co-production: A nested systems approach

Co-production with people with **lived experience of care** is a relational, situated and power-aware practice:

- It depends on trust and reciprocity (relational).
- It is informed by the identities, histories and contexts of those involved (situated).
- It seeks to uncover and address power imbalances that determine whose voices are valued and whose needs are met (power-aware).

To embed co-production meaningfully in mental health services, we need to apply systems thinking – a way of understanding how change happens across interconnected levels. Challenges like exclusion, burnout or resistance aren't isolated problems, they are signs of deeper **structural patterns, cultural beliefs and historical legacies** that must be addressed collectively.

Bronfenbrenner's ecological systems theory shows how individual experience is shaped by nested environments – from direct patient–staff relationships (**microsystem**), to team dynamics (**mesosystem**), institutional structures (**exosystem**) and wider ideologies (**macrosystem**), all unfolding across time (**chronosystem**). The Indigenist ecological systems model deepens this by placing history and culture at the centre, recognising that healing cannot be separated from colonial legacies, spiritual disconnection and ancestral responsibility. Together, these frameworks create a nested systems map – a tool for recognising how co-production must be relational, embedded and continuous across all levels of care.

History and culture

- **Description:** The foundation of all care experiences – shaped by ancestral legacies, colonial histories, racism, and spiritual or communal ways of knowing that influence how distress, healing and personhood are understood.
- **Question:** Whose histories shape ideas of credibility and care?
- **Action:** Embed cultural humility in staff induction and co-design with people from minoritised ethnic communities.

Lived experience of care

- **Description:** Embodied, emotional and relational experiences of receiving care – shaped by trauma, identity, disempowerment and systems of oppression, as well as resistance and resilience.
- **Question:** What do lived experiences reveal about gaps in safety and inclusion?
- **Action:** Centre lived experience in reviews and decision-making.

Microsystem

- **Description:** Moment-to-moment interactions between patients and staff, where language, assumptions and relational responses either affirm or undermine identity and agency.
- **Question:** Do my interactions affirm or silence a patient's safety and autonomy?
- **Action:** Use relational scripts and reflective practice to promote attuned care.

Mesosystem

- **Description:** Team cultures shaped by hierarchies, peer norms and role dynamics that influence how inclusion or exclusion is enacted.
- **Question:** What unspoken rules shape how we work together?
- **Action:** Facilitate co-led team dialogues to challenge routine-based exclusion.

Exosystem

- **Description:** Institutional structures – policies, risk protocols, documentation and resourcing – that often reflect dominant assumptions about control, risk and efficiency.
- **Question:** Whose definitions of safety and compliance shape our systems?
- **Action:** Review key policies (for example seclusion, phone bans) with lived experience panels for greater flexibility and dignity.

Macrosystem

- **Description:** Societal ideologies such as medical dominance, ableism, neoliberalism and racial capitalism, which govern what kinds of distress are recognised, resourced and legitimised.
- **Question:** Which worldviews shape how distress is understood?
- **Action:** Deliver training in intersectionality and epistemic injustice (injustice related to knowledge).

Chronosystem

- **Description:** Healing as a non-linear, culturally situated and often generational process that resists normative timelines of recovery, productivity and engagement.
- **Question:** Do our care timelines match how people actually heal?
- **Action:** Honour slow recovery, withdrawal and non-normative progress cycles.

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Acknowledgements

Nuala Ernest, Senior Editor, NCCMH

Helen Greenwood, Research and Design Officer, NCCMH

Hazel Webb, Culture of Care Programme Manager, NCCMH

Cite as: National Collaborating Centre for Mental Health. Intersectionality in inpatient mental health care: A comprehensive guide for the Culture of Care programme. London: National Collaborating Centre for Mental Health; 2026.

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