Mental Health Strategy EqIA

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This is the Equality Impact Assessment of the mental Health Strategy. Under equality legislation, the Council has a legal duty to pay 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

The duty to pay 'due regard' is required to be demonstrated in the decision making and the implementation process. Assessing the potential equality impact of proposed strategy is the means by which we show 'due regard'.

1. Introduction

1.1 Equality and mental health

Advancing equality refers to the inclusion and equitable treatment of protected groups and a need to eliminate discrimination, advance equality of opportunity and foster good relations within communities. The strategy includes an objective to promote mental wellbeing and prevent mental health problems developing across all groups among those that research has identified as more likely to experience poor mental health, and to improve their recovery rates.

1.2 Inequality and mental health

There are three main ways that inequality is important in mental health:

- people who experience inequality or discrimination in social or economic contexts have a higher risk of poor mental wellbeing and developing mental health problems;
- people may experience inequality in access to, and experience of, and outcomes from services; and
- mental health problems result in a broad range of further inequalities.

1.3 Human rights and mental health

The shared objectives of the strategy are clear in supporting the right of people, whether they have a mental health condition or are at risk of developing one, to:

- fair and dignified treatment;
- full social and economic participation;
- having autonomy, choice and control over their lives; and
- being safe and protected from harm.

All of these are about human rights.

2. The Strategy

Mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our work and to achieving our potential. Good mental health and wellbeing also bring wider social and economic benefits. But to realise these benefits everyone needs to take action and to be supported to do so. In terms of Equality, people need to take responsibility for caring for our own mental health and that of others, and to challenge the blight of stigma and discrimination. The council has objectives for employment, for education, for safety and crime reduction, for reducing drug and alcohol dependency and homelessness, and these can not be achieved without improvements in mental health.

The objectives were selected as being the broad objectives relevant to the general aims that first, all people should have better mental health and fewer mental health problems, and second, people with mental health problems should have access to the most appropriate services, not suffer harm and have a positive experience of care and support.

Improving mental health outcomes for all necessitates considering the needs of groups at higher risk of mental health problems and those with protected characteristics. Promoting equality and reducing inequality in all of these groups was one of the underpinning principles in selecting the six objectives. The impact of the six objectives on the protected groups is considered below. This reflects the differing needs and inequalities relevant to those groups and indicates any likely outcomes specific to particular protected groups.

3. Six objectives

- **More people will have good mental health -** more people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well;
- **More people with mental health problems will recover -** more people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live;
- **More people with mental health problems will have good physical health -** fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health;
- **More people will have a positive experience of care and support** - care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest

choice and control over their own lives, in the least restrictive environment, and should ensure people's human rights are protected;

- **Fewer people will suffer avoidable harm -** people receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service; and
- **Fewer people will experience stigma and discrimination -** public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

4. Analysis of the objectives

4.1 Objective 1: More people will have good mental health

Common mental health problems such as depression and anxiety affect many people with different characteristics, and the impact is felt much more widely across the community, for instance through the effect on friends, family and carers.

In older people, certain groups are at higher risk; for instance, as many as 40% of those in care homes experience depression. Social isolation is a key contributory factor in depression in older people. Although less common than depression, dementia is a key issue for the older age group. The mental health needs of older people from ethnic minorities can be difficult to identify and diagnose – especially in the case of dementia. The stigma associated with the condition means that few people from ethnic minorities may come forward for diagnosis. There is good evidence that stress can lead to mental health problems and that people or groups who face particular challenges are at greater risk than the general population.

Women are at greater risk of anxiety disorders, eating disorders, self-harm and sexual, emotional or physical violence, which are associated with higher rates of mental health problems. One in four women requires treatment for depression at some time. Post-natal depression affects a significant minority of women. If it is left undiagnosed and untreated, it can result in significant harm not just to women, but also to their children and wider families.

Fewer men seek treatment for depression, which may in part reflect men's fear of stigmatisation than to be an accurate indicator of the incidence of male depression. Male mental distress is more likely to result in violent behaviours towards self and others, so that men are three times more likely to die from suicide than women. Suicide rates are particularly high among younger black men and unemployed men.

More than one in three people who are described by the Equality Act 2010 definition of gender reassignment have attempted suicide. Men are also more likely to receive treatment for mental health problems under the Mental Health Act. African-Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act and are disproportionately represented in secure units.

People with mental health problems meet the criteria for being disabled under the legislation. Health promotion and preventative services have a statutory duty to

address the needs of people with mental health problems. The primary purpose of the mental health strategy is to reduce the number of people developing mental health problems and improving the quality of life of those with mental health problems.

The strategy recognises that a number of individuals with other disabilities e.g. learning disability have higher rates of mental health problems. The intervention outlined in the strategy and supporting document contain both universal approaches and those targeted at high risk groups such as those with long term physical health problems and other disabilities. In adopting this approach of proportionate universalism as outlined in the Marmot review the strategy aims to reduce inequality across all groups including all disabled groups.

Services should be accessible by all people with disability including for example those with sensory impairment. It makes the explicit recommendation that all people with learning disability and autism will have access to mainstream services.

4.2 Objective 2: More people with mental health problems will recover

Objective two is about ensuring improved outcomes of mental health services for all individuals. There is good evidence to suggest that a number of groups, including those with protected characteristics, have less good access, experience of and outcomes from mental health services.

One of the cornerstones of tackling inequality in service provision is delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.

Development need to address the importance of good information so that services can monitor the use and experience of services by different groups.

4.3 Objective 3: More people with mental health problems will have good physical health.

Physical health and mental health are inter-related. 50% of people with depression or anxiety have long-standing physical disorders compared with 30% of the general population while 25% of people with long term physical conditions also have mental ill-health.

Long term physical conditions are associated with increased risk of mental health problems. For instance, rates of depression are doubled in diabetes, hypertension, coronary artery disease and heart failure, tripled in end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease and seven times more common among those with two or more chronic physical conditions compared to healthy controls. 50% of people with depression or anxiety have long-standing physical disorders compared with 30% of the general population while 25% of people with long term physical conditions also have mental ill-health.

4.4 Objective 4: More people will have a positive experience of care and support

A poor experience of care is associated with poor mental health outcomes, increased risk of non-compliance and early termination of treatment. It is therefore important, especially in the context of the need for early intervention, to ensure a good experience of treatment for mental health.

This is potentially an issue for a large number of people. People who received care for mental health conditions were mostly positive about how they were treated. The 2010 Care Quality Commission survey of community mental health service users found that three in five service users (59%) felt that they had received a good to excellent care. However, service users were less satisfied about their ability to exercise choice and control, for example through being able to participate in treatment decisions, being informed about the likely side effects of medication and having access to emergency care.

The strategy supports the delivery of privacy, dignity, equitable, culturally sensitive and age appropriate services to tackle discrimination and unequal access to services. It further recognises that: ‘One of the cornerstones of tackling inequalities in service provision is delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers.

4.5 Objective 5: Fewer people will suffer avoidable harm

There is little information on the experiences of children and young people in mental health services. This cannot easily be measured because standard survey tools exclude children aged under 16 from sampling frames. However, monitoring children’s experience is important to ensure that it is delivered appropriately, does not produce additional trauma or stress and delivers improved outcomes. In recognition of this, a number of tools are being developed according to a variety of measures.

Compulsion in treatment, and the related implications for people’s human rights, is a particular issue for mental health services. Men, especially black men, appear to face a higher degree of compulsion in seeking or receiving care for their mental health problems. The consequence of this is that black men are more likely to be sectioned under the Mental Health Act (1983) or to be referred for treatment via the criminal justice system. In its annual report on the use of the Mental Health Act, the 2010 Care Quality Commission stressed the importance of proportionality where human rights might be affected in delivering care, for example when restricting patient autonomy or liberty.

Older people and disabled people also experience adverse impact on their human rights through reduced ability to consent to or influence treatment received, for example as a result of dementia or communication barriers.

The strategy recognises that all people including all those with protected characteristics should have confidence that the services they receive are safe.

Harmful incidences will require investigation with equal vigour across all protected characteristics.

4.6 Objective 6: Fewer people will experience stigma and discrimination

A key source of discrimination and unfair treatment faced by people with mental health problems, is the stigma that they face from society because of misconceptions about mental illness.

One of the harms caused by the stigma is the adverse impact on people's human rights, through denying them the right to fair and dignified treatment. Other harms include social and economic effects, such as the lowering of people's self-esteem. This can lead to increased isolation, reduced employment opportunities and other material disadvantage.

Moreover, stigmatising attitudes by authorities and service providers can result in restrictions on the civil liberties and human rights of people with mental health problems. Stigma can result in discrimination against people with poor mental health, across a range of areas including housing, education and employment.

Stigma contributes to worsening the prognosis for mental illness. The strategy notes that worry about stigma can trigger a destructive spiral of behaviours in people with poor mental health, such as a refusal to accept their condition and treatment avoidance.

The harm caused by stigmatisation of mental illness extends more widely than just people with poor mental health. Family, friends and carers of people with mental health problems often face stigma by association, with similar consequences for their own well-being and human rights**.**

The impact of stigma and discrimination against people with poor mental health is to further reduce their well-being, through personal, social and financial stress. Groups who already face discrimination, such as people from black and minority ethnic communities and older people, undergo further compounding of these effects. Cultural bias against dementia can increase the risk that older people in some ethnic minorities do not receive appropriate care.

5. Conclusion

This assessment recommends that the Board continue with this decision.

Throughout the development of strategy due regard was given to the elimination of discrimination, the advancement of equality of opportunity and fostering of good community relations. This last equality issue requires that services work together to challenge the stigma associated with mental illness.

The strategy was adjusted to include specific mention of the development of work to counteract stigma and the improvement in the quality of care. Also there is still work to be completed so that partners can be confident about why people from particular ethnicities are not represented similarly in community or in-patient care.

The strategy will benefit from further service user input, in the development plan stage. A wider input into the plans and actions will ensure that the strategic focus is supported by patients and users and is not the views of Mental Health Professionals.

In the consultation feedback the requirement of services to design themselves around the Users' needs was highlighted, moving away from the expectation that Users should present or fit into pre-define pathways created to fit with service priorities.