NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages

Analysis of the Impact on Equality (AIE)

Supporting document to: No Health without Mental Health: a cross-Government mental health outcomes strategy for people of all ages

Department of Health

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STATEMENT OF DUTIES

The Equality Act 2010 mandates a duty within the public sector to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

- foster good relations between persons who share a relevant protected characteristic and those who do not share it.

To meet these duties, authorities are required to analyse the impact of proposed policies, strategies and action plans across all of the protected groups.

In this Analysis of the Impact on Equality (AIE), we evaluate the impact of the mental health outcomes strategy, and attempt to anticipate and recommend ways to avoid any discriminatory or negative consequences for a particular group, on the grounds of:

- Age

- Disability

- Gender reassignment

- Marriage and civil partnership

- Pregnancy and maternity

- Race (including, ethnic origin, nationality)

- Religion or belief (including lack of belief)

- Sex

- Sexual orientation

What do we mean by equality and diversity?

Equality is essentially about **creating a fairer society** where everyone can participate and has the opportunity to fulfil their potential. It is underpinned by legislation designed to address unfair discrimination (past, present or potential) that is based on membership of a particular group. In some circumstances, positive action is encouraged to address discrimination. It is often summarised in terms of

- Equal access

- Equal treatment

- Equal outcomes

- Equality of opportunity

Diversity is about the **recognition and valuing of difference** in its broadest sense, and creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual. The term describes the range of visible and non-visible differences that exist between people. Managing diversity harnesses these differences to create a productive environment in which everybody feels valued, where talents are fully utilised and in which organisational goals are met.

Equality and diversity are not interchangeable but are interdependent. There is no advancement of equality if difference is not recognised and valued. Chapter 6 of the mental health strategy summarises actions on equality.

Public Sector Duty

The general equality duty is underpinned by specific duties, to help public bodies meet the general duty. The public sector equality duty is a specific duty, which comes into effect in April 2011. The public sector equality duty covers all of the protected characteristics and all public organisations are required to create equality objectives and publish information which enables the public to monitor the organisation's ability to promote equality, foster good relations and eliminate discrimination.

Human Rights

Human Rights and equality are inextricably linked, deriving as they do from the same fundamental principles: equal respect for the dignity of every person. A human rights approach treats the individual as a whole person and seeks to address their requirements holistically. At the heart of human rights is the belief that everybody should have autonomy, be treated fairly and with dignity – no matter what their circumstances.

The Equality and Human Rights Commission identifies 15 rights protected by the Human Rights Act 1998. These can be summarised as follows:

- being treated fairly and with dignity;

- taking part in the community;

- living the life you choose; and

- being safe and protected from harm.

In summary, this legislation places a requirement on public bodies to assess their current provision, identify the needs of their 'customer' base and then work with those people to develop the right services, anticipating needs and differentiating the interventions in order to achieve equity of access, experience and outcome.

Recent public mental health work supports the Human Rights Act by highlighting the links between poor mental health and inequalities. We know that poor mental health can both be a consequence of inequality and result in social, economic and health inequality. For example, poor mental health is more common in areas of deprivation. It can lead to higher risk health behaviours (e.g. smoking and drug misuse). This, combined with unequal access to quality healthcare, can result in poor health outcomes and shortened life expectancy.

Delivering equality in mental health

Data standards

Establishing data standards refers to the collection and analysis of service data by the protected characteristics of the Equality Act 2010. This creates a framework in which inclusion, equity and service provision for all groups and communities can be monitored.

QIPP and metrics

The Quality, Innovation, Productivity and Prevention (QIPP) programme aims to support improvements in care and delivery, while reducing costs and providing increased efficiencies. Services which respond to individuals' needs across communities can be more cost effective, by enhancing access to timely, effective services and reducing barriers to inclusion. The programme will be analysed for its impact on equality.

Equality Delivery System (EDS) levers and new architecture

The Equality Delivery System is a new framework designed to support delivery equality in health care within a patient-led NHS. It is due to be rolled out from April 2011. This will involve commissioners and providers using local data and working with local user/interest groups to identify equality priorities on a four-year cycle.

There are a number of planned actions for the EDS:

- Gathering accurate data on local priorities, such as local need for mental health services – using channels such as the community and voluntary sectors, LINks, and, in the future, HealthWatch;
- Establishing mechanisms that allow local user groups to engage with providers and commissioners; empowering and supporting them to engage effectively; and
- Monitoring and evaluating effectiveness of service delivery and effective governance, especially around equality needs.

The EDS aims to improve the equality performance of the NHS. NHS organisations will be graded. In partnership with local communities and the NHS, organisations will identify and agree one of four grades: excellent, achieving, developing and under-developed. Where organisations and local interests are unable to agree on a particular grade, the view of local interests will be prioritised.

Based on this grading, NHS organisations will prioritise the areas that require improvement. This assessment will be undertaken annually to ensure that the grading accurately reflects organisations' achievements and areas that require further development.

Consultation, engagement and involvement

The **Ministerial Advisory Group (MAG)** on equality in mental health will continue to meet with the Minister of State for Care Services to monitor progress.

This AIE builds on work undertaken to develop the Equality Impact Assessment for *New Horizons: a shared vision for mental health*, the previous Government's mental health programme*.* As part of the development of *New Horizons,* equality screening was completed and the results of that screening were published within the *New Horizons* Equality Impact Assessment published in July 2009.[1] A further Equality Impact Assessment was published in December 2009.[2]

In June 2009 a public consultation on *New Horizons* was carried out. In order to avoid duplication of effort and resource a further consultation has not taken place. The issues covered in the *New Horizons* consultation remain valid and the responses and conclusions have been used to inform this AIE. These are contained in the Evidence Base **(Annex A)**.   The complete consultation report can be found here: New Horizons consultation report available at: http://tinyurl.com/NewHorizonsConsultationReport

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[1] New Horizons Equality Impact Assessment, July 2009 available at: http://tinyurl.com/NewHorizonsEQIAJuly2009

[2] New Horizons Equality Impact Assessment, December 2009 available at: http://tinyurl.com/NewHorizonsEQIADecember2009

AN OUTCOMES STRATEGY FOR MENTAL HEALTH

The aim of the mental health strategy is to:

- improve the mental health and wellbeing of the population and keep people well: and

- improve outcomes for people with mental health problems through high-quality services that are accessible to all.

It recognises that effective action is needed to eliminate the stigma that can contribute to poor mental health. Stigma can lead to people suffering in silence, and can affect their ability to recover.

The strategy sets out six high-level shared objectives, and is supported by a *Call to Action* which has been developed with key partners.

In this document, we examine the available evidence on need, access to treatment and outcomes across the equality strands and analyse the impact of the proposals in the strategy.

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.

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.

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.

Mental Health Act 2007

The Mental Health Act 2007 made important changes to the mental health and mental capacity legislation in England and Wales. The application of the Act raises a number of issues relating to the appropriate use by authorities of the powers they are granted under the Act to detain or otherwise restrict the civil liberties of people with certain mental health conditions.

The use of Community Treatment Orders (CTOs) under the Act, allows mental health patients to be discharged into the community, conditional on compliance with a treatment programme. The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO.[3]

The CQC also highlighted a number of other factors which have an adverse impact on patients' human rights. For example, in some facilities inadequate staffing ratios affected people's rights to fair and dignified treatment. The rights of vulnerable adults, and children and young people to dignified treatment, and to be safe and protected from harm, were adversely affected by the lack of Child and Adolescent Mental Health Services (CAMHS) units, or of single-sex provision in some facilities.

Significantly, the CQC noted that many service providers did not collect data which would have permitted it to monitor equality and anti-discriminatory compliance. This consequently limited the impact of strategies designed to reduce inequalities.

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[3] Care Quality Commission (2010), Monitoring the Use of the Mental Health Act in 2009/10

MENTAL HEALTH VISION

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 by the Government to do so. We all need to take responsibility for caring for our own mental health and that of others, and to challenge the blight of stigma and discrimination. Our objectives for employment, for education, for safety and crime reduction, for reducing drug and alcohol dependency and homelessness cannot be achieved without improvements in mental health.

A wide range of partner organisations, including user and carer representatives, providers, local government and government departments have worked with the Department of Health to agree a set of shared objectives to improve mental health outcomes for all individuals and the population as a whole. 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 strategy has three guiding values and principles outlined in chapter two. These are freedom, fairness and responsibility.

The impact of the six shared 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.

SIX SHARED OBJECTIVES

1. **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;*

2. **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;*

3. **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;*

4. **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;*

5. **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*

6. **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.*

Analysis of the objectives

An analysis of the impact on equality of each of the six objectives follows. The objectives aim to improve the mental health and wellbeing of all people including all with protected characteristics. The analysis of impact did not suggest there would be any negative impact on any of the groups. In some cases the positive affect on a particular group is well understood and is therefore assumed and not stated expressly and there are potential indicators available to measure progress. In other cases, it is much more difficult to estimate the potential positive impact. Chapter six of the strategy (**Annex A**) addresses the issues of promoting equality and reducing inequality and considers inequality in relation to each protected characteristic.

Shared objective 1: 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*

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

The Labour Force Survey suggests that common mental health problems account for more than 40% of all days lost to ill health.[4] The 2007 Survey of Psychiatric Morbidity among Adults in Great Britain found that 23% of the survey population in England reported at least one psychiatric disorder and 7% reported two or more disorders. [5]

There is overwhelming evidence that the key factors which increase the risk of developing mental illness are inequality and poor mental wellbeing, and that these have a mutually reinforcing effect. For example, children from the lowest quintile of household income are at three times greater risk of mental health problems than children from the top quintile. For example, children from the families with a gross weekly household income of less than £100 are at three times greater risk of mental health problems than children from households with an income of £600 or more. This will include some children from minority ethnic families. Similarly during adulthood, all mental health problems except alcohol dependence are more common in those from lowest 20% household income compared to top 20% household income [6, 7]

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 (stigma is addressed in more detail under shared objective six).

Mental health in communities

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

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[4] HSE, Labour Force Survey 2009/10
[5] McManus S, Meltzer H, Brugha T et al (2009) Adult Psychiatric Morbidity in England, results of a household survey (2007) Health and Social Information Centre, Social Care Statistics
[6] Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004 ONS
[7] McManus S, Meltzer H, Brugha T et al (2009) Adult Psychiatric Morbidity in England, results of a household survey (2007) Health and Social Information Centre, Social Care Statistics

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.

Socio-economic issues are also important factors influencing to adult mental health with every mental health problem except alcohol dependence being more common in adults from lowest 20% household income compared to top 20% household income as highlighted below.[8] .These effects are greater for men in the following mental health problems:

- Common mental disorder is 2.7 times more common in men and 1.4 times more common in women from lowest 20% household income compared to highest 20% household income.[9]
- Post-traumatic stress disorder is 3.3 times more common in men and 2.3 times more common in women from lowest 20% household income compared to top 20%.
- Self-harm is 3.2 times more common in men and 2.5 times more common in women from the lowest 20% household income compared to the highest 20%.
- Suicide attempts are 5.0 times more common in men and 3.2 times more common in women from the lowest 20% household income compared to the highest 20%.
- Psychotic disorder is 9 times more common in adults from the lowest 20% household income compared to the highest 20%.
- Eating disorder in past year is 1.7 times more common in men and 1.2 more common in women from the lowest 20% household income compared to the highest 20%.

The following problems disproportionately affect women:
- Alcohol dependence in past 6 months is 1.4 times more common in men and 2.0 more common in women from the highest 20% household income compared to the lowest 20%.
- Dependence on any drug is 4.6 times more common for men and 33 times more common in those from lowest 20% household income compared to top 20%.

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[8] McManus S, Meltzer H, Brugha T et al (2009) Adult Psychiatric Morbidity in England, results of a household survey (2007) Health and Social Information Centre, Social Care Statistics
[9] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

Men are particularly affected by certain issues. 90% of those living on the streets are male and have high rates of mental illness. Mental health problems are much more common among offenders - 95% of prisoners are male. Similarly, the majority of veterans are male with almost all those suffering PTSD as a result of experiences in combat being male. Personality disorder occurs more commonly in men (5.4% of men have personality disorders, compared with 3.4% of women). Alcohol and substance misuse are more common in men who are three times more likely to be alcohol dependent and more than twice as likely to misuse Class A drugs. Boys are four times more likely to be diagnosed with a behavioural, emotional or social difficulty. Within mental health settings, higher rate of formal admissions under the Mental Health Act amongst the black and minority ethnic (BME) population also significantly affects BME men[10].

More research and better data analysis is needed to determine the incidence of poor mental health among lesbian, gay and bisexual people, both male and female.

Service provision issues in rural areas

There are particular challenges when providing health services to rural communities. Communities in rural areas are more dispersed and so can require more effort and greater resources to deliver an equitable service. Distance, travel times and availability of transport are critical for patients in accessing healthcare in rural areas. The demographic profile of people in rural areas is also different with higher rates of older people. Recruiting staff with the requisite specialist skills, and the experience to work autonomously in remote rural communities may also be costly and difficult.

Equality analysis (the Equality Action Plan contains priority areas derived from the equality analysis)

- *All*

There is considerable evidence that some protected groups are at higher risk of developing mental health problems, have lower wellbeing and may have reduced access to, a different experience of, and outcome from a range of mental health services. Objective one is about improving the mental wellbeing of all individuals and reducing the risk of developing mental health problems. The strategy has made it clear that this will require both universal and targeted approaches to ensure the needs of all groups including the protected characteristic groups are met. Joint strategic needs assessment (JSNA) will be a significant part of this process as they will identify the particular needs of the local population and should pay particular attention to the needs of high risk groups, This in turn will inform planning of local public mental health responses. Chapter five of the strategy outlines the mechanisms for local planning; the central role of JSNA and the requirements on local bodies to promote equality and address inequalities.

- *Age*

The strategy has identified the importance of mental health promotion and mental ill health prevention in older people. It gives detailed evidence for effective local interventions in the companion document: *No health without mental health; Delivering better mental health outcomes for people of all ages* from paragraph 1.72

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[10] Wilkins D, Kemple M, Delivering Male: Effective practice in male mental health, Men's Health Forum 2010

onwards. It also details indicators in the proposed public health outcomes framework by which progress could be monitored. Implementation of these interventions aims to reduce the number of older people developing mental health problems and increasing the number with improved wellbeing. The strategy draws attention to the greater number of older people living in rural communities and their additional needs. The strategy emphasises the need for all health promotion and prevention work to be age-appropriate across the life course.

- *Disability*

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.

The strategy specifically states that the 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.

- *Gender reassignment*

The strategy recognises that the delivery of a truly personalised approach that identifies the needs of each individual will ensure that there is a comprehensive understanding of the mental health needs of all people including transgender people. This will ensure they have access to prevention and health promotion services.

- *Marriage and civil partnership*

Evidence suggests being married is associated with better mental health.[11] There is less evidence on the benefits of being in a civil partnership; however, there is evidence that being in a good supportive relationship is beneficial for mental health. The strategy does not specifically address marriage or civil partnership. It does address the importance of good social and personal relationships. It outlines a number of effective psychological approaches that may support people in forming improved social relationships.

- *Pregnancy and maternity*

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[11]Scott K M et al (2009), Gender and the relationship between marital status and the first onset of mood, anxiety and substance use disorders, Psychological Medicine, Cambridge University Press 26 November 2009

The strategy outlines the importance of good maternal health and the importance of good health throughout pregnancy and post-natally. This can ensure good outcomes for the mother and for the child. Under objective one there are two key areas for action outlined: **starting well** and **developing well**. A number of key interventions to address maternal health before, during and after pregnancy are outlined under section 1.6-1.46 of *No health without mental health; delivering better mental health outcomes for people of all ages*. This section details a number of effective local intervention and government actions, for example, the expansion of health visiting. The outcome of these initiatives will be improved maternal heath and improved mental health outcomes for mother and child. There is considerable evidence outlined in this section on the range and effect of different interventions.

- *Race (including, ethnic origin, nationality)*

The strategy acknowledges in several sections the lower wellbeing and higher rates of mental health problems of some BME groups. It is explicit about ensuring that health promotion and ill health prevention approaches must be targeted at high-risk groups. This means that programmes such as Sure Start, The Healthy Child and others must be delivered in such a way that they are accessible to families from black and minority ethnic groups. Such approaches, which combine targeted and universal approaches, will ensure a narrowing of the health inequality gap between groups.

- *Religion or belief (including lack of belief)*

The strategy recognises that to improve outcomes for all people it will be necessary to incorporate religion and belief into the assessment of all individuals. Evidence suggests that having religious or other beliefs can be associated with better mental health, although this is not directly addressed in the strategy, as there is insufficient evidence in this area to inform policy.

- *Sex*

Rates of mental health problems are generally higher in boys compared to girls. They are also exposed to different experiences, for example, rates of sexual abuse. Men and women also have different rates of mental health problems. The different pattern of mental health problems across the sexes is explicitly recognised in the strategy. The strategy outlines a number of different health promotion and prevention approaches across all ages. Some are common to all sexes: improved wellbeing approaches in employment. Others, such as those during pregnancy, are targeted at women, for example, during pregnancy (see above). Men have higher rates of alcohol and substance misuse, and offending behaviour. These are also considered in the strategy. A number of indicators for tracking progress are outlined in the strategy and supporting documents. These will be available by sex so that rates of progress across different mental health problems can be considered.[12]

- *Sexual orientation*

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[12] Hunt R, Fish J (2008) Prescription for Change, Stonewall

The strategy recognises the higher rates of some mental health problems in lesbian, gay and bisexual people. A priority for action is to improve monitoring of access to services and experience and outcome by sexual orientation. This will enable local services to understand whether prevention and promotion services are being appropriately accessed.

Shared objective 2: 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*

Children and young people

The evidence on the link between poor mental health in children and socio-economic inequality is very robust. As previously mentioned, children from the families with gross weekly household income of less than £100 are at three times greater risk of mental health problems than children from households with an income of £600 or more.[13] Low social aptitude, little social support, few friendships and parents who disapprove of their child's friends increase the risk of emotional and conduct disorder.

Mental health problems affect all aspects of a child's life, including educational achievement, physical health and social functioning. They also have serious repercussions on the life of the family and the community. Children with poor mental health suffer poorer outcomes across a range of factors in later life, including a high risk of mental illness and of continuing to live in poverty.[14]

Particular striking features are that children and young people with conduct disorder are 17 times more likely to be excluded from school and four times more likely to be two or more years behind in intellectual development.[15] Those with emotional disorders are almost five times more likely to self-harm or commit suicide, and are over four times more likely to be in poorer health or to have long periods of time off school.

Some estimates suggest that between a quarter to a half of mental health problems in adults could be averted with timely and effective interventions in childhood and adolescence. However, ONS survey results show that only 25% of children and adolescents with conduct and emotional disorder are seen by CAMHS and receive less support from other services even though these are the most common mental health problems in this age group.[16] 55% of children with Autism and 57% of those with Aspergers levels of impairment or symptoms are undetected and not receiving any additional needs support in education or health.[17]

The mental health strategy's focus on supporting local delivery of universal public health and early education, with a strong focus on disadvantaged families, recognises and responds to this fact. Taken together with proposals in the recent Public Health White Paper to increase the number of health visitors and to continue the work of the Family Nurse Partnership and the Healthy Child Programme, there is considerable potential for action to support children at high risk and improve their future outcomes.

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[13] Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004 ONS
[14] Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain 2004, ONS
[15] Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain 2004, ONS
[16] Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain 2004, ONS
[17] Russell G, Ford T, Steer C, Golding J (2010) Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use. J Child Psychol Psychiatry, 51(6), 643-51

The strategy highlights efforts to ensure that those from higher risk groups receive treatment and recover as quickly as the general population.

Older Adults

35% of people with mental health problems are over 65, their mental health problems are often associated with poor physical health and social isolation. However, mental health problems including depression among older people is less often diagnosed or treated promptly in primary care with only 15% of older people with depression discussing their symptoms with their general practitioner and less than half of these receiving adequate treatment. [18] [19]

Dementia is also a key mental health issue for older people. It affects five per cent of people over the age of 65 and 20 per cent of those aged over 80. However, only a third of cases of dementia are currently ever diagnosed, meaning opportunities to minimise harm and promote good life quality are not taken. Prevalence of dementia in England is predicted to rise from 680,000 in 2007 to 1.01million people by 2031. [20]

The national review and consultation on the Equality Bill 2010 (including the reviews by the Centre for Policy on Ageing) provided evidence of:

- age-based services not related to clinical need, meaning that older people are denied specialist services (even when they have had mental health problems for years) by virtue of being over 65;

- greater provision for younger people than for older people of crisis response and preventative services;

- much lower rates of specialist referral for older people than younger people with depression;

- discrimination against people suffering from dementia in service provision (for example, intermediate care).

Black and minority ethnic (BME) Communities

The report on the five-year Delivering Race Equality in Mental Health Programme (DRE), published in December 2010[21] made clear that better monitoring and collection of information and better use of data to inform commissioning and provision intentions in health and social care is required. This should focus on what works for which communities; and how it can be captured in order to change and improve existing systems and processes. This could be done through the CQC, which could, as part of its regulation of health and adult social care services for people with mental health problems, include a focus on equality of access and experience of services. A measure of success of the DRE programme is that the CQC has strongly signalled this as an approach it will take.

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[18] Godfrey M, Townsend J, Surr C et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University &Division of Dementia Studies, Bradford University.
[19] Chew-Graham C, Burns A, Baldwin R, (2004) Treating depression in later life: We need to implement the evidence that exists. British Medical Journal, 329, 181-2.
[20] Knapp M, Prince M, (2007) Dementia UK: A report into the prevalence and cost of dementia, Alzheimer's Society, London
[21] Wilson M. (December 2010) Race Equality Action Plan: a five year review, Delivering Race Equality in Mental Health Care, NMHDU

Research from the Delivering Race Equality (DRE) community engagement programme (2005-2008) identified factors that supported the journey towards recovery. Although these findings relate to BME communities, they are also relevant to the wider population.[22]

Factors that facilitate recovery were identified as: support from family and friends, 'keeping busy', a positive attitude, faith and religion, and medication. Lack of support from family and friends, the stigma of mental illness, a return to an unchanged environment after treatment, a poor experience of treatment, and disbelief that recovery is possible, were seen as obstacles to recovery.

Service user and carer satisfaction with mental health services were key to recovery. As one of the community organisations commented: ' Where someone's illness was explained and understood and a choice of treatment offered, in general, people had a much better perception of the mental health services provided.'

The research recognised that a more active role for BME communities and service users could help to provide effective support and help people to manage the transition out of treatment effectively. They could also provide an early intervention support network.

Based on the work of the DRE programme, the strategy specifically aims to tackle race-related inequality in mental health services and to meet the needs of BME communities in order to provide better support and care for all.

Furthermore, the DRE Community Engagement Project enabled a more active role for BME communities and BME service users, through an increase in the number of community members and organisations involved in the studies and by identifying barriers and opportunities for improving service accessibility and provision.

There is a higher rate of poverty among minority ethnic communities, which is on average twice as high as for the White British population. Over half of Bangladeshi, Pakistani and Black African children in the UK grow up in poverty. Taken together, these facts suggest that the impact of inequality on adult and child mental health among minority ethnic communities is particularly high.

The mental health needs of older people from minority ethnic communities also present particular difficulties, especially in the case of dementia, largely due to cultural factors. These include stigma attached to mental health conditions in some minority ethnic communities, and the need for culturally sensitive care.

Domiciliary care is often necessary, as many minority ethnic communities regard residential care as inappropriate. However, this can work to increase the isolation both of older people as well as their carers.

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[22]Fountain J, Hicks J (2010) Delivering Race Equality in Mental Health Care: report on the findings and outcomes of the community engagement programme 2005-2008, University of Central Lancashire

Equality analysis (the Equality Action Plan contains priority areas derived from the equality analysis).

- *All*

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. As the strategy states:

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.

The strategy also underlines the importance of good information so that services can monitor the use and experience of services by different groups.

- *Age*

There is good evidence that older people have not always received as high quality mental health services as younger people. For example, older people have higher rates of depression, and much of this is unrecognised and untreated. , only 15% of older people with depression discuss their symptoms with their general practitioner and less than half of these will receive adequate treatment. [23] [24] Older people are at particular risk if they are isolated, physically unwell or living in a residential home. The strategy outlines a number of approaches to improve the recognition and treatment of depression in older people (see **Annex A** – paragraph 6.15). It also highlights the importance of recognising dementia and provides information about work being undertaken through the Dementia Strategy. Implementing the range of effective local approaches (as outlined in the strategy and supporting document) aims to lower numbers of older people becoming depressed and to increase numbers of those who do become depressed receiving timely and adequate treatment, resulting in speedier recovery.

- *Disability*

People with mental health problems meet the criteria for being disabled, within the meaning of the Equality Act 2010. 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 and should have access to mainline mental health services. It also states that all services should be accessible to disabled people including those with sensory impairment.

- *Gender reassignment*

Transsexual people sometimes require help directly for mental health problems which are related to transsexual issues. In addition, they may require help for other

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[23] Godfrey M, Townsend J, Surr C et al (2005) Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University &Division of Dementia Studies, Bradford University.
[24] Chew-Graham C, Burns A, Baldwin R, (2004) Treating depression in later life: We need to implement the evidence that exists. British Medical Journal, 329, 181-2.

unrelated mental health problems. The strategy recognises that transsexual people may suffer considerable discrimination. They are at higher risk of mental health problems including alcohol and substance misuse, suicide and self-harm. Greater awareness of the problems faced by this group by health and social care staff including mental health staff is critical to improving outcomes.

- ***Marriage and civil partnership***

Married women are far less likely to be depressed or anxious than single women or those who cohabit. The rate of common mental health problems is higher among divorced women than married women and higher still for separated women. The only group of men who are more anxious or depressed than women are recent divorcees. There are insufficient surveys conducted on the impact of mental health and civil partnerships to adequately analyse. The importance of maintaining good relationships is recognised in the strategy as an important aspect of recovery. The needs of families and carers, who are often spouses, is also recognised.

- ***Pregnancy and maternity***

This is primarily covered under objective one. In addition, the strategy recognises that certain groups of mothers such as single and teenage mothers, may be at higher risk of developing mental health problems. It outlines a number of initiatives to target this group with the aim of reducing the risk of postnatal depression. BME women are under-represented within postnatal depression services. This is recognised in the strategy.

- ***Race (including, ethnic origin, nationality)***

people from some BME groups are more likely to be admitted to mental health services under the Mental Health Act. Some black men experience high rates of admission to secure units. The reasons for this are not fully understood but there are likely to be many factors. The strategy recognises this and outlines a number of approaches to help services better understand and address these findings. These are covered in **Annex A**, paragraph 6.22 and in the action plan at the end of this AIE.

There is little variation between white, black and south Asian men in the rates of common mental health problems. Among women, rates of all common mental health problems are higher among south Asian women.

The rate of access to the talking therapies programmes by people from BME groups is being actively monitored

- ***Religion or belief (including lack of belief)***

Having a religion or belief may assist the recovery from mental health problems.

The strategy recognises that inequality may arise due to different religious background or belief in a number of ways. For instance, religion can be closely related with other aspects of identity. Since more people from BME backgrounds identify themselves as religious as shown by service data, services disproportionately affect people from BME backgrounds by failing to address religion.

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Similarly, people who hold religious or other beliefs may have poorer experiences of services because core aspects of their identity are overlooked or they have no means of religious expression (for example, prayer rooms). This may cause anxiety and prove detrimental to their recovery.

Evidence indicates that religion may be protective, particularly in relation to suicide.

The role of religion or belief can also be important in people's explanations for their mental health problems – different conceptualisations and language between an individual and services will affect engagement and success of treatment and care.

The strategy recommends that local services incorporate religious and other beliefs into their assessments and ensure there are facilities for individuals to express their religions and beliefs. Such approaches could also result in a better understanding of the relationship between beliefs and mental health .

- *Sex*

There is considerable evidence on the different rates of mental health problems in men and women, on how differently men and women express their problems and their willingness to seek help from services. An understanding of these differences will enable services to ensure that they can meet the different needs of boys and girls and men and women. The strategy highlights a number of examples of different problems across the two sexes and outlines effective interventions; for example, ensuring sexual safety in inpatient units for women. The majority of veterans with mental health problems are men and their needs are addressed in considerable detail within the strategy. These issues are discussed in chapter 2 of the strategy.

- *Sexual orientation*

The strategy recognises that LGB people are at significantly higher risk of poor mental health compared to heterosexual people. Access to services and outcomes by sexual orientation is not well understood and information is under-collected and analysed. The strategy recognises that further information about the experience of current services and effective approaches is needed.

Shared Objective 3: 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.*

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. [25] [26] 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.

People with learning disabilities have a particularly high risk of mental illness.

There is strong evidence of a higher prevalence of mental health problems among people living with HIV, compared with the general population. People who have been diagnosed with HIV are more likely to develop a mental health problem, for example anxiety or depression.[27]

Having a severe mental illness is a known risk factor for suicide. Because a significant number of suicides occur during a period of inpatient care or shortly after discharge, managing risk effectively and ensuring good continuity of mental health care are essential.

A new suicide prevention strategy will be published in Spring 2011. This will be accompanied by an AIE and be informed by work in this document.

People with mental health problems are less likely to benefit from screening programmes.

People who have physical health conditions which cannot be medically explained have an increased risk of depression and anxiety and are also less likely to be satisfied with the services they receive. This is a matter of concern for those who seek services and for those who commission and provide them.

Equality analysis (the Equality Action plan contains priority areas derived from the equality analysis).

- *All*

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[25] NICE (2009) Depression in adults with a chronic physical health problem: treatment and management http://www.nice.org.uk/nicemedia/**pdf**/ CG91FullGuideline.pdf
[26] Moussavi S, Chatterji S, Verdes E *et al.* (2007) Depression, chronic disease and decrements in health. Results from the world Health Surveys. *Lancet, 370,* 851–858.
[27] Psychological support services for people living with HIV (July 2010), National AIDS Trust

As stated above, and recognised in the strategy, people with mental health problems often have poor physical health and increased premature mortality. People with chronic physical health problems have higher rates of mental illness. A number of approaches to tackle this are outlined in the strategy. Key to the success of these will be ensuring that all groups with protected characteristics have access to these approaches. For example, health screening programmes, smoking cessation services and the new Suicide Prevention Strategy will need to consider the implications for all protected characteristics and actions necessary to advance equality and eliminate unlawful discrimination.

- *Age*

Access to health screening and promotion programmes as well as smoking cessation services need to respond to all ages. Older people experience long-term physical health conditions and are at greater risk of co-morbidity of physical and mental health problems. The strategy has outlined a number of prevention interventions for older adults as well as outlining the needs of older people with both physical and mental health problems.

- *Disability*

People with mental health problems meet the criteria for being disabled under the legislation. Actions under objective 3 are aimed to improve the physical health of people with mental health problems A range of psychological interventions are detailed in the strategy including the extension of the Talking Therapies programme . These can make a considerable difference to the long-term health and well-being of people who have long-term physical and mental ill health.

- *Gender reassignment*

The impact of gender reassignment on the physical health of transsexual people would benefit from more research. There is little data analysis on self-inflicted injury, suicide rates and gender reassignment.

- *Marriage and civil partnership*

Divorced men are three times more likely than married men to have contemplated suicide at some point in their life. Divorced women are twice as likely as married women to have thought about suicide. A new suicide prevention strategy is being planned which will detail action to prevent suicide across different groups including those with protected characteristics.

- *Pregnancy and maternity*

A holistic approach to physical and mental health is needed to improve pre- and post-natal care for mothers, especially teenage mothers and should also address the needs of those at significant risk of developing mental health problems. This is particularly because 50 per cent of women who take their own lives have been in contact with psychiatric services during their maternity[28]. Approaches to pregnancy and maternal health have already been covered under Objectives 1 and 2

- *Race (including, ethnic origin, nationality)*

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[28] Mind (2006) Out of the Blue? Motherhood and Depression.

The strategy recognises that the higher rates of physical health problems in people with mental health problems may complicate existing health inequalities across different BME groups. For example, African Caribbean and Southern Asian communities are at higher risk of diabetes.

The strategy recognises that approaches such as improved screening, smoking cessation programmes etc will have to be tailored to meet the needs of all groups to reduce these inequalities gaps.

Rates of suicide ideation and attempts also vary by ethnicity.[29] This will be further discussed in the Suicide Prevention Strategy.

- ***Religion or belief (including lack of belief)***

Rates of suicide attempts and self-inflicted injury by religion or belief system require more data collection and analysis to inform an equality analysis.

- ***Sex***

Different rates of mental health problems across the sexes have been covered under Objectives 1 and 2. Self-inflicted injury and suicide attempts are higher among women than men. Of those reporting self-inflicted injury, more women received medical or psychiatric help than men. This will be further discussed in the new Suicide Prevention Strategy.

- ***Sexual orientation***

Disproportionate access to screening and health care programmes for LGB people impacts upon their life expectancy and physical health and this may therefore also affect physical health problems secondary to or complicating mental health problems. The strategy recognises that screening and other approaches to improving the physical health of people in all protected characteristic groups has to be considered to improve outcomes. LGB communities have also been shown to be at greater risk of deliberate self harm than heterosexual people.

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[29] McManus S, Meltzer H, Brugha T et al (2009) Adult Psychiatric Morbidity in England, results of a household survey (2007) Health and Social Information Centre, Social Care Statistics

Shared Objective 4: 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*.

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. Approximately one in three (30%) GP consultations are related to a mental health problem. In 2003, nearly one in four people in Britain (23%), responding to a longitudinal survey, reported that they had received some treatment or service for a mental health problem within the previous 18 months.[30] [31]

Choice, autonomy, personalisation and involvement in decision-making are all recognised as key components of high-quality culturally competent care. The main inequalities relating to autonomy, choice and control , relate to the service user's ability to exercise choice, participate actively in decision making and work with service providers to co-design personalised services.   These are inequalities that affect 'seldom-heard' groups, such as children and younger people, older people, disabled people, women, people from ethnic minorities, as well as people from poorer socio-economic groups.

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. [32]

There is little robust information on the experience of mental health in-patients. The Count Me In Census has been conducted annually since 2005 by the Care Quality Commission. Although the Census offers a valuable record of mental health in-patients, it does not cover quality of services or patient experience.

An analysis of the results of a previous Care Quality Commission (CQC) survey showed that Asian/Asian British service users were significantly more likely to be dissatisfied because of inadequate information or choice. However, Asian groups were also significantly more likely than all other ethnic groups to have trust and confidence in their psychiatrist. [33]

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[30] Norwich Union (2004), State of the Nation index

[31] ONS (2003), Better Or Worse: A Longitudinal Study Of The Mental Health of Adults In Great Britain

[32] Care Quality Commission (2010), Survey of community mental health services

[33] Department of Health and ONS (2009), Report on the self reported experience of patients from black and minority ethnic groups

Equality analysis (the Equality Action plan contains priority areas derived from the equality analysis).

- *All*

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.

The Care Quality Commission has recommended that patients should participate in drawing up and reviewing their care plans as much as possible, if such care is to result in rebuilding their autonomy and helping their recovery.

- *Age*

The strategy supports a personalised approach including the roll out of personal budgets to all age groups. It has outlined approaches to improve the well-being of older people and better treatment of depression and dementia and other mental health problems in age appropriate settings. The NHS has produced a toolkit to support tackling age discrimination in older peoples services and this is being piloted in older peoples mental health services.

- *Marriage and civil partnership.*

This is covered under Objectives 1 and 2.

- *Disability*

This is extensively covered under Objectives 1, 2 and 3. Disabled people are less likely than non-disabled people to use information to make choices about the care they receive (21% vs. 31%). They will therefore need access to advocacy and other services. This is recognised in the strategy, for example the role of Healthwatch.

People with learning disability, sensory impairment or communication difficulty will require specific support to access and move across mental health difficulties. This is specifically addressed within the strategy.

- *Gender reassignment,*

This is covered under objective 1 and 2.

- *Pregnancy and maternity*

This is covered under Objectives 1 and 2 and 3. Provision of a mother and baby facilities will help avoid mothers being separated from their children during ill health and support service users' choice and control.

- *Race (including, ethnic origin, nationality)*

BME groups experience of mental health services is covered under Objectives 1 and 2 and in the Action Plan. Black and minority ethnic service users are less likely to be satisfied than their white counterparts because of a perceived lack of choice and receipt of inadequate information. Moreover, patient surveys from among the BME

community showed that disparity in service user's experiences affected patient's satisfaction rates and perception of quality service provision. Ongoing surveys such as the Care Quality Commission community team survey will continue to break down information by ethnicity so that improvements in this area can be monitored.

- ***Religion or belief (including lack of belief)***

There is minimal data about the care and support received by service users based on their religion or belief. More research is required. The strategy explicitly recognises the importance of having facilities available in mental health services for people to express their religion or belief.

- ***Sex***

This issue is covered is some detail under Objectives 1 and 2. The importance of single-sex areas has been highlighted in the strategy, as has sexual safety.

Experiences of services differ between women and men. However, there is little difference between the proportion of men and women who use information to make choices about the care they receive (33% men use information compared to 30% women).

- ***Sexual orientation***

More robust monitoring of patient satisfaction across all protected characteristics and in particular sensitive areas such as sexual orientation can lead to a better understanding of how services can be improved to meet the needs of lesbian women, gay men and bisexual people.

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Shared Objective 5: 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.*

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.[34]

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.

Equality analysis (the Equality Action plan contains priority areas derived from the equality analysis).

- *All*

The strategy recognises that all people including all those with protected characteristics should have confidence that the services they receive are as safe as any in the world. Harmful incidences will require investigation with equal vigour across all protected characteristics. Greater access to independent mental health advocacy and second opinion appointed doctors (SOADs) are important requirements for all protected groups.

The new Suicide Prevention Strategy will ensure action across all protected characteristic groups with the aim of reducing inequality.

- *Age*

The strategy has outlined the importance of age appropriate environments for older people including those who are physically frail .The Mental Capacity Act (2005) protects the rights of older people who do not have capacity. Its use is being monitored.

- *Disability*

Disabled people may encounter a reduced ability to exercise their human rights where they are unable to participate in care and support decisions. The Mental

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[34] Care Quality Commission (2010), Monitoring the Use of the Mental Health Act in 2009/10

Health Act 2007 and Mental Health and Capacity Act 2005 will require monitoring across all protected characteristics.

- ***Gender reassignment***

Post-operative sensitivity in relation to transsexual people and their access to male and female facilities such as single sex wards will support preventative approach to mental health problems in transsexual people.

- ***Marriage and civil partnership***

Statistics about the proportion of married people or people entering civic partnership that inflict self-injury or commit suicide will be covered in more detail in the 2011 Suicide Prevention Strategy.

- ***Pregnancy and maternity***

Domestic and sexual violence is more common among women than men and increased further for pregnant women.

- ***Race (including, ethnic origin, nationality)***

Black and minority ethnic communities were also at greater risk of compulsory admission to mental health services and were over-represented in high security units. This issue is discussed under objectives 1 and 2 and included in the Action Plan.

- ***Religion or belief (including lack of belief)***

Data collection and analysis of the experiences of groups by religion and belief is unavailable. Expanding the Mental Health Minimum Dataset would address this.

- ***Sex***

This is addressed under Objectives 1 and 2 and in the Action Plan. Availability of same sex facilities will work to reduce sexual violence against women in services.

- ***Sexual orientation***

There is disproportionately poor data gathering and analysis on sexual orientation and avoidable harm in comparison to some other protected characteristics.

Stigma and mental illness

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.

Impacts of stigmatisation

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.

- **Human rights**

Stigma works against the human rights of people with mental health problems by increasing the risk of discrimination in key areas of daily life.

In addition to negative social attitudes, legally sanctioned 'structural stigmatisation' can bar people who have ever had a mental health condition from full participation in social or public life, for example by disqualifying them from public office even after a full recovery.

- *Age*

Older people may experience stigma because of their age, physical disability and mental health problems. The issues are explicitly recognised in the strategy and approaches to tackle this within services outlined.

- ***Race and Ethnicity***

People from BME groups may also suffer stigma and discrimination, which can increase their risk of developing mental health problems. They can then suffer additional stigma and discrimination.

The stigma attached to mental health problems within some groups and cultures may result in people avoiding acknowledging their mental health problems and seeking help e.g. Asian and Gypsy and Travelling communities. this can result in under-diagnosis, under-treatment and poorer prognosis for recovery.

Gypsies, Roma and Irish Travellers have been an invisible group, as they have not been previously counted in census categories. Nevertheless, this group is highly vulnerable to social exclusion and disadvantage. This includes impaired literacy, decreased life expectancy, high rates of self harm and suicide.

Gypsies and Travellers are nearly three times more likely to experience anxiety than average and just over twice as likely to be depressed. Women in these communities are twice as likely to experience mental health problems as men.

- ***Sex***

Stigma affects men and women in different ways – men are more likely to avoid seeking treatment for a mental health problem, seeing it as an admission of weakness.

Although women are more likely to seek treatment, they may fear stigmatisation for different reasons e.g. fear that seeking treatment for post-natal depression might result in their baby being taken away.

Time to Change

Tackling stigma in mental illness is not a subject for legislation. It requires culture change to address the underlying social attitudes. The Time to Change programme led by Mind and Rethink has engaged with mental health service users, sports groups, employers and many others to build a much better public understanding of mental health and to engender commitments to change.

The government will actively work with this social movement over the next few years to understand how to collectively make greater in-roads into the social barriers faced by people with mental health problems and to help deliver on the shared ambitions set out in the mental health strategy.

The Attitudes to Mental Illness survey is key to understanding the impact of the campaign, and will be evaluated in 2011.

Equality analysis (the Equality Action plan contains priority areas derived from the equality analysis).

- *Age*

More older adults than younger people link stigma to mental health problems, which adversely effects their health seeking behaviour. This will have an increasing impact as the number of older people increases in an aging population. Anti-age discrimination legislation and strategies will need to address this.

- *Disability*

Tackling stigma requires changing attitudes about mental ill health and recognition of a link between disability discrimination and poor mental health

- *Gender reassignment,*

Transsexual people are likely to have inadequate or inappropriate access to services3.

- *Marriage and civil partnership*

Information regarding marriage, civil partnership and efforts to reduce stigma and discrimination around mental health is under-researched.

- *Pregnancy and maternity*

Stigma about mental health problems negatively impacts upon women because of a fear that poor mental health will result in damaging judgements about their parental abilities.

- *Race (including, ethnic origin, nationality)*

Disproportionate numbers of compulsory admission of certain BME groups requires more investigation. The impact of stigma on help seeking behaviour is greater among some ethnic minority communities

- *Religion or belief (including lack of belief)*

People who experience inequality or religious or belief based discrimination are at increased risk of poor mental wellbeing or poor mental health.

- *Sex*

Some men are reluctant to seek treatment for a mental health problem because it is seen as embarrassing or a sign of weakness. Women are more inclined to seek treatment but fear discriminatory attitudes about mental heath problems and motherhood will lead to inappropriate social service intervention.

- *Sexual orientation*

Stigma can contribute to poor mental health and can lead to LGB people opting not to seek support with mental health problems. This can affect their ability to recover fully and to seek early and appropriate help and support.

EQUALITY ACTION PLAN

This action plan indicates where lead responsibilities for implementing and monitoring actions lie. However, we recognise that the plan may need to be updated to accommodate any changes in legislation and to ensure an effective transition from the current to future systems.

Equality analysis	Objective	Indicator	Lead	Time scales
Age	Improve access and outcomes for older people in Talking Therapy services **(Shared Objective: 1 and 5)**	Proportion of Talking Therapy users reflects age profile of local population and mental health issues Increase in referral rates and numbers of people who take up service	IAPT Programme	March 2014
	Extend Talking Therapy services to children and young people **(Shared Objective: 1 and 5)**	Performance indicators include the number of children and young people diagnosed with psychological distress and using Talking Therapy services.		
	Improve health related quality of life for older people **(Shared Objective: 1)**	There are relevant indicators in NHS Outcome frameworks and proposed Public Health and Social Care outcome frameworks.	NHS Commissioning Board, Public Health England and Health and well being boards.	
Disability	Improved awareness of mental health problems and other disabilities in primary care	Identify and monitor number of people who are identified and treated for mental health problems in primary care	CQC	March 2014
	Improved recognition of physical health problems in people with mental health problems in primary care	Proportion of people with serious mental illness who have a physical health review annually; and the proportion of people with diabetes who are screened for depression Both indicators in QOF	NHS Commissioning board	March 2014

Equality analysis	Objective	Indicator	Lead	Time scales
	Improved physical health in people with mental health problems **(Shared Objective: 1, 2, 3 and 6)**	Under 75 Mortality rates in people with serious mental illness is an outcome indicator in NHS Outcome framework Increasing life expectancy including healthy life expectancy is proposed indicator in Public Health outcomes framework (other relevant indicators are smoking rates for people with serious mental illness. Extended access to talking therapies for people with long term conditions and medically	NHS commissioning Board Public Health England IAPT Programme	
	Improved awareness of the needs of people with learning disabilities **(Shared Objective: 1,2 and 6)**	Assess impact of advice and use of Local HealthWatch	CQC	
Gender Reassignment	Equality objectives (under the Public Sector Duty) include the implementation of anti-discriminatory practices for people with gender dysphoria. **(Shared Objective: 6)**	Monitor and review survey data through Mental Health Minimum Dataset	NHS Information Centre	March 2014
Pregnancy and maternity	Work with pregnant women and new mothers to provide the advice and support they need to cope ante natal and post-natal depression and other mental health problems. **(Shared Objective: 1 and 2)**	Monitor impact of: 1. Joint Strategic Needs Assessments 2. Health visitor programmes 3. Family Nurse Partnership programmes 4. Sure start programmes etc Relevant indicators in proposed Public Health outcome framework include:	Local commissioners and providers	March 2015

Equality analysis	Objective	Indicator	Lead	Time scales
		Maternal smoking prevalence Incidence of low birth weight of term babies, under 18 conception rate		
Race	The overarching objective is to ensure use of the Mental Health Act in BME groups is not disproportionate. To achieve this we need a better understanding of the underlying causes.	Monitor use of Mental health Act including community treatment orders by ethnicity	NHS Commissioning Board.	March 2015
		Monitor elements of impact cultural competency within services, including language needs access, work with the community and voluntary sectors	Local commissioners and providers	March 2015
	Analyse access of all BME groups to independent mental health advocacy and second opinion appointed doctors (SOADs) **(Shared Objective: 2, 4 and 6)**	Monitor numbers of people accessing independent mental health advocacy (IMHA) services and second opinion appointed doctors(SOADs)	Care Quality Commission, HealthWatch England, Local HealthWatch (and LINKs)	March 2015
	Enhance demographic data analysis of patient access by race, in line with the Talking Therapy Data Standards **(Shared Objective: 2 and 6)**	Increase in authenticated data of BME communities	IAPT Programme	March 2013
Religion or belief	Assess and where appropriate increase access to chaplaincy services to meet diverse spiritual needs **(Shared Objective: 1 and 5)**	Mental health trusts have a Chaplaincy Service and a Spirituality Strategy in place	Local HealthWatch NHS Information Centre	March 2014

Equality analysis	Objective	Indicator	Lead	Time scales
Sex	Working with men to support them through transitions of fatherhood and family formation, when they are at increased risk of mental stress.**(Shared Objective: 1 and 2)**	Men's mental health intervention includes monitoring of transitions of fatherhood and family formation	Local commissioners and providers	March 2014
	Reduced violence and abuse experienced by women **(Shared Objective: 1 and 2)**	Public health outcomes framework has proposed indicators: Reduced rates of repeat incidents of domestic abuse; and Reduction in rates of violent crime including sexual violence	Public Health England	March 2014
	Guidance on single sex accommodation and access to women-only days areas is followed **(Shared objective: 4)**	NHS Operating Framework	Local commissioners and providers	March 2012
Sexual orientation	Rates of self-inflicted injury among LGB reduced **(Shared Objective: 6)**	Monitoring of self-inflicted injury includes sexual orientation	Local commissioners and providers	March 2015
Human rights, inclusion and engagement	Reduce stigma around mental health issues **(Shared Objective: 3 and 6)**	Attitudes to Mental Illness Survey	NHS Information Centre	March 2015
	Tailor screening programmes to meet the needs of people with protected characteristics. **(Shared Objective: 3)**	Increase in numbers and proportion of people with mental health problems receiving effective/evidence based support to secure or retain employment	Local commissioners and providers	March 2014
		Reduction in the difference in the employment rate between the general population and all people with mental health problems[35] Relevant indicators in NHS outcome framework and proposed Public Health	NHS Commissioning board Public health England Local health and wellbeing boards	

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[35] Sainsbury Centre for Mental Health (2010), Mental health inequalities: measuring what counts: partnership seminar 16 March 2009

Equality analysis	Objective	Indicator	Lead	Time scales
		outcomes framework Adult social care outcome framework has proposed indicator – proportion of people using social care and carers who express difficulties in finding information about local services; And the proportion of carers who report they have been consulted or included in discussions about the person they care for.		
	Continue publication of patient experience statistics for all MH service users, with disaggregation by protected characteristics. **(Shared Objective: 4)**	Monitor use of Mental Health Act	CQC	March 2015
		Monitor use of social circumstances reports through the Care Quality Commission		March 2015
	Where the use of seclusion, control or restraint is unavoidable, service providers should ensure that they are used proportionately and appropriately and with due regard for human rights, patients' consent to treatment is sought. (**Shared Objective: 4 5 and 6)**	Monitor numbers subject to community treatment orders Relevant indicators in NHS outcome framework : Ensuring that people have a positive experience of care-patient experiences of community mental health services. A number of safety indicators are outlined in all three proposed outcomes frameworks and these can be analysed according to protected characteristics e.g. prescribing errors. Number of people presenting to A&E with self-injury.	CQC	March 2015

FOR THE RECORD
NAME OF PERSON WHO CARRIED OUT THIS ANALYSIS: Stephen Waring
DATE ANALYSIS COMPLETED: 28th January 2011
NAME OF RESPONSIBLE DIRECTOR/DIRECTOR GENERAL: David Behan
DATE ANALYSIS WAS SIGNED: 30th January 2011

Extract from: No Health without mental health - A cross-Government mental health outcomes strategy for people of all ages

6: Improving outcomes in mental health: promoting equality and reducing inequality

6.1 Tackling health inequalities and promoting equality, as enshrined in the Equality Act 2010, is vital if the Government is to deliver health outcomes that are among the best in the world. As the Marmot Review demonstrated, the social gradient in many health outcomes for people in disadvantaged groups and areas accounts for England's poorer health outcomes in comparison with other similar countries[80] . Aspects of people's identity and experiences of inequality interact with each other. For example, people from black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment.

6.2 Promoting 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.

6.3 Effective approaches to reducing differences in access, experience and mental health outcomes are built from the best available evidence on why and how these variations occur. Marmot showed that, among other factors, poor childhood, housing and employment (and also unemployment) increase the likelihood that people will experience mental health problems and that the course of any subsequent recovery will be affected. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

6.4 The Equality Act 2010, informed by consultation with stakeholders from all sectors of the community and a major review of evidence on inequality, replaced the three existing public sector equality duties – pertaining to disability, race and gender – with a new Equality Duty. It covers nine **protected characteristics**, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics, which are:

• age
• disability
• gender reassignment
• marriage and civil partnership
• pregnancy and maternity
• race
• religion or belief
• sex
• sexual orientation.

6.5 The Analysis of the Impact on Equality (AIE, formerly called an Equality Impact Assessment (EqIA)), which accompanies this strategy, considers the evidence of the differential impact of these characteristics and sets out an action plan to address these issues. There is also an extensive set of evidence of different types annexed to the AIE which underpins it. The Analysis also sets out actions for promoting equality.

6.6 There are three aspects to reducing mental health inequality:

- tackling the inequalities that lead to poor mental health;
- tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
- tackling the inequalities in service provision – in access, experience and outcomes.

6.7 *Healthy lives, healthy people* makes clear the Government's ambition to reduce health inequalities and improve the health of the poorest, fastest.

6.8 That has not always been the effect of previous initiatives, and there are some significant inequalities, both in the differing rates of mental health problems across different groups and in people's access to, experience of and outcomes from mental health services. Some of the evidence is summarised here. More is set out in the AIE that accompanies this strategy.

6.9 A fundamental principle in tackling inequality is that all protected characteristics should be considered so as to avoid unjustifiable discrimination. At local level, needs assessment will determine the areas of greatest inequality that local strategies will need to address.

6.10 Reducing inequalities requires a multi-stranded approach that tackles the economic, social and environmental determinants and consequences of mental health problems. Such an approach needs to take into account the fact that people have more than one protected characteristic. Approaches must also take into account people's living environments and social circumstances, which are critical to the onset and course of their mental health problems. This approach is embedded in both this strategy and other cross-government initiatives. Tackling the determinants is a key strand of *Healthy Lives, Healthy People*. It stressed the importance of both universal approaches and targeted interventions aimed at those facing the greatest disadvantage in society, so that their health can improve most quickly. *Healthy Lives, Healthy People* emphasised the need to start early, so as to ensure that all children have the best start in life and continue to develop well.

6.11 Inequalities that arise for people with protected characteristics are compounded by the stigma and discrimination surrounding mental ill health. That is why the Government has taken action to tackle public attitudes towards mental illness, one of the key objectives of this strategy. This is covered in Chapter 3 above (objective (vi)).

6.12 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, so that they have more control over the support they receive.

6.13 The Government is working to close the equality gap for all people with protected characteristics. It has also identified a number of other groups that are known to have reduced access to mental health services, for example homeless people, veterans, people with personality disorder and offenders.

6.14 In this chapter we consider the specific groups protected by the Equality Act 2010. Research evidence[81] has highlighted the challenges. Strategic solutions should be informed by current positive practice and other new and emerging research.

Improving outcomes for older people with mental health problems

6.15 Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention. Symptoms of depression are common and sometimes short-lived, but for some may develop into a clinical depression. Some 11% of older people will have minor depression and 2% a major depression.[82] Older people with physical ill health, those living in residential care and socially isolated older people are at higher risk.[83] Yet these problems often go unnoticed and untreated. Studies show that only one out of six older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.[84] As well as the impact on quality of life, untreated depression in older people can increase need for other services, including residential care. However, older people can respond very well to psychological and medical treatments. This includes carers of people with dementia, so that they are better supported to manage challenging behaviours. As the Department of Health completes the nationwide rollout of psychological therapy services for adults who have depression or anxiety disorders, we will pay particular attention to ensuring appropriate access for people over 65 years of age. People who remain healthy into older age are more likely to continue in employment if they wish, and to participate actively in their communities. The supporting document, *Talking Therapies: A four-year plan of action*, explains this in detail. We will continue to monitor older people's access to the new psychological therapy services.

6.16 Improving the quality of care for people with dementia and their carers is a major priority for the Government. For every 10,000 people over the age of 65,500 have dementia, with 333 not having this diagnosed. The Government is committed to more rapid improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them. This approach is set out in *Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy*[85] (September 2010) – the revised, outcomes-focused implementation plan for the National Dementia Strategy. More information on the mental health of older people is provided in the companion document to this strategy, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages.*

6.17 The Department of Health, the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists and the British Psychological Society will continue to co-operate and develop ways of improving the recognition of depression in older people in primary care. A new training programme will be made available shortly.

6.18 From 2012 the NHS and local government will be required to comply with the Equality Act 2010 and its provisions on discrimination on grounds of age.

Improving outcomes for black and minority ethnic people with mental health problems

6.19 The evidence on the incidence of mental health problems in BME groups is complex. The term BME covers many different groups with very different cultural backgrounds, socio-economic status and experiences in wider society. People from BME groups often have different presentations of problems and different relationships with health services. Some black groups have admission rates around three times higher than average, with some research indicating that this is an illustration of need. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

6.20 African-Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act. South East Asian women are less likely to receive timely, appropriate mental health services, even for severe mental health conditions.

6.21 Tackling the inequalities for BME communities has been a central focus for a number of years. However, the outcomes have in some ways been disappointing.

6.22 *Race Equality Action Plan: A five-year review*[86] looks back at the work of the Delivering Race Equality in Mental Health Care programme and describes some of the key challenges, successes and learning. It provides a strong base from which commissioners and service providers can make improvements. These will rely on:

- local collection and monitoring of information on ethnicity and culture;
- better use of these data to inform commissioning and provision in health and social care;
- a focus on outcomes that work for individuals and communities;
- monitoring and evaluating effectiveness of service delivery, especially around equality needs; and
- establishing mechanisms that allow local user groups to engage with providers and commissioners, and that empower and support them so that they can engage effectively.

6.23 This will be underpinned by the new statutory responsibilities of the NHS Commissioning Board and GP consortia. In addition, Department of Health research

and analytical staff will continue to make best use of research in developing effective approaches for reducing race inequality in mental health.

Improving outcomes for disabled people with mental health problems

6.24 There are two aspects to the consideration of the outcomes for disabled people with mental health problems:

- people with mental health problems meet the criteria within legislation for disabled people; and
- disabled people with mental health problems may face barriers, either barriers to physical access or communication barriers (particularly in the case of deaf people). This is critical in mental health provision, which relies heavily on communication and relationships for supporting improved outcomes. Also, an estimated 25–40% of people with learning disabilities have mental health problems.

6.25 Commissioners and service providers will need to continue to ensure that mental health services are accessible to all disabled people. Arrangements need to be in place for deaf people so that they are able to communicate, and have equitable experiences of and outcomes from services.

6.26 The special educational needs and disability Green Paper will consider, among other things, how to make sure that there is better early intervention to prevent later problems for children with special educational needs and disabilities, including those who have underlying or associated mental health problem.

6.27 There are two important aspects to the improvement of mental health services for people with learning disabilities and autism:

- inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems; and
- development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism (recognising the increased risks of a range of physical and mental health problems for this group).

6.28 People with autism may be refused support because they do not fit easily into mental health or learning disability services. This has been a long-standing problem. The autism strategy, *Fulfilling and Rewarding Lives*, and the recent statutory guidance *Implementing 'Fulfilling and Rewarding Lives': Statutory guidance for local authorities and NHS organisations to support implementation of the autism strategy*, [87] outlined priorities for improvement, including:

- the development of diagnostic services and pathways to care and support;
- the availability of mental health services for people with autism, where appropriate; and
- greater awareness of autism among healthcare and social care professionals.

Improving outcomes for lesbian, gay and bisexual people with mental health problems

6.29 People who are lesbian, gay and bisexual all have a higher risk of mental health problems and of self-harm. [88] They also suffer more attacks and violence. Experiences of mental health services are reportedly poor, and monitoring of sexual orientation is patchy, making it less easy to develop tailored service responses. A priority action for securing improved outcomes is to achieve routine local monitoring of access to services, experience and outcome by sexual orientation.

Improving outcomes in relation to gender inequality

6.30 There are many differences in the rates and presentation of mental health problems between men and women, and boys and girls. Improved awareness of these issues among staff is important.[89]

Women

6.31 Recorded rates of depression and anxiety are between one and a half and two times higher for women than for men. Rates of deliberate self-injury are two to three times higher in women than men. Women are at greater risk of factors linked to poor mental health, such as child sexual abuse and sexual violence – an estimated 7–30% of girls (3–13% of boys) have experienced
childhood sexual abuse. Around one in ten women have experienced some form of sexual victimisation, including rape. Studies have shown that around half of the women in psychiatric wards have experienced sexual abuse.

6.32 Sexual safety in inpatient and residential environments is particularly important. This includes the provision of women-only day areas in mental health service buildings and adherence to NHS policy on mixed sex accommodation. Staff need to be supported so that they can appropriately explore with women whether they have had experience of sexual violence. Issues relating to pregnancy and maternal health are dealt with in Chapter 5 and in the AIE.

Men

6.33 Three-quarters of people who commit suicide are men. Men are three times more likely than women to be dependent on alcohol and more than twice as many men in psychiatric units are compulsorily detained.[90] Services should be sensitive to the ways in which men present mental health problems.[91]

Improving outcomes in relation to gender reassignment

6.34 This strategy uses the definitions set out in the Equality Act 2010. Gender reassignment refers to, among others:

- people who plan to, or have undergone, physiological change or other attributes of sex; and
- people who are referred to as transsexual.

6.35 People who identify with this protected characteristic are subject to some of the greatest discrimination in our society. They are at increased risk of alcohol and substance misuse, suicide and self-harm.[92] It is important that staff in health, social and education services are aware of the raised risks in these groups. The issue of increased suicide risk will be covered in more detail in the forthcoming suicide prevention strategy.

Religion or belief

6.36 Inequalities arise in mental health services, in relation to religion or belief, in four main ways:

- The relationship with other aspects of identity (for some cultures ethnicity and religion are virtually inseparable). Service data show that more people from BME backgrounds identify themselves as religious. By failing to address religion, services disproportionately affect people from BME backgrounds.
- Potential for people who hold religious or other beliefs to have poorer experiences of services because core aspects of their identity are overlooked or they have no means of religious expression (for example, prayer rooms). This may cause anxiety and prove detrimental to their recovery.
- Evidence indicates that religion may be protective, particularly in relation to suicide.
- The role of religion or belief in people's explanations for their mental health problems – different conceptualisations and language between an individual and services will affect engagement and success of treatment and care.

6.37 If positive outcomes are to be achieved, services will need to incorporate religion and belief into the assessment of individuals. Local services will achieve better outcomes if they make resources and facilities available for people to express their religion or belief.

The role of government in reducing health inequalities

6.38 The Department of Health has made tackling health inequalities a priority. It is under a legal obligation to promote equality across the characteristics protected in the Equality Act 2010. Subject to Parliamentary approval, the NHS Commissioning Board and GP consortia will be under a specific statutory obligation to reduce inequalities in healthcare provision.

6.39 One of the underpinning principles in the development of the NHS Outcomes Framework has been the need to promote equality and reduce inequalities in health outcomes. From 2012/13, the framework will be used by the Secretary of State for Health to hold the NHS Commissioning Board to account, and to achieve levels of ambition where they have been agreed. Levels of ambition will, where possible, take into account the variation and inequalities in outcome indicators, such as equalities characteristics, disadvantage and where people live. The framework will help the NHS Commissioning Board to play its full part in promoting equality in line with the Equality Act.

6.40 The Department of Health has created an Equality and Diversity Council, chaired by the NHS Chief Executive, to raise the profile of equality and diversity issues across the NHS and to support the NHS in implementing the Equality Act. The Council reports to the NHS Management Board and is working to develop and deliver change to make the NHS more personal, fair and diverse. Goals include creating a framework that encourages NHS organisations and staff to work closely with the communities they serve, and ensuring that managers consider equality and diversity issues and champion good practice.

6.41 The Council has commissioned work to develop an Equality Delivery System for the NHS, which will draw on current good practice. This system is being designed to improve the delivery of personalised, fair and diverse services to patients, and to provide working environments where staff can thrive. So far, over 660 people from NHS organisations, patient groups and other interest groups have provided feedback on the proposals.

6.42 The question of equality in mental health raises highly complex – and often highly sensitive – issues. The Department of Health will continue to work with people affected, carers, families, communities and relevant agencies to refine its understanding of the issues. The Department will reconvene the Ministerial Advisory Group on equality in mental health, where the leading organisations in the field will be invited to work with the Minister of State for Care Services on progress.

REFERENCES

80 Marmot M (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, available at: www.marmotreview.org

81 See NMHDU Fact File 5, available at: www.nmhdu.org.uk

82 Godfrey M, Townsend J, Surr C et al. (2005) *Prevention and Service Provision: Mental health problems in later life*. Leeds: Institute of Health Sciences and Public Health Research, Leeds University, and Division of Dementia Studies, Bradford University.

83 Craig R and Mindell J (eds) (2007) *Health Survey for England 2005: Health of older people*. Leeds: NHS Information Centre.

84 Chew-Graham C, Burns A and Baldwin R (2004) Treating depression in later life: we need to implement the evidence that exists. *British Medical Journal* 329: 181–182.

85 Department of Health (2010) *Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy*, available at: http://tinyurl.com/DementiaStrategyImplementation

86 Department of Health (2010) *Race Equality Action Plan: A five year review*, available at: www.nmhdu.org.uk/news/race-equality-action-plan-a-five-year-review/

87 Department of Health (2010) *Implementing 'Fulfilling and Rewarding Lives': Statutory guidance for local authorities and NHS organisations to support implementation of the autism strategy*, available at: http://tinyurl.com/AutismStatutoryGuidance

88 Equality and Human Rights Commission (2010) *How Fair is Britain? Equality, human rights and good relations in 2010. The First Triennial Review*, available at: http://tinyurl.com/EHRCTriennialReview

89 Williams J and Paul J (2008) *Informed Gender Practice: Mental health acute care that works for women.* London: National Institute for Mental Health in England; National Mental Health Development Unit (2010) *Working towards Women's Well-being: Unfinished business*, available at: www.nmhdu.org.uk/silo/files/working-towards-womens-wellbeing-unfinished-business.pdf

90 Wilkins D (2010) *Untold Problems: A review of the essential issues in the mental health of men and boys.* Men's Health Forum and National Mental Health Development Unit.

91 Wilkins D and Kemple M (2011) *Delivering Male: Effective practice in male mental health.* Men's Health Forum, Mind and National Mental Health Development Unit.