

Equality Impact Assessment

On

**Access to Mental Health
Commission Services for People
With Mental Health Needs**

By



**Draft Report
Summary
April 2008**

CONSULTATION ANNOUNCEMENT

This document is being offered for public consultation. It reports the result of an Equality Impact Assessment (EQIA) carried out by the Mental Health Commission (MHC). The focus of the EQIA is on "Access to Services of the Mental Health Commission in Relation to People with Mental Health Needs".

Further copies of the full report can be requested from the MHC. A summary of the document will also be made available by request in alternative formats such as Braille, audiocassette, large print and disc. It will also be available by request in minority languages to meet the needs of those not fluent in English.

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Consultation on the EQIA will end on 11 July 2008. Alternative consultation methods will also be used to elicit views. You may therefore receive further communication from us.

All consultation comments should be forwarded to Paul McBrearty at the Mental Health Commission.

We hope that you will find the time to comment on this document.

Key Abbreviations Used

BME	black and minority ethnic
EQIA	equality impact assessment
LGB	lesbian, gay and bisexual
MHA	Mental Health Act (1983)
MHC	Mental Health Commission for Northern Ireland
MHO	Mental Health (Northern Ireland) Order (1986)
Section 75	Section 75 of the Northern Ireland Act (1998)

Executive Summary

This document reports the findings of an Equality Impact Assessment (EQIA) conducted by the Mental Health Commission (MHC). The EQIA looks at “Access to Services of the Mental Health Commission in Relation to People with Mental Health Needs”.

The EQIA was carried out with reference to the “Practical Guidance on Equality Impact Assessment”, by the Equality Commission for Northern Ireland (2005b).

The Organisation

The Mental Health Commission was founded in 1986. It was set up under the provisions of the Mental Health (Northern Ireland) Order, 1986. The Commission is an independent body, responsible for keeping under review, the care and treatment of individuals in Northern Ireland with a learning disability or mental health needs. The Commission also has a duty to monitor the operation of the order.

The Policy

This EQIA concentrates on the work of the Commission in relation to those with mental health needs. It attempts to investigate access to services of the Mental Health Commission from an equality perspective. The scope of the EQIA specifically encompasses four aspects of the Commission’s work:

- the review of hospitals and community facilities
- the review of improper detentions
- the review of treatment plans
- the review of untoward events.

The Review of Hospitals and Community Facilities

The Commission is required to undertake both announced and unannounced visits to psychiatric hospitals and community facilities in Northern Ireland. The purpose of the visit is to appraise the key aspects of care that patients receive; to meet with those patients, or their relatives, who have requested an interview; and to see patients

who have been detained for three months or more as well as speaking with senior personnel who are involved in their care.

The Review of Improper Detentions

The Commission must also review the legality of the detentions under the Order. The process of detaining an individual is tightly prescribed by legislation and thus involves clear documentation. The Commission undertakes to scrutinise this documentation to ensure that the process, as defined by legislation, is complied with. Any forms which have been completed inappropriately and thus calling the legality of the detention into question, are highlighted.

The Review of Treatment Plans

Another function of the Commission is to scrutinise the treatment plans of all patients detained for three months or longer. The Commission assesses these forms for clinical acceptability, and evidence of consent. In non-consenting treatment such surgical operations and electro-convulsive therapy, it also examines treatment forms for evidence of a second opinion.

The Review of Untoward Events

The Commission also has a duty to enquire into all untoward events reported to them, specifically investigating any cases where there may have been deficient or ill treatment. Whilst priority is given to the local resolution of conflicts, the Commission will investigate all those complaints that have not been resolved locally. The Commission also has a duty to investigate all *serious* untoward events, which may include suicide, suspected suicide and sudden death, allegations of physical/sexual abuse and misappropriation of patients' possessions.

Screening

The policies were screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. The purpose of screening, as stipulated by the Equality Commission guidance, is to identify those policies, which are likely to have a significant impact on equality of opportunity. Once they are identified the greatest resources can then be devoted to them.

Following a re-screening exercise of its policies in 2004, the Commission revised its decision not to conduct any Equality Impact Assessments (EQIAs).

Data Collection

The assessment faced two fundamental challenges, both originating from the fact that the Commission's activities in relation to the four areas under scrutiny are highly specialised.

(1) Research on the needs or experiences of individuals from groups under Section 75 with regards to the Commission's services is virtually non-existent. Secondary sources, in short, provide hardly any data from which immediate conclusions as to the equality impacts of the Commission's work in relation to people with mental health problems can be drawn.

(2) The lack of data that can be drawn upon from secondary sources is to a large degree reflected in the data collected through the engagement with voluntary sector organisations. With a couple of notable exceptions, few representatives had had any direct contact with and experience of the Commission's services. Many representatives thus felt unable to comment directly on current practice by the Commission and any resulting equality implications.

Both circumstances called for a wider approach to the data collection for the EQIA. It was decided that, in addition to eliciting any views from those who had a detailed knowledge and experience of the Commission, data would be collected on:

- (1) the needs of people from Section 75 groups with regards to mental health services and
- (2) the experience of mental health services by members of Section 75 groups.

The data was collected with a view to generating conclusions as to key areas for consideration by the Commission.

The most fundamental challenge, however, resulted from the fact that the potential users of the Commission's services would encounter the Commission at a time of their lives in which they experience an acute period of crisis. Their vulnerability raises ethical as well as practical issues about any direct engagement for the

purpose of this EQIA. The Commission recognises, on the other hand, that the experience of the individual is ultimately key to the undertaking. It therefore sought to bridge the gap by approaching advocacy networks in order to draw on the experience of advocates for people with mental health problems.

Eventually, data for the EQIA was gathered from several sources in the following ways:

- qualitative data from a roundtable discussion with voluntary sector organisations
- qualitative data from a range of one-to-one interviews
- qualitative and quantitative data from secondary sources (i.e. a review of existing research in the field)
- qualitative data from a focus group with MHC staff.

Summary Assessment of Main Findings

It is acknowledged that the quality of the data collected in the course of the assessment varies. At times, issues emerge from only one source. In other cases, evidence is anecdotal. Moreover, without conducting further original research one cannot ultimately be certain that issues identified by research conducted in England and beyond hold for Northern Ireland. All these constraints are rooted in the fundamental lack of existing research on the experiences of individuals from Section 75 groups with mental health needs in Northern Ireland, in particular with regards to the Commission's services.

These caveats need to be taken on board but rather than dismissing the findings as 'unreliable' from a scientific point of view, Equality Commission guidance urges that each issue needs to be examined on its own merit. Ultimately, the assessment should be seen as an opportunity to put provisions in place that will contribute to safeguard from negative impacts arising.

The assessment has raised a number of issues pertaining to the potential for differential and adverse impact regarding the Commission's services for people with mental health problems in relation to each of the nine groups (gender, age, marital status, religion, political opinion, dependents, sexual orientation, ethnicity and disability). They are based on differences in needs, access to

and the experience of mental health services by individual groups under Section 75.

The groups that appear to be affected most by the policies are based on gender, age and disability. In the following, these findings are discussed in relation to their relevance across the four areas of work of the Commission:

- the review of hospital and community facilities
- the review of improper detentions
- the review of treatment plans
- the review of complaints and untoward events.

The findings in turn will form the backbone for the final conclusions: the proposed action points by the Mental Health Commission. First, however, fundamental barriers to accessing the Commission's services are discussed.

Fundamental Barriers to Accessing the Commission and its Services

Voluntary sector representatives raised a number of fundamental issues that are seen to pose barriers for users and carers accessing the Commission's services in general, regardless of their background:

- Evidence suggests that there is a lack of clarity surrounding the Commission, its existence, role and remit vis-à-vis service providers and other regulatory bodies such as the Mental Health Review Tribunal and the Regulation and Quality Improvement Authority. This is mostly ascribed to a lack of information available.
- The interviews and roundtable discussion also point to basic communication needs of particular groups of users and carers. There are indications that the needs of members of BME groups as well as people with a disability are not being met, due to a lack of information in alternative formats such as translations or audio and pictorial formats.
- There are moreover indications that the current profile of Commissioners as predominantly coming from white backgrounds and lacking in members from younger age

groups causes concerns regarding perceptions of their approachability by some groups of service users.

The Review of Hospital and Community Facilities

A key function of the Commission is to review the quality of treatment and care that individuals receive in the hospital and community facilities. There are indications to suggest that (1) needs in relation to mental health services are group-specific and (2) access to and the experience of mental health services results in a number of differential impacts across all of the nine groups.

The data points to concerns regarding a lack of information provided to patients in writing on their treatment and care, the Commission and access to advocacy services. This conclusion is corroborated by the fact that the Commission itself frequently receives complaints by service users regarding a lack of information provided by Trusts.

The findings moreover indicate that a number of groups might be subject to negative and discriminatory attitudes from staff. This appeared to be a particularly salient issue, affecting in a disproportionate way:

- women (when negative attitudes towards certain disorders such as self-harming are displayed as they are a predominantly female feature),
- older individuals (due to ageist attitudes),
- members of BME groups (due to racism),
- those of a minority religion (e.g. religious discrimination),
- as well as lesbian, gay and bisexual individuals (due to homophobia).

There are also indications that available services may not be meeting the needs of individuals from certain groups. The research revealed the following concerns:

- a potential lack of privacy in hospital settings, affecting in particular women (especially those who have been a victim of physical and sexual abuse) as well as lesbian, gay and bisexual individuals, combined with a lack of choice for single sex wards; a lack of appropriate consideration for issues around confidentiality, causing distress at times for people

from BME backgrounds and their families and carers as well as for lesbian, gay and bisexual people

it should be noted that in many cases a lack of privacy afforded to patients is rooted in a lack of appropriate accommodation; moreover, it should be borne in mind that the level of privacy also depends on a person's level of need – specific criteria are used to distinguish the level of observation an individual is placed under

- dietary requirements may remain unmet, affecting in particular people from minority ethnic backgrounds as well as minority religions
- a potential lack of sufficient support for young people moving from children to adult services during the transition period
- a potential lack of sufficient information and support for patients with dependents, in particular for maintaining relationships with their dependants during the period of detention (e.g. when children are removed from their care), leading to an increased anxiety about their inability to fulfil their role as a carer
- few facilities have appropriate environments for visiting of dependent children

however, this should be seen in the context of the need to consider the best interest of children; some hospitals in fact have a policy in place that children are not to be admitted on to the ward as visitors on their own

- concerns have also been raised regarding the lack of assessment of children of people with mental health needs given the indications that children of psychiatric inpatients are at a higher risk of psychiatric disturbance themselves
- a potential lack of access to community networks / additional support by voluntary sector organisations, affecting in particular people from BME backgrounds
- a potential lack of access to religious places of worship for some minority religions, combined with an overall lack of understanding of minority religions

on the other hand access to religious services appears less of an issue in relation to majority religions as ministers and priests would visit facilities.

The Commission would argue that accommodation appears to account for a number of the potential inequalities that have been identified. Facilities vary substantially between hospitals resulting in geographical inequalities – accordingly, specific needs are more likely to be met in certain hospitals than in others. While this points to key issues to be taken into account for any new builds, it also means that the scope for addressing these matters in existing facilities is somewhat limited.

Finally, it should be noted, however, that evidence of good practice also exists, indicating that cultural needs are being identified and accommodated in certain parts of the service. This predominantly affects individuals from various religious (e.g. staff liaising with appropriate chaplains) and political affiliations (e.g. staff facilitating attendance at commemorative events).

Review of Improper Detentions

The Commission also undertakes to monitor all forms relating to a detention to ensure that there are no improper detentions. The data suggests imbalances across three of the groups (age, ethnicity and sexual orientation) with regards to detentions. Particular attention is drawn to the diagnostic process:

➤ age

It has been suggested that criteria used for diagnosing psychiatric illness in younger individuals may not be valid to the same extent for older individuals.

➤ ethnicity

Evidence shows that people from BME groups are substantially more likely to be detained. It has been argued that doctors involved in the assessment of a patient often lack in understanding of the cultural and religious context in which symptoms are presented. Likewise, cultural stereotypes have been thought to play an important role.

While, at present, it is likely that the share of patients from BME backgrounds is still substantially smaller in Northern Ireland than in England, it is important to take note of these findings given the recent rise in the migrant population. Important lessons can thus be learned to help organisations and staff prepare for the future.

With regards to gender it becomes clear that in Northern Ireland, more men are involuntarily detained than women. While, in relation to England, it has been suggested that gender-based interpretation of behaviour may play a role, it would appear that more research is needed before more definite conclusions are drawn.

The findings also indicate that LGB individuals do not appear to have equality of opportunity regarding the initial admission for assessment, based on the fact that same-sex partners are not recognised until other avenues have been exhausted.

Review of Treatment Plans

Another function of the Commission is to review the treatment plans of all patients detained for three months or longer. The findings provide indications of a number of differential impacts across five of the groups (gender, age, ethnicity, disability, and dependents).

- Secondary sources indicate that certain groups are likely to experience differences regarding the diagnosis of mental illness and the subsequent treatment given. This appears to be a particularly important issue affecting gender (e.g. depression is more likely to be diagnosed in females than in males).
- Both the literature and interviewees argue that a limited understanding of certain disorders by health care professionals has important implications for older individuals (e.g. dementia).
- The literature suggests that the side effects of some medications may place certain groups at a disadvantage, which also appears to be an important issue for older individuals (e.g. medication can be affected by hormonal changes in older men) and those with dependents (e.g. the effects of drugs on the foetus of women with mental illness).

Moreover, women are likely to experience more side effects as they are prescribed more drugs than their male counterparts.

- Secondary sources reveal that people from BME groups are likely to be adversely impacted by treatment patterns in practice. They are more likely to receive stronger types of treatment (medication and ECT) as well as stronger dosages. Likewise, they are particularly affected by the lack of access to talking therapies and complementary therapies.
- Findings from both the literature and interviewees indicate that certain groups may not be given appropriate information on their treatment. This seems to be important for older individuals and people with a disability (e.g. their level of capacity is often assumed rather than assessed and consent may not always be actively sought) as well as people from BME backgrounds, due to a lack of information materials in translation and under-use of interpreters.

Review of Untoward Events and Complaints

The Commission has a responsibility to review all untoward events and complaints. The data suggests that various groups have particular needs which are relevant to the Commission's role. This affects in particular gender, age, marital status and sexual orientation.

- The literature points to instances of abuse by patients on patients or by staff on patients, which is an important issue affecting women in a disproportionate way (e.g. women are subject to sexual and/or physical abuse).

The literature also points to differential levels of risk with regards to suicide on the basis of:

- gender (e.g. suicide is higher in males),
- age (e.g. young and old men are at increased risk of suicide),
- marital status (e.g. single men are more likely to commit suicide) and
- sexual orientation (e.g. LGB individuals are more likely to attempt suicide).

A final point that emerged from the findings is in relation to complaints. The interviews suggest that some groups have greater needs for support in raising a complaint. This appears to be an important issue particularly for older individuals as well as members of BME groups placing them at a disadvantage (e.g. they would be more reluctant to voice concerns and are not given sufficient support in raising complaints). A lack of information in translation and in accessible formats on the right to raise a complaint and on how to do so constitute further concerns.

Proposed Action Points

Taking on board these issues the Mental Health Commission proposes undertaking actions in the following areas. The constraints posed by the existing lack of sanctions it can employ vis-à-vis service providers should be borne in mind.

(1) Communication

The Commission, as a matter of urgency, will implement a communication strategy aimed at raising the profile of the organisation amongst users, carers, the voluntary sector, and members of the general public. It will ensure that

- all information materials will be subjected to a readability test (such as plain English); materials will also be produced in translation and accessible formats
- the Commission seeks to engage with voluntary sector organisations to facilitate their input in the production of information materials.

Moreover, the Commission will establish and develop its own website and explore the potential for carrying out “open sessions” for service users and their carers in the premises of selected voluntary sector organisations.

(2) Training and Development Opportunities for Commissioners and staff

The MHC will ensure that Commissioners themselves as well as administration staff continue to receive focused training on the needs of individual Section 75 groups.

(3) Appointment of Commissioners

The MHC will engage with the DHSSPS (as the authority responsible for appointing Commissioners) to explore further opportunities for encouraging individuals from under-represented groups to serve as Commissioners.

(4) Review of Hospital and Community Facilities

The Commission will seek to review their checklist for visits of hospital and community facilities in order to scrutinise the extent to which the needs of particular groups under Section 75 are met in the provision of treatment and care.

- training

The Commission will seek assurance from service providers that staff receive training on the needs of individual Section 75 groups. Particular attention will be given to the training Part II and Part IV doctors receive to inform the diagnosis of patients from minority groupings. Likewise, the Commission will seek evidence what types of attitudinal training (such as on anti-racism and anti-homophobia) is delivered.

The Commission recognises the constraints posed by labour market conditions in Northern Ireland i.e. the difficulty to recruit specialist psychiatrists. In light of this, Trusts will be encouraged to facilitate the development of specialist knowledge, for instance in the form of specialist staff in wards which can be called upon in particularly complex cases (e.g. Alzheimer's Disease; Autistic Spectrum Disorders; Eating Disorders).

- policies

The Commission will monitor to what extent service providers have appropriate anti-discrimination policies in place.

- promotion of diversity

The Commission will seek evidence regarding efforts by service providers to promote diversity (through the prominent display of posters, leaflets etc.) in care settings.

- provisions for privacy

The Commission will seek information as to the provisions hospitals have in place in relation to privacy.

- support for people with dependants

The Commission will draw attention to the ways in which patients are supported in maintaining relationships with their dependents. The Commission would hold that any monitoring of the assessment of children of psychiatric inpatients would fall outside its remit.

- access to external support services

The Commission will seek information on the extent to which patients are being facilitated in accessing external support services, such as opportunities for linking in with community networks in the case of people from BME backgrounds.

- support in meeting particular needs

Further attention will be given to the extent to which individuals are assisted through arrangements for prayer and worship as well as arrangements for alternative diets.

The Commission will also seek to engage with service providers to explore the scope for developing a joint orientation pack for new/returning patients and their carers. This should be available in alternative formats and could contain relevant and up-to-date information on a range of issues such as:

- the role of the Commission
- the role of the Mental Health Review Tribunal
- external support services
- voluntary organizations
- how to raise complaints
- support services available.

(5) Review of Treatment Plans

The Commission will expand their review of treatment plans, where possible, to ensure that:

- the potential for side-effects and possible level of severity has been noted
- the doctor records the patient's level of capacity

- if the individual is incapacitated that an advocate has been involved
- complementary therapies, if suitable, are offered
- they also record the results of their un/announced medicinal inspection.

The Commission will also seek to require hospitals to demonstrate that they have provided core information on treatment to patients in writing and alternative formats.

(6) Review of Improper Detentions

The Commission will consider demanding more detailed information to be recorded on detention forms in relation to clinical descriptions to allow closer scrutiny of the basis of an admission.

The Commission will raise its concerns regarding the lack of acknowledgement of the role of same-sex partners in the admission process with relevant authorities with a view to lobbying for changes to the Mental Health Order.

The Commission will also seek assurance from hospitals that they have facilitated the use of interpreters in the assessment process, where relevant.

(7) Review of Untoward Events and Complaints

The Commission will seek to engage with voluntary sector organisations with a view to designing specific support measures for older people as well as people from BME backgrounds and people with a disability in raising a complaint (e.g. by developing tailored information materials).

(8) Monitoring

Finally, the Commission will engage with service providers to explore the scope for expanding the collection of monitoring data in relation to seven of the nine groups in order to alert staff involved in the treatment and care of specific needs and to enable monitoring of equality of opportunity and outcome for groups under Section 75.

Monitoring

After completion of the EQIA, a delivery plan will be drawn up to implement specific action points emanating from the assessment. The delivery will be monitored on an ongoing basis and the organisation's Annual Review of Progress will contain a report on the implementation of the EQIA.

The organisation will seek to expand provisions for quantitative monitoring in relation to seven of the nine groups (gender, age, religious affiliation, dependents, marital status, disability and ethnicity). Options for qualitative monitoring with regards to sensitive issues (i.e. sexual orientation and political affiliation) will be explored, pending publication and further advice from the Equality Commission.

The Mental Health Commission commits itself to revising the policies if the monitoring results highlight any differential and adverse impact.