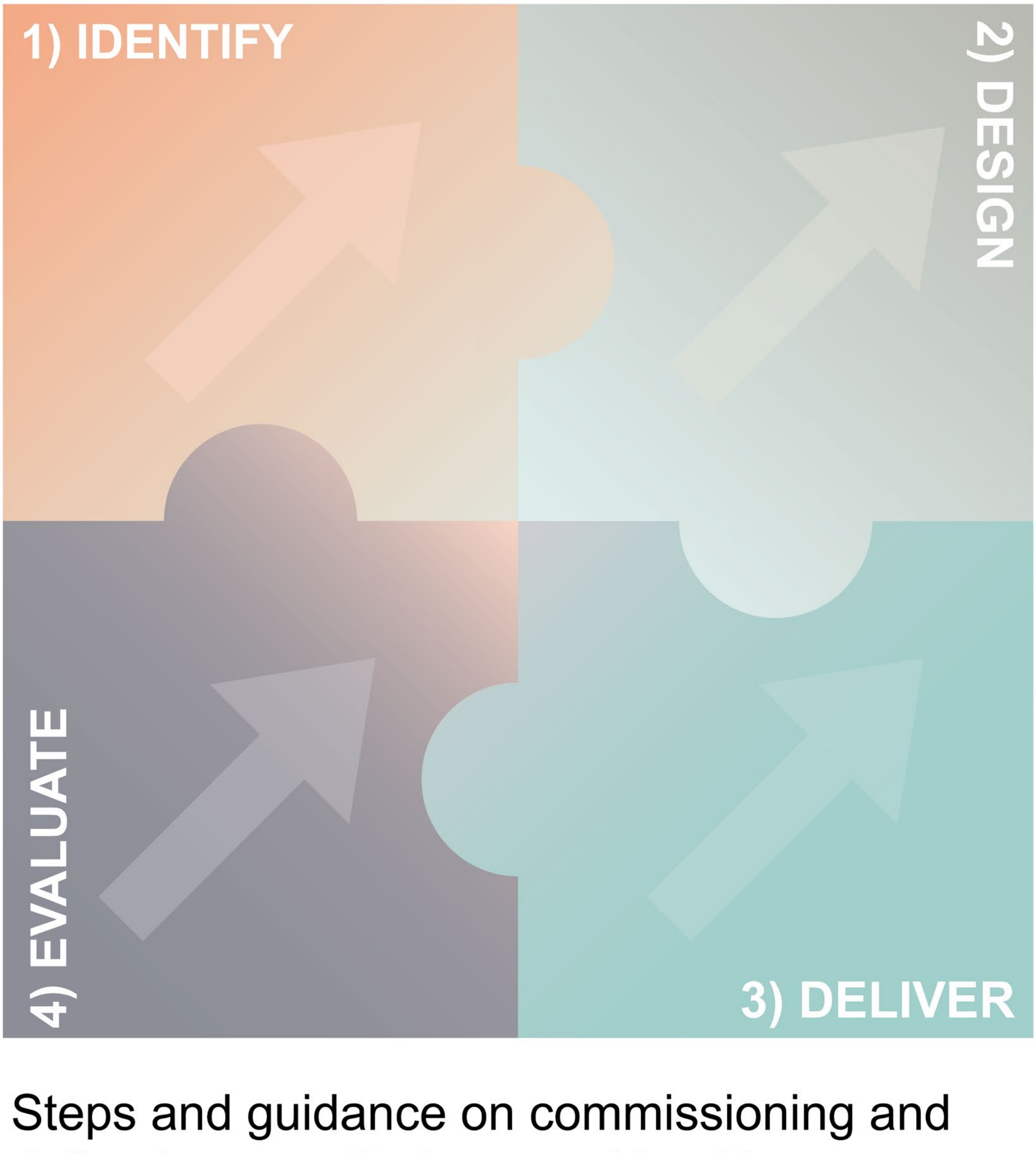
Advancing Mental Health Equality



Steps and guidance on commissioning and delivering equality in mental health care

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

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Vision for the Advancing Mental Health Equality resource

Identifying and reducing health inequalities in access, experience and outcomes is essential to the delivery of high quality mental health care.

The aim of the AMHE resource is to ensure that all mental health care, and mental health promotion, is responsive to the strengths and needs of each individual and community's identity and culture.

Not only are there moral, legal and economic imperatives for advancing equality, but learning and collaborating with all sections of society provides a valuable opportunity to innovate and enhance the way we provide care.

Simply put, **there is no quality without equality.**

Contents

Introduction

Inequality exists across all aspects of society, particularly in health. The extent of health inequalities in England is well-reported, but was brought to light most notably in 2010 with the publication of The Marmot Review report: Fair Society, Healthy Lives[1] which explicitly described the social gradient in health and the relationships between social status, economic position and health inequalities. The Marmot Review called for action from the central and local government, the NHS and the private sector to reduce health inequalities. Inequalities in mental health care are no exception. Mental health inequalities are varied and pervasive, affecting the access, treatment and outcomes that people can expect to receive.

This Advancing Mental Health Equality (AMHE) resource was developed to support commissioners and service providers to tackle inequalities in mental health care and to ensure that support, care and treatment is:

- high quality
- appropriate to meet needs
- accessible and serves people, regardless of any structural, societal or cultural barriers, or protected (or other) characteristics
- supportive, compassionate and fair
- effective, leading to the best possible outcomes.

Despite previous efforts, evidence suggests that some groups of people continue to experience inequalities when it comes to access, experience and outcomes. This resource draws on numerous studies of the potential factors contributing to and perpetuating inequalities in mental health, as well as the large body of research, policy development and guidance aimed at reducing inequalities in mental health care and tackling stigma and social attitudes. While prevention forms a key part of any discussion about inequalities, primary prevention at a public health level falls outside the scope of this document. Nevertheless, this resource draws upon relevant discussions and ongoing work to ensure that there is a consistent message around prevention of poor mental health and its relevance to equality.

Box 1: Policy Objectives of The Marmot Review (2010)

Reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Source: Fair Society, Healthy Lives (2010)

Access

- Certain groups of people are less able to access the care they need, which means they may not receive appropriate help, may receive help too late, or via a less-therapeutic or non-ideal route.
- Although sometimes referred to as 'hard to reach' groups, more often than not, these people are simply not adequately enabled or supported to access appropriate care.

Experience

- People's experiences of care, including the types of care and treatment they receive, differ in quality according to various factors.
- A person's experience of care and treatment can be affected by the timing of services getting involved in their lives.
- People with specific characteristics are predisposed by service and commissioning design or culture, as well as wider societal barriers, to have a poorer experience of care.

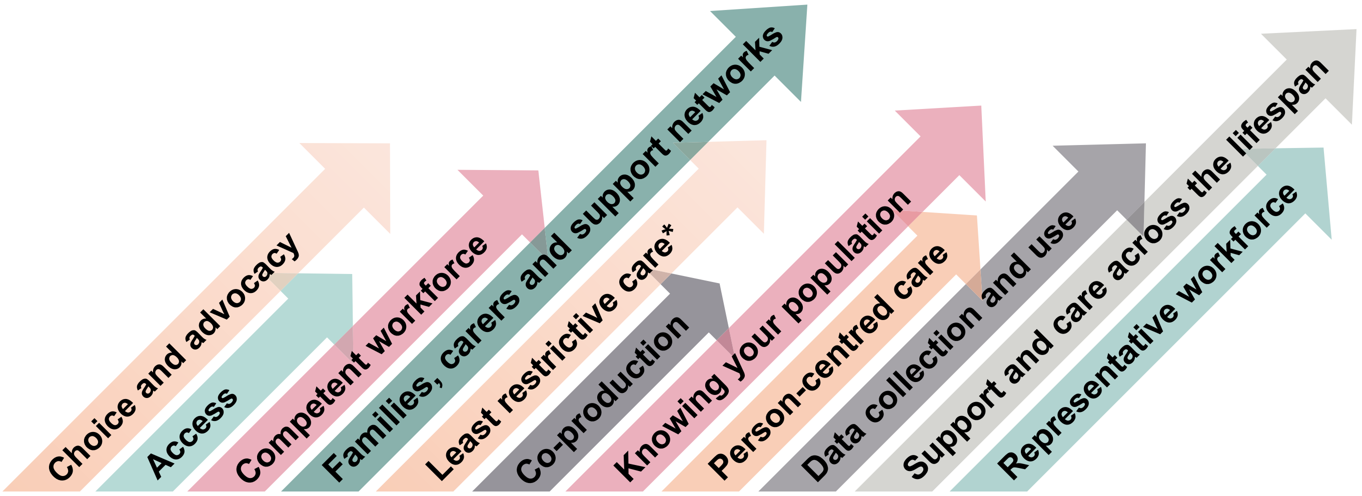
Outcomes

- It is important to note that both access to care and experiences of care influence a person's outcomes and likelihood of recovery.
- People who have difficulty accessing help, and who experience differential treatment, can have worse outcomes than people who do not experience such difficulties.

This AMHE resource is designed to be used alongside the Framework for Community Mental Health Care in Adults and Older Adults (forthcoming) and Working Well Together: Evidence and tools to enable co-production in mental health commissioning.[2]

The AMHE resource outlines comprehensive and practical steps for commissioners and service providers to reduce inequalities in an achievable and measurable way. It provides detailed guidance and methods on how to identify and reduce inequalities related to mental health support, care and treatment. It will also support commissioners and service providers to evaluate and review their services, to measure the impact of changes and to identify areas for improvement.

> *Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially Black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.*
>
> The 5YFVMH



AMHE KEY PRINCIPLES

These key principles were co-developed with people with lived experience, mental health professionals, commissioners and service providers through focus groups, workshops and consultations. They are **specific to advancing equality in mental health care** and apply to all organisations, health and social care settings, services, and those commissioning them.

Choice and advocacy: People who use services, their families, carers and support networks (as appropriate) are actively and continually involved in decisions about their care and treatment and are provided with adequate support to communicate and make decisions. Commissioners and service providers resource local voluntary, community and social enterprise (VCSE) organisations to carry out advocacy as an integral part of the service delivery package.

Access: All individuals in a community, including those from diverse population groups, have equal access to mental health assessment, support, care and treatment that meets their needs. Commissioners and service providers ensure that potential barriers to access for people who may be at risk of experiencing mental health inequalities are understood and actively minimised through flexible and responsive services.

Competent workforce: Staff working in mental health services are equipped with appropriate skills and training to minimise inequalities, and possess the competences to deliver fair, non-judgemental and least restrictive care.

Families, carers and support networks: Services include families, carers and support networks (as appropriate) in a person’s care. Services recognise that some families and carers may experience difficulties accessing care and support for themselves and, as such, procedures are in place to identify and address their needs, regardless of whether their needs are related to their caring role.

Least restrictive care:* Service providers work to ensure that restrictive practices are only used when absolutely essential for the safety and protection of the person or others. Services actively address any potential inequalities associated with the use of restriction. All people are able to access appropriate, timely support to reduce the potential need for restrictive care.

Co-production: Co-production with people with lived experience is an essential and ongoing part of the commissioning, service development and service evaluation process; it is essential to advancing equality at every stage.

Knowing your population: The development and delivery of mental health care actively reduces inequalities by understanding the local population, its demographics, care needs and any gaps in service provision.

Person-centred care: Care is focused on the strengths and needs of the individual. Support, care and treatment are flexible enough to meet the varied needs of different groups and populations, including intersecting factors, to reduce the risk of unequal treatment.

Data-collection and use: Quality data is regularly collected and used to identify and minimise inequalities in access, service provision, treatment experience and outcomes. Data is used to understand issues relevant to people with intersecting characteristics that may perpetuate inequalities.

Support and care across the lifespan: Services are age– and developmentally appropriate to meet changing needs throughout a person’s life and reduce the risk of age-related inequalities.

Representative workforce: The workforce is representative of the local population. Commissioners and service providers understand inequalities in access to job roles across all levels of the organisation, and actively provide support and opportunities for underrepresented groups.

* Definitions of restrictive practice as defined by the NCCMH Improving Mental Health Safety Programme are outlined in Appendix 9

Background

Everyone has the right to be treated with respect and dignity, without discrimination, and to access appropriate mental health and social care when it is needed. However, inequalities in mental health support, care and treatment are evident in the health and social care system. This is particularly the case for people who possess one or more protected characteristic under the Equality Act 2010, or other specific characteristics (see **Box 2**), as well as for people who experience inequalities resulting from the relationship between multiple protected (and other) characteristics (intersectionality). High levels of inequality in access to, and experience of, mental health care are evident for a number of population groups,[3] particularly: Black, Asian and Minority Ethnic (BAME) communities; children and young people; homeless people; lesbian, gay, bisexual, transgender and/or queer/questioning 'plus' (LGBTQ+)[4] people; and people living with physical or learning disabilities.[4]

> *Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things.*
>
> Kimberlé Crenshaw,
> Columbia Law School interview, 2017

Improving access to NICE-recommended interventions is a central theme of the NHS Five Year Forward View for Mental Health (5YFVMH)[5] and, more recently, in the NHS Long Term Plan.[6] The 5YFVMH makes specific recommendations for reducing the inequalities that some communities, such as children, experience in accessing interventions, but its focus is relatively narrow.[5] The NHS Long Term Plan goes a step further with commitments to tackle inequalities in several areas of health care across different populations, including for people who are homeless, those with severe mental health problems and people with learning disabilities. But truly tackling the profound inequalities apparent in mental health care requires an approach that advances equality across all aspects of mental health care policy, development and delivery.

Helpful resources

Modernising the Mental Health Act. Increasing choice, reducing compulsion. Final Report of the Independent Review of the Mental Health Act 1983 (2018).

Independent Review of the Mental Health Act 1983: supporting documents (2019).

Box 2: Some characteristics that may increase the risk of experiencing inequalities

The 9 protected characteristics (Equality Act 2010)

1. age;
2. disability;
3. gender reassignment;
4. marriage and civil partnership;
5. pregnancy and maternity;
6. race;
7. religion or belief;
8. sex;
9. sexual orientation.

Other characteristics

- socioeconomic status, which includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural)
- refugees and asylum seekers
- migrant
- looked-after children
- homeless people
- prisoners and young offenders
- traveller communities
- veterans

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[a] In LGBTQ+, the 'plus' refers to all identities including, but not limited to, asexual, pansexual, intersex and nonbinary.

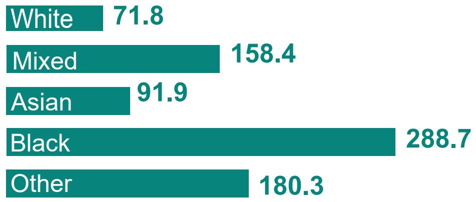
Facts and figures

Ethnic minorities are at an increased risk of involuntary detention under the Mental Health Act *(CQC, 2018)*

In England during 2017/18, amongst the five broad ethnic groups, rates of detention for the **Black or Black British Group** were over **four times** those of the **White group**

A more detailed breakdown shows that per 100,000 population, the **Black Other group have the highest rate of detention** (745.9 detentions) – **over ten times the rate for the White British group** (69.0 detentions). The '**Any Other Ethnic group**' had the **second highest rate** of detention (432.9 detentions) *(NHS digital 2018)*

Number of detentions under the Mental Health Act per 100,000 population



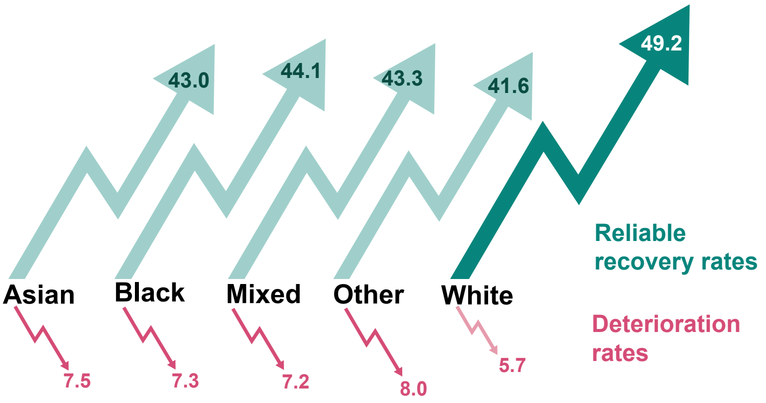
Ethnicity – broad category data. Mental Health Services Data Set, NHS Digital 2017/18

A systematic review and meta-analysis of **UK** and **international literature** found that **all minority populations in the countries studied**, **including migrants**, were **at increased risk of involuntary detention** *(Barnett et al, 2019)*

Recovery rates following psychological therapies are higher among white ethnicities compared to all other ethnicities

Deterioration rates are greater in non-white ethnicities compared to white ethnicities

(IAPT Data Set, NHS Digital, 2017/18)



People who are transgender can experience very specific stigma when it comes to accessing mental health care and support

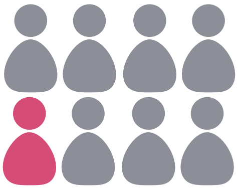
There are higher rates of suicide in the LGBTQ+ population

Nearly **half** of **transgender people** under the age of 26 report that they have **attempted suicide** *(The RaRE Research Report, 2015)*

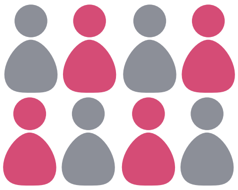
Among LGBTQ+ young people, **7 out of 10 girls** and **6 out of 10 boys** described having **suicidal thoughts** *(Statham et al., 2012)*

Bisexual people are consistently reported to suffer poorer mental health than any other sexual orientation group *(Taylor, 2017)*

One in eight 5 to 19 year olds had at least one mental health problem
(NHS digital, 2018)



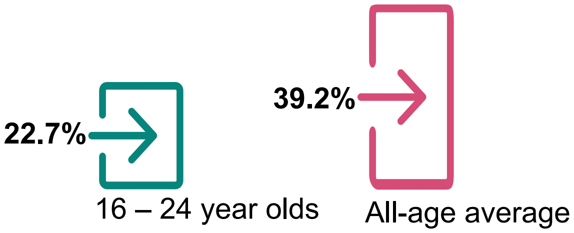
Almost half of all looked-after children and young people meet the criteria for a mental disorder *(Ford et al, 2007; Meltzer et al, 2003)*



Up to 75% of mental health problems emerge before the age of 25 *(Kessler et al, 2005)*, however, many young people struggle to access appropriate mental health care or fail to make the transition from children's to adult's services

People with symptoms of common mental health problems accessing any form of treatment

(NHS Digital, 2014)



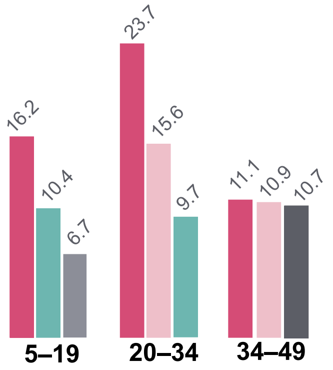
A study of the transition from children's to adult's mental health services in the UK found that **less than 4%** of those accepted by adult services experienced optimal transition *(Singh et al, 2010)*

Suicide is the leading cause of death in males between the age of 5 and 49

Proportion of deaths in England and Wales 2017

- 🟥 Suicide and injury/poisoning of undetermined intent
- ▨ Accidental poisoning
- 🟩 Land transport accidents
- ■ Ischaemic heart diseases
- ▨ Homicide and probable homicide

(Office of National Statistics, 2018)

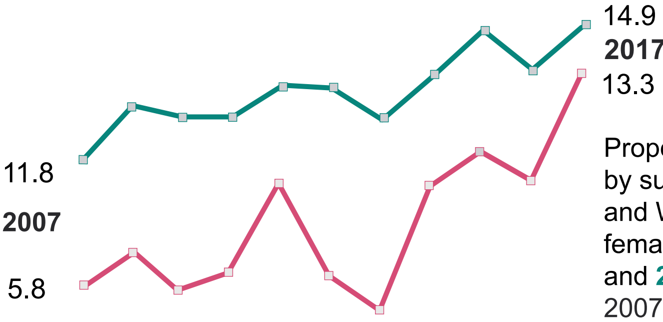


Women are more likely than men to experience mental ill health, and mental ill health among women is on the rise.

One in five women (19%) experience a common mental disorder (such as anxiety or depression), compared with one in eight (12%) men. *(Adult Psychiatric Morbidity Survey, 2014)*

Suicide is the leading cause of death in females between the ages of 5 and 34

There has been a notable increase in the proportion of deaths by suicide in females aged 5 to 19



Proportion of deaths by suicide in England and Wales for females aged 5 to 19 and 20 to 34 between 2007 and 2017

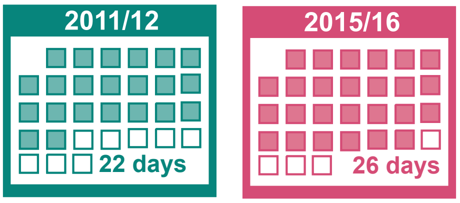
(Office of National Statistics, 2018)

Older adults may face more difficulties due to the myth that depression is a normal part of aging

(NHS England 5YFVMH, 2015)

Waiting times in old age psychiatry increased from an average of 22 days in 2011/12 to 26 days in 2015/16

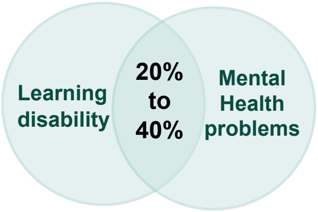
(Age UK FOI request)



Average number of days waiting

People with learning disabilities can be more likely to experience poor mental health compared with the general population

People with a learning disability can also encounter increased barriers to accessing mental health care

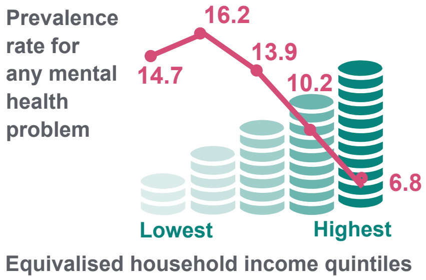


Studies screening for psychiatric symptoms estimate that between **20% and 40%** of people with learning disabilities also have a mental health problem

(Taylor et al, 2004)

People in lower income households are more likely to have unmet mental health treatment requests compared with high income households

For example, children and young people living in the households with the lowest level of equivalised income were more than twice as likely to have a mental health problem than those in the highest *(NHS digital, 2018)*



50% of people sleeping rough in London in 2017/18 reported a mental health support need

(CHAIN Annual report, 2018)

Every second person sleeping rough in London has a mental health need

The case for change

The economic case

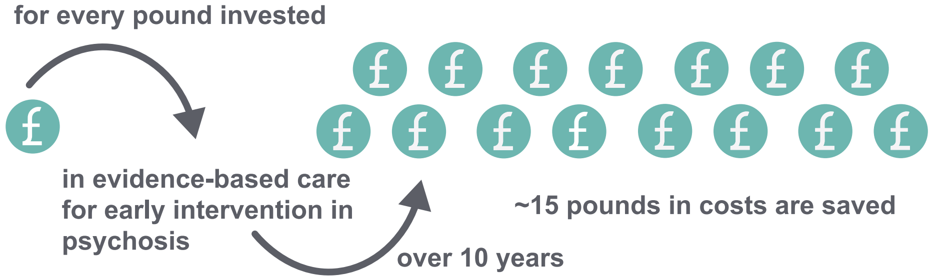
Improving mental wellbeing has the potential to benefit the economy

(Knapp et al, 2011; Knapp and Parsonage, 2017)

Prevention and early intervention can improve clinical outcomes, avoiding or reducing mental health care costs and enhancing an individual's ability to contribute to the economy by means of employment.

> *Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.*
>
> *Source: Fair Society, Healthy Lives: The Marmot Review (2010)*

The Centre for Mental Health and the London School of Economics demonstrated that



for every pound invested

in evidence-based care for early intervention in psychosis

over 10 years

~15 pounds in costs are saved

Similar savings are shown for other conditions such as conduct disorder

(Knapp et al, 2011)

Improving an individual's mental health can also indirectly improve their physical health, further reducing costs for the healthcare system.

Additional healthcare costs associated with inequalities £5.5 *billion*

(Marmot, 2010)

Beyond the healthcare sector, the annual cost of health inequalities is estimated to be:

£31-33 *billion* **in lost productivity**

and a further

£20-32 *billion* **in welfare costs and lost taxes**

The legal case

NHS commissioners are bound by the Health and Social Care Act (2012) to reduce health inequalities in access, experience and outcomes

Other relevant legislation includes:

Equality Act (2010)
Human Rights Act (1998, revised version)
Health and Social Care Act (2012)
Mental Health Act (1983, amended 2007)
Mental Capacity Act (2005), including Deprivation of Liberty Safeguards

A fuller summary of the most relevant legislation can be found in appendices

The moral case

Those with serious mental health illness have a reduced life expectancy of approximately 10–20 years compared with those without a mental health problem

(Chesney et al, 2014)

This statistic suggests that having a mental health problem in itself leads to unequal health care, which can include a lack of support to access care for physical health concerns

This clear inequity establishes a moral imperative and call to action

Time for action

The Equality and Human Rights Commission have recently called for the Public Sector Equality Duty (Equality Act, 2010) to be strengthened and for public bodies to take firm action to address challenges in achieving equality

Lessons from developing other frameworks and guidance

Table 1 summarises the most frequently reported anecdotal inequality issues raised by a range of clinical, commissioning and people with lived experience advisers to the NCCMH across the development of several pathways, frameworks and guidance.

Table 1: Most frequently reported mental health inequalities

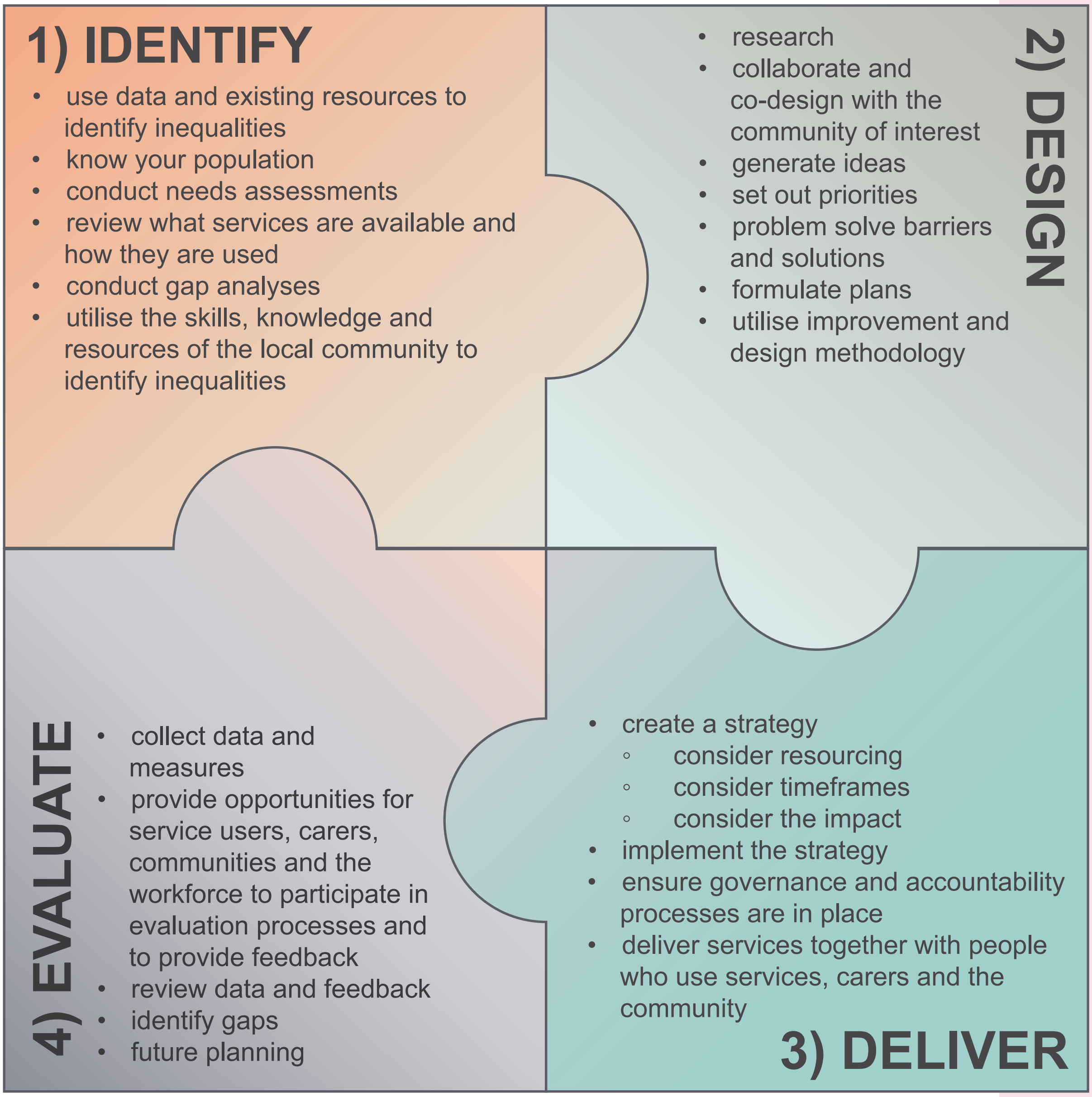
Access	
People from BAME communities	• Some BAME groups are more likely to access acute care through a criminal justice route than through the healthcare system. • Some people from BAME groups mistrust services based on previous negative experiences.
Children and young people	• Difficulty accessing appropriate out-of-hours crisis services results in reliance on A&E. • Lack of adequate mental health support in schools.
Older people	• Lack of awareness of mental health problems and how to access mental health support.
People who are homeless or sleeping rough	• A person with housing difficulties may have difficulty registering with a GP because of having no fixed abode, and will therefore struggle to access help through primary care.
People with learning disabilities	• Diagnostic overshadowing: mental health concerns can be wrongly perceived as being part of another condition, leading to difficulties accessing the right help.
Gypsy and traveller communities	• People from these communities can have similar difficulties as those who are homeless, in that their living status makes it more difficult to access primary care.
Experience	
People from BAME communities	• Cultural competence: services do not always consider cultural differences, religious beliefs and social stigma as part of mental health support. • Increased use of the Mental Health Act 1983 (amended 2007)[7] compared with white British people.
Women in need of support for perinatal mental health	• Services are few and far between; where services are available, they are not always culturally appropriate or able to meet the diverse needs of different racial and ethnic groups.
People with a diagnosis of emotionally unstable personality disorder	• Often labelled as ‘attention-seeking’ or ‘manipulative’. • Exclusion from services for repeated presentations and various other reasons.
LGBTQ+ communities	• Stigma due to a lack of understanding of LGBTQ+ • For transgender people, issues surrounding gendered wards can lead to poor experiences of care.
Older people	• Age-appropriateness: all-age services are not always best able to meet the specific mental health needs of older people.
Outcomes	
Middle-aged males	• Suicide rates: increased risk of suicide in middle-aged males due to men being less likely to seek help for a mental health problem compared with females.
People with co-occurring physical health concerns	• Diagnostic overshadowing: mental health problems are more likely to be ignored in favour of treating the physical illness. Conversely, physical health problems may be overlooked because of mental health issues.

AMHE: Advancing Mental Health Equality

Guidance for commissioners and service providers

This section includes methods for advancing equality, including helpful step-by-step guidance to support appropriate and thoughtful commissioning and service provision. While specific to mental health support, care and treatment, the principles and methods in this resource should be generalisable to other services, settings and populations as well.

Figure 1: The 4-step process for recognising, identifying and addressing inequalities and advancing equality



1) IDENTIFY

- use data and existing resources to identify inequalities
- know your population
- conduct needs assessments
- review what services are available and how they are used
- conduct gap analyses
- utilise the skills, knowledge and resources of the local community to identify inequalities

2) DESIGN

- research
- collaborate and co-design with the community of interest
- generate ideas
- set out priorities
- problem solve barriers and solutions
- formulate plans
- utilise improvement and design methodology

3) DELIVER

- create a strategy
  - consider resourcing
  - consider timeframes
  - consider the impact
- implement the strategy
- ensure governance and accountability processes are in place
- deliver services together with people who use services, carers and the community

4) EVALUATE

- collect data and measures
- provide opportunities for service users, carers, communities and the workforce to participate in evaluation processes and to provide feedback
- review data and feedback
- identify gaps
- future planning

1. IDENTIFY: Understanding inequalities

STEP 1A:[b] Use existing data and resources

The use of data is pivotal for identifying inequality issues. By asking the questions in **Box 3**, commissioners and service providers should be able to identify where action is needed. Even where data are insufficient to identify all inequalities, the available research and evidence can suggest what is likely to be needed based on the demographics of the local population. Also, identifying inadequate data should be a trigger for prioritising this area for data improvement (**STEP 4A** provides guidance on collecting data for evaluating and improving services).

Co-production Top Tip

People with lived experience can help to identify gaps in data collection processes and make informed suggestions for updating indicators. Meaningfully include and involve people with lived experience in decisions about changes to data collection processes. This could involve inviting people with lived experience to data improvement meetings in the same way that clinicians and health professionals might be consulted.

Box 3: Questions for identifying mental health inequalities.

These questions are expanded upon in the sections below.

Commissioners and mental health service providers should be able to answer the following questions:

1. Who are our local population? What are the mental health needs in this population?
2. What mental health services are available? What services are we missing?
3. Who is and who is not accessing mental health services?
4. What kinds of treatment are people receiving?
5. What kinds of experiences are people having?
6. What do the outcomes of mental health care look like for our population?

For all questions above, can we break down the answers according to protected (and other) characteristics to help us gain a better understanding?

Additional questions commissioners and providers may want to ask:

- How do our mental health and social care services work together?
- How do our mental health services work with other public services (schools, universities, police and criminal justice system, young offender institutions etc.)?
- Are there delays in accessing services and in receiving care and treatment?

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[b] Although they are presented sequentially, Steps 1A and 1B of this resource need not occur in this order. In some circumstances, it may be more appropriate to reach out to communities first or to carry out data scrutiny and community working concurrently. Both steps are equally important in the identification of inequality issues and should be carried out as integral parts of the process to advance equality.

One vital resource for identifying inequalities is the Statutory Guidance on Joint Strategic Needs Assessment [JSNA] and Joint Health and Wellbeing Strategies.[7] This process is used by local authorities and clinical commissioning groups to assess the health needs of the local population and inform local decision-making. JSNAs provide information and describe trends on the health and wellbeing of the local population, inequalities that exist and the views of local communities. Existing NHS data can also be used to identify needs and plan for improvement. The 2015 Open Public Services Network report from the Royal Society for the encouragement of Arts, Manufactures and Commerce (RSA) specifically explores how this data can be used to identify inequalities in mental health care.[8]

Positive Practice Example

Steps2Change

Steps2Change is proactive about identifying and tackling inequalities in service access; they routinely monitor access for underserved patient groups and subsequently target engagement and communication activities to these groups.

Box 4: Joint Strategic Needs Assessment (JSNA)

The JSNA was introduced by the Department of Health in 2008 to strengthen joint working between the NHS and local authority services.

JSNAs help local authorities and Clinical Commissioning Groups (CCGs) assess the current and future health and wellbeing needs of the local population to inform decision making at a local level.

The JSNA should:

- characterise the health and wellbeing status of the local community
- identify inequalities
- describe the views of the local community
- highlight key findings about local population needs identified

Who are our local population? What are the mental health needs in this population?

Understanding the needs of the population, and gaps in service provision, relies on population data. Demographic data are readily available from several sources, as shown in **Box 2**. Since inequalities vary across England, it is important to break down the data by locality where possible. This is not without challenges, as noted in the table. Breakdowns of ethnicity data can be particularly challenging given the different ways in which information is categorised across different bodies and organisations. It is important to understand the mental health support needs and experiences of the different communities making up these categories. It may be necessary to collate data from a variety of sources to understand where a specific locality sits within a wider population, which may require deeper scrutiny of existing data sources and additional research on intersecting characteristics of the local population.

Table 2: Data sources for understanding the local population

Data source and URL	What does this source do? What can it tell you?	What does it not do? Limitations?
Population data sources		

General
Office for National Statistics (ONS)
	- Independent official UK population statistics
	- Population can be filtered by:
	  ◦ sex
	  ◦ age
	  ◦ local authority
	  ◦ constituent county
	- Employment and unemployment rates
	- Health and wellbeing data, including analyses of social and economic data
	- Expenditure on private and public health care in the UK
	- Data on the mental health of children, adolescents and adults, including registered suicides by age and sex
		- While data can be filtered by local authority, this may not necessarily map onto the CCG locality, requiring extra scrutiny of the data to gain an accurate representation of an area

Sexual orientation, UK: 2017 Office for National Statistics (ONS)	- Lesbian, gay or bisexual population in the UK by sex - Lesbian, gay or bisexual population in the UK by age - Lesbian, gay or bisexual population by ethnicity - English regions by lesbian, gay or bisexual population	- Regional data are not at a level of granularity that allows for data scrutiny at a local level
2011 Census Office for National Statistics (ONS)	- Breakdown of the 'out of term' population by age, sex and location - Small area population estimates in England and Wales - Population estimates by marital status and living arrangements - Census microdata allows for some comparison of characteristics	- Key population statistics for England and Wales are broken down by local authority only
English Indices of Deprivation 2015	- Measures of deprivation in small areas or neighbourhoods	- Most of the indicators for this data were last updated in 2012/13

Data source and URL	What does this source do? What can it tell you?	What does it not do? Limitations?
Health and care statistics landscape for England	• Links to numerous key official health and social care statistics • Can be filtered by 'theme' and 'geography' in order to locate data	• The purpose of the tool is not to provide the data itself but to provide links to health and care data across a range of areas
NHS Digital Mental Health Data Hub	• Interactive dashboards and useful links on mental health data in England including: ◦ Mental Health Act statistics ◦ mental health services data quality ◦ mental health bulletin annual statistics ◦ data on psychological and talking therapies	• The purpose of the tool is not to provide the data itself but to provide links to, and information about, existing NHS mental health data
NHS current official statistics publications	• Useful publications for understanding statistics associated with different health needs and the performance of a range of health services, including: ◦ patient-reported outcome measures (PROMs) ◦ mental health community teams' activity ◦ hospital activity ◦ NHS staff survey	• The purpose of the tool is not to provide the data itself but to provide access to current and official statistics publications that can be used to gather a wide range of health and care information about a local area
NHS Digital general practice data hub	• Provides information about the prevalence of certain conditions by area (via the Quality Outcomes Framework (QOF)); this data can be broken down by year, region, sub-region and CCG	• Does not break down information by patient age, gender or sub-type of condition/disease
Targeted analyses of local population health needs		
Sustainability and transformation partnerships (STPs)	• Place-based systems of care for the future of health and care services in an area over 5 years from 2015 • A plan for health care within a geographical 'footprint' which covered between 300,000 and 2.8 million people, led by a named individual • STPs include three main healthcare issues to tackle for an area: improving quality and developing new models of care; improving health and wellbeing; improving efficiency of services • All plans are publicly available for each 'footprint' and provide a useful overview of information on its demographics, wellbeing statistics, prevalence of long-term conditions and information on the mental health of the local population • Shared proposals between NHS organisations and local councils • Local population needs (e.g. the needs for children and young people within a local area)	• STPs cover all of health and integrate social care, so they do not focus specifically on the mental health of the local population • Data provided in plans is not very granular but provides an overall picture of health for an area, coupled with priorities for improvement and change

Data source and URL	What does this source do? What can it tell you?	What does it not do? Limitations?
JSNA	The Better Mental Health: JSNA Toolkit helps commissioners and service providers understand needs within the local population, with specific guidance on the following: • Understanding place, including: ◦ housing and homelessness ◦ employment and working conditions ◦ community wellbeing and social capital • Understanding people, including: ◦ population size, characteristics and demographics including vulnerable groups ◦ equity of access (with a focus on ethnicity) ◦ comorbidity in mental health and physical illness ◦ suicide and self-harm • Perinatal mental health • Children and Young People, including: ◦ planning quality mental health and care services ◦ transition to adult services • Working age adults, including ◦ common mental health problems ◦ severe mental illness ◦ integrating physical and mental health • Living well in older years	• Completed JSNAs will provide valuable information. However, not all needs may have been assessed
ONS Measures of National Well-being Dashboard	• Local authority wellbeing indicators include measures of personal wellbeing (happiness, life satisfaction, purpose/meaning and anxiety) and health measures (including estimated prevalence of mental health disorders)	• The four measures of personal wellbeing are somewhat simplistic, and the questions used to generate wellbeing can be seen as ambiguous • Only wider wellbeing indicators are published – rather than locally collected indictors – giving only a broad picture across the UK

Data source and URL	What does this source do? What can it tell you?	What does it not do? Limitations?
Public Health England's (PHE) Fingertips tools	- A range of data profiles concerning a huge variety of health conditions (including a Mental Health, Dementia and Neurology profile) - Information and intelligence that can support commissioning, planning and provision of local services by bringing together a wide range of publicly available information about the local area - The Mental Health, Dementia and Neurology profile includes several data tools (see Box 5) - Data can be broken down by area type, area and region and services can easily compare themselves to others - Incidence and prevalence data are available including treatment rates, waiting times, hospital visits, admissions data, rates of self-harm, alcohol use etc. - Summary data reports are produced quarterly and annually by NHS Digital	- There is so much data contained in the Fingertips profile that it is time consuming to navigate (however, helpful User Guides are easily available)
NHS England RightCare Intelligence products (see Box 6)	- Equality and Health Inequality data packs: each pack is tailored to a local health system to support in-depth analysis of inequality issues - Each pack contains executive statistical summary slides and a section on unplanned hospital admissions, showing the CCG Improvement and Assessment Framework (IAF) health inequalities indicator and the Absolute Gradient of Inequality (AGI) for unplanned hospital admissions; comparisons of this indicator with English CCGs and demographically similar CCGs - Other data packs include Mental Health Conditions packs and Long Term Conditions packs - Packs are based on 2016/17 data; there are 207 packs split into the four regions for England (North, South, Midlands and East, London). There is a specific pack for each NHS CCG	- Mental health is not the sole focus of the Equality and Health Inequality data packs and most of the mental health data are focused on Improving Access to Psychological Therapies (IAPT) care, broken down by sex, age and ethnicity - There are unique data limitations for some CCGs, including limitations with regard to constructing accurate rates for ethnic groups (some are based on population estimates only)

It is important to note that people who are socially excluded (for example, people who are homeless) are not always labelled in the data and may be 'hidden' or underrepresented. Developing an accurate picture of the population may rely on triangulation of data or other statistical methods. To ensure a robust interpretation of the data, assistance from clinical academics or local university departments (as well as people with lived experience and VCSE organisations) should be considered – but this would need to occur within data sharing, safeguarding and confidentiality protocols. The data collected should also be shared locally between services in the interests of transparency and joined-up working.

Helpful resources

MindWell Leeds – funded by NHS Leeds CCG, MindWell collates information from the NHS, Leeds City Council and the VCSE sector into a single online resource where people can quickly and easily find information about available support services, help for what to do in a crisis and support for practical issues such as housing and debt concerns.

Box 5: PHE Mental Health Fingertips Profiles

The following profiling tools provide information and intelligence to support mental health commissioning, planning and local service provision. They bring together a wide range of publicly available information, providing a broad picture of mental health as well as focusing on specific topic areas. The tools enable and advocate benchmarking against peers with the aim of supporting improvement, not judgement.

Mental health and wellbeing JSNA Toolkit

Perinatal mental health

Children and young people's mental health and wellbeing

Common mental health disorders

Co-occurring substance misuse and mental health issues

Mental health crisis care

Severe mental illness

Suicide prevention

What mental health services are available? What services are we missing?

What services are available?

Commissioners and providers should give specific thought to VCSE services available in their communities, as well as statutory services, to paint an accurate picture and identify areas in need of improvement. This can be achieved by creating and regularly updating a 'community assets map' (see **Box 7**). This is a local directory or database of both statutory and non-statutory services in an area. The F*ramework for Community Mental Health Support, Care and Treatment for Adults and Older Adults* (forthcoming) provides more detail on community assets mapping.

Helpful resources

Mental Health data and analysis: a guide for health professionals

Guidance for commissioners and health professionals to make decisions about mental health services and interventions based on data and analysis.

Public Health England (2017)

Additionally, it may be useful for commissioners to perform regular audits of existing VCSE organisations to identify the types of services and activities offered. This audit should also identify organisations that have closed as this may flag a gap in provision. Including the local community and people with lived experience in the audit can also provide valuable information about local need.

What other mental health services are needed?

Community asset maps (or directories) should be cross-referenced with local population and demographic data to ascertain whether provision is sufficient to meet local needs. This is where regular audits identifying existing services and closures could be beneficial for planning and setting out priorities.

Are services working together?

Joined-up and inter-agency working is better able to support people in need of care, and is one of the key drivers behind the development of NHS STPs and integrated care systems (ICSs). Lack of appropriate joined-up working can perpetuate inequalities when people 'fall through the gaps' in care. Recognition of where such gaps exist is helpful for prioritising change and reform in order to advance equality.

Box 6: NHS RightCare Intelligence Products

The NHS RightCare products are a valuable resource for commissioners. As well as general health care data, they can provide specific resource packs on mental health by CCG.

Equality and Health Inequality RightCare packs provide useful case studies to support commissioners in tackling inequalities

Box 7: Community assets maps

These databases list the available resources and assets in local or wider communities – these could be focused on health and wellbeing, or on more general activities. Community assets maps are typically hosted online, can be easily maintained and kept up-to-date, and can be used by anyone in the community. Having an easily accessible list of resources allows people to see what can benefit their wellbeing and help them connect with groups in their local community.

Box 8: Excerpt from 'The Framework for Community Support, Care and Treatment for Adults and Older Adults'

Developing a place-based model of community mental health care

The Framework proposed here applies the collaborative model to the delivery of community mental health care. In this case, providers include VCSE organisations, the local authority and other providers of social care, as well as statutory primary and secondary healthcare providers.

Who is and who is not accessing mental health services?

To identify inequalities in access, local population data (including demographics) should be cross-referenced with data on service usage. **Table 3** provides a sample of resources that can be used for this purpose. This data should be broken down by demographics in order to understand how it relates to protected (and other) characteristics. There are challenges with this as some data sources record demographic information differently and routine reporting is not always consistent. However, this is continually improving and any issues with data collation and linkage should be recorded and flagged with the appropriate agency.

Table 3: Data sources on mental health service use

Service area	What data should be used?	Where can this data be accessed?
Mental health hospital admissions	• Mental Health Act Assessments • informal or voluntary admissions • formal admissions or admissions under a section of the Mental Health Act 1989 (revised 2007) • length of stay • method of admission	Mental Health Services Data Set (MHSDS)
GP contacts for mental health-related needs	• problem/complaint type • condition prevalence • practice-level prescribing data • quality outcomes framework (QOF)	NHS Digital general practice data hub
Referrals to mental health services	• method of referral, for example: • self-referral • via GP • via internal team • via A&E (e.g. liaison team) • via general hospital ward • type of service referred to, e.g. IAPT service • referrals to child and adolescent mental health services (CAMHS) • referrals to specialist older adults' services • outcomes of referrals • number of referrals • referral waiting list times	Mental Health Services Data Set (MHSDS) NHS Digital general practice data hub PHE Fingertips
Mental health presentations (including instances of self-harm) to A&E	• number of mental health presentations • type of mental health complaint • outcomes of presentations	Mental Health Services Data Set (MHSDS)
Presentations/contact with mental health crisis services	• number of contacts/presentations to crisis care • outcomes of contact/presentations	Mental Health Services Data Set (MHSDS)
IAPT (referrals and use)	• several indictors for IAPT treatment	PHE Fingertips

Box 9: Using the MHSDS to identify inequalities

The MHSDS (NHS Digital) is a large and flexible model of all NHS-funded mental health services in England. It provides the national picture as well as an opportunity to compare data across CCGs. It is particularly useful for outlining NHS mental health service use by local area. Because collected data is broken down by factors such as age, ethnicity, source of referral etc. it provides a timely picture of mental health service use by different groups of people. For these reasons, it is an invaluable resource for any commissioner or provider seeking data about their services and the people using them, and can help to identify local inequalities in need of attention.

- NHS Digital regularly publishes statistics relating to mental health, learning disabilities and autism services in England. This Mental Health Services Monthly Statistics summary can be used to aid operational decision making as it is derived from MHSDS data.
- The MHSDS Specifications and Guidance outlines the data that is submitted to the dataset. Some of the data indicators will be of particular interest to commissioners and providers in identifying inequalities; for example, data is now broken down to include all nine protected characteristics of the Equality Act, and has recently been linked with the Maternity Dataset to include information on pregnancy/maternity status.
- The MHSDS Monthly Data file (under the Resources section) breaks down data about mental health service use by CCG. It is also a useful source of raw information as it contains specific data on the number of people using services during the reporting period, broken down by age bracket (0–17, 18–64 and 65+ years).
- Providers and commissioners of mental health services can also retrieve Commissioner and Provider Extracts – processed data from the MHSDS covering their services and the people who use them (visit the NHS Digital website for more information).
- Monthly Access and Waiting Times data is also available via NHS Digital for people on the Early Intervention in Psychosis (EIP) pathway
- NHS Digital is constantly updating these resources to ensure that data is relevant and reflective of the current picture.

Limitations of the MHSDS

Whilst the MHSDS is a useful tool, it is not without limitations, and should be used in combination with other data sources including research and community intelligence. For example, there is no national data linkage for social care services and only inferences can be made about social care contact using referral source data. In addition, no prescribing data is collected, including data on social prescribing for mental health conditions. Quality of input is not yet optimal but is being continually improved and updated so that all data can be broken down by demographic information and protected characteristics.

Commissioners and providers should proactively report and share this information with data handlers, including any gaps identified. It is important to be transparent about information gaps to avoid misinterpreting the existing data, and to define a baseline from which progress can be made. Some excluded groups of people may not be accurately represented by the data collected by statutory bodies. This is where support and input from the VCSE sector can be particularly useful, especially if people are using VCSE services instead of NHS-provided care (**STEP 1B** provides more information on working with communities).

Box 10: Older People's Mental Health Data Catalogue (Public Health England)

Information on prevention, identification and treatment of depression in older people.

What kinds of support, care and treatment are people receiving?

It is important to understand not only the services that are available but the types of care that people receive (experiences of care are discussed in the next section). Linking availability data with information on service uptake can provide insight into the factors that could be contributing to inequalities.

For example, although overall operational data may indicate satisfactory waiting times for referral and treatment, this may hide inequalities if commissioners and services do not have a complete picture of who is getting this care. This is important when considering specific groups who are more likely to experience unique barriers to mental health care, such as children and young people, older adults, BAME communities or people with learning disabilities.

Useful data are available, especially at local or trust level, about which types of care people are receiving. The data sources in **Table 3** are also useful here, but should be collated with data on the use of community assets, including VCSE services.

Helpful resources

Health Survey for England (NHS Digital)

Reports changes in lifestyle and health of people in England and allows local authorities to compare local indicators with national figures.

What kinds of experiences are people having?

Understanding people's experiences is vital to addressing inequalities (working with communities to identify inequalities is discussed in **STEP 1B**). There are already several rich sources of information on people's experiences (such as the Friends and Family Test), collected using various patient-reported experience measures (PREMs). Data from experience measures should be incorporated into any research to identify inequalities. To understand the experiences people are having, it is equally, if not more important, to work with people and communities (see **STEP 1B**).

One of the key barriers to understanding different people's experiences can be lack of routine reporting on characteristics such as sexuality and gender identity, or differences in categorisation of demographic information. This should be considered when thinking about gaps in data and identifying the need for new or updated data indicators.

Helpful resources

A Whole Systems Approach to Tackling Inequalities for Lesbian, Gay, Bisexual and Trans (LGBT) People: A Toolkit

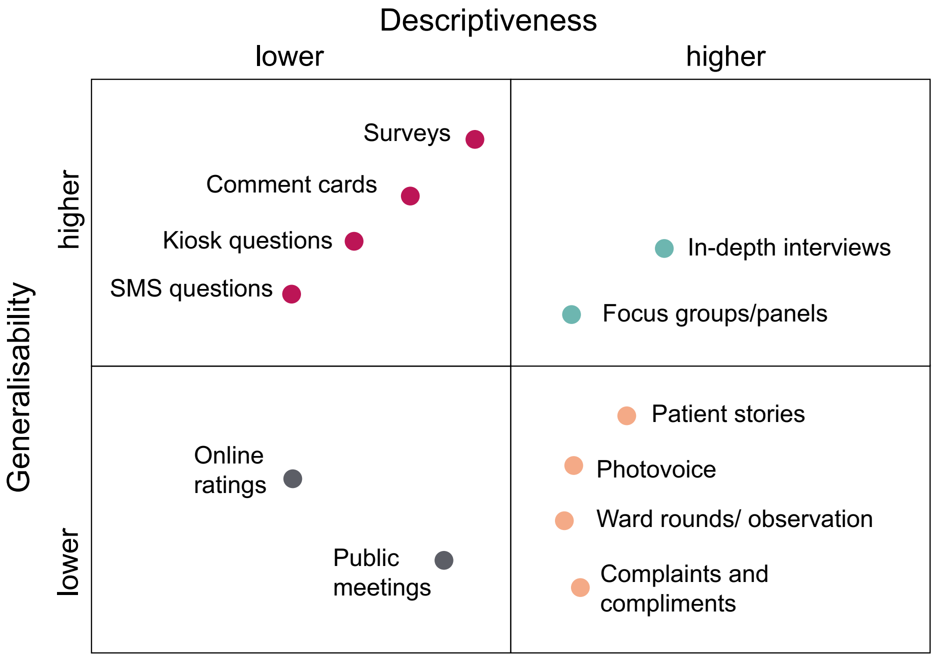
The National LGB&T Partnership (2018)

Helpful resources

Improving Access to Psychological Therapies (IAPT) Learning Disabilities Positive Practice Guide

The Mental Health Foundation (2015)

Figure 2: Methods for measuring patient and carer experiences of health services



Source: adapted from Measuring Patient Experience, The Health Foundation, 2013

What do the outcomes of mental health care look like for our population?

Commissioners and providers should review available outcome measures data from local mental health services to gain valuable insight into how the local population is responding to care in their area. Where data are not collected or gaps are present, outcome measures data collection should be prioritised.

The IAPT programme is an exemplar in its routine collection of outcome measures; data are broken down for different groups and demographics within the population (see the Improving Access to Psychological Therapies Manual for more information).

In addition to routine outcome measures data, other data can (directly or indirectly) point to the outcomes of mental health care; indicators could include relapse, re-admission and re-referral rates, suicide and self-harm statistics, and employment and education rates for people who use or who have used services.

Box 11: NHS Digital Data set 1H – Proportion of adults in contact with secondary mental health services living independently, with or without support.

This data set is part of Measures from the Adult Social Care Outcomes Framework, England – 2017-18

STEP 1B: Work with communities

To meaningfully advance equality, it is essential to work with communities to identify problems and inequalities, and ensure that services and solutions to problems are co-produced. Commissioners and providers should assign resources to building strong, ongoing relationships with the local community, with diverse, inclusive representation in mind. This is not always easy, and it takes time, but working closely with communities to identify problems is of great value and can improve the suitability of solutions.

Commissioners and service providers should be asking the same questions when working with communities (e.g. in focus groups, interviews or surveys), as they ask of the existing data and resources:

Helpful resources

People not process: Co-production in commissioning

Think Local Act Personal

Integrated commissioning for better outcomes: A commissioning framework 2018

Local Government Association (2018)

Box 12: Questions for identifying mental health inequalities

1. Who are our population? What are the mental health needs in this population?
2. What mental health services are available? What services are we missing?
3. Who is and who is not accessing mental health services?
4. What kinds of treatment are people receiving?
5. What do the outcomes of mental health care look like for our population?
6. What kinds of experiences are people having?

Communities are a valuable source of qualitative data – as important as the quantitative resources described in **STEP 1A**. Intelligence obtained through community engagement can be especially useful in identifying gaps in the data, providing information on experiences of care and pointing to those groups (such as people who are homeless, for example) that may be 'hidden' in the numbers. In other words, the voices of the community tell you what the data might not.

This section provides information on utilising the knowledge and experiences of the local community (including service users, their support networks, local professionals and VCSE providers) to identify mental health inequalities in need of attention.

How to work with communities to understand inequality issues

Working with communities provides an opportunity for a richer and deeper understanding of inequalities than numerical data and statistics alone. There are several ways in which communities can be meaningfully involved in identifying inequalities. A few are discussed in Table 4.

Table 4: Methods of working with communities to understand inequalities

Methods of working with communities to understand inequalities	
Run exploratory focus groups with stakeholders, people with lived experience and carers	• Explore issues around inequality and mental health by inviting people to talk about their experiences in a focus group setting • Seek support from local universities, academics or research groups skilled in delivering focus groups, transcribing and analysing data • Recruit people to focus groups through mental health services, the VCSE sector and local community groups, as appropriate
Distribute surveys	• Target local populations by distributing surveys in a variety of media: online, through VCSE services, education settings, health services and others that target mental health inequality issues • If designing a new survey, co-design it with appropriately skilled professionals and people with lived experience as far as possible. This is important to ensure that the language, terms and concepts are accessible to the local population and the sub-groups within it • Surveys should be culturally inclusive, employing the language around mental health and wellbeing that is used by diverse communities
Enable input from community groups	• Seek support from local community groups, VCSE services, schools and colleges, social care providers etc. • Community groups might be able to offer support with qualitative data collection methods • Co-develop local directories (e.g. community assets maps) to capture available services or gaps in the provision of local groups and networks
Enable input from other services that work with people who are at risk of experiencing mental health inequalities	• Seek input from other services (e.g. services supporting people with learning disabilities or people with experience of assertive outreach care) about the inequality issues they are aware of locally and ideas for solving them
Make involvement accessible, easy and fair	• Provide Easy Read, age-appropriate versions and language translations of surveys • Provide payment and cover expenses for people to attend meetings or interviews • Provide support with transport if people need to travel • Hold focus groups or interviews locally • Hold interviews over the phone • Provide access to online forums, online surveys and feedback opportunities • Target underserved populations who are not likely to engage or who may be 'hidden' in the data • Where necessary, use alternative means of communication including large text, braille or communication aids such as the Mental Health Pack.

Box 13: Excerpt from 'The Framework for Community Support, Care and Treatment for Adults and Older Adults'

Communities can be a positive influence on equality, but they can also perpetuate inequality by, for example, having restricted access to community assets and by not addressing stigma. Mental health services should adapt to the specific needs of the people living within their community in order to tackle inequalities. Regarding access, reasonable adjustments should be made for people who have disabilities or complex needs.

When working with communities, everyone, including community members, people with lived experience and VCSE sector workers should be valued and rewarded for their input.

See *Working Well Together: Evidence and tools to enable co-production in mental health commissioning*[2] for more detailed information on co-production in commissioning.

Co-production Top Tip

The environment for co-production should be safe and inclusive. It is important to consider how the environment may act as a barrier to contributions e.g. women may not feel comfortable disclosing a history of abuse in a group predominantly composed of men.

> *I would make part of the training for everybody to spend time listening to experts by experience. Talking to them about good experiences and bad experiences that those people have had with the services, to give them pointers on how to handle people in crisis. I would make it compulsory in training for all professionals.*
>
> A person with lived experience working with NCCMH

Co-produced example - Part 1

The following is an example of an age-related inequality. It is fictitious and was generated during a collaborative workshop involving people with lived experience, professionals and commissioners. It illustrates how commissioners and service providers could use the steps outlined in this resource to advance mental health equality.

A commissioning or service provider team is working towards implementing new pathways to mental health care, with a focus on improving access. They want to know more about age-related discrepancies in access to mental health services. Below are some examples of how any age-related inequalities might be investigated using Steps 1A and 1B (this list is not exhaustive).

STEP 1A: Use data and existing resources

The MHSDS

- Commissioners and providers can access publicly available data summaries and tables via NHS Digital. They can also request Provider and Commissioner Extracts specific to their own services and the patients for whom they are responsible, from the Bureau Services Portal.
- Commissioners and providers can use the MHSDS to look at the proportions of people from different age brackets (0–17, 18–64, 65+ years) using NHS mental health services, and how the service is accessed (e.g. the referral source).
- Comparing access patterns by age with other CCGs with similar demographics, together with the national picture and an understanding of local population characteristics can highlight potential inequalities in terms of unmet need for certain age groups.

The Older People’s Mental Health Data Catalogue

- This catalogue is organised by Prevention, Identification and Treatment and includes data on demographics (population age, ethnicity and life expectancy) and mortality.
- Data sources, links and guidance notes are included; much of the data is sourced from PHE Fingertips.
- Commissioners and providers can use the catalogue to get a picture of older people’s mental health; information about identification and treatment is particularly useful in making inferences about modes of access and types of care received.

Children and Young People’s Mental Health and Wellbeing Profiling Tool

- This PHE Fingertips tool is publicly available and provides local and national-level data to provide commissioners and providers with the means to benchmark their area against others.
- Data pertains to identification of need, protective factors and primary prevention for children and young people.

Mental Health of Children and Young People in England, 2017 Survey

- Commissioners and providers can access information on children and young peoples’ contact with mental health services, including service/professional type and mode of access (e.g. teacher, educational support services, mental health specialist, physical health specialist).

STEP 1B: Work with communities

Reaching out to communities to identify inequalities

- Commissioners and providers can work with other organisations (such as universities or VCSE services) to run exploratory focus groups with stakeholders, community members, people with lived experience and carers, to meaningfully explore topics such as barriers and facilitators to accessing mental health support, care and treatment. Such activities can be targeted at populations identified in **STEP 1A** to further explore issues or seek advice about what data should be looked at as a priority (i.e. which age groups might be under-represented in certain services).

1. IDENTIFY
Summary

1A Use existing data and resources

Use existing data, statistics and resources to answer questions about the local population, mental health service use, available services in the community and to understand experiences and outcomes:

- population data and statistics
- community assets ‘mapping’ or local directories
- data on service usage
- experience measures
- outcome measures

Break data down by demographics, protected (and other) characteristics

1B Work with communities

Work with communities to gain a more in-depth understanding of inequalities from those affected: the community, people with lived experience, carers and the workforce:

- run focus groups
- distribute surveys
- enable input from community groups
- enable input from other services that work with people who are at risk of experiencing mental health inequalities
- make involvement accessible, easy and fair

Challenges in identifying inequality issues

- demographic data is not always captured, and where it is captured, can be inaccurate or unclear (e.g. ‘White – Other’)
- data from different sources is not always amalgamated, which can make it hard to use
- distrust in services can mean people are not willing to share experiences or raise issues
- cultural and language barriers
- service information is not always accessible to all
- data can ‘hide’ certain populations such as refugees, asylum seekers and people who are homeless, perpetuating patterns of isolation
- data may not always be accurate
- co-occurring conditions, such as substance use problems, may obscure mental health needs

2. **DESIGN**: Generating ideas and problem solving

Once mental health inequalities are identified, the logical next step is to think about how to address them. This section focuses on generating ideas and problem solving.

STEP 2A: Research

Research is essential to the design process, especially at the initial stages. Research should focus on three key questions (See **Box 14**).

What could be done to solve these issues?

Strategies for generating ideas and problem solving should be inclusive, seeking out the advice, opinions and expertise of a range of key stakeholders. This includes professionals, members of the community and people with lived experience, among others. Ideas generation and problem solving should be carried out with the same level of intensity as **STEPS 1A** and **1B**, and many of the same strategies and processes can be used.

Ask the community

The community is a valuable source of information – their ideas for problem solving will, in many cases, be directly linked to first-hand experience. Also seek the views of people who use or work in services that have experience with the identified issues. Stakeholders and the community may be able to point out existing services, initiatives and methods that have successfully tackled inequalities. See Methods of working with communities to understand inequalities in **STEP 1B**.

Identify positive practice

Services or localities that have taken positive steps to tackling inequalities should be used as exemplars. Looking to examples of good practice is a useful way of learning from success, and can also be time– and resource-efficient because it is likely that mental health inequality issues identified in one locality will be shared – or at least similar – to those of another.

Box 14: Key research questions

1. What could be done to solve these issues?
2. What (if anything) is already being done locally?
3. Can we improve or build on existing efforts?

Co-production Top Tip

The preferred language and terminology should be discussed and agreed upon to ensure activities are accessible to all and respectfully handled.

Helpful resources

The Positive Practice in Mental Health Collaborative

A multi-agency collaborative that identifies and disseminates positive practice in mental health services. National awards celebrating good practice are held annually, including a specific award category for addressing inequalities in mental health.

They may share demographic characteristics, areas may be geographically similar or there may be commonalities in the structure of services. Efforts should be made to understand what action was taken, how it was set up and delivered, and what positive impact this action may have had. Black Thrive is an example of positive practice, showing how community engagement and involvement are being used to address mental health inequalities experienced by the Black community in one London borough. **Appendix 3** contains a summary of all the positive practice examples included in this resource.

Positive Practice Example

Black Thrive model of working with communities

Black Thrive is a partnership between services and community partners that seeks to enable change across the London Borough of Lambeth so that Black communities can thrive and improve their mental health and wellbeing. It was set up following the identification of gross inequalities across many areas of mental health support, care and treatment experienced by Lambeth's Black community.

Black Thrive's work with communities is designed to:

- address the asymmetry of power
- use dialogue to identify shared goals
- focus on both top-down and bottom-up approaches to change
- deliver and embed change
- ensure accountability through transparency
- build trust

The structure of the Black Thrive Model includes the following elements:

- a steering committee provides strategic leadership
- working groups drive change on multiple issue areas and prioritised work streams
- a shared measurement system provides critical data for evaluating progress and ensuring constant improvement
- a facilitating team provides hands-on project leadership to support the functioning of the initiative as a whole

Black Thrive gives the Black community in Lambeth a platform to contribute meaningfully to service design, commissioning and development decisions, to influence policy and processes and give feedback to service providers about their experiences and ideas for improvement.

Source: Black Thrive www.blackthrive.org.uk (2019)

Refer to the existing evidence base

Commissioners and providers should look to the evidence base to identify effective interventions and methods when seeking to address the mental health inequalities identified in their local area. There is extensive research into the effectiveness of interventions (including policy implementation, service design approaches and the development of bespoke services) to tackle a range of inequality issues experienced by different populations.

Co-production Top Tip

Ensure the working group accurately reflects the community of interest, in terms of diversity and protected characteristics.

Appendix 2 contains a summary of the research conducted in the development of this resource, including research identifying barriers and facilitators to methods or interventions for addressing mental health inequalities (see **Appendix 2** and Table 6 in STEP 3B).

Table 5 provides a summary of mental health equality interventions that have been empirically evaluated within research studies, as well as the target populations who have been involved in this research.[c]

Table 5: Summary of interventions for tackling inequalities in mental health

Type of intervention	Brief description	Population or inequalities targeted
Delivering education and training	Delivering skills-based training/ teaching or providing information or tools for self-learning. *May be delivered to the individual who has, or is at risk of, a mental health problem (e.g. training to aid self-management of symptoms), to the individual's family or teachers (e.g. training in parenting techniques or behaviour management) or to the health professionals who work with individuals with mental health problems (e.g. cultural competency training).*	Socioeconomic disadvantage; BAME communities; people with a sensory impairment; first-time mothers; people with a learning disability; young people; refugees
Providing psychological support	Delivery of psychological therapies that promote the wellbeing of the recipient, such as cognitive behavioural therapy or interpersonal therapy. *May be aimed at an individual who has an existing mental health problem (intervention) or an individual who is at risk of a mental health problem (prevention) e.g. during pregnancy.*	Socioeconomic disadvantage; maternity; minority ethnic communities; homelessness; young offenders; gay and bisexual communities
Restructuring the care team	The addition of new members to an existing care team, the introduction of a new role to the team or the shifting of duties amongst the team. *Directed at care teams. Changes may occur at a local level (e.g. within a single service or region) or at a national level as a result of change in policy.*	Socioeconomic disadvantage; first-time mothers; older people; BAME communities; aboriginal communities; young people; those with limited English proficiency; transgender communities; rural or remote communities
Engaging the community	Involving community members or organisations in mental health support or education, outside of the health care setting, to improve engagement. *May include outreach, co-production, education campaigns or the delivery of care in a community-based setting.*	Socioeconomic disadvantage; BAME communities

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[c] These interventions reflect the findings from an international mapping review, categorised according to an intervention taxonomy adapted from Clarke et al.[10] See **Appendix 2** for more information about the review.

Providing financial incentives or removing financial barriers	Offering free provisions or money, providing subsidised services or removing financial barriers to accessing care or treatment. *May be delivered via policy change (e.g. national change in health insurance policies) or may be targeted at disadvantaged groups (e.g. renewal or regeneration of deprived housing areas).*	Socioeconomic disadvantage; BAME communities; transgender communities; young people; those living in poverty in low– and middle-income countries
Improving access to testing and screening	Improves the accessibility of testing or screening by addressing logistical, social or financial barriers. *May introduce more routine mental health assessments for specific populations or address issues which can impede access to testing, such as diagnostic overshadowing (e.g. with a comorbid physical condition or learning disability).*	Socioeconomic disadvantage; BAME communities; people with a learning disability; migrant populations; people with a comorbid physical health problem
Improving access to psychological treatments	Addresses logistical barriers to accessing psychological therapies in order to reach a wider population or decrease wait-list durations. *May be national programmes addressing logistical barriers (e.g. lengthy waiting lists and lack of resources) or engagement programmes aimed at reaching underserved communities.*	Socioeconomic disadvantage; rural or remote communities; aboriginal communities; religious communities; older people; BAME communities; people with a learning disability
Enhancing language/ literacy and communication	Improving language or communication skills in order to improve engagement or adherence to care. *May be delivered to the individual with a mental health problem to improve accessibility of care (e.g. for those with limited proficiency in the local language or those who have a sensory impairment) or to the health professional to improve therapeutic communications with specific communities.*	Immigrant populations; people with a sensory impairment; BAME communities
Culturally adapted interventions	Tailored interventions which work within the cultural context of the recipient and take greater account of their cultural background and experiences. *May include culturally modified versions of well evidenced therapies (e.g. cognitive behavioural therapy) or bespoke interventions specifically developed for the community of interest.*	Socioeconomic disadvantage; older people; BAME communities; religious communities; asylum seekers and refugees; aboriginal communities
Technology-based support	Providing information, skills-based training or therapeutic regimens delivered through the Internet, typically via mobile devices. *Often targeted at communities who have logistical barriers to accessing care, but may also be implemented in healthcare settings to improve information exchange between members of a care team.*	Socioeconomic disadvantage; young people; BAME communities; older people; new or expectant mothers; rural or remote communities; aboriginal communities

What is already being done locally?

Where mental health inequality issues are identified, it is likely that other services, organisations or bodies are already working to address them. It is important for commissioners and providers to understand the existing initiatives of local authorities or other areas of health and social care to avoid unnecessary duplication and to enhance joined-up working. It is also important to look at how existing initiatives could be supported or improved.

STEP 2B: Formulate plans

This section discusses two examples, out of a range of methods, that can be used to generate ideas and formulate plans. When following one of these methods, or developing others, it is crucial that the process of generating ideas is inclusive, and plans are formulated with meaningful input from all involved.

Nominal group technique

The nominal group technique is commonly used to enhance the effectiveness and efficiency of planning in health services. It helps groups generate ideas and reach consensus through a structured process,[11] aimed at preventing any single person from dominating discussions and encouraging all group members to participate. The result is a set of prioritised solutions or recommendations that represent the group's preferences. This can then be used to set priorities and plan for implementation.

Commissioners and providers should consider this technique when looking to generate plans and problem solve, while tackling inequalities in mental health.

A quality improvement approach: theory of change

A theory of change maps out the path between what a programme or initiative does (actions, activities or interventions) and the change it is intended to achieve, within a particular context. A theory of change works by first identifying desired long-term goals and then working backwards to identify the conditions that must be in place (and the causal relationships between them) for those goals to be achieved. One method used when taking a theory of change approach is to use a driver diagram (see Figure 3).

Helpful resources

Mapping the maze

Services for women experiencing multiple disadvantages in England and Wales.

Agenda and AVA (2017)

Positive Practice Example

Dial House @ Touchstone – Leeds

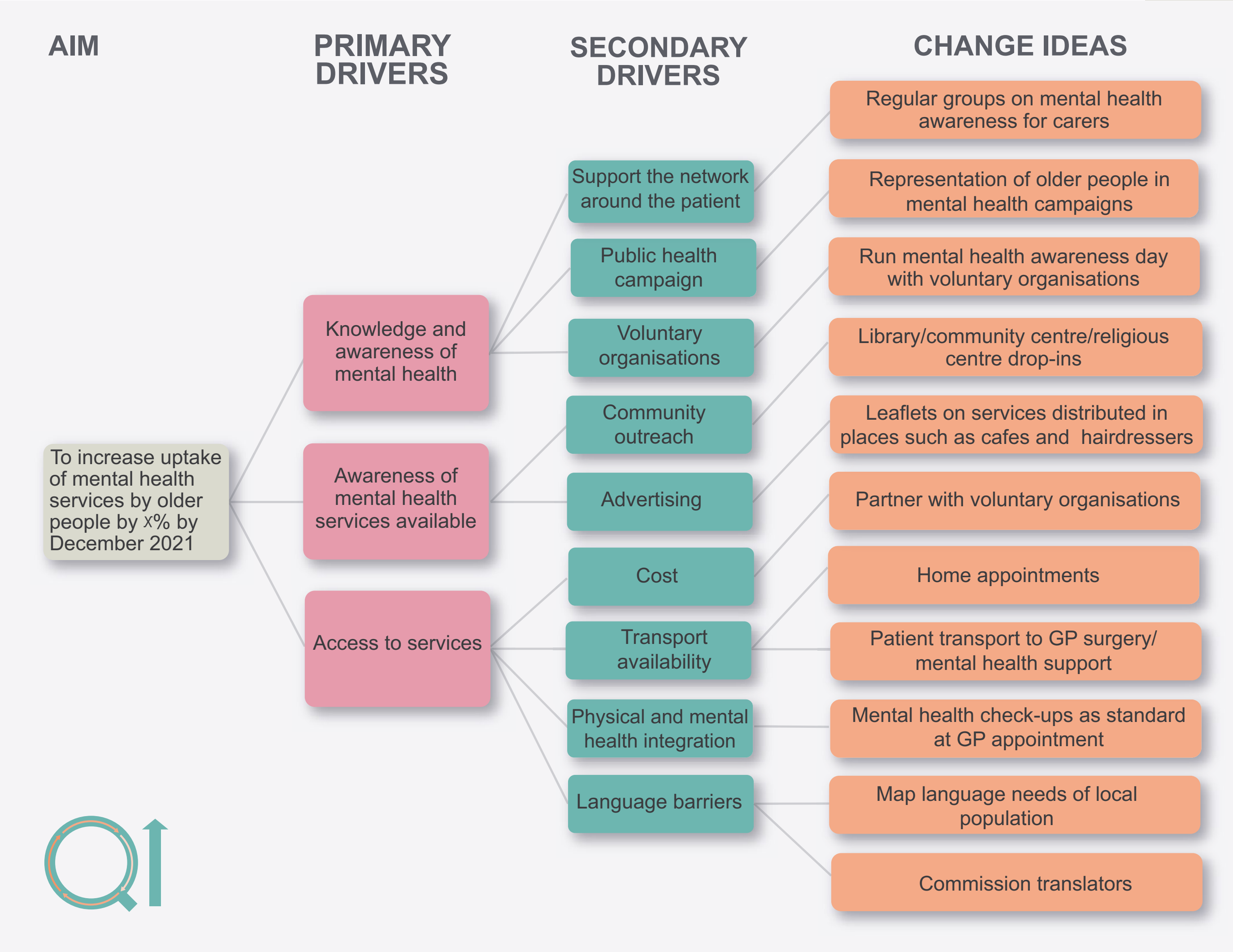
Dial House @ Touchstone is a specialised service provided by the Leeds Survivor-Led Crisis Service (LSLCS). Dial House @ Touchstone offers a culturally sensitive and accessible service with a focus on improving access to, and experience of, mental health services for people from BAME communities.

Box 15: The five-stage process of the nominal group technique

1. Individual 'silent generation' – group members write down their ideas
2. Individual 'round-robin' – group members feed back their ideas, which are succinctly recorded on a flip chart
3. Group clarification of each recorded idea
4. Individual voting and ranking ideas by priority
5. Discussion of results and focus on potential next steps

Source: Sink (1983). Using the Nominal Group Technique Effectively

Figure 3: Driver diagram: a workshopped example



Co-produced example – Part 2

The following is an example of an age-related inequality. It is fictitious and was generated during a collaborative workshop involving people with lived experience, professionals and commissioners. It illustrates how commissioners and service providers could use the steps outlined in this resource to advance mental health equality.

You identify an inequality in your local area: there are high numbers of older people (65+) who have mental health problems but are largely unaware of how to seek help. As a result, older people in your area are underrepresented in mental health services, suggesting some unmet need.

STEP 2A: Generate ideas and formulate plans

a) How could you better understand the problem?

- Engage with the community, people with lived experience, carers and professionals to understand what factors are driving this issue

b) How could you solve this problem?

- Work with the community and local services to increase awareness about how people can access help (e.g. campaigns for older peoples' mental health, leaflets advertising services through letter boxes and in GP waiting rooms)
- Work with the community and local services to support older people to access mental health care more easily
- Identify existing examples of positive practice; seek out services that have successfully tackled similar issues
- Ensure services are available and age-appropriate to meet the specific mental health needs of older people

c) Who could you work with?

- The VCSE sector (e.g. Age UK) to seek advice on reaching older people
- Day centres; support staff to put mental health and wellbeing on the agenda during events and activities
- GPs, to encourage older people to access IAPT and support them to do so
- Support workers, paid carers, family members and unpaid/informal carers to increase awareness of help available
- Other services that older people are likely to access – these may or may not be health related (e.g. GPs, social care, housing services or physical health services such as specialist physical health clinics etc.)

d) What resources might be needed?

- Workforce upskilling, such as improved training in older people's mental health and supporting them to access care
- The provision of a 'one stop shop' aligned with primary care networks
- Outreach workers in rural areas or areas of deprivation
- Leaflets/hard-copy resources to hand out at appropriate locations

STEP 2C: Set out key priorities

The preceding steps helped lay the foundation for priority-setting – deciding which actions to take and when. Questions to consider when setting out key priorities include:

- What are the immediate priorities in your local area?
- What small changes can be made?
- What are the short-term, medium-term and long-term solutions?

Commissioners and providers should set priorities as part of the commissioning cycle, service design and development processes. As with all steps, priority-setting should be collaborative and co-produced.

Co-production Top Tip

Host consultation exercises setting out priorities. People with lived experience can be especially helpful in determining:

- which issues need more immediate action
- small changes that can be made quickly to improve things

> *Mental health care in our communities is vital for thriving and cohesive neighbourhoods, where the quality of life for every individual counts. To cater for the needs of diverse citizens, they need to be actively involved in commissioning decisions and service design that responds to their needs. Then, all parties have a genuine chance to get the nature of the support right, and provided at the right time. The community framework robustly assists this process.*
>
> Jacqui Dyer, Black Thrive, Equality Advisor to NCCMH and NHS England

2. DESIGN

Summary

2A Research

Research to better understand what could be done to solve the issues identified in the previous steps:

What could be done to solve these issues?

- Ask the community
  - See **Methods of working with communities to understand inequalities** in **STEP 1B**
- Identify positive practice
  - What action was taken? How this was set up and delivered? What positive impact did it have?
  - Services, areas or localities that have taken positive action to tackle inequalities should be used as exemplars
- Refer to the existing evidence base
  - Assess the effectiveness of interventions and methods for addressing mental health inequalities in the local area

What is already being done locally?

Understand the existing initiatives of local authorities or other areas of health and social care to avoid unnecessary duplication and to enhance joined-up working.

2B Formulate plans

Formulate plans for taking action. Use reliable methods and involve people with lived experience in the process. Some examples of how this could be done:

- nominal group technique
- quality improvement approaches (theory of change, driver mapping)

2C Set out key priorities

Set out key priorities; start small if needed. Ask people with lived experience for their views and opinions to identify:

- the immediate priorities in your local area
- what small changes can be made
- the short-term, medium-term and long-term solutions

3. DELIVER: Tackle and reduce inequalities; implementing change

STEP 3A: Create a strategy

STEPS 1 and 2 form the basis of a strategy for change. The next stage is to incorporate ideas and priorities into service design, development or improvement.

Consider resourcing

Facilities required

The strategy should include a facilities plan. Making use of existing facilities and working closely with community assets should be considered.

Staffing and competences

Workforce resourcing is an essential component of any strategic implementation plan, especially when the aim is advancing equality. Any actions outlined within a strategy must be adequately resourced and, therefore, commissioned. Workforce competence is of equal necessity. The forthcoming *Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) Framework* (see Box 18) contains the principles underpinning a model of mental health workforce competences. There is a specific focus on advancing equality of access, experience and outcomes, as well as promoting equality and diversity in the workforce. For more information on measuring cultural competence, see the forthcoming *ESCaSS Framework*. Specific competences required for self-harm and suicide prevention are outlined in the Self-harm and Suicide Prevention Competence Framework.

Consider resourcing

The strategy to advance equality should include a timeline and goals that are achievable and measurable at specific time points. Using SMART goals can be helpful (see Box 17).

Box 16: Questions for delivery planning

1. What resources are needed?
    - facilities
    - staffing
    - competences – will training be required?
2. What are the timeframes?
3. What impact should this have?

Co-production Top Tip

Co-develop the strategy with meaningful input from stakeholders, including people with lived experience. They will be able to offer unique contributions based on their experience regarding what works/does not work. Treat all consultants as equal, valued members of the team.

Box 17: SMART Goal Setting

- **Specific** – state what you will do, using action words
- **Measurable** – provide a way to evaluate using qualitative and quantitative data
- **Achievable** – possible to accomplish and within scope/remit
- **Relevant** – contributes to an improvement and makes sense in line with overall goal
- **Time-bound** – state when this will be done, be specific on dates or timeframes

Box 18: Excerpt of competences from the ESCaSS Framework (forthcoming)

Establishing care, engagement, formulation and assessment

- Ability to work with difference (cultural competence, value sets, communities etc.)
- Awareness and knowledge of mental health problems for children and young people
- Knowledge and understanding of children and young people's development
- Ability to communicate effectively with all people of differing ages, developmental stages, backgrounds, and colleagues across all methods of communication (for example, verbal, non-verbal, face to face, phone, email, written records)

Supporting effective care provision

- Awareness and knowledge of the principles for the delivery of care/support
- Ability to engage families and carers to support the delivery of care/interventions
- Ability to support access to mental health care

Organisational Culture

- Enabling a culture of communication, openness and transparency
- Proactively working to advance mental health equality

See also: Competence framework for CAMHS (UCL CORE)

Consider impact

Any plans for change, development or improvement should be subject to Equality Impact Assessments (EIAs) to ensure the possible effects on equality, including potential negative impacts, have been considered. Commissioners and service providers should consider including a paragraph in EIAs to explain what it is used for and why it is important in relation to the proposed change. This will be useful for data monitoring purposes but will also reduce the likelihood that EIAs are completed as a 'tick-box' exercise.

The strategy should also outline the methods that will be used to measure impact. Measures should include the impact on people who use services and their carers, on staff and local leaders, and the impact on the community.

STEP 3B: Implement the strategy

A mapping review was conducted to identify barriers and facilitators to interventions for reducing mental health inequalities.

Table 6 summarises the studies, drawn from an international pool, that explicitly report facilitators. See **Appendix 2** for more information about the review.

Helpful resources

Easy Attractive Social Timely (Behavioural Insights Team (BIT)): (EAST): Four Simple Ways to Apply Behavioural Insights

Table 6: Summary of preliminary findings from the AMHE mapping review

Inequality issue	Populations at risk of inequality	Facilitators
Limited treatment options and service limitations	Homeless people; pregnant women with low socioeconomic status	• Diversity of treatment options (e.g. provision of outreach, home-based care, help over the phone, street clinics)[12] • Collaborative agency approach[13]
Perceived or real discrimination	Aboriginal communities; ethnic minorities	• Staff trained in providing culturally appropriate alternatives to mainstream care[14]
Access to care (including physical access, such as transportation)	People with disabilities (intellectual or physical); homeless people; people with co-occurring substance-use problems; people with low socioeconomic status; people living in rural or remote locations; young people with low socioeconomic status	• Integration of different services[15] • Reducing transportation barriers through use of mobile health interventions[16] • Provision of services within geographical reach[17] • Services provided in close proximity to where people live[18] • Support for people's ability to access treatment considering their working conditions[19] • Involvement of the person's family in their care[19] • GP as the first point of contact and with a link to external agencies; collaboration between GPs and other health care workers[20] • Convenient location and provision of outreach[13] • Internet-based interventions, as these offer flexibility regarding time and location, low effort, accessibility and (sometimes) anonymity[21] • Widened programme/intervention eligibility (e.g. allowing women who already have a child to participate in the programme)[22]
Financial constraints	Homeless people; people with low socioeconomic status; ethnic minorities	• Removal of financial barriers to prescription medication[23] • Reduce the financial costs associated with data usage by consolidating content onto health apps and minimising the need for online linkages[24] • Provision of free health services and treatment[25] • Provision of affordable services within reach and financial support for families with low socioeconomic status[17] • Subsidies for treatment-related expenses[19]

Communication issues	Ethnic minorities; immigrants and migrants; people with disabilities (intellectual or physical)	• Define and provide specific staff training on communication-strategies focused on health needs of the identified population (e.g. migrants)[26] • Meeting the needs of people with low literacy using health apps that provide audio recordings, audio-visual displays and diagrams as well as written information[24]
Awareness of available services	Older people; ethnic minorities	• Making campaigns more relevant and effective, use of simpler more positive language, use of less individualistic language (e.g. ‘me’), respecting different beliefs[27] • Community engagement[28] • Primary care professionals to map community activities[28] • Engaging the local targeted community (including members of the religious community e.g. the local rabbi)[29]
Trust in services or ‘the system’	People living in rural or remote locations; aboriginal communities; ethnic minorities	• Facilitation of opportunities for disclosure through tele-mental health methods[30] • The building of trusting relationships[18]
Appropriateness of available services	Aboriginal communities; ethnic minorities; immigrants	• Provision of culturally appropriate alternatives to mainstream care[14] • Cultural and linguistic competence of staff; cultural reference points[15] • Developing services that are acceptable to people at risk of disadvantage such as older people and ethnic minorities[16] • Making services ‘holistic’ and ensuring ‘cultural safety’ of primary health care services[18] • Providing access to male and female therapists, provision of choice in care and maintenance of confidentiality[29]

How a strategy is implemented will depend both on the needs of the local population and the steps taken prior to this stage to identify inequalities and generate ideas for change. Some examples of what could be implemented include:

- A co-produced access improvement initiative aimed at a group in the community identified as underserved
- An increase in resources to target a resource inadequacy (such as in workforce or facilities)
- A targeted mental health education or mental health service awareness programme

Helpful resources

Reducing Health Inequalities through New Models of Care: A Resource for New Care Models

This resource provides an analysis of the opportunities for new models of care and place-based health systems to improve health and reduce health inequalities, building on experience of vanguards across England

UCL Institute of Health Equity (2018)

- Implementation of an evidence-based framework to tackle inequalities
- The provision of a targeted service type
- The provision of targeted outreach for underserved groups within the community
- The provision of a programme to improve accessibility of language and access to translators
- A training programme for staff to improve care or build competence
- Setting up an integrated working alliance to allow services to jointly support particularly vulnerable individuals at increased risk of unequal access, experience and outcomes
- A built-in governance and accountability structure

The Joint Commissioning Panel for Mental Health (JCPMH) has issued guidance relating to groups at risk of experiencing inequalities in care, such as people from BAME backgrounds[32] (drawing on recommendations from Delivering Race Equality), people with learning disabilities,[33] older adults and deaf people.[34] While these guides are beneficial, it is clear that a different approach is required to support the delivery of more equitable mental health services, including fundamental changes in service development, service delivery, resource allocation and service organisation.

Positive Practice Example

South Staffordshire wellbeing teams

The wellbeing teams are passionate about improving access to psychological therapies for all, and closely monitor the protected characteristics of the people who use their services. The service now has staff trained in British Sign Language to improve access for people with hearing impairments. A dedicated, Health Service Journal (HSJ) award-winning staff member has also adapted materials into Braille to increase access for people with visual impairments.

Governance and accountability

Governance and accountability are of great importance across all of healthcare, but especially in tackling inequalities. Most governance equality duties are set out within the legislation (see **Appendix 1**). Commissioners and service providers should also consider building additional governance structures into their plans to ensure actions taken are justifiable and effective.[35]

Helpful resources

JCPMH Commissioning Guidance:

Guidance for commissioners of mental health services for people from black and minority ethnic communities

Guidance for commissioners of child and adolescent mental health services

Guidance for commissioners of mental health services for people with learning disabilities

Guidance for commissioners of older people's mental health services

Box 19: CQC Equality Objectives 2019–2021

1. Confident with difference – person-centred care and equality
2. Accessible information and communication
3. Equality and the well-led provider
4. Equal access to care and equity of outcomes in local areas
5. Continue to develop a diverse CQC workforce with equal opportunities for everyone and a culture of inclusion

Source: Care Quality Commission

Co-produced example – Part 3

The following is an example of an age-related inequality. It is fictitious and was generated during a collaborative workshop involving people with lived experience, professionals and commissioners. It illustrates how commissioners and service providers could use the steps outlined in this resource to advance mental health equality.

You identify an inequality in your area: there are high numbers of older people (65+) in your area who have mental health problems but are largely unaware of how to seek help.

STEP 3B: Implement the strategy

What steps could you take to implement the plan for change?

Cultural and behavioural steps

- Work with communities and services to normalise the language around mental health; change the dialogue
- Ensure mental health is discussed in physical health appointments and that systems and procedures are in place to enable timely follow-up by the appropriate professionals
- Work with other services and sectors to campaign for recognition of mental health problems in older adults

Work with the community

- Map the local community; understand the assets and services available
- Engage the local community: assess what work could be done with local services such as shops, pharmacies, hairdressers and barbers to improve mental health awareness and increase knowledge of help available locally
- Reach out to people from different communities in different and innovative ways (such as through religious institutions, online, GPs, community groups, schools and colleges) to get help with implementing the strategy
- Ensure the relevant people are in the room when discussing the problem and working to resolve it (including people who use services, carers and other people from the community)
- Ensure the community is aware of the strategy, understands its use and how individuals can help to implement it

  A specific example provided by a member of the working group: Services wanting to increase awareness and access to mental health services for older people should consider working through schools and other similar avenues to get messages to extended families. Older people may be more removed from (mainstream) public life, so this method could increase the likelihood that young people take the messages home and share them with family.

Practical solutions

- Commission a pop-up screen for GP prescription software, prompting them to inform older people of alternative options to medication e.g. therapy, IAPT
- Introduce nudge techniques (e.g. text messages, emails or phone calls) to remind people of what's available locally to help with mental health needs
- Include people's stories as part of campaigns and advertisements to improve representation of older people (i.e. co-produced, inclusive and diverse 'advertising')
- Undertake co-produced EIAs for any and all strategies and initiatives

3.

DELIVER
Summary

3A

Create a strategy

Create a strategy guided by SMART goals. Be sure to consider:

- resourcing
  - staff and facilities required
- timeframes and scheduling
- impact
  - ensure equality impact assessments (EIAs) are completed

3B

Implement the strategy

Implement the strategy for change. The interventions chosen will depend on the needs of the local population and the steps already taken to identify inequalities and generate ideas for change. Some key facilitators to interventions include:

- Maximise accessibility and affordability by locating services where people live
- Provide choice in care, offering a diversity of treatment options such as outreach, home-based care, street clinics and help over the phone
- Ensure staff are adequately trained to provide culturally appropriate alternatives to mainstream care
- Offer services or activities online, offering flexibility in time and place, low effort and (sometimes) anonymity
- Take a collaborative agency approach, integrating different services to support specific communities

Governance and accountability

Build additional governance structures into plans to ensure all actions taken are justifiable and effective.

4. EVALUATE:
Evaluating and improving services

Evaluation should be continuous and run alongside improvement. It is essential that this area of advancing equality is co-produced with people with lived experience. This section discusses some of ways in which commissioners and providers can ensure services are continually evaluated and improved.

Helpful resources

Mental Health of Children and Young People in England, 2017 Survey

Adult Psychiatric Morbidity Survey

STEP 4A: Collect data and measures

Data should be collected on a continuous basis – not just at the beginning or end of implementing an initiative or intervention. That said, data collected during **STEP 1A** and **1B** should be utilised here as a reference point for measuring change. The following resources and processes can be useful at this stage of the process:

- patient-reported experience measures (PREMs)
- patient-reported outcome measures (PROMs)
- self-assessment tools (such as those developed by the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists)
- data on access (broken down by demographics)
- NHS England STP Progress Dashboard
- benchmarking performance to measure the impact of change

Helpful resources

LGBTQ mental health: Exploring advocacy approaches to health inequalities

Jobson (2018) Mental Health Foundation

Positive Practice Example

Leeds Assertive Outreach Team

This team are currently co-developing a bespoke, fit-for-purpose Patient-Reported Experience Measure (PREM) with users of the service.

Co-production Top Tip

Commissioners and providers should ensure that people in the community, those with lived experience and families and carers have the opportunity to contribute to the service evaluation process. Engagement and involvement should be meaningful (not tokenistic) and inclusion of such initiatives should be part of the commissioning plan, resource and budget. A forum or meeting for feedback could be held in an appropriate local community setting to encourage attendance and enable people to contribute openly, in a safe space.

Box 20: An excerpt from the forthcoming ESCaSS Framework – workforce competences related to service evaluation and improvement

Intervention and service-level monitoring and evaluation

Staff with leadership and management responsibilities:

- Ability to plan evaluation, taking into consideration service objectives and response to feedback
- Ability to use appropriate methods to collect data and information; analyse available service data
- Ability to contribute to the development and planning of services
- Ability to monitor interventions and service delivery against national/local targets and plans
- Ability to work collaboratively to set goals for service improvement and monitor progress towards these goals
- Ability to use outcomes of any evaluation to challenge current practice and develop care provision

Quality Improvement

Staff with leadership and management responsibilities:

- Knowledge and understanding of the tools and methods available for planning quality improvement interventions
- Ability to design, plan and manage a quality improvement process
- Ability to monitor performance and key outcomes at regular intervals, to provide feedback and make any necessary adjustments to the process
- Ability to work collaboratively with staff, people with mental health needs, and families and carers throughout the quality improvement process

STEP 4B: Provide opportunities for feedback from people who use services, carers, the community and the workforce

As with STEPS 1A and 1B, quantitative and qualitative data can be used to evaluate the impact of changes on the advancement of equality. See STEP 1B for Methods of working with communities to understand inequalities.

The workforce's views on equality are important in service evaluation (see Box 20). Their feedback and opinions can be collected in a number of ways, such as:

- accessible platforms for staff to provide feedback; these can be in-person sessions or online forums
- staff-identified training needs collected as part of the appraisal process (this can be anonymised, as appropriate)
- staff satisfaction surveys

Co-production Top Tip

When preparing for co-production activities, everyone involved should develop and agree a shared set of values, principles and ground rules. The aims of the project should also be co-defined and reiterated at the beginning of each activity or meeting.

STEP 4C: Review data and feedback

Feedback and data should be regularly reviewed and collated to provide a picture of what is or isn't working and explore the possible reasons. Any changes affecting EIAs should also be reviewed. Reviewing data on the following areas can provide important insight into where improvements are needed:

- rates of service use:
    - take-up and referrals
    - rejections and outcomes following rejections (e.g. referred to other service)
    - use of Mental Health Act section
    - presentations to services (primary and secondary care)
    - people who re-refer/re-present/re-admit

As always, this data should be disaggregated by demographic characteristics, where possible, to allow for a richer understanding of issues for different people, including the impact of intersectionality. Services should also be reviewed in line with existing legislation (see **Appendix 1**).

Finally, the evaluation and review should be used to influence further commissioning and service provision decisions. It should help commissioners and providers understand what is or isn't working, identify any gaps or needs and plan to tackle these in the future.

Positive Practice Example

The Rainbow Alliance, Leeds

The Rainbow Alliance creates a social movement in which staff, service users and carers collaborate with the shared goal of enhancing the quality of care for the LGBTQ+ community, across the organisation.

Box 21: Using the Public Sector Equality Duty process:

This fictitious example was provided by a professional member of the AMHE stakeholder group and shows how to identify inequalities and take an organised, informed and transparent approach to monitoring progress and continually delivering improvement

- Identify the problem: You identify that 40% of older people in care homes have mild to moderate mental health problems and would benefit from IAPT services; yet the data tells you that only 22% accessed such services in the last 12 months
- Objective(s): to increase the proportion of older people accessing IAPT services to 30% over the next 12 months
- Generate ideas and problem-solving strategies: Work with the appropriate people to develop ideas and strategies to achieve your objective
- Take action: Implement the strategy
- Evaluate and improve: After 12 months, you review the situation and assess what actions appear to work best; use this information to further improve access rates over the next 12-month period.

4.

EVALUATE

Summary

4A

Collect data and measures

Continuously collect the qualitative and quantitative data needed to meaningfully assess, review and evaluate the service. Data should measure the impact of the service or initiative on inequalities. Important tools and resources include:

- patient-reported experience measures (PREMs)
- patient-reported outcome measures (PROMs)
- self-assessment tools (such as those developed by the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists)
- data on access (broken down by demographics)
- NHS England STP Progress Dashboard
- benchmarking performance to measure the impact of change

4B

Provide opportunities for feedback

Provide appropriate opportunities for feedback from people who use services, families and carers, community members and the workforce. Collate qualitative and quantitative data to paint a richer picture.

Ensure that opportunities for feedback are equal, accessible and fair. See STEP 1B for Methods of working with communities to understand inequalities.

Collect staff views, feedback and opinions through:

- accessible platforms for staff to provide feedback; these can be in-person sessions or online forums
- staff-identified training needs collected as part of the appraisal process (this can be anonymised, as appropriate)
- Staff satisfaction surveys

4B

Review data and feedback

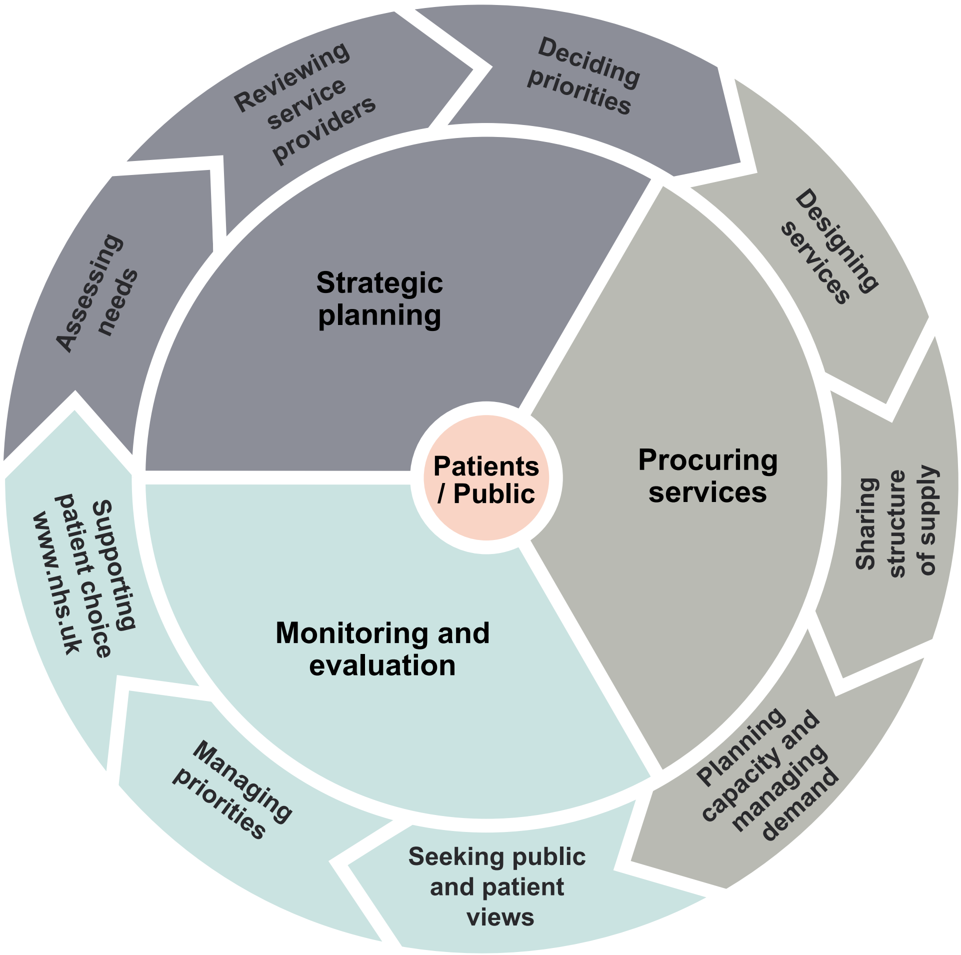
Review data and feedback; involve people with lived experience in this process.

Evaluation and review should be used to influence further commissioning and service provision decisions. It should help commissioners and providers understand what is or isn’t working, identify any gaps or needs and plan to tackle these in the future.

Advancing equality: the commissioning cycle

The NHS commissioning cycle (**Figure 4**) shows the different stages that are undertaken by commissioners. **Table 7** outlines a few key recommendations for advancing equality at each stage of the commissioning cycle. These recommendations are based on feedback received following extensive consultation with stakeholders, including ICS/STP leads, mental health professionals and people with lived experience.

Figure 4: The commissioning cycle



Source: NHS England

Table 7: Recommendations for advancing equality throughout the commissioning cycle

Commissioning cycle stage	
Strategic planning	
Assessing needs	• identify population needs/unmet need • identify existing services and assets • use demographic data
Reviewing service provision	• identify what is currently being offered and where the gaps are • identify what proportion of the local population should be receiving a service and identify any gaps
Deciding priorities	• based on identified need • use quality improvement templates (theory of change, driver diagrams)
Procuring services	
Designing services	• design services that directly map onto population needs • design services co-productively with people with lived experience, the community, providers and commissioners
Shaping structure of supply	• design a supply structure that can manage demand and use resources efficiently • allow need to shape how services are structured • innovate methods for information-sharing
Planning capacity and managing demand	• work with the VCSE sector • inter-agency working • ensure efficiency of resource use
Monitoring and evaluation	
Supporting patient choice	• patient satisfaction and experience measures • involve people who use services (and carers/families) in evaluations
Managing performance	• staff competency frameworks (include cultural competence) • identify training needs and commission accordingly
Seeking public and patient views	• engage with communities, people who use services, families and carers to monitor service • qualitative as well as quantitative monitoring data

Question: What could services do better to meaningfully include people with lived experience in service development? 'Include lived experience experts at board level/in the governance processes which drive service development and the commissioning process.'

Source: STP Clinical Mental Health Lead, CCG Mental Health Clinical Lead/ Commissioner

Definitions and abbreviations

Definitions

Term	Definitions
Carer	Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and include those who care for people with mental health problems, long-term physical health conditions and disabilities.
Co-production	Co-production is an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them.
Intersectionality	Intersectionality describes the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism and classism) combine, overlap or intersect, especially in the experiences of marginalised individuals or groups. The term was coined by American civil rights advocate Kimberlé Crenshaw in her analysis of the oppression of Black women.
Person-centred care	Flexible care based on the need of the person rather than the service. People are: treated with dignity, compassion and respect, are offered coordinated and personalised support, care or treatment, and are supported to recognise and develop their strengths and abilities, enabling them to live as independent and fulfilling a life as possible.
Support network	A group of people, organisations or individuals who provide emotional and/or practical support to someone in need. A support network can be made up of friends, family members, peers, volunteers, health and social care professionals or supportive online forums and social networking sites.
Transition	The process of transfers of a person’s care between care settings and/or locations, including the initial planning, the transfer itself and the support provided throughout.

Abbreviations

Term	Definitions
5YFVMH	Five Year Forward View for Mental Health
AGI	Absolute gradient of inequality
AMHE	Advancing Mental Health Equality
BAME	Black, Asian and Minority Ethnic
CAMHS	Child and adolescent mental health services
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CMHS	Community-based mental health services
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYPMHS	Children and young people's mental health services
EIA	Equality impact assessment
EIP	Early intervention in psychosis
ESCaSS	Effective, safe, compassionate and sustainable staffing
HSJ	Health Service Journal
IAF	Improvement and assessment framework
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care Systems
JSNA	Joint Strategic Needs Assessment
LGBTQ+	Lesbian, gay, bisexual, transgender, questioning and 'plus', to include all identities such as asexual, pansexual, intersex and non-binary
LSLCS	Leeds Survivor Led Crisis Service
MHA	Mental Health Act
MHCP	Mental Health Care Pathways
MHSDS	Mental Health Services Data Set
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHE	Public Health England
PREMs	Patient-reported experience measures
PROMs	Patient-reported outcome measures
QI	Quality Improvement
QOF	Quality and Outcomes Framework
RSA	Royal Society of Arts Manufactures and Commerce
STP	Sustainability and Transformation Plan/Partnership
VCSE	Voluntary, community and social enterprise

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