Equalities In Health

NHS Greater Glasgow and Clyde

Inequalities Sensitive Practice Initiative

Final Report

Primary Care Mental Health

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EXECUTIVE SUMMARY

This is the final report of the Inequalities Sensitive Practice Initiative's (ISPI) work within the Primary Care Mental Health Services Glasgow City.

ISPI is managed within NHS Greater Glasgow and Clyde's Corporate Inequalities Team funded by the Scottish Government as one of 14 projects in Scotland which are contributing to a Multiple and Complex Needs Initiative (MCNI). The MCNI was launched by the then Scottish Executive in 2006 to identify how public services can improve their response to people with multiple and complex needs.

The central aim of ISPI at local level was to find out what will help NHSGGC and its partners improve the effectiveness and efficiency of front line services in reducing health inequalities and to determine what type of planning and policy arrangements are required to sustain service improvements.

This report forms part of a suite of reports from the other ISPI settings: Integrated Children's Services; Maternity Services and Addiction Services together with reports from the ISPI Learning and Development Officer and Avante Consulting's independent evaluation report of the overall initiative. In addition the Scottish Government have commissioned an evaluation of the MCNI by Cambridge Consultants.

The reports are available for a wide audience including the Scottish Government, Directors, Managers and Practitioners within NHSGGC and other Scottish Health Boards and should be useful in developing strategic and operational approaches to the development of inequalities sensitive practice. All of the ISPI reports will be available on NHSGGC's Equalities in Health Website www.equality.scot.nhs.uk.

ISPI was active within the Primary Care Mental Health Setting from April 06 until December 08. The initiative identified the key characteristics of inequalities sensitive practice within PCMH teams and through engagement with team leaders and practitioners drew some conclusions as to the barriers and enablers for this kind of practice.

The report describes the key achievements, outputs and outcomes from the work and draws conclusions and recommendations which are of relevance to the further development of PCMH and the wider organisation of NHSGGC.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Working alongside the Primary Care Mental Health (PCMH) Teams in NHS Greater Glasgow and Clyde has afforded the opportunity to identify and describe the key elements of inequalities sensitive practice

Some the key factors which support an inequalities sensitive approach are listed below:

- **A social model of care** allows practitioners more scope to develop ISP than the traditional medical model. Good practice should be fixed firmly within this model.

- **Data collection and reporting systems** which are robust and are linked to performance **management**. There are gaps in data obtained in relation to inequalities which needs to be collated and analysed more robustly.

- **Learning & development** opportunities that relate specifically to different clinical backgrounds. Making the links for professional bodies between clinical training and inequalities sensitive practice.

- **Routine enquiry is embedded into the assessment process.** Practitioners are prompted to routinely sensitively enquire about Gender Based Violence (GBV) and socio economic issues via written questions within referral forms.

- Practitioners have the **knowledge, skills and understanding** required to be competent in dealing with the impact of inequalities on health. .

Taking the findings in relation to Primary Care Mental Health as a whole it has been identified that Mental Health Practitioner's views are a useful starting point for policy makers and planners who operate at a more strategic level.

Recommendations:

NHS Greater Glasgow and Clyde

- An Evaluation of ISP within Primary Care Mental Health services should be carried out
- Learning and Development Opportunities which support practice should be available and accessible
- Dissemination of Practical Tools e.g. ISPI DVD should be coordinated and managed centrally
- Structured supervision/support mechanisms for staff dealing with disclosure of abuse should be developed
- Securing a dedicated resource operating across the wider mental

health network would maintain the development of Inequalities Sensitive Practice
- A champions approach which could be supported by a dedicated resource to achieve a wider reach across the mental health network should be developed
- Routine sensitive enquiry into GBV and poverty should be evidenced in the assessment process
- Better mechanisms and structures for practitioners to link the Mental Health Partnership need to be further developed

National

The Scottish Government should work with Special Health Boards to ensure that

- Pre registration and post registration workforce development programmes are developed to support mental health practitioners practice in an inequalities sensitive way
- Data collection processes and mechanisms should be developed to support planning and practice.
- Performance management and efficiency targets should be applied to inequalities sensitive workforce development activity at local Health Board level

CHAPTER ONE: INTRODUCTION TO the Inequalities Sensitive Practice Initiative

INTRODUCTION

This is the final report of the Inequalities Sensitive Practice Initiative and its work within Primary Care Mental Health services in Glasgow City. It is intended to describe the main activities, achievements, outputs and outcomes of this work and ends with conclusions and recommendations which are pertinent for the PCMH teams and the wider organisation. The report forms part of a suite of reports which include reports of the other ISPI settings (Addictions, Integrated Children's Services and Maternity Services) and the independent evaluation report of ISPI conducted by Avante Consulting. The reports are aimed at a wide range of managers and practitioners and should be useful in strategic and operational approaches for the development of inequalities sensitive practice.

A copy of all of the ISPI reports can be accessed on NHSGGC's Equalities in Health website www.equality.scot.nhs.uk.

This first chapter gives an overview of the national policy context for addressing health inequalities and

gives a brief background to the overall Inequalities Sensitive Practice Initiative (ISPI)

Background and context

Health inequalities are the medical (both physical and psychological) consequences of a series of inequalities experienced by people in their everyday lives which relate to socio-economic status, gender, age, race, faith and belief, sexual orientation and disability status or a combination of these factors.

The effect of power differentials, discrimination and socialisation, acts as a pathway into poor health, which can limit access to health and social care and can affect the quality of response by both individual practitioners and care systems.

A drive to reduce the impact of inequalities on health is reflected in Scottish and UK health and social justice policies. Legislative requirements for Public Services in relation to race, disability and gender equality are in place.

The Multiple and Complex Needs Initiative

In 2006 the Scottish Executive (now the Scottish Government) launched a Multiple and Complex Needs Initiative (MCNI) aimed at improving public services for those with multiple and complex needs. The initiative recognises that people with multiple and complex needs find it difficult to access services, and/or maximise their own benefit from them, because they experience a range of barriers and discrimination

Research has shown that existing public service providers find it difficult to deal with clients who have multiple or complex combinations of problems[1]. The MCNI focussed on what needs to improve in relation to service user experience of Public Services, This was expressed as a service experience 'cycle':

- **Getting In**- awareness of and access to the service
- **Getting On**- initial assessment by, working with and experience of the service; and
- **Getting Through**- moving forward, beyond and outwith the service

Who Has Multiple And Complex Needs?

The Scottish Government commissioned a literature review by Anne Rosengard Associates[2] to

[1] Breaking the Cycle- Taking stock of progress and priorities for the future- Social exclusion Unit September 2004

[2] Rosengard A. Laing,I. Ridley, J. and Hunter,S. (2007), A Literature Review on Multiple and Complex Needs. Scottish Executive, Social Research.

inform and guide the development of the MCNI. This literature review established that a very wide range of people can be described as having multiple and complex needs including:

- People with mental health problems
- Young and older people
- Those fleeing abuse and violence - mainly women and refugees
- Those culturally and circumstantially disadvantaged or excluded - minority ethnic groups; travelling people
- People with a disability
- People who present challenging behaviours to services
- People who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services
- People who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion
- People who have a 'dual diagnosis' of mental ill health and substance misuse, or of other combinations of medically defined illness.

The MCNI commissioned 14 projects across Scotland. These projects represent a wide range of service settings and client groups and were in the main operational between April 2006 and December 2008.

ISPI managed by NHS Greater Glasgow and Clyde and is one of these projects. ISPI took a unique approach amongst the projects in that it focussed on existing practice within the context of organisational change.

The Inequalities Sensitive Practice Initiative

ISPI is managed by the Corporate Inequalities Team of NHS Greater Glasgow and Clyde (NHS GGC). Inequalities in health are a major challenge for NHSGGC. the Boards boundaries have within them some of the most deprived communities in Scotland and health inequalities are widening. In recognition of this, NHSGGC's has identified tackling inequalities as one of its key organisational transformational themes. The organisation has accepted that it needs to plan and deliver its services differently in order to impact more significantly and equitably on the health of its community. The organisation has described 10 goals that will drive the development of an inequalities sensitive health service. These ten goals can be grouped under 3 main headings:

- Engaging with Populations and Patients
- Developing the Workforce
- The Health Service's Role in Society

A key function of NHSGGC's Corporate Inequalities Team is to develop tools and approaches aimed at helping the organisation change and achieve these goals. ISPI is one of these approaches.

The central construct of ISPI has been to both:

- inform national learning and policy development
- **and**
- identify what will help NHSGGC and its partners improve the effectiveness and efficiency of front line services in reducing health inequalities and to determine what type of planning and policy arrangements are required to sustain service improvements.

The model used by ISPI has been to focus on practice at the point of transaction and interaction between practitioner and service user. The main focus for the initiative was on 2 key aspects of inequality, namely gender inequality and socio-economic inequality. However it is important to be clear that the work of ISPI should be seen as a paradigm for work within all aspects of inequality and discrimination. Individuals are not defined by one identity; issues relating to race, sexual orientation and disability also need to be identified as part of the development of inequalities sensitive practice.

The initiative sought to achieve national and organisational learning through 4 Project Leads working closely with managers and practitioners in each of 4 diverse practice settings as follows:

- Maternity Services
- Integrated Children's Services :Parents and Children Together Teams (PACT)
- Addictions Services
- Primary Care Mental Health Services

A Learning and Development Officer and a Communications Officer worked with the Project Leads across the 4 settings.

The teams and settings selected were done so on the basis that they had, or were in the process of adopting, a model of inequalities sensitive practice that recognised the need to move beyond traditional, medicalised responses to the health consequences of inequality and discrimination. The Project Leads had the clear objectives of

- **describing** the key characteristics of inequalities sensitive practice within these settings, in order to develop tools for practice development at an organisational level.

- **identifying** what the enablers and barriers to inequalities sensitive practice are, in order to contribute to the organisations development as an inequalities sensitive health service.

- **embedding** and sustaining an inequalities sensitive service approach within each of the 4 practice settings at a wider level than that of the individual teams.

A high level steering group, responsible for the effective governance of the initiative, was established and chaired by NHSGGC's Head of Inequalities and Health Improvement. In addition, each of the 4 settings had their own implementation groups, chaired by a setting lead or 'champion'. In some settings working and task groups were set up to carry out specific tasks.

Evaluation

Avante Consulting. was commissioned to undertake an independent evaluation of ISPI.

The Scottish Government commissioned an evaluation of all 14 MCNI projects from Cambridge Consultants. This report will be published by the Scottish Government in March 2009.

The rest of this report focuses on the work of ISPI with the Primary Care Mental Health Teams in Glasgow.

CHAPTER TWO: Rationale, Aims, Approach and Activities

Introduction

This chapter describes the rationale, aims and approach which underpinned the work of the Inequalities Sensitive Practice Initiative with the Primary Care Mental Health teams who operate at a Community Health and Care Partnership (CHCP) level and are also part of the Mental Health Partnership (MHP). It describes the context within which a range of activities took place.

Rationale

ISPI identified Primary Care Mental Health Teams as one of the four settings to work with due to some activity on gender sensitivity which has already taken place with the Pathways Primary Care Mental Health Team prior to the initiative. Some of the early findings and learning points from the South West Community Health & Care Partnership (SW CHCP) on gender sensitivity are available in an evaluation report.[3] The Primary Care Mental Health Teams although set up to provide brief intervention

often work with individuals who have complex needs.

Previous pilot work had also been carried out in relation to gender mainstreaming in East Glasgow and Clydebank. In the initial bid to the then Scottish Executive it stated that although approximately 80% of the work would focus on South West Glasgow another geographical area would come on board once the initiative was underway. The geographical area chosen was the North CHCP.

The PCMH Team is part of a North Glasgow Mental Health Network taking a partnership approach. The Partnership is a broad group of stakeholders who aim to help the people of North Glasgow access the right service at the right time to improve mental health and well-being. Unlike the Pathways team in South West there has been no explicit inequalities work carried out prior to ISPI. Choosing the North as the other geographical area for ISPI work would also potentially allow for comparisons to be made in relation to ISP.

There are Primary Care Mental Health Teams in each of the 5 Glasgow CHCPs. These teams were set up at different times. The Pathways team were set up in 2005. There was growing evidence supporting the implementation of psychological therapies within a stepped care framework (NICE Depression Guideline, December 2004). [4] Stepped care requires interventions of different intensity e.g. guided self help, therapeutic groups or individual therapy.

In addition to this there are teams in each of the non Glasgow and Clyde areas which are made up of a variety of mental health practitioners e.g. Psychologists, Counsellors, CBT therapists etc with Carr-Gomm Scotland the social care provider working alongside PCMH Teams in the 5 Glasgow CHCP's.

AIMS

The aim of the work with the Primary Care Mental Health teams was to identify and establish the mechanisms for extending and integrating the development work within primary care mental health into the mainstream delivery of mental health services and to identify ways of assessing the impact on overall health gain of recipients of the service.

Objectives

- To describe the key elements and drivers for Inequalities Sensitive Practice (ISP) in light of the current stage of development within Primary Care Mental Health

[3] Rona Fitzgerald, Evaluation of Inequalities, Gender Sensitivity and

Primary Care Mental Health Pilot Work in South West Glasgow (2006)

[4] NICE Depression Guideline, December 2004

- To determine the nature of the policy, organisational and practice enablers and inhibitors which would allow for the successful implementation of ISP within Primary Care Mental Health
- To define the appropriate planning frameworks for informing and integrating ISP into mainstream service provision
- To identify current strengths and weaknesses in current data collection systems for sensitivity to gender and socio-economic status
- To devise and develop a systematic approach to data collection and effective monitoring systems and to utilise these in the development of practice and to inform establishment of performance indicators and measure impact.
- To utilise the findings of the evaluation of ISPI to inform policy, planning and performance management

A logic model was used as an outcomes focused planning and evaluation tool. Logic models allow work to be divided into logical steps: assumptions; inputs, activities, outputs, and outcomes as follows

1. Assumptions , for example regarding organisational culture, management 'readiness'
2. Inputs (resources such as money, employees)
3. Work activities, programs or processes,
4. The immediate outputs of the work that are delivered
5. Outcomes or results that are the long-term consequences of delivering outputs.
6.

The basic logic model typically is displayed in a flow diagram such as below:

ASSUMPTIONS-- >INPUTS --> ACTIVITIES --> OUTPUTS --> OUTCOMES

The full logic model for the Primary Care Mental Health setting can be found in Appendix 1.

In retrospect the aims and objectives set for the work of ISPI were ambitious and proved difficult for the initiative to achieve given the organisational context within which the work took place and the relatively short time frame and limited resources available to it. A more detailed analysis of this is contained in a later section of this report.

Context

The Mental Health Partnership is responsible for overseeing all adult mental health services across NHS Greater Glasgow and Clyde. Although local teams are part of the MHP they are managed at a Community Health and Care Partnership level. Each geographical

area has a Head of Mental Health who is responsible for the day to day management of local services within their CHCP area. The Mental Health Network in each CHCP consists of Community Adult Mental Health Teams in addition to an Out of Hours and Crisis service. There is a Primary Care Mental Health Team based in each of the CHCP and CHP areas.

The Primary Care Mental Health Teams were established at different times. The teams have developed at different stages adopting and/or adapting the stepped model of care as they progressed. The ISPI Project Lead has been able through attendance at the Primary Care Team Leaders meetings to observe their development and the challenges within this.

There have been difficulties accessing all of the teams due to the initial agreement to focus geographically on the Pathways Team in South West and North PCMH Team. Team Leaders were focused on service development with inequalities sensitive work not seen as a priority in the initial stages. However regular attendance at the Team Leaders meetings has stimulated interest and involvement from other teams who are more willing to engage as service developments have progressed.

Approach

A project lead was recruited to manage the initiative within the Primary Care Mental Health setting. A setting implementation group was established and chaired by the Mental Health Operations Manager for SW CHCP which was also initially attended by the setting lead. This individual had responsibility for supporting and providing some guidance on the work of the Project Lead. This support and leadership has been vital to the progress of the initiative. Despite a change in role from Primary Care Development Manager to Head of Mental Health SE CHCP they have retained responsibility and shown strong leadership and support.

An important relationship was developed between ISPI Project Lead and the Primary Care Team Leaders. Being a member of that group and attending meetings allowed an ongoing sharing of the learning across all the primary care mental health teams in Greater Glasgow & Clyde

Regular reflective and highlight reports were produced by the Project Lead; these were shared with the Setting Lead and Setting Implementation Group and used to evaluate the progress of the initiative on an ongoing basis.

The independent evaluators Avante Consulting worked with the initiative from the outset, using an action research approach; this included 1:1 interviews and focus group sessions with senior managers, team leaders and mental health practitioners.

The Project Lead worked closely with the PCMH Team Leaders, regularly attending and participating in their monthly leads meetings. Throughout the time of the initiative, interactive, facilitated meetings, themed workshops and action learning events took place in which team leaders and their staff were encouraged to identify the key ingredients of their practice including the barriers and enablers they encounter in implementing their model of practice.

As ISPI aimed to mainstream the learning from the initiative, the Project Lead linked into as many networks as possible which helped take forward the work.

Activities

The following list of activities was undertaken in the Primary Care Mental Health setting. The list is not exhaustive but is lifted from the Logic Model that was developed and agreed by the PCMH SIG.

1. Gathering of baseline information; audit needs assessment and referral systems etc.

In order to develop a better understanding of the setting a useful starting point was to establish a baseline of information both qualitative and quantitative. By being co-located with the Pathways Team it meant that this could be done by attending team and allocation meetings alongside practitioners. A lot of the activity made use of observation skills and researching local documents e.g. CHCP Development Plans for priorities in relation the service provision and/or redesign.

2. Establish working relationships across Greater Glasgow & Clyde Primary Care Mental Health sector and linked social care agencies

A key partner in the work has been the social care provider Carr-Gomm Scotland who is commissioned to work across the mental health network and have been particularly supportive of the ISPI approach.

In SW CHCP links were made into the SW Mental Health Service Providers Network which is attended by representatives from across the mental health network i.e. community adult mental health and Platform, a service users project. Links into the North Mental Health Network also

allowed the opportunity to establish good working relationships.

3. Collate evidence on best practice through literature search, local practice, SIGN guidelines etc

This activity is on-going as developing an understanding of Inequalities Sensitive Practice (ISP) requires highlighting to practitioners evidence and examples of good practice where they are available. This is an area that practitioners found useful and there is the opportunity now through the new Equalities in Health website (www.equalitiesinhealth.org) to populate this so that health and social care professionals can easily access an up to date and relevant resource which relates to practice.

4. Link into mechanisms for user involvement and user satisfaction feedback

This area of activity was particularly challenging in the primary care mental health setting. Most people accessing a service will see a practitioner for 6 – 8 sessions. Links were made into local provision for user involvement at a CHCP level. Access was given to local projects who are experienced in involving service users. This access proved to be informative in relation to people at the more severe and enduring end of the mental health spectrum.

However due to a positive working relationship with Carr-Gomm Scotland attendance by the Project Lead at Service User Involvement Focus groups enabled opinions to be sought. One particular service user stated *"I want to be asked questions from workers that ask how I spend my time, what my life is like on a day to day basis, and what my ambitions might be. I don't expect that my worker will be able to sort everything for me but by asking I know they are interested in my life".* From that particular individual's point of view it means workers showing a genuine interest in people's life's which helps the relationship between practitioner and the individual accessing a service.

From an ISP point of view this is a powerful message that practitioners need to hear. Practitioners with a clinical role need to understand that the therapeutic relationship can be improved by showing a genuine interest in an individual's life and that people do not expect practitioners to "solve" all their issues.

5. Influence the agenda for specific community development workers in relation to mental health

A large part of the role of ISPI has been to influence practitioners, policy makers and planners. However it is also crucial to operate at a community development level. This was done by attendance at the SW CHCP Equalities Meeting chaired by the Planning Manager which allowed access to community development workers and an opportunity to influence thinking and share

experience. In the North of the city attending the North Mental Health Network offered the opportunity to do the same. This allowed dissemination of information on ISPI through the networking opportunities it presented as a well attended Network. Opportunities to consult first hand with service users on inequalities issues was offered through this Network and informal feedback could be given via the Project Lead back to mental health practitioners on what people want from services.

6. Source, develop and adapt training and learning and development opportunities

This area of activity is arguably the most appreciated and understood by practitioners. ISPI has taken care not to be seen as a training initiative however this has been a key area of activity across all 4 settings. Awareness raising sessions have taken place across primary care mental health in relation to gender, gender-based violence, poverty and employability. Access has been given to other relevant training opportunities and some informal sessions have been delivered in relation to good practice. The Learning and Development Officer has been influential in this activity. The development of an Equalities Impact Assessment (EQIA) Tool for training courses is being developed via a sub group of the Learning and Development SIG.

7. Link into and influence local organisational and development processes

Contributions were made to local CHCP Development Plans in order to influence priorities. This included influencing the plans to consider working with the wider definition of gender-based violence as opposed to limiting definitions of service developments that work with domestic abuse only. This is particularly significant given the new NHS GG & C GBV Action Plan 2008 – 2011 which covers the wider spectrum of violence. By working with people at a local level to develop their understanding of these issues they are arguably more receptive to making a more significant contribution towards achieving this plan.

8. Develop a strategy for communicating and informing the relevant people

There is an ISPI Communications Plan which clearly outlines communication routes and priority areas. This plan covers local and national routes and priorities. This can be accessed on the equalities in health website highlighted earlier in the report. (www.equalitiesinhealth.org)

9. Gain support, time and investment from practitioners

This has been perhaps the most time consuming activity. Given that ISPI wants to influence the role of the frontline practitioner getting investment from them and senior management was vital. Negotiation with Mental Health Operations Managers allowed staff to be freed up to take part in training for example. There is overlap with some of the activities as establishing good working relationships has allowed this activity to be carried out successfully. Some practitioners have adopted champion's roles thus giving up more of their time but they have recognised the value in doing this for their practice and also service development.

10. ***Provide ongoing feedback to relevant senior management groups***

Providing feedback to senior management is vital. This has been done directly or via other key individuals in the setting. For example feedback from the Setting Lead and the Health Improvement and Inequalities Manager (MHP) to the Mental Health Partnership's Senior Management Group has been done on behalf of the Project Lead. However there are various monthly highlight reports and six monthly reflective reports made available for information. Direct presentations have taken place at a variety of meetings e.g. The Mental Health Senior Management Team, SW CHCP. In addition to this Corporate Inequalities Team colleagues have fed progress into their relevant meetings.

11. Contribute to the development and implementation of the equality scheme in primary care mental health

Attendance at the MHP Equalities Scheme Meeting which has a focus on developing a plan that helps the Partnership meet the detail of the scheme has allowed feedback to be given on an ongoing basis as the plan is adapted and improved. ISPI is explicitly mentioned in this scheme. There has been the opportunity to influence thinking in relation to inequalities in mental health through presentations for example. ISPI has had wider reach than primary care mental health by contributing to this meeting as it is attended by practitioners and managers from the wider mental health network e.g. forensic mental health

CHAPTER THREE: ACHIEVEMENTS, OUTPUTS AND OUTCOMES

This chapter will look at the key achievements, outputs and outcomes for the work of ISPI within the PCMH setting.

Outputs to Outcomes

Within the Logic Model there are a total of 7 outputs that are designed to meet the short term outcomes. As stated earlier all 13 outcomes have not been fully met however some of the outputs
have made a contribution to them which are not always measurable due to the evidence often being small in numbers or difficult to capture.

1. Multi-disciplinary staff trained in inequalities sensitive practice

At the outset it was acknowledged that training multi-disciplinary staff in ISP was required. The training has covered employability for example goes someway to meeting the first short term outcome which is *increased detection of poverty.* Given the links between poverty and employment workers now ask questions in relation to people's employability and have a clearer idea of their role in doing this therefore practice has improved as confidence has developed. ***There is also an agreement following the sessions for some of the teams to record people's employment status and report on this*.**

BOX 1 – QUOTES from the Employability Sessions which indicate one thing you have learnt or will do differently

"Heightened awareness of crucial link between mental health and work/meaningful activity"

"More confident talking about employability aspirations with clients- focus on the steps as opposed to getting a job right away"

"Information re employability and reassurances re own practices regarding this"

"How to appropriately address employability as life enhancement and not frightening"

"Understand the difference between employability and employment"

2. ***ISP systems for assessment, care planning and referral for women and men with multiple and complex needs***

Within the primary care mental health teams that have direct ISP contact there has been a willingness to examine current ways of working in relation to what the system currently does and what can change to ensure a more ISP approach. This output links to outcomes 1 – 6 and 8. Some changes have been made following short sessions that were led by the Project Lead in relation to Gender-based Violence and gender sensitive practice. ***Practitioners attending those sessions routinely consider whether the locations of services are accessible and safe***. Carr-Gomm Scotland ***routinely offers a choice of sex of worker*** when a referral is received.

Learning and Development

Action Learning

The Primary Care setting has used an Action Learning approach in working with practitioners to evidence what works and what does not? An Action Learning Event took place in September 2007 with East, Clydebank and North. Some staff had input in relation to inequalities via previous demonstration pilots. They described ***shifts in practice*** over time as they developed a better understanding of ISP and how this related to their role. Practitioners described the following as enablers.

A move away from a medical led model to a ***social model of care was described as being supportive of developing ISP***. ***Joint working*** was highlighted as key given the new CHCP structures. They stated that having ***regular and supportive supervision*** which has ISP as a standing item on the agenda as vital to help them develop further working in an ISP way. Training opportunities with a particular focus on inequalities was appreciated by practitioners who said it helped them think of inequalities as wider than just disability or race.

It is important to capture how ISPI has impacted on other organisations. Carr-Gomm Scotland have been a key partner in the ISPI work. They attended and contributed to the Action Research event and the learning workshops. The approach adopted by the Project Lead has been supported by Carr-Gomm Scotland who work in a person centred way. One of the benefits for Carr-Gomm working with ISPI has been expressed by some of the staff who say that there is now more opportunity to discuss ISP. Carr-Gomm practitioners commented on how exploring various issues such as gender has helped them to revisit some aspects of service provision which in turn has helped ensure an even better experience for people accessing services.

Box 2 – Practitioners comments from the event

"Presented well, made me think about my practice and changes I might make to it"

"-Very good to network with colleagues in different areas and to air and listen to views"

"-Time to reflect and talk about inequalities sensitive practice"

"Discovered more about ISPI and its aims and recognised the need for further understanding"

"Still not sure how to be gender sensitive in actual practice"

"Exploring the issues made me more aware of barriers"

One practitioner described at the Learning Event his journey in relation to developing an understanding of ISP as follows

"If you asked me at the beginning of ISPI I would not have hesitated to say that I am very inequalities sensitive in my approach. Now a year down the line I have no idea if I am or not!"

This highlights some practitioners concerns that they have taken for granted because they are in a caring profession that they would automatically be sensitive in their approach. When they are given the ***time to reflect on practice they are then able to be more critical in their thinking***.

Training Evaluations

These evaluations are further evidence of the difference providing ISPI awareness raising sessions can have. Staff have been keen to return to work and make practical changes. After an Employability training session recently one team acknowledged that they did collate this information but did not put it into their database. By formally recording employment status it would then allow them to report directly on this. It was decided that on return to base this would be incorporated into the ***data collection system*** and this complimented current good practice as they already ***routinely enquire*** into people's status. Practitioners who traditionally did not feel they had any role now understand that they do have a role in asking at assessment and signpost to support if required. There is also recognition by practitioners from a variety of different teams that this is a more effective way of engaging with people accessing services.

Learning and development tools

In addition to the learning and development workshops on gender and poverty, a learning and development DVD was produced based on a typical Primary Care Mental Health practice scenario depicting some of the key characteristics of sensitive enquiry in relation to GBV. These are listed below:

Box 3 - Key Characteristics of Practitioners who use an ISP approach

- **Empathetic** approach to **asking** and **responding** to disclosure of abuse
- **Actively listening** to what a person has to say
- **Open** and **honest** in dealing with questions
- **Committed** to helping someone make changes
- **Willing** to assist in helping someone understand difficult feelings

- **Knowledge** about what other services can help and signpost

The DVD was produced with support and input from a PCMH Team Leader and Counsellor. This resource can be utilised both within PCMH and at a wider organisation level.

More detail regarding the DVD and its utility can be found in the ISPI Learning and Development report at **www.equality.scot.nhs.uk**

The development of a practice descriptor detailing quality standards and associated workforce competencies will be produced and placed on the above web site. In addition to the practice descriptor some "Personal Stories" of practitioner's experiences of ISPI and a case study on partnership working will be placed on the site.

Personal Stories

Practitioners have an appetite for evidence which relates to other practitioners experiences. Some interviews have taken place from different disciplines to capture some of the key learning in relation to practice. Emily was an Assistant Psychologist who is now currently doing a Doctorate in Psychology. She described her experience of ISPI as follows:

"A lot of work in inequalities is thinking of opening up the mind and not putting people in boxes. I have seen a lot of patients with inequalities issues and this does require a lot of work at a supervisory/training level. Developing this understanding has impacted on my work. I have shifted from initially thinking this is simple i.e. gathering statistics but it is more complex than that. Making an observation about mental health I would say that we are not there yet. Inequalities are not a separate area of work but a part of what mental health practitioners should do. It needs to be more integrated into clinical practice as it does seem separate in relation to making a therapeutic intervention.

Further interviews with a practitioner who is from a counselling background describes being involved with ISPI as like being on a journey when you don't quite get to the end of it as something else always comes up. As someone who has been involved in inequalities work prior to ISPI she described some of the challenges that she faces as she moves to a different level of understanding. ***A key issue for this practitioner (and others) is challenging other people***. She describes her surprise at the attitude of some other practitioners as she stated that particularly with the voluntary sector there was an expectation that they would be more "clued up". As a potential solution she identified training as a solution

but not formal training some of the ***informal work*** carried out by the Project Lead that was done in a way that was more ***practitioner centred***.

Box 4 – Key Learning in Relation to Practice

- *A **social model** of care is **supportive** of developing ISP*
- ***Increasing confidence** in practitioners helps with **routinely asking questions** in relation to **GBV and socio-economic issues***
- *Practitioners who work in a **person centred way** considering the **whole of a persons life circumstances** are best placed to support people*
- Robust **data collection** is a central component and should be directly linked to **performance management**

Barriers to achieving our outcomes

There have been many barriers as well as levers facing ISPI. It is important to make

these as transparent as possible to create a better understanding of how ISP can be

mainstreamed. Below are some of the barriers that have been experienced:

Data Collection

There appears to be a gap in terms of consistency across the teams. For example, the data collection varies from robust to inconsistent. This is a basic starting point for ISPI. ISPI has highlighted using a cycle of enquiry approach. The beginning of this cycle relies on having access to quality data. This in turn can then be analysed, changes implemented, evaluated and reviewed. This issue has been raised with the Setting Lead to inform discussions at the ISPI Steering group regarding possible future action. In order to provide evidence of unmet needs more ***robust data collection needs to happen***. Although the primary care mental health teams are to a greater or lesser degree following a stepped model of care (described in Chapter 2) this is done differently in each geographical area. There is some sensitivity around access to 1 – 1 interventions as this has resource implications. Not all the teams have a website for example where self help materials can be downloaded for use. There is possibly an element of competition between different geographical areas. There is a data collection tool that teams can use. A potential solution would be 1 – 1 support around how best to complete this tool as despite guidance notes this is not completed in a robust fashion by all teams.

Staff Attitudes

This appears to be one of the **single biggest barriers to ISP**. ISPI has sensitively challenged some views that practitioners have on gender sensitivity in particular. For example some practitioners still believe that treating women and men the same is providing a service that is equal. There appears to be little evidence of

a clear understanding of gender sensitive practice. Some people understand this as service provision being equal for men and women. Some of the issues around the impact of gender and gender socialisation on mental health are not fully explored currently. However staff are generally open to discussing these issues further but need a forum in which to do so. Currently there is the opportunity to have ISP as a standing item on the agenda of the Team Leads meeting and the MHP Equality and Diversity Scheme meeting. There is ***no need to set up an additional forum*** when these 2 meetings could potentially provide opportunities for staff development.

Organisational Change

This has proven to be an on-going key challenge for ISPI. Both social work and health have undergone ***restructuring*** and changes to staff conditions and pay which appears to have in many cases resulted in a de-motivated workforce who can perceive developing an ISP approach as added work and pressure. ***Strong leadership*** can use this as an opportunity to motivate staff by highlighting and promoting the benefits of adopting this approach which has been described by some practitioners as helping improve their motivation.

Staff ***engagement*** is crucial to develop an understanding of ISP. This barrier is difficult to overcome as it is out with the control of ISPI. However by being able to demonstrate that working in an inequalities sensitive way provides better outcomes for people then there is scope to overcome some of the negativity that could prevail. Many staff who have been through a pay and benefits review like Agenda for Change and have also been involved with ISPI have stated that this involvement has helped ***motivate them as they can clearly see the benefits of adopting an ISP approach both for patients and themselves as a practitioner.***

Timescales

Timescales have always been challenging for ISPI given the resource and timescale available in relation to the scale of inequalities. Despite this the ISPI team has strived to achieve as much of what has been set out as possible in partnership with others.

Long Term Outcomes

In the Logic Model there was one Outcome which was beyond the lifespan of ISPI. This outcome stated that Inequalities sensitive practice would be embedded across primary care mental health settings in NHS GG & Clyde. The challenge for an initiative like ISPI is getting those that have been involved with the initiative to continue with the mainstreaming of

an ISP approach. ISPI has a further extension from January 2009 until March 2009 during which time further engagement with the wider system will take place to ensure actions are agreed upon to imbed the learning into the system.

CHAPTER FOUR Conclusions and Recommendations

Conclusions

The Inequalities Sensitive Practice Initiative within Primary Care Mental Health was successful in identifying some of the key characteristics of inequalities sensitive practice. This key learning can now be utilised in both the further development of PCMH teams and across the wider Mental Health Network. The information gathered and analysed has provided detail on the barriers and enablers to this kind of practice that have been identified. These include:

- Strong effective leadership that visibly prioritises addressing inequalities
- Continued partnership working at a CHCP level
- The provision of structured and protected time for staff support and supervision
- Access to adequate resources, including time and staffing levels for the relationship building necessary for inequalities sensitive practice
- The lack of alignment of practice with policy, planning and performance management at corporate and local levels. This is not only about mechanisms or systems but also how staff from these groups engage with each other and the perceived or actual differentials in power across these groups.

ISPI has achieved many of the outputs it set out to produce, however the achievement of the outcomes set will need to be progressed through securing the integration of the learning and recommendations from the initiative into National and NHSGGC's mainstream activity.

Local Recommendations

- An **evaluation** of Primary Care Mental Health services should be carried out.

The Primary Care Mental Health teams were set up approximately 3 years ago. There needs to be an evaluation of how effective they have been in meeting the needs of the population. It would be an opportunity for the evaluators to also benchmark ISP. This could give more

weight to current good practice and highlight areas for improvement. Given that the teams vary in how well data is collated there could be scope to emphasis the importance of this in relation to performance management.

- Learning and Development Opportunities which support practice should be available and accessible

Given the positive response to opportunities provided by ISPI there needs to be a more joined up response to providing opportunities especially around Sexual Abuse. This is a challenging area that requires support in relation to practice. There is the opportunity to do this linking into the current work/activity of the Gender-Based Violence Action Plan which is now available on the Equalities in Health website. A questionnaire was sent around some of the teams which asked what teams might need in relation to training and support. Information gathered through the work of ISPI will add weight to this exercise as feedback from ISPI work has shown that teams like training to be delivered on a team by team basis. This appears to be less threatening than big training sessions where it is difficult for some practitioners to ask questions. ***Training needs to be offered in a tiered way. Different roles require different input and therefore training needs to be tailored to the practitioner's previous skill, knowledge and experience.***

- Dissemination of Practical Tools e.g. ISPI DVD should be coordinated and managed centrally

There are some practical supports developed by the ISPI team that will support changes in practice if utilised and disseminated appropriately. These include the practice descriptors, a DVD, and Personal Stories from a practitioner's point of view. The Equalities in Health website is a good resource which can accommodate the personal stories and practice descriptors which can be accessed and then utilised by practitioners. There has been little work done with GP's who have a key role in referring people to primary care mental health services. Therefore it would be a useful and valuable tool if it could be shown across all 5CHCP's at Protected Learning time. All CHCPs have dedicated time which allows GP practices time out for a half day to look at relevant areas of learning. This would be an ideal opportunity to target not only GP's but also practice staff. The ***DVD could be utilised in training opportunities across the mental health network. There is a training co-ordinator for the MHP who should incorporate the DVD into a programme of learning.***

- Structured supervision/support mechanisms for staff dealing with disclosure of abuse should be developed

Given the challenging nature of some of the work there needs to be more support for staff who deals with disclosure of abuse. There are opportunities through supervision to do this which again may require training for those who are acting in a supervisory capacity. There is some work that has to happen in relation to external supervision of counsellors for example as this happens out with the NHS. This should be addressed within ***workforce development programmes which are linked into a national recommendation looking at pre and post registration***

- Dedicated resource operating across the wider mental health network would maintain the development of Inequalities Sensitive Practice

Some of the challenges in this setting related to having responsibility for one part of the mental health network. The community mental health teams (CMHT) had very little input from ISPI as this was not the focus of the ISPI work. Given the interest shown by staff from the secondary sector it would be supportive of helping them look at practice if a dedicated resource was available. This could expand on the existing idea of developing a network of equality and diversity champions which has been jointly developed by the Health Improvement and Inequalities Manager and Patient Services Manager with the MHP. There are plans to employ someone to support Inequalities work in the wards but this still leaves a gap in support for CMHT's. ***An inequalities manager should be employed to fill this gap and further develop an understanding of inequalities sensitive practice.***

- Champions Approach

In order to support PCMH teams to improve data collection which in turn helps with the cycle of enquiry teams could have a champion within each of them teams whose responsibility would be to take the lead on this. Data collection is currently the responsibility of administrative staff who often do not understand why they are collating the data that they do. A more senior member of the team working more closely with them to do this with a view to analysing the information collated. The ***champions should have some responsibility for leading service improvement and changes.*** However this would always be done ***in conjunction with the team leader***. An inequalities manager could lead and support them in this work. Links should also be made to the aforementioned network of equality and diversity champions to share learning.

- Routine enquiry of GBV and poverty which is embedded in the assessment process

There are opportunities with the GBV plan to ensure that across the mental health network people are routinely asked about gbv. The same logic should be applied to issues related to poverty. This currently happens in an ad-hoc fashion. However employability training has taken place in 4 of the 5 CHCP areas which have resulted in teams acknowledging where they currently do this work and where changes need to be made in the assessment process. The Pathways team in South West as a result of the training ask and collate employment status. They are able to report back on this information. If this is an issue for someone they can then refer them appropriately for support whether that is mainstream or specialised mental health and employability services.

The teams should routinely ask about gbv and poverty. In addition to this they should collate data so that they can report back on this and are able to signpost on to the most appropriate service for support.

- Better mechanisms and structures for practitioners to link to the Mental Health Partnership

There needs to be better communication between the partnership and practitioners at a CHCP level. This could link into the role of the champions who could ensure a better use of the current communications system. The membership of the MHP Equality and Diversity Group is constantly reviewed for appropriate membership. ***A practitioner from the primary care mental health setting who has a champion's role should sit on this group to inform and influence decisions which can also be fed back to the Team Leaders meetings.***

National

- The Scottish Government should work with Special Health Boards to ensure that

- Pre registration and post registration workforce development programmes are developed to support mental health practitioners to practice in an inequalities sensitive way
- Data collection processes and mechanisms should developed to support planning and practice.
- Performance management and efficiency targets should be applied to inequalities sensitive workforce development activity at local Health Board level

APPENDIX 1

1. Assumptions	Resources	Activities	1.1.1 Outputs	Outcomes 1.2 Short term Within 2 years	Outcomes Medium term At end of 2 years	Outcomes Long term *Beyond 2 years*
All health and social care partners support collaborative working on ISP All practitioners have an understanding of the effects of socio-economic factors on wellbeing The MHP supports the work of ISPI CHCPs support the work of ISPI Mainstreaming ISP is desirable and achievable ISP will be embedded in service processes Political direction and support around health inequalities will be sustained Current health and social care structures maintain the profile of ISPI	Project Lead – Primary Care Mental Health ISPI Co-ordinator and ISPI team Local Steering Group Relevant Heads of Planning & Health Improvement in SW and North CHCPs Relevant practitioners in Clydebank and East CHCP Primary Care Team Leaders' Group Evaluation support e.g. PHRU Public Health Networks Carr-Gomm Scotland Mental Health Partnership	Gather baseline information: audit, needs assessment & referral systems etc Establish working relationships across Greater Glasgow & Clyde Primary Care Mental Health sector and linked social care agencies Collate evidence on best practice through literature search, local practice, SIGN guidelines etc Link into mechanisms for user involvement and user satisfaction feedback Influence the agenda for specific community development workers in relation to mental health	Multi-disciplinary staff trained in inequality sensitive practice ISP systems for assessment, care planning and referral for women and men with multiple and complex needs Specific protocols that enhance collaborative interagency working Data collection systems that facilitate ISP developments & evaluation User Involvement mechanisms Procedures are gender proofed in line with the Equality Scheme Mechanisms identified to feedback and progress	1. Increased detection of poverty related issues 2. Increased access to support for income maximisation 3. Increased detection of gender based violence experienced by both women and men and associated trauma 4. Increased access to support for survivors of GBV 5. Increase in short term interventions aimed at addressing abuse related trauma 6. Increased detection in risk factors for children requiring implementation of child protection procedures 7. Increased uptake of PCMH services by BME communities, men, young and older age groups as well as those experiencing multiple	Mechanisms are identified and established for extending and integrating developmental work into mainstream delivery in primary care mental health settings Ways are identified of assessing impact on overall health & wellbeing of service recipients in PCMH using inequalities sensitive interventions	Inequalities sensitive practice is embedded across primary care mental health settings in NHSGG & Clyde

2. Assumptions	Resources	Activities	2.1.1 Outputs	**Outcomes** 2.2 Short term **Within 2 years**	**Outcomes Medium term** **At end of 2 years**	**Outcomes Long term** ***Beyond 2 years***
Operational Managers will support activities e.g. training & practice development Able to gain access to service protocols, data collection systems etc across Greater Glasgow & Clyde	management support CH(C)P User Involvement staff Corporate Inequalities Team Equality and Diversity Team Patient Focus Public Involvement	Source, develop & adapt training and learning & development opportunities Link into and influence local organisational & development processes Develop a strategy for communicating and informing the relevant people Gain support, time & investment from practitioners Provide ongoing feedback to relevant senior management groups Contribute to the development and implementation of the equality scheme in primary care mental health	the resource and planning implications of working in the primary care mental health setting in inequality sensitive ways	forms of disadvantage 8. Identified changes in patterns in referrals to secondary care 9. Perspectives of particular groups of service users are involved at various stages 10. Identified enablers and inhibitors for the mainstreaming of inequalities sensitive practice into policy and planning 11. Production of inequalities sensitive performance indicators 12. Identified planning frameworks which support the development of inequalities sensitive practice 13. Identifiable processes which support the requirements of the Equality Scheme (with a particular focus on gender)		