NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties)(Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

Adult ADHD Pathways

Is this a: Current Service ☐ Service Development ☐ Service Redesign ☐ New Service ☐ New Policy ☐ Policy Review ☒

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

Introductory note

NHS Greater Glasgow and Clyde (NHS GG&C) Health board have decided to publish this EQIA for Adult mental health services and Adult ADHD pathways alongside those for Specialist children's services (SCS) and the Adult Autism Service. The EQIA is published against the background that there is no longer available funding for a Neurodevelopmental disorder (NDD) service, thereby the Board must reapply its access criteria for mental health support. This approach – involving as it does, the application of clinically-evidenced access criteria – does not engage section 149 of the Equality Act 2010. Nevertheless, the Board, as a responsible public body, was keen to understand the impacts on particular cohorts, and undertook this EQIA for that reason, as well as to present due diligence and outline the wider context around the policy review and to outline mitigations as far as possible for potential inequalities for all populations involved.

Background – Introduction

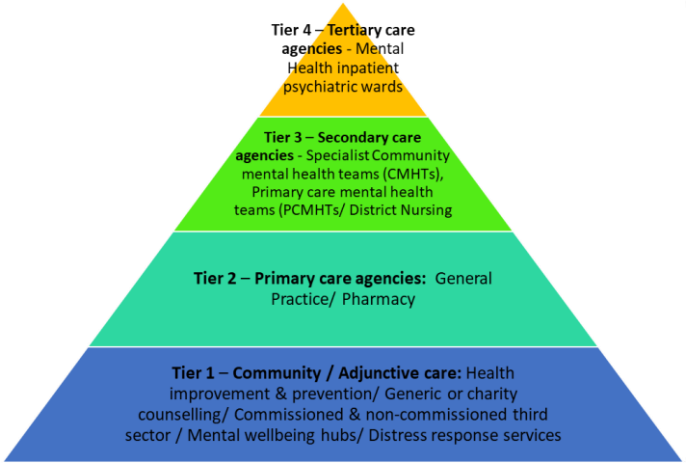
Since 2020, Adult secondary care mental health services have seen an unprecedented increase in referrals for individuals seeking assessment for Attention Deficit Hyperactivity Disorder (ADHD). This represents new work for our community mental health teams (CMHTs), GP/primary care teams and specialist services without any additional resource.

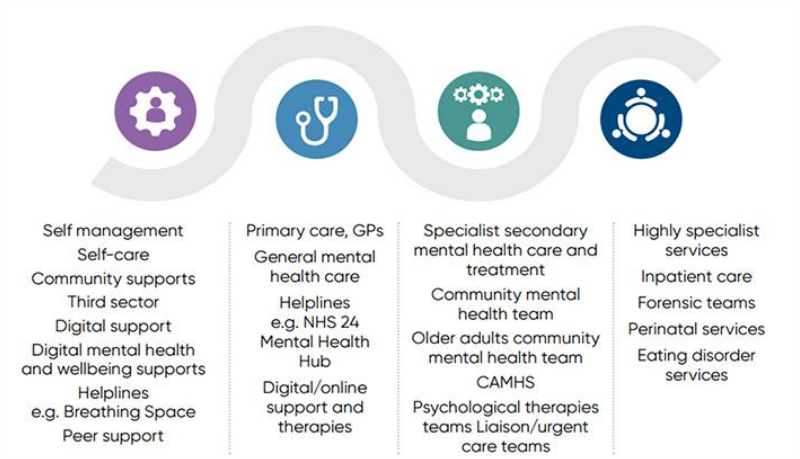
It is estimated that between 3-4%[i] of the population experience ADHD symptoms. This means there will always be a significant mismatch in demand and capacity without a significant increase in resources. All NHS GG&C Health and Social Care Partnerships (HSCPs) saw similar trends over time and so set up waiting lists as contingency measures utilising borrowed resource from existing CMHTs (these provisions are therefore not substantive services). All were intended as interim measures pending the provision of a board wide specialist Neurodevelopmental Disorder (NDD) service. However there are now lengthy waiting list numbers and waiting times across all HSCPs. See **Table 1** below for up to date data.

The Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde[ii]: 2023 – 2028, dated 25 05 2023 states *"There has been a significant increase in demand for assessment for attention deficit hyperactivity disorder (ADHD) since 2018. This will require a review of the pathways for neurodevelopmental disorders (including Autism) and tie in with the neurodevelopmental specification for children and young people*."

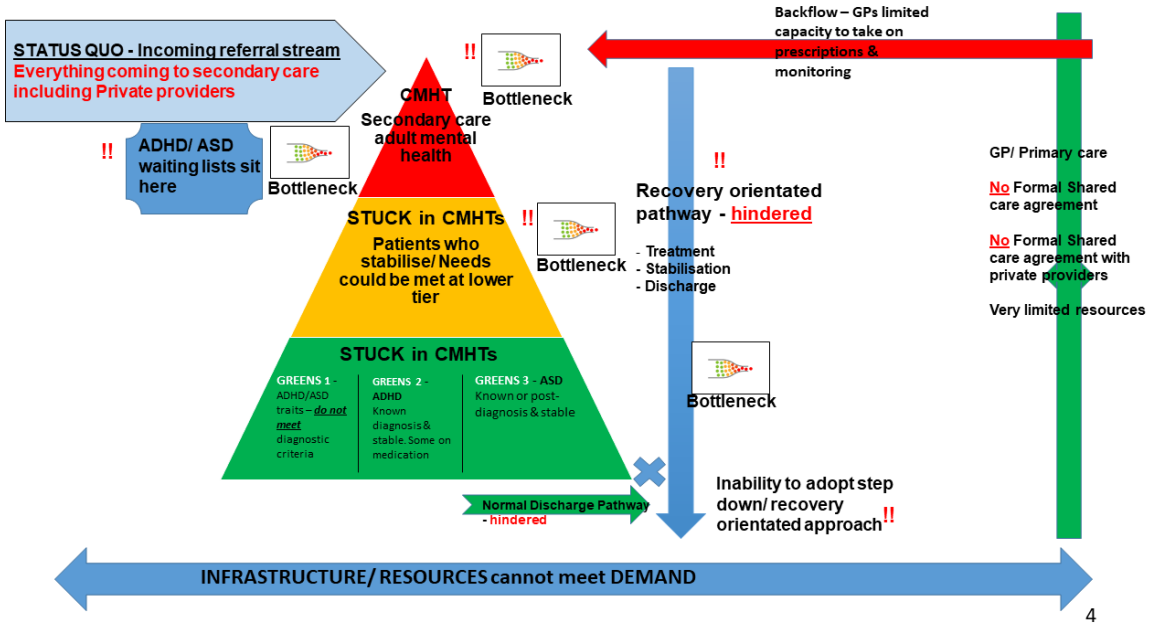
In 2022, an NDD service (at that time costed at £1.5 million, it is anticipated that any new costings would be much higher due to ever increasing demand) was agreed in principle by the Mental Health Programme Board, which was contingent on the commissioning of third sector provision and development of a Shared care agreement with Primary Care to allow for a tiered treatment approach for individuals within a consultation, treatment and step down model. By November 2023, due to the changed financial landscape, funding was not available for the preferred option of an NDD service. Therefore, what was hoped to be developed to support the Mental Health Strategy, was no longer possible.

Please see **Figure 1 and Figure 2[iii]:** which outline roles and remits of different tiers**:**





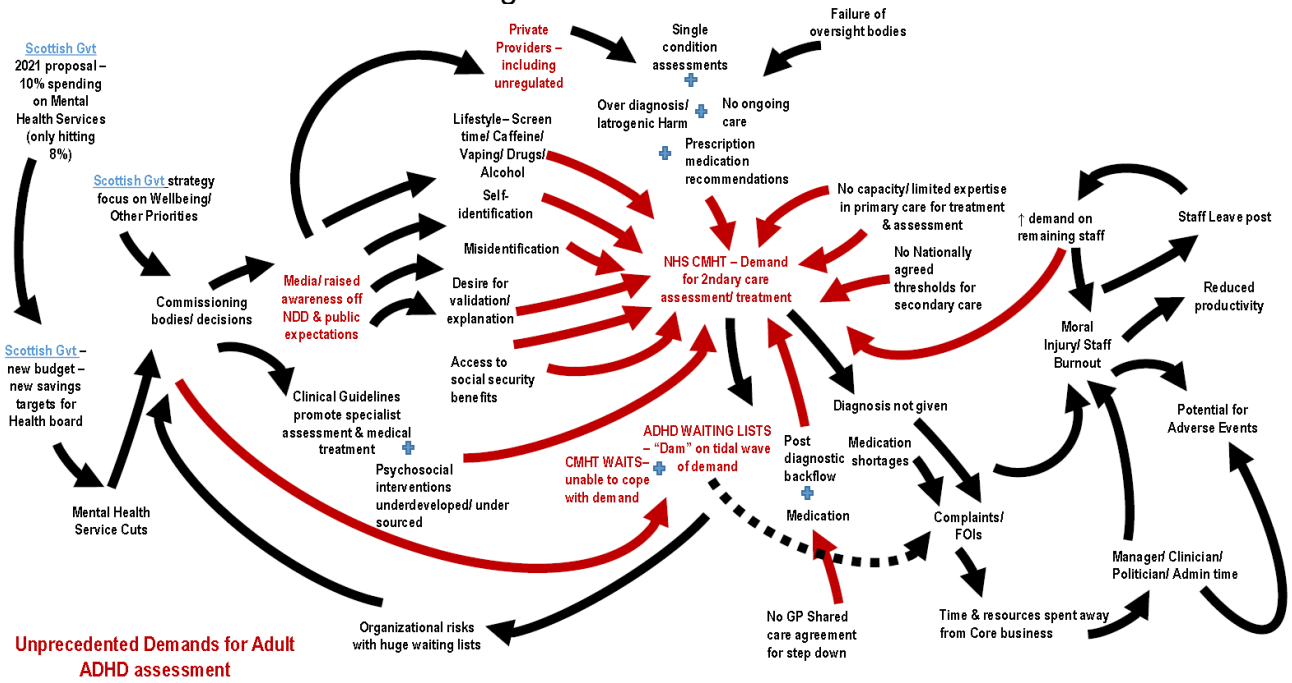
The current scenario is underpinned by notable infrastructure and resource issues at secondary care level, primary care and GP level which cannot and will not be able to cope with the unprecedented new demand. Core adult mental health services at a secondary care level were not originally commissioned for Neurodivergent assessment, treatment and management as a part of core business on this scale, and certainly not for individuals whose needs could be met at lower tier levels or by individual self-management alone. Primary care level services and GPs also have very limited capacity to absorb increased demand as it currently is projected. Parallel challenges also exist in SCS and the Adult Autism team (AAT). Please see **Figure 3** which outlines the resource, infrastructure and flow challenges for adult mental health services in this context:



There are a complex interplay of reasons for the current scenario. There are similar trends noted across not only NHS GG&C, but Scotland and the other devolved administrations in the United Kingdom. This links in to trying to understand the drivers of increasing demand which exist at a societal level, including increased awareness via social media coverage and access (See **Figure 2** below), but to a certain extent also require an understanding about the natural differences and divergences which occur in all of us as human beings (See **Figure 3**).

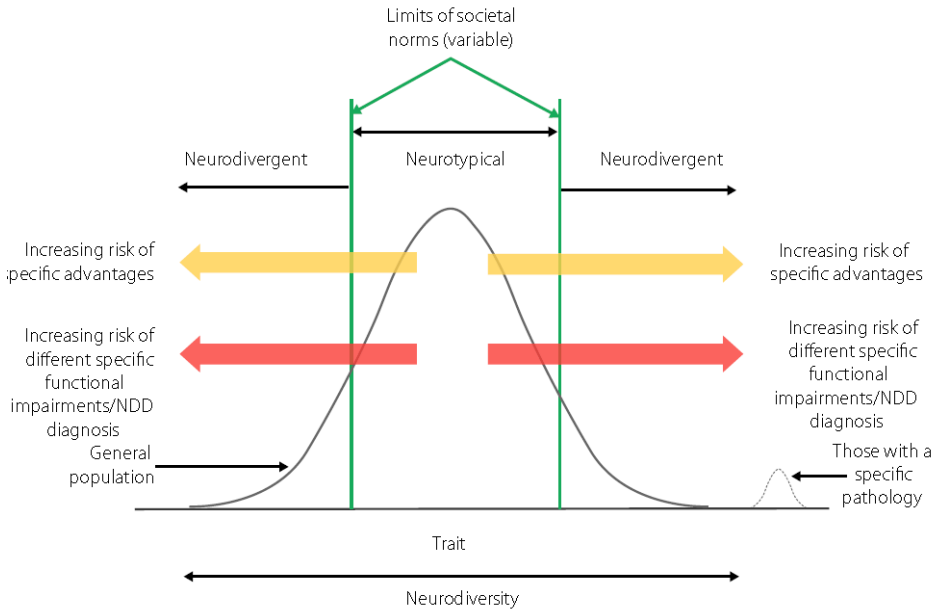
Figure 2: "Unprecedented demands for NDD" below highlighting the scale of the scenario in NHS GG&C. It can now be classified as one pocket of a National and International public health challenge fuelled by greater awareness, the influence of social media, and evolving

societal attitudes towards neurodivergence.



Neurodivergence

Neurodivergence itself is a part of natural human diversity, and should not always be classified as pathological. The risk of overdiagnosis and misdiagnosis should also be noted as these can potentially be harmful. Approaches to assist individuals seeking care from services should span biopsychosocial and practical adjustments, but also a degree of psychoeducation and individual empowerment. This include helping individuals recognise not only their difficulties, but also their strengths and abilities. Please see **Figure 3**[iv]:



While neurodivergence itself is not considered one of the 9 a protected characteristics[v], some neurodivergent conditions such as ADHD under the Equality Act 2010[v] could meet the criteria for disability, if the condition itself it has had a long-term, substantial adverse effect on a person's ability to carry out normal day-to-day activities, which would meet the criteria for pathology. As noted above, not all those with neurodivergence will meet the threshold for pathology, significant impairment to functioning or disability. The Learning Disabilities, Autism and Neurodivergence bill (LDAN)[vi] consultation report was published by The Scottish Parliament on 26.08.2024. Some of the themes it highlighted about the upcoming legislation stated:

(1) *"It was felt that capacity issues (including funding, staffing and staff retention issues, training, and the general availability of services/facilities) would need to be addressed to ensure the proposals can be implemented in a meaningful way[vii].*

(2) *"The status quo is not an option. It is not acceptable for our community to continue to face the discrimination and struggles that are sadly too commonly experienced by us all.*

(3) *"There must be accountability. We need a new mechanism to hold people and organisations to account and to uphold our rights. The form this takes will be informed by the responses to this public consultation".*

(4) *"People with lived experience must be included. For too long, decisions that impact us have been made without us. Once this proposed Bill passes into law, those with lived experience must have a significant role in its implementation and evaluation".*

(5) *Promotion of "inclusivity, understanding and acceptance" for those with Neurodivergence where there is awareness and understanding amongst employers in particular and the Social security system. "Clear information and guidance is available on the*

right to social security and how to apply, including for people without a formal diagnosis".
(6) "People without a formal diagnosis should know how the Bill applies to them"

Core mental health populations

Core mental health populations are those with severe, enduring and acute mental health presentations with relevant diagnoses, risk (such as suicide, homicide or self-harm) related directly to their mental disorder with notable complexities requiring specialist secondary care input from a CMHT. These populations can be classified as possessing protected characteristics and disabilities under the Equality Act 2010 and if they require input from a CMHT either for medium or longer term, they all meet the criteria for significant treatable pathology.[viii]

Currently CMHTs are unable to meet their own core business demands (for which services are specifically commissioned), and are routinely exceeding the 4 week target for new generic assessments. This does not include emergency assessments and care or medical reviews. The increase in demand (3.5% year on year plus 700% for NDD assessments) is exacerbated by the effect of current CMHT staffing gaps sitting at 11%[ix]. There has been no increase in staffing resource to CMHTs despite this increase in demand and Mental Health services still only receive 8% of proposed 10% of allocated spending as outlined by the Scottish Government[x].

Safe service provision for the notably disabled Core mental health populations for whom services were originally commissioned is compromised with the status quo.

Waiting lists – Table 1

As at 05.10.2025, for ADHD alone, the rate of incoming referrals board wide is 80-90 per week. Waiting list numbers and waits are summarised below.

Waiting list	No. of patients	Shortest- Longest wait
Boardwide Adult ADHD	8480	0 – 219 weeks/ 3.9 years

HSCP breakdowns for ADHD waits

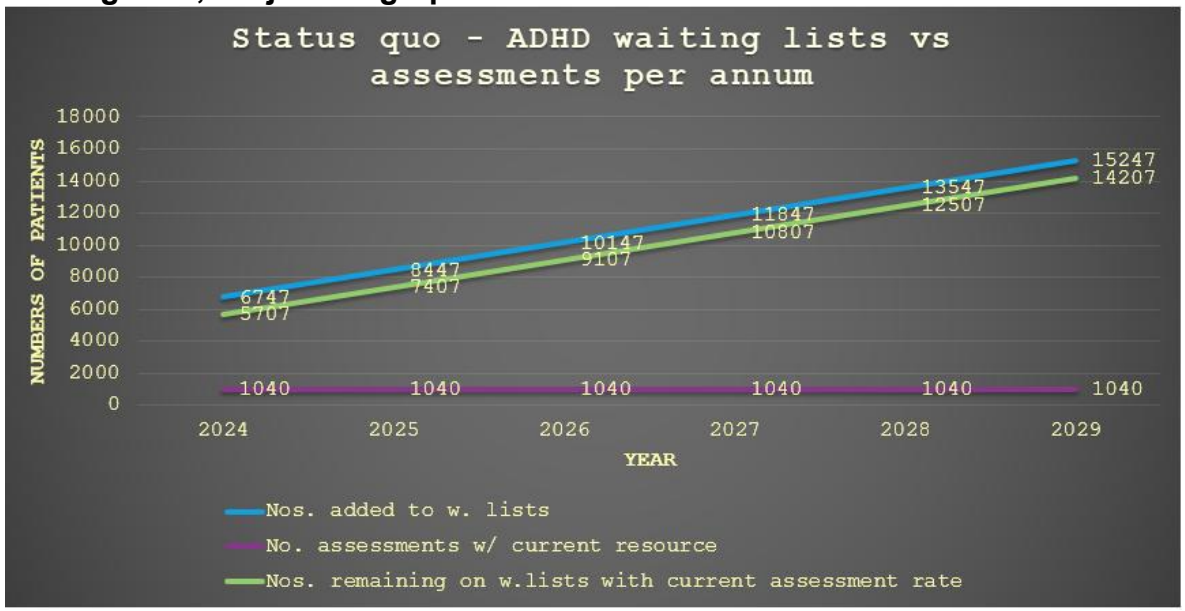
Glasgow City	4904	0 -219 weeks/ 3.9 years
Renfrewshire	2314	2 -174 weeks / 3.1 years
East Dunbartonshire	540	0 - 148 weeks/ 2.6 years
East Renfrewshire	406	0 - 122 weeks/ 2.2 years
Inverclyde	226	0 - 181 weeks/ 3.2 years

West Dunbartonshire	90	0 – 109 weeks/ 1.9 years

The "do nothing" option/ status quo

With current aligned resources if the status quo were to continue, projections are that by 2029, Adult ADHD waiting lists would sit with approximately 14,000 individuals. There is a corporate risk that without more focussed waiting list validation and clearly defined criteria and pathways for assessment and treatment (in the absence of a substantive service for NDD) individuals on waiting lists will have to wait many years for assessment and a further significant wait to receive treatment in CMHTs. For context regarding the current pressures and aligned resources - if waiting lists were to close at this current date, it would take approximately 25-30 years to clear the waiting lists.

See Figure 4, Projection graphs:



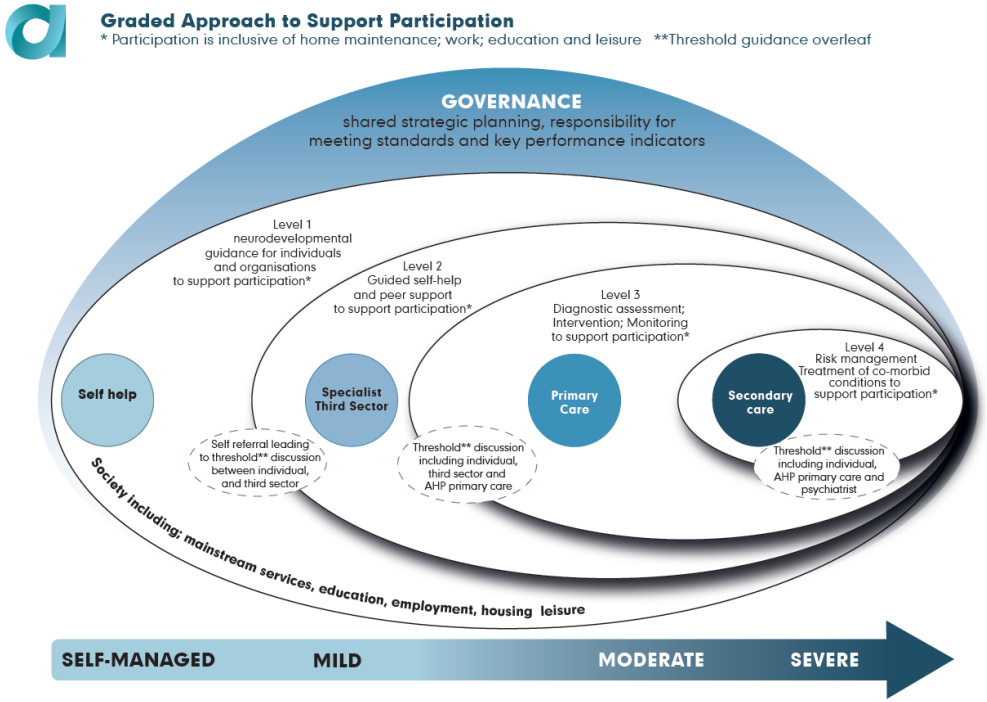
There are approximately 4900 patients already on CMHT caseloads who are prescribed stimulant medications for ADHD. Many of these are stable and no longer require higher tier input but cannot be stepped down to primary care due to a lack of a formal shared care agreement. This is creating bottlenecks in already pressurised CMHTs. For all other patient groups there is a clear negative impact on their care and treatment due to the demand for ADHD assessments. Many CMHTs are exceeding the 4 week generic assessment target. In the last 12 months, of the approximately 10,000 generic assessments undertaken – only 43% were within target.

For specialist mental health services such as Addiction Recovery Services (ADRS); Older Peoples' Mental Health (OPMH) and Perinatal services, Eating disorders and
Forensic psychiatry there is also no additional resource for de novo assessments or treatment for ADHD for individuals who meet criteria for NAIT levels 1-3.

The status quo, underpinned by a lack of existing resource and infrastructure is significantly disadvantaging not only Core mental health populations, but also creating false expectations of services for those seeking assessment for ADHD who are sitting on lengthy waiting lists with increasing waiting times. This does not align with the Scottish Government's NHS Scotland operational improvement plan which pledges that by March 2026, no individual should be waiting longer than 1 year[xi] for an outpatient appointment. There is no current scope to provide robust, timely, holistic and recovery-orientated care for those seeking ADHD assessment to a standard that staff would like to deliver. CMHT staff are under pressure with demands from core populations who have to be prioritised for those with the most significant pathology and presenting risks.

Proposals
With no funding to take forward the preferred option of a substantive NDD service previously agreed in principle by the Mental health programme board, the following proposals were escalated in order to support recalibrating of clinical criteria for CMHTs as reverting back to practice in keeping with service specifications for which services are commissioned. This does not constitute a substantive service change as ADHD waiting lists are not substantive services. Escalation was via all Mental health governance and leadership structures to Chief officers and the Corporate Management Team (CMT). Of note – the proposals are in reference to Adult populations only (age 18-65 cohort). Proposals for the Adult autism team (AAT) and Specialist Childrens' services are being considered under a parallel process and have separately published EQIAs.

Proposal 1: Reapplication of CMHT acceptance criteria to waiting lists against NAIT level 4 (previously referred to as Red), NAIT level 3 (previously referred to as Amber), NAIT levels 1-2 (previously referred to as Green) categorisation for Core mental health populations and new ADHD referrals from a set agreed date - If individuals do not fulfil criteria for NAIT 4 level categorisation, they will no longer be accepted to ADHD waiting lists from set agreed implementation date. This would bring ADHD assessments in line with tiered treatment approaches as for other mental health conditions and would be in keeping with recommendations from the National clinical ADHD Pathway Feasibility Study[xii] commissioned by Scottish government undertaken by the National Autism Implementation Team (NAIT). Additionally, The Royal College of Psychiatrists ADHD in adults: Good practice guidelines,[xiii] also state *"only those at the more severe end [of pathology] are referred to specialist mental health services" and that "as with other mental health conditions, diagnoses assessment and management of ADHD in the NHS context needs to involve the whole multidisciplinary team"*. This would also be in line with the National Access Policy[xiv].



Proposal 2: Waiting list validation

- **Pooling existing ADHD provisions plus additional time limited requested resources with centralised oversight to review existing waiting lists and those already in services** – the expertise developed by staff within ADHD roles is invaluable and should be celebrated and supported. This resource and expertise can be pooled for a time limited period and used to review existing waiting lists for re-triage against core CMHT business and NAIT criteria (short term); proceeding to assessment if NAIT level 4 criteria met and re-aligned to ongoing treatment of those already in CMHT services (medium – longer term).
- **Existing waiting lists, following re-triage – NAIT levels 1-3 - assessments will not proceed -** Following further validation and re-triage, individuals who are triaged as NAIT levels 1-3 will not proceed to further assessment. Individuals on waiting lists will be signposted to appropriate alternative supports and correspondence will be supported by corporate communications in a planned consistent manner. It should be noted that if assessments were to proceed with current aligned resource, at the current rate (with the caveat of no NAIT levels 1-3 additions to waiting lists), calculations estimate that it would take **approximately 25-30 years** to clear the waiting lists.

Proposal 3: Private provider acceptance criteria – individuals privately diagnosed with ADHD seeking continuing care in NHS services will also be subject to reapplication of CMHT acceptance criteria from set agreed implementation date – CMHTs and GP colleagues continue to see a rise in patients who have been diagnosed with ADHD by Private Providers. Those diagnosed with ADHD are then requesting stimulant medication to be commenced or continued in the NHS. GP colleagues have limited capacity to provide this as do CMHTs. Most other Scottish Health boards do not accept private referral diagnoses, or only accept those that meet secondary care criteria. There is a current GGC policy on these in place which does allow acceptance if the assessment is deemed robust enough to diagnose ADHD, however it has created some challenges:

- Most of these providers are not regulated. The quality of assessments varies and the governance around single condition assessments differs from NHS governance standards with a risk of misdiagnoses, iatrogenic harm and other differential diagnoses being missed.
- A two-tiered system whereby individuals who can afford private assessments can get them faster than those who cannot
- Individuals are given unrealistic expectations by private providers that continued treatment will be guaranteed in the NHS
- There are significant capacity issues in CMHTs to continue accepting these referrals as numbers continue to rise, and especially as yet no agreed formal shared care agreements with GP colleagues due to their capacity issues.
- Ongoing concerns raised by front line clinical staff about bouncing private referrals between primary and secondary care due to lack of shared care agreements (NHS or private) and disagreements about responsibilities to prescribe and monitor patients thereby creating conflicts. Increased burden on adult secondary care clinical staff due to extra workload from ADHD including as per the current NHS GG&C policy for private referrals to quality assess assessments before acceptance to GG&C statutory services. This is potentially British Medical Association (BMA) challengeable as it is extra workload additional to current job plans since the unprecedented increase in ADHD demand. It is also not NHS secondary care clinicians' role or responsibility to quality-assess private provider assessments.

Proposal 4: Development of a Corporate communications plan– A central communications plan will support the proposals to aid formal communications about implementation. This will include correspondence with individuals newly referred, those already on existing waiting lists and those who may present to primary care seeking assessment. All changes will be clearly outlined on the NHS GG&C website, Right Decisions - ADHD (Guidelines) | Right Decisions (scot.nhs.uk), outlining the relevant dates for when provisions will change. This will help communicate the changes to staff, the public and the continued effort to respond to enquiries, complaints and FOIs.

Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name:	**Date of Lead Reviewer Training: TBC**
Dr C Blayney, Clinical Lead for Mental Health Strategy, NHS GG&C	GCHSCP Lead for Equality and Fairer Scotland provided support and guidance with the EQIA process.

Please list the staff involved in carrying out this EQIA
(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

Dr C Blayney, Clinical Lead for Mental Health Strategy, NHS GG&C Ms A Hill, Lead for Equalities & Fairer Scotland, Health Improvement Team, NHS GG&C Ms P McGoldrick, Change & Development Manger, NHS GG&C

		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
1.	**What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.**	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** - Referral information is held on EMIS (electronic record keeping system) and includes basic demographics, sex, veteran status etc. Clinical information review of original referrals and decisions made at triage meetings are also held on EMIS. Any specific information about pre-assessment impaired functioning is held in the referral and chronological account of care on EMIS. - Equalities data is not collated in a consolidated manner on EMIS dashboards or otherwise for all individuals on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. - Barriers for consolidating the equalities data – there is no current EMIS dashboard solely for ADHD waiting lists, and it is not routinely collected, presented or analysed in a	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** – **(1)** the lack of data is preventing a deeper understanding Boardwide about the varying different sub-cohorts of individuals on ADHD waiting lists. Therefore tailored support or communication is also lacking for those on waiting lists. See **Figure 3** for the potential for different cohorts. **(2)** No clear current stratification or prioritisation of those on waiting lists is in place. This is potentially contributing to frustrations among individuals who are waiting lengthy times to be seen, whose expectations and needs cannot be met timeously. The proposals will mean many of these individuals will not be assessed. The Health Board recognises that a certain cohort will have to seek out other means of assessment and treatment, while others will be left without access to a statutory provision if they do not meet NAIT thresholds for CMHT input. This may cause distress for some individuals and their families. Some individuals will not be able to access an assessment which may lead to a diagnosis or life-improving medication via the current NHS provisions due

		consolidated manner locally in CMHTs. **<u>Cohort 2 – Individuals currently using the service (those with diagnosed ADHD, receiving medication via CMHTs)</u>** - EMIS holds basic demographics, sex, veteran status. Clinical information including referral, assessment, degree of impaired functioning and diagnostic information is held in the chronological account of care and on clinical letters on EMIS. - Equalities data is not collated in a consolidated manner on EMIS dashboards or otherwise for all those with a diagnosis of ADHD receiving treatment. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. - Barriers for consolidating the equalities data – there is incomplete diagnostic coding for those on CMHT caseloads and all CMHTs hold ADHD patients on differing named caseloads on EMIS. The information is not routinely collected, presented or analysed in a consolidated manner locally in CMHTs. **<u>Additional note re: Cohorts 1 & 2</u>** Cohort 2- individuals already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of approximately 5000 patients to primary care for	to a lack of a funded lower tier service. There is a commitment to address this for the longer term outlined below. **Mitigating factors** – **(1)** There is progress being made with the development of an ADHD dashboard where this data will be collated centrally for oversight. **(2)** Proposals will involve re-application of clinical criteria, re-triage of the waiting lists and signposting to the NHSGG&C self-help pack materials, the Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> and NHS GG&C website. **(3)** There is ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more resources for ADHD assessment via a tiered, multi-system approach. Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(5)** The Royal college of psychiatrists have recently published (2025) a report[xv] – ***<u>"Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"</u>*** which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD. **<u>Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving medication via CMHTs)</u>** **Negative impacts** – **(1)** due to incomplete diagnostic coding and patients sitting on differing named caseloads in all CMHTs, there is a lack of accurate data about the equality profile of those with ADHD receiving treatment.

		ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients, especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity and as yet, a lack of a GP shared care agreement. CMHTs are not enforcing a "discharge and not reaccept" operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create a two tier system for those diagnosed and commenced on treatment before and after implementation of the new proposals and Cohort 1 – a proportion of those on adult ADHD waiting lists. Rationale for this is outlined in the aforementioned paragraphs. Negative impacts and mitigations are outlined in the next columns. **Cohort 3 – Core Mental Health populations** - Referral information is held on EMIS (electronic record keeping system) and in includes basic demographics, sex, veteran status etc. Clinical information in the original referral and decisions at triage meetings are also held on EMIS. Any specific information about pre-assessment impaired functioning is held in the referral and chronological account of care on EMIS. - Equalities data is not collated, analysed or	This extends to those who no longer require to be seen in a secondary care service due to stability, but a step-down recovery orientated approach cannot be adopted due to a lack of resource in primary care and lack of a share cared agreement. **See Figure 3. (2)** Regardless of NAIT criteria, this cohort will remain in treatment unless they default or decide to cease it by choice at any point in their journey. These patients may become anxious when new proposals are implemented and worry about the future of their treatment. If they default from treatment, they may not be re-accepted to back into CMHT services unless they meet NAIT level 4 criteria and subsequently may opt have to seek alternative provisions to recommence medication. **Mitigating factors** – **(1)** operational steps to identify and communicate with all those with ADHD in CMHTs (regardless of NAIT level or stratifications status) is underway. **(2)** These individuals will be communicated with by text or letter in the first instance which will include signposting to the NHSGG&C self-help pack materials, the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website. and reassured that their treatment will continue as usual, however if they default from treatment and no longer meet NAIT level 4 criteria, their care and treatment may have to be sought from elsewhere if they wished to recommence. **(3)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities. **(4)** Processes for non-urgent enquires and complaints are being set up for individuals if

		reviewed regularly either locally or at a Boardwide level for this cohort. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. **There is no EQIA for Core mental health populations and how the current status quo is affecting them.**	they wish to present these. **<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – **(1)** Due to incomplete diagnostic coding and lack of consolidated data, there is a lack of accurate data and deeper understanding about the equality profile of Core mental health populations overall, and how the current status quo is affecting them. **Mitigating factors** – **(1)** There are ongoing efforts to improve diagnostic coding for all individuals on CMHT caseloads, including core mental health populations. **(2)** Deeper dive quality improvement projects or audits could be commissioned to improve this data collection to further in inform tailored support for this cohort in terms of inequalities. **(3)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities. **(4)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
2.	**Please provide details of how data captured has been/will be used to inform policy content or service design.**	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** Any equality data captured from initial referral information is held on Clinical record keeping systems (EMIS) and will be used to re-triage all the waiting lists as a part of waiting list validation and reapplication of CMHT criteria. This will help tailor access to assessment if NAIT level 4 criteria are	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** – **As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a

	Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	met and signposting for those who meet NAIT levels 1-3 criteria. The NHS GG&C resource pack includes advice covering different domains and an inventory of wider supports. **Cohort 2 – Individuals currently using the service (those with diagnoses of ADHD, receiving medication via CMHTs)** Across the HSCPs, improving data capture for this cohort is in progress. Regardless of NAIT criteria, this cohort will remain in treatment unless they default or decide to cease it by choice and would only be reaccepted if NAIT 4 criteria met. This includes for stable individuals who cannot be stepped down to primary care due to a lack of a shared care agreements with GPs. **Cohort 3 – Core Mental Health populations** Across the HSCPs, improving data capture for this cohort is in progress. Due to known high levels of disability in this population and a lack of an EQIA to assess how the current status quo is affecting them, this is a known gap in deeper knowledge and understanding.	diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **Mitigating factors** – **(1)** Signposting to the NHSGG&C self-help pack This includes advice covering different domains and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website. **(2)** Ongoing improvement in data capture is being progressed to gain a better understanding of caseload profiles and NAIT level criteria for all Cohorts 1-3. **(3)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities. **(4)** Processes for non-urgent enquires and complaints are being set up for individuals if they wish to present these. **(5)** There is ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more resources for ADHD assessment via a tiered, multi-system approach. Previously agreed proposals for a Boardwide

			Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(5)** The Royal college of psychiatrists have recently published (2025) a report[xv] – **"***Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
3.	**How have you applied learning from research evidence about the experience of equality groups to the service or Policy?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐	**(1)** This demand is not unique to NHS Greater Glasgow and Clyde but is an observed national and international trend and there is a requirement for a national public heath response to this. The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups. **(2)** Other Health Boards in Scotland (NHS Borders, NHS Highland, NHS Lanarkshire, NHS Grampian and NHS Ayrshire and Arran) have elected to implement secondary care criteria for all ADHD referrals to adult mental health services. Some health boards are further down the line in terms of implementation stages and senior leadership representatives from all the Boards continue to liaise to understand processes, learning and advocate for both core mental health and neurodivergent populations. Proposals bring query ADHD referrals and treatment approaches in line with referrals for all other psychiatric presentations for example mild to moderate anxiety or mood	**Negative impacts** – **As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **(2)** There is no EQIA for Core mental health populations and how the current status quo is affecting them. **Mitigating factors** – **(1)** Due to the widespread National trends seen across Scotland, there is ongoing engagement between the Health Board, Scottish

	3) Foster good relations between protected characteristics ☐ **4) Not applicable** ☐	disorders – assessment and treatment for which is via a tiered model. CMHTs will only be able to function effectively if they are allowed to focus on the management of those with significant psychopathology. **(3)** The Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028, dated 25 05 2023 states *"There has been a significant increase in demand for assessment for attention deficit hyperactivity disorder (ADHD) since 2018. This will require a review of the pathways for neurodevelopmental disorders (including Autism) and tie in with the neurodevelopmental specification for children and young people*." **(4)** An accurate diagnosis in the current climate can support an individual to access prescribed ADHD medications (if clinically indicated and preferred by the individual), workplace supports in the form of reasonable adjustments, access to social security and other social supports e.g. household assistance, depending on the degrees of functional impairments and disability. These are underpinned by the evidence-based clinical guidelines for biopsychosocial interventions for ADHD[i]. There is also Scottish government guidance on how individuals can be supported by multidisciplinary professionals to access relevant supports[xvi].Types of supporting information from a professional - mygov.scot	Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more resources for ADHD assessment via a tiered, multi-system approach. **(2)** Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(3)** There is growing momentum for a public health approach and The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups **(4)** The LDAN bill consultation advocates for individuals gaining access to reasonable adjustments, social security etc. without the need for a diagnosis. Once the LDAN bill is published, this will provide legal protections for access for individuals to these measures without the need for a diagnosis. If LDAN bill not passed, we will review EQIA. **(5)** There is no universal policy across Scotland stating that a neurodevelopmental (NDD) or disability diagnosis is required for referral to disability social work services. Staff feedback suggests local variation. **(6)** The Mental Health Strategy is progressing the ADHD proposals as a priority, being cognisant of the extremely difficult scenario. There is ongoing engagement via governance structures as a priority and commitment to monitoring evolution of a wider public health approach to address the needs of those with neurodiversity. **(5)** The Royal college of psychiatrists have recently published (2025) a report – *"Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD. **(6)** Completion of an EQIA for core mental health populations

		<u>Core mental health populations -</u> There is no EQIA for Core mental health populations and how the current status quo is affecting them.	and how the status quo as outlined above is affecting them is recommended following on from this EQIA.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support.** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).**	There has been regular engagement with all the relevant stakeholders including: • Mental health stakeholders • Neurodevelopmental Disorder steering group • Heads of Service (HoS) • Clinical Directors – all specialties • Allied Health Professional Leads (Occupational Therapy, Psychology and Pharmacy) • Specialist Children's Services. • Primary Care colleagues • GP Clinical Directors • the Local Medical Committee (LMC) • Public Health Consultant with remit for Mental Health • Chief Officers for all the HSCPs • Corporate Management Team, NHS GG&C Stakeholders recognise the wider demands of ADHD and how services have struggled to cope at all different levels with the new demands. Stakeholders are not in favour of the "do nothing" option given the pressures and demands, and are supportive of the recommendations proposed below in the absence of the previous preferred option of a commissioned NDD service.	**Negative impacts** – **(1) As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis or medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **(2)** It is anticipated that there may potentially be a significant impact on primary care who may see repeated attendances by individuals seeking re-referral or requesting recommencement and ongoing prescribing and monitoring of ADHD medications if the option is not available to them in CMHTs. - Regarding **NHSGGC's corporate aims**, approach to equality and diversity and environmental impact are assessed as follows: **(1) Better Health –** proposals may have a **<u>Negative</u>**

	1) Remove discrimination, harassment and victimisation **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable**	Lived and Living experience engagement has proceeded in terms of feedback from individuals with ADHD including a number of lived experience focus groups facilitated by third sector organisations and a lived experience staff forum. This feedback was used to develop and refine the self-help pack resource prior to finalisation and publication. A plan to further develop and strengthen this resource as required within the next 6 to 12 months, with robust lived experience contributions and facilitation from the NHSGGC Public Engagement Public Involvement (PEPI) team is being developed. While there is no requirement to engage with service users in applying the National Access Policy, the application of realistic medicine principles does intend to engage with service users by "*listening to understand patients' problems and preferences*"[xvii]. We recommend future planned engagement with individuals with lived and living experience with different cohorts **(1)** representation from core mental health populations **(2)** representation from those with query ADHD **(3)** representation from those with diagnosed adult ADHD. This would help to garner a wider understanding about how the status quo has affected all relevant populations. In the absence of new funding to develop a specialist NDD service there is a consensus view that the do nothing option is not sustainable and	impact for those on ADHD waiting lists for the short-medium term, although core CMHT mental health populations will see **Positive** impact. **(2) Better Care –** proposals may have a **Negative** impact for those on ADHD waiting lists for the short-medium term, although core CMHT mental health populations will see **Positive** impact. **(3) Better Value -** proposals will have a **Positive** impact for core CMHT mental health populations, as resource will re-align to the services' commissioned needs for this population. **(4) Better Workplace** – proposals will have a **Positive** impact on CMHTs as staff will be able to focus on core mental health work which is what they have primary training and expertise in and were originally employed for. **(5) Equality & Diversity – proposals will have an overall Negative impact** on those seeking ADHD assessment but a **Positive** impact on Core mental health populations as the **resources are currently pitted against each other.** **(6) Environment - Neutral** impact **Realistic medicine[xviii] principles that apply:** **- Managing risk better** – The proposals would allow safer risk management for: **(1)** Core adult mental health population cohorts - for whom services are commissioned. Risk management is a key element of clinical care (e.g. suicide and self-harm risk). **(2)** Lengthy adult ADHD waiting lists and waiting times currently present a risk to individuals whose needs and expectations cannot be met, as well as risk to the organisation with huge numbers on waiting lists with no

		represents a poor service for core mental health populations, individuals seeking ADHD assessment, staff and stakeholders. **There is no EQIA for Core mental health populations and how the current status quo is affecting them**	viable prospect of an available tiered robust service. **(3)** There continues to be risk to staff wellbeing and recruitment and retention due to the status quo. This also dovetails the impact on key corporate aims which are outlined above. **- Reducing harm and waste** – The proposals will allow refocus on core adult mental health populations and reduce the harms associated with the above outlined risks. It would allow the re-absorption of borrowed resources from CMHTs which were redirected for adult ADHD waiting lists. **- Reduce unwarranted variation** – The proposals are in keeping with moves made by other Health Boards across Scotland who have all seen similar adult ADHD demands and have had to put in place the application of similar clinical criteria for CMHTs. It would also reduce variation across the six Health and social care partnerships (HSCPs) in NHS GG&C itself, as the same approach would be adopted across the Board. **Mitigating factors** – **(1)** Signposting to the NHSGG&C self-help pack This includes advice covering different domains and an inventory of wider supports. **(2)** Ongoing engagement with primary care colleagues and a central corporate communications approach to support both primary and secondary care across the HSCPs. Individuals will be able utilise these routes and receive feedback via these pathways. Processes for non-urgent enquires and complaints are being set up for individuals if they wish to present these. **(3)** Due to the widespread National trends seen across Scotland, there is ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team

			(NAIT) and the Royal College of Psychiatrists to advocate for more resources for ADHD assessment via a tiered, multi-system approach. **(4)** Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(5)** There is growing momentum for a public health approach and The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups **(6)** The LDAN bill consultation advocates for individuals gaining access to reasonable adjustments, social security etc. without the need for a diagnosis. Once the LDAN bill is published, this will provide a legal protections for access for individuals to these measures without the need for a diagnosis. If LDAN bill not passed, we will review EQIA. **(7)** The Mental Health Strategy is progressing the ADHD proposals as a priority, being cognisant of the extremely difficult scenario. There is ongoing engagement via governance structures as a priority and commitment to monitoring evolution of a wider public health approach to address the needs of those with neurodiversity.**(8)** The Royal college of psychiatrists have recently published (2025) a report– "*Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD.**(9)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(10)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical

			criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
5.	**Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good**	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **<u>(1)</u>** Across the HSCPs, ADHD assessments for those on waiting lists take place in different formats. Some HSCP assessment provisions see patients face to face, others through purely remote assessments via video consultation or telephone consultations and others provide a hybrid model. For in person assessments, locations are based in CMHT clinics. High priority core mental health cohorts may require face to face assessment depending on their presentation. Individuals who would meet NAIT level 4 criteria may also require face to face assessment depending on their presentation. Due to nature of potential risks and mental disordered presentations, if warranted, any individuals who meet certain thresholds, can also be subject to assertive outreach e.g. emergency domiciliary visits. **(2)** Re-triage process – as outlined above, staff working in existing ADHD provisions and additional time limited resources from relevant qualified mental health staff (therefore with appropriate expertise and qualifications) will undertake the re-triage process. This will involve review of clinical information in the original referral, chronological account of care on EMIS, clinical letters, patient and carer questionnaires, background questionnaires and	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** – **(1) As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **<u>Additional note re: Cohorts 1 & 2</u>** Cohort 2- individuals already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of approximately 5000 patients to primary care for ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients,

	relations between protected characteristics. **4) Not applicable**	physical health information on clinical portal and reviewing against criteria for core mental health populations and NAIT levels. Guidance for staff will be published to ensure consistency of application of criteria. Individuals will not be contacted or reviewed during the re-triage process and therefore it is not anticipated that there will be an impact on individuals' communication or other support needs. **<u>Cohort 2 – Individuals currently using the service (those with diagnoses of ADHD, receiving medication via CMHTs)</u>** Across the HSCPs, ADHD follow-up in CMHTs takes place in different formats. Clinics involve seeing patients face to face, others are purely remote appointments via video or telephone consultation and others provide a hybrid model. For in person assessments, locations are based- in CMHT clinics and some include medical monitoring clinics for those on ADHD medications which currently require in person attendance at CMHT clinics. This includes for stable individuals who cannot be stepped down to primary care due to a lack of a shared care agreement. There is ongoing progress of DOCCLA pathways to set up remote digital pathway systems for medication monitoring for those on ADHD medications. EQIAs have been completed for DOCCLA pathways in the Health Board. **<u>Cohort 3 – Core Mental Health populations</u>**	especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity and as yet, a lack of a GP shared care agreement. CMHTs are not enforcing a "discharge and not reaccept" operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create a two tier system for those diagnosed and commenced on treatment before and after implementation of the new proposals and Cohort 1 – a proportion of those on adult ADHD waiting lists. Rationale for this is outlined in the aforementioned paragraphs. Negative impacts and mitigations are outlined below. **Mitigating factors** – **(1)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities. **(2)** High priority core mental health cohorts may require face to face assessment depending on their presentation. Individuals who would meet NAIT level 4 criteria may also require face to face assessment depending on their presentation. Due to nature of potential risks with mental disordered presentations, if warranted, any individuals who meet certain thresholds, can also be subject to assertive outreach e.g. emergency domiciliary visits. **(2)** Proposals

		Digital innovation pilots such as DOCCLA implementation are for ADHD patients or an overseeing carer only. They are not for Core mental health populations – many of whom have significant physical co-morbidities and monitoring needs e.g. antipsychotic monitoring, again which cannot always be done in primary care due to a lack of resources. Due to high levels of disability in this population, DNA (do not attend) rates can be high which often require escalation to assertive outreach. Digital innovation and engaging carers would also significantly aid this cohort of individuals, however the current innovations are only focussed on ADHD populations – many of whom may not meet criteria for significant disability, especially if stabilised on medication. **There is no EQIA for Core mental health populations and how the current status quo is affecting them.**	will involve re-application of clinical criteria, re-triage of the waiting lists and signposting to the NHSGG&C self-help pack materials. The self-help pack includes advice covering different domains and an inventory of wider supports. **(3)** Processes for non-urgent enquires and complaints are being set up for individuals if they wish to present these. **<u>Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving medication via CMHTs)</u>** **Negative impacts** – **(1)** For stable and optimised functioning-individuals with ADHD whose profiles are in keeping with NAIT levels 1-3, who no longer require to be reviewed in secondary care, there is a lack of a step-down recovery orientated approach due to a lack of resource in primary care and as yet a lack share cared agreements. If on ADHD medications, these individuals still have to attend in person appointments due to a lack of alternative options for submitting their monitoring results. **Mitigating factors** – **(1)** Ongoing engagement with DOCCLA set up remote digital pathway systems for medication monitoring for those on ADHD medications. If implemented, this would give this cohort more freedom and accessibility to convenient remote monitoring rather than physical having to attend clinics. **<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – **(1)** Digital innovation pilots such as DOCCLA implementation are for ADHD patients only. They are not for Core mental health populations **(2)** There is no EQIA for Core mental health populations and how

			the current status quo is affecting them. **Mitigating factors** – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability. **(2)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(3)** Explore how Digital innovation pilots such can be resourced and extended for Core mental health populations once DOCCLA ADHD pathways are established.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
6.	**How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and**	**<u>Waiting List Validation - Cohort 1 – Individuals on ADHD waiting lists</u>** Holding information text messages with embedded links to letters will be distributed to all on adult ADHD waiting lists to inform them about upcoming review of waiting lists, as well as the commitment to further correspondence via letter once waiting list validation is complete. This process will be done via the NHS GG&C e-health Netcall Hub. For any individuals where texts are not delivered, there will be a feedback mechanism via the Netcall hub which will inform letters going to individuals. Following the full re-triage process – individuals who meet criteria for NAIT levels 1-3 will be contacted via letter to inform them that assessments will not be proceeding. Letters will also include signposting to the NHSGG&C self-help pack materials which include advice covering different domains and an inventory of wider	**<u>Waiting List Validation - Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts - As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis a diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option.

	victimisation **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☒ **The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.**	supports. **<u>NHS GG&C Digital resources and self-help pack</u>** Links to the NHS GG&C website and Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> sections will be provided on letters. The self-help pack has been validated via GG&C equality channels and will be available digitally, via QR code, in printable formats in different languages including for deaf and blind individuals. Both secondary and GP colleagues will have access to this and be briefed on appropriate signposting. It has had been reviewed and feedback submitted by lived and living experience groups. Digital innovation pilots such as DOCCLA implementation are for ADHD patients or an overseeing carer only and not core mental health populations. **<u>Cohort 2 – Individuals currently using the service (those with diagnoses of ADHD, receiving medication via CMHTs)</u>** Operational steps to identify and communicate with all those with ADHD in CMHTs (regardless of NAIT criteria) is underway. This will be via letter or text in the first instance. and signposted to the new proposals and pathways on the Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> and reassured that their treatment will continue as usual, however if they default from treatment and no longer meet NAIT 4 criteria, their care and treatment would	**<u>Additional note re: Cohorts 1 & 2</u>** Cohort 2- individuals already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of approximately 5000 patients to primary care for ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients, especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity and as yet, a lack of a GP shared care agreement. CMHTs are not enforcing a “discharge and not reaccept” operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create a two tier system for those diagnosed and commenced on treatment before and after implementation of the new proposals and Cohort 1 – a proportion of those on adult ADHD waiting lists. Rationale for this is outlined in the aforementioned paragraphs. Negative impacts and mitigations are outlined in the next columns. **Mitigating Factors** – **(1)** Planned communications in 2 stages – initial texts to inform about upcoming review of waiting lists and following review, follow-up letters regardless of NAIT level, will inform individuals of outcomes and signpost to the NHSGG&C self-help pack

		have to be sought from elsewhere if they wished to recommence. There will be a cohort of individuals who would be eligible for DOCCLA monitoring. Once identified, these individuals will be communicated with, on boarded and counselled by clinicians about remote digital monitoring. EQIAs have been completed for DOCCLA pathways in the Health Board. Both the DOCCLA patient app and the patient-facing leaflets can be provided in multiple languages. **Cohort 3 – Core Mental Health populations** Digital innovation pilots such as the DOCCLA projects are for ADHD patients only. They are not for Core mental health populations – many of whom have significant physical co-morbidities and monitoring needs e.g. antipsychotic monitoring, again which cannot always be done in primary care due to a lack of resources. Due to high levels of disability in this population, DNA (do not attend) rates can be high which often require escalation to assertive outreach. Digital innovation and engaging carers would also significantly aid this cohort of individuals, however the current innovations are only focussed on ADHD populations – many of whom may not meet criteria for significant disability, especially if stabilised on medication. There is no planned communication with core mental health populations about the proposals (as they will remain in treatment) or their lack of access to the DOCCLA systems. **There is no EQIA for Core mental health**	materials (which are available in different formats). The self-help pack includes advice and an inventory of wider supports. Signposting to the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website will also be a part of communications. **(2)** FAQs, options for non-urgent enquiries and complaints will be available for individuals if they require further clarity **(3)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations which will be communicated in letters to them. **(4)** The self-help pack has been validated via GG&C equality channels and will be available digitally, via QR code, in printable formats in different languages including for deaf and blind individuals. **(5)** As per usual practices, if language, BSL interpreters or braille letters are required for an individual, this can provided. **Cohort 2 – Individuals currently using the service (those with diagnoses of ADHD, receiving medication via CMHTs)** **Negative impacts - As above** – Regardless of NAIT criteria, this cohort will remain in treatment unless they default or decide to cease it by choice at any point in their journey. These patients may become anxious when new proposals are implemented and worry about the future of their treatment. If they default from treatment, they may not be re-accepted to back into CMHT services unless they meet NAIT level 4 criteria and subsequently may opt have to seek alternative provisions to recommence medication. **Mitigating factors** – **(1)** operational steps to identify and communicate with all those with ADHD in CMHTs

		populations and how the current status quo is affecting them. **Staff communications** GP information sessions have occurred and these have been followed up with a GP FAQ document. Corporate communications for enquiries and complaints will span GPs and primary care colleagues. Adult mental health staff communication and engagement is underway with formal Boardwide sessions scheduled. All staff will have access via links to the self-help resources; the Right decisions and NHS GG&C website. Adult secondary care staff packs will be available.	(regardless of NAIT criteria) is underway. **(2)** These individuals will contacted by via letter or text in the first instance and signposted be pointed to the new proposals and pathways on the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions, as well as self-help materials. They will be reassured that their treatment will continue as usual, however if they default from treatment and no longer meet NAIT 4 criteria, their care and treatment would have to be sought from elsewhere if they wished to recommence. **(3)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations which will be communicated in letters to them. **(4)** The self-help pack has been validated via GG&C equality channels and will be available digitally, via QR code, in printable formats in different languages including for deaf and blind individuals. **(5)** As per usual practices, if language, BSL interpreters or braille letters are required for an individual, this can provided. **(6)** Staff will be able to support individuals or their carers to on-board to the DOCCLA digital platform if there are any specific barriers to this identified. **(7)** EQIAs have been completed for DOCCLA pathways in the Health Board. Both the DOCCLA patient app and the patient-facing leaflets can be provided in multiple languages. **Cohort 3 – Core Mental Health populations** **Negative impacts** – **(1)** Digital innovation pilots such as DOCCLA implementation are for ADHD patients only. They are not for Core mental health populations **(2)** There is no EQIA for Core mental health populations and how the current status quo is affecting them.

			Mitigating factors – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability. **(2)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(3)** Explore how Digital innovation pilots such can be resources and extended for Core mental health populations once DOCCLA ADHD pathways are established. **Staff communications** **Negative impacts** – nil highlighted re: communications. All resources will be available digitally or in printable formats for all staff as well as briefing sessions.

7	Protected Characteristic	Service Evidence Provided	Impact for all on waiting list or receiving treatment. Age Specific impacts
a)	**Age** **Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design).** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination,**	**<u>Licensing for ADHD medications based on age and prescribing risks</u>** The licensed uses of ADHD medications vary between the different types and also between different brands. ADHD medications can be stimulant medications (related to amphetamines) or non-stimulants. Safe prescribing practices are vital for patients to minimise risks to their health, especially if there are other mental health or physical co-morbidities or interactions with other medications, or risks of abuse and diversion which is recognised risk[i]. Licencing applies for children age 6 – 18. They are not licenced for under the age of 6. Adult populations aged 18-65 are also not licenced for ADHD medications. Transfers of care from SCS will still be accepted with the initial point of transition being aged 18. There are also notable SCS ADHD waiting lists and associated challenges – this is being addressed in a separate EQIA. **Some examples** - **Elvanse** - the manufacturers' SPC for Elvanse mentions use in children over 6 years and in adults (with symptoms from childhood) but don't specify an upper age range. Limited data in elderly and that close monitoring and dose adjustments may be needed. - **Concerta XL** - similar guidance to Elvanse, no mention of specific dose range in adults but	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **As above** – **For age cohort 18 -65**, **Negative impacts** – **(1)** The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **(2)** SCS have similar challenges in parallel and these are being addressed in a separate EQIA. **<u>Additional note re: Cohorts 1 & 2</u>** Cohort 2- individuals already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of approximately 5000 patients to primary care for ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients, especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity and as yet, a lack of a GP shared care agreement. CMHTs are not enforcing a

	harassment and victimisation **2) Promote equality of opportunity** **3) Foster good relations between protected characteristics.** **4) Not applicable**	states that methylphenidate should not be used in the elderly (under posology section of SPC). - **Equasym XL** - only licensed in children over 6 and specifically state not licensed in any adults. **<u>CMHT populations</u>** CMHTs are commissioned to see populations aged 18 – 65. All those on adult ADHD waiting lists will fall into this age bracket. Some brands of ADHD medication are not licenced in this cohort. However CMHT clinicians and the general ethos, for those coming through the system with a diagnosis within the current infrastructure has meant that clinicians have been prescribing medication when clinically indicated, safe to do so and if it was a patient's preference on an off-licence basis. This can be done in accordance with General medical council (GMC) Prescribing unlicensed medicines – professional standards – GMC[xix]. NHS GG&C also have their own off-licence prescribing guidance. There are some individuals sitting on CMHT caseloads who are over the age of 65 with diagnoses of ADHD as Older peoples mental health services (OPMH) do not always accept transfers of care for ADHD patients. Transfers of care are accepted based on diagnosis and frailty and tend to be over the age of 65. These individuals may need closer monitoring for physical co-morbidities and risks. With ongoing increase in demand on CMHTs and no option for transferring care to OPMH, there will	"discharge and not reaccept" operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create a two tier system for those diagnosed and commenced on treatment before and after implementation of the new proposals and Cohort 1 – a proportion of those on adult ADHD waiting lists. Rationale for this is outlined in the aforementioned paragraphs. Negative impacts and mitigations are outlined in the next columns. **Mitigating factors**- (**1)** Transfers of care from SCS will still be accepted at the point of transition age 18 for core SCS populations and those with neurodivergent conditions with application of NAIT criteria. This cohort may not require long term CMHT input and so may be stepped down to primary care at some point if stable and if GP can prescribe, or if the individuals opt for private prescriptions via local shared care arrangements and may qualify for DOCCLA digital monitoring. **(2)** Signposting to the NHSGG&C self-help pack This includes advice covering different domains and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> and NHS GG&C website. **(3)** Processes for non-urgent enquires and complaints are being set up for individuals if they wish to present these. **(3)** Due to the widespread National trends seen across Scotland, there is ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more

		be further increased demand on CMHTs, further compromising CMHT capacity. The age 18-65 will be the most widely affected by the proposals. **OPMH populations** In the OPMH population, ADHD medication brands are also not licenced for those aged over 65 and this cohort are at higher risk of age-related physical co-morbidities, therefore there are wider risks to consider when prescribing ADHD medications in older populations. There are no OPMH adult ADHD waiting lists and safe prescribing should always be a priority. Numbers in these services are relatively small. The proposals for will also apply to OPMH populations. **Other psychiatric specialties** Furthermore, the proposals will apply to all psychiatric specialties. There are no extra resources in psychiatric specialties to do de novo Adult ADHD assessments unless NAIT 4 criteria is met and further assessment and management is deemed to be clinically indicated. None of the psychiatric specialties have ADHD waiting lists. ADRS, eating disorders, perinatal specialties all accept patients aged 18 upwards without an upper age limit unless there are specific OPMH services (e.g. Older people's liaison service). Due to ADHD medication being off licence in adult populations, specific risks need to be considered in the specialties (e.g. polysubstance use in ADRS, low BMI in eating disorders, polypharmacy	resources for ADHD assessment via a tiered, multi-system approach. **(4)** Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(5)** There is growing momentum for a public health approach and The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups **(6)** The LDAN bill consultation advocates for individuals gaining access to reasonable adjustments, social security etc. without the need for a diagnosis. Once the LDAN bill is published, this will provide a legal protections for access for individuals to these measures without the need for a diagnosis. If LDAN bill not passed, we will review EQIA. **(7)** The Mental Health Strategy is progressing the ADHD proposals as a priority, being cognisant of the extremely difficult scenario. There is ongoing engagement via governance structures as a priority and commitment to monitoring evolution of a wider public health approach to address the needs of those with neurodiversity.**(8)** The Royal college of psychiatrists have recently published (2025) a report – "*Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD. **OPMH populations/ Other specialties, age 18 – no upper limit** **Negative factors** - **(1)** OPMH referrals and other psychiatric specialties will be subject to the same criteria as CMHT populations. Even though numbers are smaller and there are no waiting lists – there may still be some individuals who will not be able to be assessed for query ADHD unless they meet

		etc.) in the psychiatric specialties. Age increases risks for physical co-morbidities and therefore risks with prescribing ADHD medication, therefore some cohorts of individuals may not be eligible for ADHD medications in the specialties due to this. Proposals for Specialist Childrens' services are being considered under a parallel process and will have separate EQIAs.	NAIT 4 criteria and may opt to seek alternative assessment routes. **(2)** Prescribing medication in these cohorts with very specialist needs with increasing age - due to the off-licence status of ADHD medications and other co-morbidities will require to be taken into consideration more carefully depending on nuances. **(3)** Safe and considered prescribing practices for ADHD medications as off licence prescribing when considering risks to in the elderly population will be protective for these patients and risks with ADHD stimulant medication prescribing. **Mitigating factors** – **(1)** Access to secondary care adult mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core mental health populations including those with NAIT level 4 complexities. This also applies to OPMH and all psychiatric specialties for their core populations – access pathways for those with the highest level of need will remain intact. **(2)** Regardless of age or specialty – signposting can proceed to the NHSGG&C self-help pack which includes advice covering different domains and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website. **(6)** Transfers of care from SCS will still be accepted. **(7)** SCS currently prioritise those who are aged 17 on ADHD waiting lists and nearing the cut off for transfer to adult services, in order to assess, treat and transfer in a timeous fashion. **Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving treatment via CMHTs)** **Negative impacts** – **(1)** Stable and high functioning individuals aged 18-65 who would categorise as NAIT levels 1-3 and no longer require to be seen in secondary care but a

			step-down recovery orientated approach cannot be adopted due to a lack of resource in primary care and as yet, a lack of a share cared agreement. If on ADHD medications, these individuals still have to attend in person appointments due to a lack of alternative options for submitting their monitoring results. **(2)** OPMH - Patients in services >65 age who are already diagnosed, on medication and in services can be counselled that their treatment will continue but subject to review based on co-morbidities and prescribing risks and about lack of licencing for their prescriptions. But they may not be re-accepted back to services if they default from treatment. **Mitigating factors** – **(1)** Ongoing engagement with DOCCLA set up remote digital pathway systems for medication monitoring for those on ADHD medications age 18-65 who are the core population in employment. If implemented, this would give this cohort more freedom and accessibility to convenient remote monitoring rather than physical having to attend clinics which can impact employment. **(2)** OPMH and other specialties – DOCCLA could be explored to extend to them but ongoing monitoring will be subject to off-licence prescribing regulations due to age and prescribing risks depending on specific nuances. **Negative impacts** – **(1)** Stable and high functioning individuals in the age 18-65 age group who would categorise as NAIT levels 1-3 and no longer require to be seen in secondary care but a step-down recovery orientated approach cannot be adopted due to a lack of resource in primary care and as yet, a lack of a share cared agreement will remain stuck in CMHTs. This also applies to those transferring from SCS who, if on ADHD medications, these individuals still have to attend in person appointments due to a lack of alternative options for submitting their monitoring

			results. **(2)** Older adult cohorts, where individuals are stable cannot proceed down a step-down recovery orientated approach due to a lack of resource in primary care and as yet, a lack of a share cared agreements, and non-acceptance of transfers to OPMH. They will remain stuck in CMHTs and require to attend for physical health monitoring. **(3)** As ADHD medications are not licenced for >65s, some clinicians may refuse to prescribe ADHD medication in line with clinical safety risks which some individuals may not agree with. **Mitigating factors** – **(1)** Ongoing engagement with DOCCLA set up remote digital pathway systems for medication monitoring for those on ADHD medications. If implemented, this would give the age 18-65 cohort more freedom and accessibility to convenient remote monitoring rather than physical having to attend clinics. **(2)** Extending DOCCLA pathways for >65 populations and to other specialties if they have diagnosed ADHD and are on medication in the other specialties already. **(3)** DOCCLA has a separate EQIA completed.
	Protected Characteristic	**Service evidence provided**	**Impact for all on waiting list or receiving treatment. Disability Specific impacts**
(b)	**Disability** **Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?** **Your evidence should**	**<u>Cohort 3 - Core mental health populations</u>** Core mental health populations are those with severe, enduring and acute mental health presentations with relevant diagnoses, risk (such as suicide, homicide or self-harm) related directly to their mental disorder with notable complexities requiring specialist secondary care input from a CMHT. The other psychiatric specialties have their own service specifications which define their core business as per their specific commissioning. These populations can be classified as possessing protected characteristics	**<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – There is no EQIA for Core mental health populations and how the current status quo is affecting them. As outlined in the background above, CMHTs are unable to meet their own core business demands (for which services are specifically commissioned), and are routinely exceeding the 4 week target for new generic assessments. This does not include emergency assessments and care or medical reviews. The increase in demand (3.5% year on year plus 700% for NDD assessments) is exacerbated by the effect of current CMHT staffing gaps sitting at 11%. There has been no increase in staffing resource to CMHTs despite this

	show which of the 3 parts of the General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity** **3) Foster good relations between protected characteristics.** **4) Not applicable** ☐	secondary to disability under the Equality Act 2010 due to a mental impairment, whereby *"the impairment has a substantial and long term adverse effect on a Person's ability to carry out day-to-day activities"* [v]. These core populations - if they require input from a CMHT or other psychiatric specialties either for medium or longer term, they all meet the criteria for significant treatable pathology.[viii] Currently CMHTs are unable to meet their own core business demands (for which services are specifically commissioned), Safe service provision for the notably disabled Core mental health populations for whom services were originally commissioned is compromised with the status quo. Definitions of core mental health populations – which includes those who meet NAIT 4 criteria are: - **Severe, persistent and acute mental health disorders or presentations associated with significant functional impairment or cognitive disability:** • psychosis from schizophrenia spectrum disorders • first episode psychosis • severe and recurrent depression • bipolar affective disorder • eating disorders • early onset dementia • those with co-morbid mental health	increase in demand and Mental Health services still only receive 8% of proposed 10% of allocated spending as outlined by the Scottish Government. **Mitigating factors** – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability. There are unknown and unquantified negative impacts to this population due to the status quo. **(2)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(3)** Explore how Digital innovation pilots such as the DOCCLA pathways can be extended for Core mental health populations once DOCCLA ADHD pathways are established. **(3)** Access to mental health services based on clinical need for all populations will remain intact, focussing on those with the highest risk and complexity. **(4)** Undertaking a scoping exercise across the six HSCPs to ensure full understanding of social work acceptance criteria for disability as well as adult mental health services would aid cross-sector understanding and consistency. **Privately diagnosed individuals – Cohort 1** **Negative impacts** – **(1**) Individuals whose private referral profiles would be in keeping with NAIT levels 1-3 or if the quality and governance standards of the referred private assessments are not in keeping with quality standards at triage, these individuals may opt to seek alternative routes for assessment or medication prescribing if a positive diagnosis was made by the private provider. **(2)** Those on NHS adult ADHD waiting lists may include individuals who have been privately diagnosed. However the waiting lists will also

		disorders and drug or alcohol misuse of harmful or dependent levels • mild learning disabilities • acquired brain injuries. - Additional to the above (which are the most commonly treated conditions seen in CMHTs), there are also other mental health diagnoses and co-morbidities included in the International Classification of Disease, Version 11 (ICD-11)[xx] or Diagnostic and statistical manual of Mental Disorders (DSM-V)[xxi] which would meet the criteria for assessment and treatment in a CMHT. - Longer term mental health disorders which considerably impact on functioning and are characterised by poor treatment adherence requiring proactive follow up, assertive outreach and/ or detention under the Mental Health Act (MHA) - Any acute, moderate to severe mental health presentation where there is also a significant risk of self-harm, harm to others or risk of suicide, self-neglect or vulnerability to exploitation amounting to a crisis presentation. - Disorders requiring skilled or intensive evidence based treatment within current established pathways which are not available in primary care e.g. Mentalisation based therapy for Borderline Personality Disorder (BPD) - Complex trauma and severe disorders of personality requiring engagement and	include those who cannot afford private assessments, thereby creating inequity compared to privately diagnosed individuals. **(3)** Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility. **Mitigating factors – (1)** By reapplying the same criteria for to privately diagnosed individuals, NHS-referred query ADHD referrals and core mental health populations, there will be more equity of access for all those who have the highest levels of disability. **(2)** Privately diagnosed individuals who meet CMHT criteria will still be accepted for CMHT care. **(3)** Privately diagnosed individuals can seek further advice from their own private provider regarding ongoing treatment options and access to workplace adjustments, social security and other adjustments which will prevent inappropriate shifting of responsibilities to the NHS from private providers, especially when governance structures, regulation and oversight may be lacking or differ. **(4)** Privately diagnosed individuals can still be signposted and utilise the NHS GG&C self-help pack and resources. **<u>Privately diagnosed individuals – Cohort 2</u>** **Negative impacts** – **(1**) Some private providers may have misdiagnosed individuals if their governance structures are not as robust, especially if they are not regulated by Healthcare improvement Scotland (HIS) or the Care quality commissions (CQC) – this is beyond the span of NHS GG&C's remit or control. **(2)** If individual GP practices decide

		management who qualify for formulation-led evidence-based clinical interventions only available in secondary care. - Neurodivergent disorders (Autism, ADHD) which meet the criteria as <u>additional</u> co-morbid disorders alongside the above complexities and/or conditions outlined above, or single condition of the most severe nature. - **CORE STRANDS** - Risk management and assessment and management of high levels of complex needs which cause significant impaired functioning related directly to the above criteria are core strands of clinical practice. **There is no EQIA for Core mental health populations and how the current status quo is affecting them.** **<u>Privately diagnosed individuals – Cohort 1</u>** Individuals who are diagnosed with adult ADHD privately but are also on our NHS GG&C adult ADHD waiting lists will be subject to the same reapplication of clinical criteria outlined in the proposals, including for quality standards of assessments and credentials of assessors. Therefore from an NHS perspective, the most disabled population (NAIT level 4) will still have access to CMHTs if this emerges during the re-triage process or via other communication of all those on Adult ADHD waiting lists. Some cohorts whose referral profiles would be in keeping with NAIT levels 1-3 <u>or</u> if the quality and governance	to agree to shared care agreements with private providers, this will further compound inequities based on socioeconomic status and affordability as well as potential postcode inequity. This is beyond the remit or responsibility or secondary care adult mental health services. **(3)** Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility. **(3) Mitigating factors – (1)** By reapplying the same criteria for to privately diagnosed individuals, for NHS-referred query ADHD referrals and core mental health populations, there will be more equity of access for all those who have the highest levels of disability. **(2)** Privately diagnosed individuals who meet CMHT criteria will still be accepted for CMHT care. **(3)** Privately diagnosed individuals can seek further advice from their own private provider regarding ongoing treatment options and access to workplace adjustments, social security and other adjustments which will prevent inappropriate shifting of responsibilities to the NHS from private providers, especially when governance structures, regulation and oversight may be lacking or differ. **(4)** Privately diagnosed individuals can still be signposted and utilise the NHS GG&C self-help pack and resources. **<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** - **As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed as they will not meet the criteria for significant impact on functioning or disability.

		standards of the referred private assessments are not in keeping with quality standards at triage, these individuals may opt to seek alternative routes for assessment or medication prescribing if a positive diagnosis was made by the private provider. Specific difficulties in relation to privately diagnosed individuals are outlined in the background section. **<u>Privately diagnosed individuals – Cohort 2</u>** Individuals who were diagnosed with adult ADHD privately and were accepted to CMHTs under the current policy (which was a holding position policy until a substantive NDD service was commissioned – which is not longer the case). This cohort are currently receive ongoing treatment in CMHTs. Those patients who have received a private diagnosis and have been screened and added to the CMHT waiting list prior to the implementation date, will remain on the CMHT waiting list and offered a consultation to consider treatment options. As described above, those who receive a private diagnosis and are referred post the implementation date will only be accepted if they meet the NAIT level 4 threshold. **<u>Additional note re: Privately diagnosed Cohorts 1 & 2</u>** Cohort 2- individuals who were privately diagnosed already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within	**Mitigating factors** – **(1)** NAIT 4 level pathways and access to CMHTs based on clinical need for core mental health populations is a pathway which will remain intact for these populations – this includes those with the highest level of disability. **(2)** Access to mental health services based on clinical need for all populations will remain intact, focussing on those with the highest risk and complexity. **(3)** Regardless of NAIT level criteria following review of the waiting list, – signposting can proceed to the NHSGG&C self-help pack which includes advice covering different domains including accessing reasonable and work adjustments as well as social security and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> and NHS GG&C website **<u>Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving medication via CMHTs)</u>** **Negative impacts** – **(1)** For stable and optimised functioning-individuals with ADHD whose profiles are in keeping with NAIT levels 1-3, who no longer require to be reviewed in secondary care, there is a lack of a step-down recovery orientated approach due to a lack of resource in primary care and as yet a lack of NHS share cared agreements. If on ADHD medications, these individuals still have to attend in person appointments due to a lack of alternative options for submitting their monitoring results. **Mitigating factors** – **(1)** Ongoing engagement with DOCCLA set up remote digital pathway systems for medication monitoring for those on ADHD medications. If implemented, this would give this cohort more freedom and accessibility to convenient remote monitoring rather than physical having to attend clinics, with the prospect of potential future GP shared care agreements. **(2)** Ongoing development of NHS GP

		CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of this cohort to primary care for ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients, especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity or if GPs have no shared care agreements with private providers. CMHTs are not enforcing a "discharge and not reaccept" operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create inequity and a two tier system for those who were privately diagnosed and continued on treatment in CMHTs before implementation of the new pathways. But it also creates inequity for individuals as a whole seeking query adult ADHD assessment who cannot afford private assessments, as well as the additional complication of the variability in governance, regulation and quality standards among different private providers. If individual GP practices decide to agree to shared care agreements with private providers, this will further compound inequities based on socioeconomic status and affordability as well as potential postcode inequity. This is beyond the remit or responsibility	shared care agreements.

		or secondary care adult mental health services. The new pathways into CMHTs will mitigate some of these inequalities regarding privately diagnosed individuals as the same thresholds will apply to all incoming referrals. Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility. **Cohort 1 – Individuals on ADHD waiting lists** Neurodivergence itself is not one of the 9 a protected characteristics[v], but some neurodivergent conditions such as ADHD and Autism under the Equality Act 2010[v] could meet the criteria for disability, if the condition itself it has had a long-term, substantial adverse effect on a person's ability to carry out normal day-to-day activities, which would meet the criteria for pathology and resultant disability. As noted above in **Figure 3**, not all those with neurodivergence will meet the threshold for pathology or significant impairment to functioning. There is potential for a direct or indirect impact of people not being assessed or having a route to a diagnosis for those who	

		categorise as NAIT levels 1-3, and may result in a barrier to accessing reasonable adjustments, social security, workplace supports or medications (if clinically warranted and preferred by an individual) without a formal diagnosis. **<u>Cohort 2 – Individuals currently using the service (those with diagnoses of ADHD, receiving medication via CMHTs)</u>** Many of this cohort are stable individuals with optimised functioning (NAIT levels 1-3) who cannot be stepped down to primary care due to as yet, a lack of a shared care agreements. Across the HSCPs, ADHD follow-up in CMHTs takes place in different formats. Clinics involve seeing patients face to face, others are purely remote appointments via video or telephone consultation and others provide a hybrid model. For in person assessments, locations are based-in CMHT clinics and some include medical monitoring clinics for those on ADHD medications which currently require in person attendance at CMHT clinics. This can be inconvenient and potentially a hindrance for working adults who do not meet the criteria for disability being stuck in a secondary care clinic. There is ongoing progress of DOCCLA pathways to set up remote digital pathway systems for medication monitoring for those on ADHD medications. EQIAs have been completed for DOCCLA pathways in the Health Board.	

		Proposals for the Adult autism team are being considered under a parallel process and will have separate EQIAs.	
(c)	**Gender Reassignment**	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
	Impact for all on waiting list or receiving treatment. – see above **Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity** **3) Foster good**	As highlighted in the NHSGGC LGBTI+ Health Needs Assessment, LGBT+ people *may* be more likely to have learning or developmental differences including dyslexia, Autistic Spectrum Disorder (ASD)/Asperger's and Attention Deficit Hyperactivity Disorder (ADHD), and are therefore potentially more likely to be impacted be impacted by this change. Equalities data is not collated in a consolidated manner on EMIS dashboards or otherwise for any mental health cohorts on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. Barriers for consolidating the equalities data, including LGBT data – there is no current EMIS dashboard solely for ADHD waiting lists, and it is not routinely collected, presented or analysed in a consolidated manner locally in CMHTs. Cross-matching those on ADHD waiting lists with Gender service waiting lists would be one way to collate data on this. This would aid our understanding of the profiles of	**<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts - As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. This may include LGBT+ people seeking assessment for ADHD. **Mitigating factors** – **(1)** the reapplication of clinical criteria will be based on clinical evidence. **(2)** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit.

	relations between protected characteristics **4) Not applicable**	patients in our services or on waiting lists to further evaluate any potential disproportionate impact on people with the protected characteristic of Gender reassignment.	
(d)	**Marriage & civil partnership**	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
	Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership? **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity** **3) Foster good relations between**	**No overt anticipated disproportionate impact** There is not enough data or research available to definitively state whether the proposals will have a disproportionate impact on those with the protected characteristic of marriage and civil partnership.	**Impact for all on waiting list or receiving treatment. – see above** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit.

	protected characteristics **4) Not applicable**		
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(e)	**Pregnancy and Maternity** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity**	**Perinatal services** Proposals will apply to all psychiatric specialties including perinatal services. There are no extra resources in perinatal services to do de novo Adult ADHD assessments unless NAIT 4 criteria is met and further assessment and management is deemed to be clinically indicated. Perinatal psychiatry does not have ADHD waiting lists. Due to ADHD medication being off licence in adult populations, specific risks need to be considered in the pregnant population, including risks to the unborn baby from any prescribing, but especially stimulant or non-stimulant ADHD medications. Individual patient risk assessment and clinician discretion to formulate a care and treatment plan is recommended to be tailored to the individual.	**Negative impacts –** Even though numbers are smaller and there are no waiting lists – there may still be some individuals who will not be able to be assessed for de novo query ADHD unless they meet NAIT 4 criteria and may opt to seek alternative assessment routes. **Mitigating factors - (1)** Access to secondary care adult mental health specialties – including perinatal mental health services based on clinical need, risk and complexity will remain an intact pathway open for all populations with reapplied clinical criteria, with a refocus on core business, including those with NAIT level 4 complexities. **(2)** Regardless of specialty – signposting can proceed to the NHSGG&C self-help pack which includes advice covering different domains including and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website. **(3)** Safe and considered prescribing practices for ADHD medications as off licence prescribing when considering risks to unborn babies will be protective for pregnant patients (especially considering the wider physiological burden on individuals during pregnancy at baseline and risks with ADHD stimulant medication prescribing). **(4)** Pregnant patients with query ADHD, especially those who are deemed to present as NAIT level 4 can be referred on to social work and/or the Blossom team in NHS GG&C who can support patients with social

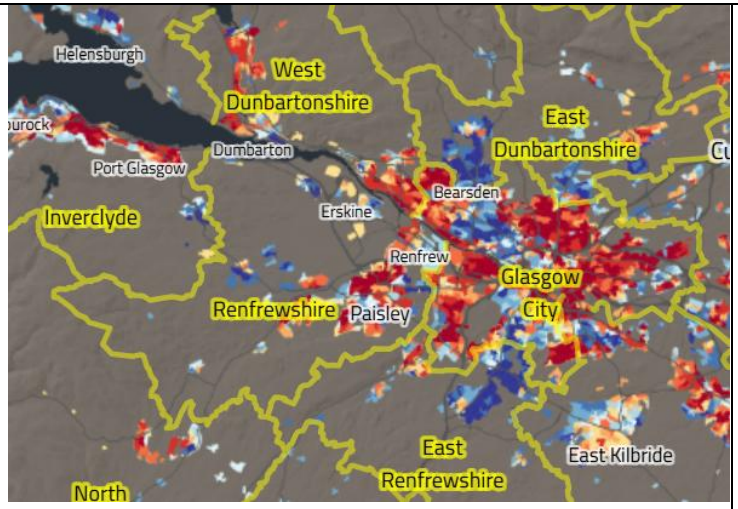
	3) Foster good relations between protected characteristics. **4) Not applicable**		complexities and vulnerabilities for assessment.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(f)	**Race** **Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity**	**No overt anticipated disproportionate impact although cultural norms and awareness may vary among different ethnic groups.** There is not enough data or research available to definitively state whether the proposals will have a disproportionate impact on those with the protected characteristic of race. Re-triage process – as outlined above, is not anticipated to have an impact due to communication or language needs. Staff working in existing ADHD provisions and additional resources from relevant qualified mental health staff (therefore with appropriate expertise and qualifications) will undertake the re-triage process. This will involve review of clinical information in the original referral, chronological account of care on EMIS, clinical letters, patient and carer questionnaires, background questionnaires and physical health information on clinical portal and reviewing against criteria for core mental health populations and NAIT levels.	**Impact for all on waiting list or receiving treatment. – see above** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any disproportionate impact on people with the protected characteristic of race. We will explore the development of a plan for capture of more robust ethnicity data and analysis to support the NHS GG&C Health Board's anti-racism plan. The self-help pack has been validated via GG&C equality channels and will be available digitally, via QR code, in printable formats in different languages to mitigate for language barriers.

	3) Foster good relations between protected characteristics **4) Not applicable**		As per usual practices, if language barriers are highlighted as something that may affect appropriate communication with individual's difficulty, relevant interpreters or information can be provided in other languages. There is a DOCCLA EQIA for the Health board. Both the DOCCLA patient app and the patient-facing leaflets can be provided in multiple languages.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(g)	**Religion and Belief** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation**	**No overt anticipated disproportionate impact although cultural norms and awareness may vary among different religious groups.** There is not enough data or research available to definitively state whether the proposals will have a disproportionate impact on those with the protected characteristic of religion and belief.	**Impact for all on waiting list or receiving treatment. – see above** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any potential disproportionate impact on people with the protected characteristic of religion and belief.

	2) Promote equality of opportunity **3) Foster good relations between protected characteristics.** **4) Not applicable**		
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(h)	**Sex** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of**	There is a growing awareness to consider Neurodivergence across a range of presentations including masking in females. There is ongoing research into this in the UK[xxii] and globally. This might mean that disproportionately, females with potential ADHD may not present to services. It should be noted that masking can occur with a range of other conditions (e.g. other mental health disorders, coping skills, stress, substance misuse, trauma), not just neurodivergence. It may also not be unique to females only, and can occur in any individual regardless of sex. There is not enough data or research available to definitively state whether the proposals will have a disproportionate impact on those with the protected characteristic of sex or not.	**Impact for all on waiting list or receiving treatment. – see above** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any disproportionate impact on people with the protected characteristic of Sex.

	opportunity **3) Foster good relations between protected characteristics.** **4) Not applicable**		
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(i)	**Sexual Orientation** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of**	As highlighted in the NHSGGC LGBTI+ Health Needs Assessment, LGBT+ people *may* be more likely to have learning or developmental differences including dyslexia, Autistic Spectrum Disorder (ASD)/Asperger's and Attention Deficit Hyperactivity Disorder (ADHD) and are therefore potentially more likely to be impacted be impacted by this change. Equalities data is not collated in a consolidated manner on EMIS dashboards or otherwise for any mental health cohorts including individuals on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. Barriers for consolidating the equalities data, including LGBT data – there is no current EMIS dashboard solely for ADHD waiting lists, and it is not routinely collected, presented or analysed in a consolidated manner locally in CMHTs. Some information may be able to be garnered from	There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any potential disproportionate impact on people with the protected characteristic of Sexual orientation.

	opportunity **3) Foster good relations between protected characteristics.** **4) Not applicable**	other Adult mental health dashboards. There is not enough data or research available to definitively state whether the proposals will have a disproportionate impact on those with the protected characteristic of sexual orientation or not.	
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
(j)	**Socio – Economic Status & Social Class** **Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?** **The Fairer Scotland Duty (2018) places a duty on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic**	**<u>Cohort 3 - Core mental health populations</u>** High numbers of core mental health populations reside in areas that classify as being "deprived" under the Scottish Index of Multiple Deprivation (SIMD)[xxiii], thereby as well being disadvantaged due to their psychiatric condition(s) and resultant disability, they may be further disadvantaged because of low income but also mean fewer resources or opportunities across the seven domains of income, employment, education, health, access to services, crime and housing. A snapshot of the NHS GG&C areas on the SIMD map (data from 2020) shows lots of high areas of deprivation (Red) amongst others with lower levels (deeper shades of blue) across the spectrum.	**<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – There is no EQIA for Core mental health populations and how the current status quo is affecting them. As outlined in the background above, CMHTs are unable to meet their own core business demands (for which services are specifically commissioned), and are routinely exceeding the 4 week target for new generic assessments. This does not include emergency assessments and care or medical reviews. The increase in demand (3.5% year on year plus 700% for NDD assessments) is exacerbated by the effect of current CMHT staffing gaps sitting at 11%. There has been no increase in staffing resource to CMHTs despite this increase in demand and Mental Health services still only receive 8% of proposed 10% of allocated spending as outlined by the Scottish Government. **Mitigating factors** – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability. There are unknown and unquantified negative impacts to this population due to the status quo. **(2)** Completion of an EQIA for core mental health

	disadvantage when making <u>strategic</u> decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available here: <u>Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot)</u> Seven useful questions to consider when seeking to demonstrate 'due regard' in relation to the Duty: 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence? 2. What are the voices of people and communities telling us, and how has this been determined (particularly	 **Privately diagnosed individuals** There is potential for inequity of impact for those who may choose to pay for an assessment privately. However individuals who are diagnosed with adult ADHD privately, will be subject to the same reapplication of clinical criteria outlined in the proposals, therefore the most disabled population will still have access to CMHTs. Some cohorts whose profiles would be in keeping with NAIT levels 1-3 will have to seek alternative routes for medication prescribing. Specific difficulties in relation to privately diagnosed individual's vs those who cannot afford private assessments, as well as variability in governance among different private providers are outlined in the Background section and summarised again below. CMHTs and GP colleagues continue to see a rise	populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(3)** Explore how Digital innovation pilots such as the DOCCLA pathways can be extended for Core mental health populations once DOCCLA ADHD pathways are established. **(3)** Access to mental health services based on clinical need for all populations will remain intact, focussing on those with the highest risk and complexity regardless of socioeconomic status. **(4)** Undertaking a scoping exercise across the six HSCPs to ensure full understanding of social work acceptance criteria for disability as well as adult mental health services would aid cross-sector understanding and consistency, especially for those residing in higher SIMD areas. **(5)** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including core mental health populations and those on ADHD waiting lists for Boardwide overview. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any disproportionate impact on people with the protected characteristic of socioeconomic status and social class. **<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** - **As above** - The proposals will mean many individuals on ADHD waiting lists will not be assessed as they will not meet the criteria for significant impact on functioning or disability, including those who reside and are impacted by higher SIMD deprivation areas. **Mitigating factors** – **(1)** NAIT 4 level pathways and access to CMHTs based on clinical need for core mental health populations is a pathway which will remain intact for these

	those with lived experience of socio-economic disadvantage)? 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage? 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions? 6. How has the evidence been weighed	in patients who have been diagnosed with ADHD by Private Providers. Those diagnosed with ADHD are then requesting stimulant (or non-stimulant) medication for ADHD to be commenced or continued in the NHS. GP colleagues have limited capacity to provide this as do CMHTs. Most Health boards do not accept private referral diagnoses, or only accept those that meet secondary care criteria. There is a current GGC policy on these in place which does allow acceptance if the assessment is deemed robust enough to diagnose ADHD, however it has created some challenges – **(1)** Most of these providers are not regulated. The quality of assessments varies and the governance around single condition assessments differs from NHS governance standards with a risk of misdiagnoses, iatrogenic harm and other differential diagnoses being missed. **(2)** A two-tiered system whereby individuals who can afford private assessments can get them faster than those who cannot **(3)** Individuals are given unrealistic expectations by private providers that continued treatment will be guaranteed in the NHS **(4)** There are significant capacity issues in CMHTs to continue accepting private referrals as numbers continue to rise, and especially with as yet, no formal shared care agreements with GP colleagues in future due to their capacity issues, and a lack of private shared care agreements between GPs and private providers. **Privately diagnosed individuals – Cohort 1**	populations – this includes those with the highest level if disability and spans those privately diagnosed. **(2)** Access to mental health services based on clinical need for all populations will remain intact, focussing on those with the highest risk and complexity. **(3)** Regardless of NAIT level criteria following review of the waiting list, – signposting can proceed to the NHSGG&C self-help pack which includes advice covering different domains, including on accessing reasonable and work adjustments as well as social security and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - ADHD (Guidelines) | Right Decisions and NHS GG&C website **(5)** Processes for non-urgent enquires and complaints are being set up for individuals if they wish to if they wish to present these. **Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving medication via CMHTs)** **Negative impacts** – **(1)** For stable and optimised functioning-individuals with ADHD who reside in higher SIMD areas or come from higher socioeconomic status backgrounds, whose profiles are in keeping with NAIT levels 1-3, who no longer require to be reviewed in secondary care, there is a lack of a step-down recovery orientated approach due to a lack of resource in primary care and as yet, a lack of share cared agreements. If on ADHD medications, these individuals still have to attend in person appointments due to a lack of alternative options for submitting their monitoring results. **Mitigating factors** – **(1)** Ongoing engagement with DOCCLA set up remote digital pathway systems for medication monitoring for those on ADHD medications. If implemented, this would give this cohort more freedom and accessibility to convenient remote monitoring (including those in employment or with other commitments and demands) rather than

	up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome that are associated with socio-economic disadvantage? 'Making Fair Financial Decisions' (EHRC, 2019)21 provides useful information about the 'Brown Principles' which can be used to determine whether due regard has been given. When engaging with communities the National Standards for Community Engagement22 should be followed. Those engaged with should also be advised subsequently on how their contributions were factored into the final decision.	Individuals who are diagnosed with adult ADHD privately but are also on our NHS GG&C adult ADHD waiting lists will be subject to the same reapplication of clinical criteria outlined in the proposals, including for quality standards of assessments and credentials of assessors. Therefore from an NHS perspective, the most disabled population (NAIT level 4) will still have access to CMHTs if this emerges during the re-triage process or via other communication of all those on Adult ADHD waiting lists. Some cohorts whose referral profiles would be in keeping with NAIT levels 1-3 or if the quality and governance standards of the referred private assessments are not in keeping with quality standards at triage, these individuals may opt to seek alternative routes for assessment or medication prescribing if a positive diagnosis was made by the private provider. Specific difficulties in relation to privately diagnosed individuals are outlined in the background section. **Privately diagnosed individuals – Cohort 2** Individuals who were diagnosed with adult ADHD privately and were accepted to CMHTs under the current policy (which was a holding position policy until a substantive NDD service was commissioned – which is no longer the case). This cohort are currently receive ongoing treatment in CMHTs. Those patients who have received a private diagnosis and have been screened and added to the CMHT waiting list prior to the implementation date, will remain on	physically having to attend clinics, with the prospect of potential step down with future GP shared care agreements. **Privately diagnosed individuals – Cohort 1** **Negative impacts** – **(1**) Individuals whose private referral profiles would be in keeping with NAIT levels 1-3 or if the quality and governance standards of the referred private assessments are not in keeping with quality standards at triage, these individuals may opt to seek alternative routes for assessment or medication prescribing if a positive diagnosis was made by the private provider. **(2)** Those on NHS adult ADHD waiting lists may include individuals who have been privately diagnosed. However the waiting lists will also include those who cannot afford private assessments, thereby creating inequity compared to privately diagnosed individuals. **(3)** Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility. **Mitigating factors – (1)** By reapplying the same criteria for to privately diagnosed individuals, NHS-referred query ADHD referrals and core mental health populations, there will be more equity of access for all those who have the highest levels of disability regardless of SIMD index. **(2)** Privately diagnosed individuals who meet CMHT criteria will still be accepted for CMHT care. **(3)** Privately diagnosed individuals can seek further advice from their own private provider regarding ongoing treatment options and access to workplace adjustments, social security and other adjustments

		the CMHT waiting list and offered a consultation to consider treatment options. As described above, those who receive a private diagnosis and are referred post the implementation date will only be accepted if they meet the NAIT level 4 threshold. **<u>Additional note re: Privately diagnosed Cohorts 1 & 2</u>** Cohort 2- individuals who were privately diagnosed already in services on medications whose presentations are consistent with NAIT levels 1-3 will continue in treatment within CMHTs. NHS GG&C and all stakeholders involved recognise that mass discharge of this cohort to primary care for ongoing prescriptions and monitoring is not feasible logistically due to GP capacity or fair to patients, especially with a risk of postcode inequity if GP colleagues opt to not continue a prescription due to their capacity or if GPs have no shared care agreements with private providers. CMHTs are not enforcing a "discharge and not reaccept" operation and prefer to collaborate with GP colleagues to develop a step down pathway. As mentioned above, if this cohort default from treatment, DNA or opt to cease treatment they would only be reaccepted to CMHT if they met NAIT level 4 criteria and would have to seek reinstatement of their prescription from elsewhere if they wished to recommence. NHS GG&C recognise that this may create inequity and a two tier system for those who were privately diagnosed and continued on treatment in	which will prevent inappropriate shifting of responsibilities to the NHS from private providers, especially when governance structures, regulation and oversight may be lacking or differ. **(4)** Privately diagnosed individuals can still be signposted and utilise the NHS GG&C self-help pack and resources. **<u>Privately diagnosed individuals – Cohort 2</u>** **Negative impacts** – **(1**) Some private providers may have misdiagnosed individuals if their governance structures are not as robust, especially if they are not regulated by Healthcare improvement Scotland (HIS) or the Care quality commissions (CQC) – this is beyond the span of NHS GG&C's remit or control. **(2)** If individual GP practices decide to agree to shared care agreements with private providers, this will further compound inequities based on socioeconomic status and affordability as well as potential postcode inequity. This is beyond the remit or responsibility or secondary care adult mental health services. **(3)** Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility. **(3) Mitigating factors – (1)** By reapplying the same criteria for privately diagnosed individuals, for NHS-referred query ADHD referrals and core mental health populations, there will be more equity of access for all those who have the highest levels of disability regardless of socioeconomic status. **(2)** Privately diagnosed individuals who meet CMHT criteria will still be accepted for CMHT care. **(3)** Privately diagnosed individuals can seek further advice from their own private

		CMHTs before implementation of the new pathways. But it also creates inequity for individuals as a whole seeking query adult ADHD assessment who cannot afford private assessments, as well as the additional complication of the variability in governance, regulation and quality standards among different private providers. If individual GP practices decide to agree to shared care agreements with private providers, this will further compound inequities based on socioeconomic status and affordability as well as potential postcode inequity. This is beyond the remit or responsibility or secondary care adult mental health services. The new pathways into CMHTs will mitigate some of these inequalities regarding privately diagnosed individuals as the same thresholds will apply to all incoming referrals. Privately diagnosed individuals may be in a more favourable position compared to those without private diagnoses or seeking NHS assessment when applying for reasonable adjustments or supports – however that will be dependent on the organization they seek supports from and if those specific organisations accept the individual's private diagnosis. This is out with the spans of NHS GG&C's remit or responsibility.	provider regarding ongoing treatment options and access to workplace adjustments, social security and other adjustments which will prevent inappropriate shifting of responsibilities to the NHS from private providers, especially when governance structures, regulation and oversight may be lacking or differ. **(4)** Privately diagnosed individuals can still be signposted and utilise the NHS GG&C self-help pack and resources.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action**
(k)	**Other marginalised groups**	Homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people	**<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – There is no EQIA for Core mental health

	How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?	involved in prostitution, asylum seekers & refugees and travellers do commonly come into contact with adult secondary care mental health services. They often have complex needs and meet the criteria for secondary care assessment and input and many of the core mental health populations have profiles with these backgrounds. There may be individuals in Cohort 1 – those on ADHD waiting lists from the above groups, or Cohort 2 - those with diagnoses of ADHD on medication.	populations and how the current status quo is affecting them. As outlined in the background above, CMHTs are unable to meet their own core business demands and have populations in high SIMD deprivation areas. **Mitigating factors** – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability, including those from marginalised group. There are unknown and unquantified negative impacts to this population due to the status quo. **(2)** Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. **(3)** Access to mental health services based on clinical need for all populations will remain intact, focussing on those with the highest risk and complexity. **(4)** Undertaking a scoping exercise across the six HSCPs to ensure full understanding of social work acceptance criteria for disability as well as adult mental health services would aid cross-sector understanding and consistency, especially for marginalised group. **(5)** There is ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services (inclusive of Cohort 2), including core mental health populations, those on ADHD waiting lists (Cohort 1) for Boardwide overview. This would aid our understanding of the profiles of patients in our services or on waiting lists to further evaluate any disproportionate impact on people with the protected characteristic of marginalised groups.
8.	**Does the service change or policy development include**	There are no cost savings anticipated with the policy review. There are prospective cost savings to the Health Board in terms of no funding being	**<u>Cohort 3 – Core Mental Health populations</u>** **Negative impacts** – There is no EQIA for Core mental health populations and how the current status quo is affecting them.

	an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups? **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** **2) Promote equality of opportunity** **3) Foster good relations between protected characteristics.** **4) Not applicable**	allocated to mental health services for an NDD service. Due to similar trends for query ADHD assessments across all HSCPs since 2020, waiting lists were set up as contingency measures utilising borrowed resource from existing CMHTs (and are therefore not substantive services). Due to CMHTs being unable to meet their own core business demands, reabsorption and realignment of borrowed resources from ADHD provisions back to CMHTs would mean refocus on those populations for whom services are commissioned on a substantive basis. The costs associated with ADHD medications will continue to be funded by HSCP budgets. As at July 2025 – there are 4900 patients diagnosed with ADHD and on medications. No cost savings anticipated in the short term. In 2022, an NDD service (at that time costed at £1.5 million, it is anticipated that any new costings would be much higher due to ever increasing demand) was agreed in principle by the Mental Health Programme Board, which was contingent on the commissioning of third sector provision and development of a Shared care agreement with Primary Care to allow for a tiered treatment approach for individuals within a consultation, treatment and step down model. By November 2023, due to the changed financial landscape, funding was not available for the preferred option	**Mitigating factors** – **(1)** Once proposals are implemented – services – which are commissioned for Core mental health populations only - can re-prioritise the needs of those with the highest levels of disability when resources are realigned back to CMHTs. **(2)** Completion of an EQIA for core mental health populations and is recommended following on from this EQIA. **<u>Cohort 1 – Individuals on ADHD waiting lists</u>** **Negative impacts** – **wider Health board cost savings due to lack of funding for an NDD service** - The proposals will mean many individuals on ADHD waiting lists will not be assessed. Following the re-triage process, individuals who do not meet CMHT criteria may opt to seek alternative routes of assessment, treatment and some will not be able to access an assessment which may lead to a diagnosis or life-improving medication via the current NHS provisions due to a lack of a funded lower tier service. This may cause distress for some individuals and their families. There is a commitment to address this for the longer term outlined below. There is a gap in provisions at a primary care level for individuals whose presentations (NAIT levels 1-3) do not meet the criteria for assessment in CMHTs. A commissioned NDD services as previously preferred with a tiered approach to care would have addressed this gap but is no longer an option. **Mitigating factors**- (**1)** Signposting to the NHSGG&C self-help pack This includes advice covering different domains and an inventory of wider supports, the Right Decisions Website, akin to NHS Highland - <u>ADHD (Guidelines) | Right Decisions</u> and NHS GG&C website. **(2)** Processes for non-urgent enquires and complaints are being set up for individuals if they wish to present these. **(3)** Due to the

		of an NDD service. Therefore what was hoped to be developed to support the Mental Health Strategy, is no longer possible.	widespread National trends seen across Scotland, there is ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more resources for ADHD assessment via a tiered, multi-system approach. **(3)** Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(5)** There is growing momentum for a public health approach and The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups **(6)** The LDAN bill consultation advocates for individuals gaining access to reasonable adjustments, social security etc. without the need for a diagnosis. Once the LDAN bill is published, this will provide a legal protections for access for individuals to these measures without the need for a diagnosis. If LDAN bill not passed, we will review EQIA. **(7)** The Mental Health Strategy is progressing the ADHD proposals as a priority, being cognisant of the extremely difficult scenario. There is ongoing engagement via governance structures as a priority and commitment to monitoring evolution of a wider public health approach to address the needs of those with neurodiversity.**(8)** The Royal college of psychiatrists have recently published (2025) a report – "*Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD. **Cohort 2 – Individuals currently using the service (those with diagnoses ADHD, receiving medication via CMHTs)** **Negative impacts** – If this cohort default from treatment,

			they may not be re-accepted to back into CMHT services unless they meet NAIT level 4 criteria and subsequently may opt have to seek alternative provisions to recommence medication. Potential cost saving for medication and DOCCLA. **(1) Mitigating factors** – **(1)** For stable and optimised functioning-individuals with ADHD there is a cost to the HSCP for medication and upcoming costs for DOCCLA remote monitoring for 3 years which is funded by the health board. **(2)** Ongoing engagement with DOCCLA set up remote digital pathway systems. Once implemented, this would give this cohort more freedom and accessibility to convenient remote monitoring (including those in employment or with other commitments and demands) rather than physically having to attend clinics, with the prospect of potential step down with future GP shared care agreements. No cost saving anticipated.
9.	**What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering**	All staff are required to complete learnpro module on equality and human rights. CMHT staff who are currently working in ADHD provisions have a specialist interest in ADHD and have developed expertise via clinical practice and have done individual continued professional development (CPD) to enhance their skills. **Generic Adult Mental Health Services have local internal teaching and Boardwide CPD for medical staff and doctors in training–** there may have been some Neurodevelopmental disorder related teaching sessions, but information on how much and how often is not	There is a mandatory requirement for ongoing CPD for all mental health staff. The content of this is often self-directed and variable or based on NES curriculums or specific-speciality requirements with the exception of universal mandatory training such as the learnpro module on equality and human rights. **Negative impacts** – NDD training may be adhoc and likely only constitutes a small percentage of overall teaching and training for all staff due to the enormity of mental health and clinical practice. **Mitigating factors** – **(1)** Widespread training for core mental health populations – which is what staff are primarily trained for and what services are commissioned for is appropriate. **(2)** Ongoing commitment to CPD for all staff and further

	equality, diversity and human rights.	available. If available, adult ADHD-specific training is a small percentage due to the enormity of mental health and how teaching requirements also have to align to the NHS Education for Scotland (NES) curriculum. **<u>Other ADHD training – adhoc completed by some staff across the Health Board</u>** 2 OTs have completed the NES Diagnosis and assessment of ADHD training including the Diagnostic Interview for Adults with ADHD (DIVA). **<u>CPD – all mental health staff</u>** All mental health staff are required to be appraised on a yearly basis and ongoing CPD is a mandatory requirement. Most training needs will be catered to expertise for core mental health populations and clinical knowledge relevant to this.	addition of neurodiversity training for those who meet NAIT 4 criteria would be pertinent to proposal implementation. General NDD CPD would be helpful for wider education and understanding among staff.

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right

to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

There is a potential impact on the human rights of patients seeking assistance for a query ADHD assessment if their profiles are in keeping with NAIT levels 1-3. There is also a potential impact on core mental health populations who due to cognitive impairment or levels of disability may struggle to advocate for themselves and may not realise the negative impact on them due to the status quo, whereby by services and staff are under significant pressures in order to meet current demands and the needs of all those being referred to services.

Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

F – While there is no requirement to engage with service users in applying the National Access Policy[xiv], the application of realistic medicine principles does intend to engage with service users by "*listening to understand patient's problems and preferences"*. Planned engagement with individuals with lived and living experience with different cohorts **(1)** representation from core mental health populations **(2)** representation from those with query ADHD **(3)** representation from those with diagnosed adult ADHD to garner a wider understanding about how the status quo has affected them is recommended. Timelines TBC. **(4)** Undertaking a scoping exercise across the six HSCPs to ensure full understanding of social work acceptance criteria for disability as well as adult mental health services would aid cross-sector understanding and consistency.

A – **(1) Core Mental heath populations** - There is no EQIA for Core mental health populations and how the current status quo is affecting them. Completion of an EQIA for core mental health populations and how the status quo as outlined above is affecting them is recommended following on from this EQIA. Further qualitative and quantitative evaluation recommended. **(2) Individuals on ADHD waiting lists** – further gather data describe how those whose profile meet NAIT levels 1-3 needs can be met and advocate for this via official channels. **(3) Individuals with ADHD** – further empower those in services down a recovery-orientated pathway and ensure care is optimised. **(4)** There is

ongoing work to improve collation of equalities data in a consolidated manner on EMIS dashboards or otherwise for all individuals in secondary care adult mental health services, including on ADHD waiting lists for Boardwide overview. Individual cases would have to be reviewed for further profiling or there would have to be commissioning of a Boardwide profiling audit.

I – **(1)** Ongoing engagement between the Health Board, Scottish Government, National Autism Implementation Team (NAIT) and the Royal College of Psychiatrists to advocate for more resources for adult ADHD assessment via a tiered, multi-system approach. **(2)** Previously agreed proposals for a Boardwide Neurodevelopmental Disorder service in NHS GG&C could be revisited with the right resourcing. **(3)** There is growing momentum for a public health approach and The United Kingdom Government have set up a National Taskforce to review the wider National scenario - NHS England » ADHD taskforce members and new subgroups – monitor outcomes of this **(6)** The LDAN bill consultation advocates for individuals gaining access to reasonable adjustments, social security etc. without the need for a diagnosis. Once the LDAN bill is published, this will provide a legal protections for access for individuals to these measures without the need for a diagnosis. If LDAN bill not passed, we will review EQIA. **(7)** The Mental Health Strategy is progressing the ADHD proposals as a priority, being cognisant of the extremely difficult scenario. There is ongoing engagement via governance structures as a priority and commitment to monitoring evolution of a wider public health approach to address the needs of those with neurodiversity.**(8)** The Royal college of psychiatrists have recently published (2025) a report – "*Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland"* which is in keeping with appropriate multi-system approaches for meeting the needs of individuals with ADHD – advocate for these approaches.

*

- **F**acts: What is the experience of the individuals involved and what are the important facts to understand?
- **A**nalyse rights: Develop an analysis of the human rights at stake
- **I**dentify responsibilities: Identify what needs to be done and who is responsible for doing it
- **R**eview actions: Make recommendations for action and later recall and evaluate what has happened as a result.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

☐ Option 1: No major change (where no impact or potential for improvement is found, no action is required)

■ Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)

☐ Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)

☐ Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

11. If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	**Date for completion**	**Who is responsible?(initials)**
Ongoing consultation and/or co-design with service users	31.10.2026 **(1)** Change & development team **(2)** PEPI team **(3)** Public health Consultant with remit for mental health	
Ongoing evaluation of the service impacts (qualitative and quantitative) including differential impacts across all equality groups	30.04.2026 **(1)** Clinical lead for mental health strategy **(2)** Change & development team **(3)** Business Intelligence	
Completion of a CMHT specific EQIA	01.12.2026 **(1)** Clinical lead for mental health strategy **(2)** Change & development team	

Ongoing 6 Monthly Review please write your 6 monthly EQIA review date:

Lead Reviewer:	**Name**	**Dr Chanpreet Blayney**
EQIA Sign Off:	**Job Title**	**Clinical Lead for Mental Health Strategy**
	Signature	
	Date	**17.11.2025**
Quality Assurance Sign Off:	**Name**	**Alastair Low**
	Job Title	**Manager, Equality and Human Rights Team**
	Signature	**A Low**
	Date	**18/11/2025**

NHS Greater Glasgow and Clyde

NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	**Initials**
Action:	Can be populated from above		
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	**Initials**
Action:			
Reason:			
Action:			
Reason:			

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	**Initials**
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

This EQIA is being published at the start of the implementation stage for this project. This will be updated and re-published after 6 months to include any planned activity and further opportunities for mitigating action.

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to:
alastair.low@ggc.scot.nhs.uk

[i] **Attention deficit hyperactivity disorder (Quality Standard)** (2018) - National Institute for Health and Care Excellence (NICE). http://www.nice.org.uk - Prevalence | Background information | Attention deficit hyperactivity disorder | CKS | NICE

[ii] **NHS Greater Glasgow & Clyde Mental Health Strategy** (2023-2028) - NHSGGC Mental Health Strategy 2023-2028 - NHSGGC

[iii] **Multi-Agency Partnership Approach to Distress Framework for Collaboration** (2025) – The Scottish Government - 6. The Mental Health System - Mental health - distress framework for collaboration: multi-agency partnership approach - gov.scot

[iv] **Shah. P, Boilson. M, Rutherford. M, Prior. S, Johnston. L, Maciver. D, Forsyth. K** - Neurodevelopmental disorders and neurodiversity: definition of terms from Scotland's National Autism Implementation Team (2022) – The British Journal of Psychiatry Editorial – Neurodevelopmental disorders and neurodiversity: definition of terms from Scotland's National Autism Implementation Team | The British Journal of Psychiatry | Cambridge Core

[v] **The Equality Act** (2010) – The United Kingdom Legislation - Equality Act 2010: guidance - GOV.UK

[vi] **Learning Disabilities, Autism and Neurodivergence (LDAN) Bill: Consultation** (2023) learning-disabilities-autism-neurodivergence-bill-consultation.pdf

[vii] **Equalities, Human Rights and Civil Justice Committee Papers** (December 2024) - Paper-1--SPICe-briefing.pdf

[viii] **Disability rights and the Equality Act** (2010) **-** When a mental health condition becomes a disability - When a mental health condition becomes a disability - GOV.UK

[ix] **Adult and Older People's Mental Health Services Member Report (2024)** – NHS Benchmarking Network - Dashboard | NHS Benchmarking Network

[x] **NHS recovery plan: progress report (2023) -** Supporting documents - NHS recovery plan: progress report 2023 - gov.scot

[xi] **NHS Scotland operational improvement plan** (2025) **– Improving access to treatment -** Improving access to treatment - NHS Scotland operational improvement plan - gov.scot

[xii] **Adult- Neurodevelopmental Pathways Pathfinder Report 2023** (2023) National Autism Implementation Team (NAIT) **-** NAIT-Adult-Diagnosis-Referral-Thresholds-Stepped-Care-Pathway-2021.pdf (thirdspace.scot)

[xiii] **Attention deficit hyperactivity disorder: Good Practice Guidelines** (2023) – Royal College of Psychiatrists in Scotland [CR235] - cr235-adhd-in-adults---good-practice-guidance.pdf (rcpsych.ac.uk)

[xiv] **NHSScotland: national access policy (2023) -** NHSScotland: national access policy - gov.scot

[xv] **Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland** (2025) **-–** Royal College of Psychiatrists in Scotland **-** rcpsychis-ndc-paper.pdf

[xvi] **Types of supporting information from a professional (**2025) – The Scottish Government **-** Who you can get supporting information from - mygov.scot

[xvii] **What Realistic medicine is and what it isn't** (2025) **-** About – Realistic Medicine

[xviii] **Realistic Medicine** (2025) Realistic Medicine – Shared decision making, reducing harm, waste and tackling unwarranted variation

[xix] **Prescribing unlicensed medicines** (2025) – General medical council (GMC) - Prescribing unlicensed medicines - professional standards - GMC

[xx] **International Classification of Disease**, **Version 11** - ICD-11 (2022) - ICD-11

[xxi] **Diagnostic and statistical manual of Mental Disorders, Version 5** -DSM-V - (2013) - Diagnostic and Statistical Manual of Mental Disorders | Psychiatry Online

[xxii] **Butura A - ADHD in girls and women: the significance of subjective perceptions, inner experiences, context-specific symptoms, and masking -** Student thesis: Doctoral Thesis › Doctor of Philosophy (2025), Kings College London - ADHD in Girls and Women: The Significance of Subjective Perceptions, Inner Experiences, Context-Specific Symptoms, and Masking. - King's College London

[xxiii] **Scottish Index of Multiple Deprivation** (2020) **- Scottish Index of Multiple Deprivation 2020 - gov.scot**