Equality Impact Assessment Tool: Policy, Strategy and Plans

(Please follow the EQIA guidance in completing this form)

1. Name of Strategy, Policy or Plan

Health and Social Care Partnerships/ Greater Glasgow and Clyde Health Board, Transformation programme: Mental Health Services

Please tick box to indicate if this is: Current Policy, Strategy or Plan ☐ **New Policy, Strategy or Plan** ☐

2. Brief Description – Purpose of the policy; Changes and outcomes; services or activities affected

NHSGGC Mental health services will be undergoing a significant transformational programme across a 5 year period. The nature and detail of the strategy driving this change has yet to be confirmed however it is likely that any changes to mental health services will present risk of detrimental impact on vulnerable patient groups. With this in mind, this Equality Impact Assessment was undertaken to formally capture contextual information relating to mental health issues for different protected characteristic groups and will be used to inform final strategy development, subsequent service change proposals and the raft of service level equality impact assessments that will be undertaken to ensure any service change is compliant with the HSCP and Health Board's legal duties in respect of their Public Sector Duty.

This Equality Impact Assessment will be re-visited once the final strategy is complete and will be used to provide a baseline for final strategy assessment.

3 Lead Reviewer

David Walker – Head of Operations

4. Please list all participants in carrying out this EQIA:

Harley, David (Planning and Performance Manager); Esther Milligan (In-patient Services Manager); George Ralston (Professional Lead for Psychology); Salmon, Eileen (Professional Nurse Advisor); Julie McKelvie (OT MENTAL HEALTH ADVISER); Gwen Agnew (OT Professional Advisor for Partnerships); Linda Hall (Lead Professional Nurse Advisor Mental Health Services); Janet Hayes (Planning Manager); Isla Hyslop (Head of OD); Christine Laverty (Head of Addiction Services); Rhoda MacLeod (Head of Sexual Health Services); Colin McCormack (Head of Mental Health Services); Fiona Moss (Head of Health Improvement & Inequality); Phillips, Katrina (Head of Mental Health & Addictions); Smith, Michael (Lead Associate Medical Director); David Taylor (Senior Organisational Development Adviser); Debbie Miller (Social Work); Sheena Morrison (Head of Social Work Services South); Jim McBride (Social Work); Jennifer McCourt (Finance Manager (Adults)); McNeill, Fiona (Head of Adult Services South)

5. Impact Assessment

A Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Equality
The transformational strategy will be required to explicitly reference the equality Act (2010) and articulate how any proposed changes in service provision will meet the requirement to eliminate unlawful discrimination, advance equality of opportunity promote good relations.

B What is known about the issues for people with protected characteristics in relation to the services or activities affected by the policy?		
		Source
All	All In Scotland, one in four people will experience poor mental health each year. Anxiety and depression are the most common, but others may include schizophrenia, personality disorders, eating disorders and dementia. Mental health services are delivered primarily through the NHS and local authorities in partnership with the voluntary and independent sectors, and the majority of NHS services for those with mental health problems are carried out in the community and are delivered through primary care and community mental health services. Poor Mental Health is not evenly distributed across either society or geography. Socioeconomic factors such as poverty, unemployment, poor working conditions and a lack of education can all affect an individual's mental wellbeing, and can increase the risk of developing poor mental health. Thus, mental health is often worse among more deprived communities, where an elevated exposure to other lifestyle factors such as alcohol and drug use, poor diet, poor physical health and a lack of access to appropriate services further increase the prevalence of mental disorders (World Health Organisation 2013a). Family circumstance and early years also play an important role in mental health. The current legislative and policy framework for mental health service provision is multifaceted, and involves a wide range of different Acts, national policies and initiative. Nowell R. (2014): Mental health in Scotland, SPICe briefing 14/36, The Scottish Parliament	
Sex	Each section must be read within the context of the intersectionality of all the protected characteristic Mental Health Foundation, women and mental health; web-link: https://www.mentalhealth.org.uk/a-to-z/w/women-and-mental-health found that there are no significant differences between the numbers of men and women who experience a mental health problem overall, but some problems are more common in women than in men. Women are more likely to have been	

	treated for a mental health problem than men (29% compared with 17%). This reflects women's greater willingness to acknowledge that they are troubled and get support. It may also reflect doctors' expectations of the kinds of health problem that women and men are likely to encounter. About 25% of people who die by suicide are women. Again, women's greater emotional literacy and readiness to talk to others about their feelings and seek help may protect them from suicidal feelings. Being a mother also makes women less likely to take their own life. Women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society. The traditional roles for women from some ethnic groups living in the UK can increase their exposure to these risks. The social factors particularly affecting women's mental health include: • more women than men are the main carer for their children and they may care for other dependent relatives too - intensive caring can affect emotional health, physical health, social activities and finances • women often juggle multiple roles -they may be mothers, partners and carers as well as doing paid work and running a household • women are over represented in low income, low status jobs - often part-time - and are more likely to live in poverty than men • poverty, working mainly in the home on housework and concerns about personal safety can make women particularly isolated • physical and sexual abuse of girls and women can have a long-term impact on their mental health, especially if no support has been received around past abuses. • Mental health problems affecting more women than men Men's Health Forum web-link: https://www.menshealthforum.org.uk/key-data-mental-health found that there is considerable debate about the true level of common mental health disorders in men and whether larger numbers of men than women may be undiagnosed. In a 2016 survey by Opinion Leader for the Men's Health Forum, the majority of men said that they would take time off work to get medical help for physical symptoms such as blood in stools or urine, unexpected lumps or chest pain, yet fewer than one in five said they would do the same for anxiety (19%) or feeling low (15%). The Men's Health Forum has argued that the following might provide a better picture of the state of men's mental health than the number of clinical diagnoses: •	

	Over three quarters of people who kill themselves are men (Reference Office for National Statistics (ONS). • Men report significantly lower life satisfaction than women in the Government's national well-being survey – with those aged 45 to 59 reporting the lowest levels of life satisfaction (Reference: ONS) • 73% of adults who 'go missing' are men (Reference: University of York). • 87% of rough sleepers are men (Reference: Crisis). • Men are nearly three times more likely than women to become alcohol dependent (8.7% of men are alcohol dependent compared to 3.3% of women) (Reference, Health and Social Care Information Centre (HSCIC). • Men are three times as likely to report frequent drug use than women (4.2% and 1.4% respectively) and more than two thirds of drug-related deaths occur in men (Reference: Information Centre). • Men make up 95% of the prison population (Reference: House of Commons Library). 72% of male prisoners suffer from two or more mental disorders (Reference: Social Exclusion Unit). • Men are nearly 50% more likely than women to be detained and treated compulsorily as psychiatric inpatients (Reference: Information Centre). • Men have measurably lower access to the social support of friends, relatives and community (References: R. Boreham and D. Pevalin). • Men commit 86% of violent crime (and are twice as likely to be victims of violent crime) (Reference: ONS). In the research by Cormac I. and Tibanyi P. (2006): Meeting the mental and physical healthcare needs of carers; Advances in Psychiatric Treatment, May 2006, 12 (3) 162-172; BJPsych Advances: Web link: http://apt.rcpsych.org/content/12/3/162#ref-47 defined that carers are non-professionals who provide help and support to people who are sick, infirm or disabled (Singleton et al, 2002). The role of the carer is especially important when the person who receives care is unable to live independently without the carer's help. A young carer is a child or young person under the age of 18, carrying out significant caring tasks and assuming a level of responsibility for another person that normally would be undertaken by an adult. They found that caring responsibilities may arise at any time in life. Carers may have to adapt and change their daily routine for work and social life, perhaps incurring personal and financial costs. They may become isolated from other members of their family, friends and work colleagues. In an ageing population, family	

	members are expected to undertake complex care tasks, often at great cost to their own well-being and health. An estimated 40–50% of all carers provide care for another family member or friend with a mental health problem. Of these, about 11% care for people with dementia, 14% for people with learning disabilities or an autistic-spectrum disorder, 7% care for people with psychosis, schizophrenia or depression, and 8% for those with both mental and physical illness or disabilities. In a survey by Singleton et al(2002), almost two-thirds of carers had more than eight family members or friends to whom they felt close and these carers were less likely to have mental health problems (13%) than carers in smaller social groups, of whom 26% reported mental health problems. Carers who are more vulnerable to health problems are women, elderly or very young people, those with pre-existing poor physical health, carers with arduous duties and those with few social contacts or support. Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness. Sources within this section	
Gender Reassignment	Each section must be read within the context of the intersectionality of all the protected characteristic A study by McNail et al involving 794 participants, within mental health services, 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill-health. 26% felt uncomfortable being asked about their sexual behaviours. 17% were also told that their mental health issues were because they were trans, when they disagreed and saw them as separate. 45% used mental health services more before transition, 18% more during, and 0% used mental health services more post-transition. 10% of the participants had been an inpatient in a mental health unit at least once. 38% of those experienced difficulties within the inpatient unit due to being trans or having a trans history, including harassment, misgendering and uncertainty about placement within single sex facilities. Rates of current and previously diagnosed mental ill health were high, with many participants additionally feeling that they may have experienced particular issues which remained undiagnosed. Depression was the most prevalent issue with 88% feeling that they either currently or previously experienced it. Stress was the next	

	most prevalent issue at 80%, followed by anxiety at 75%. For all but stress and depression, more participants felt that they had a mental health concern which remained undiagnosed, than had received a diagnosis. McNeil J. et al (2012): Trans Mental Health Study 2012, Scottish Transgender alliance	
Race	Each section must be read within the context of the intersectionality of all the protected characteristic Mental Health Foundation: Black, Asian and minority ethnic (BAME) communities; web link: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities found different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from black and minority ethnic groups living in the UK are: • more likely to be diagnosed with mental health problems • more likely to be diagnosed and admitted to hospital • more likely to experience a poor outcome from treatment • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health. These differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs. It is likely that mental health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English. African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking	

	treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons. This may be because they are reluctant to engage with services, and so are much more ill when they do. It may also be that services use more coercive approaches to treatment. The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognized or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems. Research has suggested that Western approaches to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being. There is very little knowledge of the extent of mental health problems in the Chinese community. It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help. Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide. These higher rates may, in part, be caused by social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services. In the Scottish Health and Ethnicity Linkage Study of 4.65 million people exploring ethnic variations in disease in Scotland (2011) (section on mental health) web link: http://www.ed.ac.uk/usher/scottish-health-ethnicity-linkage/key-publications data on 4.6 million people were analyzed, whose records in the 2001 Scottish Census included their self-defined ethnic group. These were linked anonymously to data on all first cases of hospitalization for any psychiatric disorder during seven	

	years from 2001-08 and all episodes of compulsory treatment under the Mental Health (Scotland) Act 2003) during three years from 2006-09. Nine ethnic minority groups were compared to the White Scottish majority. Compared to the White Scottish population, Other White British men and women had lower rates of hospitalisation for all psychiatric disorders combined, mood disorder, psychotic disorder, and compulsory treatment. In the Any Mixed Background group, women had higher rates for all psychiatric disorders combined, and men and women had higher rates for psychotic disorders and compulsory treatment. Indian women had lower rates for all psychiatric disorders combined. Pakistani men and women had lower rates for all psychiatric disorders combined but higher rates for mood disorders. Rates for all psychotic disorders combined were twice as high among Pakistani women. Chinese men and women had the lowest rates for all psychiatric disorders combined and mood disorder but higher rates for compulsory treatment. South Asians had higher rates of compulsory treatment. African men and women had the highest rates for psychotic disorders and relatively high rates for compulsory treatment. This study shows varying patterns of psychiatric hospitalisation by ethnic group in Scotland, with the differences only partly explained by socio-economic circumstances. For South Asian and Chinese groups in particular, they suggest under and late utilisation of mental health services. The findings indicate the need for culturally appropriate and sensitive mental health services that will improve access for minority ethnic groups to community and specialist mental health services. Sources are within this section.	
Disability	Each section must be read within the context of the intersectionality of all the protected characteristic The links between poverty and ill-health are well established and people living with long term ill-health or disability are more likely to be living in poverty, a key factor in poorer health outcomes that have far-reaching effects on individuals and their families. (Dobbie L. and Gillespie M. (2010) :The Health Benefits of Financial Inclusion: A Literature, Review Report for NHS Greater Glasgow and Clyde: Scottish Poverty Information Unit) As research has demonstrated, the existence of co-morbid mental health problems alongside long-	

	term physical health conditions is a particularly common and pernicious form of multi-morbidity (Naylor et al 2012). All physical health problems have a psychological dimension, particularly when they involve learning to live with a long-term condition, which may require a profound process of internal adaptation and can be accompanied by significant functional impairment, economic disenfranchisement and social isolation. (Naylor C. et al (2016): Bringing together physical and mental health, A new frontier for integrated care; Kings Fund) People with learning disabilities present with a higher prevalence of poor mental health compared to those without. In a 2007 UK population based study of 1023 people with learning disabilities, it was found that 54% have poor mental health.(Mental health Foundation (2016) Mental Health in Scotland: Fundamental Facts 2016) Scottish Health Survey 2015 •The proportion of adults who have ever attempted suicide was 6% in 2014/15. •Prevalence of having ever attempted suicide was much higher in the most deprived areas (10%) than in the least deprived areas (3-4%) in 2012-2015. •Levels of self-reported harm increased between 2008/2009 (3%) and 2014/2015 (7%). •In 2014/2015, 1 in 10 (10%) adults exhibited two or more symptoms of depression, indicating moderate to high severity. •The proportion of adults reporting one or more symptoms of depression in 2014.2015(20%) was significantly higher than the proportion in both 2012/2013 (17%) and 2008/2009 (14%). In 2012-2015, younger age groups were more likely than older age groups to report at least one symptom of depression (18% to 23%) of those aged 16-64 compared with 10% to 13% of those aged 65 and over). The proportion of adults reporting two or more symptoms was highest for those aged 35-64 (10-11%) and lowest for those aged 65 and over (6-7%). Patterns of overall prevalence by age were similar for both men and women. Sources are within this section.	
Sexual Orientation	Each section must be read within the context of the intersectionality of all the protected characteristic In a study by Lesbian, Gay, Bisexual and Transgender (LGBT) Youth Scotland of 273 people aged 13-25 found that 40% of LGBT youths consider themselves to have a mental health condition (compared to 25% of the population overall), with higher levels of poor mental health reported by	

	transgender individuals (66.7%) and bisexual women (63%). Homophobic and transphobic bullying was reported as a significant contributing factor to mental health problems. (Mental health Foundation (2016) Mental Health in Scotland: Fundamental Facts 2016) Mental Health and LGB young people: Health Inequalities for LGB Young People in NHSGGC Schools Surveys found that: • LGB young people experience a stark inequality in their health and wellbeing • The outcomes are worse for young women • Some indication the findings are worse for bisexual young people • Mental health is the most concerning finding • Greater challenges with sources of support (parents, carers, friends etc) • School is a setting where LGB young people have a range of worries and adverse experiences • 11% gay/ bisexual boys and 29% lesbian/bisexual girls reported poor mental health Sources are within this section.	
Religion and Belief	Religion and Belief Each section must be read within the context of the intersectionality of all the protected characteristic With regards to religion, the same 2012 report found that Hindus had the highest levels of positive mental wellbeing (53.2) but this was not significantly different from the Scottish average (49.9). Roman Catholics had significantly lower than average wellbeing (49.4) and Other Christians had slightly, but significantly, higher wellbeing (50.9). Mental health Foundation (2016) Mental Health in Scotland: Fundamental Facts 2016	
Age	Each section must be read within the context of the intersectionality of all the protected characteristic Older people's mental health relates both to earlier life experiences and also to particular experiences, conditions, and contexts specific to ageing and the post-retirement period. Experiences of mental and physical health differ throughout the older age period. Evidence from England, for example, shows risks of depression increasing markedly beyond 80 years of age. (Naylor C. et al (2016): Bringing together physical and mental health, A new frontier for integrated care; Kings Fund) In Scotland, children and young people (only measured for those aged 16-19) who are more socioeconomically deprived are significantly more likely to experience many types of mental health problems. (Mental health Foundation (2016) Mental Health in Scotland: Fundamental Facts 2016) Sources are within this section	

Pregnancy and Maternity	Each section must be read within the context of the intersectionality of all the protected characteristic The experience and impact of social determinants varies across life, and influence people at different ages, gender and stages of life in particular ways. The prenatal period has a significant impact on physical, mental, and cognitive outcomes in early life and throughout life. A mother's maternal health is particularly important and poor environmental conditions, poor health and nutrition, smoking, alcohol and drug misuse, stress, and highly demanding physical labour can all have a negative effect on the development of the foetus and later life outcomes.(Allen J. (2014); Social determinants of mental health, World Health Organisation) Despite increasing figures for those affected by perinatal mental health problems, about 40% of women in Scotland have no specialist perinatal mental health provision. • Depression and anxiety affects 10 to 15% of women during pregnancy and first post-natal year, and is the most common mental health issue experienced during pregnancy.(Mental health Foundation (2016) Mental Health in Scotland: Fundamental Facts 2016) Sources are within this section	
Marriage and Civil Partnership	Each section must be read within the context of the intersectionality of all the protected characteristic Simon R.W. (2002); "Revisiting the Relationships among Gender, Marital Status, and Mental Health," American Journal of Sociology 107, no. 4 (January 2002): 1065-1096 found that three decades ago, Gove introduced his sex-role theory of mental illness, which attributes women's higher rates of psychological distress to their roles in society. Central to his hypothesis is that marriage is emotionally advantageous for men and disadvantageous for women. This study revisits this topic with data from the National Survey of Families and Households. The analyses indicate that the emotional benefits of marriage apply equally to men and women, but that men and women respond to marital transitions with different types of emotional problems. Richards M. et al (1997); the effects of divorce and separation on mental health in a national UK birth cohort; Psychological Medicine, Published online: 01 September 1997, pp. 1121-1128 Volume 27, Issue 5 web link: https://www.cambridge.org/core/journals/psychological-medicine/article/div-	

	classtitlethe-effects-of-divorce-and-separation-on-mental-health-in-a-national-uk-birth-cohortdiv/0E5ACBCC208189F7105935BA9E5686D5 suggested that divorce and separation were associated with increased anxiety and depression, and increased risk of alcohol abuse. This was the case after adjusting for educational attainment, age at first marriage, parental divorce, childhood aggression and neuroticism, and current financial hardship, lack of a confidante and frequency of social contact with friends or family. Associations between divorce and psychopathology were observed even though half of those separated or divorced were re-married or reunited with their spouses at the time of the analysis. The conclusions are that divorce and separation have a specific and long-term impact on mental health. Hegarty K. (2011); Domestic violence: the hidden epidemic associated with mental illness; The British Journal of Psychiatry Feb 2011, 198 (3), pp 169-170 pointed out that domestic violence is a common hidden problem for women attending clinical practice and is a major cause of mental ill health globally. Domestic violence is defined by the World Health Organization (WHO) as any behaviour within an intimate relationship that causes physical, psychological or sexual harm. Such behaviour includes acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviours, for example isolating from family and friends, monitoring movements and deprivation of basic necessities. The WHO multicountry study on women's health estimated that 15–71% of women had ever been physically or sexually assaulted by partners. Domestic violence is the leading cause of morbidity and mortality for women of childbearing age, with the main contribution being from the mental health consequences of abuse. Domestic violence has an intergenerational effect with children witnessing abuse having multiple health problems. Men are less likely than women to be victims of combined physical, emotional and sexual abuse from their partners and thus have been researched to a less extent. Scottish Women Aid (1999); Impact of domestic abuse on women's mental health; information briefing No 5 ; Volume 29, Issue 2 March 1999 , pp. 367-380 reflected that despite huge efforts and achievements in tackling domestic abuse across Scotland, it remains an endemic and largely	

	hidden problem which jeopardises women's mental health. Research shows that rates of depression are much higher among women experiencing domestic abuse than the general public (Helfrich et al 2008). Domestic abuse is also likely to be the most common single background factor for female patients in mental health settings (Sutherland et al 1998). The response that women encounter through mental health services is often one which individualises the symptoms. However, in order to fully support women's mental health, it is vital that the symptoms are viewed within the wider context of abuse experiences. Chen J. H. et al (1999) ;Gender differences in the effects of bereavement-related psychological distress in health outcomes ;Psychological Medicine; Published online: 01 March 1999; web link: https://www.cambridge.org/core/journals/psychological-medicine/article/gender-differences-in-the-effects-of-bereavement-related-psychological-distress-in-health-outcomes/D78FEBFCB29BF16CB4EDBC38E451B3B3 study examined whether traumatic grief, depressive and anxiety symptoms formed three distinct factors for widows and widowers focusing on whether high symptom levels of traumatic grief, depression and anxiety predicted different mental and physical health outcomes for widows and widowers. Three distinct symptom clusters (i.e. traumatic grief, depressive and anxiety symptoms) were found to emerge for both widows and widowers. Widows had higher mean levels of traumatic grief, depressive and anxiety symptoms. High symptom levels of traumatic grief measured at 6 months predicted a physical health event (e.g. cancer, heart attack) at 25 months post-intake for widows. High symptom levels of anxiety measured at 6 months predicted suicidal ideation at 25 months for widowers. In conclusion the results suggest that there are gender differences in the levels of psychological symptoms resulting from bereavement and in their effects on subsequent mental and physical health for widows and widowers. Sources are within this section	
Social and Economic Status	Each section must be read within the context of the intersectionality of all the protected characteristic Scotland's mental health is not equally distributed across society. Those living in deprived areas have a generally lower level of mental wellbeing, and have more GP consultations for conditions such as depression and	

	anxiety. For example, data for 2010/11 shows that the number of people from the most deprived areas presenting with anxiety was twice that compared to the least deprived areas10 (62 and 28 per 1,000 patients respectively), and for the period 2007/11, the suicide rate in the most deprived areas was 26.4 persons per 100,000 population compared to 7.1 per 100,000 in the least deprived areas (Audit Scotland, 2012; ScotPHO, 2012). (Nowell R. (2014): Mental health in Scotland, SPICe briefing 14/36, The Scottish Parliament). The association between low income and mental disorders is accounted for by debt in some studies. A population study in England, Wales, and Scotland found that the more debt people had, the more likely they were to have some form of mental disorder, even after adjustment for income and other sociodemographic variables. (Allen J. (2014); Social determinants of mental health, World Health Organisation) Sources are within this section	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders Each section must be read within the context of the intersectionality of all the protected characteristic Furthermore, studies have identified a worsening of mental health problems among refugees since arrival in the UK. One of the main causes of poor mental health particular to refugees is pre-migration trauma, which could have been caused by torture or gender based violence. This can lead to isolation and loneliness caused by “dislocation from home and culture” and the status of being an asylum seeker. Refugees and asylum seekers may also experience poor or exacerbated mental health for the same reasons as others in society, such as poverty, relationship problems, bereavement, addiction, and violence or abuse. Mental health difficulties affect men, women and young people from all backgrounds, although people’s experiences will be gendered and influenced by culture and belief systems. (2016) Refugees, mental health and stigma in Scotland, Policy Briefing, See Me, Scottish Refugee Council and the Mental Health Foundation) Sources are within this section	

C Do you expect the policy to have any positive impact on people with protected characteristics?

	Highly Likely	Probable	Possible
General	None	More recovery focused and proactive strategies can lead to empowerment for individuals and that communities can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs to examine and develop options and innovations to shape future services provisions.
Sex	None	More recovery focused and proactive strategies can lead to empowerment for men, women and non-binary individuals can flourish	Any changes provide opportunities to consult, engage and involve men, women and non-binary stakeholders, patients and staffs to examine and develop options and innovations to shape future services provisions. Also to note that there is little to no research on non-binary people that can reflect their views.
Gender Reassignment	None	More recovery focused and proactive strategies can lead to empowerment for Tran-individuals can flourish	Any changes can provide opportunities to consult, engage and involve Tran-men and Tran-women stakeholders, patients and staffs to examine and develop options and innovations to shape future services provisions.
Race	None	More recovery focused and proactive strategies can lead to empowerment for black	Any changes can provide opportunities to consult, engage and involve stakeholders, patients and

		and ethnic minority individuals can flourish	staff from black and ethnic minority communities to examine and develop options and innovations to shape future services provisions
Disability	None	More recovery focused and proactive strategies can lead to empowerment for individuals and that communities with disabilities can flourish	Any changes can provide opportunities to consult, engage and involve stakeholders, patients and staffs with disabilities to examine and develop options and innovations to shape future services provisions.
Sexual Orientation	None	More recovery focused and proactive strategies can lead to empowerment for LGB individuals and that communities can flourish	Any changes can provide opportunities to consult , engage and involve LGB stakeholders, patients and staffs to examine and develop options and innovations to shape future services provisions
Religion and Belief	None	More recovery focused and proactive strategies can lead to empowerment for individuals with religious, beliefs and non-belief can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs with religious, beliefs and non-belief to examine and develop options and innovations to shape future services provisions.
Age	None	More recovery focused and proactive strategies can lead to empowerment for individuals of all ages can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs of all ages to examine and develop options and innovations to shape future services provisions.
Marriage and	None	More recovery focused and	Any changes can provide

Civil Partnership		proactive strategies can lead to empowerment for individuals in marriage and civil partnerships can flourish	opportunities to consult , engage and involve stakeholders, patients and staffs in marriage and civil partnerships to examine and develop options and innovations to shape future services provisions.
Pregnancy and Maternity	None	More recovery focused and proactive strategies can lead to empowerment for individuals pregnant and maternity leave can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs that are pregnant and on maternity leave to examine and develop options and innovations to shape future services provisions.
Social and Economic Status	None	More recovery focused and proactive strategies can lead to empowerment for communities in the range of social and economic status can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs in the range of social and economic status to examine and develop options and innovations to shape future services provisions.
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	None	More recovery focused and proactive strategies can lead to empowerment for individuals and that communities from marginalised groups can flourish	Any changes can provide opportunities to consult , engage and involve stakeholders, patients and staffs from marginalised groups to examine and develop options and innovations to shape future services provisions.

D Do you expect the policy to have any negative impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General	In general people with protected characteristics can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals and communities	None
Sex	In general men, women and non-binary persons can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts on men, women and non-binary individuals	None
Gender	In Tran-men and Tran-	Failure to implement recovery	None

Reassignment	women can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	focused and proactive strategies can lead to negative impacts on Tran-men and Tran–women and their communities.	
Race	In general black and ethnic minorities' community can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts on black and ethnic minorities' community.	None
Disability	In general people with disabilities can be negatively impacted due to changes in services. It is important that any discrimination is identified in early	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals with disabilities and their communities.	None

	stages and actions taken to mitigate the worst of its impact as soon as possible		
Sexual Orientation	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals with disabilities and their communities.	Failure to implement recovery focused and proactive strategies can lead to negative impacts on LGB individuals and their communities.	None
Religion and Belief	In general people with religious, belief and no belief can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts individuals with religious, beliefs and no belief and their communities.	None
Age	In general people of all ages can be negatively impact due to changes in services. It is important that any discrimination is identified in early	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals of all age groups and their communities.	None

	stages and actions taken to mitigate the worst of its impact as soon as possible		
Marriage and Civil Partnership	In general people in marriage and civil partnership can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals in marriage and civil partnership and their communities.	None
Pregnancy and Maternity	In general people who are pregnant and on maternity leave can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to negative impacts on individuals who are pregnant and maternity leave.	None
Social and Economic Status	In general people from lower social and economic status	Failure to implement recovery focused and proactive strategies can lead to negative impacts on	None

	groups can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	individuals in social and economic status and their communities.	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	In general people in marginalised groups can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to implement recovery focused and proactive strategies can lead to disempowerment of individuals and communities from marginalised groups.	None

E Actions to be taken		
		Responsibility and Timescale
E1 Changes to policy	This impact assessment will be used to ensure the final strategy document is cognisant of equality legislation and mindful of the need to explicitly state how it will eliminate unlawful discrimination, advance equality of opportunity promote good relations. It will be used as a guide to ensure assessment of the final agreed strategy is robust and transparent.	
E2 action to compensate for identified negative impact	Strategy vision is being developed at this stage Responsible Officer - D Walker Completion Date 31/03/18 Consultation, engagement and involvement events/ sessions with stakeholders, patients and staff on any proposed changes in service delivery within Mental Health services across GGC and HSCPs will be undertaken . Responsible Officer - D Walker Completion Date 31/03/18 Local service EqIAs will be completed once specific service proposals for each part of mental health services are available. Responsible Officer - D Walker Completion Date31/03/18 Final strategy to be considered by the Core Leadership Group and Senior Management Team Responsible Officer - Core Leadership Group and Senior Management Team Completion Date – 31/03/18	

E3 Further monitoring – potential positive or negative impact		
E4 Further information required	This document serves to inform future planning arrangements in relation to the transformational programme for mental health services. As the programme develops so further information will become available in the form of consultation and engagement outcomes and actions derived from service level Equality Impact Assessments.	

6. Review: Review date for policy / strategy / plan and any planned EQIA of services

6 month review to be sent April 2018

Lead Reviewer: **Name: David Walker**
Sign Off: **Job Title Head of Operations**
Signature
Date: October 2017

Please email copy of the completed EQIA form to EQIA1@ggc.scot.nhs.uk

Or send hard copy to:

Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH