A SERVICE EVALUATION EXPLORING POTENTIAL DIFFERENCES BETWEEN SERVICE USERS AND THE LOCAL POPULATION OF A LONDON BOROUGH ON THE BASES OF PROTECTED CHARACTISTICS

Plain language summary:

This project explored potential differences between the population in a London borough and service users on the caseload of a community mental health team, on the bases of age, sex, ethnicity, disability, sexual orientation, and gender reassignment. This project was carried out in two parts: the first part was to compare demographic data from service users and from the borough to obtain percentage differences. The second part of this project was to present the percentage differences to the team for discussion. Themes were extracted from the team discussions and recommendations were made for service development, clinical practice, and future research. The findings of this service evaluation have been shared with some key shareholders, and there is potential to share the findings of this evaluation more widely within the Trust.

Introduction

It has long been established that health inequalities exist across various socio-economic and cultural factors within the UK (Dalgren,1995; McNamara et al, 2020). The impact of the Covid-19 pandemic, coupled with the rise of social justice movements within recent years, have brought to the forefront, the need for tackling health inequalities for socially disadvantaged and vulnerable groups of people (Mein, 2020; Kim et al.,2020).

In 2020, the National Health Service (NHS) England and NHS Improvement set up an "Advancing Mental Health Equalities taskforce" for which they called on all Mental Health Services to "take concrete steps to fight stigma and inequalities across the sector" in accordance with the Department of Health and Social Care Long-Term Plan for the NHS (NHS Improvement, 2019; NHS England, 2020).

Although the NHS Long-Term Plan has been criticised for lacking clarity and direction in its plan for reducing health inequalities (Ford et al., 2019), research has shown that the Covid-19 pandemic led to a significant rise in demand for mental health services (Centre for Mental Health, 2020) which revealed that people with protected characteristics are more likely to experience health inequalities (McCann & Monaghan, 2020; Kelsall-Knight, 2022).

The Equality Act (2010) provides the framework for identifying characteristics protected by law. The Equality Act recognises nine protected characteristics. These are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The aim of the Equality Act is to prohibit the direct and indirect discrimination of people on the basis of these nine protected characteristics.

Nonetheless, research continues to show that access to mental health services is not equally distributed across the population in England (Centre for Mental Health, 2020). For example, statistics show that only 6 percent of older people with depression are referred to mental health services in comparison to 50 percent of younger people (Burns 2015). Additionally, Black people in the UK have been found to be less likely to be referred to psychological therapies than their White counterparts (Equality and Human Rights Commission, 2018). In a meta-analysis conducted by Semlyen et al.

(2018) they found that people who identify as LBGT on average, wait longer to be seen by a mental health specialist than people who identify as heterosexual.

These findings indicate an urgent need for mental health services within the NHS to actively tackle and reduce mental health inequalities. In order to reduce mental health inequalities for socially disadvantaged groups, it is imperative that mental health services identify inequalities within their services (NHS England, 2020). As such, this service -related research project aims to identify potential mental health inequalities within a Community Mental Health team on the bases of protected characteristics.

Service Context:

The service is an Adult Community Mental Health Service based within a London borough. In line with the NHS Long Term Transformation Plan, certain teams within the service have transformed, including the team within which this project was conducted. As such, this project uses data collected from clients and staff under the new Mental Health and Wellbeing Team – South (MHWT-S) which covers the south of the borough.

The MHWT-S is an adult mental health service for people who meet the threshold for secondary care in terms of risk and complexity and will need MDT input in their care. As such, the team comprises of two Consultants, Nurses, Social Workers, a Community Clinical Psychologist and two CAP apprentices, Support and Recovery Time (STR) workers and Peer Support Workers.

Rationale for project

Consistent with the NHS Long Term Plan for mental health services, this project is in part, an effort to address potential mental health inequalities for service users under the new MHWT-S. However, the rationale for this project extends beyond the new MHWT-S. It is hoped that findings from this project will inform all three teams, including the Central and North Community Mental Health Teams as they form part of the wider Adult Community Mental Health Service that provides secondary mental health care to people within the London borough.

In addition, the borough published Health and Wellbeing Strategy report in 2016, in which they stated that the borough was committed to reducing health inequalities for

people on the bases of their age, race, sex, disability, sexual orientation, and gender reassignment by the year 2020 (Waltham Forest Health and Wellbeing Board, 2016). The report identified that people with these protected characteristics were the most vulnerable in the borough. As such, it was imperative that the project should focus on these six protected characteristics as it relates to the borough.

Thus, another rationale for evaluating potential disparities between the local population and service users under the MHWT-S on the bases of age, race, sex, disability, sexual orientation, and gender reassignment was to ensure that through this project, the team could evaluate whether vulnerable people within the borough were underrepresented within the service.

Aims And Scope Of Service Evaluation:

The objectives of this service-related project are a) to investigate potential inequalities in the new MHWT-S' caseload on the bases of age, sex, ethnicity, disability, and sexual orientation. b) If any discrepancies are found, to present the data to the MHWT-S team to generate understanding of why these discrepancies exist. The general objective of this project is that the findings will increase awareness among staff, with hopes that this would facilitate action towards reducing any potential mental health inequalities that may be found for service users in the team's geographical area.

Research Questions:

The research questions for this project are as follows:

1. Do the demographics of service users under the MHWT-S match the general demographics people within the borough on the bases of age, sex, ethnicity, disability, sexual orientation, and gender reassignment?
2. If any discrepancies are found, what are the factors that would explain those discrepancies from the understanding of clinicians within the MHWT-S?

Method

Project Design:

This was a service-related evaluation of the demographics of service users under the MHWT-S in comparison to the general population within the borough. This project was conducted in two parts. The first part was to extract demographic data from service users on the team's caseload using data from the electronic notes system. This was retrieved using PowerBi Software which was then compared to the demographic data of the borough to obtain percentages.

The second part of the research was to then present the comparison data to the team to obtain qualitative data which was analysed to generate general themes.

Ethical Approval:

Ethical approval from the service was not required for this project However, prior to discussing the data on percentage differences with the team, consent was sought from all staff present to record the discussion on an encrypted Trust Smart Phone.

Data Gathering:

Data about service user demographics was obtained from the Electronic notes system using PowerBi software, as this is GDPR compliant and commonly used within the Trust for all service-related research and audits. This sample size for service users under the MHWT-S was 486 as of October 2022.

Population data for age, gender, ethnicity and disability were obtained from the 2011 census data as the 2020 census data had not yet been released at the time of this project. For sexual orientation, population data was gathered from the Annual Population Survey (2018) while data for Gender reassignment was gathered from the National LGBT Survey (2017)

An important caveat is that although the geographical area covered by the MHWT-S is technically the southern part of the borough, the population data covered the whole of the borough (i.e., not just the southern part of the borough) as there was no current demographic data by ward at the time of conducting this project. Furthermore,

extending the population data to the whole of the borough had positive implications for the service as it would provide current population demographic data for all three teams.

Qualitative data was collected through a team discussion. There were approximately 10 clinicians present during the discussion.

Data Handling:

Demographic data of service users were categorised to correspond with the categories in the current population data available. For example, in the ethnicity data, White Irish, and White Turkish were categorised as "White other" and Chinese and Filipino were categorised into "Asian Other" to match categories used in the Greater London Authority (GLA) ethnic group projections for 2020 (Greater London Authority, 2020).

Where patient data was categorised as "unknown" or "not stated", they were re-categorised as "none recorded". For example, patient data on gender reassignment showed "unknown" for all 486 service users under the MHWT-S but staff reported working with service users under the team who identify as transgender.

Data Analysis:

This project used a mixed-methods approach. Demographic data of service users were exported to Microsoft Excel to obtain percentage differences and chi-square analyses of the data. The data was presented to the team using Canva Software. Qualitative data from the team's discussion was recorded and listened to, and general themes were identified to explain their understanding of the percentage differences in the demographic data.

Results

Demographic data was collected and analysed for service users under the new MHWT-S as of October 2022. This data was compared to the most current population data for each protected characteristic. The results are discussed below:

Research Question 1:

Do the demographics of service users within the WF MHWT match the general population demographics in the area on the bases of age, sex, ethnicity, disability, sexual orientation, and gender reassignment?

The percentages of service users who fall into each of the six protected characteristic was carried out and compared to the percentage of people within the borough who also fall under the protected characteristic.

Extensive statistical analysis was not conducted for these figures, except for percentage differences as this project used a mixed method analysis with the extensive part of the analysis being the qualitative analysis from the team discussion.

Data for Age

Figure 1

Clustered column chart showing the total number of service users and people in the borough across various age categories
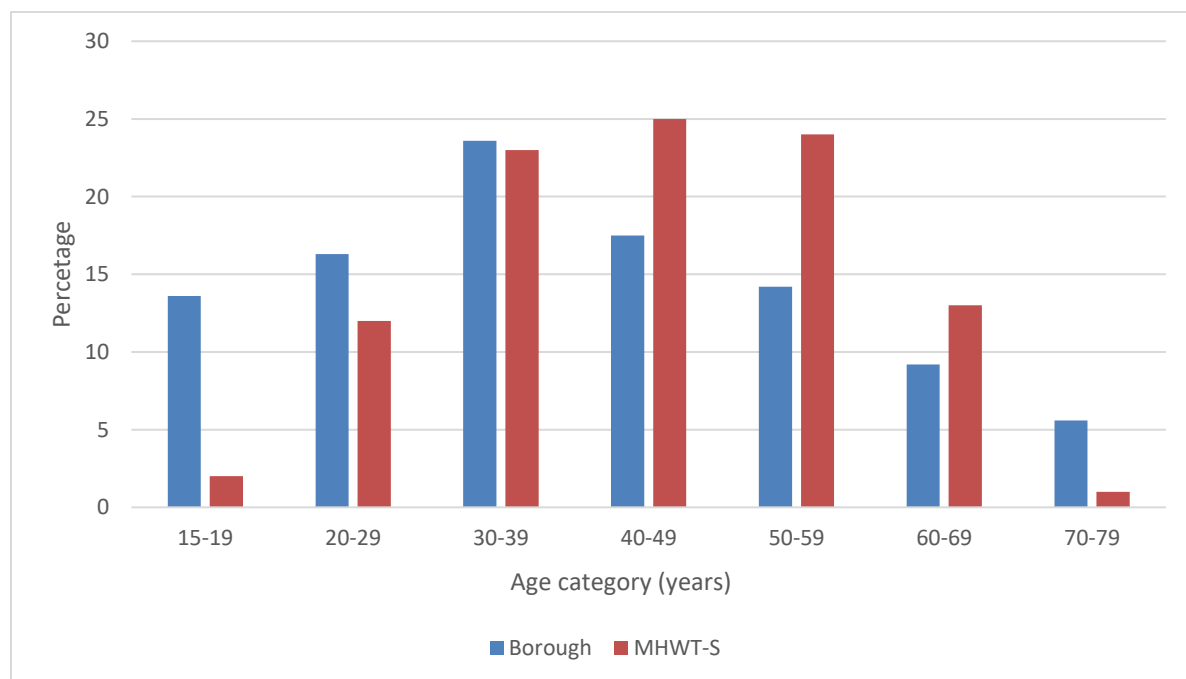

Note. The population data for age was retrieved from the 2011 census data as the 2020 census demographic data for specific boroughs had not yet been released at the time of this project.

From the percentage data, it appears that the borough has higher rates of adults between the ages of "30-39" years old while the team has higher rates of service users between the ages of "40-49" years old, followed closely by service users between the ages of "50-59" years old. Furthermore, the lower number of "15-19" years old and "70-79" years old would be expected given that the team only accepts people who are 18years+ and less frail as "frailty" would meet the criteria for the Older Adults Service and therefore, they would not be under the MHWT-S. To summarise the data shows that the average age category of service users under the MHWT-S is slightly younger than the borough population.

Data for Gender

Figure 2

Clustered column chart showing the distribution of gender for the borough and for service users under the MHWT-S
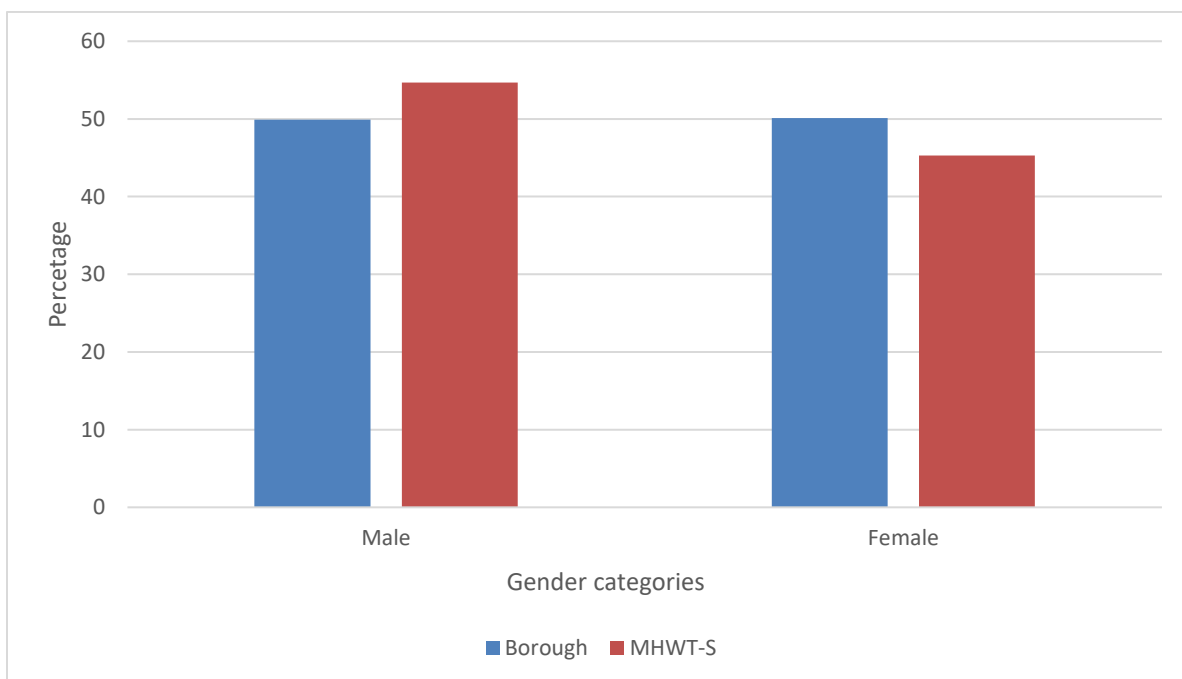
Note. Gender for service users was categorised into "male" and "female" to match the 2011 Census data as there were no records of others not fitting into these categories.

From the distribution above, it appears that there are generally more men in the MHWT-S than women, in comparison to the community, where there are women than

man in the borough. This was presented to the team for discussion and the general consensus from the team was that this finding was to be is expected as they have noticed that there tends to be more men in community mental health services in comparison to women.

This finding was interesting as the research shows that women are more likely than men to engage in help-seeking behaviours from informal and formal sources including mental health services (Douglas & Kevin, 2016) . The team's understanding of this data was that men are more likely to come into mental health services through sectioning or through other services such as the police and are more likely to be medicated or remain under the medical stream while women are more likely to engage with psychology when referred. This is supported by my colleague's research which showed that although there were more men than women in the team, more women were accessing psychology in comparison to men in the team.

Data for Ethnicity

Figure 3.

Clustered column chart showing the distribution of service users and the local population across ethnic subcategories.
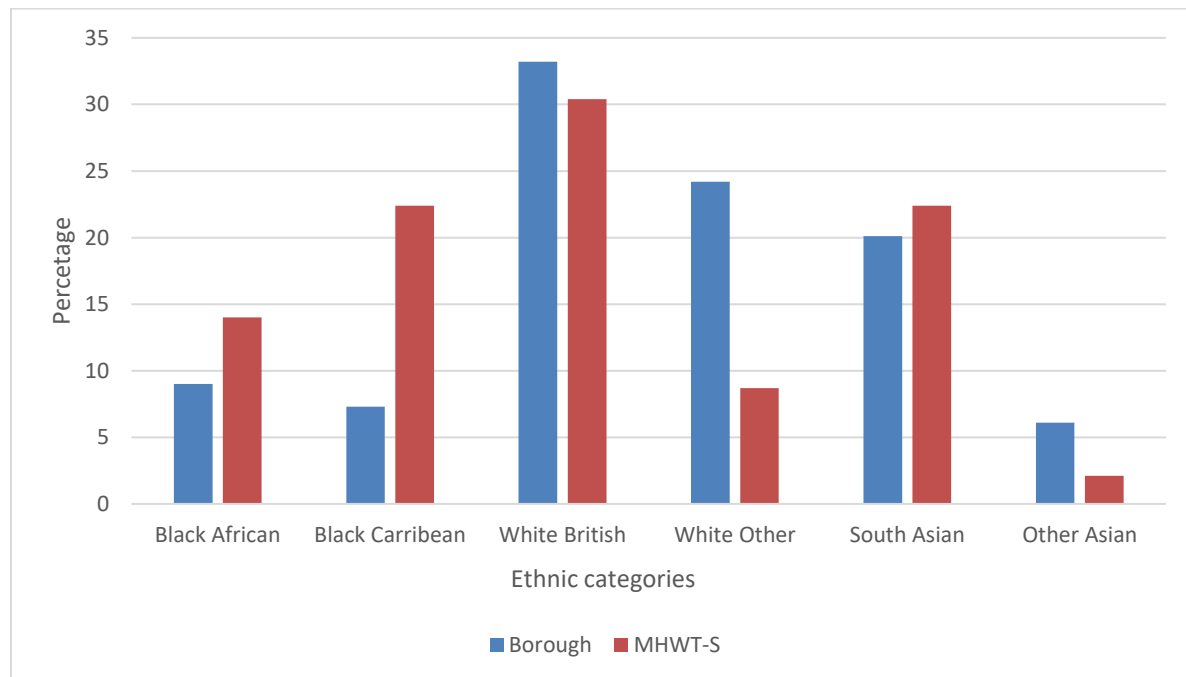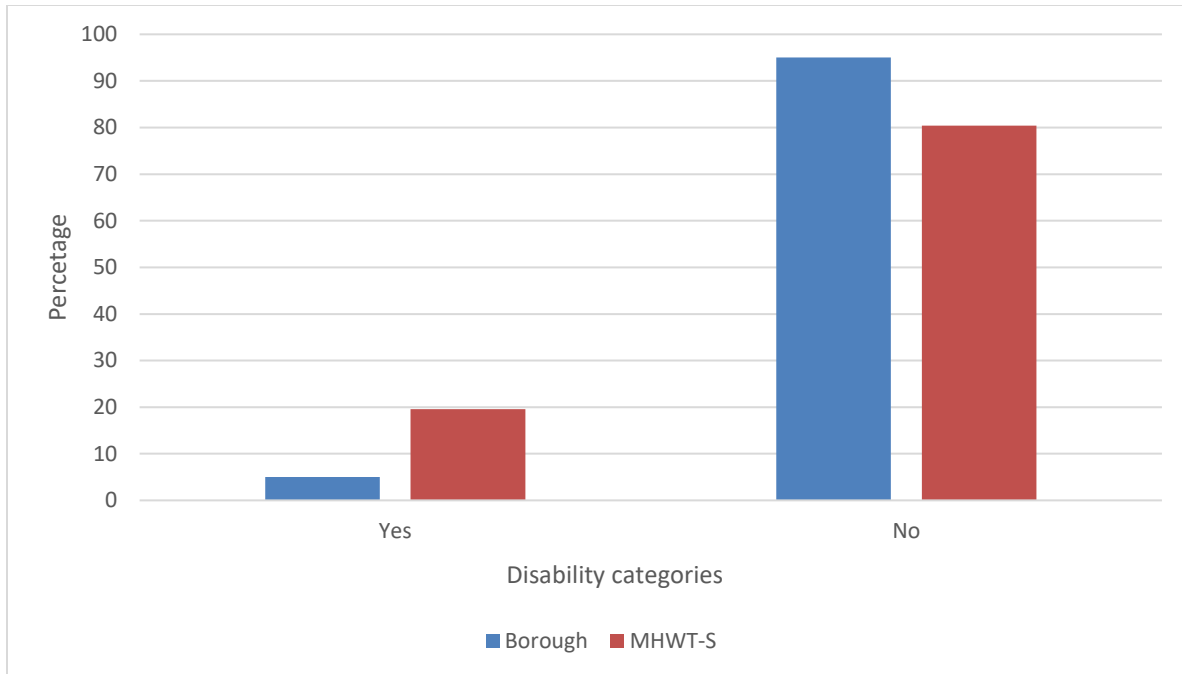
Note. The data for Ethnicity was retrieved from the GLA Ethnic Group Projections data for Waltham Forest (Greater London Authority, 2020). As such, the ethnic categories from patient records were matched to the categories listed in the GLA ethnic projections data.

        The data in Figure 3 above shows discrepancies between the population and service users on the bases of ethnicity. While the ethnic categories are in no means exhaustive of the various subcategories within this domain, the data appears to indicate that "Black Caribbean" and "Black African" ethnic groups are overrepresented among service users under team while "White Other" and "Asian Other" are underrepresented among service users under the MHWT-S. The qualitative analysis below shows the teams understanding of this data. However, it is important to clarify that, "white other" is in reference to Eastern European service users as this is representative of the borough population and matches the census data. From the demographic data for service users, the data recorded for Turkish = N (5) and Polish = N (2) were the only nationalities and numbers recorded on the electronic system for Eastern European. As there more than seven service users of Eastern European descent in the team, the data indicates that much of this data is not being recorded for service users**.**

Data for Disability

Figure 4.

Clustered column chart showing the distribution of service users and the local population across disability categories.

Note. The borough population data for Disability was retrieved from the 2011 census data as there was no current data for dis ability within the borough. The categories for disability were "yes" and "no". This was matched with categories on the patient records and where responses indicated "none recorded", this was re-categorised as "no" while responses indicating "not specified" were re-categorised as "yes".

From the figure above, it appears that there were no substantial discrepancies for disability although there were higher rates of service users who identified as disabled in comparison to the general local population in the borough.

However, similar to much of the data, it appeared that this data was also not being recorded for service users as there was insufficient data for service users who identified as having a disability. Nonetheless, the team's understanding of this data was that this was also to be expected as service users are more likely to present with co-morbid conditions. This was not expanded in the qualitative analysis as this was an expected finding and therefore did not gather much discussion.

Data for Sexual Orientation

Figure 5.

Clustered column chart showing the distribution of sexual orientation for the borough and for service users under the MHWT-S
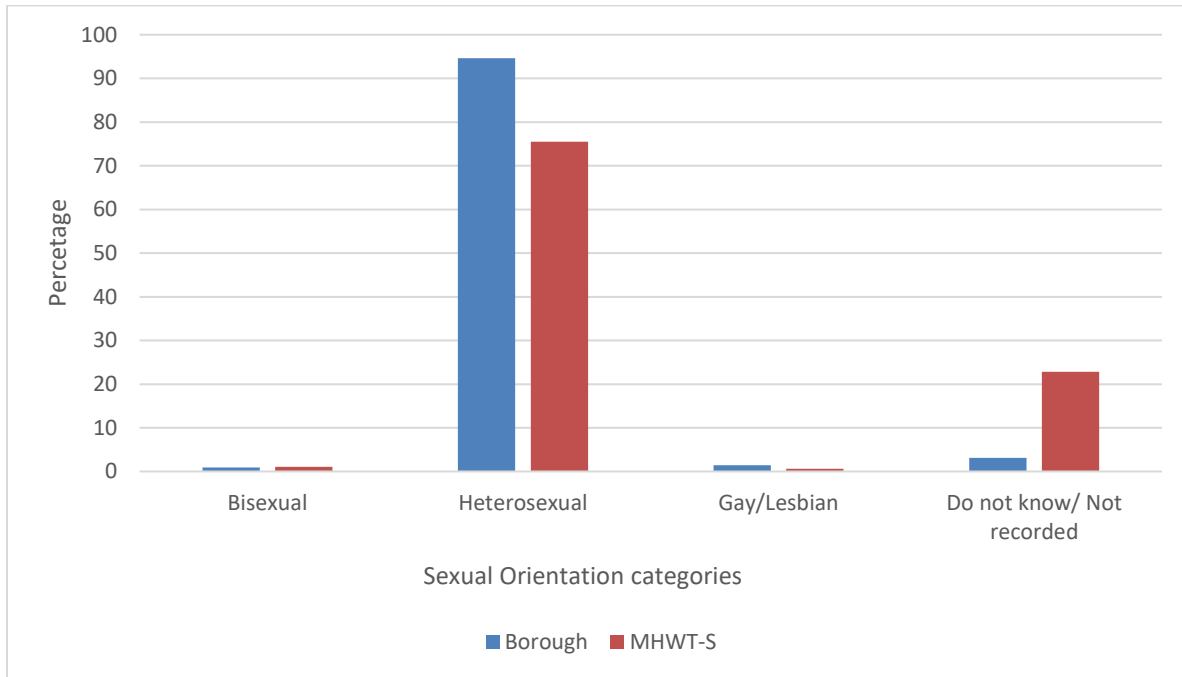
Note. As there are currently no local level data on sexual orientation (as this data has not been collected as part of the census for many years), the most reliable data for sexual orientation is from the Annual Population Survey which collects self-reported information on sexual identity from various households across the nation. As this data contained more current national population data on sexual orientation, this data was compared with patient data on the bases of sexual orientation. The category "other and do not know" in the population data was matched with "not recorded" in the patient data

The results indicate differences in the "do not know/ not recorded" category for the MHWT-S in comparison to the national data. The interesting finding from this category was that much of the data for this category for service users was not recorded. Therefore, no meaningful comparison could be made for this category.
The team's discussion for this results in this category was analysed in the qualitative data below as this generated a lot of discussion in the team.

Data for Gender Reassignment

Table 1.

Data on gender reassignment for the national population in comparison to patient data from the MHWT-S

	National Data	MHWT-S Patient Data
Non- Binary	6.9%	None recorded
Transgender/ Trans Identity	6.4%	None recorded

Note. There is no local data on Gender reassignment. As such, the most reliable population data for gender reassignment is from the National LGBT Survey (2017). Figures for the national data is representative of respondents to the survey who identify as "non-binary" and "transgender/trans identity".

Data from the MHWT-S patient records show no data for gender reassignment. However, it does not clarify what "none recorded" means as staff mentioned working with service users who identify as "trans identity". Therefore, like much of the data, there was insufficient service user data for this category to make any meaningful comparisons.

Research Question 2:

What are the factors that will explain the discrepancies, if any, from the perspective of clinicians within the WF MHWT?

Qualitative data collected from a team discussion on the figures above was analysed to explore factors that would explain key discrepancies in the data. The discussion was approximately 45 minutes long and some protected characteristics were discussed in more detail than others. Key discrepancies that were discussed in

relatively more detail are ethnicity, sexual orientation, and gender reassignment. Analyses for these protected characteristics are reported below:
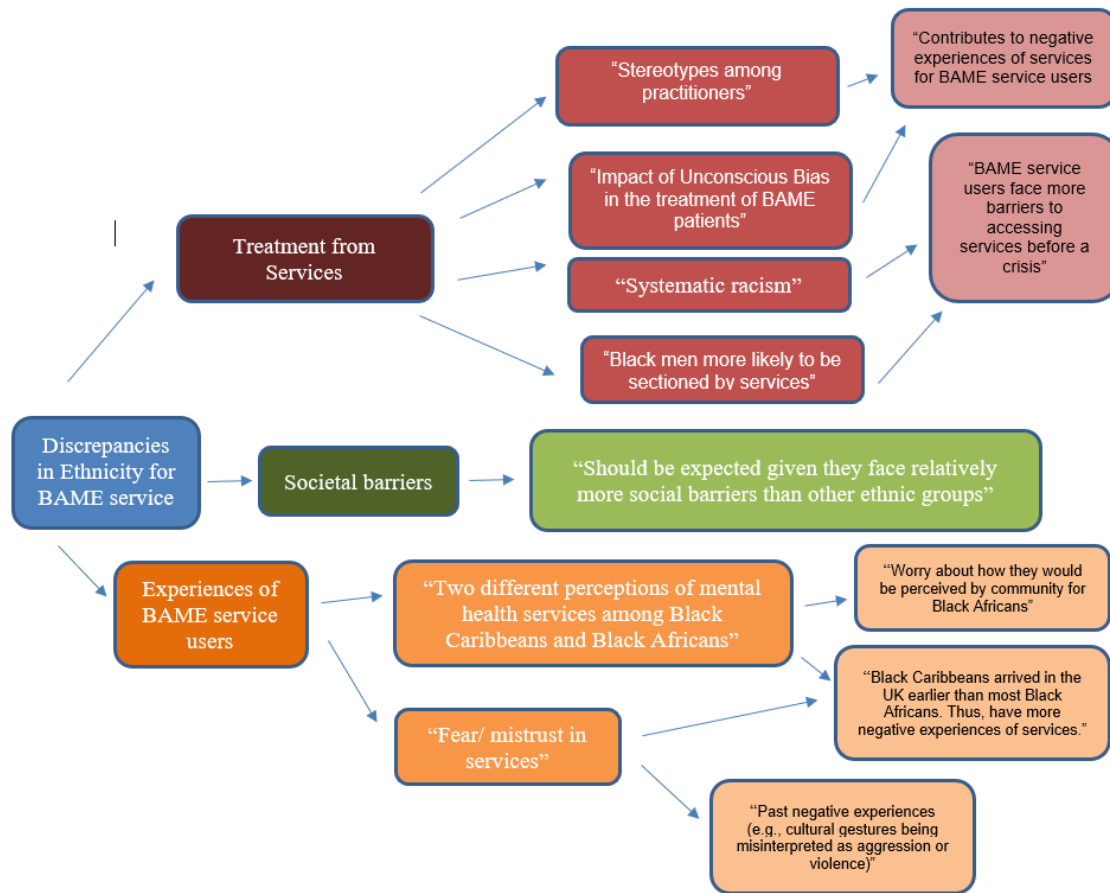
Qualitative Analysis for Ethnicity

Figure 6

Final map showing three main themes and their subthemes for discrepancies in Ethnicity.

Qualitative analysis for ethnicity focused on the huge discrepancy between black service users and population data. The team's understanding of the factors contributing to discrepancies in the ethnicity data was categorised into three main themes: *"treatment from services", "societal barriers"* and *"experiences of BAME service users".* Sub-themes with quotation marks are direct quotes of clinicians within the MHWT-S.

For context, the team has more clinicians from Black Caribbean and African backgrounds which may have influenced the discussion on this data with regard to sharing their experiences with service users from Black Afro-Caribbean backgrounds. Although the data showed that service users from "White Other" (i.e., Eastern European service users) are underrepresented in the team, the team's understanding was that in their experience, service users from Eastern European backgrounds tend to travel back to their respective countries from mental health treatment and would often not engage with mental health services in the UK, perhaps due to the language barrier.

Qualitative Analysis for Sexual Orientation

Figure 7

Diagram showing three main themes and their subthemes for discrepancies in Sexual Orientation.
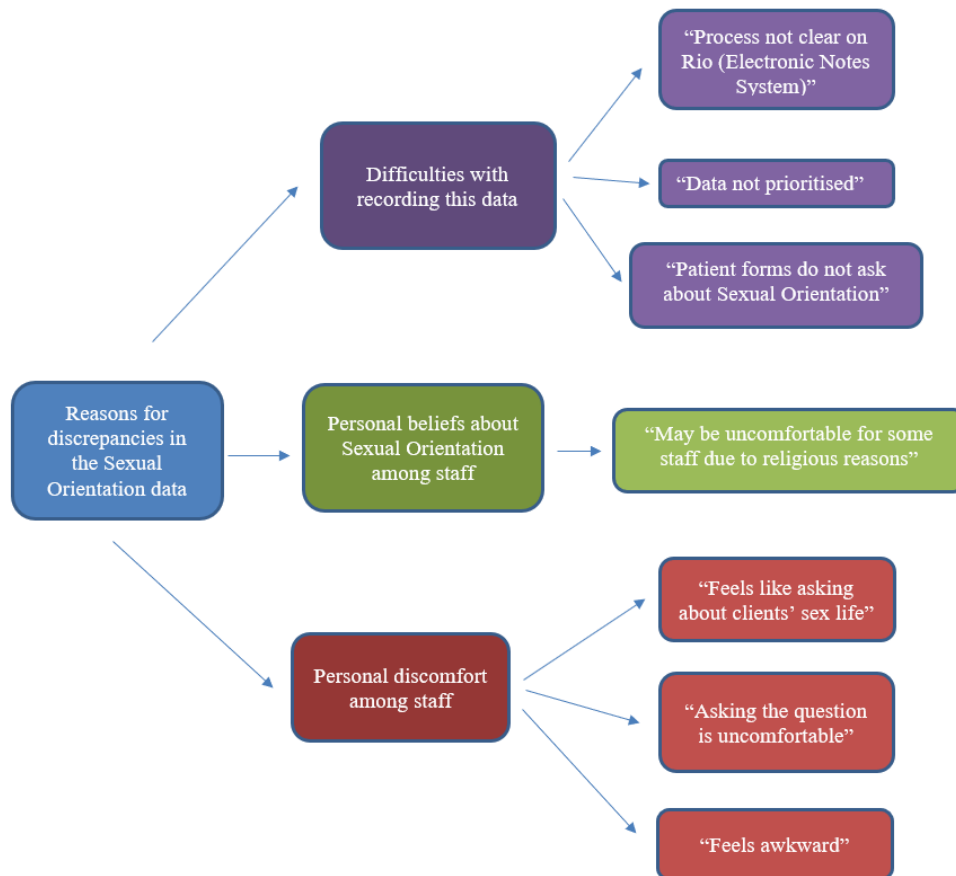
Qualitative analysis for factors contributing to discrepancies in the sexual orientation data revealed three main themes from the perspective of clinicians: *"difficulties with recording data on Rio", "personal beliefs about sexual orientation among staff"* and *"personal discomfort among staff".* Sub-themes are indicated in the diagram above. Nonetheless, the general discussion from this data was that staff were either "too busy" to record this data or "felt uncomfortable" asking clients about their sexual orientation. In addition, staff were confused about the difference between sexual orientation and gender identify which indicated that more training was need to increase awareness on both sexual orientation and gender identity categories.

Qualitative Analysis for Gender Reassignment

Figure 8

Diagram showing three main themes and their subthemes for discrepancies in Sexual Orientation.
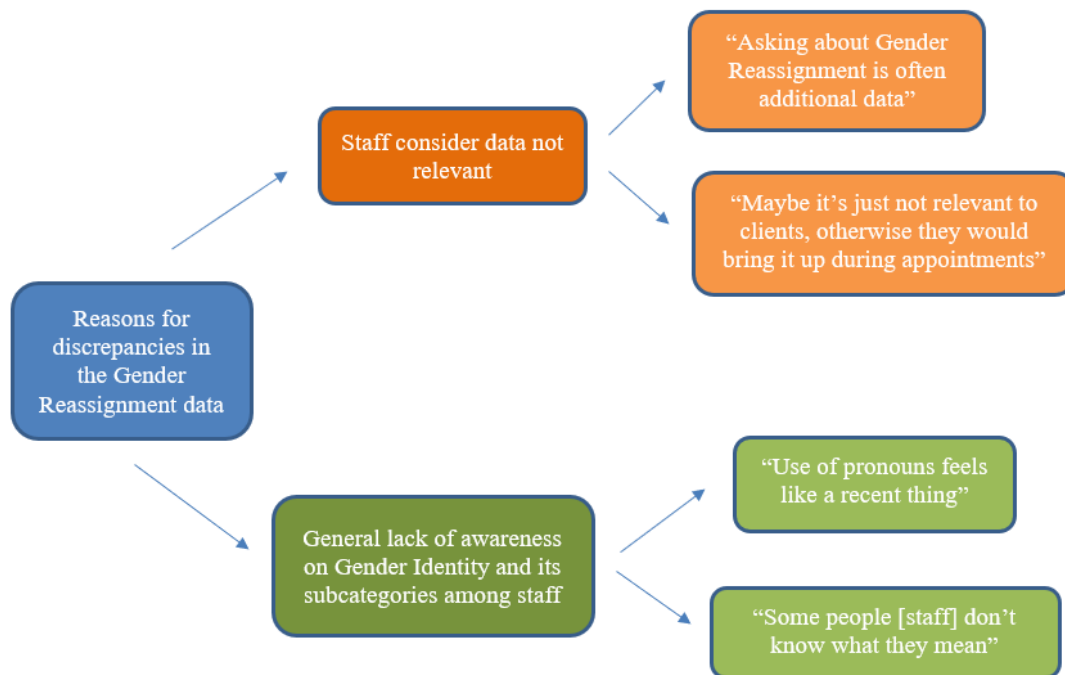
For gender reassignment, qualitative analysis showed two main themes from the team's discussion on the data - *"Staff considering data not relevant"* and a *"general lack of awareness on Gender Identity among staff"* . Similar to the discussion on sexual orientation, staff in the team felt that the data was not relevant for their practice and agreed that more training would be needed to understand the subject much better.

Discussion

The purpose of this service evaluation was to explore whether service users represent the local population on the bases of age, gender, ethnicity, disability, sexual orientation, and gender reassignment. The findings of this service evaluation revealed substantial discrepancies for ethnicity, sexual orientation, and gender reassignment. These protected characteristics were discussed with the team and qualitative analyses explored clinicians' perspective on the discrepancies. From the qualitative analyses, themes such as "lack of awareness among staff", "difficulties with recording the data on the system", "systematic racism", "treatment from services", "unconscious bias", "patient experiences of services" were identified by staff as factors contributing to the discrepancies.

Another discussion that emerged from presenting the comparison data to staff within the MHWT-S was a need to address those disparities for service users under the team's caseload. Staff identified the need for Equality and Diversity training to address unconscious biases among staff. They also identified a need for training on Sexual Orientation and Gender Identity categories and how to invite those conversations in their field of practice. Furthermore, the team identified the need to record all patient data to ensure that notes systems accurately reflect the identity of the patient.

Strengths and Limitations:

A strength of this evaluation is that it the patient data is accurate the time of doing this project. Suggesting that the data was likely to be representative of all service users under the MHWT-S as of October 2022.

A limitation for this project was that population data was sourced from the 2011 census data as the 2020 census data had not yet been released at the time of conducting this project. As such, by using older data, the findings may be less accurate due to the likelihood of the borough population changing a lot. For the purposes of usefulness to the service, this project will be repeated once the 2020 census data becomes available.

Similarly, the lack of accurate patient demographic data was another limitation of this project as it impacted on comparisons being carried out for those protected characteristics. Although this limitation was a substantial finding in itself, it did not allow for intersectionality to be considered in this project, which could have enriched the qualitative data for this project.

Another key limitation for this project, is that it evaluated potential discrepancies within the caseload, not inequality of access (i.e., whether service users were referred and declined), inequality of experience (i.e.. What they received once in the service) or inequality of outcome.

Nonetheless, following the discussion, in which the percentage data was presented to the team to collect qualitative data, the general feedback from the team was that they wanted to have more of these discussions on inequalities. However, the reality of working in an MDT means that often the urgent need to discuss individual caseloads, social care needs, patient complexity and other service needs takes precedence over having these important conversations.

As such, this report provides some recommendations for service development, clinical practice, and future research.

Recommendations for Service Development:

From this research, it was apparent that there was insufficient demographic data for sexual orientation and gender reassignment. To improve this, the service could consider providing training on LGBTQ+ awareness to make staff more confident in having these conversations with service users. Furthermore, notes systems such as Rio could be improved to facilitate the easy recording of all demographic data. The service

could also include sexual orientation and gender identity categories on patient forms for accurate data collection.

A major part of the qualitative data revealed several factors for the discrepancies in ethnicity. One of the factors being "unconscious bias among staff". The team identified that ongoing training on addressing their own unconscious biases was imperative to reducing mental health equalities among service users on the team's caseload. This is supported by the "circles of fear" model by (Keating, Robertson, Francis, & McCulloch, 2002) which proposes that due to negative experiences with mental health services, minoritized groups often feel reluctant to seek help leaving them at risk of worsening symptoms, which increases the likelihood of services using coercive interventions, further reinforcing their negative perceptions of services.

As such, the team could consider community outreach interventions to build trust among ethnic minoritized groups in the community. That may mean applying community intervention models to current ways of working such as encouraging service user network/family meetings in community spaces, collaborating with community organisations on mental health awareness projects where people can be given the space to have their questions answered.

Recommendations for Clinical Practice:

Findings from this service-related project suggest that there is potential for more outreach and community projects to engage more ethnic minoritized groups within the community who would otherwise fall through the gaps of conventional psychology.

Furthermore, referral pathways for psychology within the team could be evaluated to ensure equity of access for minoritized groups of people. Most importantly, that ethnic minoritized groups of people are treated with the awareness of the "circles of fear" (Keating et al., 2002) that may influence their understanding, perception, and engagement with psychology. As such, ongoing training on cultural humility; particularly on understanding gestures, body language, the impact of systematic racism on perception of services, will be imperative to establishing a psychological service within the team, that is culturally competent and feels safe for service users from ethnic minoritized communities.

Recommendations for Future Evaluations and Research:

Further research could re-run the analysis with 2020 census data pending its full release in 2023. This analysis will provide current population data which will produce a more accurate comparison of the data.

Furthermore, future evaluations could identify groups that are the most under-represented and over-represented within the team and run focus groups for service users from those backgrounds in order to try to understand the barriers from the perspective of those communities.

In addition, future projects could evaluate whether clinicians are representative of the locality they serve on the bases of protected characteristics and perhaps evaluate the challenges or benefits to the service from the perspective of clinicians, when clinicians are/are not representative of the local community.

Lastly, a future project could evaluate the whole pathway into the MHWT-S e.g., demographics of who gets referred to Single Point of Access (SPA) and who gets accepted/ declined, to inform the team on whether these discrepancies occur at the point of referring to services, or after other services have assessed clients.

Dissemination to Stakeholders:

The findings of this project were presented to the MHWT-S team and the findings on ethnicity were shared with the Transformation Steering Group for the locality as well as the Anti-racist Practices in Psychological Therapies Working Group within the trust. There is also potential to share the findings of this project with various staff networks across the trust, such as the LGBT+ network to facilitate more awareness training for staff outside of the network, the Psychology Professions Conference and the North and Central Community Mental Health Teams who are yet to transform as part of the NHS Long Term Plan.

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