NHS Greater Glasgow and Clyde Mental Health Services Equalities Annual Report

Highlighting progress in responding to equalities across Mental Health, Learning Disabilities and allied services

2013-14

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Introduction

In December 2012 the Equalities Development Group for Mental Health Services was proud to have received the Chairman's award for Working Well Together, in recognition of the collaborative approach that has been taken to moving the equalities agenda forward.

Through the group, we have sought to recognise and reflect the diverse efforts that staff and services are taking to address equalities issues through the means of a comprehensive annual report. In each of the last three years, colleagues have been able to demonstrate the wide range of approaches being taken, their energy and their enthusiasm to effect change.

This year's annual report amply demonstrates that this effort has been sustained during 2013-14 across Mental Health, Learning Disability and Addiction services in Greater Glasgow and Clyde. A very broad range of equality and inequality issues are being addressed.

We have had the added impetus this year of creating a new initiative, Equal Minds, as response to the challenge set in every part of the Greater Glasgow and Clyde system to strengthen collective efforts on tackling inequalities. Briefly, the Equal Minds initiative is a combination of Board-wide developments, such as a renewed focus on sensitive enquiry (and the recording of this) plus support for staff-led initiatives across service teams. The Inverclyde case study in this report (page 31) demonstrates one example of this Equal Minds initiative being implemented within a local partnership structure.

The work examples cited in this report span human rights dimensions (including in both learning disability and forensic settings), innovative approaches to asset mapping for well-being and specific initiatives to raise awareness of LGBT issues. Also featured is gender-based work, such as promotion of women's recovery within an addiction services context, work on hate crime and a focus on financial inclusion.

While all acknowledge there remains much to do, this enthusiasm of teams to share good practice and learning is to be commended. We hope you find this annual report of interest, and would encourage you to take the initiative and get in touch with teams if you want to know more about the work they are undertaking.

Dr Trevor Lakey
Health Improvement and Inequalities Manager - Mental Health, Alcohol and Drugs

East Dunbartonshire: Assets Approaches

Lead: Fran McBride, Head Occupational Therapist

Social Assets in Action is a Better Together funded partnership project led by IRISS, East Dunbartonshire CHP, East Dunbartonshire Council and third sector partners to support the implementation of an assets-based model in community mental health (and wider) services.

The project aimed to incorporate strength-based practice in the delivery of mental health services by piloting Personal Asset Mapping, and to broaden awareness of community assets in order to show options outside of public service delivery. This includes the development of a Community Well-being (asset) Map.

Personal Asset Mapping (PAM) is the practice of making a visual representation of the positive influences in a person's life. The evaluation of the project highlighted that Personal Asset Mapping, with its visual approach, can make a big difference to service users who try it.

This can occur after even just one session making a map and so has great potential to promote well-being.

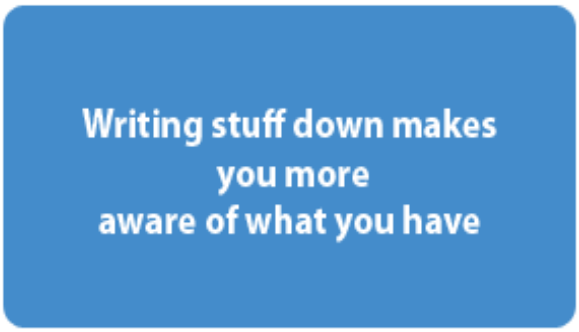
As one person, who is supported by services, said: "It's like a grateful list on a bad day when you feel there is nothing to live for. Writing stuff down makes you aware of what you have. I didn't realise what I had. It makes me think about why I do some things and how I could make more use of things that are on the outskirts."

We've created WITTY (What's Important To You?), an app for iPad as a digital version of personal asset mapping, to help individuals understand the positive assets and factors which they have and can better use in their day-to-day life. The app was developed for use in partnership between service users and practitioners.

Crucial to note is that the icons can be used to represent many factors that promote well-being.

The next phase of this project is to:

* Formally launch the East Dunbartonshire Community Asset Map and the WITTY App, including the outputs from the project
* Introduce the app to mental health practitioners and third sector partners, developing a strength based approach (training programme started in December 2013)
* Introduce the use of iPads to support interventions with mental health service users.



The East Dunbartonshire Community Asset Map is located at www.eastdunassets.org.uk

The Personal Asset App can be downloaded free from the App Store at http://appstore.com/witty

You can view the evaluation of this work online at: http://www.iriss.org.uk/resources/social-assets-action-evaluation-report

Learning Disabilities Services

Leads: Emma Anderson and Hazel Wilson, Bowel Cancer UK
Clare Donaghy, NHSGGC Health Improvement
Isla McGlade, Clinical Academic Lecturer Practitioner, Glasgow Caledonian University and Leader Learning Disability Services, NHS Greater Glasgow and Clyde Team:.

The Project
Supporting people with learning disabilities to take care of their bowels and encourage good bowel health amongst them.

Who are your target audiences?
NHS Greater Glasgow and Clyde Health Needs Assessment 2011 recommendation 27 challenged organisations and individuals to increase their awareness of, and participation in, health screening programmes for people with Learning Disabilities and their carers.

The report highlighted information from a variety of origins including Learning Disability Services, local authorities, academic departments and provider organisations supporting the need for input and support.

Recommendation 27 of the Health Needs Assessment states that “screening for gastro-intestinal cancer is as relevant, or more relevant, for people with Learning Disabilities as for the general population, and should be equally made available and actively promoted to people with Learning Disabilities in the prescribed age-range, and their carers.”

In 2010/11, Glasgow-based Learning Disabilities health improvement groups highlighted that people with Learning Disabilities and their care providers often experienced a lack of awareness about their bowels, good bowel health, bowel cancer and bowel screening.

Therefore it is now more important than ever that people with Learning Disabilities have equal access to screening services and health information which could help to reduce their risk and enable early diagnosis.

Together, Bowel Cancer UK and NHS Greater Glasgow and Clyde’s Health Improvement and Learning Disability Services aimed to increase awareness and participation of health screening programmes for people with Learning Disabilities and their carers.

The project team consulted service users, their families, and paid carers throughout. Together we aimed:
* To take a multi-disciplinary approach to maximise uptake of screening programmes
* To identify consultation and involvement opportunities for People with Learning Disabilities in order to develop recommendations
* To contribute to the development of communication/ training/ recommendations/ resources
* To identify local opportunities to increase awareness of promotion of key messages to supporters and carers of People with Learning Disabilities.

Project Aims
The Project aimed to create an information pack which addresses the poor uptake of bowel screening in people with Learning Disabilities and bridge an identified gap in accessible resources for people regarding bowel health and screening.

The resource, alongside a bespoke training programme, was offered to families and paid carers and a thorough dissemination plan was created which, together, would ensure that the information was consistent, well managed and could be easily updated and amended for use in other regions.

A participatory approach was undertaken. A working group of experts and professionals in this field was formed with specific responsibilities allocated.

The group met every ten weeks to discuss progress, share learning and decide next steps. Our primary focus was to ensure that people with Learning Disabilities and their carers informed the shape of this project at every stage.

Six focus groups were conducted by Health Improvement staff and specialist Learning Disabilities Nurses across NHS Greater Glasgow and Clyde with a total of 30 participants. Representative groups included The Health Advocacy Group Inverclyde, the Mainstay care provider, Carers Plannit and West Dunbartonshire Focus Group.

The Scottish Consortium for Learning Disabilities supported group activity ensuring an accessible record of the groups' discussions.

The project was continually evaluated and this data was collated and reported upon by an external evaluator. Training sessions were also offered across the Greater Glasgow and Clyde area for paid and family carers.

Student Learning Disability nurses from Glasgow Caledonian University also participated in sessions. Each training session ran to date has been individually evaluated, with a six-month follow-up phone evaluation being undertaken with each attendee to assess progress against their individual action plan.

The resource has also gone through the NHS Health Scotland Equality Process and the Department of Health Information Standard. This process will be repeated annually.

What are the benefits? Feedback from both staff and patients...

Bowel Health and Screening leads the way in both partnership working and a multi-layered approach. The network aims to naturally develop further links through this project. This includes sharing best evidence in practice, shared approaches and even closer networking between the NHS, care providers, third sector and the national screening programme.

The resource was designed to enable the information to be updated as easily as possible, with the hope that in the future it could be rolled out UK-wide. This would represent a significant cost-saving to the NHS, which at present creates and distributes this type of information on a region-by-region basis

The resource pack for people with Learning Disabilities accompanied by a specific pack for carers is underpinned by the principles of personalisation. The aim was for people with Learning Disabilities and their carers to be at the centre of the resource development so that they could access and participate in the bowel screening programme in an informed manner, and know where to seek additional support if required.

As needed, people with Learning Disabilities can follow the accessible pack

and work through information to promote informed choice and the details of collecting a sample. For some people this will involve family members, professionals and care workers to share and make informed decisions, manage risk and identify resources.

This also reflects the NHS Quality Improvement Scotland position that: the health needs of people with a Learning Disability are greater and more complex and often present differently from those of the general population.

People with a Learning Disability are more likely than the rest of the population to have impairment to communication and therefore require special consideration in terms of accessible information and packs such as this.

People with a Learning Disability have the same right as everyone else to health services

People with Learning Disabilities most importantly have the same right as everyone else to access health services and these should be provided within the current legislative framework and in a way that upholds the principles of inclusion and respect, and conforms to professional standards. In other words, services should be safe, effective and person centred.

The resource pack was endorsed by NHS Scotland in September 2012 and received Cross Party approval in February 2013.

Funding was secured from Awards from All. Awards for All is a Lottery grants programme that funds small, community-based projects across the UK. NHS Health Scotland and the Scottish Government have committed to funding the reprint costs of the resource for 2014 and 2015.

An abstract submission and subsequent symposium for the above work together with three further developments was accepted for the Royal Collage for Nursing Annual International Nursing and Research Conference in April 2014.

Web-links

http://www.bowelcanceruk.org.uk/resources/bowel-health-and-screening/

http://www.bowelcanceruk.org.uk/media-centre/latest-news/resource-launched-in-scotland-for-people-with-learning-difficulties/

References

Personalisation: A Shared Understanding Changing Lives Service Development Group: The Scottish government 2009

Promoting Access to Health Care for People with a Learning Disability NHS Quality Improvement Scotland 2010

The Health Care Quality Strategy; The Scottish Government 2010.

The Keys to Life - Improving Quality of Life for People with Learning Disabilities; The Scottish Government 2013

NHS Greater Glasgow & Clyde Health Needs Assessment 2011

Introduction to Human Rights and Equalities legislations
Human Rights Legislation

Human Rights principles have a long tradition in UK law, dating back to the Magna Carta (1215) and the Bill of Rights (1689), with rights to liberty, fair trial and prohibitions against torture and slavery.

The Human Rights Act codifies these rights and put them into an accessible framework.

Human Rights Act 1998
The Human Rights Act 1998 (also known as the HRA) came into force in the United Kingdom in October 2000.

It is composed of a series of sections that have the effect of codifying the protections in the European Convention on Human Rights into UK law.

All public bodies (such as courts, police, local governments, hospitals, publicly funded schools, and others) and other bodies carrying out public functions have to comply with the Convention rights.

The Scotland Act 1998 required that the Scottish Parliament cannot create laws that are incompatible with the European Convention on Human Rights, nor can the Scottish Government take any action, or inaction, which might breach those rights.

This means, among other things, that individuals can take human rights cases to domestic courts; they no longer have to go to Strasbourg to argue their case in the European Court of Human Rights.

The European Convention on Human Rights (ECHR) was adopted in 1950, containing a total of 18 Articles and six Protocols. ECHR legally binds 47 European countries and the European Union institutions. The ECHR is a 'living instrument' which means it can develop over time to keep pace with social changes.

Human Rights Act 1998
The main United Nations human rights treaties are:
• Universal Declaration on Human Rights
• International Covenant on Civil and Political Rights
• International Covenant on Economic, Social and Cultural Rights
• UN Convention on the Rights of the Child
• UN Convention against Torture
• International Convention for the Elimination of all forms of Racial Discrimination
• International Convention for the Elimination of all forms of Discrimination against Women
• International Convention on the Rights of Migrant Workers
• International Convention on the Rights of Disabled People

The Human Rights Act sets out the fundamental rights and freedoms that individuals in the UK have access to. They include:
* Right to life
* Freedom from torture and inhuman or degrading treatment
* Right to liberty and security
* Freedom from slavery and forced labour
* Right to a fair trial
* No punishment without law
* Respect for your private and family life, home and correspondence
* Freedom of thought, belief and religion
* Freedom of expression
* Freedom of assembly and association
* Right to marry and start a family
* Protection from discrimination in respect of these rights and freedoms
* Right to peaceful enjoyment of your

property
* Right to education
* Right to participate in free elections

Some human rights are absolute; this means that they cannot be interfered with under any circumstances or for any reason
(for instance, freedom from torture, inhuman or degrading treatment).

Others rights are qualified, meaning that they can be interfered with under certain circumstances and for specific reasons (for instance, right to liberty and security).

Where rights are qualified, the state can only interfere with it if the interference is in accordance with law and proportionate (for instance, detention on mental health grounds is lawful interference with an individual's liberty as long as it is done in accordance with the Mental Health Act 1983 and is proportionate).

An action is proportionate if it is appropriate and not excessive in the circumstance.

Scotland's National Action Plan for Human Rights

The Scottish Human Rights Commission has developed Scotland's National Action Plan for Human Rights (SNAP) (2013) after four years of research.

The plan aims to improve human rights protection in Scotland. The main areas of concern when drawing up the document included: care, disability rights, health, criminal justice and business.

Although this is the first human rights action plan in the UK, they do exist in other countries, such as Sweden, Spain, New Zealand and Australia.

Included in this section are two projects within Mental Health Services that demonstrate the development of Human Rights approach within service deliveries.

Case Study 1: Human Rights in Netherton Learning Disabilities Unit

Lead: Elaine Shepherd, Senior Change Nurse

Background

The following report outlines a summary of approaches taken to implement a human rights framework to the care and treatment provided within a Learning Disabilities Unit of NHS Greater Glasgow and Clyde.

The support of people with challenging behaviour has the potential to raise human rights issues. The greater the perceived challenge, the more potential there appears to be to lose sight of person-centred practice.

Using a Human Rights approach enables the practitioner to develop strategies and values which are compatible with current best practice. It enables us to work in partnership with the person. It also reminds us to consider how their experiences of disability, sexuality, gender and ethnicity affect their quality of life, and how they may display distress.

Noreen Shields, Elaine Shepherd, Susan Fleming and Sofi Taylor had a session with Carole Ewart (Ewart Communications is a public policy and human rights consultancy service) who spoke with us about the international obligations and case laws resulting from Human Rights from the EU court of Human Rights.

In preparing this report, no attempts have been made to understand the direct correlation between the activities undertaken, and any progress that may have been made in developing a shared understanding of human rights issues between the staff and service users in the Unit.

This is due to services redesign and time limitation. The purpose therefore has simply been to describe the range of approaches that were used within the Unit, and the subsequent findings as they relate to the human rights of individuals, and a person-centred approach to care, within the Unit.

The Project

The aim of this initiative was to translate human rights issues against everyday practices in the Unit. This would be achieved by working together with clients, carers, advocacy groups and other professionals, to ensure service provision within the Unit is provided in a person centred way, underpinned by Human Rights legislation.

Human Rights

When the UK government introduced the Human Rights Act 1998 (HRA), it is said that its intention was to do more than require government and public authorities to comply with the European Convention. It wanted to create a 'human rights culture' among public authorities and among the public at large.

There are many reasons for putting human rights at the heart of our service. We should all aim to maximise outcomes for patients, service users and staff by approaching service responses and decisions in a person-centred way, thus continuing to improve care processes through mutuality and reduce complaints/litigation.

A good way to understand human rights is to see them as a vehicle for making Fairness, Respect, Equality, Dignity and Autonomy (FREDA) central to our lived experience as human beings. These core values are brought to life by a range of different human rights that make them real.

Challenging Behaviour and Human Rights Issues

While the behaviour of people with Learning Disabilities challenges carers and services, complex and competing human rights issues may emerge. It is suggested that a human rights-based approach to challenging behaviour offers a vehicle for balancing the ethical issues involved.

The impact for an individual of displaying a 'challenging behaviour' can, as discussed by Emerson (2001), go far beyond the physical impact of the behaviour. Emerson highlighted that the response to a person displaying challenging behaviour included abuse, inappropriate treatment, exclusion, deprivation and systematic neglect.

These practices have obvious human rights implications. For this reason, it may be helpful to consider other terms, such as 'Positive Behaviour Support' to reframe the previous approach to 'managing challenging behaviour'.

With the development of services for people with learning disabilities and the move for all to be part of the community, there has been a conscious shift in processes related to behavioural interventions, aided by the acceptance of applied behaviour analysis and the person-centred values approach.

Background Literature

The central concept in putting human rights ideas into practice is that if we focus on balancing the rights of all who are engaged in 'challenging behaviours' we can manage the risks to all involved within a more positive framework (Greenhill & Whitehead, in press; Whitehead et al, in press).

The Human Rights Act (1998) currently enshrines in British law a particular formulation of the human rights held by all people. The state has a duty to respect, protect and fulfil these rights.

As workers employed by the state, many health and social care practitioners in Mental Health and Learning Disabilities services have a 'positive obligation' to uphold these rights for the people we serve. This may require particular creativity in upholding the rights of people with intellectual disability who are challenging to services.

Triggers for the Initiative

An EQIA was carried out within Netherton, a longer stay assessment treatment service for people with Learning Disabilities who may also display 'challenging behaviour'. The EQIA highlighted a number of areas that required improvement.

Included within the action plan were the following:

- a need for training in the areas of Equality & Diversity. This was progressed by the Health Improvement Lead (Equality & Diversity) and targeted nursing staff from all inpatient Learning Disability services. This training was used to meet eKSF and SVQ Level 3 criteria;
- support capacity building for clients. This was progressed by setting up a group with members of the Corporate Inequalities Team, clients and nursing staff, facilitated by student nurses training at Glasgow Caledonian University. Capacity building with service users was designed to identify ways in which clients could acquire the confidence and skills to influence service developments across Learning Disability Services.

During the workshops, eight clients stated that although they were given the opportunity to give their opinion, it was not always used to influence the service delivery.

Project Outline - Changing the Culture
Three face-to-face interactive sessions as part of staff development were put in place.

There was free flowing discussion on:
* Human Rights Act in context of the UN and EU as human rights instruments
* How Human Rights impact on our daily lives
* How Human Rights translate in laws, policies and practices
* And how the power relationships between themselves and service users are displaced due to the lack of understanding of human rights issues.

General feedback was that the staff enjoyed the discussion and felt that it has enables them to reflect on their practices and consider the impact and consequence of human rights.

Staff Questionnaire
In order to provide a measure of progress, staff completed a questionnaire, approximately three months after attending an education session.

This questionnaire posed a series of questions to which the respondent would select one of the following responses: Yes, No, Don't Know. Staff responded Yes to all questions which asked whether they were aware of various policies, reports etc.

Questions about practice development in the areas of human rights were also answered positively with staff indicating that they had access to information about human rights in the Unit, that it should be part of KSF and PDP reviews.

Areas of person-centred practice appeared in positive answers to questions such as:

* Do you think that our Human Rights practices can result in a reduction of psychotropic medication given to service users?
* Are you able to make special provisions for service users to develop their care plan?

Some of the questions asked staff for their views about how service users are supported to have their human rights met.

These responses could then be explored in greater detail during discussions with service users, and included questions such as:
- Are service users aware of all review dates?
- Are service users able to access advocacy services for their review?
- Are service users involved in the development of their care plan?
- Are service users able to have access to all documents prior to their review meeting?

There were some responses within the questionnaire exercise that displayed some creativity in the ways in which staff respond to the needs of service users. Examples given of assisting service users to maintain contact with family and friends, and described approaches that included using Skype, webcams, internet and email.

Staffs were also asked to describe NHSGGC policies that were linked to their human rights.

The most popular response was the Equality and Diversity Policy. Others listed the Work Life Balance Policy, Equal Opportunities Policy, Family Friendly Policy, Whistle Blowing Policy and Healthy Working Life Policy.

Service User Interviews

Service user interviews were arranged with six people at Claythorn House and Netherton. Five residents were interviewed over the course of two days, with one person refusing to meet. Four of the interviews provided relevant information. Of those interviewed, two were known to the interviewers.Interviews were carried out independently by EqualSay Advocacy, who structured interviews around the Lead Reviewer Questions from the HRIA.

Following feedback from EqualSay, there is an impression amongst the review group that there were limitations in this approach.

EqualSay had not been involved in the project from the outset, and may therefore have had insufficient detail to facilitate effective discussion.

There is a sense that many of the statements used within their feedback were lacking the sort of follow-up questioning that might have extrapolated some of the issues key to the human rights of people within the Unit.

Service users did not appear to understand the term Human Rights, and EqualSay reported that service users didn't really see any connection between the way they lived their lives and human rights as explained by us.

It was expressed that people felt well treated within Netherton, although there are issues raised within the feedback which should be explored in a meaningful way with service users.

It was suggested that further engagement with EqualSay should be used to support opportunities for service users and staff to identify ways to contribute meaningfully, to their care, and developments within the Unit.

There was no real impression within the report that the service users had a good understanding of their rights or how to have them met.

EqualSay reflected, following completion of their report, that the individuals they know within the Unit now appear more willing to speak honestly about their impressions, as well as feeling more empowered to ask for their rights to be met. This in itself suggests some measure of progress.

The biggest impacts were on the staff group, very soon after these training sessions, the Learning Disability service redesign resulted in closing a unit and opening another in Gartnavel Royal Campus. The staff group were moved around to other units along with their Senior Change Nurse.

Just before this move, the Senior Change Nurse reported that she felt that she had changed her approach to working with service users. This was described as turning the question around to ask what the service could do to best meet the requests of service users, instead of the previous response to simply say that something couldn't be done.

After the move, she noted that the staff that had undergone the human rights training functions differently from staff who did not.

They have a better attitude, are more aware of the power relationships between themselves and service users, and service users' respond better to them.

The Clinical Effectiveness Facilitator was asked to capture some of these changes however with the staff movements and new ward, it became impossible.

Conclusions

In December 2012, at the Mental Health Services Equality Event, there were presentations on Human Rights and Mental Health. The Scottish Association for Mental Health presented the legislative

context by way of an overview and Margo Pratt, Clinical Effectiveness presented the Netherton's experience of how this translated into everyday practice in the Unit.

This project was seen to be a success, and motivated Martin Montgomery (the then General Manager for Forensic and Learning Disability Services) to have the Human Rights mapping completed on this service, which has now been completed.

Inverclyde Mental Health Services also expressed an interest in developing a human rights focus within their service.

The Project Group agreed key outcomes that they felt had been successful within this project:
* Making the EQIA Process a real experience that staff understood in the context of their everyday working lives. Using a Rights Based Approach allowed the Team to focus on the ethos of this process, and the reality of inequality, often based on assumptions or historical legacies, in service provision;
* Helping staff to understand the delicate balance of power. This included highlighting the many rights that staffs have, both in the workplace and in their everyday lives, and considering how this is reflected in the way in which they support service users to have their rights met;
* Helping service users to understand the balance of rights. Examples given by service users highlighted an understanding of the impact of their behaviour on the rights of others in the Unit, whether they were staff or other service users.

The Project Group also identified areas that may have improved the review of this exercise. These included:
* Involving key contributors at an early stage - EqualSay had not been involved from the outset and this had an impact on their role within the project
* Consider evaluation requirements before making changes within the service. Clinical Effectiveness was able to help to describe the process and relate various outputs to the original objectives. However, data was not available to provide a clear link between each of the activities and the impact of that individual activity on the overall success of the project.

A range of tools were developed either directly or indirectly as a result of this project. These included:
* Mapping Document – Human Rights in Forensic Services
* Evaluation Tools: including interview frameworks for staff and service users, format for development events, questionnaires, etc

Support is available for other Teams looking to adopt this approach. Contact Sofi Taylor, the Health Improvement Lead (Equality & Diversity) in the first instance.

Thanks to:
Margo Pratt (Clinical Governance),
Noreen Shields (Corporate Inequality Team) and
Carole Ewart (Ewart Communications is a Public Policy and Human Rights consultancy service) for their commitment to this project.

Case Study 2: Human Rights Mapping in Forensic Service

Lead: Mark Gillespie, Nurse Consultant

Background

This important piece of work was a direct outcome from the Human Rights Assessment project in Netherton
Residential Unit. The then General Manager tasked a small steering group to progress this human rights work within the Forensic Service. The Advocacy Service was a partner in this group.

The group decided to undertake a Human Rights mapping as an initial 'snap shot' of what is working in this service. Advocacy service's role was to engage the service users to work on their priorities which will be part of this project. The concerns/ issues section were the outcomes of this engagement.

Concerns/Issue	Article	Work Schedule	Progress
Access to Bedroom / Siesta Time (Concerns were raised by the Mental Welfare Commission in regards to how patients access bedrooms within Rowanbank Clinic).	Article 3 The right not to be treated in an inhuman or degrading way.	1. Development of a draft access to bedroom paper. 2. Consultation exercise to develop a questionnaire on bedroom access involving patients, carers and advocacy. 3. Development and dissemination of new Bedroom Access protocol.	* Complete and submitted to Clinical Governance meeting. * A short life working group made up of patients, advocacy and staff met to discuss the issue of bedroom access. The group developed a questionnaire that was distributed to all the patients within Rowanbank Clinic (N=66). They received 24 returns which equates to 36% of the patient population. The results of the questionnaire and the working group discussion have resulted in a move

Concerns/Issues	Article	Work Schedule	Progress
			away from the rigid access to bedroom to a system based on individual need and flexible access. New bedroom access protocol has been developed and is due to be ratified at the Clinical Governance meeting.
Environment Concerns in regards to: * Decoration * Home-style Model	Article 3 The right not to be treated in an inhuman or degrading way.	1. Consultation and discussions with PFI partners and patients in regards to establishing parameters in altering room aesthetics. 2. Lifecycle schedule as per Public Finance Initiative contract.	* Achieved and agreed with work commencing. * Patients now have the options of four different colour schemes within their own bedroom plus: the Special visiting room was re-decorated; the Elder Ward furniture was upgraded; the Community Centre was re-decorated; all low stimulus rooms were re-decorated and upgraded; and flooring was replaced in Larch, Holly and Sycamore Wards.
	Protocol 1, Article 1: The right to peaceful enjoyment of posses-sions.	1. Consultation exercise involving Patient Council and Advocacy Service. 2. Re-examination of treatment model within low secure which includes issues around accessing personal effects.	* Exercise completed. * Revised treatment model in low secure endorsed and accepted.

Concerns/Issue	Article	Work Schedule	Progress
		3. Development of a new 'Personal Effect' protocol for Low Secure. 4. Development of a new 'Personal Effect' protocol for Medium Secure.	* New personal effects protocol developed for low secure service. * This has been post-poned due to recent security breaches and discussions are ongoing.
	Article 9 The freedom of thought, conscience and religion; and Article 10: The right to freedom of expression.	1. A mapping exercise to be completed to highlight the current interface of patient/ carer involvement with care and treatment. 2. From the results of the mapping exercise the development and dissemination of a Patient/Carer Position Paper.	* Mapping exercise complete. * Short life working group has been developed and will present the position paper to the Clinical Governance Group.

This mapping project was completed in 2013 and at present the Human Rights Steering group is included into the Health Improvement and Equality Group, which will oversee the next part of this project. Human Rights remain a priority within Forensic Services.

Compass User Conference - June 2013
Sharing Heritage

Lead: Dr Rachel Morley, Consultant Clinical Psychologist, Compass Team

Background
Compass is part of NHS Greater Glasgow and Clyde's Trauma Service and is the team for asylum seekers and refugees who have mental health difficulties arising from complex trauma including torture, sexual violence and Female Genital Mutilation (FGM).

The Compass Team have had a successful service users' involvement group operating since 2006. Compass users contribute to Compass service design and have their voice heard on issues affecting the mental health of asylum seekers and refugees.

The user group also plans an annual user conference that takes place as part of Refugee Week. The conference provides an opportunity for staff from a variety of agencies (including Health) to learn directly from the lived experiences of asylum seekers and refugees.

It is also an opportunity to celebrate positive stories of recovery, resilience and integration.

2013 Conference - Sharing Heritage
The theme of Sharing Heritage allowed us to celebrate the diversity of language and cultural background of Compass service users and the importance of services working in a culturally sensitive way.

The conference also explored the importance of creating a shared heritage in Scotland and celebrating the integral part asylum seekers and refugees play in Scotland's cultural identity.

This theme of 'sharing heritage' resonated throughout the day. A welcome was given by Compass service users in their own language. Then St Stephen's Primary School in Sighthill sang a traditional Ugandan song and Bun Sgoil Innis an Villt, a Gaelic school in Bishopbriggs, sang a song in Gaelic.

Guests
The following people attended the Compass 2013 conference:
* six Compass staff
* 13 Compass User Group members
* five guest speakers
* 44 Compass users and family members
* NHS interpreters
* 19 staff from the NHS and other agencies
* eight people invited by service users (Pastors/community members)

Invited Speakers
We were privileged to have very helpful and enlightening speeches from invited guests who spoke about the importance of the contribution asylum seekers and refugees were making to Scotland and the significance of creating together a shared heritage.

Anne Hawkins opened our service users' conference. As the then Director of Glasgow Community Health Partnership she has been a strong advocate of improving mental health services and making sure health services are accessible to groups who might otherwise be marginalised.

Bob Dorris spoke as a Member of Scottish Parliament and within his role as a member of the Cross-Party Group on Racial Equality in Scotland. He has worked as an active mentor in the political shadowing scheme and has contributed directly to Compass users who have been able to become involved in this scheme.

Deirdre Flanigan, the Communications and Outreach Coordinator at the Scottish Human Rights Commission gave a human rights perspective.

She said: *"Mental healthcare itself engages many human rights issues: the right to life, the right to liberty, the right to freedom from torture, inhuman or degrading treatment or punishment, and the right to respect for private and family life."*

Mohammed Razaq, a Glasgow councillor, gave a very helpful Glasgow perspective on the work he was involved in to contribute to the integration of asylum seekers and refugees and the important contribution that was being made by asylum seekers and refugees in school and communities.

Dr Sharon Doherty of the Compass Team spoke about how our culture influences how we see ourselves and what we expect of ourselves and others in our lives.

She spoke about the importance of Mental Health Services being aware of the differences between western and non western cultures in how people speak about and show their distress and different models of healing and recovery.

She also spoke about the need for services in the West to use treatments that address how the mind and body feel following trauma. Therapy is an opportunity to acknowledge cultural differences between the therapist and the client and to create a bridge between the culture of the therapist and the service user.

Compass Service User's Shared Stories

In addition to having speeches by invited speakers, talks were given by four past and present Compass service users. They spoke of what had helped them in their psychological recovery and what they had held on to in relation to the importance of their own culture and heritage and how they had been helped to integrate into life in Scotland. Below is an excerpt from one of these talks.

"It is a personal story of the journey towards rebuilding belief, trust and hope in the future. The questions that often cross my mind about Compass are: "How do they know? How do they do it?" Vague questions they are!

"Living here in Glasgow as taught me to acknowledge not just the cliché "small world"; but also the phrase: troubled world! What goes on in world communities impacts the UK and Scotland in particular in varied ways. One such impact is the flowing arrival of asylum seekers and refugees.

"I salute the compassionate, patient, non-judgemental and highly professional members of the Compass Team who are dedicated to addressing the mental issues affecting asylum seekers and refugees.

"...former and current users of Compass Team services come from varied parts of the world. We could be likened to varied species of birds perching on this coveted nest of solace. Yet as diverse as we are, the common on-going issues with the majority of people of ethnic minority living are untold mental and sometimes physical disfigurement. Worse still, nearly all of us are initially unaware that we have these issues.

"I remember affirming to my GP when he proposed referring me for mental assessment that I definitely wasn't "mad"! This is when I was persuaded to understand these are issues of the mind arising from such experiences as torture, loss of earned wealth, displacement and the senseless loss

of, and/or detachment from, our loved ones.

"Digging individual people out of these deep and varied emotional pits is my lame way of painting the picture of the enormous work that Compass Team is entrusted with among traumatised refugees and asylum seekers.

"Returning to those questions; "How do they know?" and "How do they do it?", this team of highly professional people in the functioning of the human mind and body support is patiently on our journey of finding personal peace within.

"They teach us about the functioning of the human brain and mind, help us to identify those events and environments that get us to feel the way we do.

"They then empower and support us to recognise the recurrence of these thoughts and patterns in our daily lives and teach us to develop practical mechanisms and action to response and counter these moments.

"In brief, they teach us in-depth skills of emotional intelligence about our individual past and present; and positive action to face the future."

Celebration-Compass Service users wanted a Scottish theme to this celebration of shared heritage. Everyone made brooches of heather wrapped in tartan. Jointly we made a shared Scottish flag –now proudly displayed in Compass waiting room.

The result of Creative writing workshops for young people involved with Compass was also displayed. The group created a variety of pieces of work including "a postcard about Scotland".

Then there was a drama performance performed by Compass young people and Ignite Drama.
After food shared together a new inclusive version of Auld Lang Syne especially written for the occasion was sung to close the day.

Feedback
"Oh my, it was the best ever, it was so great, everything was so great, everyone loved it." (interpreter)

"The Conference was an inspiring and informative event, which I really enjoyed and it was great to see the work up on display." Marc Shermanm, Creative Writing Workshop coordinator.

"Thank you for inviting us to the Compass Refugee Week event, which I attended. Really, interesting talks and testimonies." Mary Kate Dickie, Community Engagement Worker, Scottish Refugee Council.

"I thought the day was brilliant. I really gained an understanding of the work of Compass and its impact on the lives of refugees and asylum seekers in Glasgow. The speeches from the users were particularly moving and insightful. I really appreciated the opportunity to engage with the various cultural activities and was thrilled to be able to make my own thistle brooch. The sense of community and strong spirit of working together was evident throughout the day."
Deirdre Flanigan, Communications & Outreach Coordinator, Scottish Commission Human Rights.

Zero Tolerance: Position Statement
Directorate of Forensic Mental Health & Learning Disabilities

Lead: Mark Gillespie, Nurse Consultant

Introduction
The Mental Welfare Commission (MWC) has developed a guidance called 'Zero tolerance; measured response: Responding to dangerous incidents in mental health or learning disability care settings'.

The Directorate of Forensic Mental Health & Learning Disability (DFMH&LD or the Directorate) in response to this guidance developed a short-life multidisciplinary working group to examine our current and potential future position in regards to involving criminal justice agencies following aggressive behaviour by our patient group.

Background
The MWC wrote the guidance over concerns about how criminal justice agencies become involve following aggressive behaviour by people receiving treatment for mental illness or learning disability. Their concerns ranged from involvement that may not have been appropriate to service users who had been assaulted or threatened by other service users who felt that staff responses were not appropriate to the incident.

The MWC view point is that staff may be caught between;
* Providing appropriate and sensitive care for people whose mental disorder results in dangerous behaviour, and;
* Reporting significant incidents to the Police in order to protect the person, other service users and themselves.

The MWC examined the factors that staff took into account when deciding what action to take following an incident. In particular, they wanted to know how staff made decisions on whether or not to involve the Police.

They came up with the following categories;
* The severity of the incident
* The views of the victim
* The events leading up to the incident
* The perception of the person's mental state and motivation for the incident
* The person's views and capacity to learn from the incident
* The views of others who know the person well
* The person's legal status
* The risk of recurrence
* The impact on other service users

The MWC also examined what are the expectations of police involvement and listed several examples of the benefits and drawbacks to police involvement.

They concluded with two essential outcomes that should be included when services develop new policies on reporting incidents of dangerous behaviour in mental health and learning disability settings.

These are:
1. Ensuring the safety of all persons. This includes immediate action to ensure safety, short-term action to reduce the risk of recurrence and longer term action to make sure that warning signs are known.
2. Ensuring that the needs of the person (and any others affected by the incident) for care and treatment continue to be met in a safe and appropriate care setting.

They recommended that services develop clear and consistent policies on dealing with incidents of dangerous behaviour. These should give general guidance to staff on situations where police involvement is indicated and these should be clear, easily understood and available to all staff. Each

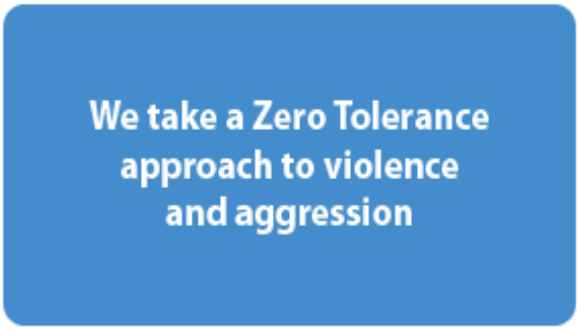
incident should be treated on its own merits and services should avoid rigid policies which should prevent a culture that is seen by patients, carers and staff as 'punishment'.

The Directorate's Current Position

Historically, Rowanbank Clinic developed reporting protocols in regards to police involvement.

These indicate that the Police will always be contacted if a crime has, or may have been, committed. This refers to both patients and staff.

The protocol also makes reference to where a criminal act has been observed or is suspected to have occurred by a third party, but the victim is unable or unwilling to make a complaint to the Police. In such cases, the circumstances will be reported to the Police, who will decide whether there is sufficient evidence to report the matter to the Procurator Fiscal.



However, in reality, police involvement when a patient behaves in an aggressive or threatening manner is dependent on the reaction of the individual staff member involved in the incident and may involve the clinical team if the incident warrants police involvement. This has resulted in the involvement of police to aggressive or threatening behaviours being ad hoc and with significant variance between individuals and clinical teams.

Staff are supported during these types of incident by a combination of de-briefing and clinical supervision.

Future Position

The Directorate's future position is to develop a standard protocol for the reporting of aggressive or threatening incidents to the Police.

This will take cognisance of the following issues:

Context/Severity

The Directorate acknowledge the importance of responding assertively to severe incidents of verbal and physical aggression. Incidents of verbal aggression include derogatory or threatening language in relation to an individual's age, race, culture, disability, gender, spirituality or sexuality.

To avoid rigidity in our position, we have omitted examples of incidents which we would define as severe physical aggression. These incidents will be assessed on a case by case basis and in close collaboration with the clinical team.

Consistency/Continuity

Until now, the decision to report serious incidents of verbal and physical aggression to the Police has, at times, been dependent on the victim's subjective perception of the incident. It is common for individuals to avoid involving the Police in situations where it is felt that the violence and aggression is in the context of acute mental illness rather than being due to anti-social behaviour.

The Directorate has moved towards a position in which the decision and responsibility for reporting severe incidents is not taken by the individual involved but by the organisation. The organisation is committed to maintaining a safe environment for patients, staff and carers and will not tolerate violent and aggressive behaviours perpetrated by patients and/or relatives or carers.

It is important to note than any individual who is subjected to verbal or physical

aggression within our premises has the legal right to involve the Police. This right is supported by the organisation.

However in situations where there have been episodes of violence and severe aggression, the Directorate will automatically involve the Police. This position is intended to represent a Zero Tolerance approach rather than a low tolerance approach.

Once this position is ratified via the Clinical Governance Group, we will be able to respond consistently to and manage incidents categorised as severe.

Capacity of the person

Patients may lack capacity to make decisions or assume accountability for their actions for a variety of reasons.

These include active psychotic symptomatology; mild, moderate or severe learning disability; traumatic brain injury; or other cognitive impairment such as alcohol-related brain damage.

Whilst issues of capacity will be taken into account when an episode of severe violence or aggression has occurred, police involvement should still continue to be mandatory. In these individuals, a cumulative history of violent and aggressive behaviours may inform decision making processes surrounding access to the most appropriate services.

Individual rights (staff and patients)

In any situation in which an individual staff member, patient or carer has felt physically or psychologically harmed by a violent and aggressive incident, they are legally entitled to involve the Police.

Any individual who wishes to involve the Police following such an incident will receive full support and cooperation from the organisation.

In the case of individuals who are victims of a violent and aggressive incident, but do not wish police involvement, the clinical team will need to gauge the incident and if the incident actions are against the law and would result in police contact in other settings then the Police should be contacted. The individual should be informed and supported throughout this process.

Service responsibility and liability

The service has a responsibility to provide a safe and secure environment for all employees, patients, carers and any visiting allied health professionals.

In view of this, the Directorate will promote a Zero Tolerance culture. The organisation will consistently report severe incidents of violence of aggression to the Police. All incidents of violence and aggression will be managed in the context of local policies and procedures.

Conclusion

The short life multidisciplinary working group will need to develop and expand on the issues outlined in the future position section of this paper.

In addition the group will need to develop a standardises protocol on police involvement when reporting an aggressive or threatening incidents.

This will be taken to the Clinical Governance Group for ratification before wider distribution and consultation from Advocacy, the Police and the Procurator Fiscal's Office.

Hate Crime Position Paper

Lead: Mark Gillespie, Nurse Consultant

Introduction
The issue of Hate Crime and the protection of service users and staff from such crimes has received wide publicity recently, with the publication of the UK Government document Challenge it, Report it, Stop it: The Government's Plan to Tackle Hate Crime' in March 2012.

To support this issue the Directorate of Forensic Mental Health & Learning Disability (DFMH&LD or the Directorate) should have a position in how to manage, report and support service users or staff who may be the victim of Hate Crimes that is consistent with national and NHSGGC policy.

Background
Hate crime is defined in Scottish law as any crime which is motivated by 'malice or ill will' towards a particular social group based on their: disability (including mental health), transgender identity, race, religion or faith, and sexual orientation.

The Offences (Aggravation by Prejudice) (Scotland) Act 2009 was created to protect victims of crime who are targeted as a result of hatred of their actual or presumed disability, sexual orientation or transgender identity

Hate crime can range from verbal abuse, and bullying through to actual bodily harm, torture and murder.

Hate crime can also include crimes like vandalism, spitting, threatening behaviour, hate mail and graffiti.

Anyone may become a victim of hate crime, merely because the perpetrators believe that person to belong to an identifiable group or-because of their association with people from that group.

Any crime committed because of prejudice against someone's actual or presumed disability is classed as an aggravated hate crime. If a crime is classed as aggravated, the courts will take this into account when deciding sentences. In most cases, if it's proven the main motivation was prejudice, sentencing will be more severe.

Research has shown that any victim of crime can suffer symptoms of depression, anger, anxiety and post-traumatic stress. One study has shown that whereas victims of non-biased crime can experience a decrease in these symptoms within two years, victims of bias, or hate crime, may need as long as five years to overcome their ordeal (Herek et al 2002).

The Directorate's Current Position
More generally, the Directorate has developed reporting protocols in regards to police involvement.

These indicate that the Police will always be contacted if a crime has, or may have been, committed. This refers to both patients and staff.

The protocol also makes reference to where a criminal act has been observed or is suspected to have occurred by a third party, but the victim is unable or unwilling to make a complaint to the Police. In such cases, the circumstances will be reported to the Police, who will decide whether there is sufficient evidence to report the matter to the Procurator Fiscal.

However, when a patient has behaved in a manner deemed to be Hate Crime orientated, police involvement has at times been dependent on the reaction of the individual staff member involved in the incident.

At times this has resulted in the clinical team instigating police involvement if it has been felt to be warranted, even when the affected member of staff has not. As such, the involvement of police in potential Hate Crimes incidents has to date been ad hoc and with significant variance between individuals and clinical teams.

Staff are supported during these types of incident by a combination of de-briefing and clinical supervision.

Future Position

The Directorate's future position is to develop a standard protocol for the reporting of Hate Crime incidents to the Police.

This will take cognisance of the following issues:

Context/Severity

The directorate acknowledges the importance of responding assertively to severe incidents of Hate Crime. Each incident will be assessed on a case by case basis and in close collaboration with the clinical team and may consider other relevant variables such as frequency, duration, and capacity.

Consistency/Continuity

Until now, the decision to report severe incidents of potential Hate Crime to the Police has, at times, been dependent on the victim's subjective perception of the incident.

It is common for individuals to avoid involving the Police in situations where it is felt that the Hate Crime is in the context of acute mental illness rather than being due to anti-social behaviour.

The Directorate has moved towards a position in which the decision and responsibility for reporting severe incidents is not taken solely by the individual involved but by the organisation.

The organisation is committed to maintaining a safe environment for patients, staff and carers and will not tolerate Hate Crimes perpetrated by staff, patients and/or relatives or carers.

It is important to note than any individual who is subjected to a Hate Crime within our premises has the legal right to involve the Police. This right is supported by the organisation, and as such, all reported incidents of Hate Crime should be discussed in the context of potential police involvement. This position is intended to represent a Zero Tolerance approach rather than a low tolerance approach.

Capacity of the person

Patients may lack capacity to make decisions or assume accountability for their actions for a variety of reasons. These include active psychotic symptomatology; mild, moderate or severe learning disability; traumatic brain injury; or other cognitive impairment such as alcohol-related brain damage.

Whilst issues of capacity will be taken into account when an episode of a Hate Crime has occurred, police involvement should continue to be a potential outcome. A cumulative history of Hate Crime related behaviours may inform decision making processes when considering involvement of the Police.

Individual rights (staff and patients)

In any situation in which an individual staff

member, patient or carer has felt physically or psychologically harmed by a Hate Crime incident, they are legally entitled to involve the Police. Any individual who wishes to involve the Police following such an incident will receive full support and cooperation from the organisation.

In the case of individuals who are victims of a Hate Crime incident but do not wish police involvement, the incident should be discussed within the local clinical team and any decision not to involve the Police should be documented. The individual should be informed and supported throughout this process.

Service responsibility and liability

The service has a responsibility to provide a safe and secure environment for all employees, patients, carers and any visiting allied health professionals.

In view of this, the Directorate will promote a Zero Tolerance culture. The organisation will consistently report severe incidents of Hate Crimes to the Police. All incidents of Hate Crime will be managed in the context of local policies and procedures.

Conclusion

The short life multidisciplinary working group will continue to meet to further develop and expand on the issues outlined in the future position section of this paper.

In addition the group will need to develop further guidance on police involvement when reporting a Hate Crime incident. This will be taken to the Clinical Governance Group for ratification before wider distribution and consultation from Advocacy, the Police and the Procurator Fiscal's Office.

References

Herek, G. M., Cogan, J. C., & Gillis, J. R. (2002). Victim experiences in hate crimes based on sexual orientation. Journal of Social Issues, 58, 319–339.

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Alcohol and Drug Services
Promoting Women's Recovery

Lead: Glasgow Recovery Network
Frances Rodger, Equality Manager, Alcohol and Drug Services

Background
Following a Recovery Consultation Event on 19th June 2013 in Glasgow and the resulting Recovery Report from the event, it was recognised that the area of 'Women in recovery' could be further developed and progressed to promote women's involvement and 'Recovery 2 agenda'.

To facilitate this, two Women's Conversation Café's took place within North-West Sector of Glasgow and South Sector of Glasgow.

Women from all over Glasgow were invited to attend and participate. Both Conversation Café events were organised by women in recovery and these women have become part of an established core of the recovery movement in Glasgow.

Women's Conversation Cafe (North West)
North West Sector Glasgow hosted the first Women's event in August 2013. As expected the conversations were interesting, productive and varied, and common themes emerged

These included:
* Offering a safe, informal environment where women can relax; allowing them to address the stress and anxieties at their own pace with the support of other women in similar positions. Informal 'soft' activities such as beauty treatments and crafts are useful tools in creating the right atmosphere.
* Childcare issues must be addressed, but also need to recognise other caring responsibilities to parents, siblings, their partner etc.
* Keeping women engaged is a real challenge as all recognised that they often put their own needs last on their list of priorities. Women also need to feel that membership can be fluid so that the commitment is not another stressful responsibility.
* The Women's Network of support needs to stretch across the city with no geographical boundaries. We also need consistency across the city via the Recovery Sub Group. Priority is to consolidate existing resources and create consistency of support across the city for women.
* Financial constraints are a particular concern for women who do not feel safe walking alone or in the dark.
* Services need better links to the Women's Recovery Network, particularly prisons. It is the practice in the north-west where women in recovery access clinics and identify women ready to move on. This needs to be replicated across the city.
* Ongoing fear of women that they will lose their children prevents them from engaging with any services. Need to get Women's Recovery Network to offer support in GP surgeries to allay fears.
* Welfare reform issues are having particularly negative effect on women. There is no recognition of voluntary work within DWP agenda. Women are being locked into mandatory programs with no recognition of training or skills. Women's Recovery Network could create a robust program across the City and negotiate DWP via the ADP.

South Development Session
With the support from the members of SWAN (a local Recovery group), the second Women's Recovery Conversation Café was held in November 2013.

The event was attended by 58 people and the vast majority were women in recovery.

The questions were informed by the themes identified at the first women's event in the North West Sector.

Question 1
* What do we need to do to support women to stay in recovery?

Question 2
* What do you need to feel safe? What would your life be like when you are safe?

Question 3
* If money was no object what would services look like?

Once again the feedback was fruitful and key themes can be identified. These have been divided into suggested strategic priorities and suggested actions.

Suggested Strategic Priorities
1. Female only support service for those in recovery.
2. Parenting courses tailored to the issues faced by mothers in recovery.
3. Mother and child support service offering three tiers of assistance
- support for individual women in recovery
- support for the children of those women
- support for the mother and child as a unit.
4. Women's Recovery Coordinator for the City.
5. 24 hour Recovery helpline for the city.
6. Housing Association initiative needs to consider tenancy provision for mothers and children in recovery.

Suggested Actions - for Women in Recovery
1. Crèche facilities as a standard option.
2. Female only literacy and numeracy classes for those in recovery.
3. Female only self defence classes for those in recovery.
4. Consider transport options for women travelling to and from groups at night, alone - pool of nominated drivers?

Suggested Actions- for all Recovery Volunteers
1. Training for trainers in relapse prevention for recovery volunteers.
2. Financial advice sessions tailored to those in recovery.

Suggested Actions for Further Consultation
1. Seek very specific responses to clarify housing and family support themes.

Recommendations
These findings have been taken be taken to the Alcohol and Drug Partnership Recovery Sub group for consideration and further discussion.

The findings will also be incorporated into the Review of Community Addiction Teams in Glasgow and will help shape the Community Services for the future.

Case Study 3: Leverndale Hospital LGBT Awareness Day

Lead: Leverndale Hospital Health Improvement Group

Anti Stigma Partnership LGBT group had a planned event in Leverndale Hospital in August 2013 at 'The Rendezvous' cafe, Leverndale Hospital. This event was a request from the Health Improvement Group located within the hospital.

Aims of the day:
* To create an informal and safe environment for staff to explore LGBT issues.
* To create opportunities for dropping by for a chat at one of stalls or be in one of the masterclasses.

The stalls which provide information were from:
* LGBT Youth
* Tackling Homophobia
* Scottish Transgender Alliance
* Sense Scotland
* Police Service Scotland
* Life Link
* Gay Men Health
* Unite the Union, LGBY section
* Information on NHS Credit Union and
* See me project

We also had three masterclasses on: LGBT awareness, Good practices working with Trans-patients and data collection. These Master Classes were well attended.

In total it was estimated that the number was between 60 to 80 staff/visitors participated in this event. The minimum time spent by attendees was 15 minutes, staff networking and gathering information from colleagues and stalls. The maximum time spent was four hours, with participants staying for the masterclass and interacting with the stall holders.

We had 34 evaluation returns from this event.

Results included:
One Key learning outcome that I can share with colleagues:
* Terminology Explained!!!
* Importance of statistics
* Encouraging others to access training on trans people
* General outline of trans issues
* Good information about communication from Sense Scotland

All returns suggested that staff had gained something from this event,

Twenty-two returns suggested that they have also learned from this event.

Feedback included:
* Would like to go to other events, group debates, and conferences.
* Very informative and easy to understand
* Today has been a great event.
* Well organised, enjoyed meeting everyone

Ten returns suggested that they already have knowledge about this issue however they felt that they have gained something from this event.

These feedbacks were:
* Thank you!
* The impact of knowledge has on people
* Have something similar in other sites

Two returns suggested that they have no prior knowledge of this issue however felt that they have learn a great deal from this event.

The feedback was:
* Transgender in wards
* Valued information, very informative

Renfrewshire CHP – Mental Health, Addictions & Learning Disability Services: Approach to Financial Inclusion

Lead: Susan Clocherty, Health Improvement Lead

Background
NHSGGC's financial inclusion guidance for staff states that a routine enquiry to patients on money worries should be a feature in most services.

Mental Health and Addictions Services have agreed improvements are required around financial inclusion.

In Renfrewshire CHP, there has been increased activity on financial inclusion in these services over the last few years. This paper summarises this. It will be used for discussions with other areas and locally to identify further possible improvements.

Renfrewshire CHP
Mental Health Services have taken a whole systems approach to Financial Inclusion across all teams.

These teams include:
- Primary Care Mental Health Team (PCMHT)
- Community Mental Health Team (CMHT) - 2 teams across Renfrewshire
- Intensive Home Treatment Team (IHTT)
- Inpatient Services

Also involved are third sector organisations and Recovery Across Mental Health (Renfrewshire Association for Mental Health)

What we've done so far
The NHS works closely with Money Advice Services situated within the Local Authority and the third sector. Activities include:
- Strategic planning
- NHS routine enquiry money and debt worries
- Direct referrals to Money Advice Services
- Awareness sessions for NHS staff, often jointly provided by NHS and Money Advice staff
- Financial capability interventions (such as helping patients with welfare reform)
- Joint work on marketing and publicity materials such as DLA to PIP with the NHS sharing key contacts for the Local Authority Publicity to distribute as widely as possible to those most likely to be affected

As part of our redesign of PCMHTs, mini EqIAs have been carried out which will identify current approaches to offering financial help to patients. This is helping inform how we will further improve this.

Last year, Renfrewshire CMHT also identified a need for an improved approach to financial inclusion.

To take this work forward a member of staff - a CPN - was identified to be a trainer for trainers on financial inclusion. This role included attending extra training and attending financial inclusion seminars.

A steering group has also been set up to direct the work of the 'Making Advice Work project' which provides welfare advice and financial capability to clients attending mental health and addiction services.

Funded by the Scottish Legal Aid Board, it is a partnership between Renfrewshire Council and RAMH (Renfrewshire Association for Mental Health).

The CPN attends the steering group to ensure links with the teams are good and that referrals are being made.

The Intensive Home Treatment Team (IHTT) and Acute Services have also linked well with the financial inclusion services available.

A graduate intern has provided input to the services regarding how patients can apply to the Scottish Welfare Fund and Community Care grant.

This has worked well with applications to these funds helping to facilitate earlier discharge for patients. Grant forms are now available on the wards.

The graduate, himself, has stated that as a result of working with patients, he now has a better understanding of what it's like to have a mental health issues as he had never been in contact with anyone who has had these problems before. He reported he thinks it will help him to do job his job with more empathy.

Helping clients access financial and welfare benefits advice

The Network Employability Service
The Network Employability Service offers vocational rehabilitation to people who are in secondary mental health and addiction services in Renfrewshire.

A financial advice worker has been employed and works within the team for an half day per week to provide individualised welfare benefits counselling.

Between October 2013 and January 2014, this person had 24 referrals resulting in 56 interventions. This included:

- advice on claims
- applications for PIP
- Better Off in Work calculations and
- onward referrals

This number of interventions may not include any gains from benefit claims that are still to be decided and they will go into the next financial year.

Making Advice Work project (SLAB): 32 clients were referred from Mental Health and Addiction staff: financial gain £39,766.35 for Oct to March 2014

Addiction Services
Addictions Services have highlighted a gap in financial advice for this client group and workers are now employed as part of the aforementioned 'Making Advice Work' project and offer clinics within the addictions setting, both for welfare advice and financial capability.

The services include:
- Renfrewshire Drug Service
- Integrated Alcohol Team and Alcohol Problems Clinic

Learning Disability Services
The Renfrewshire Council Welfare Reform Vulnerable Adults Group is tasked with mitigating the effects of welfare reform in this group of clients.

A Health Improvement Lead is part of this group and is working in partnership to explore ways of providing support. To date, a small number of roadshows have taken place.

Case Study 4: Inverclyde CHCP

Leads: John Mitchell, In-patient Manager Lead Nurse; Liz McVicar, Nurse Team Lead, Inverclyde Primary Care Mental Health Team

Inverclyde Equality Strategy

The Inverclyde Community Health and Care Partnership (CHCP) is a Partnership between Inverclyde Council and NHS Greater Glasgow and Clyde bringing together both NHS and Local Authority responsibilities for community-based health and social care services within a single, integrated structure.

With the formation of the Community Health and Care Partnership (CHCP) in 2010, NHS Greater Glasgow and Clyde (NHSGGC) and Inverclyde Council (IDC) joined forces to continue this tradition by bringing community based health and social care services closer together wherever possible. This means working in partnership to deliver more accessible integrated and high quality services which are jointly planned and community focused.

Inverclyde CHCP has a joint planning arrangement for Mental Health, Addictions and Learning Disability Services.

In the last year, settings have all been involved in:

- Initiatives around psychologically minded practice, which is a holistic approach, covering equalities issues
- Use of the Scottish Recovery Index (Version 2)
- Learning from EQIAs

The Equal Minds Project is lead by the Mental Health Services Equality Development group to develop equality structures, empowered and ownership of local equality initiatives and promotion of joint working with the voluntary sectors.

This project was put forward in 2013 to the MHS Strategy Performance Group and was accepted as part of their commitment to equality. Inverclyde CHP stepped forward to mainstream this project into their everyday work with service users.

For Inverclyde CHP their priorities are:

* User engagement and staff training on Equality and Human Rights
* Mental Health, Addiction and Learning Disabilities and
* Releasing Time to Care, Inequality Sensitive Practices and People Centred Care

The aims are to:

* Develop Equality Champions in each sector.
* Training programmes on Equality and Human Rights
* Events that engagement and promoted mental wellbeing for the public in Inverclyde and
* Evaluate and evidenced outcomes

The approach of Inverclyde Primary Care Mental Health Team (IPCMHT) is given as a case study.

Introduction to IPCMHT

IPCMHT has a history of considering equalities issues. This includes a major programme of considering the needs of older people within primary care mental health services.

In 2013-14, the team won an award for its feedback from patients from Inverclyde CHCP. The work this year has included: 'Equal Minds Project'.

Scottish Recovery Indictor 2 (SRI 2)

SRI 2 is the revised and enhanced Scottish Recovery Indicator (SRI) launched in October 2011.

It builds on the success of the original SRI introduced in 2007 which has been used by a range of services across Scotland.

SRI 2 enables mental health practitioners to provide ever more recovery focused services. This structured process enables staff working in mental health services to demonstrate their commitment to recovery.

SRI 2 is centred on 10 recovery indicators. These are based on evidence about what works in recovery, (for instance,'service is strengths based' and 'goals are identified and addressed').

The service reflects on its practice against these recovery indicators using six sources of evidence:
* Assessments
* Care Plans
* Service Info
* Service Provider
* Service User
* Informal Carer

A total of 108 SRI 2 were completed within NHSGGC. Inverclyde Primary Care Team completed the SRI-2 and using this process identified the following:
* There is a shortfall on equality issues (for example, people with disabilities and how services impact on their needs).
* There are strength and empowerment in partnership working with service users on mutually agreed goals.
* The self refer system is gaining benefits for the service.
* Working in partnership with other organisations and service users can provide an holistic approach to person centred care and promote the recovery agenda.

The team continue to work on improving the service provision, SRI 2 give them time to step back, review and reflect on the service as a whole , set an action plan to take the service forward.

Team used the Equality & Diversity Learnpro e-modules which the Nurse Team Lead put in place to enable all members of the team to complete the Equality and Diversity Learnpro e- modules together as part of their personal and professional development.

This is a shared experience and the staffs were able to reflect on their practices as part of their learning.

The team identified a PCMH Champion for equalities - a Band 5 Staff Nurse who works with the Team Lead as EqIA Champion and supported by the whole team.

Nurse Team Lead, Liz McVicar has completed training on coaching conversations and is now regularly practicing coaching skills with her staff in clinical and line management supervision.

This enables staff to make their own decisions with her support in clinical and operational practice, and enables them to improve their leadership skills and become more positive role models, thus improving the delivery of psychological therapy in clinical practice.

Pilot of a therapy supervision checklist using peer observation

As part team development, a therapy supervision checklist was developed to provide consistency to be used in all staff supervision.

This checklist focuses on the development of personal interface skills including:
* Maintaining collective,
* Therapeutic relationships,
* Expression of appropriate empathy and genuineness,
* Maintaining professionalism and boundaries,
* Elicits and give appropriate feedback,
* Demonstrate knowledge of CBT model,
* Demonstrate ability to use guided discovery,
* Effectively sets agenda and structures session,
* Reviews and assigns useful homework,
* Assists with problem solving,
* Remains within scheduled time
* And others.

The feedback from the staff was positive and useful.

NHSGGC EQIA of PMCHT Service Redesign and team did a local 'mini-eqia'.This shows a strong commitment to equalities issues and testing new tools as summed up by this comment from the Team Leader:

The 'mini'EqIA' is not a replacement for the EqIAs. However, an assessment that can be complete quickly to review the equality elements within the service. The 'mini EqIA' can also indicted a full EqIA is needed; it is very useful within a long starting functioning service.

Inverclyde CHCP services are heavily involved in the roll out of the NHSGGC Equal Minds Initiative.

Thinking ahead

It is really clear to us all when we read this annual report that there has been significant work across a range of areas and examples of real leadership in taking forward the NHS Greater Glasgow & Clyde equalities agenda.

The passion and enthusiasm staff have shown for tackling inequalities in many innovative developments is truly inspiring.

The innovative work across care groups as diverse as learning disabilities, forensic settings, community and with those experiencing addictions, indicates what is possible.

I also note that when staff get involved in equalities work they immediately see the essential nature of it within our goal of providing first class services. They then build on this work, as is clear from the work within forensic services and within Inverclyde.

In this year, 2013- 2014, the NHSGGC Board recognised the need to re-emphasise the importance of this area of work.

The Mental Health Services Equalities Development Group has viewed this as an opportunity to improve our workplan and add the new dimension of the Equal Minds Project. This renewed focus will be an asset to moving this work forward on multiple fronts.

2014-2015 is a big year for us all. We have the Referendum, the Commonwealth Games and integration of social work and health within Glasgow city.

The latter work will provide many opportunities to work with colleagues from social care and the voluntary sector. This potentially gives us the scope to develop our work and for it to have an even greater impact across our communities.

However, challenges for us remain. They include keeping inequalities work on everyone's agenda; ensuring we are getting the right outcomes in our work; and where we have successes, getting them to be shared and worked to scale across the new Health and Social Care Partnerships.

The Mental Health Equalities Group hopes that the energy and dynamism that is our staff group can ensure we build on the good work that is happening across this system and achieve the best outcomes for the people of Greater Glasgow and Clyde.

Dr. George E Ralston
Professional Lead for Psychology and MHS Equality Lead

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Thanks to all colleagues who contributed to the update materials from the range of services represented in this report and to the wider colleagues, service users and partners who have contributed to all the programmes above.