An exploration of primary care policy and practice for reducing inequalities in mental health

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Summary

Background

Mental health problems in individuals and in the Scottish population are less well defined by routine data and diagnostic criteria than are physical health problems, but they have similar relationships with social gradients. Primary care in Scotland in recent years has been given an emphasis on health inequalities and on prevention and is also expected to provide frontline services and ongoing support to patients with mental health problems. Addressing health inequalities and inequalities in mental health are thought to require action on social circumstances as well as on biological conditions. However, the health service works within an established biomedical culture influenced by the strong medical workforce system and the broader political emphasis on accelerated economic growth. Policies express a general expectation that all public sector services have addressing health inequalities built in to their functions, but there is evidence to suggest that primary care has not yet found its place in meeting this expectation. To date there have been few concrete proposals for action and no guidelines for primary care to address health inequalities. The study set out to identify the contribution that primary care can make to reducing and preventing inequalities in mental health.

Process

Interpretive policy analysis was used as the framework for the study. In contrast to traditional policy analyses, which take an objective approach to comparing policy interventions, interpretive policy analysis can help to synthesise perspectives or reframe debates. It regards stakeholders' interpretations of policy as drivers for change on the ground rather than the policies themselves. Stakeholders are described as being within three "communities of meaning" of policymakers, implementing agencies and service users, and each grouping can have several internal communities making different interpretations of the same policy.

There were four communities of meaning relevant to this study: policymakers; primary care strategic staff; primary care and mental health frontline professionals; and services a patient might encounter. The policymakers' perspectives on health inequalities and inequalities in mental health were drawn from an appraisal of nine health and social policies current at the time of the main study period (2002 – 2006). The other three communities were identified within one Community Health Partnership in the West of Scotland. Data were collected using document analyses, observation of a primary care

mental health needs assessment and interviews with 21 frontline primary care and mental health professional staff from 14 disciplines. Identification of the services a patient might expect in relation to inequalities in mental health was elicited through frontline professionals' responses to a vignette.

Findings

All nine policy documents in the appraisal included aims to tackle some aspects of health inequalities, but inequalities in mental health were barely mentioned. The documents presented a disjointed picture of definitions for inequalities that lacked a clear overall interpretation of inequalities in health. They also proposed actions which often did not flow from the definitions and clouded the identification of expectations on primary care for addressing inequalities in mental health. For example, documents suggested that poverty, area deprivation and other social circumstances were linked with health inequalities, but the emphasis for action was skewed towards individual lifestyles and organisational change. The confused policy picture was mirrored by similar disjunctions between definitions and actions among strategic and frontline professional staff. In addition, there were clear differences between definitions identified in policy documents and those given by professionals, suggesting that frontline professional staff appeared to draw information about mental health and inequalities from public media and practice experience rather than from research and policy.

Observation of a mental health needs assessment included an appraisal of the local strategic context and additional interviews with key senior staff. The observation found that inequalities were not considered for action in the mental health needs assessment nor in most of the other local strategic processes. This was despite some key strategic staff's individual perspectives that social inequalities can impact on mental health, and despite information about local social and mental health inequalities being made available. The observation concluded that the culture of the organisation was not conducive to tackling inequalities in mental health.

Frontline and strategic staff were generally unclear about identifying a patient's social circumstances which might put them at most at risk of developing mental health problems. Although some frontline professionals linked mental health and social inequalities in defining health inequalities, most were unlikely to intervene on addressing a patient's social circumstances. While frontline professionals and strategic staff almost universally defined health inequalities as differential access to services, few indicated that they would take action to ensure access, for example, following a patient's non-attendance.

Conclusion

The culture of the observed primary care organisation was not conducive to driving change on inequalities in mental health, and its contribution to reducing and preventing inequalities in mental health is at an early stage. Interpretive policy analysis identified disjunction and gaps in understanding and leadership to address inequalities in mental health at policy, planning and practice levels, but also identified potential areas for development. The study concluded that some of the building blocks are already in place for the primary care organisation to respond to policy leadership on inequalities in mental health should that time come.

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Declaration of authorship

All of the work reported in this thesis was designed, conducted, analysed and written up by the author.

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Introduction

The idea for this study arose from a web of various strands from my professional and personal experiences over the past two decades. For most of the 1990s I worked as a health visitor and co-ordinator of a community health project in a deprived area of Glasgow where I saw at first hand the impact of deprivation on health. I was both moved and horrified in turns by insights into people's lives encountered there. Men, disenfranchised through years of poverty and second generation unemployment from local shipyard and factory closures, struggled to make sense of their lives. There were children from as young as five recruited into gangs and taught to shoplift by older gang members or, even worse, abused by them. One local three year old was murdered by a ten year old boy from a family on my caseload. I worked with women who were abused and controlled by their violent partners and for some the only way out was to descend into drug or alcohol abuse with or without prostitution. Others struggled on, perhaps taking up volunteering, part-time local employment or cleaning work. Eventually, slowly, over a number of years, I witnessed some of these women and men gradually fighting off their adversities and finding a place where they could at least breathe easily. *The Black Report* (Townsend and Davidson, 1982) and subsequent health inequalities research unequivocally linked these difficult social circumstances to poor health outcomes as well as to ameliorative and preventive roles for health policy.

Some years later, I worked for the Public Health Institute of Scotland on establishing new public health practitioner (PHP) posts in all Scottish Local Health Care Cooperatives, which were the primary care structures at the time. The posts were the first of their kind in that they were to take a population perspective to improving health in primary care rather than work within a service-led or topic based agenda, and many of the postholders developed addressing inequalities in health as an explicit aim. The year of their inception was 2002 and perhaps the PHPs were a bit ahead of their time, as many of them encountered barriers to developing their work on health inequalities. The evaluation of the posts was completed in 2005 and concluded that the most effective driver for the PHP's work was where they had good support from within their organisations, particularly when their line manager provided that support. Unfortunately, the evaluation also found that fewer than half of the PHPs across Scotland felt supported in this way. This was more than 20 years after *The Black Report* and at a time when Scottish health and social policies were beginning to propose that social inequalities might be important in health. Yet primary care was not able to support practitioners whose jobs were established to improve health by taking social circumstances into consideration. My sensitivity to social inequalities in health was evidently not shared universally by primary care colleagues across Scotland. So where

was the understanding and support in primary care for doing something – anything – about inequalities in health?

These were the concerns that began to shape ideas for the study as a part-time PhD programme which would provide a channel for my questions as well as inform my "day job". In 2002 research evidence was demonstrating that health inequalities were worsening and also that mental health was becoming increasingly problematic not just in Glasgow's run down housing schemes but across the globe. Mental health appeared to be dealt with separately from health inequalities in policy, research and practice but was subject to the same social patterns as physical health. In addition to health inequalities, mental health also appeared to be an increasingly important issue on the primary care agenda. I embarked on the study to explore the possibilities for primary care to respond to the health consequences of social problems and to search for the dynamic in primary care for addressing inequalities in mental health.

Chapter 1

Background: literature and policy review

Introduction

The background to the thesis is introduced in this chapter through a review of relevant research literature and a reflection on policy documents and academic commentaries. The focus was placed on inequalities and mental health in primary care, and the period from 2002 to 2006 was selected for the review of policy. The initial search strategy included academic databases and websites and later built on references and concepts from relevant papers. The approach that was taken is described below.

Search terms used in the initial search strategy were as follows:

- Inequalities in health
- Inequalities in mental health
- Health inequalities
- Mental health inequalities
- Primary care and health inequalities
- Primary care and mental health inequalities
- Health inequalities and general practice.

Free text terms were used.

The following databases were systematically searched using Reference Manager to search and store results:

- Ovid
- Medline
- Embase
- Cinahl.

Websites of relevant organisations were searched in the initial stages as follows:

- Child Poverty Action Group
- Department of Health (England)
- Equal Opportunities Commission
- Information and Statistics Division, Scotland
- Joseph Rowntree Trust
- Mind
- NHS Confederation
- National Institute for Mental Health in England
- National Programme for Mental Health and Well Being
- Office of National Statistics
- Sainsbury Centre for Mental Health
- Scottish Executive
- Scottish Development Centre for Mental Health
- The King's Fund
- World Health Organisation.

The review is reported in five sections as follows:

1. Health and social inequalities
2. Mental health as an emerging modern problem
3. Biomedical and social models for health
4. Policy context for primary care and mental health
5. Conclusion: Primary care and inequalities in mental health.

Section 1: Health and social inequalities

Introduction

Inequalities in health have been recognised as a public health issue since the second half of the 19th century (Macintyre, 1997). Since then, their measurement, causal factors and potential for amelioration have continued to stimulate a great deal of research and debate. Even the term "health inequality" can be interpreted in different ways. For example, health inequality and health inequity are often used interchangeably although the former more accurately refers to observed measurement, while the latter suggests an element of unfairness with factors that are potentially amenable to change (Whitehead and Dahlgren, 2006). To complicate matters further, "inequalities in health" is sometimes used to emphasise the unfairness aspect of differences rather than the difference itself, which is more likely to be described as "health inequalities". The term

most commonly used in the literature and policies tends to be "health inequalities" although the intended interpretation is not always clarified. Differences within the population are to be expected, but it is when these differences are as a result of an unequal distribution of resources or when the differences prevent an individual reaching their potential that they are unfair. My interpretation of "health inequalities" used throughout this thesis is that there is usually an aspect to health inequalities that is unfair, whatever terminology is used.

In this section, the extent of health inequalities in Scotland is described and the main theories for causes of health inequalities are explored. There is evidence that mental health follows a similar pattern of inequality and relationship to social factors as for physical health, but there are differences between measuring mental health and physical health which require further exploration. Therefore, inequalities in mental health will be discussed in the following section within a broader discussion of mental health.

Health inequalities in Scotland

While overall health and life expectancy have improved in Scotland, the health gap has widened during the past two decades (Leyland *et al*, 2007) in common with other Western countries (Mackenbach *et al*, 2003). Almost every physical and mental health indicator demonstrates differences between rich and poor as well as gradients relating to both social class and to geographical areas. Scottish figures for 1999/2001 demonstrate that reductions in mortality resulted in an increased life expectancy of three years for men in the last decade, and 2.4 years for women in the same time period (Scottish Executive, 2003a). When these figures are broken down by area, they tell a very different story. For example, for 1999/2001 in one of Scotland's most affluent areas life expectancy for men increased by 5.6 years, while in one of the most deprived areas it decreased by 2.8 years (NHS Health Scotland, 2004). If differences between areas are measured by healthy life expectancy instead of life expectancy the inequalities observed are even greater, as people in the most disadvantaged areas spend a longer period of their lives in ill health (Wood *et al*, 2006). For example, for 2001, women living in areas within the most deprived quintile for Scotland spent 12.1 years in poor health and 21.1 years with limiting long-term illness, compared with 6.1 and 14.2 years respectively for women living in the least deprived quintile areas. Other striking differences between deprived and affluent areas include: breastfeeding rates which in 2001/2006 were at 20.3% for women under 20 and 67.8% for women over 40 in the most affluent areas but only at 7.5% for women under 20 and 27.2% for women over 40 in the most deprived areas (Information and Statistics Division, 2007b); and alcohol-related hospital

admissions, which in 1999/2001 stood at a rate of 643 per 100,000 in the most affluent areas but over three times higher at 2293 per 100,000 in the most deprived areas (NHS Health Scotland, 2004).

The decline in male mortality between 1981 and 2001 (for ages 0-64) was calculated to be due to a 62% fall in deaths from ischaemic heart disease and a 50% reduction in deaths due to lung cancer, cerebrovascular disease, chronic respiratory disease and accidents (Leyland *et al*, 2007). Over the same time period, there were also increases in deaths due to suicide, chronic liver disease, and mental and behavioural disorders due to substance misuse, but these increases were seen only in the more deprived areas. Reasons for mortality between 1981 and 2001 varied by age group as well as geography and also showed different patterns for women and men. For example, differences in age affected mortality rates from ischaemic heart disease, which fell by 64% for men at ages 45-59, but by 36% for men aged over 74. During the same time period, suicide rates increased for men but reduced for women, and deaths from chronic liver disease increased twofold for women and threefold for men (Leyland *et al*, 2007). Greater increases in inequalities have also been demonstrated for remote, rural areas compared to urban areas for all cause mortality in both men and women between 1979 and 2001 (Levin and Leyland, 2006). Leyland *et al* (2007) demonstrated that the increases in male mortality from suicide and chronic liver disease in lower social classes were the main cause of the increase in inequalities in mortality, but difficulties in attributing social class to women and to older people meant that the relationship between mortality and social class could be analysed accurately only for men aged 20-64.

The relationship between social inequalities and health

The publication of the *Black Report* in 1980 (Townsend and Davidson, 1982) stimulated a new wave of health inequalities research that has repeatedly demonstrated that mortality and morbidity increase as social status decreases, with the greatest burden of poor health borne at the bottom of the social hierarchy (Acheson, 1998). The relationship between social inequalities and poor physical and mental health has been demonstrated for a wide range of factors, including low income (Wilkinson, 1996; Shaw *et al*, 1999; Lynch *et al*, 2000), social position (Power and Matthews, 1997), ethnic origin (Nazroo, 1998), gender (Annandale and Hunt, 2000), age (Heer and Woodhead, 2002), belonging to an excluded population group (Heer and Woodhead, 2002) and geography (Sloggett and Joshi, 1994; Leon *et al*, 2002).

A great deal of inequalities research has sought explanations for differences in the health of different groups of people. The Black Report proposed four potential explanations. The first was that health inequalities could be the result of an artefact of measurements failing to take into account diminishing numbers in the poorest occupational classes. The authors themselves dismissed this idea, demonstrating that the numbers were not diminishing as much as supposed. The next explanation was that inequalities could be due to natural and social selection where physical weakness causes people to drift to lower social classes but with no causal relationship. There was some support for this as a cause but the authors concluded that it was unlikely to be a strong enough factor alone. The third explanation was that health inequalities resulted from materialist or structuralist causes, and the fourth was that they could be explained by cultural and behavioural factors (Townsend and Davidson, 1982). The latter two explanations have been the subject of further research and debate and they are explored below along with other theories that have since emerged.

Materialist/Structuralist

While Townsend and Davidson (1982) stated that they believed a materialist explanation was the most likely, they suggested that different factors might have more impact at different stages in the life course, and that the complexity of the evidence prevented emergence of a clear explanation. For example, low income in itself was difficult to accept as an explanation for health inequalities. It did not take account of the social gradient which was later demonstrated clearly by the Whitehall study, where people who were on high incomes still had relatively poorer health than people on even higher incomes (Marmot *et al*, 1991). If the materialist explanation of low income being the direct cause of poor health was correct, everyone who lived in poverty would have poor health and it would only have been the poor who suffered poor health with everyone else remaining well (Bartley, 2004). The alternative explanation was that relative poverty rather than absolute poverty was to blame for health inequalities, but again straightforward explanations were not forthcoming.

For example, the role of neo-materialism versus a psychosocial model to explain the relationship between income inequality and ill health was the subject of an argument for more than a decade between Lynch and Wilkinson (Pearce and Davey Smith, 2003). The perspective put forward by Lynch represented the neo-materialist school of thought, that health inequalities were the result of poor public provision of services and amenities such as safe and healthy food, housing and safe environments, leading to absolute deprivation and poverty (Lynch *et al*, 2000). Wilkinson agreed that a lack of resources led to ill-health but that health inequalities were the result of relative income inequality

within a population and that it was the psychosocial effects of living in an unequal society that led to illness with attendant feelings of hopelessness, lack of trust, hostility and depression (Wilkinson, 1996; Marmot and Wilkinson, 2001). The debate over whether absolute or relative poverty is the most important factor has been difficult to disentangle, as political systems that allow income inequality to increase might also be likely to under invest in the social structures that support people living in disadvantaged circumstances (Pearce and Davey Smith, 2003).

Culture

The cultural and behavioural explanation proposed in the *Black Report* was also questioned by further research, and different versions of this explanation continue to be debated. For example, one version focuses on behaviour and also links to the selection explanation. This argument assumes that people with lower status and low income are perhaps genetically deficient in certain personal characteristics such as being less intelligent, less confident or with less self-control. Consequently, they are thought to indulge in unhealthy behaviours because they fail to understand the impact that these behaviours might have on their health, or because they are unable to control their impulses to over-indulge. However, evidence that counters this perspective has concluded that there is unlikely to be a genetic explanation. For example, a cross sectional and prospective cohort study found that IQ did not fully explain the socioeconomic gradient in health (Batty *et al*, 2006) and that risk-taking behaviour linked to disadvantaged childhoods was found to harm only those who, in later life, continued to be affected by low income (Bartley, 2004).

Another aspect of a cultural explanation looks at the impact of social groups on decision-making (Carlisle, 2006). Research by Bourdieu in the 1980s proposed that people make decisions within the boundaries of their social groups, aligning themselves with the group they belong to or aspire to through an acquired and unconscious system of decision-making (Williams, 1995). This social positioning is described by Bourdieu as "habitus" and is formed directly in relation to people's social locations, therefore both classifies and maintains existing social structures. Through this process health related decisions are taken to "fit in" rather than to follow specific health beliefs resulting from health education. Groups following what might be described as a healthy lifestyle also take up unhealthy behaviours which would not fit with the positive health behaviour model described by health education practitioners as the driver for good health (Williams, 1995).

Biological causes

Another research strand to explain health inequalities has focused on the role of biological responses to factors such as stress, worry and powerlessness. The study of neuroendocrinology has provided some understanding of the physiological responses to different types of stress. McEwen (1998) linked these responses to social inequalities by explaining the impact on development of physical disease from combined and sustained stressors. Acute stress resulting from major life events such as bereavement or other shocks that might spark a "fight or flight" reaction can have long-term consequences, as can chronic stress from the cumulative load of sresses experienced day after day such as abuse in the home, workplace or neighbourhood. McEwen described the build up of biological responses to stress as allostatic load, created through the psychological and biological ways in which people cope with a challenge, although it can also be affected by consumption of tobacco and alcohol, diet and exercise. The allostatic load can accumulate over time causing biological damage and wearing out systems in people who have greater exposure to acute and chronic stress, consequently contributing to health inequalities.

McEwen's findings were echoed by the Whitehall II cohort study, which was set up to track the relationships between changes in social and economic circumstances, psychological states, health behaviours and biological pathways to clinical and subclinical disease (Marmot and Brunner, 2005). The cohort study recruited 10,000 male and female civil servants working in Whitehall's London offices between 1985 and 1988. Whitehall II has provided the basis for numerous studies of the relationship between social gradients and health, in particular demonstrating that ill health was related to occupational and social factors and not purely the result of poverty alone. The study also included a long-term aim to determine biological mechanisms leading to social inequalities in cardiovascular disease and diabetes. The main findings of the study to date have included the following: that there is an inverse relationship between socioeconomic status and coronary heart disease, diabetes and metabolic syndrome; that neuroendocrine, inflammatory and haemostatic mechanisms contribute to health inequalities – for example, job strain can predict coronary heart disease, common mental disorder, and sickness absence from work; and that psychosocial factors at work, at home and in the community play a role in disease development (Marmot and Brunner, 2005).

Lifecourse effects

The influence of lifecourse effects is another theory that has emerged from inequalities research. This explanation looks beyond the relationship between health and social circumstances at a fixed point in time, exploring the link between health in later life and early deprivation or other adverse situations in childhood. The lifecourse approach has established that disadvantage in infancy, adolescence and early adulthood all contribute to poor health in later adulthood, and that chronic disadvantage is particularly detrimental to health. On a more positive note, the research has also confirmed that improving socio-economic circumstances in adulthood can, at least in part, compensate for a disadvantaged start in life. Schoon and Parsons (2002) demonstrated that children who had experienced early social disadvantage were more likely to leave school without qualifications and to be unemployed at age 26. Those children from disadvantaged backgrounds who did achieve qualifications and employment had certain protective factors in place, such as being female, being born to a mother with some extended education, having a father who helped with domestic tasks and having parents who were involved with the child's education. However, less able children from privileged backgrounds were still more likely to obtain degree level qualifications and employment than the protected children from disadvantaged backgrounds. Another protective factor in childhood found by researchers using Whitehall II data was having a "warm and secure relationship with parents" (Bartley, 2006, p16). A positive childhood environment led to better mental health in later life, regardless of circumstances, and also led to the development of a resilient personality.

Social divisions and discrimination: gender and ethnicity

The final set of social factors linked to health inequalities included in this review are the social divisions. Those particularly noted within Scottish policy at the time of writing were gender, ethnicity, disability, age, faith and sexual orientation. A review of studies on the influence of gender on health pointed out that sex and gender influence the health of both men and women, with sex affecting genetic, hormonal and metabolic variations resulting in different patterns of heart disease, infections, auto-immune problems and reproduction (Doyal *et al*, 2003). In addition, gender roles shaped by different patterns of living and working conditions, and differences in access to resources also put men and women at differential risk of developing some health problems while protecting them from others.

There is some debate as to what these differences mean for the health of men and women, for example, research has not yet clarified why women have higher life

expectancy but more minor illness than men. Researching gender inequalities has been described as problematic, as our society's norm is a culture of patriarchal ideology, structure and relationships and this includes the strongly male focus for research into class inequalities in health because of the difficulties in allocating a social class to women (Popay and Groves, 2000). In addition, while there are differences between men and women, there are also some similarities such as with some diseases suffered and the patterning of illness within male and female groups. For example, the effect of gender on health inequalities between men and women was found to be small or non-existent in relation to morbidity in men and women working in the same occupation at the same levels (Emslie *et al*, 1999). Another study showed that men and women consult GPs at similar rates and at similar points in the disease process when consulting GPs for the same minor illnesses (Wyke *et al*, 1998). While such studies have demonstrated similarities in the ways in which men and women of similar social standing reacted to certain illnesses, the impact of gender on health inequalities is more likely to be as a result of inequalities between men and women in society in general. These might include differences in access to income and power within the home and work, although these change over time and between societies as gender roles and relationships evolve (Arber and Cooper, 2000).

The impact of ethnicity on health is no less complex. First is the issue of who might belong to a minority ethnic group. Ethnicity, race and culture are complex, multi-dimensional concepts which are rarely taken into account when defining ethnic groups in research studies (Nazroo, 1998). Research on ethnicity and health often assumes homogeneity within groups, which might be described, for example, as black or white or South Asian. Second, the issue of racism is said to be inherent in health research which often assumes that the health of immigrants is poor, or it might focus on issues such as promiscuity, underachievement or diseases specific to particular ethnic groups (Bhopal, 1997). Another complexity is that differences between ethnic groups and the general population can often be explained by social class, education and income, but these factors do not explain all the differences, including those occurring between different ethnic groups (Bartley, 2004). Aspinall and Jacobson (2004) found very different patterns of mortality, morbidity and service use in people from different ethnic backgrounds, including:

- Bangladeshi and Pakistani men and women reported worse health than the general population
- Coronary heart disease was higher in South Asian groups than in the general population, with the poorest groups of Pakistani and Bangladeshi origin having the highest rates
- Mortality from lung cancer in England and Wales was higher for men and women from Scotland and Ireland, but lower for men and women in other migrant groups
- Infant mortality rate for infants born in England and Wales to mothers born in Pakistan was double the overall mortality rate.

The health of people from ethnic groups is believed to be poorer as a result of being discriminated against, by being excluded from elements of mainstream white society and resulting in failure to achieve economic success (Nazroo, 1998). For example, while it is true that some groups within the ethnic minority population are achieving rapid social mobility and catching up with the indigenous white population, the majority of people from ethnic minority groups are still disadvantaged in this respect (Performance and Innovation Unit, 2001). Nazroo (1998) believes that studying these processes in ethnic groups will lead to a better understanding of the influence of health inequalities in general, since the main causal factor for ethnic health inequalities is the same as for any other aspect of health inequalities: as a consequence of an "inequitable capitalist society" (Nazroo, 1998, p727).

Action to reverse or prevent health inequalities

Research-based policy recommendations

The interaction between social inequalities that leads to poor health is clearly variable between individuals and groups, which means that there is unlikely to be a straightforward policy solution (Shaw *et al*, 1999). The *Black Report* (Townsend and Davidson, 1982) acknowledged the multi-causal complexity of health inequalities, and proposed implications for policy and suggestions for further research. The report identified three main objectives which underpinned 30 recommendations, summarised as follows:

1. Better collection and use of health service data, including:
   - Monitoring health in relation to social and environmental conditions
   - Better understanding of the health effects of smoking, diet, alcohol and tobacco
   - Study of the interaction of social factors and ill health over time and within small areas.

2. Health and social services:
   - To give children a better start in life
   - To encourage good health among a larger proportion of the population
   - To reduce the risks of early death among disabled people in order to improve their quality of life, and to reduce the need for institutions as far as possible.

3. Wider strategy, including:
   - Anti-poverty strategy
   - Focus on families and children, such as pre-school education and nutrition
   - Community resources such as housing, and disability benefits
   - Priority given to a co-ordinated Government policy to improve the nation's health.

The Conservative Government mostly ignored the policy recommendations in the *Black Report,* blaming the potential expense of the recommendations (Shaw *et al*, 1999). However, as demonstrated above, the Report stimulated an industry of health inequalities research. Almost two decades later *The Independent Inquiry into Inequalities in Health*, more widely known as the *Acheson Report*, was commissioned by the Department of Health with a remit to summarise the available information on inequalities in health in England, to identify priority areas for future policy development and to contribute to the development of a new strategy for health (Acheson, 1998). The subsequent report reached similar conclusions to the *Black Report* about the social gradient and health inequalities, and both reports concluded that a dual strategy of action within and outside the health care system was required to reduce health inequalities. In particular, the *Acheson Report* identified three crucial areas for policy development, with some similarities to its predecessor:

   - all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities
   - a high priority should be given to the health of families with children
   - further steps should be taken to reduce income inequalities and improve the living standards of poor households.

The *Acheson Report* also recommended a range of policies focused on healthy lifestyles, called for the achievement of equity to be built into NHS planning at all levels and argued for a duty of partnership between NHS and local authorities and other agencies to ensure that joint programmes to address health inequalities are in place and monitored. Full implementation of the *Acheson Report* has not been achieved, but it is thought to have been successful in helping to define health inequalities as a policy problem and to demonstrate that all policies have the potential to impact on health inequalities (Exworthy *et al*, 2003). While the *Acheson Report* focused mostly on England, *Towards a Healthier Scotland*, Scotland's public health White Paper (Scottish Office, 1999), stated that it had been influenced by its findings.

Inequalities targets

Following on from the *Acheson Report* and a further review carried out by the Treasury, the Department of Health announced a target for health inequalities for England and Wales and the development of a cross-departmental Public Service Agreement to ensure commitment across all departments for its implementation (Department of Health, 2003). The Government aimed to reduce health inequalities by tackling the wider determinants of health such as poverty, poor educational outcomes, worklessness, poor housing, homelessness, inequalities and the problems of disadvantaged neighbourhoods. The target was to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality by 2010 and was underpinned by two objectives:

- starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole
- starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

In Scotland, a health inequalities target was introduced in the Scottish Executive *Building a Better Scotland Spending Proposals 2005-2008* (Scottish Executive, 2004a) and was sited within social inclusion policy as part of *Closing the Opportunity Gap* (Scottish Executive, 2004b). The Scottish target had some similarities with the target for England and Wales but took a different approach in that it was aimed at community planning partnerships to take the lead rather than the NHS. The Scottish target was to reduce health inequalities by increasing the rate of improvement for under 75 coronary heart disease mortality and under 75 cancer mortality (1995 – 2010) for the most deprived communities by 15% by 2008 (Scottish Executive, 2004a).

The main routes for achieving these targets were expected to be through *Towards a Healthier Scotland* (Scottish Office, 1999) and *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003b), both of which had health inequalities as an overarching aim although no specific interventions were proposed. Primary care would contribute to achieving the target through taking on anticipatory care as outlined in *Delivering for Health* (Scottish Executive, 2005b). Other *Closing the Opportunity Gap* objectives and targets included reducing child poverty, helping young people to develop life skills, providing work opportunities for all those who are able, supporting older people by providing a decent quality of life, and building strong communities. Therefore it might be argued that the Scottish Executive had taken on the message from the *Black Report* that health should be taken in context with social and environmental conditions if health inequalities were to be tackled. Exworthy *et al* (2003) argued that policy in the UK had begun to take on health inequalities as an objective, but that more work was needed to define the problem of health inequalities clearly, increase its currency as a public issue and to create a critical mass and co-ordinated approach across Government departments.

Determinants of health versus determinants of health inequalities

The *Closing the Opportunity Gap* approach would also fit with recommendations from research that more "upstream" action on determinants of health would be necessary if inequalities were to be tackled successfully (for example, Graham and Kelly, 2004; Crowley and Hunter, 2005; Whitehead and Dahlgren, 2006). In addition, Graham and Kelly (2004) argued that the determinants of health inequalities should be distinguished from determinants of poor health as these represent two different social processes and therefore would require different actions to tackle them. Determinants of health have been described as follows: fixed biological factors such as age, sex and heredity; modifiable personal factors including behaviour and lifestyle choices; social and community interaction; access to essential facilities and services; and economic, cultural and environmental conditions (Whitehead, 1995). The adverse impact of all of these factors on health increases as social position decreases, resulting in an uneven distribution of risk factors across the population. An individual's social position results from a complex set of interlinked social hierarchies including income, geographic location, ethnicity, gender, age and sexuality, and their combination determines the ways in which people are perceived by society or are enabled to access opportunities (Whitehead, 1995). Work to tackle health inequalities should therefore focus on the reasons why decreasing social position increases the potency of risk factors rather than focusing on the risk factors alone (Graham and Kelly, 2005). Graham (2004) contends that there are potentially three distinct approaches to tackling health inequalities of:

remedying health disadvantages, closing health gaps and narrowing health gradients. Clarification of which approach is being taken by any initiative is important as each of these requires a different set of research questions or policy goals.

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Section 2: Mental health as an emerging modern problem

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Introduction

It has already been mentioned that patterns of inequality identified for physical health also apply to mental health, and these will be discussed in more depth within this section. Mental health is often treated in isolation from physical health with mental and physical health and social services planned and delivered separately, and inequalities research focusing almost exclusively on physical health. Research evidence demonstrating links between mental and physical health appears to be uncommon enough to be picked up by the general media. For example, Hunt *et al* (2007) demonstrated a link between death from coronary heart disease and psychological factors stemming from gender constructs and this was notable enough to appear in the Sunday Times and Times Online as reported by O'Kane (2007). Difficulties in measuring mental health have raised different debates in relation to inequalities than those for physical health, and therefore it is argued that they require to be discussed separately in this thesis. Two fundamental issues contributing to difficulties in measurement are the vagaries of terminology and different approaches to diagnosis, and this section discusses both of these. The section also outlines current thinking in the treatment of mental health problems, unhappiness in the population and efforts to promote positive mental health.

Describing "mental health"

As for health inequalities, mental health can be described using many terms, each with potentially slightly different meanings or, equally, potentially the same meanings. For example, commentators such as Rogers and Pilgrim (2003) have noted that "mental health" is commonly used to mean "mental illness" such as when describing services. The term "mental illness" was used most frequently in *Delivering for Mental Health* (Scottish Executive, 2006a) and in the English *National Service Framework for Mental Health* (Department of Health, 1999) but the Scottish *Framework for Mental Health Services* (Scottish Office, 1997) used the term "mental health problems" most frequently. Other terms were used in the three documents, as illustrated in Table 1.1.

Table 1.1 Terms used in mental health policy documents

Delivering for Mental Health (2006)	English *National Service Framework (1999)*	Scottish *Framework for Mental Health Services (1997)*
Mental illness (used most frequently) Other terms used were: mental health conditions mental health problems mental health difficulties mental health needs mental health problems or illness	Mental illness (used most frequently) Other terms used were: mental health needs mental health problems	Mental health problems (used most frequently) Other terms used were: mental illness mental health difficulties mental health needs

In addition, the terms "severe", "enduring" and "severe and/or/to enduring" were used in all three policy documents and those disorders thought to be less severe but affecting greater numbers of the population were described variously in the documents as "less severe", "common", "wider" or "moderate".

While policy documents were less explicit than research papers in describing diagnostic categories for conditions under discussion, they used two broad categories of severe/enduring and mild/moderate in order to attempt to identify implications for service provision. The conditions within the categories were occasionally specified, although they tended to differ between documents. For example, the *Framework for Mental Health Services* (Scottish Office, 1997a) distinguished "severe and enduring" mental health problems from "moderate" mental health problems, in that people suffering from the former problems would have complex health needs and would need medication together with active social support, while those with the latter were said to need short term, focused treatments and social support to address their symptoms. *Delivering for Mental Health* described mental illness as being "severe and enduring such as schizophrenia, bi-polar disorder and dementia […to] a wider range of disorders and illnesses including depression and anxiety" (Scottish Executive, 2006a, p vi). The English *National Service Framework* (Department of Health, 1999) gave a similar list to that in *Delivering for Mental Health* for severe disorders although omitted dementia and added severe anxiety and severe eating disorders. None of the documents suggested that it was giving definitive categories, but none referred to any difficulties in defining mental health problems.

I have tried to use the term "mental health problems" throughout the thesis unless describing or referring to a paper or document which has used a different term. Generally "mental illness", "disorder" or "condition" is used when referring to prevalence rates in recognition of the fact that prevalence figures being available mean that a specified condition has been diagnosed and recorded. While papers accessed for this review did not usually justify their choice of terminology, I believe that the term "mental health problems" encompasses diagnosed, classified illnesses along with undiagnosed conditions which are potentially no less of a problem to sufferers than those that have been diagnosed.

Prevalence of mental illness

Related to the difficulties in diagnosing mental health problems is the inexact process of estimating prevalence figures, resulting in a variety of statistics being offered. For example, the Scottish anti-stigma campaign called "See Me" opened its campaign and website with the following assertion, "One in four people in Scotland will experience a mental health problem at some point in their lives" (See Me Website, n.d, accessed May 2007). The source and date for this statistic is not clarified but it is argued that it might have come from the World Health Organisation (WHO) which estimated from a study including Western and Eastern countries that 25% of the world's population will have a mental illness at some time in their lives with one in 10 individuals and one in four families affected at any one time (World Health Organisation, 2001). The most common conditions found in this study were depression, anxiety and substance abuse disorders. Mental health problems affect all regions in all countries and the WHO estimated that mental health problems account for almost one-third of the disability in the world. A prevalence estimate for Great Britain was calculated by the Office of National Statistics (ONS) Psychiatric Morbidity Survey in 2000, which found that approximately 20% of adults suffered from some form of mental health problem with about one in six adults (aged 16 to 74 years) having a neurotic disorder (mostly anxiety and/or depression) and the most prevalent disorder being mixed anxiety and depression (Singleton *et al*, 2000).

There have been many attempts made to estimate prevalence of mental health problems and the implications for the workload of primary care and psychiatric services. These attempts appear rarely to reach exactly the same conclusions although there has been general agreement that severe, enduring conditions affect a much smaller section of the population than milder depressions and anxiety. For example, Hatloy (2005) estimated that if 300 people in 1000 experienced mental health problems in a year, 230 would visit a GP, 102 of these would be diagnosed as having a mental health problem, 24 would be referred to specialist psychiatric services and six would be admitted to

psychiatric hospital. In Scotland for 2005/2006, GPs saw 79% of their practice population for whom depression was recorded for 18% of consultations with women and 8% with men, and anxiety recorded for 13% of women and 6% of men. The peak age for consultation for both of these conditions for both men and women was 35-44 (Information and Statistics Division, 2007). Prevalence of other conditions is on a different scale, with one in 25 adults diagnosed as having a personality disorder and the prevalence of psychotic disorder being one in 200 (Singleton *et al*, 2000).

Overall, prevalence of mental health disorders is similar for women and men, although women are more likely to have anxiety and depression and men have higher rates of substance use disorders and antisocial personality disorders (World Health Organisation, 2001). Women are also more likely to suffer from eating disorders and self-harm (Mentality, 2002), but suicide rates are higher in men. For example, in Scotland in 2005 men were almost three times more likely to die from suicide than women (Choose Life, 2007). The 2000 ONS Psychiatric Morbidity Survey found that women were more likely to suffer from a neurotic disorder than men, although there was a small significant increase in the number of men being assessed with a neurotic disorder between 1993 and 2000 (Singleton *et al*, 2000). The Scottish Health Survey used the GHQ 12 in 1998 to assess general levels of happiness, anxiety, depression, stress and sleep disturbance, and again found that women were more likely than men to have these mental health problems (Gray and Leyland, 2005). In addition, unemployed men were almost 2.5 times more likely to have a high GHQ 12 score (indicating mental health problems) when compared with their employed counterparts (Shaw *et al,* 2000). The proportion of men in Scotland with a high GHQ 12 score in 2003 was 13% which has not changed since 1995 but the score has declined slightly for women from 19% in 1995 to 17% in 2003 (Gray and Leyland, 2005).

Diagnosis of mental health problems

Most people suffering a mental health problem make contact with a GP. A diagnosis of mental illness is usually made using a standardised clinical assessment which the WHO (2001) believes can be as reliable and as accurate as for common physical illness. The usual process for diagnosis and treatment for patients with mental health problems presenting in primary care is that the GP makes an assessment and, if possible, offers treatment at the local surgery which might include advice and information, medication or counselling (Stewart, 2006). Diagnosis of a mental health disorder is recorded using the international standard diagnostic classification which is used for most general epidemiological and health management purposes, The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) or its

American counterpart, the Diagnostic and Statistical Manual version IV (DSM-IV) (World Health Organisation, 1992). The 2007 version of ICD-10 Chapter V lists all mental and behavioural disorders under the following headings:

- Organic, including symptomatic, mental disorders
- Mental and behavioural disorders due to psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood (affective) disorders
- Neurotic, stress-related and somatoform disorders
- Behavioural syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behaviour
- Mental retardation
- Disorders of psychological development
- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder.

Despite the WHO's confidence in standardised assessment, accurate diagnoses of mental health problems have been disputed due to difficulty in separating physical and mental health problems, the lack of proof of a biological basis for mental illness and the danger of medicalising unhappiness. For example, 70% of patients across the world with mental health disorders present with physical symptoms including sleeping problems and unexplained headache (World Health Organisation, 1998). The lack of an agreed biological basis leads psychiatric illness to have less clear construct validity than physical illness, which results in less consistent diagnoses (Roger and Pilgrim, 2003). Rogers and Pilgrim (2003) argued that the variability in diagnosis is due partly to professional responses to patients experiencing despair and distress being shaped by a wide range of individual and social influences, including drug company profit, poverty, patriarchy and racism. In a similar vein, Dowrick (2004) questioned the validity of depression as a medical concept because of the disputes it has raised within psychiatry, the lack of biological basis and the lack of universal effectiveness of anti-depression medication. Dowrick (2004) also argued that the overlap between depression and a range of physical diagnoses, medically unexplained symptoms and social difficulties resulted in depression being unsuitable for a medical approach to treatment. This argument was also suggested by an observational study which found that medical knowledge and diagnostic tools played only a small part in GPs diagnosing depression in women, with the focus in the consultation instead being on an assessment of the women's social circumstances and their responses to them (Maxwell, 2005).

Treatment for mental health problems

The Scottish Intercollegiate Guidance Network (SIGN) and National Institute for Health and Clinical Evidence (NICE) produce evidence-based guidelines to help clinicians and patients decide appropriate treatment (National Institute for Health and Clinical Evidence, 2005; Scottish Intercollegiate Guidance Network, 2006). For example, the NICE guidelines contain algorithms for options to follow depending on the patient's sets of symptoms, together with the most recent evidence-based treatments weighted for degrees of effectiveness. Treatments described for mental health problems by NICE are, at the time of writing, based around a stepped care model of action that encourages local treatment rather than hospitalisation wherever possible and includes a range of medical and non-medical interventions such as selective serotonin uptake inhibitors (SSRIs), cognitive behavioural therapy (CBT) and bibliotherapy (reading material usually based on CBT approaches) (National Institute for Health and Clinical Evidence, 2005).

On diagnosis, a patient might expect to be referred by their GP to a psychiatrist or a Community Mental Health Team which usually includes psychiatric nurses, social workers, occupational therapists and psychologists (Stewart, 2006). Primary Care Mental Health teams and voluntary organisations might also be available in some areas, contributing to a wider range of accessible services (Scottish Executive, 2006a). The WHO (2001) found that, at a global level, less than half of those individuals needing care for mental health made use of the services available, and this was related both to the stigma attached to individuals with mental and behavioural disorders and to the inappropriateness of the services provided (World Health Organisation, 2001). Services might therefore not be working as well as they might. For example, one criticism from academic commentators asserted that psychiatric services had become "cursory administrative interviews and medication revision" (Rogers and Pilgrim, 2003, p169).

Philp *et al* (2002) found that while the incidence and prevalence of depressive illness in males and females appeared to have remained steady in Scotland between 1998 and 2000, prescriptions dispensed in the community for anti-depressants rose from 1.2 million per year in 1992 to 2.3 million per year in 1998 then to 2.8 million per year by the year 2000. Other mental illness related prescriptions, such as for anxiolytics, remained steady over the same time, suggesting that anti-depressants were now being prescribed for conditions other than diagnosed depression. Philp *et al* (2002) also demonstrated that, in Scotland, about 40% more was spent per head on anti-depressants than in England and 30% more was spent on anxiolytics, despite the ONS survey (Singleton *et al*, 2000) showing similar prevalence rates of neurotic disorders in the two countries. Reasons for discrepancies between diagnosis of depression and prescribing anti-depressants were explored by Morrison *et al* (2007) who found that a combination of

factors contributed to the rise in the use of anti-depressants, including an increased awareness in general of depression from national campaigns, acceptability of use of drugs as a result of pharmaceutical promotion and lack of accessibility of alternative treatments and socio-economic deprivation, where high levels of deprivation were associated with high levels of prescribing.

Inequalities in mental health

The lack of clarity in diagnosis of mental illness has been thought to have compromised the potential for appropriate professional responses and has also been argued to have resulted in misinterpretation of inequalities in mental health (Rogers and Pilgrim, 2003). A less dramatic social gradient for mental illness has been demonstrated than for physical illness, but it has been argued that the social impact of mental illness on disability and morbidity should make mental health no less of a priority for health policy initiatives (Fryers *et al*, 2005). Mental and physical illness have been shown to be linked in many ways in individuals; for example, depression being predictive of heart disease (World Health Organisation, 2001) and the ability to talk about problems being a protective factor in deaths from coronary heart disease in men (Hunt *et al*, 2007). Therefore it might seem surprising that there could be different social patterns for mental and physical health problems. Rogers and Pilgrim (2003) attributed the obscuring of social patterns in mental health to the biomedical approach in psychiatry which they argue individualises psychopathology and divorces mental illness from social causes. A similar argument was made by Muntaner *et al* (2000) who identified that both sociology and psychiatric epidemiology have studied mental health in relation to social inequalities since the 1920s. However, the number of published articles on social class and physical health rose sharply in the 1990s while the number of published articles on social class and mental health during the same period barely increased.

While many studies such as those reviewed by Muntaner *et al* (2000) and Fryers *et al* (2005) have identified a clear social gradient in mental health, others have questioned the links between socio-economic deprivation or social class and mental health. For example, a study of suicide in young people found that there was a stronger relationship between indicators of social fragmentation and suicide than socio-economic factors, and concluded that societal shifts towards individualism were to blame rather than poverty (Eckersley, 2005). However, a more recent study of suicide in adults in Scotland identified a strong relationship between suicide and both social class and area socio-economic deprivation when the definition of suicide was broadened to include intentional self harm and undetermined deaths (Platt *et al*, 2007). The study by Platt *et al* also found a widening gap between the most deprived and least deprived quintiles from 1989

to 2004. Further evidence of the inverse relationship between social class and mental illness in Scotland was demonstrated by prevalence of depression and incidence of anxiety having a positive correlation with area deprivation (McLaren and Bain, 1998). McLaren and Bain also demonstrated that there was a clear gradient in first admissions to hospital for psychiatric care for schizophrenia by deprivation category using hospital admission data, but less variation by deprivation for schizophrenia using primary care-derived data. This suggests that there may be under-representation of the prevalence of mental health problems identified through primary care systems since prevalence figures are based on data from a representative but small proportion of Scottish GP practices (Philp *et al*, 2002). Therefore, data that depended on patients presenting to primary care might not pick up the full impact of depression in men (Rogers and Pilgrim, 2003) or the mental health status of people from vulnerable population groups (Philp *et al*, 2002).

Mental and behavioural disorders are generally understood to be the result of a complex interaction between biological, psychological and social factors. Determinants of prevalence, onset and course of mental health and behavioural problems have been described as including social and economic factors, sex and age, serious conflicts and disasters, presence of major physical diseases and the family environment (World Health Organisation, 2001), with poverty and the female role proposed as the two most consistently recognised risk factors for common mental health problems (Mentality, 2002). Other risk factors for poor mental health have been found to include unemployment, homelessness, poor housing, bullying, racism, prison, drug and alcohol problems, sexual abuse and domestic violence (Singleton *et al*, 2002). Some occupational groups are thought to be particularly vulnerable to stress-related mental health problems including teachers, nurses, managers, doctors, farmers and carers, and certain groups, such as parents with mental health problems and adults with complex needs, were thought to be at particular risk of not having their mental health needs met (Social Exclusion Unit, 2004).

Mental illness and unhappiness in the population

There have been a plethora of social processes and questionable motives proposed as contributing to the current problems of mental illness and unhappiness in the population. For example, cultural characteristics of materialism and individualism as evident in Western countries are believed by Eckersley (2005) to impact negatively on psychosocial factors including social support and sense of control. Eckersley also proposed that the Western culture had acted to change personalities to become more extravert and anxious in recent decades. Individualism was also proposed as resulting in problems being personalised, reducing willingness to protest collectively against social

problems and leading to a massive growth in the therapy industry (Furedi, 2004). Also related to theories of individualism, the social processes that result in people feeling obliged to strive to achieve greater income and status through competing with fellow citizens has been blamed for rising depression, drug abuse and crime rates (Layard, 2005; James, 2006). Increase in wealth for the most successful competitors has led to a culture of inequality as described by Marmot and Wilkinson (2001) which demonstrates more aggression and violence and less trust between citizens. If all of the above social processes, cultural factors, individual motivations and more are the elements that together with biology make up our mental health and illness, it is argued here that any one or two professional disciplines are unlikely to hold the answer to current mental health problems.

Promoting mental health

As successful treatments for mental health problems continue to be sought, mental health promotion and positive psychology appear to be attracting increasing interest including from the mental health policies current at the time of writing (policies are discussed in more detail below in Chapter 1 Section 4). Mental health policy in England has integrated the promotion of mental health and mental health service provision within the *National Service Framework for Mental Health* since 1999 (Department of Health, 1999). This framework set out seven standards with mental health promotion given centre stage by including it as the subject of Standard One, which aimed to reduce discrimination and social exclusion associated with mental health problems. To achieve Standard One, local services were to prioritise mental health promotion in their health improvement programmes and take every opportunity within social inclusion to promote mental health and prevent mental illness. However, *Making it Happen* (Department of Health, 2001a), a Department of Health guide to mental health promotion, acknowledged that to deliver mental health promotion as outlined in Standard One would involve a major change in the way that the NHS works (Department of Health, 2001a).

In Scotland, the *Framework for Mental Health Services* (Scottish Office, 1997a) and its successor, *Delivering for Mental Health* (Scottish Executive, 2006a), emphasised the need for support for prevention as well as illness treatment, although both policies focused on treatment of diagnosed mental illness. Building on the Scottish *Framework*'s recognition of the need to support prevention, the *National Programme for Improving the Mental Health and Well-Being of the Scottish Population* (Scottish Executive, 2003b) was set up in 2002 to integrate positive mental health and well-being into the wider public health and health improvement agenda, including enabling effective prevention of

mental health problems. For example, among many other objectives, the Programme intended to support training for service providers on the use of the evidence in mental health improvement, support ongoing programmes such as working with the public and voluntary sectors to improve services for people with anxiety and depression in the community, and to begin to identify key issues in relation to mental health/mental illness and inequalities (Scottish Executive, 2003b).

The Programme has since developed a range of projects and commissioned research and has made available reports and information on improving mental health and well-being and on inequalities in mental health (WellScotland website, 2007). From 2003 to 2007, the programme focused on raising awareness and promoting mental health, stigma and discrimination, suicide and recovery. It commissioned research on a range of topics including public attitudes, arts, creativity and mental health, what works for mental health improvement, establishing national mental health and well-being indicators, and inequalities in mental health. In contrast to the English approach which aimed explicitly to integrate mental health promotion with health service provision and to make links with social inclusion structures, the Scottish *National Programme for Improving Mental Health and Well-Being* made their primary target audience a broad spectrum of local authorities, voluntary sector and health services. While this inclusive approach recognised the broader causes and consequences of mental health problems, it also meant that specific roles in promoting mental health for most groups, including primary care, were not specified.

The concept of public mental health moved beyond mental health promotion, advocating a whole population approach along with targeted action for individuals at risk in order to prevent mental illness and promote mental health (Hannah and Halliday, 2002). Public mental health recognised a need to take a broader perspective to mental illness than the current dominant focus on treatment and care in order to explore further the relationship between physical and mental health, and the relationship between mental health and social circumstances. The public mental health model appeared to offer an opportunity to look beyond a biomedical model for mental health to introduce a social model to address mental health problems. The biomedical and social models for health, impacting on both physical and mental health, are explored in the following section.

Section 3: Biomedical and social models for health

Introduction

An exploration of primary care practice to address inequalities in health and in mental health requires consideration of the different approaches that shape health care interventions for individuals and communities. There are two clear models prominent in current discourse on health and illness: a biomedical model and a social model. Attempts have been made to develop combined models and some practitioners might use elements of both, but nevertheless, the two approaches remain strongly distinct. Generally, a biomedical model focuses on symptoms or a condition and requires an expert to identify the problem and decide on a course of action. A social model focuses on the person, their circumstances, and the reason for the illness or condition, and they are included in finding a solution. The NHS was founded on a belief that a biomedical model of health care, made available and accessible to everyone in the population, would have the effect of improving health status across the country. Less than 30 years after the founding of the NHS the concept of a social model of health was introduced, which downplayed the role of health care in improving population health status and recognised the powerful impact on health of social factors including housing, poverty and discrimination. This section discusses the main components of biomedical and social models of health.

Biomedical model of health care

The biomedical model is concerned with pathology, where medical practice is based on developing a relationship with the patient in order to gather and analyse data on which to base a diagnosis of disease (Anon, 2007). From the diagnosis, the medical practitioner designs and implements the best course of action or treatment. The scientific basis of medicine was developed in the 18th century when experiment and observation began to be used to identify causes of disease (Anon, 2007). Further scientific advances in the 19th century that continue to underpin current practice include the discovery of the germ theory of disease and development of antibiotics, anaesthetics and medical imaging (Anon, 2007). These medical advances were credited with dramatic reductions in deaths, for example from infectious diseases, leading to an "age of optimism" in medicine and faith in the effectiveness of medical science (Tudor Hart, 1988). The British medical profession began with a strong egalitarian focus that resisted an attempt by a parliamentary Act to create a less qualified grade of doctor to treat the poor (Tudor Hart, 1988), and many doctors involved at the inception of the NHS were known to have a social conscience or were on the political left (Rivett, 1998). This sense of

egalitarianism was overtaken by a model of medical professionalism, still in force at the time of writing. This model has been criticised for overemphasising medical science and ignoring the social context of disease, resulting in doctors treating patients as passive subjects rather than intelligent participants (McKeown, 1976; Tudor Hart, 1988). However, commentators have argued that the medical mindset continues to drive the NHS despite the strong focus on managerialism evident since the 1980s (Pollok, 2004; Hunter, 2006).

The place of drugs in the biomedical model

Pharmaceutical advances have been an important element of the biomedical approach to improve population health since the rapid growth of synthetic medicinal chemistry in the 19th century (Rivett, 1998). Huge advances were made particularly in controlling infections, reducing pain and the development of new vaccines alongside new understanding of physiology, biochemistry and clinical medicine. Doctors have been believed to have gained power and status as a result of their role as gatekeepers to pharmacological developments (Gabe *et al*, 2006), which it is argued here is likely to continue as the pharmaceutical industry assumes an increasingly critical role in the UK's economic development. For example, priorities for health care research in Scotland set in 2003 were described as clinically and commercially focused as part of Scotland's plans for economic improvement, with the pharmaceutical industry playing a key part (Scottish Parliament, 2003). However, the Office of Fair Trading described drug expenditure as a cause for concern when the NHS was found to spend about £8 billion a year on branded prescription medicines (Office of Fair Trading, 2007).

The industry's entanglement in health care training and research has become well established, and the links between the pharmaceutical industry and health care have attracted increasing scrutiny (Moynihan, 2003). The need to promote commercial products appears to be difficult to balance with a focus on patient's needs, suggested by the regular accusations of industry bias published in medical journals including many backed up by evidence. For example, a North American systematic review found that clinical studies funded by pharmaceutical companies were more likely to produce results that favoured the company than studies that were funded by other sources (Lexchin *et al* 2003). In England, the 2006 National Research Strategy proposed measures that were likely to further increase the decision-making powers of the pharmaceutical industry in clinical research carried out by the NHS and universities. This was argued to potentially reduce opportunities for biomedical research on patients' needs to be prioritised in favour of commercial interests (Pollock *et al*, 2006).

General medical practice and the NHS

Since the NHS was established in the UK in 1948, health care has been controlled by politicians and civil servants to a greater extent than in other Western countries (Webster 2002). However, in setting up the NHS considerable concessions were made to the medical establishment, including general medical practitioners (GPs) retaining independent status and consultant led teaching hospitals in England and Wales retaining their independent administration (although Scottish hospitals agreed to nationalisation). In addition, some larger teaching hospitals such as Great Ormond Street continued to retain enough financial power through private fundraising to reject Government proposals for administration changes (Pollock, 2004).

Demands on the NHS continued to grow and by the 1970s the economic crisis and cuts in public expenditure prevented the NHS from meeting its aims. From 1979 the new Thatcher Government began to implement progressive changes to the NHS (Webster, 2002). One of the progressions was to give GPs greater administration powers through fundholding, as their role as gatekeepers into secondary care was regarded as a potential route to cost-containment of hospital care. Fundholding gave GPs the opportunity to drive the NHS for the first time but Pollock (2004) argued that this approach was limited by confining it to practices rather than populations, as practice coverage was not wide enough to enable efficient planning. General Practitioners were thought to have neither the skills nor the incentives to take a population approach, which made them dependent on health authorities who were at that time losing their planners as they became purchasing organisations (Pollok, 2004).

Over the 1990s, GPs gradually moved towards fundholding, but this ended with the change of Government in 1997 by which time about half of GPs had joined the scheme (Webster, 2002). While GPs' administrative power was diluted since re-structuring began again in 1997, they have continued to engender trust within the general public and it is argued that their medical power appears to remain strong. For example, part of GPs gatekeeping function has been taken on by nurses through the centralised out of hours services, NHS Direct in England and NHS 24 in Scotland. It might appear at face value that a biomedical model could be threatened by replacement of GPs by nurses on the front line for at least some aspects of care. However, initial evaluation of NHS 24 found that it had not reduced the workload of other health care providers such as Accident and Emergency or the Scottish Ambulance Service (Heany *et al*, 2005), suggesting that the biomedical model of care remains in place, in this sphere at least. In addition to changes in nursing presenting a potential challenge to medical dominance, challenges have also come over time from managerialism, the rise of self-help groups and lay knowledge, feminist critiques, lawyers and journalists (Gabe *et al*, 2006).

Although these challenges reflect changes in wider society, Gabe *et al* (2006) argued that while they signalled a need for re-examination of professional dominance, challenges to date were unlikely to disempower medicine in the near future (Gabe *et al*, 2006).

The strength and power of medical networks for maintaining their position can be further illustrated by audits in both Scotland and England of the implementation of the 2003 NHS consultants' contract (Audit Scotland, 2006; National Audit Office, 2007). Both audits found that despite a salary increase of 27% over three years (taking a consultants' salary to three times as much as received by a senior nurse), there had been no increase in direct care, no improvements in flexibility, no change in private practice and no conclusion as yet regarding impact on productivity.

Psychiatry and the biomedical model

Psychiatry in the UK is currently clearly based on a biomedical model, although attempts have been made to challenge this. The current model for psychiatry was thought to be established following advances in general medical knowledge at the end of the 19th century which contributed to a search for organic causes of mental distress (Darton, 1999). A major contribution to the current model was made in the 1950s with the development of chlorpromazine which was said to have helped to transform lunatic asylums by calming patients, and thereby enabling psychiatrists and psychotherapists to engage with patients who might have been thought of previously as hopeless cases (Turner, 2007). Turner noted that the "holy grail" of psychiatric research is to link psychiatry to scientific medicine by identifying physical pathways to mental illness. Until that link is found, it is argued that reliance on medication to treat mental illness is likely to continue to draw criticism, such as from Moncrieff and Kirsch (2005) who questioned the efficacy of antidepressants for adults as recommended in the NICE guidelines.

Many physical treatments were attempted on patients with mental illness throughout the first half of the 20th century. These took place mostly within large institutions, and they included drug treatments, surgery and electroconvulsive therapy (Darton, 1999). In the second half of the century, major challenges to the mainstream psychiatric model were mounted, particularly through a movement called "anti-psychiatry". Further challenges came from influential psychiatrists RD Laing and Thomas Szaz, who were occasionally associated with anti-psychiatry although their views were not always consistent with the movement (Double, n.d.). RD Laing viewed schizophrenia as a strategy developed by a patient to be able to live in an unliveable situation. He challenged the dehumanising of the patient and, while some of his practices were criticised, he is credited with

revolutionising modern therapeutic techniques from his emphasis on listening skills and contextualising symptoms of madness. Thomas Szasz also courted some criticism, but he rejected mainstream psychiatric practice because it was based on unproven claims for physical causes of mental illness (Double, n.d.). More recent challenges to mainstream psychiatry appear less confrontational, and instead of attempting to propose new theories of madness, they attempt to bring the social context of mental illness together with the biomedical model. For example, a network of psychiatrists called the Critical Psychiatric Network was set up in England to provide constructive criticism of diagnosis based on a biomedical model, in order to create an understanding of the reasons for a patient's presentation (Double, 2002). In addition, a movement called post-psychiatry was described as arising as a result of health policies that linked poverty, unemployment and mental illness (Bracken and Thomas, 2001). Post-psychiatry was said to intend to democratise mental health by linking new service developments to contexts, values and partnerships.

Slightly aside from mainstream psychiatry, a social model for mental health appears to have become established within the mental health promotion field. This relatively new concept, described as public mental health and well-being and mentioned above in Section 2, embraces a similar model of social determinants of mental health as for general health (Taylor *et al*, 2007). There is also a new emphasis by the Scottish Executive on the practice of self help being promoted in primary care at the time of writing as a result of the successful introduction of the *Doing Well by People with Depression* initiative (Scottish Executive, 2006b). These developments appear to sit outside psychiatry as methods of improving accessibility of services to people with the less severe mental health problems, aiming to prevent inappropriate referral to secondary care and freeing up GP time. Consequently, it is argued here that they are not presented as a challenge to mainstream psychiatry, but as a complementary service.

Social model of health

The biomedical model for health in general appears to have been challenged (and defended) vigorously for much of the last 50 years. The first major challenge came from a medical Professor of Social Medicine, Thomas McKeown, who demonstrated in the 1960s and 1970s that the dramatic improvements in reducing deaths from certain diseases coincided with, and were eclipsed by, improvements in living conditions, nutrition, hygiene, and new reproductive behaviour. He argued that misinterpretations of the role of medical care in improvements in health have led to a "misuse of resources and distortion of the role of medicine" (McKeown, 1976, p xiii), and that internal medical interventions had a small effect on population health compared with external influences

and personal behaviour. His perspective was brought to the policy arena in 1974 in a Canadian Government report, *A New Perspective on the Health of Canadians* (Lalonde, 1974) also known as the *Lalonde Report*, which placed health care as one of four determinants of health alongside environment, biology and lifestyle (Ashton and Seymour, 1988). The *Lalonde Report* was groundbreaking in that it highlighted that a great deal of premature death and disability was preventable, and it contributed to the concept of health promotion through the WHO *Alma Ata Declaration* in 1978 (World Health Organisation, 1978) and later the *Ottawa Charter for Health Promotion* in 1986 (World Health Organisation, 1986).

The *Lalonde Report* had been produced within a policy context which required the containment of increasing demand for health care and resources, and it tried to do this in two ways. First, by stating that health care was only one factor in improving health, it argued for resources to be moved away from health care and second, by focusing on lifestyle as one of the determinants of health, it emphasised individual responsibility for health (Tuohy, 2007). Critics have contended that the *Lalonde Report* was subsequently misused and deliberately misinterpreted by governments keen to promote individual responsibility for health, resulting in "victim-blaming" strategies that have diverted attention from the focus on social determinants of health (Poland *et al*, 1998; Tuohy 2007). The UK preventative health initiative in 1976, *Prevention and Health: Everybody's Business,* also took the stance that the sick brought their illness on themselves, and placed responsibility for improving health on the individual (Webster, 2002). The *Lalonde Report* continues to inform individually-focused health policy in England; for example, the Wanless Report, *Securing Good Health for the Whole Population* (Wanless, 2004) referred directly to the *Lalonde Report's* assertion of lifestyles as a determinant of health. Despite the *Wanless Report* describing lifestyle determinants within a context of social circumstances, it emphasised individual choice as the route to better health.

Following on from the *Lalonde Report*, the WHO set a new agenda for a social model for global public health. The *Alma Ata Declaration* in 1978 recommended promoting health through a new approach described as primary health care which encompassed social, biomedical and health services research and public health experience (World Health Organisation, 1978). It called on governments to integrate this approach across all sectors and thus established a multisectoral approach to health promotion, which was linked specifically to both economic development and social justice. The *Alma Ata Declaration* also emphasised the importance of equity in health and introduced the goal for health to be improved for all by the year 2000. The subsequent publication in 1981of 38 targets for *Health for All by the Year 2000* aimed to ensure that resources for health were equitably distributed and that essential health care was available to all (World Health Organisation, 1981). In 1986, the *Ottawa Charter for Health Promotion* also built

on the *Alma Ata Declaration*, and recommended that health promotion policy should be based on the five key principles of:

- Healthy public policy
- Creating supportive environments
- Strengthening community action
- Strengthening individuals
- Re-orienting health services.

The *Ottawa Charter* identified the prerequisites for health as being peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (World Health Organisation, 1986).

By the 1990s, academics had begun to develop new models to seek to understand the social determinants of health. One influential British working group described social determinants as being grounded in the everyday experience of people's lives. They named the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport as being the main factors, but that the factors interacted resulting in a complexity of problems that were unlikely to have a straightforward remedy (Marmot & Wilkinson, 1999).

Evans and Stoddart, also from Canada, built on a critique of the *Lalonde Report* for their population health model for social determinants of health shown in Figure 1, below (Evans and Stoddart, 1994). They argued that the *Lalonde Report* could be interpreted as a call for more interventionist social policies but that it was the alternative interpretation at the other end of the political spectrum that was widely taken on, that is, by individualising the wider determinants of health. This interpretation resulted in policies for more health care rather than less, maintaining and protecting the existing health care institution rather than challenging or broadening it. Evans and Stoddart, in a similar vein to McKeown, argued that a misinterpretation of the benefits of health care led to a misuse of resources intended for improving health. They went on to argue that that the demand for increased resources for health care would continue to rise as medical advances continued to develop. This would have an overall negative effect on the health of the population, since resources would have to be diverted to health care from economic development and other actions that might improve population well-being (Evans and Stoddart, 1994). The model was welcomed as providing insight into social determinants of population health, but was also criticised for their belief that prosperity from economic development would naturally lead to improvements in health across the whole population. Evans and Stoddart omitted any discussion of the known link between

Western economic development and health inequalities and they had also proposed that curative health care spending should be cut without suggesting an alternative, potentially further reducing access to services for the most vulnerable people in poor health. (Poland *et al*, 1998).

Figure 1.1: Evans and Stoddart's population health model for social determinants of health (Evans and Stoddart, 1994)
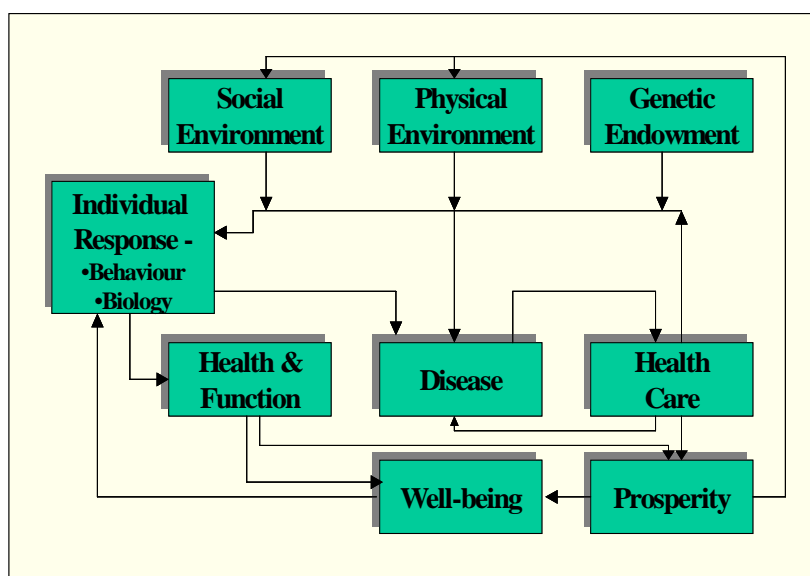
Another model for explaining the existence of and links between biological, social and cultural determinants of health factors was created by Dahlgren and Whitehead (1991, quoted in Whitehead 1995), illustrated in Figure 2. Biological determinants such as age, sex and hereditary factors were placed at the centre of the model as being fixed and unmodifiable, and these were surrounded by the first layer of influence on an individual which could be amenable to change. The first modifiable layer contained personal behavioural and lifestyle factors followed by and linked to the second layer of social and community interaction. The next layer represented factors encountered as part of daily life, including food supplies and access to essential facilities and services. The economic, cultural and environmental conditions in society formed the final layer, although these conditions affect every other layer.

It is argued here that the Dahlgren and Whitehead model suggested more fluidity between the different factors that create and destroy health than Evans and Stoddart's model. The Dahlgren and Whitehead model does not give centre stage to health care or any other individual factor and while it gives weight to structural conditions depicted as the top layer, it suggests that these conditions infuse all the other factors rather than stand alone. However, as for the Evans and Stoddart model and McKeown's thesis, it

does not include recognition of how changes come about in society, for example, whether market forces or political struggle created the impetus for improved living conditions (Poland *et al*, 1998).

Figure 1.2: Dahlgren and Whitehead's model for the social determinants of health (Dahlgren and Whitehead (1991), quoted in Whitehead, 1995)

Source: Dahlgren and Whitehead, 1991
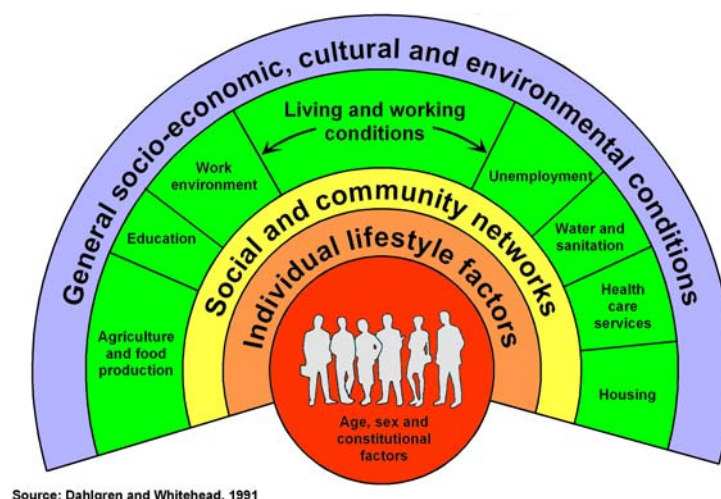
The Dahlgren and Whitehead model was originally created as a background to an exploration of the policies and strategies in existence across Europe that would address equity in health (Whitehead, 1995). Whitehead used the model to describe the impact of social inequalities on health, and the text accompanying the model argued that a social gradient existed for most of the factors, with conducive factors for health having less impact as social status declined. This resulted in an uneven distribution of risk factors across the population. However, the published diagram of the model did not include a depiction of social inequality as described in the text. It is argued that this left the model open to an interpretation that ignored the inequality dimension contrary to its original intention. Unfortunately, the pictorial version of the model has since appeared in countless research, teaching and policy documents to explain the social determinants of health, but is often unaccompanied by text about health or social inequalities. Therefore, echoing criticisms of the *Lalonde Report*, it is argued that the two most often quoted models used at the time of writing to describe and understand social determinants of health have been partially interpreted to omit discussion of inequalities and, as noted by Poland *et al* (1998) and Williams (2003), without identifying the interaction between social structure and forces for change.

In their arguably partially-digested form the social determinants of health have now been taken on by policy across the UK, but have been incorporated into a lifestyle focus in both the *Wanless Report* in England (Wanless, 2004) as noted above, and in Scotland's public health White Paper, *Towards a Healthier Scotland* (Scottish Office, 1999). However, the social determinants did not even make the transition from the *Wanless Report* into the English White Paper, *Choosing Health* (Department of Health, 2004): rather, they were claimed to be dealt with elsewhere. Wherever they were to be addressed by policy, social determinants of health appear to have been separated from the curative health care agenda.

Biomedical model versus social model

It is interesting to note that challenges to biomedical dominance in health care have largely come from outside the medical profession with the exception of that by Thomas McKeown, although he clearly dissociated himself from a biomedical perspective, having moved away from medicine and endocrinology to become a Professor of Social Medicine (McKeown, 1976). In contrast, challenges or proposed modifications to biomedical psychiatry appear to have come from within psychiatry itself, as illustrated by Laing, Szaz and the more recent Critical Psychiatric Network discussed earlier in Chapter 1. However, a British Medical Journal supplement might have tapped into a new phenomenon of a self-critical medical profession. The journal ran a readers poll to invite votes for the most important medical advances since the late 18th Century. They invited a panel of experts to write short pieces in favour of each of the advances proposed and the list included the development of antibiotics, the germ theory of disease, chlorpromazine, medical imaging, the contraceptive pill, sanitation and many more. Sanitation was the only social measure proposed, and perhaps surprisingly, given the dominance of a biomedical model suggested above, sanitation won the most votes (Anon, 2007).

While a social model of health appears to be gaining ground in at least some quarters of health policy, the biomedical model and its proponents appears to remain strong within health care and health improvement in the UK. For example, the health belief and behavioural change models of health promotion are based on the premise that medical science can provide a convincing evidence base for improving health (Hunter, 2006). Western politics are driven by strong business forces that downplay the role of poor housing, poverty and discrimination in poor health, and an individualistic, mechanistic view of health and disease is thought to suit a political administration that seeks to avoid challenging market forces and consequently favours curative medicine (Poland *et al*, 1998). Within this context, it remains to be seen whether the groundswell of a holistic,

non-discriminatory, social model of health can compete for recognition, if it is seen to challenge the well-established medical networks and the importance placed on the commercial success of biomedical research in economic development. The NHS now appears to be looking beyond health policy to address inequalities in health rather than within its own structures. The following section explores the wider policy context for primary care in Scotland, focusing particularly on the development of objectives for improving population health, reducing health inequalities and the primary care role in mental health.

Section 4: Policy context for primary care and mental health

Introduction

This section explores the overarching policy context for primary care and mental health in Scotland, and focuses particularly on policy drivers for improving health and well-being in the Scottish population.

Vision and priorities for Scotland

At the time of writing, the document that set the agenda for policy in Scotland from the governing administration was the *Partnership Agreement* (Scottish Parliament, 2003), a joint statement from the leaders of the Scottish Labour Party and the Scottish Liberal Democrats. The Partnership Agreement stated a set of principles for all Scottish policy as follows:

- Growing Scotland's economy (themes: enterprise and lifelong learning; transport; rural)
- Deliver excellent public services (themes: improving public services; health; education)
- Support stronger, safer communities (themes: children and young people; justice; social justice; sports, culture and the arts)
- Develop a confident, democratic Scotland (theme: governance).

Objectives based on the above principles were outlined in the spending strategy *Building a Better Scotland: Spending Proposals 2005-2008, Enterprise, Opportunity, Fairness* (Scottish Executive, 2004a) and resources were allocated annually to each political

portfolio in a budget statement, with the most recent budget statement at the time of writing being the *Draft Budget Statement 2007-2008* (Scottish Executive, 2006c).

Building a Better Scotland stated that growing the economy was the top priority for the Scottish Executive in order to raise the quality of life for people in Scotland. Improving public services was to be achieved by increasing the levels of investment with a focus on people receiving them. Scotland's health is mentioned in the strategy as a key challenge, with priorities for health including staff contracts, re-designing services to meet the needs of patients and putting health promotion at the heart of long term plans. Efficient Government was another key objective, with a target set to achieve annual efficiency savings. Local authorities, health boards and other public bodies which make efficiency savings from within their spending allocations would be able to retain those savings and redirect them to their own frontline services. Safe, strong and sustainable communities were regarded as being essential for economic growth with housing, environment, access to support and advice and increased public participation being key arenas. The Health and Community Care section introduced for the first time in Scotland, a target to reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15%. Indicators for monitoring progress on health inequalities were to be coronary heart disease, cancer, smoking, smoking during pregnancy, teenage pregnancy and suicides in young people.

Political portfolios

The *Draft Budget Statement 2007-2008* (Scottish Executive, 2006c) outlined 12 areas of responsibility for nine ministerial portfolios and three specialised areas. The ministerial portfolios were: Communities; Health and Community Care; Transport; Education and Young People; Finance and Public Service Reform; Environment and Rural Development; Tourism, Culture and Sport; Enterprise and Lifelong Learning; and Justice. The other three areas of responsibility were: Scottish Executive Administration; Crown Office and Procurator Fiscal; and the Food Standards Agency. There were also four cross-cutting themes to which all portfolios had to demonstrate their contribution and these were: growing the economy, closing the opportunity gap, equality and sustainable development. The cross-cutting themes were explained in more detail in the following documents:

The Framework for Economic Development in Scotland (Scottish Executive, 2004c) identified productivity as the critical factor in improving Scotland's economic growth and living standards. Education, entrepreneurial skills, electronic and physical infrastructure and efficient management of resources were key elements.

Closing the Opportunity Gap (Scottish Executive, 2004a) dealt with tackling poverty and disadvantage by increasing access to services and opportunities for all, and closing the gap between the most disadvantaged communities and the Scottish average. Key elements were employment for vulnerable and disadvantaged groups, improving children's confidence and skills, regeneration of deprived communities and increasing the rate of improvement in people's health status. The health inequalities targets were to be monitored under this theme.

The Equality Strategy (Scottish Executive, 2000) intended to underpin everything the Scottish Executive does. It aimed to remove discrimination on the basis of gender, ethnicity, disability, sexual orientation, age, faith or religion. Promoting equality, tackling discrimination and addressing inequality were stated as fundamental to delivery of the four main Scottish Executive principles.

Choosing our Future: Scotland's Sustainable Development Strategy (Scottish Executive, 2005a) aimed for a sustainable, innovative and productive economy with high levels of employment and a just society which would promote social inclusion, sustainable communities and personal well-being. Protecting and enhancing the environment and using resources efficiently were key aims.

Health and Community Care Portfolio

The main focus for the NHS within the Health and Community Care Portfolio as stated for 2007 – 2008 was to meet targets from the most recent health strategy, *Delivering for Health* (Scottish Executive, 2005b), including focusing on preventative medicine, targeting action to address inequalities in health, increasing access through improving waiting times, service re-design, a new mental health delivery plan, new hospitals and more local diagnosis and treatment. Research was described as being funded by a combination of non-commercial, commercial and internal sources. It was notable that funding from one pharmaceutical company for a new health care research initiative was at almost the same level as the non-commercial and internal sources combined (£33m versus £39m). The *Draft Budget Statement 2007-2008* stated that Scottish health care research had been shown to be the most productive in the world. Consequently, health care was said to contribute to the economy by attracting substantial resources for health care research as well as by ensuring that the labour force remained healthy and available for work.

Objectives for mental health services were said to be to develop and improve their focus on promotion, prevention, protection, quality, care and recovery, and they should be

delivered in hospitals, people's own homes and in communities. The community care elements of the portfolio included investing in social care services through local authorities and the voluntary sector to promote independence where possible, support carers and to reduce inappropriate admissions and long stays in hospitals.

At the time of writing, the Scottish Executive Health Department worked through 14 area-based and 8 special NHS Boards, and provided additional funding allocations to national priorities. Approximately 80% of health spending in Scotland was allocated to the area NHS Boards to improve health and to provide integrated health and community care services (Scottish Executive, 2006c). Allocations to each NHS Board and to GP Prescribing were based on a formula recommended by the Arbuthnott Committee, which was based on four main indicators as follows:

- The size of the NHS Board population
- The age and sex profile of each NHS Board population
- Levels of ill health and life circumstances in each NHS Board population
- Excess costs of delivering services in rural and remote areas.

The Arbuthnott Formula had been in use since 2001 and was reviewed in 2006 in order to take into account new information becoming available such as data on ethnicity, equity issues explored through unmet need pilot initiatives and to include other health services such as pharmacy and dentistry. The revised formula was expected to be approved in 2007 (NHS Scotland Resource Allocation Committee, 2006).

Policies and strategies for health and well-being

The White Paper driving NHS service delivery in Scotland, at the time of writing, was *Partnership for Care* (Scottish Executive, 2003d), and *Towards a Healthier Scotland* (Scottish Office, 1999) was the most recent White Paper for public health. In addition, key Scottish Executive Health Department strategies for primary care, mental health and improving health and well-being included:

- *Framework for Mental Health Services*, 1997
- *Improving Health in Scotland: The Challenge*, 2003
- *National Programme for Mental Health and Well-Being Action Plan 2003-2006*
- The *Quality and Outcomes Framework* for GPs (QOF), 2004
- *Community Planning Statutory Guidance*, 2004
- *Delivering for Health*, 2005
- *Community Health Partnership Statutory Guidance*, 2005
- *Delivering for Mental Health*, 2006.

NHS Boards make their own decisions about spending within a framework of standards and priorities which changes over the years. At the time of writing this was outlined in the Scottish Executive Health Department Delivery Plan Objectives and Targets within the *Draft Budget Statement 2007-2008* (Scottish Executive, 2006c). Each NHS Board was to develop and agree an annual Local Delivery Plan based on these objectives, incorporating a range of linked performance measures.

The NHS in Scotland was undergoing rapid change over the lifetime of the study presented in the thesis, and a recent history of developments is discussed here in order to describe the context for the study and the direction of travel for primary care and mental health services. One of the changes was that Community Health Partnerships (CHPs) replaced Local Health Care Cooperatives (LHCCs) as the structures under which primary care and mental health were managed and organised. The other main development was that *Delivering for Mental Health* (Scottish Executive, 2006a) was published in the month after the data collection was completed. *Delivering for Mental Health* was not included in the policy analysis carried out for the study (described in Chapter 4) as it was published at a time that was too late to drive change within the study period. However, it was included in the review of policies in this Chapter in order to identify future directions for mental health policy in Scotland.

Development of Community Health Partnerships and integrated service delivery

Designed to Care (Scottish Executive, 1997) was the Scottish White Paper which introduced a modernisation programme for the NHS of dismantling the internal market and working towards a system of integrated care. Primary care was to be delivered through Primary Care Trusts (PCTs) and Local Health Care Co-operatives (LHCCs). Scottish PCTs would have fewer budget holding responsibilities than their English counterparts, but provided staff such as nurses, allied health professionals and health centre management and were later (from 2002) merged with NHS Boards. LHCCs were to work in association with GPs, dentists, pharmacists and opticians who remained as independent contractors but were encouraged to be given places on boards of LHCCs. Objectives for LHCCs were described as providing services to patients, working with public health to plan for meeting the defined health needs of the LHCC population, clinical governance and to develop population-wide approaches to health improvement and disease prevention (Scottish Executive, 1997). The White Paper's plans introduced clear moves towards working in partnership with other agencies and for integration between primary care and the acute sector, and between primary care and social care services. This also introduced an objective for primary care to begin to take a population approach to improving health as well as to deliver services to individual patients.

In a separate but linked policy process, a national collaborative group called the Joint Future Group was set up by the Scottish Office in 1999 (Joint Future Group, 2000) to support the move towards integration between health and social services, including co-located services with joint funding and joint management. The Group was initially to focus on older people but then to move onto other client groups, and reforms eventually included services for people with learning disabilities, and people with alcohol and drug problems.

A survey in 1999 found that local working between LHCCs and social work had developed substantially since the introduction of LHCCs particularly in relation to community care, although joint working between primary and secondary care was less developed (LHCC Best Practice group, 2000). Recommendations from this report influenced the objectives of the next re-structuring of LHCCs.

The process of integration and further reform in Scotland continued in the next NHS White Paper *Partnership for Care* (Scottish Executive, 2003d). LHCCs were to evolve into Community Health Partnerships (CHPs) but the new bodies would have statutory underpinnings instead of being voluntary groupings, and would be part of the NHS Boards. CHPs were to establish a substantive partnership with Local Authorities (social work, housing, education and regeneration were specified), patient involvement through establishing Patient Partnership Forums for patients and staff, have more devolved budgetary responsibilities and a duty to promote health improvement (Scottish Executive, 2003d). The White Paper also required health boards to work with local authorities to ensure more effective working with social care in appropriate locality arrangements, and to integrate the management of primary and acute services. CHPs were expected to play an increasingly central role in integration of services locally as they matured into their partnerships in order to improve the health of local populations as part of an ongoing programme of development and modernisation in public services (Scottish Executive, 2003d).

CHPs were the main delivery mechanism for *Delivering for Health* (Scottish Executive, 2005b) with contributions from local authorities and community planning. *Delivering for Health* highlighted the changing health care needs in Scotland as a result of an ageing population with an increase in emergency hospital admissions and in people living with long term conditions. It emphasised: preventive medicine; more intensive and continuous care in the community, including support for self-care and targeting of resources; the introduction of anticipatory care to identify and treat those at greatest risk; and encouragement for people to take greater control over their own health. Although *Delivering for Health* was focused on health care provision, the general policy theme of integration was continued by asking GPs to move away from individual, practice based

services towards an ethos of teamwork. It also recommended that the roles of health professionals should be extended including widening the circle of professionals who can prescribe.

In *Delivering for Health* both GPs and CHPs were expected to base their services on local needs, and the GPs Quality and Outcomes Framework (QOF) was described as the mechanism that would align GPs' services with the needs of local communities. The QOF was developed for the new GMS contract, established by the *Primary Medical Services (Scotland) Act 2004.* The aim of the QOF, established as a voluntary scheme, was to provide financial incentives for achieving a specified level of points for a range of evidence-based indicators chosen primarily to achieve fewer hospital admissions through better management of chronic diseases (Pay Modernisation Team, 2004). The indicators and points were reviewed for the period of 2006 to 2007, to include a broader range of incentives including more mental health points; a register and needs assessment for people with learning disabilities; and a register of carers. *Delivering for Health* (Scottish Executive, 2005b) also included 5 performance targets for mental health: one to establish a register of mental health patients, one to bring long-term mental health patients in for assessment every 15 months and three relating to monitoring patients on lithium.

Improving health and well-being

Alongside the development of integrated health and social services, collaborative approaches to improving health and well-being were becoming established through formal and informal local partnerships. These became further formalised through the establishment of community planning. These approaches linked primary care into the planning structures for other public service provision, and provided the mechanism for collaborating to work towards population health improvement.

Health improvement and health inequalities

Partnership for Care gave a higher profile to health improvement and reducing health inequalities in CHPs than had been given to the LHCCs. *The CHP Statutory Guidance* document (Scottish Executive, 2004d) stated that the focus for health improvement should be on:

- Population health
- Influencing Boards through needs assessment
- Working with disadvantaged communities
- Health promotion
- Taking a wide perspective on health
- Working with partners
- Improving well-being, life circumstances and lifestyles especially in disadvantaged communities.

These arenas reflected Scottish public health and health improvement policy documents, that is, *Towards a Healthier Scotland* (Scottish Office, 1999) and *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003e), and arguably built on years of research and practice in public health, health education and health promotion. It also reflected that health improvement, as a step on from health promotion, was increasingly understood as a partnership activity between the health, local authority, voluntary and community sectors, rather than residing only in the health domain.

The focus in the CHP guidance for health inequalities was also stated as being to work in partnership to address the needs of the full range of community groups (Scottish Executive, 2004d). While partnership working was again reinforced as the appropriate approach to take there were no other indicators or objectives to clarify what might have been expected of CHPs in relation to addressing health inequalities. Instead, the Scottish targets for reducing health inequalities were included in *Closing the Opportunity Gap* (Scottish Executive, 2004a), therefore coming under the umbrella of regeneration policy to be delivered through the mechanism of community planning (discussed later in this section).

An annual report for health improvement was published in 2006 under the title of *Delivering a Healthy Scotland* (Scottish Executive, 2006b), describing itself as providing an update on the successes of the Scottish Executive's cross-cutting, whole Government approach to health improvement. It identified a slightly different four cross-cutting themes for the Scottish Executive than the *Draft Budget Statement 2007-2008* as discussed above, replacing equality with boosting educational achievement and used each theme as a chapter heading identifying health improvement programmes under each theme. An additional chapter included a section on health inequalities following sections on alcohol, tobacco and combined diet and physical activity. The health inequalities section described enhanced primary care services in deprived areas as the NHS contribution to a multi-agency approach to tackling health inequalities. It is argued that in using this format, the report suggested the NHS role in health inequalities to be a biomedical, behaviour change model alongside tobacco, diet and physical activity.

Equality and diversity

The *Equality Strategy* (Scottish Executive, 2000) represents a different but linked policy stream, where equal opportunities were to be promoted throughout the public sector and to prevent, eliminate or regulate against discrimination on the grounds of sex, marital status, race and ethnicity, disability, age, sexual orientation, social origin, beliefs or opinions. The strategy sits as a cross-cutting theme in *Building a Better Scotland* (Scottish Executive 2004a) but legislation has also helped to establish promotion of equality in the NHS and in society. First, the *NHS Reform (Scotland) Act 2004* placed a duty on NHS Boards to promote equal opportunities. More recently, the *Equality Act 2006* established a single Commission for Equality and Human Rights to prevent discrimination on the grounds of age, religion or beliefs and sexual orientation throughout British society. The *Equality Act* also introduced a "gender duty" on public authorities requiring them to promote equality of opportunity between men and women, and prohibited sex discrimination in line with the *Race Relations Act* and the *Disability Discrimination Act*.

Fair for All (Scottish Executive, 2002a) is the mechanism that the NHS in Scotland has developed to incorporate equality into health policy formulation and implementation. It was established by the Scottish Executive Health Department in 2002 to ensure that health services became "culturally competent", and would prevent discrimination on the basis of ethnicity. The following year, *Partnership for Care* (Scottish Executive, 2003d) stated that the principles of *Fair for All* should be extended so that health services would respond sensitively to the individual needs, background and circumstances of all people's lives and to eliminate discrimination and promote equality of opportunity for everyone. In 2006 the *Fair for All* scheme was extended and now covered ethnicity, gender, disability, age, faith and sexual orientation. It sought to integrate all equalities considerations into health policy formulation and delivery, and an Equality and Diversity Toolkit (Scottish Executive, 2004e) was produced to support NHS organisations in meeting the *Fair for All* objectives.

Community Planning

As mentioned above, health inequalities is one arena where joint objectives have been developed by the Scottish Executive as a move towards integrated public health structures. The mechanism for co-ordinating the planning and development of public service provision, including improving health and well-being in communities, was embedded in Community Planning Partnerships (CPPs) which brought together public,

voluntary, community and private sector agencies and interests for social, economic, health and environmental planning. CHPs and CPPs were now linked through legislation, policy and emerging practice.

The Local Government in Scotland Act 2003 provided the statutory basis for community planning in Scotland. The aims of CPPs were to engage communities in making decisions about public services and to ensure organisations work together to provide better public services. They were also intended to provide a better link between national and local priorities by influencing national direction, but to co-ordinate the delivery of national priorities in a way that is sensitive to local needs and circumstances (Scottish Executive, 2004f). The Act also gave the NHS and other public bodies a "duty to participate" in the community planning process which was reinforced for the NHS by the *NHS Reform (Scotland) Act 2004.* Participation was specified in relation to health improvement by charging NHS Boards and Local Authorities with responsibility to work together to produce local health improvement plans. In addition, amongst other powers, the *Local Government in Scotland Act 2003* gave Local Authorities a power of well-being which expected them to take a creative and innovative approach to improving well-being as well as providing statutory services. The Community Planning Guidance suggested that key factors that might contribute to promotion or improvement of well-being might include economic factors such as availability of jobs; social factors such as housing or safe communities; environmental factors such as clean air, water and streets; and health factors such as promotion of good physical, social and mental health, and policies that impact on health inequalities (Scottish Executive, 2004g).

Mental health services and improving mental health and well being

The most recent strategy for mental health at the time of writing was *Delivering for Mental Health* (Scottish Executive, 2006a), which superceded the *Framework for Mental Health Services* (Scottish Office, 1997). As the *Framework for Mental Health Services* was the strategy in place at the time of the data collection for this study, a discussion of both strategies are included here. In addition, the *National Programme for Mental Health and Well-Being* was in place to focus on prevention and promotion.

The *Framework for Mental Health Services* was created following a report on closure of psychiatric hospitals in 1995 in which the Scottish Office committed to providing direction for the development of local, comprehensive strategies for mental health services. The focus was to be on joint planning and service provision between health, social work and housing for people with severe and/or enduring mental health needs including dementia, but not to include people with learning disabilities, substance misuse or alcohol

problems unless they also had a mental health problem. Implementation of the *Framework* was supported by a range of funding packages and documents including reports on mental health needs assessments, research and development initiatives and guides to good practice. In addition, the Framework was added to over the following years until 2004 with additional service profiles or good practice guidance, including for postnatal depression (1999 and 2004), talking treatments (2001), eating disorders (2001) and dementia (2004). The *Framework* also emphasised that there was a need to contribute to prevention as well as treatment, although its detailed plans focused on treatment of diagnosed mental illness (Scottish Office, 1997).

Prevention and mental health promotion was taken up by the *National Programme for Improving the Mental Health and Well-Being of the Scottish Population* (Scottish Executive, 2003b) which was established in 2002 to integrate positive mental health and well-being into the wider public health and health improvement agenda, including enabling effective prevention of mental health problems. For example, among many other objectives, the Programme intended to support training for service providers on the use of the evidence in mental health improvement, support ongoing programmes such as working with the public and voluntary sectors to improve services for people with anxiety and depression in the community and to begin to identify key issues in relation to mental health/mental illness and inequalities (Scottish Executive, 2003b). The Programme has undergone a review in order to inform strategic direction for mental health improvement in Scotland which is expected to report in 2007.

Delivering for Mental Health (Scottish Executive, 2006a) was a very different document from the *Framework for Mental Health Services.* Carrying forward the theme of integration between agencies, and building on the *Mental Health (Scotland) Act 2003*, it applied the principles for achieving improved health care services outlined in *Delivering for Health* (Scottish Executive, 2005b), but also looked beyond the NHS to partnerships with the local authorities, the voluntary sector and users and carers. It took a broad view of mental health including acknowledging inequalities in mental health, and advocating a population approach to tackling mental illness, linking this with social inclusion, poverty and deprivation. It also included a focus on depression and anxiety along with severe and enduring mental illness as well as on suicide. In addition to flexible delivery mechanisms, it proposed a range of assessment tools and performance management frameworks and identified priorities, including the non-medical management of mental health such as psychological treatment, peer support, and halting the increase of anti-depressant prescribing.

The NHS reforms in 2004 gave Community Health Partnerships (CHPs) responsibility for managing or coordinating integrated mental health services and psychological

services (Scottish Executive 2004d). Integration of mental health services between Joint Futures and CHPs was expected to improve access to appropriate support for mental health service users and their carers whether services were provided by the NHS, local authorities, or the voluntary sector (Scottish Executive 2004h). The list of functions for this integrated approach was long, such as establishing links between the NHS and a wide range of local authority and community based services for mental health problems, including health promotion. The process of integration was said to have potential for establishing a relationship between primary care, social circumstances and mental well-being.

Section 5: Conclusion – inequalities in mental health and primary care

Introduction

During the period chosen for the study (2002-2006) there was a clear emphasis in Scotland for accelerating economic growth, and the main aim for the public sector was to contribute to this. The health care sector was regarded as a major contributor to economic growth by attracting substantial research resources from commercial sources as well as contributing to strengthening the potential future workforce. Health and social services were being integrated primarily to deliver services more efficiently and to save money, although the main focus for savings appeared to be for re-investment back into the public sector rather than for direct benefits to patients or the health of the population. Independent contractors in primary care, that is the GPs, pharmacists and dentists, were included in the drive towards integration although their independent status was not immediately at risk of being challenged. Additional resources for health and social care would be required as the population continued to age, to become more dependant and to live longer with chronic diseases. The responses to these population problems assumed that more efficient and effective health care could be provided with clearer tools and pathways for interventions, together with financial incentives for independent contractors and medical consultants in return for them accepting more directive management systems. There was also a range of initiatives to encourage patients to take on more self-help.

At the same time the tasks of improving population health and reducing inequalities on behalf of the NHS were being given to Community Health Partnerships (CHPs) who were unlikely to have built up expertise or capacity for this alongside service delivery imperatives. At the time of writing, there was no specific guidance for CHPs for reducing health inequalities other than expectations that this would happen if CHPs worked in

partnership with Community Planning Partnerships (CPPs), the voluntary sector and community groups. Inequalities in mental health were also proposed to be tackled in this way, with the CPPs' increased focus on deprivation and poverty. However, incentives and performance measures continued to favour service delivery targets such as waiting times and disease outcomes, creating some confusion as to how primary care was to prioritise social determinants of health in order to address inequalities. Research highlighted that primary care can impact on access and outcomes of service provision differentially, although not always in a positive sense, and some of the findings from this research is described below.

The role of primary care in addressing inequalities in health

Primary care was said to have been placed at the centre of NHS efforts to reduce the effects of inequalities because of its knowledge and information about local health needs (Department of Health, 2001b). In addition, it was thought to be able to provide continuous, comprehensive and co-ordinated care to both individuals and communities (Primary Care Modernisation Group, 2002).

Studies of the role of primary care in relation to inequalities have demonstrated that some population groups more than others have less access to, and poorer outcomes from, NHS services. For example, a study in the West of Scotland found that socio-economically deprived patients were 44% more likely than affluent patients to develop heart failure but 23% less likely to be followed up by their GP on an ongoing basis (McAlister *et al*, 2004). Inequalities in outcomes from NHS treatments have also been demonstrated in relation to gender, ethnicity and, to a lesser extent, socio-economic status (Adamson *et al*, 2003). The physical situation of frontline health services might also contribute to inequalities in health and there have been many descriptions of the existence of the "Inverse Care Law" within healthcare services since it was first identified by Julian Tudor Hart in 1971 (Tudor Hart, 1971). The Inverse Care Law refers to the unequal distribution of services where there are less health services in areas where needs are greatest, although the term is also used by some researchers to refer to unintentional provision of services to those who are more able to articulate a need, rather than to those who are most in need of services.

An example of inequality in primary care comes from a study carried out with GPs in Glasgow. The study found that increasing socioeconomic deprivation was associated with shorter consultations as well as there being higher prevalence of patients with psychological distress, which generally required a longer consultation time for identification. The study concluded that the GPs in the deprived study areas were under

more time pressure, and suggested that this resulted in patients who were not psychologically distressed having shorter consultations than they might have had if they attended GPs in less deprived areas (Stirling *et al*, 2001). Another example of inequality in health interventions can be found in population health, where interventions which are effective in improving health across a population have been found to be ineffective in reducing the inequalities gap (Acheson, 1998). For example, a study of over 40 countries demonstrated that even specifically "pro-poor" health interventions attained better coverage among better-off groups than disadvantaged ones (Gwatkin, 2003).

Health inequalities targets were set in Scotland not through healthcare policy but under *Closing the Opportunity Gap* as part of the Communities portfolio, which built on previous action points set for Scotland's social justice policy (Scottish Executive, 1999). Twenty-nine action points were set for creating the conditions that, if met, were thought to reduce social inequalities and consequently, close the health gap. Action points covered reducing child poverty, helping young people to develop life skills, providing work opportunities for all those who are able, supporting older people by providing a decent quality of life, and building strong communities. The Scottish Executive published annual reports on progress with the 2002 version stating that their programme of joint working and joint funding across departments including health have had some successes, such as in reducing the number of children living in low income households (Scottish Executive, 2002). Measures that reduce child poverty are thought to be important in preventing mental and physical health inequalities, since research has demonstrated that low childhood socio-economic status has been found to have an adverse effect on adult health, irrespective of later upward social mobility (Poulton *et al*, 2002).

There is limited evidence for actions that primary care can take to reduce health inequalities, reflecting the strong bias in inequalities research in general towards measuring and describing differences rather than evaluating or describing interventions (Millward *et al*, 2003). In any case, research evidence has been found to have a limited influence on policies in Scotland in relation to health inequalities (Petticrew *et al*, 2004; Whitehead *et al*, 2004; Mackenzie *et al*, 2006). Macintyre *et al* (2001) highlighted that while the lack of studies on the effects of interventions should not be used as an excuse to do nothing there is evidence that policy based on unproven and misguided information can have adverse effects. On a more positive note, one systematic review on the effectiveness of health service interventions to reduce health variations concluded that there are some interventions which the NHS can support either alone or in collaboration with other agencies such as removing barriers to accessing health care (Arblaster *et al*, 1996). In addition, there are some studies describing an increase in

access for disadvantaged population groups following concerted efforts of services, for example, in cervical screening (Baker and Middleton, 2004).

Primary care policy and inequalities in mental health

As noted earlier in this Chapter, GPs see around 80% of their practice population in a year, and more than two thirds are likely to consult on mental health. This has been estimated to be equivalent to about three quarters of the people who suffer mental health problems, suggesting that a proportion of sufferers are missed or remain unseen by primary care (Rogers and Pilgrim, 2003). For patients coming forward, the roles of primary care in mental health are primarily to diagnose accurately, treat or refer as appropriate, try to prevent hospital admission and to keep prescribing at a minimum (Scottish Executive, 2006a).

A review of evidence for interventions that can improve mental health (Mentality, 2002) concluded that there is robust evidence for a number of primary care interventions for improving mental health; including enhancing well-being and self esteem, benefits advice, improving access to services for vulnerable groups, supporting employment schemes, and prescribing exercise and learning activities. This perspective backs up an earlier review which recommended that for adults, mental health promotion should be addressed in the context of general health promotion interventions (Tilford *et al*, 1997). *Improving Health in Scotland: The Challenge* (Scottish Executive, 2003e) stated that its main aims were to improve the health of all people in Scotland and to narrow the health gap. It also stated that promoting positive mental health and preventing mental ill health were essential components of all health improvement work. However, attention has not been given to how practitioners implement such recommendations. Kelly *et al* (2004) found that the use of evidence to change practice by primary care practitioners is likely to require an elaborate process of turning evidence into advice and guidance, followed by supporting change within complex systems. In addition, despite policy recommendations, mental health promotion and improvement is not included in performance assessment or clinical governance for CHPs or in the GP contract, which is likely to give it less priority than other aspects of service delivery and development. To date, there has been very little said in policy for addressing inequalities in mental health.

In conclusion, it appears that the roles for primary care in addressing health inequalities or inequalities in mental health appear to be desirable by policy, but no guidance or support is offered that might help primary care to introduce new practice. Researchers and commentators have proposed the need for change within the NHS to meet new objectives for improving health. Focusing on the health and well-being of a population

rather than illness was described as a new perspective for primary care (Gillam *et al*, 2001), and an All Party Parliamentary Group concluded that major cultural change would be required for primary care to deliver on targets for the improvement of the health of their populations (All Party Parliamentary Group on Primary Care and Public Health, 2002). Increasing integration between the NHS and other agencies and structures including local authorities, community planning and service users appears to be the locus in the public sector for improving health and well-being and reducing inequalities. In the absence of clarity in policy for primary care to adopt practices that might support addressing inequalities in mental health, and in the light of the evidence for health inequalities summarised in this chapter, it is argued that primary care could potentially contribute to widening the health gap rather than narrowing it.

Chapter 2

Aim and research questions

Introduction

The literature and policy review described in Chapter 1 identified that inequalities in health status between affluent and deprived groups were clearly widening, and that reducing inequalities in health appeared to be desirable by health and social policies. At the same time, mental health was becoming increasingly visible in policies as an aspect of population well-being, which created links between mental health and social circumstances rather than focusing exclusively on directing mental health services for individuals. Primary care was thought to be a key structure to contribute to these policy aspirations through services to individuals and through working with partners across populations. However, policies lacked clear, evidence-based interventions to guide primary care practice in reducing inequalities, and research in primary care demonstrated more gaps in service provision than successes. With the lack of clarity in policy and the lack of research evidence the question remained as to whether primary care structures were in a position to contribute to reducing or preventing inequalities in mental health.

Development of the research questions

My intention for the study was to explore primary care roles in inequalities in mental health, but perspectives on primary care practice for addressing inequalities in mental health were largely absent from the reviewed literature. While health inequalities had been highlighted as an apparent priority for health and social services, anomalies were identified relating to implementation such as the lack of guidelines. In addition, research evidence suggested that primary care might contribute to increasing inequalities rather than reducing them. More information was needed to assess the implications of inequalities in mental health for primary care practice in order to find a focus for the study.

To this end practice perspectives were sought at an early stage from a wide range of stakeholder groups in Scotland including professionals and managers working in primary care and mental health, senior public health specialists, academics, policy makers and the voluntary sector. Informal discussions were set up with key informants to help explore further some of the strands identified in the literature review, and to ensure that

research questions for the study would be relevant for current Scottish primary care practice. The results of these discussions are reported in full in Appendix 1 and summarised here.

The discussions with key informants suggested that primary care structures in Scotland at that time did not appear to be designing services around inequalities in mental health or inequalities in health in general. Informants who worked outwith primary care believed that primary care should and could do more about inequalities. In contrast, most informants working within or closely with primary care appeared to be more cautious about taking on inequalities, citing a lack of staff or funding in general within primary care and mental health services. Most informants believed that more effort was required at planning and service delivery levels to link evidence with practice and to forge stronger links between public health and primary care for inequalities to be tackled effectively.

These discussions confirmed that while policies had an overarching aim to tackle inequalities there was not an obvious locus or starting point within primary care for either health inequalities or inequalities in mental health. The structures around primary care could envisage a role, but managers and clinicians within primary care appeared to believe that they should have other priorities, such as integration with the acute health sector or social services. At the same time informants from all perspectives had given examples of practice where primary care staff were already engaged in activity that appeared to be relevant to inequalities in mental health.

In conclusion, the informal discussions uncovered a confused picture which did not completely rule out a role for primary care in inequalities in mental health, but lacked clarity as to what this should be at all levels from community based activity through to policy. Consequently there appeared to be potential for further, in-depth exploration to clarify the respective primary care roles in inequalities in mental health for different levels of policy, planning, management and service delivery, and the links between them. The clearest dimension appeared on the surface to be the health policy statements of addressing health inequalities being described as an overarching aim. These were taken as the starting point for the study so that policies were assumed to have expectations for primary care to address inequalities in mental health and the ensuing exploration would be to uncover primary care's responses to these expectations.

The research questions were developed further following a process of identifying a suitable framework for the exploration. Interpretive policy analysis (Yanow, 1999) was found to offer a useful approach and a discussion of its application to the study is given

in Chapter 3 Section 1. In interpretive policy analysis, communities of meaning are identified in relation to a policy or policy objective in order to make sense of the different interpretations each community might make of the same policy issue. Four communities of meaning were identified for this study as follows: policymakers as expressed through policy documents; local strategic planners and service managers; practising professionals in primary care and mental health; and service users. The research questions were then refined and finalised with these communities of meaning in mind.

The aim and research questions are given below.

Aim

The aim of the study was to identify the contribution that a primary care organisation makes to reducing and preventing inequalities in mental health.

Research Questions

1. What are the expectations from policy on primary care organisations to reduce and prevent inequalities in mental health?

2. What is meant by "primary care" and who are the key practitioners within primary care involved in work on inequalities in mental health?

3. What information is available to the primary care organisation about the patterns of mental health and health inequalities in their area?

4. What information is available to the primary care organisation about interventions that primary care can implement to reduce and prevent inequalities in mental health?

5. How are inequalities in mental health incorporated into primary care strategy and planning within the primary care organisation?

6. How do primary care professional staff access and interpret information about inequalities in mental health from research and policy?

7. How do primary care professional staff apply an understanding of inequalities in mental health in practice?

8. What are the factors that help and that hinder primary care professionals to contribute to the reduction and prevention of inequalities in mental health?

9. What more needs to be done by primary care to contribute to reducing or preventing inequalities in mental health?

Chapter 3

Methods

Introduction

Chapter 3 describes the methods chosen to collect and analyse data, and their application to the study. Section 1 provides the rationale for the choice of methods and techniques used in the study, Section 2 the process of data collection, and Section 3 describes sorting and analysing interview data.

Section 1: Choice of methods and techniques

Introduction

As indicated in Chapter 2, interpretive policy analysis was used as the framework for the study. Other approaches considered in relation to the research questions were to carry out a case study or to engage in action research, and these methods are reviewed briefly in Section 1 before going on to discuss the selected method. The research questions, as described previously in Chapter 2, were exploratory in nature, which required policy analysis and qualitative enquiry using observation, document analysis and semi-structured interviews. In addition, a vignette was used to structure part of the interviews with one group of respondents, and this is also discussed in Section 1.

Approaches explored and rejected

Case study

A case study approach was said to enable an in-depth analysis of all the factors within a defined structure (Keen and Packwood, 1995). Its aims include to gain a better understanding of a situation (Yin, 2003) and to highlight areas for further exploration (Bergen and While, 2000). This might have offered an in-depth exploration of a wide range of responses from a primary care organisation to inequalities in mental health, but given the lack of discussion of this topic in the research literature reviewed in Chapter 1, there was a risk that a case study would be attempting to examine disparate activity and

incomplete knowledge. If that were to be the case not only would there be a limit to the potential data that could be collected, but the presence of a researcher uncovering this fact might have appeared threatening to a group in the early stages of grappling with complex issues. The case study approach was therefore rejected.

Action research

An alternative to a case study approach was action research which was thought might offer an opportunity to stimulate a piece of work at the same time as investigating its context and new developments. Action research was described as attempting to generate knowledge of a system while at the same time trying to change or develop it (Reason and Bradbury, 2000), and it enables the researcher to work with people rather than "on" them, drawing on practitioners' experience (Meyer, 2000). A typology of a range of approaches to action research which moves through varying degrees of balance between the "action" and the "research" was described by Hart and Bond (1995), and the approach that would have most suited this study was that of organisational action research, since it was balanced more towards research than action. While action research would offer an opportunity to stimulate work where there might have been none, there were no accepted, evidence-based interventions for reducing or preventing inequalities in mental health. This meant that any new work would be developmental in nature and potentially difficult to define, but one of its attractions was that it would have offered an opportunity to make a contribution to the primary care organisation in return for access to study their work. The potential risks outweighed the benefits of taking this approach to the study, but the principles of making a useful contribution to the organisation and clarifying from the outset the boundaries of the researcher role were retained within the chosen method as described below.

The chosen framework: interpretive policy analysis

The framework for interpretive policy analysis adopted by the study was drawn from an account by Yanow (1999). Yanow applied the approach to health care and community work settings, which shared some similarities with the setting for this study within a primary care organisation. Yanow's interpretive policy analyses focused on human meaning and the reality of social processes, in contrast to traditional policy analysis which addresses the objective numerical analysis of policy facts. Interpretive policy analyses can help to reframe a policy debate or to generate new policy ideas by synthesising opposing arguments rather than advising on the choice of one proposal over another as in traditional methods. Stakeholders' interpretations of policies are

central to these analyses, since the wording of policies cannot be assumed to mean the same to everyone involved in implementation. Implementers and stakeholders are described as being from one of three "communities of meaning" of policymakers, implementing agencies and service users. Each community might also have several internal communities with different interpretations of the same policy. Yanow (1999) argued that stakeholder interpretations of policies were the drivers for change in practice rather than the policies alone.

Yanow described steps in interpretive policy analysis as follows:

- Identify the policy issue
- Identify the communities of meaning
- Identify the discourses, that is, the meanings being communicated
- Identify points of conflict reflecting different interpretations by different communities
- Show implications of different meanings for policy formulation or action.

In this study, the policy issue was identified as inequalities in mental health as it might apply to primary care. The four stakeholders' communities of meaning were taken to be (i) policymakers, (ii) primary care managers and strategic staff, (iii) frontline professionals from primary care and mental health, and (iv) a service user's experience. Service users' perspectives were not explored in the study, but professionals were questioned using a vignette to elicit the approaches that they might take to a service user and therefore to inentify the service a patient might expect to receive. Data were collected in different ways from each community of meaning: through document analysis of national health and social policies; document analysis of reports and strategies produced by the primary care organisation; observation of a mental health needs assessment; and semi-structured interviews with strategic staff and frontline professionals. Interviews with frontline professionals included a vignette to identify the services that a patient might expect. The methods and techniques and their application to the study are described below.

Document analysis

In an interpretive policy analysis, the researcher is interested in the ways in which the policy issue is being framed by all parties in a debate, which can be articulated verbally or in formal or informal documentation (Yanow, 1999). It has been said that any full sociological analysis must include "material traces" as well as interview data, and document analysis can provide an important element alongside other methods

(Hodder,1998). Analysis of text-based documents in a study can include documents already in existence such as policies, reports, minutes of meetings, and documents generated from the process of a study including diaries, tables and lists (Mason, 2002). Documents can also be used to help trace processes, or they can be used along with other methods of data generation. Fairclough (2003) believes that interpretations of texts as well as the texts themselves are important in researching meaning-making, therefore document analysis works well alongside interviews and observation.

Mason (2002) stated that documents are constructed in particular contexts by particular people with particular purposes and with intended and unintended consequences, and their analysis requires a reflexive process involving the author, the text and the reader (Fairclough, 2003). First, the perspective of the authors and the language or tone they apply to creating the documents is presented through production of the text, and second, the text itself is displayed using conventions and other devices to present a particular view. The third element in a document analysis is the reception of the text and the ways in which the reader makes their interpretation (Fairclough, 2003). Rather than being a passive process, reading is an activity to which the reader brings their cultural knowledge, knowledge of similar texts and their unique life experience (Atkinson and Coffey, 1997). Meaning emerges from the analysis through the relationship between the three elements, with the researcher's own frame of reference providing the springboard for a process of dialogue between the researcher and the text (Mason, 2002).

Atkinson and Coffey (1997) recommended that an interpretive standpoint rather than a critical or judgemental stance should be taken in document analysis. They suggested that documents should be taken as data in their own right with a distinct version of social reality that can be explored through a systematic and rigorous analysis. Atkinson and Coffey (1997) also suggested focusing on the form or text and language used; the relationships between other texts and the ones under examination which they described as intertextuality; and the conventions of genre. Fairclough's (2003) method of Critical Discourse Analysis provided more detailed guidance for analysing texts such as close reading or identifying meanings coming from the interplay between position, interests, values and intentions of the producers and the position, knowledge and values of the receivers. Different combinations of methods can be used depending on the context. For example, some texts are transparent with interpretation being straightforward while others require a great deal of thought about what is meant (Fairclough, 2003).

Another method of discourse analysis that has influenced current social policy is that developed by Foucault, which has been adapted to suit different studies such as one described by Carabine (2001). Carabine was less concerned with the ways in which discourse is structured and governed by internal rules, and more interested in how

discourse acts as groups of related statements which cohere to produce meanings and effects in the real world. She provided an example of the different ways in which lone motherhood was "spoken of" in Britain in the 1990s through speech, official texts, creative writing and practice, and the picture that could be built from these perspectives. Carabine (2001) found that interactions between different discourses could change the ways in which the issue was presented.

Two separate processes of document analysis were used in the present study. The first was to analyse nine national health and social policy documents using some of the close reading techniques and explorations suggested by Fairclough's Critical Discourse Analysis and also drawing on Carabine's approach to explore interactions across the policies. Reading behind the text was important in the analysis of the national policy documents to help to understand some of the influences behind the document's portrayal of health inequalities and to identify links or conflicts within and between the policies. The process used for the policy analysis is described below in Section 2 of this chapter and the findings are given in Chapter 4. The second document analysis was to describe the context for an observation of a mental health needs assessment and to identify whether local strategies and reports influenced the primary care organisation to take action on inequalities in mental health. The process of, and findings from, the observation of the mental health needs assessment are described in Section 2 of this chapter and Chapter 5 respectively, and the rationale for the method is given below.

Observation

In addition to document analysis of local strategies and reports, data were collected from a mental health needs assessment process through observing meetings of the mental health needs assessment steering group, including the outputs from the group such as minutes, reports and emails (full discussion of the rationale for the observation is given below in Section 2). Additional interviews were also carried out with some key members of the steering group as well as other strategic staff to further explore their understanding of inequalities in mental health. Observation is said to involve the researcher immersing themselves in a research setting and systematically observing dimensions of the setting such as interactions, relationships, actions and events (Mason, 2002). The researcher has to be clear about the role they might play in that setting. For example Adler and Adler (1998) described two typographies of researchers' potential roles as firstly, complete participant, participant-as-observer, the observer-as-participant, and the complete observer. The second typography focused on membership and described the roles as complete-member-researcher, active-member-researcher and peripheral-member-researcher. Mason (2002) suggested that the researcher cannot

always plan for the role in advance and that the role is likely to change in relation to events, and may have to be constantly renegotiated. The researcher should therefore be aware of the potential for different roles in advance, continue to be aware of them throughout the data collection, and understand their relevance in the interactions, situations and setting under study (Mason, 2002). Data from an observational study can be recorded in a variety of ways including audio and video recordings, fieldnotes and photographs (Mason, 2002). I explain my negotiated role as observer in Section 2 below.

Interviews

Semi-structured interviews were used in the study to gather data from key informants working as frontline professionals or as strategic managers within the primary care organisation. Interviewing informants is thought to be the most common method used in qualitative research (Mason, 2002). In order to access personal interpretations of events and processes, people need to be encouraged to express their constructions in their own terms (Jones, 1985), and conversational interviewing gives the informant more freedom and control of the information compared with surveys (Mason, 2002). Informants should be selected on the basis of being articulate, reflective and appropriate to the study, and can be recruited through purposive sampling by asking initial contacts to suggest further participants (Glaser and Strauss, 1967). However, the sample should be selected to test the researcher's argument and not only to support their theories (Mason, 2002).

Qualitative interviews aim to go below the surface of a topic, explore peoples' views in as much detail as possible, and uncover ideas that were not anticipated at the outset of the research (Britten, 1995). They also provide an opportunity to explore concepts that are not necessarily formed in people's minds (Mason, 2002). Qualitative interviews can range from being unstructured when the researcher has little prior knowledge of a topic (Morse and Field, 1996) to being structured around areas of interest for consistency between informants (May, 1991). Semi-structured interviews lie between these and usually use a list of open-ended questions (Morse and Field, 1996) designed to enable the researcher to probe respondents' answers (Britten, 1995). Both directive and non-directive questioning can be used to explore a subject and interviews can be carried out with single interviewees or as group interviews (Hammersley and Atkinson, 1983).

Interviewers are said to need a range of technical skills beyond the social skills required for more common forms of social interaction (Boulton and Fitzpatrick, 1994). Skilful interviewing depends on the extent to which the interviewer establishes rapport, elicits

information without controlling the interview and records information accurately (May, 1991). The interviewer is urged to plan and prepare for the interviews but must be able to think on their feet to decide how best to ask what they really want to know (Mason, 2002). Active listening is important for the interviewer in order to assess the relationship of the answers to the research focus and to plan the future course of the interview (Hammersley and Atkinson, 1983).

There should be a good balance between talking and listening, and the balance is likely to be different in each situation (Mason, 2002). Morse and Field (1996) suggest that interviews should start with small talk, a description of the interview procedures and then asking demographic information before moving on to the main issues. Questions must be open-ended, sensitive, neutral and clear, starting with the easier topics and proceeding to more difficult or sensitive ones (Patton, 1990). Most studies involving interviewing capture the interview by recording them and adding information later from written sources and field notes (May, 1991). Skills required for interviewing should not be underestimated as at any one time during an interview the interviewer may be listening, interpreting, deciding on appropriateness to the research topic, thinking about new ways to find out what they want to know, assessing body language or changes in demeanour, formulating a response, reflecting on something that was said earlier in the interview, keeping an eye on the time, checking the recorder and taking notes (Mason, 2002).

Data collected in an interview should be regarded as being unique to that particular encounter. For example an informant might feel that they had not been able to express their thoughts clearly or they might have told the researcher what they thought they might want to hear (Burnard, 1995). However, Hammersley and Atkinson (1983) believe that the inferences that can be drawn from data are more important than the issue of the accuracy of the information given to the interviewer.

The interviews in the study used a combination of non-directive and directive questions to encourage respondents to describe and explore their jobs, their knowledge and understanding of inequalities and, for frontline staff, to respond to a set vignette about a patient. The vignette is discussed below and the interview process is described in more detail in Section 2.

Vignette

A vignette was used in the study as part of the semi-structured interview to identify models of working adopted by the respondents. The vignette aimed to help to illuminate

the importance that participants gave to the social circumstances of a patient and their responses to them, in order to identify whether they were sensitive to the impact that social inequalities might have on the patient's mental health. Vignettes are usually brief written, spoken or pictorial representations of people in situations which can stimulate more meaningful and considered answers than straightforward questions particularly when eliciting attitudes (West, 1982). Vignettes can be used both in surveys and in qualitative research (Barter and Renold, 2000). They have been used in studies of similar topics to this study such as in eliciting attitudes of general practitioners and primary care nurses to patients with psychological and physical problems (Dale and Middleton, 1990) and to patients with advance directives (similar to living wills) (Thompson *et al*, 2003). If used at the beginning of an interview, vignettes can help to develop rapport and facilitate a discussion around participants' opinions and the terms they use (Barter and Renold, 2000).

A short vignette can include many references to key variables of interest to the study but there should be a balance between giving too much information that results in narrowing the scope for interpretation and too little information that leads to too many different interpretations within the study (West, 1982). In any case, the characters and storylines used for vignettes must be believable to respondents (Finch, 1987). Dale and Middleton (1990) used a vignette with general practitioners but found that vignettes lacked the interpersonal cues and background information important in real life consultations, and they were concerned that practitioners might adopt "professionally desirable" responses in order to portray themselves more favourably. The researcher cannot know what additional details are being filled in by respondents (Finch, 1987), although if vignettes are being used in a non-directive way respondents are allowed to define the situation in their own terms and can be encouraged to provide the factors that influence their decisions (West, 1982).

Turton *et al* (2000) used a series of vignettes to describe four potential levels of response to a primary care patient ranging from a biomedical approach with a sick individual through to a public health model. The vignette in the present study was used in a similar way to explore whether responses corresponded more closely to biomedical or social models of health. The development of the vignette and its application in the study is discussed in Section 2.

Qualitative Data Analysis

The overall aim of qualitative data analysis is said to be to transcend factual data to theoretical ideas by finding coherent patterns of ideas, thought, utterances and beliefs

(Coffey and Atkinson, 1996). In this study, grounded theory provided a framework for the data analysis as it offered a way of developing new theory drawn from the data and was said to offer insight, enhance understanding and to provide a guide to action (Strauss and Corbin, 1998). In grounded theory, as for other qualitative methods, data can be gathered from a variety of sources including interviews, observations, documents, records and films. Data are organised and interpreted through procedures of conceptualising, reducing, elaborating and linking categories before being presented as written or verbal reports (Strauss and Corbin, 1998). Strauss and Corbin (1998) described analysis as being the interplay between researchers and data, which demands creative thinking at the same time as maintaining critical thinking and a degree of rigour. Theory can then be generated through a process of comparative analysis which can be descriptive or conceptual depending on the aim of the research (Glaser and Strauss, 1967). Analysis should not be left to the end of the research process but instead data collection, analysis and theory generation should develop together with each part of the process informing the other (Strauss and Corbin, 1998).

A number of texts have provided lists of steps to guide researchers in analysis (for example Miles and Huberman, 1994; Burnard, 1995; Coffey and Atkinson, 1996) but most authors also stress that lists should not be followed prescriptively as the researcher should be guided by the context of their study. In any case, the first stage in analysis is usually to understand the text before breaking it down and coding. Mason (2002) suggested that textual data is read by the researcher on three levels: of a literal reading focusing on what is there; an interpretative reading by looking beyond the data to what can be inferred from them; and a reflexive reading, locating the researcher as part of the data. Coding helps the researcher to sort the data and to uncover underlying meanings (Morse and Field, 1996). The important analytic work lies in establishing and thinking about the linkages between codes, data categories and concepts, and the process of coding would be seen as part of the interrogation of the data (Coffey and Atkinson, 1996).

ATLAS.ti, a qualitative data software programme, was used in this study for coding and sorting data from interviews and from policy documents (ATLAS.ti, 2006). At the time of writing, ATLAS.ti and Nud*ist (now named NVivo) were regarded as the two leading software packages available for qualitative data (Barry, 1998). While such packages were designed to assist the researcher in the mechanical sorting and retrieving of data, some writers have warned of their ability to influence the ways in which researchers think about data and theory, including the dangers of encouraging inappropriate use of quantitative approaches within a qualitative study. A researcher's choice of software package is said to depend on a number of factors including experience, degree of complexity of a project, inherent methods of learning and processing information, and

confidence in computer use (Barry, 1998). NVivo was considered for the study but ATLAS.ti was thought to offer opportunities for more creative and flexible linkages between texts.

Ethics

There are a number of ethical issues that must be considered when conducting qualitative research, and those of particular relevance to this study included respecting the rights and confidentiality of respondents and potential respondents, and to take steps to maintain high professional standards throughout the study. Ethical principles include that the reasons for the research should be explicit at the design stage, clear boundaries should be set during data collection and the final product should be good quality research that protects the rights of informants (Mason, 2002). Respect for the rights of individuals means that potential informants can decide whether or not to participate in research with the researcher obliged to obtain informed consent (Singleton and McLaren, 1995). If research is to do no harm to subjects, researchers must be appropriately qualified and must consider the potential effect of their questions on participants (Singleton and McLaren, 1995).

In data analysis, the researcher has an ethical responsibility to ensure that conclusions are well founded and that appropriate generalisations are made (Mason, 2002). Anonymity and confidentiality must be maintained in the reporting and disseminating process including measures taken to ensure restricted access to data such as preventing identifying information being logged on to a computer and maintaining locked files (Singleton and McLaren, 1996).

Regular meetings with supervisors and adherence to the university code of conduct provided a professional research standards framework for this study. Ethical and management approval which encompassed all of the issues highlighted above, were granted by the primary care organisation identified as the study site before embarking on data collection. Copies of the letters of approval are included as Appendix 2.

Validity and reliability

Huberman and Miles (1998) advocated a reflexive approach in qualitative research where the researcher provides a continuous, self- conscious documentation of all factors that influence how decisions were reached, in order to enable the validity and reliability of a study to be judged. The researcher is then acknowledged as being part of the study

as the research instrument, rather than using standardised tools, as well as being part of the process of developing theory from data (Hammersley and Atkinson, 1983). In qualitative research, validity is described as a judgement of whether the researcher is measuring and explaining what they claim to be measuring and explaining (Mason, 2002). Miles and Huberman (1994) suggested a list of thirteen tactics for preventing researcher bias and increasing readers' confidence in findings including checking for representativeness of coding categories, checking for researcher effects such as stimulating behaviour in interviewees that would not have occurred under normal circumstances, checking the meaning of results that do not fit with others, following up surprises, and looking for negative evidence by having someone check field notes.

Reliability of a research study relates to the accuracy of the research methods and techniques (Mason, 2002). Reliability of a qualitative study is assessed by following the "decision trail" where the researcher clearly justifies and describes the reasons behind taking decisions (Sandelowski, 1986). In addition, the relationship between interpretation and the evidence should be made clear by including referenced quotations from respondents (Mays and Pope, 1995).

The research process was supervised by two experienced professors and additional steps were taken to test findings from the policy and data analysis by "swapping" with a colleague (described in Section 2), and seeking additional advice where relevant. Decision trails and a reflective approach are presented throughout the thesis, from the development of ideas for the study in the Introduction through to the final conclusion, in order to assist judgement of validity and reliability. In addition, my prior perspective is set out below to clarify my standpoint.

Starting point: the researcher's prior perspective

Having read and debated widely about definitions, opinions and research on health inequalities over many years, as suggested in the Introduction, my starting point for examining and questioning policy and practice was likely to be unique to me. As my perspective had the potential to influence the approach to the study, it was important to clarify my starting point before embarking on the data collection. A full discussion of my interpretation of the current debates about inequalities in health is given in the literature review in Chapter 1 and my personal and professional experiences that have also helped to shape my perspective are outlined in the Introduction. My position on inequalities in health is summarised here to help clarify the standpoint from which I began the exploration, as follows:

Inequalities in health and in mental health in the population arise as an outcome of social inequalities with poverty being the most important factor, although other social factors such as gender and ethnicity play a role, usually in combination with poverty. There is a widening gap between rich and poor in Scotland in common with other Western countries, but much debate as to whether absolute poverty can exist in a democratic society. Explanations for poor health outcomes arising from social inequalities that I find most compelling begin with material and structural factors. Countries striving for accelerated economic growth create a society that values material wealth and associates poverty with a lack of ability and ambition. There is a clear hierarchy between layers of such a society where wealth is the key to upward mobility, but the layers, bounded by a combination of history, culture, expectations and friendship networks, are difficult to move through. This leads to absence of compassion for those who are unable to access opportunities to participate in pursuing wealth, and consequently to achieve higher social status. The "losers" in this manufactured game of survival are stressed and hurt by the damaging impact of being assumed to be of less worth to society by those with greater economic power. The results of this process include damaging psychosocial effects of inequality, resulting in chronic morbidity, addictions, violence, mental health problems and early mortality.

Social divides caused by factors other than wealth and poverty also have an impact on social status but give rise to complicated issues of responsibility. For example income might be thought of as something that is desired by individuals and economists and within the power of an individual to increase (although, as already discussed, more difficult in practice than in theory), whereas gender, ethnicity or age are clearly less amenable to change. Another issue is that while we all have an ethnicity, gender and an age not everybody believes that these factors are a source of power and powerlessness. However, the raft of statutes, policies and strategies recently created to reduce discrimination on the basis of ethnicity, gender, disability, age and sexuality have arguably been produced as a response to accusations of systemic discriminatory practice. These are important issues for this study for understanding patterns of inequalities in the population as well as for exploring them within health and social care. In addition to dealing with the morbid consequences of inequalities, the NHS and Community Health Partnerships are part of our society, and are likely to demonstrate similar motivations and patterns of behaviour as seen in the wider population.

My approach to the study was no doubt influenced by my perspective, but I would argue that previous experience and explorations have led to curiosity and commitment rather than a judgemental standpoint. A rigorous and systematic approach including validation of data collection and analysis from outwith the study, together with application of

reflexivity throughout, ensured that I approached all aspects of the study with an open mind.

Section 1 has described the methods, techniques and considerations that shaped the data collection and analysis in the study. The following Sections detail their application to finding answers to the study's research questions.

Section 2: Process

Introduction

Section 2 describes the process of setting up and carrying out the study. The research questions as given in Chapter 2 required a policy document analysis to identify national policymakers' expectations on primary care about inequalities in mental health. In addition, observation and interviews were carried out in a primary care organisation to explore the ways in which professional and strategic staff access, interpret and apply information about inequalities in mental health. The section begins by identifying the study's three main "communities of meaning" as described above as being the key groups for interpretive policy analysis and the processes of recruitment and data collection for each of the communities is described.

Identifying communities of meaning

Yanow (1999) described the three communities of meaning to be policymakers, implementing agencies and service users with each community potentially having several internal communities with different interpretations of the same policy. The communities of meaning for the study were identified as follows:

Policymakers

Interpretation of and recommendations for inequalities in health and inequalities in mental health was explored in nine Scottish health and social policy documents, current during the main study period (September 2002-October 2006). Data was collected for a policy appraisal using document analysis methods.

Implementing agency

The implementing agency was identified as a primary care organisation which held two distinct internal communities of meaning. A Local Health Care Cooperative (LHCC) which re-organised over the time of the study into a Community Health Partnership (CHP) was recruited as the primary care organisation and this is discussed in detail below. The two communities of meaning were strategic staff at planning level and frontline professionals at practice level. The strategic staff were planners and managers within the LHCC/CHP although this group also contained a small number of individuals external to the LHCC/CHP who had particular influence in local strategy development. Data were collected from planners and managers through observation of a mental health needs assessment augmented by additional interviews and document analysis of local strategies, policies and reports. The second community within the LHCC/CHP was primary care and mental health professionals and data were collected through one-to-one interviews.

Service users

The importance of a service user perspective in interpretive policy analysis has been mentioned above but there were difficulties encountered in including a user perspective in this study within the timeframe and setting. Instead, the "service user" community of meaning was explored in this study by describing the service a patient might encounter from the perspective of professional staff by eliciting responses to a vignette about a patient.

The data collection from each community of meaning is described in full below under the headings of policymakers, implementing agency and a service user's experience.

Community of Meaning 1: Policymakers

The policymakers interpretation of inequalities in mental health was explored through an analysis of nine health and social policy documents. The literature and policy review in Chapter 1 found that some policies highlighted addressing health inequalities as an overarching aim but were rarely explicit about actions that should be implemented or the role of primary care in respect of inequalities. A more in-depth policy analysis was required to clarify the ways in which policies portrayed inequalities in health and inequalities in mental health. The net was cast more widely than for the literature and policy review to include policies that might have most influence on LHCCs and the new

CHPs in developing action on inequalities in general as well as specifically on inequalities in mental health. The intention was that clarification of the policymakers' messages would provide the basis from which to explore the intended and unintended consequences of these messages through their interpretations by primary care professionals.

Policy Documents

Policy documents included in the analysis were those in place for Scotland during the main data collection period of September 2002 until October 2006. Documents were included that provided statutory or governance imperatives to primary care or were intended to influence primary care and CHPs. Also included were those that offered a similar level of influence on mental health and well-being, mental health services and health or social inequalities. Key documents were sought that were likely to have influence across the whole population and the broad range of primary care professional groups encompassed by LHCC/CHP structures. Documents excluded were those that related to single issues (other than mental health), specific population groups or workforce groups such as health and homelessness, children, nursing, social work, and the GP Quality and Outcomes Framework. White Papers, implementation strategies, service frameworks and action plans for health and social services were considered for inclusion.

Nine key documents were identified that met these criteria including two White Papers, one statutory directive and six action plans spread over the topics of NHS reform, social inclusion, public health/health improvement and mental health, as follows:

NHS Directives/White Papers : White Papers and directives are produced by the Scottish Parliament to set out expectations of Ministers on public sector structures and are often underpinned by some aspects of legislative change. Those included in the study were:

- *Towards a Healthier Scotland*, Scottish Office Health Department,1999
- *Partnership for Care*, Scottish Executive Health Department, 2003
- *CHP Statutory Guidance*, Scottish Executive Health Department, 2004.

Action Plans for the NHS: Action plans provide guidance for implementation of White Paper requirements or other changes from the Scottish Executive. Those produced specifically for the NHS included here were:

- *Framework for Mental Health Services*, Scottish Office Health Department, 1997
- *Health Improvement Challenge,* Scottish Executive Health Department, 2003
- *Delivering for Health*, Scottish Executive Health Department, 2005.

Action Plans for the Public Sector: In addition to plans targeted at specific structures, action plans can also be produced for the public sector as a whole, with or without recommendations specified for individual structures. Three were identified as being relevant to primary care in relation to inequalities in health and in mental health:

- *Equality Strategy*, Scottish Executive Equalities Unit 2000
- *National Programme for Mental Health and Well-being Action Plan 2003-2006*, Scottish Executive Health Department 2003
- *Closing the Opportunity Gap*, Scottish Executive Social Inclusion Unit 2004.

The broad context for the collection of documents was an overview of primary care, mental health and social determinants of health written by the Health and the Social Justice Departments of the Scottish Executive and the documents' main collective purpose was ultimately to improve the health and well-being of individuals and populations through delivery of specified service objectives.

The policy appraisal was carried out in a different way from the literature and policy review in Chapter 1 which included a critique of relevant policies along with research papers and opinion pieces. In contrast the policy analysis employed a more in-depth, analytical exploration in order to investigate the ways in which the policy documents incorporated perspectives on health inequalities into the messages they intended to impart to service planners and deliverers.

Extracting text for analysis

The policy and strategy documents sought for the study were easily accessible in electronic format and written in a style intended to enable understanding among a wide professional and lay readership. I accessed all documents from the Scottish Executive website and developed a framework to investigate the documents systematically. The framework consisted of questions to guide the exploration of the text, and I piloted it first with a White Paper (*Towards a Healthier Scotland*) and an Action Plan (*Closing the Opportunity Gap*) before finalising the framework as shown in Table 3.1.

Table 3.1 Framework for extracting text from policy documents

Policy	82
Main Aims and Objectives	
Context and audience	
Definitions of inequalities and inequalities in mental health	
Evidence for inequalities and inequalities in mental health	
Actions for reducing, preventing and/or dealing with the consequences of inequalities in general health and mental health (note who the actions are aimed at)	
Evidence for action/ interventions	
Priority and specificity given to actions to reduce and prevent inequalities in mental health	
Use of language (eg metaphors, emotive etc)	
Additional comments	

Techniques for close reading of the policy documents was drawn from Fairclough's (2003) method of Critical Discourse Analysis as outlined earlier in this chapter in Section 1. In addition to analysing each documents' perspectives, their collective coherence as suggested by Carabine (2001) was also of interest in order to establish the policymakers' "story" being imparted to primary care professionals through the range of documents.

Each of the nine policy documents were read in detail and relevant information entered on computer under each of the headings in the framework and the new documents were imported into the ATLAS.ti computer programme for coding and sorting. The process of coding involved constant comparison between texts, building and splitting codes and quotes and eventually arriving at conclusive coding structures and six main themes.

Additional validity for the method was sought by exchanging methods of extracting data for policy appraisal with a colleague who was conducting a policy analysis using some of the same documents but a different set of questions. We tested our methods, which had been developed independently, on one chapter of one of the documents included in both of our studies by exchanging our frameworks for data collection and comparing the results. We found that while there were some differences in the ways in which we extracted data the themes arrived at were identical.

Communities of Meaning 2 and 3: Implementing agency

As mentioned above, a primary care organisation was sought as the focus for collecting data on the second community of meaning and the process of identifying a study site is described below. There were two internal communities of interest to the study: strategic staff engaged in or influencing a planning process and frontline professional staff. The processes of identification and recruitment of respondents are summarised below before describing the data collection processes.

Identifying a study site

Consideration of methods for data collection included exploring case study and action research methodology as described in Section 1 of this chapter. The case study method included the possibility of studying two or more LHCCs and using comparisons between them to gain further insight into their work on inequalities in mental health. However, the apparent lack of focused activity and knowledge within primary care at this time suggested a high risk of the available comparable data being too limited across LHCCs to enable useful conclusions to be made. This perceived risk contributed to case study methodology being rejected.

In considering action research as a method the preferred option would have been to focus on one LHCC and work closely with key local stakeholders to develop and study actions they might take to address inequalities in mental health. While the method was rejected, some benefits of studying a single LHCC for carrying out interpretive policy analysis had been recognised. In particular, focusing on one LHCC would enable its specific strategic context to be examined, explore its interpretation of national policy for inequalities in mental health, and assess the impact of this interpretation on local practice. The data gathered from the LHCC would be specific to its own strategic context but would enable direct links to be studied between decisions made through policy, local strategy and practice. There would therefore be limited use of further data from

additional LHCCs without a similar depth of exploration of all levels of policy interpretation for each LHCC.

One primary care organisation was duly required for data collection in order to explore identifiable influences from national and local policies and strategies and the internal response to inequalities in mental health. During the study period LHCCs were replaced by CHPs. Fortunately the recruited LHCC was one which retained almost exactly the same boundaries and many similar sub-structures as it evolved into the new CHP and the changeover did not affect the data collection in any way.

The study required an LHCC in which staff might be conversant with the concept of inequalities in health, for example, where differences between population groups might be most evident. LHCCs that included a mix of clearly deprived and clearly affluent communities or a sizeable proportion of black and minority ethnic groups were sought for the study. From a pool of 11 LHCCs meeting these criteria, two agreed to pursue my involvement and further discussion took place with South Ayrshire LHCC. LHCC staff there were about to embark on a mental health needs assessment and invited me to take part in order to carry out the study. A more detailed description of identifying the study site is given in Appendix 3.

Profile of South Ayrshire

The 2001 Census gave the population of South Ayrshire as 112,097 which constituted 30% of the total Ayrshire and Arran population. As described above, the decision to come to South Ayrshire was due to the balanced mix of deprived and affluent areas within the LHCC/CHP area. There were major differences between the two adjoining postcode sectors within Ayr town centre of KA7 3 and KA8 0 using indicators of social circumstances, health outcomes and access to services (NHS Health Scotland, 2004). In addition, the most marked differences within South Ayrshire were demonstrated between postcode sectors KA8 0 and KA7 4 which is adjacent to KA7 3 and covers the more affluent outskirts of the Ayr Township to the south. Postcode sector KA26 0 is the most rural sector in South Ayrshire and was also found by NHS Health Scotland to have a population worst off in most respects in relation to the South Ayrshire average. A map of South Ayrshire from the Health Scotland profile is reproduced in Appendix 4 to illustrate the relationship between the postcode sector areas and selected health and social indicators that demonstrate differences between areas are given below in Table 3.2

Table 3.2 Examples of differences in social circumstances and health within South Ayrshire (extracted from South Ayrshire Community Profile, NHS Health Scotland, 2004)

	South Ayrshire	KA7 4	KA7 3	KA8 0	KA26 0
Social Grade AB (%)	20.7	42.2	18.9	7.9	9.2
Proportion of 15 year old boys surviving to 65 (%)	81.2	90.6	85.0	71.9	80.7
Teenage pregnancies (3 year total)	12.6	3.4	11.0	18.2	19.4
Children living in workless households (%)	15.8	4.2	14.8	27.7	23.8
Alcohol related hospital admissions (age-standardised rate per 100,000)	1220.9	746.4	1043.6	2099.0	1690.0
Hospital admissions for suicide/self harm (age-standardised rate per 100,000)	391.7	70.9	315.5	635.5	560.3
Households within 5 minutes drive of dentist (%)	70.6	32.4	91.5	82.7	0

Notes on Table

KA7 4 — South of Ayr town, taking in outskirts and extending into populated rural district of Doonfoot and Alloway

KA7 3 — Ayr town centre, south of the river, including Holmston, Forehill, Belmont, Castlehill, Masonhill, Kincaidston

KA8 0 — Ayr town centre, north of the river, taking in Dalmilling and Craigie

KA26 0 — Very rural area, covering Girvan South, Ballantrae, Colmonell, Barrhill

Recruiting participants

The aim of the data collection in South Ayrshire LHCC/CHP was to explore the ways in which primary care professionals and managers interpreted and responded to inequalities in mental health within both planning and practice activities.

At planning level a strategic group agreed that a planned mental health needs assessment process could be observed with additional data to be drawn from interviews with relevant key personnel and from reports and local strategy documents. Access to

the needs assessment was provided through a Public Health Practitioner who initially led the process. Observation of the needs assessment steering group was agreed first with the planning group and subsequently with a steering group set up to oversee the needs assessment. Document analysis of policies, strategies and other publications relating to the LHCC/CHP role in mental health and inequalities in mental health was also carried out to understand the local strategic context for the needs assessment and to identify the ways in which inequalities in mental health were portrayed to the primary care organisation at a local level.

For practice level semi-structured, one-to-one interviews were planned with between 20 and 30 professionals from across the LHCC/CHP with personnel sought from all professional groups relevant to patients with mental health problems. Criteria for inclusion were as follows:

- Any professional qualification relating to primary care and /or mental health
- Working within South Ayrshire LHCC/CHP or with some responsibility for the LHCC/CHP geographical area
- Professional staff from a mix of disciplines sought
- Equivalent number if possible between primary care and mental health staff.

Staff were initially recruited with the help of the Heads of Service Group within the LHCC who provided a list of key people from all managerial structures within the LHCC who were then either recruited into the study or asked to suggest alternative participants. About half of the participants were recruited through this initial list and the remainder were identified through purposive sampling (Glaser and Strauss, 1967) on the suggestion of the LHCC Public Health Practitioners or interview participants. Purposive sampling was used to ensure a range of disciplines across primary care and mental health services would be included and that a balance could be achieved between professionals from primary care and from mental health.

Data collection: Observation of the needs assessment

The aim of observing the needs assessment was to explore the ways in which inequalities in mental health were incorporated into and acted upon by the mental health needs assessment process.

The observation of the needs assessment included attendance at steering group meetings, reading minutes and papers produced by the group and analysing a quantity of locally produced strategies, reports and papers in order to understand the local

context for primary care mental health services and where inequalities might fit. Additional interviews with strategic staff were carried out in order to explore in more depth steering group members and other key senior staff's perspectives on inequalities in mental health. My role as observer was designed with the "peripheral-member-researcher" model in mind as proposed by Adler and Adler (1998) as I was keen to offer some input to the steering group or to the CHP in return for enabling me to access their process. However, I was also keen to limit this input to exclude aspects of inequalities in mental health as I wanted to ensure that I was observing the CHP perspectives on inequalities in mental health and not my own.

The findings from the observation and interviews with strategic staff are reported in full in Chapter 5 and the role I adopted as observer is discussed below.

My role as observer

I negotiated the role of observer of the mental health needs assessment through the Lead Public Health Practitioner who acted as my key contact with the CHP and was one of the lead instigators of the needs assessment and with the Patient Services Manager who was instrumental in making the needs assessment happen. The Research and Development Manager for the NHS Board also agreed my proposed role as observer and interviewer. In order to clarify my role, I introduced myself at the beginning of every meeting and explained that I was attending meetings to observe the needs assessment as part of a larger study of inequalities in mental health and primary care. At the first two meetings I was invited to describe my research in more detail and received positive interest and encouragement from the group.

I attended an initial, exploratory, pre-steering group meeting on 19th October 2004 and every full meeting of the Steering Group thereafter. There was a delay in starting the needs assessment due to changes in staff and in the structure as it moved from an LHCC to a CHP and the first meeting of the steering group did not take place until almost a year later. By the conclusion of the needs assessment I had attended 6 steering group meetings held between September 2005 and September 2006, a meeting to interview and commission the research team and through membership of the email list had observed additional communications taking place between meetings.

My observer status meant that I generally refrained from commenting on any aspect of the process in meetings, between meetings and by email and re-iterated my role as observer when required. I made two exceptions to this, the first being to advise on the commissioning process and the second was at the steering group meeting in July 2006

when the findings from the needs assessment were being presented and discussed. I had noted that there had been few issues relating to inequalities in mental health reported at the meeting and I asked the researchers at the end of the meeting whether they had identified any. Their answer was that they had and that they would flesh their findings out for the final report.

Additional interviews

Observation data were augmented by additional interviews with five key steering group members and two additional, senior strategic officers who had influential roles within the NHS Board that impacted on the CHP. The aim of these seven interviews was to explore in more depth the understanding of inequalities held by key personnel at strategic level in or influencing the CHP as their perspective had not been clearly articulated as part of the mental health needs assessment process. The topic guide for the strategic officers is given in Appendix 5. Three of the steering group members had roles that included patient contact as well as strategic remits and they were interviewed as both strategic staff and frontline practitioners by including the vignette in their interviews. Consequently data from these interviews were analysed as both frontline practitioner data and steering group data on the grounds that they would be able to provide insight into practice as they were all senior, experienced practitioners but that their views also contributed to driving the direction and content of the needs assessment.

Data collection: Interviews with frontline professionals

Twenty-one interviews were carried out with frontline primary care and primary care mental health professionals from 14 different disciplines. Additional interviews carried out with strategic staff described above brought the total number of disciplines represented in the study to 17. For the purposes of analysis the frontline professionals were split into two groups of Generalists and Mental Health Specialists as they had potentially quite different roles with patients with mental health problems. Generalists were staff whose roles included seeing patients and/or their carers as a first contact although they might also have patients referred to them. Mental Health Specialists were staff who received all their patients as a result of referral from generalist staff. The disciplines and gender of respondents are given in Table 3.3.

Table 3.3 Discipline of frontline professional staff interviewed

Generalists	Mental Health Specialists
GPs (3) District nurses (3) Health visitors (2) Practice nurses (2) Pharmacy Advisor Homeless Persons Co-ordinator	Community Psychiatric Nurse Project Manager Primary Care Mental Health Worker (2) Physiotherapist Occupational Therapist Psychiatrist Psychologist Social Worker
Three men and nine women in total	Four men and five women in total

All interviews took place in or close to the respondent's places of work between April 2005 and October 2006. The interviews were semi-structured and designed to gather data on three main topics: respondents' core roles and scope for practice, their knowledge and understanding of theory and practice relating to health inequalities and inequalities in mental health, and their perspectives on a vignette concerning a patient called Tom (described below). It was noted in Chapter 1 that mental health promotion and improvement are included in policy recommendations for primary care and mental health staff. At the same time, these issues remain excluded from NHS performance assessment which potentially reduces the urgency to address them. In addition there is a lack of evidence for the ways in which practitioners implement recommendations for promoting positive mental health and preventing mental ill health (Kelly *et al*, 2004). Consequently, respondents were encouraged by the interview process to lead the exploration of issues particularly with regard to their usual practice in order to elicit actions that might contribute to promotion of positive mental health or reduction of inequalities in mental health. For example, the vignette included opportunities for respondents to bring in discussion of actions to promote mental well-being, such as in mentioning that Tom might have an interest in being involved in sports and in opening up the potential for exploring his family relationships or alcohol use. The interview topic guide for frontline professionals is given in Appendix 6.

Potential respondents were contacted by telephone and sent an information sheet (Appendix 7) to help them make their decision on whether or not to participate. The information sheet was also offered at the beginning of the interviews to refresh their memory of the study and to ensure they had my contact details should they require it. Permission to record the discussion was sought at the beginning of the interview and a digital recorder was used. Respondents were not identifiable on the recording and recordings were transcribed by a typist commissioned for that purpose.

The vignette was presented early in the interviews in order to draw out both the approach the participants took to Tom and to raise issues about other aspects of their practice that could be further explored later in the interview. A discussion of the development and use of the vignette is presented below.

Community of Meaning 4: A service user's experience

Service users were an important group to explore in an interpretive policy analysis but direct access to service users within the scope of the study was deemed unrealistic if other dimensions of interpretive policy analysis were to be explored. Instead of exploring the potential impact of policy directly with service users a vignette was used in the interviews with primary care and mental health frontline professionals to help illustrate the types of approaches that participants might use such as in identifying whether biomedical and/or social models were employed to address inequalities in mental health.

Vignette

An assumption underpinning the vignette was that professionals who subscribed to a social model of health would want to explore Tom's social circumstances in order to make some assessment of the social influences impacting on Tom's health to decide on different routes for offering help. It was also assumed that those subscribing to a biomedical model might be more likely to focus on the physical issues that could potentially be fixed using tried and tested treatments.

The vignette was given on paper and verbally to primary care professionals early in the interviews immediately after an introductory discussion of the respondents' core roles. It was presented as follows:

> Tom is 48. He is divorced. He shares the care of his two teenage children
> with his ex-wife and he cares for his elderly mother, who doesn't live with
> him, since his father died 2 years ago. Tom presents as a newly registered
> patient or newly referred patient with sleeping difficulties, intermittent back
> pain and frequent headaches. He smokes and he drinks two or three
> glasses of beer or wine on some days and more at the weekends and he
> has had no contact with the NHS since a sports injury 5 years ago.

The vignette aimed to achieve a balance between issues included and excluded to enable full exploration without compromising interpretation (West, 1982) as discussed in

Section 1 of this chapter. Issues were chosen for inclusion that had been shown in previous research to have a link to mental health and some key information such as income and current relationships were deliberately excluded in order to draw participants towards their own exploration of Tom's social circumstances. The rationale for choosing each factor in the vignette are given in Table 3.4.

Table 3.4 Rationale for factors given in vignette

Factor given in vignette	Rationale or linked information not given
Male patient	Women more likely to present with mild to moderate mental health problems (ISD, 2007) therefore professional required to move beyond simple assumptions or expectations
Age 48	Could be a transition time for Tom as children leave home, perhaps a career change or a new relationship, creating potential increased stress with possible impact on mental health (WHO, 2001)
Divorced	Might increase risk of mental health problems (WHO, 2001),or Tom might have been divorced for some time and now established in a new, relaxed relationship
Teenage children	Possible source of stress increasing risk of mental health problems (WHO, 2001) as they grow more independent or increased financial needs. Did not say whether they lived with him or not
Carer	Possible higher risk of mental health problems (WHO, 2001), eg if mother is not coping well. Tom might also have problems with bereavement. Vignette says nothing of physical distance between Tom and his mother, or how close or distant their relationship
Newly registered/newly referred	Perhaps moved into the area or a crisis requiring a rare visit to health services. If unknown to the service they might want to find out more about him
Sleeping difficulties, intermittent back pain and frequent headaches	Sometimes can be symptoms linked to unhappiness, tension or depression (WHO, 1998) or could be signs of developing a serious physical problem
Smokes and drinks apparently at around the recommended limit	Smoking and alcohol associated with mental health problems (WHO, 2001). Also might be associated with other substance misuse. Well-established services for these linked to primary care
Sports injury 5 years ago	Maybe takes no exercise or alternatively has remained fit since then without problems. If he doesn't exercise may be open to taking some up as it has known beneficial effects for people with mental health problems (Grant, 2006)
Deliberately no mention of employment, income, housing situation, working conditions, relationships, leisure activities	All are factors related to physical and mental health (Bartley, 2004) and voluntary organisations and projects in some areas exist to offer support and advice

Section 3: Sorting and analysing the interview data

Introduction

As described above there were four different types of data analysis applied to the study. The first was policy analysis which is described in full in Chapter 4. Within South Ayrshire observation of the mental health needs assessment including local strategy and policy documents created a large amount of data in note form and analyses of data from these processes are presented in Chapter 5. Section 3 describes the process adopted for sorting and analysing data using interviews with frontline professional staff as an illustration.

Coding and sorting data from the transcripts

ATLAS.ti (ATLAS.ti, 2006) was used to code and sort the data following a two day training programme. Pre-set headings drawn from interview questions were generally not used for coding data with the exception of some specific details requested in the interview. These details were the number of years respondents had been in practice, geographical areas they worked in and the population they worked with but they were used as background information for understanding respondents' contexts rather than providing main factors for analysis. Themes and sub-themes were allowed to emerge from the respondent's speech and named as "codes". Codes were then assigned to chunks of data described as "quotes".

The coding process

The process embarked on to code and sort the data aimed to achieve a set of stable codes which could then be investigated to identify meaning across the sample of respondents. I began by reading each transcript closely while listening to the recording of the interview to check for mistakes and mis-hearings. I did this as soon as possible after receiving the transcript to help with recall in case there had been problems with recording which happened with two interviews. Once I had checked 4transcripts I entered them into ATLAS.ti and spent some time learning how to use the software.

I read through each of the 4 transcripts again once they were entered into ATLAS.ti and began assigning codes such as Aim of first enquiry, First reaction to Tom, Exploration of Tom's circumstances, Inequalities=access, Problems addressing mental health and so

on. Around 70 codes were identified from the first 4 transcripts. A coded transcript in ATLAS.ti is given in Figure 3.1

Figure 3.1 Extract from a coded transcript in ATLAS.ti
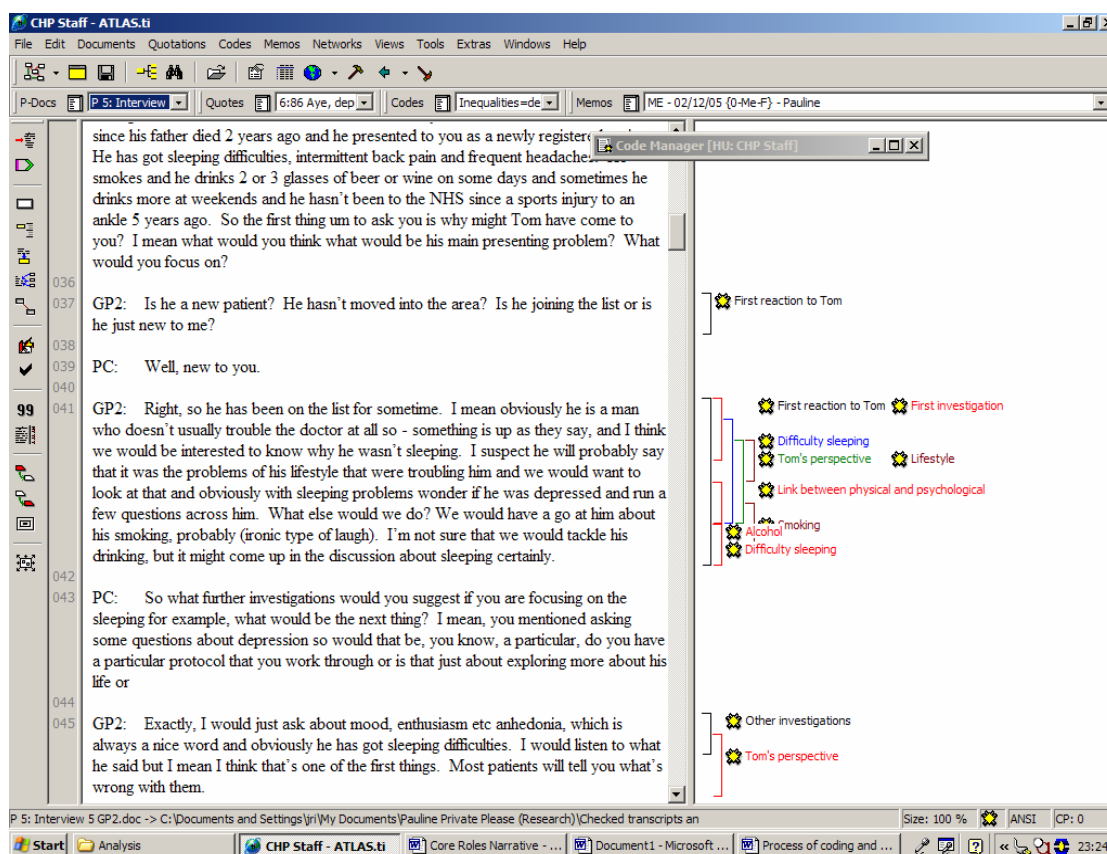
Quotes were stored under their given code headings. An extract from a list of codes is given as an illustration in Figure 3.2

Figure 3.2 Extract from the list of codes in ATLAS.ti:

Codes only became static at the stage of the final analysis and until then they were constantly reviewed, split and merged as new quotes were added and as analysis progressed. New codes were constantly being created from splitting and merging existing codes but only one completely new code was created from the final 4transcripts suggesting that data saturation was achieved.

Throughout the analysis I moved back and forward through transcripts in a process Glaser and Strauss (1967) described as constant comparison, adding quotes to codes and constantly questioning previous decisions. Major changes were usually recorded in memos in ATLAS.ti to help me to remember and understand the decision trail. Decisions about coding quotes sometimes changed as new thoughts and ideas emerged from my reading and understanding of the transcripts. The issue of bereavement offers one example of this. I had not included a code for this as an issue until Transcript 8 and felt sure I must have missed references to Tom's bereavement in previous transcripts. ATLAS.ti allowed me to search all transcripts easily for the term "bereavement" and associated terms such as "grief" and "death" but I found that to my surprise it had not been mentioned as an issue for Tom until that point.

I added transcripts to ATLAS.ti and coded them throughout the data collection period and as time allowed over an 18 month period. Occasionally I had to re-learn aspects of ATLAS.ti if too much time had elapsed between sessions. By the time initial coding was complete I was very familiar with all the transcripts and could often remember who had said what without having to spend much time searching. I continued to allow the respondents' speech to define the names of codes rather than impose specific questions at this stage although I did occasionally search for particular responses that I might have expected to see or wanted to find out about such as bereavement as described above, deprivation or use of voluntary organisations. The final number of codes at the end of this stage was 73. I believed them now to be stable as I had investigated the transcripts thoroughly including using constant comparison and questioning my decision-making throughout the process. I was also satisfied that data saturation had occurred.

Extracting meaning

The three headline topics of Core Roles, Tom and Inequalities were created to divide up the codes and provide manageable chunks of linked data to analyse although some codes did not fit neatly into one or other of the categories. I continued to move some data between the topics as the analysis progressed. Taking quotes within each code heading in turn I began to draw out their meaning or meanings by summarising or paraphrasing the points made in each quote and identifying and bringing together themes. I carried this out separately for Generalists and Mental Health Specialists to provide an opportunity to identify where their results differed and where they merged. It was particularly useful to keep them separate when exploring practical issues such as their core roles. In the final stage of analysis there were some issues where it was useful to understand the perspectives of the two groups separately and there were other issues where their combined perspective provided additional insight into the issue being explored. Themes were further developed by continuing the process of constant comparison, splitting and linking to make new links within and between codes and create new combined codes and sub-headings. I could then use these to build a comprehensive picture of the respondents' collective views to gain additional insight into the topics under scrutiny.

It should be acknowledged here that meanings are extracted in relation to the questions being asked by the research. For example a detailed linguistic analysis would identify a different perspective from individual quotes than I might in searching for coherence across quotes. The very personal analytical process that takes place in qualitative research to identify meaning is rooted in the researcher's knowledge and experience and while the internal process would be difficult to describe the basis and outcomes of

the process are explained throughout the thesis and the end product presented in the results section. An illustration of the process of meaning making from coding to analysis is given in Appendix 8.

Summary of methods and processes

Interpretive policy analysis was chosen as a useful framework for exploring all dimensions of policy perspectives and interpretations of inequalities in health and inequalities in mental health. Identifying four communities of meaning helped to focus the research questions towards relevant sources of data and document analysis and qualitative methods of semi-structured interviews and observation were employed to gather the data. A vignette was used in interviews with frontline staff in order to explore the approaches used to a patient displaying a set of vague symptoms which might or might not signal existence of mental health problems.

A study site was found that offered the opportunity of a geographical context whose profile included urban, rural, deprived and affluent areas. Personnel within the chosen primary care organisation were helpful, accommodating and interested and they ensured easy access to meetings and individual respondents. Delays in establishing the needs assessment process appeared to have potential to threaten early data collection plans but the problem was overcome with only a short extension required for the data collection period.

Document, observation and interview data analyses were guided by professional advice from professional texts and supported by university standards and supervisors and peer researcher checks. ATLAS.ti software was used for sorting and analysing data and the decision trails for the analyses were set out in this Chapter and the following four chapters of results.

Chapter 4

Results I
Policymakers' perspectives on inequalities

Introduction

Chapters 4, 5, 6 and 7 present the results from each of the four communities of meaning of: policy analysis for data relating to policymakers, observation of a mental health needs assessment for strategic planning within the CHP, interviews for data from frontline staff, and the vignette for a service user's perspective. This chapter reports the perspectives of policymakers on inequalities through document analysis of nine health and social policies.

Policy documents included in the analysis

As described in Chapter 3 Section 2, there were nine Scottish Executive policy and action plan documents included in the analysis as follows:

NHS Directives/White Papers
1. Towards a Healthier Scotland
2. Partnership for Care
3. CHP Statutory Guidance

Action Plans for the NHS
4. Framework for mental Health Services
5. Improving Health in Scotland: the Challenge
6. Delivering for Health

Action Plans for the Public Sector
7. Equality Strategy
8. National Programme for Mental Health and Well-being Action Plan 2003 – 2006
9. Closing the Opportunity Gap

The documents are numbered as above throughout the results section.

Text was extracted from the documents relating to the topics of inequalities, inequalities in health and inequalities in mental health, and coded and sorted using ATLAS.ti until

stable themes were achieved in a similar process to that described for interview data in Chapter 3 Section 3. Six headline themes were identified in addition to descriptive headings of Context and main audience. Context and Main Audience for each of the policy documents are described below for background information before the results for the six themes are presented.

Context and main audience

1. Towards a Healthier Scotland, 1999

An early White Paper from the newly devolved Scottish Parliament, *Towards a Healthier Scotland* was a statement of Scottish policy for public health. The NHS was its main audience, although it made many references to actions to improve health that involved a wide range of Scottish Executive departments and strategic agencies. For example, one of its highlighted action plans was to create a new health improvement post to focus on local authorities within the Convention of Scottish Local Authorities (COSLA). *Towards a Healthier Scotland* was produced following extensive consultation on a Green Paper entitled *Working Together for a Healthier Scotland* which achieved 800 responses. It was the first White Paper produced for public health since the change of government and it continues to underpin current public health policy in Scotland at the time of writing. For example in 2003 *Improving Health in Scotland: The Challenge* stated that *Towards a Healthier Scotland* provided its foundation.

2. Partnership for Care, 2003

Another White Paper *Partnership for Care* was produced for the NHS in order to "signal a direction of travel and a way of going forward together" (Minister's Foreword) and it followed on from the *NHS Plan for Action, Plan for Change* that had been produced two years previously. The main actions from the White Paper were to be patient-focused service planning and delivery, health improvement, national standards for service delivery, integration of health and social services, empowering staff at a local level and re-organising the NHS to reduce organisational barriers. Community Health Partnerships (CHPs) were introduced as the new structures for primary care to evolve from Local Health Care Co-operatives (LHCCs) towards more decentralised and integrated health and social care systems. *Improving Health in Scotland: the Challenge* (described below) was produced in tandem with *Partnership for Care* to provide more in-depth, strategic action for health improvement.

3. Community Health Partnerships Statutory Guidance, 2004

The *Statutory Guidance* set out the policy context, aims and benefits of CHP functions, organisational arrangements and key elements that should be included in the schemes of establishment. The Guidance followed The NHS Scotland Reform Act 2004, which created the legislative framework for the NHS re-organisation outlined in *Partnership for Care* including placing a duty on Health Boards to establish CHPs. Each NHS Board was to create a Scheme of Establishment to describe their plans for meeting the objectives set out in the *Statutory Guidance*.

4. Framework for Mental Health Services, 1997

The *Framework for Mental Health Services* was the result of a commitment made by the Scottish Office following a 1995 report on closure of psychiatric hospitals. The *Framework* provided guidance for local mental health services including the aims and dimensions that should be covered by local strategies. The intentions of the *Framework* were stated as being to assist staff in health, social work and housing to prepare a joint approach to planning, commissioning and providing integrated mental health services. In addition, it promoted implementation of existing policy by helping to achieve consensus on transition to local mental health services and priorities for action. Further guidance for mental health services for specific conditions was added to the framework over the following nine years but a new action plan for mental health services, called *Delivering for Mental Health,* superseded the *Framework* in December 2006. The 2006 action plan was not included in the study, as the *Framework* provided the policy context for the data collection period. However *Delivering for Mental Health* was added to the literature and policy review discussed in Chapter 1.

5. Improving Health in Scotland: the Challenge, 2003

Improving Health in Scotland: the Challenge was a strategic framework produced in tandem with the White Paper *Partnership for Care* to support processes to deliver health improvement in Scotland, and highlight further actions to improve health. It stated that it was written in the context of Scotland having a greater challenge to improve health than most other Western countries, for improving health across the whole population and for reducing the health gap. *Improving Health in Scotland* set out the national work programme for health improvement activities for the Scottish Executive, Health Scotland and NHS Boards. It also stated that it highlighted health improvement as a cross-cutting policy for the whole programme of government, Community Planning Partnerships,

COSLA and the impact on health from business, the voluntary sector and other strands of Scottish life. In addition, it identified that many other organisations and individuals within Scotland contributed to health improvement.

6. Delivering for Health, 2005

Delivering for Health was a framework for action to drive service improvement programmes for NHS Boards and Regional Planning groups. It was produced by the Scottish Executive in response to recommendations from a Scottish Executive-commissioned investigation into the health care needs of Scotland with the final report, *Building a Health Service Fit for the Future* (NHS Scotland, 2005) more widely known as the *Kerr Report*. The *Kerr Report* had highlighted the main healthcare issues for the near future as being an ageing population, an increase in people living longer with long term conditions, rising emergency admissions to hospital among older people, and the widening gap in life expectancy. It also acknowledged that health was improving over the population as a whole. *Delivering for Health* emphasised a shift towards preventive medicine and more intensive and continuous care in the community including support for self-care, with targeting of resources and use of anticipatory care to identify and treat those at greatest risk. It put in place a long-term action plan to prioritise prevention and proactive intervention in order to encourage people to take greater control over their own health. The plan was aimed mostly at the NHS and Community Health Partnerships but expected local authorities and community planning structures to contribute to meeting its aims.

7. Equality Strategy, 2000

The Equality Strategy was produced from within the Communities and Social Justice structures within the Scottish Executive but was targeted across the whole of public life in Scotland. It stated that it was produced as a result of a strong commitment to putting equality at the heart of policy, practices and procedures throughout the preparations for setting up the Scottish Parliament and Scottish Executive, and part of the drive to create a just and inclusive Scotland. It outlined the need to change the culture in systems, behaviour and attitudes that cause or sustain discrimination and prejudice in the Scottish Executive, the public sector and beyond. The Strategy recognised equality as a cross-cutting issue, and that all departments across the Scottish Executive had responsibility to promote equal opportunities. It aimed to prevent, eliminate or regulate against discrimination on the grounds of sex, marital status, racial grounds, disability, age, sexual orientation, social origin, beliefs or opinions.

8. National Programme for Mental Health and Well-being Action Plan 2003 – 2006

The Scottish Executive Health Department set up the *National Programme for Mental Health and Well-being* to support implementation of *Improving Health in Scotland: the Challenge,* and the programme team produced the action plan to build on earlier work on reducing stigma and suicide. The action plan set out the main areas and activities for national work on mental health and well-being and proposed an outline for action for local areas to follow. Its main focus nationally was on raising awareness and promoting mental health and well-being, reducing stigma and discrimination, reducing suicide and promoting recovery. The action plan identified the Programme's main partners and focus for influence as being the main national strategic organisations for improving health including all departments in the Scottish Executive, NHS Health Scotland and COSLA, as well as a long list of public sector service structures, voluntary sector services and community organisations.

9. Closing the Opportunity Gap, 2004

Closing the Opportunity Gap built on existing social justice strategy, in particular the report *Social Justice – A Scotland Where Everyone Matters* (1999), which set out targets and milestones for social inclusion. Social justice strategy was said to be aimed primarily to prevent individuals or families from falling into poverty and providing sustainable routes out of poverty. From September 2004 the social justice strategy was refocused by *Closing the Opportunity Gap* targets which refined previous targets and milestones. Ten targets were set with each having specific objectives and identifying the key areas where greater improvement was required. The targets focused on the public sector including health, social care, education, Job Centre Plus, Scottish Enterprise, regeneration agencies and large employers. The targets provided specific measurements and goals with indicators for performance management attached and included the health inequalities target introduced in 2004 for the first time in Scotland. The inequalities target stated that poverty affects health, and it aimed to achieve 15% greater improvement in the 15% poorest areas for under 75 coronary heart disease and cancer deaths. *Towards a Healthier Scotland, Improving Health in Scotland: the Challenge* and anticipatory care from *Delivering for Health* were named as the key strategies for action to meet the target by focusing on health care treatment and lifestyle interventions.

Headline themes from the policy analysis

Six headline themes were identified from analysis of the policies relating to inequalities, inequalities in health and inequalities in mental health as follows:

Aims: aims for the policy documents that included issues relating to inequalities

Definitions: the assumptions and ideologies found in the policy documents relating to inequalities in health and inequalities in mental health

Actions: actions proposed that related in some way to tackling social inequalities, reducing inequalities in any aspect of health, or the impact of inequalities on general and mental health

Evidence: evidence given or referred to that demonstrated the existence of inequalities in relation to any aspect of health, or evidence underpinning proposed actions

Emphasis: the priority or emphasis given to any aspect of inequalities

Anomalies: observations made where policy documents made statements that contradicted themselves or other documents.

Findings for four of the themes of aims, evidence, emphasis and anomalies are reported below under each of the theme headings, but definitions and actions are reported together since similar sub-themes emerged for both.

Theme 1: Aims

All nine documents had quite different specific aims relating to the contexts within which they were written, and they all included some aim or aspiration that suggested a contribution to addressing inequalities. Most of the documents stated multiple aims and objectives or aspirations, some of which were peppered throughout the text rather than listed under a specific "aims and objectives" section. Many of the documents included unqualified phrases including terms such as "determinants of population health" which were generally not explained or expanded upon. The stated aims occasionally referred to overarching aims for the Scottish Executive to which the policy document might contribute, rather than being stated as aims for the policy itself ,although the actual contribution of the document to the Scottish Executive aim was rarely specified. For example, *Delivering for Health* claimed to be aiming to contribute to tackling

determinants of health through "the health gap" but offered no definition of determinants of health neither did it describe how its main proposals were expected to achieve changes in population health determinants. It is feasible that it might have taken as an assumption that providing more accessible services for people with chronic physical illnesses would in itself reduce the health gap, but nowhere did it state this assumption. *Delivering for Health's* aim for improving health and health inequalities was stated as:

> *"Our overarching aim is to improve Scotland's health. Policies and actions across the Executive support that central objective. We are building an integrated approach that has the NHS at its core. The approach sets out to tackle determinants of population health, particularly through the "health gap" that blights the lives of people in our disadvantaged communities. This plan* […] *also brings together elements of wider policy the Scottish Executive has been developing for a number of years that impact on Scotland's health." Delivering for Health, Section 1:1*

Similarly ambiguous statements relating to aims or aspirations appear in many of the policy documents and the one above is presented here to illustrate the challenge posed in drawing out the documents' actual aims relating to health inequalities. Ambiguity was taken into account in order to include general aspirations in addition to stated aims. Reference was made to Whitehead and Dahlgren's work (1995) on describing policies to reduce health inequalities, so that aims to strengthen individuals and communities that included health improvement action were also included.

Aims are presented below in Table 4.1. Numbers of citations of the issue in question are given in brackets beside the code headings in all the tables in this chapter to help to judge weightings for a particular issue. It is important to note that these are not a reflection of the actual numbers of times a word or an aim appeared in the documents. I did not use a close reading technique as might be used in a linguistic analysis, but was searching for presentations of ideas. Therefore, citations of the same or similar definitions given across different documents were likely to be significant in highlighting a degree of coherence, but this meant that multiple definitions from some documents were also picked up. For example, the third code given in Table 4.1 for public service reorganisation scored seven citations across five documents. This means that one of the documents (*Partnership for Care*) held three aims for public service reform which might impact on health inequalities of; patient-centeredness, partnership with communities, and integration between services. These were thought to be sufficiently different to warrant separate citations. In contrast, two aims of "reaching out further with health improvement" and "increasing access to services" were identified from *Delivering for Health* but were regarded as too similar to be taken separately, and were coded together

within the heading of "NHS reform", and later grouped into the aim of "public service improvement".

Table 4.1 Aims relating to inequalities

Policy document Aims (instances in brackets)	1	2	3	4	5	6	7	8	9
Address prejudice and discrimination (2)							✓	✓	
Address (unspecified) determinants of health (2)		✓				✓			
Public service reorganisation or improvement (7)		✓	✓	✓		✓	✓		
Meet patients' specified needs (2)		✓							
Strengthen communities (closing the health gap and promoting inclusion) (3)					✓	✓			✓
Strengthen individuals (improve health, well-being, fitness, opportunity) (4)	✓						✓		✓
Strengthen the Scottish population (by improving health and reducing inequalities) (4)	✓	✓			✓	✓			
Strengthen targeted groups (children, homeless people, disadvantaged communities, people with severe and enduring mental illness) (4)	✓			✓		✓			✓
Tackle poverty (1)									✓
Key: 1. *Towards a Healthier Scotland* 2. *Partnership for Care* 3. *CHP Statutory Guidance* 4. *Framework for Mental Health Services* 5. *Improving Health in Scotland: the Challenge* 6. *Delivering for Health* 7. *Equality Strategy* 8. *National Programme for Mental Health and Well-being Action Plan 2003-2006* 9. *Closing the Opportunity Gap*									

The main aims for the White Papers, directives and action plans relating only to the NHS (documents 1 - 6 in Table 4.1) if taken together can be summarised as being focused largely on NHS reform, aspiring to strengthen the population by improving health and reducing health inequalities, either strengthening individuals or strengthening communities (but not both), and targeting some named vulnerable groups. Tackling broad or societal determinants of health were mentioned as aims or aspirations by two

of these documents, although the determinants were not specified and one document aimed to take a strong perspective of the views and needs of patients.

The aims for the action plans for the public sector as a whole (documents 7 – 9) were slightly different in their focus in that strengthening individuals was a more overt aim, specified as tackling prejudice, discrimination and poverty. However, they also included public sector reorganisation and strengthening and targeting disadvantaged communities.

Themes 2 and 3: Definitions and actions

Text relating to the two themes of Definitions and Actions was explored separately in the initial analysis. Due to similarities in emerging sub-themes, it was possible to identify potential links between definitions and proposed actions. The sub-themes from definitions and actions were identified as Individuals, Communities, Rich/Poor Gap, Social Factors and Organisational factors and they are presented below in Tables 4.2 to 4.6 in order to highlight and compare the ideologies used for defining the determinants of inequalities in health and mental health against proposed actions.

Interpreting ambiguous statements

Under Theme 1 Aims above, the challenge of finding aims and aspirations spread throughout the documents was described. Definitions and actions relating to health inequalities were arguably even more difficult to decipher as both were often contained in ambiguous statements whose meaning could be interpreted in many ways. This section describes the ambiguity of statements relating to definitions and actions, and details the ways in which interpretations were arrived at in order to explain the findings relating to ambiguity.

The term "definition" is used here loosely to describe the ways in which the policy documents defined the problems and factors relating to inequalities in health and inequalities in mental health. None of the policies explicitly stated that they subscribed to a particular definition or ideology but instead, they made statements that might suggest a set of beliefs about inequalities in health. For example, two statements in *Improving Health in Scotland: The Challenge* (Context Chapter) were:

> *"Scotland has high levels of inequality in health outcomes for different socio-economic groups"*

> *"Poverty in the broadest sense is a central feature of the problem"*

I interpreted these statements to mean that the authors of *Improving Health in Scotland: the Challenge* defined inequalities in health in economic terms, both as a method of measuring differences between groups and as a determinant of health.

Another example suggested that in Scotland there were:

> *"differences in opportunity and experience, as measured by income, gender and environment"*, *Towards a Healthier Scotland* (Chapter 2).

This statement could be interpreted as inequalities being a result of the ways in which individuals act or live as well as being a population phenomenon and, again, economics as well as other factors could be used to measure these differences.

As in Table 4.1 above, the numbers of citations of the issue in question are given in brackets beside the code headings in the tables below. Again, numbers are given to help to judge weightings for the different definitions given but did not reflect the actual numbers of times a word, definition or action appeared in the documents. Some definitions might appear to have been "counted" more than once from the same document but there were instances where documents used slightly different ways of expressing issues and deciding whether these were repetitions or different perspectives was occasionally problematic. The reason for this is because statements made in the documents were not always identified specifically as definitions therefore the coding represented my interpretation of the ways in which the documents described health inequalities. For example, two of the definition statements described as Quotes 1 and 2 below were both from *Improving Health in Scotland: The Challenge* and both coded as "Social Circumstances", which referred to a definition of health inequalities being combinations of social factors:

> **Quote 1.** "*Relative impact of personal choices, behaviour, environment, social environment, access to resources*"

> **Quote 2**. "*Commitment to bridge the opportunity gap for all regardless of age, gender, sexual orientation, geography, economic position, ethnicity, disability or faith*".

I coded them both in the same way because I concluded that "access to resources" from Quote 1 could be argued to have a similar implication for someone living in deprived circumstances as "bridge the opportunity gap" in Quote 2. "Social environment" in Quote 1could be argued to encompass "age, gender, sexual orientation" etc as described in Quote 2 and "environment" combined with "access to resources" in Quote 1 might have a similar implication for health as "geography" in Quote 2. At first glance these two quotes appear to deal with quite different topics. However, I inferred from these statements that the most important message from both of them, and the issue which unites the quotes, is that they both recognise that inequalities arise from a complex set of related social circumstances that need to be acted on together in order to reduce the inequality gap. On the other hand, the statements would have to be taken separately if they or the documents were suggesting that there were lists of separate issues that should be dealt with individually to tackle inequalities.

Other interpretations could also be inferred from these two statements. For example it could be argued that Quote 1 refers mostly to community influences while Quote 2 describes an individual's position in society, therefore they might be coded as, for example, "environmental/social" (Quote 1) or "individual differences" (Quote 2). However the first quote also includes personal choices and behaviour and it could be argued that in Quote 2 an individual's place in society is defined for them rather than chosen by them depending on the ways in which the society places relative values on social constructs such as gender and ethnic diversity. This interpretation might also place the first quote in an "individual" category and the second in an "environmental" one instead of the other way round. I rejected this possibility as neither interpretation fitted neatly. For example, Quote 1 would have to have been allocated to both "individual" and "environmental" if all the dimensions listed were to be captured.

Yet another possibility would have been to break down both statements in Quotes 1 and 2 above and to code each issue separately. However, as already described, my interpretation of both of these quotes was that the document author(s) wished to impart the perspective that combinations of factors were important in health inequalities rather than each factor being taken as a discrete issue. This contrasts with instances where discrete issues were mentioned, such as the way in which gender appears in the *Framework for Mental Health Services,* which stated that,

"*mental health services should take into account the 'special needs of women'*"

This quote was included under a code of "gender" with my interpretation being that the document understands specifically that women were in need of more attention and therefore there was some evidence that they had been receiving a lesser service. (The

argument that the document might not offer a true definition of gender by suggesting that women need specialist services because they differ from the "norm" of men is not dwelt on here. All perspectives that could potentially relate to any aspect of inequalities were incorporated into the policy analysis.) The *Framework for Mental Health Services* therefore proposed gender as an issue that stood on its own while Quote 2 from *Improving Health in Scotland: The Challenge* included gender within the context of other societal factors suggesting a message of complexity.

The above examples are given to illustrate the ambiguity found in relation to definitions and actions as well as my process of extracting meaning from statements that were not necessarily written for the purpose of providing the information sought for the study. They also serve as illustrations that my interpretations draw on both my pre-existing knowledge and a method drawn from discourse analysis, and my approach included the following considerations:

- that my interpretations of definitions of inequalities issues in the documents were partly gleaned from sources beyond the texts being analysed rather than assumed only from the texts being studied, described as intertextuality (Atkinson and Coffey, 1997, Fairclough 2003),
- an appreciation of the impact on policy documents of the value assumptions and ideology from multiple authors and political influences (Fairclough, 2003), and
- a commitment to the search for coherence between the documents to build a comprehensive picture (Carabine, 2001).

Thematic analysis of codes for definitions and actions

Statements related to reducing inequalities, inequalities in health or inequalities in mental health were sought for definitions and actions. Occasionally statements related to improving health or promoting better health were also included in the coding process when the context appeared to assume that health inequalities could be reduced by improving health in general.

Codes were assigned to statements in the nine policy documents relating to definitions of inequalities, inequalities in health or inequalities in mental health allowing the documents to generate the wording and names for the codes, that is, I did not start with a series of headings into which I fit the statements from the documents. Through a process of coding, sorting, re-arranging and constant comparison I concluded with an initial list of 16 codes as follows (the numbers of quotes in each code beside the code heading):

access	1	lifestyle/behaviour	2
differences between individuals	2	disability	1
environment	2	ethnicity	2
geography	4	opportunity gap	2
rich/poor gap	4	social circumstances	4
social environment	1	social injustice	1
deprivation	2	discrimination	1
gender	2	personal choice	1
economics	6		

The codes were then grouped into six themes as follows:

1. Individual choice	lifestyle/behaviour, personal choice
2. Deprived communities	deprivation, environment, geography
3. Measurement	economic differences between individuals, rich/poor gap
4. Societal factors	discrimination, social circumstances, social environment, social injustice
5. Equality groupings	gender, ethnicity, disability
6. Access to resources	access, opportunity gap

The same process of coding, sorting and comparing was carried out to identify actions for reducing, preventing and/or dealing with the consequences of inequalities in general health and mental health. Twenty-five actions were identified as follows:

Employment/education	2	Close the health gap	2
Communication	1	culturally competent services	3
Data	4	evidence	1
Access	2	leadership	3
Legislation	2	lifestyle	2
Managerial	11	multiple methods	4
Needs assessments	3	needs of carers	1
New developments	2	outwith NHS	8
Participation	3	promoting health	3
Staff development	2	strengthening communities	3
Strengthening individuals	3	targeting	7
Topics	7	reduce poverty	5
Reducing stigma	1		

These were first grouped into six themes:

1. Organisational	communication, data, managerial, access, culturally competent services, needs assessments, outwith NHS
2. Professional/developmental	evidence, leadership, new developments, staff development
3. Change at individual level	lifestyle, promoting health, strengthening individuals, topics, employment/education
4. Targeting disadvantaged communities	targeting, strengthening communities
5. Public involvement	needs of carers , participation
6. Societal change	legislation, reduce poverty, close the health gap, multiple methods, reducing stigma

On noticing similarities between the themes emerging from definitions and those emerging for actions, I tried applying the same themes to both definitions and actions, splitting and merging codes and quotes until I arrived at a structure of themes and sub-themes that were equally relevant for both. The five sub-themes emerged of Individuals, Communities, Rich/Poor Gap, Societal Change and Organisational Factors. This allowed me to search for direct links between the ways in which the documents defined issues relating to health inequalities and the actions they were proposing. Definitions and Actions are set out together in Tables 4.2 to 4.6 under each of the five headline

themes of individuals, communities, rich/poor gap, societal factors and organisational factors.

Definitions and actions sub-theme 1: Individuals

Table 4.2 Definitions and actions sub-theme 1: Individuals

Individuals									
Policy documents **Definitions** (3)	1	2	3	4	5	6	7	8	9
Behaviour/Lifestyle (linked to life circumstances) (2)	✓				✓				
Personal Choice (1)					✓				
Actions (24)									
Behaviour/Lifestyle (2)	✓					✓			
Promoting health (3)	✓					✓			
Strengthening individuals (4)				✓	✓	✓			✓
Topics (7) (children, disadvantaged groups, homeless people, children, CHD, cancer, demo projects)	✓	✓			✓				
Education/employment (2)									✓
Targeting (6) (lifestyle and primary care targeted at disadvantaged communities)		✓				✓			✓

Key:
1. *Towards a Healthier Scotland*
2. *Partnership for Care*
3. *CHP Statutory Guidance*
4. *Framework for Mental Health Services*
5. *Improving Health in Scotland: the Challenge*
6. *Delivering for Health*
7. *Equality Strategy*
8. *National Programme for Mental Health and Well-being Action Plan 2003-2006*
9. *Closing the Opportunity Gap*

The table shows that two policy documents gave three individually driven definitions of health inequalities, while these documents and four others proposed a total of 24 different individual level actions to reduce health inequalities. Both documents that gave individual definitions placed behaviour and choice in a wider context, stating that individual choice, behaviour and lifestyle were linked to social circumstances.

The proposed actions expected NHS and local authority services to improve health and reduce inequalities by targeting lifestyle advice at people in disadvantaged communities,

or through helping people into education, employment or health services. One action (in *Towards a Healthier Scotland*) proposed that an individual level approach should be taken along with tackling life circumstances although it did not provide detail about its expectations.

Definitions and actions sub-theme 2: Communities

Table 4.3 Definitions and actions sub-theme 2: Communities

Communities									
Policy documents **Definitions** (9)	1	2	3	4	5	6	7	8	9
Deprivation (2) (exclusion of deprived communities)		✓							✓
Environment (2)	✓				✓				
Geography (5) (different/deprived communities)	✓		✓	✓		✓			✓
Actions (6)									
Strengthening communities (4) (through CHPs, regeneration, employment)			✓			✓			✓
Close health gap (2) (through integration of services)			✓						

Key:
   1. *Towards a Healthier Scotland*
   2. *Partnership for Care*
   3. *CHP Statutory Guidance*
   4. *Framework for Mental Health Services*
   5. *Improving Health in Scotland: the Challenge*
   6. *Delivering for Health*
   7. *Equality Strategy*
   8. *National Programme for Mental Health and Well-being Action Plan 2003-2006*
   9. *Closing the Opportunity Gap*									

Table 4.3 shows that seven out of the nine documents included definitions that highlighted deprived or poor communities being linked to poor health, for example:

> *"the varying levels of need in different communities" Framework for Mental Health Services*, page 6.

> "*Improving health……. especially for the most disadvantaged communities*". *Community Health Partnership Statutory Guidance* p 17.

Definitions relating to communities identified differences between deprived and other communities, and also suggested a focus on geography or environment as a method of measuring the link between deprivation and poor health. While seven documents recognised differences between communities only three of the seven documents proposed actions on strengthening deprived communities such as through regeneration, service integration and reducing poverty.

Definitions and actions sub-theme 3: Rich/Poor Gap

Table 4.4 Definitions and actions sub-theme 3: Rich/Poor Gap

Rich/Poor Gap									
Policy documents **Definitions** (8)	1	2	3	4	5	6	7	8	9
Difference between individuals (2) (life expectancy, opportunity)	✓					✓			
Economics (6)	✓	✓			✓				✓
Actions (12)									
Reduce poverty (5) (financial services, welfare system, employment/education)	✓					✓			✓
Outwith NHS (8) (Community Planning Partnerships, vol orgs, life circumstances, close the gap, access to services)	✓	✓	✓		✓	✓			
Key: 1. *Towards a Healthier Scotland* 2. *Partnership for Care* 3. *CHP Statutory Guidance* 4. *Framework for Mental Health Services* 5. *Improving Health in Scotland: the Challenge* 6. *Delivering for Health* 7. *Equality Strategy* 8. *National Programme for Mental Health and Well-being Action Plan 2003-2006* 9. *Closing the Opportunity Gap*									

Table 4.4 highlights that five policy documents recognised that economics was a factor in health inequalities and two stated that there were measurable differences between people with high incomes and those with low incomes with regard to opportunity and life expectancy. Most of the definitions described measurement of differences in life expectancy between people living in disadvantaged and affluent areas, and all five documents explicitly stated a link between health and poverty.

Actions to reduce the gap between rich and poor were proposed by all five of the documents that used a rich/poor gap definition and one additional document that did not

use this category of definition. Only some of these actions related to reducing poverty while others focused on improving access to services for people in disadvantaged communities. Many of the actions were expected to be implemented outwith the NHS for example, by Community Planning Partnerships and local authorities. Voluntary organisations were also proposed as helping to improve access to services. Some documents recommended that poverty should be tackled directly but did not necessarily identify by whom for example:

> "*Getting there means a sustained attack on inequality, social exclusion and poverty*" *Towards a Healthier Scotland*, Chapter 2

Definitions and actions sub-theme 4: Societal factors

Table 4.5 Definitions and actions sub-theme 4: Societal factors

Societal factors									
Policy documents **Definitions** (14)	1	2	3	4	5	6	7	8	9
Combination of soc circumstances (4)	✓				✓				✓
Social Justice (through addressing mental health inequalities) (1)								✓	
Discrimination (1)							✓		
Gender (2)	✓			✓					
Ethnicity (3)	✓		✓	✓					
Disability (1)			✓						
Opportunity gap (2) (due to income, mental health inequalities)	✓							✓	
Actions (8)									
Culturally competent services (3)		✓		✓			✓		
Multiple methods (4) (ind. and soc. change, p/ships, inds and communities)		✓		✓	✓				✓
Eliminating stigma and discrimination (1)								✓	
Key: 　1.　*Towards a Healthier Scotland* 　2.　*Partnership for Care* 　3.　*CHP Statutory Guidance* 　4.　*Framework for Mental Health Services* 　5.　*Improving Health in Scotland: the Challenge* 　6.　*Delivering for Health* 　7.　*Equality Strategy* 　8.　*National Programme for Mental Health and Well-being Action Plan 2003-2006* 　9.　*Closing the Opportunity Gap*									

Table 4.5 demonstrates that seven documents recognized societal factors other than economics, although most either provided an apparently arbitrary list of a handful of factors or a single issue drawn from a total across all documents of 14 definitions and 10 actions. Three different perspectives on societal issues were identified. One was that certain named population groups required a culturally sensitive response from services, for example:

> *"services should be culturally sensitive to minorities and ethnic groups"*
> *Framework for Mental Health Services.*

Another perspective was given by the *Equality Strategy* which stated that discrimination towards people belonging to a less powerful minority group was the driver for health inequality rather than the actual nature of the population group itself. A third perspective on societal issues could be illustrated by differences between the experiences of individuals such as expressed here:

> *"differences in opportunity and experience as measured by income, gender*
> *and environment" Towards a Healthier Scotland* (Chapter 2)

Actions to tackle inequalities through societal issues were included in eight of the nine policy documents, with the *Community Health Partnership Statutory Guidance* being the exception. Actions ranged from very practical activities such as improving access to services, for example in *Partnership for Care;* to asking for individual and societal change as in *Health Improvement in Scotland: the Challenge;* through to wholesale elimination of stigma and discrimination identified by the *National Programme for Mental Health and Well-being Action Plan*. The latter two did not specify how these aspirations could be achieved.

Definitions and actions sub-theme 5: Organisational Factors

Table 4.6 Definitions and actions sub-theme 5: Organisational factors

Organisational factors									
Policy documents **Definitions** (0)	1	2	3	4	5	6	7	8	9
Actions (35)									
Legislation (2) (equality, health improvement)		✓					✓		
Access to health services (2)		✓				✓			
Communication (1)					✓				
Data (5) (targets, integrated data)		✓			✓		✓		✓
Managerial (4) (NHS reform, regional planning, public sector improvements)	✓	✓				✓	✓		
Integration (6)	✓		✓	✓	✓				✓
Evidence (1)		✓							
Leadership (3)		✓			✓		✓		
Staff development (2)				✓			✓		
Participation (3)			✓	✓		✓			
Needs assessment (6)			✓	✓		✓		✓	

Key:
1. *Towards a Healthier Scotland*
2. *Partnership for Care*
3. *CHP Statutory Guidance*
4. *Framework for Mental Health Services*
5. *Improving Health in Scotland: the Challenge*
6. *Delivering for Health*
7. *Equality Strategy*
8. *National Programme for Mental Health and Well-being Action Plan 2003-2006*
9. *Closing the Opportunity Gap*

Table 4.6 illustrates that no definitions were given for a link between organisations and health inequalities other than those that could be assumed from proposed actions. For example it could be argued that if better access to services for disadvantaged areas is mentioned in relation to managerial changes and integration of services, it could be assumed that the sub-text in the documents is that there has been poor access to services because of current managerial and structural barriers. If this assumption had been made in relation to all 33 actions, Table 4.6 might have suggested that 33

problems had been identified in organisations and 33 related actions had been proposed. However, this was clearly not the case. Poor access to services is not mentioned in any document either as a determinant of health, as a determinant of health inequalities or as a problem to be solved. In any case all nine policy documents included specific actions for their or other organisations to take to address health inequalities that can be summarised as creating better partnerships, targeting action at population groups or individuals with greatest need, creating better systems for change management and monitoring and reviewing changes.

Theme 4: Evidence

While there is a well-documented dearth of the use of concrete evidence in health policy (Macintyre *et al*, 2001), I searched for the ways in which evidence might be used to back up assertions about the existence of inequalities or actions proposed. Occasionally, information was given such as prevalence figures for coronary heart disease and cancer, but these were not included in the coding scheme if no mention was made of inequalities. It would be fair to say that hard evidence and information were rarely included in the documents in general but there were a number of references made to the *existence* of evidence relating to inequalities in health and in mental health and these are given in Table 4.7

Table 4.7 Evidence for inequalities in health and in mental health

Evidence for inequalities in health and in mental health	1	2	3	4	5	6	7	8	9
Physical conditions (1)		✓							
Link between health and life circumstances (3)	✓	✓				✓			
Mental health/illness (2)		✓			✓				
Population change (1)		✓							
Widening gap (2)	✓					✓			
Key: 　1.　*Towards a Healthier Scotland* 　2.　*Partnership for Care* 　3.　*CHP Statutory Guidance* 　4.　*Framework for Mental Health Services* 　5.　*Improving Health in Scotland: the Challenge* 　6.　*Delivering for Health* 　7.　*Equality Strategy* 　8.　*National Programme for Mental Health and Well-being Action Plan 2003-2006* 　9.　*Closing the Opportunity Gap*									

Table 4.7 shows that *Partnership for Care* mentioned the most evidence for the existence of inequalities. For example,

> *"Life expectancy is consistently lower than in other European Union countries. We have rising rates of suicide, particularly among young men, and rising numbers of young people, particularly girls in their early teens being treated for self-harm. This reflects a complex interaction of different factors relating to choices, life styles and life circumstances". Partnership for Care, Chapter 2*

There were no sources mentioned for any of the evidence given in the quote above as was the case for most of the instances of evidence cited in Table 4.7.

Only *Delivering for Health* provided statistical evidence for illness and service use, although again provided no direct reference to sources identified, and very little of that information was broken down for geographical areas or population groups. The only document to cite a source for evidence was *Towards a Healthier Scotland* which admitted that it was influenced by evidence for health inequalities in the *Acheson Report* although it does not cite specific evidence from the report.

Theme 5: Emphasis

Table 4.8 Emphasis on inequalities in health

Emphasis on inequalities in health	1	2	3	4	5	6	7	8	9
Overarching aim (3)	✓				✓				✓
Problematic (3)	✓	✓							
Overwhelmed (4)		✓				✓			

Key:
1. *Towards a Healthier Scotland*
2. *Partnership for Care*
3. *CHP Statutory Guidance*
4. *Framework for Mental Health Services*
5. *Improving Health in Scotland: the Challenge*
6. *Delivering for Health*
7. *Equality Strategy*
8. *National Programme for Mental Health and Well-being Action Plan 2003-2006*
9. *Closing the Opportunity Gap*

Some of the documents made special mention of inequalities in health as a particularly problematic area. Table 4.8 identifies their responses under the three headings of Overaching Aim, Problematic and Overwhelmed. Emphasis on health inequalities drew some emotional content from the authors, for example:

> "*….focus on tackling inequalities as an overarching aim*" *Improving Health in Scotland*, page… (coded as 'Overarching aim')

> "*We still have a mountain to climb in terms of health inequalities between various groups and areas*" *Towards a Healthier Scotland*, Chapter 1 (coded as 'Problematic')

> "*The health gap blights the lives of people in disadvantaged communities*" *Delivering for Health*, page… (coded as 'Overwhelmed')

Partnership for Care appeared to regard health inequalities as particularly problematic as well as quoting the most evidence for their existence as described above.

Theme 6: Anomalies

Some apparent discrepancies within or between some of the documents were identified and coded as "anomalies" and they are described below.

Action for health improvement assumed to reduce health inequalities

Health inequalities were identified as a named, serious problem and a priority for five out of the nine documents, but action on health inequalities was generally not highlighted as a stand alone issue in the same way. Instead it was more likely to be embedded within sections focusing on general health improvement. Some policy documents appeared to assume that health improvement activity in the form of the NHS or local authority providing lifestyle advice would reduce the health gap, particularly if carried out in deprived areas as described in *Improving Health in Scotland: the Challenge* and *Delivering for Health. Towards a Healthier Scotland* did separate out action on health inequalities and health improvement but it separated them completely, and then had difficulty in making the links between them. For example, the vision for better health was given as making a sustained attack on inequalities, social exclusion and poverty, but indicators of progress included fewer deaths from coronary heart disease, stroke and cancer, better recognition of depression and improved dental and oral health. There was

no narrative or action that might link the contributory factors and outcomes, or that linked NHS activity with action on wider social circumstances.

Statement of a problem not followed up by action

As suggested above, there were gaps between stated problems of inequalities in health and the proposed actions. An example of a missing link between stating the problem and recommending action was found in *Partnership for Care*. *Partnership for Care* mentioned differences in life expectancy in the health improvement section but this was not followed up in the chapters dealing with service re-design, where efforts might have been expected to focus activity on improving life expectancy. No mention was made of the potential for focusing on differences between areas or population groups, despite that there were numerous recommendations about improvements required to achieve better services. Achieving positive change in life expectancy was therefore focused on lifestyles and life circumstances of individuals as well as other organisations outside the NHS, but the NHS itself was not targeted to contribute to improvements in life expectancy. Another example of a missing link between evidence and action relating to mental health was found in *Improving Health in Scotland,* which included a statement in the Context chapter that there was a disproportion of people in disadvantaged circumstances suffering from mental illness. A later section focused on mental health but failed to mention inequalities or differences in the recommendations as a focus for action.

Summary of findings from the policy analysis

Chapter 4 described the results of an analysis of nine health and social policies to explore in depth the ways in which inequalities and inequalities in mental health were portrayed. The policy analysis represented the policymakers' angle on inequalities for an interpretive policy analysis. The policy analysis found disjunction between aims, definitions and actions across and within the policy documents. In particular, 34 citations of 14 definitions and 24 types of actions cited a total of 85 times were identified to address health inequalities across the nine policy documents. Proposed actions did not always follow the definitions given in the documents. For example, three definitions from two documents were found that described health inequalities as being linked to personal behaviour, but 24 actions across six documents were given to for actions for individual behaviour change. In contrast, 14 definitions regarding societal factors in seven documents were followed by only eight actions across six documents. A strong message that organisations should take action came from 35 actions being proposed for

organisations to address health inequalities such as improving access to services (two citations) or better data management (five citations) but there were no definitions or evidence given that linked health inequalities to organisational factors.

Inequalities in mental health were barely mentioned by any of the policies including those focusing on mental health, and there were no clear messages for primary care, or indeed any other structure, about how to define or act on inequalities in health or inequalities in mental health. Where social inequalities were included in documents, their discussion often lacked clarity and depth. Another key finding was that there was disjunction across and within policies in relation to definitions of health inequalities and actions proposed. For example, links were made between deprivation or poverty and health outcomes but actions focused on individual or organisational change. The disjunction and confused picture of the Scottish Executive's understanding of health inequalities was highlighted, particularly when a summary of collated aims, definitions and actions was brought together. This summary is given in Table 4.9.

Table 4.9 Aims, definitions and actions given in nine health and social policy documents

1. Towards a Healthier Scotland		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Strengthen individuals Strengthen the population Strengthen targeted groups	Behaviour/Lifestyle Environment Geography Differences between individuals Economics Combination of social circumstances Gender Ethnicity Opportunity gap due to income	Behaviour/lifestyle Promoting health Topic focused Reduce poverty Actions for others outwith NHS Managerial Integrated services
2. Partnership for Care		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Address determinants of health Public service reorganisation Meet patients specified needs Strengthen the population	Deprivation Economics	Topic-focused Targeted at disadvantaged communities Actions for others outwith NHS Legislation for equality Access to health services Data - targets Managerial Evidence Leadership

3. CHP Statutory Guidance		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Public service reorganisation	Geography Ethnicity Disability	Actions for others outwith NHS Integrated services Participation Needs assessment

4. Framework for Mental Health Services		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Public service reorganisation Strengthen targeted groups	Geography Gender Ethnicity	Strengthening individuals Culturally competent services Multiple methods Integrated services Staff development Participation Needs assessment

5. Improving Health in Scotland: the Challenge		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Strengthen communities Strengthen the population	Behaviour/lifestyle Personal choice Environment Economics Combination of social circumstances	Strengthening individuals Actions for others outwith NHS Multiple methods Communication Data - targets Integrated services Leadership

6. Delivering For Health		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Address determinants of health Public service reorganisation Strengthen communities Strengthen the population Strengthen targeted groups	Geography Difference between individuals	Behaviour/lifestyle Promoting health Strengthening individuals Targeting disadvantaged communities Strengthening communities Reduce poverty Actions for others outwith NHS Access to health services Managerial Participation Needs assessment

7. Equality Strategy		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Address prejudice and discrimination Public service reorganisation Strengthen individuals	Discrimination	Culturally competent services Legislation Data Managerial Leadership Staff development
8. National programme for Mental Health and Well-being Action Plan		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Address prejudice and discrimination	Social justice through addressing mental health inequalities	Eliminating stigma and discrimination Needs assessment
9. Closing the Opportunity Gap		
Aims for addressing inequalities in health	**Definitions**	**Actions**
Strengthen communities Strengthen individuals Strengthen targeted groups Tackle poverty	Deprivation Geography Economics Combination of social circumstances	Strengthening individuals Education/employment Targeting at disadvantaged communities Strengthening communities Reduce poverty Multiple methods Data Integrated services

While most documents referred to evidence of the existence of health inequalities and emphasised their importance, some documents admitted that addressing health inequalities was likely to be problematic. However, evidence of anomalies within documents suggests that work is required to identify roles for the NHS in addressing health inequalities. For example, some documents claimed that all NHS action should be underpinned by inequalities, but then confined proposed actions to interventions to be taken within health improvement structures or functions. It is argued that the claim for inequalities to underpin all action would be strengthened by proposing actions that were relevant across all parts of the service.

Chapter 5

Results II

Local strategic planning for inequalities in mental health

Introduction

As described in Chapter 3, the extent to which inequalities in mental health was incorporated into a Community Health Partnership (CHP) strategic planning and development process was explored through observation of a needs assessment process. The aim of observing a mental health needs assessment was to explore ways in which objectives for addressing inequalities in mental health might be incorporated into a strategic process within the (CHP). The observation focused on the first of the two groups within the implementing agency community of meaning for the interpretive policy analysis (as described in Chapter 3, Section 1), with the second group being the frontline professionals. Findings from interviews with frontline staff are reported in Chapters 6 and 7. Data was collected for the observation through three processes of appraisal; of relevant local strategies and papers, attendance at meetings of the Needs Assessment Steering Group, including appraisal of minutes and papers produced by the group; and one-to-one interviews with key strategic officers. The findings from each are reported below under the three section headings of:

- Section 1: Local strategic context for inequalities in mental health
- Section 2: Needs assessment process: history, progress, papers and outcomes
- Section 3: Interpretation and application of inequalities in mental health at strategic level within the CHP.

Section 1: Local strategic context for inequalities in mental health

Introduction

The local strategic context in South Ayrshire CHP for inequalities in mental in health and for the needs assessment was explored through relevant local documents that were concurrent with the data collection period. The documents were searched to identify sources of information regarding inequalities in health and inequalities in mental health that might influence the CHP's perspective. Most of the papers examined were produced by Ayrshire and Arran NHS Board and South Ayrshire Council, and some were

produced by local partnership groups or national organisations. The documents included population profiles, public health and health improvement documents, mental health services strategies and the Community Health Partnerships scheme of establishment, as follows:

- South Ayrshire Community Health Profile, Health Scotland, 2004
- Ayrshire and Arran Director of Public Health Report, 2004
- Health Inequalities and Health priorities in South Ayrshire: a Discussion Paper. Adrian Shaw and Chris Doyle, South Ayrshire Council, Draft, December 2004
- Ayrshire and Arran NHS Board Mental Health Strategy 1999
- National Mental Health Services Assessment Locality Report for Ayrshire and Arran, Scottish Executive 2003
- Improving Mental Health and Services in Ayrshire and Arran: Report and Implementation Plan, 2004
- Mental Health (Care and Treatment) (Scotland) Act 2003 Draft Joint Local Implementation Plan, Ayrshire and Arran, version 2, July 2004
- South Ayrshire Council Mental Health Strategy 2004-2007, Draft 3, July 2004
- Ayrshire and Arran Local Health Plan 2005-2008, July 2005
- South Ayrshire Joint Health Improvement Plan 2004-2007
- Health Inequalities Action Plan, Ayrshire and Arran Health Board, Draft January 2005
- Ayrshire and Arran Community Health Partnerships Scheme of Establishment December 2004.

Some of the documents above were provided by South Ayrshire CHP staff, and three were accessed on the internet. The remainder were accessed on request from the Communications Team at Ayrshire and Arran NHS Board.

Profiles of the South Ayrshire population

In addition to the NHS Health Scotland profile of South Ayrshire summarised previously in Chapter 3, Section 2, another profile was prepared by South Ayrshire Council to attempt to identify health inequalities and health priorities for South Ayrshire. Inequalities between communities were examined using the indicators of mortality, mental health, sexual health, drug and alcohol abuse, smoking and healthy lifestyles at datazone levels as distinct from the Health Scotland analyses which used postcode sectors. Their analysis concluded that there was very little variation between communities for mental health indicators and no correlation between economic or social deprivation and high levels of alcohol or drug misuse. The Ayrshire and Arran's *Director of Public Health's*

Annual Report of 2004 was similarly inconclusive about links between mental health and inequalities and placed mental health under the heading of "Healthcare and Governance". The mental health section outlined national strategic direction and local services that had been developed in response to the *National Programme for Mental Health and Well-Being*.

Mental health strategies for South Ayrshire

An array of mental health strategies for broad direction and for specific services had been produced by both Ayrshire and Arran NHS Board and South Ayrshire Council, and while strategies were published by one or the other agency, most stated that they were developed by multi-agency groups. To an outside observer, the combination of strategies appeared to be occasionally repetitive, involving time-consuming processes for the authors, and resulted in similar conclusions about gaps in services and funding.

The *Ayrshire and Arran Mental Health Strategy* was produced in 1999 by the NHS Board in response to the *Framework for Mental Health Services in Scotland* (Scottish Office, 1997) but was said to have been developed by a multidisciplinary, multi-agency project Board which also included service users. The strategy aimed to create an integrated service addressing health, social and housing needs for the following groups:

- People with severe and enduring mental health problems
- People with a learning disability, substance misuse or alcohol problem who also have a mental health problem
- People with mental health problems who commit offences
- People who experience mental health difficulties which may or may not be enduring but vary in severity, frequency and duration.

The Mental Health Strategy 2004-2007 developed by South Ayrshire Council (draft 2004) noted that Year 1 of the NHS 1999 Strategy had been funded resulting in the introduction of new services but funding had not been made available beyond year 1 resulting in gaps in some services.

In 2002 another multi-disciplinary, multi-agency group met to review pressures and problems within mental health services across Ayrshire and Arran, and a stakeholders meeting was subsequently arranged to explore views of service users and carers and staff groups (Community Health Division, November 2004). A redesign project was then set up and named *Improving Mental Health and Services in Ayrshire and Arran,* which was said to fit within the framework of the *National Programme for Mental Health and*

Well-Being, implementation of the 2003 *Mental Health (Care and Treatment) Act,* and a model for mental health services called the *Tiered Model of Healthcare*. The redesign project identified nine priority topics focused on re-shaping service delivery in line with national priorities such as providing appropriate 24-hour care, person-centred care management approaches, improving services to primary care, improving mental health profiles and developing information and systems. These priorities were also said to inform South Ayrshire Council's *Mental Health Strategy* (South Ayrshire Council, July 2004) along with the *Choose Life Action Plan*. Actions and timescales for implementation of the Mental Health Act were specified in the *Joint Local Implementation Plan for Ayrshire and Arran* (JLIP) which involved the NHS Board and all three Ayrshire Councils, and identified JLIP Coordinators and Implementation Coordinators for each of the four partners.

An objective view of progress on mental health services at local level was provided for all areas across Scotland by the National Mental Health Services Assessment which was set up by the Scottish Executive to assess the extent to which existing mental health services could meet the objectives of the 2003 *Mental Health Act*. The *Ayrshire and Arran Locality Report* produced from the assessment identified that users and carers' priorities were to provide services that were responsive to locally identified needs such as for people with drug and alcohol problems, carers, homeless people with a mental illness and to highlight mental illness as something everyone needs to play a part in. In addition, challenges were identified in implementing the Act, including getting GPs involved in the development and delivery of mental health services, improving transport, recruiting and retaining Mental Health Officers and pressure on the one forensic psychiatrist.

Inequalities or variations were not mentioned in any of the documents other than issues relating to particularly vulnerable groups, which were usually credited as being raised by service users and carers.

Reducing health inequalities

The main plan where health inequalities might have been prioritised was the *NHS Ayrshire and Arran Local Health Plan 2005- 2008,* which brought together the three Joint Health Improvement Plans from each of the Ayrshire Council areas. The Local Health Plan identified that there were considerable variations in health and deprivation across the NHS Board area and proposed the use of the Scottish Index of Multiple Deprivation to pinpoint specific areas of need, although the use of datazones in the profile mentioned above had been unable to link deprivation to health outcomes. The plan

highlighted that the NHS Board carried out an Equity Audit for Coronary Heart Disease (CHD) Services in 2002 which demonstrated that people living in areas with higher levels of deprivation, including North and Central Ayr within South Ayrshire, had higher levels of need for CHD services but were less likely to receive interventions. The audit focused on statin prescribing but also suggested that the results provided evidence that the NHS had the potential to increase inequalities through inequitable service provision. It also noted that poverty and socio-economic deprivation had a huge impact on health inequalities, but that other factors including gender, race, disability, employment and education should also be considered in strategic planning. An Equity Audit for Mental Health was said in the Plan to be underway but had not been carried out by the time of writing in 2007. The Local Health Plan also included sections on mental health and on mental health improvement, where core mental health services across Ayrshire and Arran were listed, and the local response to the *National Programme for Mental Health and Well-Being* was described as already given in the *Director of Public Health Report 2004*.

A Draft *Health Inequalities Action Plan* was produced around the same time as the Local Health Plan by Ayrshire and Arran NHS Board. This short, draft report again re-iterated that there were measurable inequalities between affluent and disadvantaged areas. It also stated that depression was expected to be the second most prevalent illness worldwide by 2020 and that people in deprived areas are nearly one and a half times more likely to suffer from a mental health problem than those living in an affluent area. The draft paper did not provide specific actions but outlined a range of planning processes and broad aspirations to reduce health inequalities, including work on priority health topics, lifestyles and life circumstances such as improving access to health services for the most disadvantaged groups and ensuring effective sharing of information between agencies.

The role of Community Health Partnerships

There were three Community Health Partnerships (CHPs) linked to Ayrshire and Arran NHS Board for North, South and East Ayrshire, each of which was coterminous with a separate Council. The Scheme of Establishment for NHS Ayrshire and Arran CHPs set out their vision for delivering the healthiest life possible for the people of North, South and East Ayrshire as being based on principles that emphasised understanding and meeting local needs, integrating services and reducing inequalities within and between local communities.

Community mental health services were to be managed within the CHPs. Each of the three CHPs were to host some area-wide services but a decision had not been reached on the management arrangements for Clinical Psychology and Psychiatry. Each CHP would also have partnership arrangements at strategic level for community care planning, children's services planning, joint health improvement planning and supporting people and implementation of the Joint Future Agenda.

Summary for local strategic context

There was no lack of strategies and polices setting out different aspects of managing and delivering mental health services or consulting staff, patients and carers on their perspectives of what the services should provide. Inequalities in health made a startling appearance in the Local Health Plan which offered an unusually frank analysis of the potential for the health service to contribute to inequalities through service provision, and that poverty and socio-economic circumstances had a strong impact on health inequalities. These issues did not appear to have been picked up by other reports with the one exception being a draft health inequalities strategy. However, this had been in the process of being written for some time and had no expected date of publication.

Section 2: Needs assessment process

Introduction

The observation of the needs assessment process was carried out in order to identify the ways in which the CHP incorporated information, definitions and actions for inequalities in mental health into a planning process. As mentioned in Chapter 3, the observation included attendance at meetings from a pre-meeting agreeing that the needs assessment should go ahead until the last steering group meeting, which received the final report.

History and development of the needs assessment

The needs assessment had first been proposed in June 2003 by a Specialist Registrar in Public Health Medicine to assess mental health and health care needs of adults aged 16 and over in South Ayrshire. It proposed using epidemiological, corporate and comparative methods in order to enable setting of priorities and targeting of services to

those areas which were least well resourced. The aim of the needs assessment was said to identify the needs of the three categories of people outlined in a report previously produced by the Scottish Needs Assessment Programme. The three categories were the public at higher risk through life events or through being socially or economically disadvantaged, the mentally unwell who had psychopathology but were not chronically disabled, and those with major disabilities as a result of chronic mental health disorders.

The proposal had not been funded when originally drawn up and the following year, the Lead Public Health Practitioner (PHP) in the (then) LHCC had taken it up and produced a scoping paper based on the original proposal. Drivers for change were noted in the scoping paper as being evidence of health inequalities where people with enduring mental health problems had poorer physical health and poorer access to health services, that the demography was changing with increasing numbers of elderly people and less people of working age, and that there were information sources available, including recent guidelines and standards that highlighted best practice for mental health services.

The scoping paper was submitted to a new strategic group for mental health in October 2004 which approved the proposal in principle (along with approving my involvement as an observer) and supported its presentation to the LHCC Clinical Governance Group. Delays in setting up a steering group meant that the process did not start for another year. Finally, funding was agreed by the Clinical Governance Group and the first meeting of the Needs Assessment Steering Group took place in September 2005. Attending that meeting was a Consultant in Public Health Medicine who had prepared the initial proposal as a Specialist Registrar, a Consultant Psychiatrist, a Health Improvement Officer, an Evaluation Officer and a Public Health Practitioner. The main focus for the meeting was to review the original papers and finalise the proposal.

The original aims for the needs assessment were thought by the group to be too ambitious. Instead, the group agreed that the needs assessment should focus on creating a sound evidence base to back up existing services by assimilating existing information and assessing service provision against user and carer needs. The Consultant Psychiatrist proposed that the group described as the "public at high risk" from the original proposal should be taken out of the needs assessment on the grounds that existing data covered people already in the system who were generally affected by moderate to severe mental illnesses. Perhaps surprisingly in the light of the emphasis on the link between inequalities and mental health in the original proposal and in the subsequent scoping paper, the group agreed that inclusion of the "public at high risk" group would mean too large a piece of work. Instead they believed that it would be

important at this stage to "put something on the table" by focusing on easily accessible information which could then be added to at a later date.

The final agreement was that the two categories of people to be included would be adults aged 16-65 who were mentally unwell, and those who suffered major disabilities as a result of chronic mental health disorders. Both primary and secondary care should be explored, including referral patterns, prescribing patterns and geographical variations. Older people and people with addictions should be excluded on the grounds that these populations were covered by NHS Board-wide services and the South Ayrshire (now) CHP could not make decisions on its own about these services. Forensic services and children were also said to be dealt with through other strategy routes and therefore should also be excluded. Dual diagnosis of mental health problems along with substance misuse, older people and learning disability should be acknowledged as an important issue but not included as they were thought to be too complex to explore within this process.

The proposal to exclude the "public at high risk" was agreed virtually unopposed with the exception of one member's attempt to explore needs relating to social circumstances and *Choose Life,* because people at risk of suicide would not necessarily come within the included categories. This suggestion was turned down with the preferred route of looking at one aspect of mental health at a time and the group confirmed its focus to be on services for adults with severe and enduring mental health problems. Another objection given to looking more broadly at mental health problems in the population was that CHP clinical leads were thought to be potentially difficult to engage in the process if a drive towards equitable primary care service provision across social circumstances were to be focused on, as this might be construed as a threat to GP's current pattern of providing services.

The proposal was finalised with the parameters agreed as above and the CHP Clinical Governance Committee approved the funding request. The group used the funding to commission a literature review prior to commissioning a research team to carry out the needs assessment.

Recruitment and management of commissioned research

Draft invitations to tender for commissioning researchers for the literature review and the needs assessment were produced and circulated by email to the Steering Group for comment. Both processes are described below.

Literature Review

Four research teams submitted bids to carry out the literature review, and one team was chosen following email discussion between four steering group members. It was to be carried out over a six-week period and was to focus on the following topics:

- Severe and enduring mental illness including schizophrenia
- Psychotic illnesses – depression, hypomania, manic depression
- Anorexia and bulimia nervosa
- Anxiety
- Mental illness in young people age 16-18
- Suicide and deliberate self-harm.

The following questions were to be asked:

- Incidence and prevalence
- Epidemiological and associated characteristics of the disease groups (eg demography, socio-economic deprivation)
- Evidence-based interventions for effective management, and
- Role of primary care in their management.

The literature review was carried out within its proposed timescale and comments were received by email on the draft final report from the Consultant Psychiatrist and Consultant Psychologists. In particular, the psychologists were concerned about the selection of studies included in the review and asked that the paper not be placed on the NHS Board intranet until their concerns were dealt with. The final report was later circulated to the steering group and to the needs assessment research team in the early stages of their research. The literature review was not discussed at any of the steering group meetings but it was given to the needs assessment research team who in turn acknowledged it in their final report, but did not make any comment on its contents.

The literature review concluded that there was little good quality evidence to support many decisions about treatment for mental illness in primary care, but that primary care had an important role in effective diagnosis and referral. This role included having to see through patient's presenting issues to more deep-seated mental health problems that might not be immediately apparent. In addition, primary care staff were said to be able to increase effectiveness of mental health treatment by ensuring follow-up from secondary care and supporting compliance with medication.

Needs assessment

The research brief for the needs assessment described the two target populations for the needs assessment as:

1. The mentally unwell (those with significant psychopathology but without chronic disabling characteristics) such as depressive episode, phobias, panic disorder, anxiety, mixed anxiety/depressive disorder

2. Those with major disabilities as a result of severe and enduring mental health disorders – serious persistent or intermittent psychological disturbance with at least one of the following – psychotic diagnosis, organic illness or injury, previous compulsory admissions, long period in hospital, serious risk of self-harm, limited social skills, requiring home support for community living.

The objectives were as follows:

- To gather and interpret routine and survey data applicable to the population with mental health needs, national or local
- To gather information on services in South Ayrshire currently available to mental health service users
- To gather views of the users on whether their needs are being met (much of this available from a 2002 review)
- To gather views of the service providers on local health needs and services
- To use the above to identify priority health needs to be addressed.

Three survey methods were expected to be employed:

- Epidemiological – prevalence and incidence data from local and national surveys and sources
- Corporate – views of service providers, users and carers to look at identified, met and unmet needs
- Comparative – collecting data on provision of mental health services in South Ayrshire and where relevant, Scotland, eg from SKIPPER 3, prescribing data, ISD, GPASS.

A team of researchers were recruited by a Steering Group sub-group (including me as observer), and they carried out the needs assessment between January and July 2006. The Needs Assessment Steering Group were involved at the beginning of the research in providing papers or being interviewed by the research team and again at a late interim

stage when they were consulted on initial findings and direction. The draft final report was presented to the steering group in September 2006 in order to discuss its findings and the proposed recommendations. Issues and questions raised by the steering group at that meeting were generally in agreement with the researchers' findings.

The key issues presented in the final report of the needs assessment were as follows:

Data: ISD had provided an analysis of prevalence of patients between the ages of 16 and 65 in 2006 with severe and/or enduring mental illness (their term) in South Ayrshire. The analysis found 508 patients within seven categories:

- Three or more psychiatric admissions in the last three years
- Inpatient admission over 90 days within the last three years
- Formal psychiatric admission in the last three years
- Discharged with a principal diagnosis of schizophrenia in the last seven years
- Discharged with a principal diagnosis of bipolar disorder in the last seven years
- Discharged with a principal diagnosis of other psychotic illness in the last seven years
- Discharged with a principal diagnosis of severe psychotic depression in the last seven years.

The needs assessment also identified that there were two databases holding local service use data for general practice and for mental health services. They did not allow transfer of data between them and used different diagnostic criteria, although there were proposals in place to enable more consistency within and between them.

Planning processes: the researchers found that there was confusion among mental health service providers about strategic issues and about which groups were responsible for making decisions about the range of mental health issues. There was a lack of a clear strategic plan and they proposed a need for a pan- Ayrshire and Arran plan with a South Ayrshire dimension.

Service providers: the researchers gathered some data from service providers through one-to-one interviews, and they found that there was a great deal of desire for improvements in mental health services. In particular, service providers wanted better integration between services and the voluntary sector in order to improve their clients' life circumstances. However, they reported that they were restricted from working in this way due to lack of time and funding. The issue of rural access to services was raised, particularly about provision of out of hours cover as this did not exist in South Ayrshire at that time.

Patient information: there had been a resource directory but it was out of date, and service providers did not always know about all the services or patients were thought to forget about services they had been told about.

Views of users and carers: an additional three interviews with service users had been carried out by the needs assessment research team in order to enhance information from a previous consultation. Views expressed were similar to those of the service providers.

Main recommendations proposed: There were three main groups of recommendations proposed as follows: to improve statistics and data across services and across the NHS Board area; to produce a mental health plan for the NHS Board area in conjunction with the local authorities which should be linked to a South Ayrshire implementation plan to ensure local solutions at the same time as consistency across the Board area; and that specific needs identified should be addressed regarding information, 24 hour cover and staffing and resource levels.

Terminology used in the reports

Inconsistencies in terminology used to define mental health and illness in research and policy were noted in Chapter 1, Section 2 of this thesis. Similar inconsistencies were mirrored in the mental health needs assessment within the final reports of both the literature review and the needs assessment. For example, the literature review used only the term "mental illness" in its search terms but other terms were used throughout the report. The needs assessment also used different terms interchangeably throughout the report and, with no trace of self-reflection, included all of the terms found throughout the report on page 1! Terms used in both reports are listed in Table 5.1.

Table 5.1 Terms applied to mental health problems in final reports

Commissioned Literature Review Final Report	Needs Assessment Final Report
Mental health treatment programmes Treatment and management of mental illness Mental health conditions Disease groups Mental health disorders Mental health problems	Mental health needs assessment Mental health problems Mental health disorders Mental illness Mental ill health People with mental health needs

Coverage of inequalities in the final reports

The literature review final report included several mentions of social inequalities and their links with mental health. This was despite that the research brief included specific mention of inequalities only in relation to including socio-economic deprivation as a factor in reporting incidence and prevalence of mental health conditions. In addition, search terms for the review included only "socio-economic deprivation" and "age" from a total of 64 terms covering mental health conditions, therapies and demographics. The review reported that it had explored incidence and prevalence, epidemiological characteristics, evidence-based interventions and the role of primary care in the management of schizophrenia, depressive disorders, anorexia and bulimia nervosa, anxiety, suicide and self harm. It also included older people as a specific group due to the population profile of South Ayrshire.

Inequalities in mental health were mentioned in the body of the report in relation to socio-economic circumstances, ethnicity, gender and age. The report stated that South Ayrshire had a higher proportion than the Scottish average of older people, had 20 datazones within the 15% most deprived in Scotland, and only a very small proportion of ethnic minority groups. The report also noted that low socio-economic status, poor education, low income and unemployment were risk factors for developing most common mental health disorders, bipolar disorder and for suicide and self harm; major depression was thought to affect older people more than younger; the highest suicide rates were found in older men; and that nearly three times more men than women committed suicide every year but women outnumbered men four-fold for non-fatal deliberate self harm. In relation to service use, the report noted that patients with anxiety problems often remained undiagnosed by primary care, and this was thought to be due to their presentation of a number of problems at an appointment. These patients were also more likely to make frequent medical appointments, undergo extensive diagnostic testing, report their health as poor, smoke cigarettes and misuse illicit substances. Therefore, practitioners were thought to be likely to fail to identify anxiety by focusing too readily on the other presenting symptoms.

The needs assessment final report also described deprivation in South Ayrshire and quoted from a research paper (not the commissioned literature review), a list of risk factors for mental health problems. The final report was divided into sections covering: Approach and Methods; Mental Ill Health Estimates for South Ayrshire; Planning Processes for Mental Health Services; Mental Health Services in South Ayrshire; Issues Raised by Service Users and Carers; and Recommendations and Conclusions. Deprivation was identified as an issue relevant to mental health in South Ayrshire with 12 postcode sectors reported as being worse than the Scottish average for suicide and

deliberate self-harm, and eight postcode sectors being worse than the Scottish average for first psychiatric admissions. The sector KA7 was significantly worse (over 300% higher than average) for these same indicators but considerable variation across South Ayrshire was also noted with the conclusion that there was likely to be variations in need for services. The report also listed a wide range of risk and protective factors that can affect mental health such as education, employment, safety, limiting long term illness, deprivation and financial security. The South Ayrshire population was shown to experience some risk factors for poor mental health that were higher than the Scottish average including unemployment, alcohol related hospital admissions, drugs related deaths and domestic abuse rates.

Access to services was an issue raised in the needs assessment by service providers and users as well as by service profiles. Problems highlighted were that South Ayrshire had the lowest number of consultant psychiatrists in Scotland and a low ratio of psychologists to population; staff serving patients in rural areas had far to travel due to lack of suitable accommodation for services; and voluntary sector services providing support for life circumstance-related issues suffered recent cuts in funding. Consequently, together with other understaffed mainstream services, patients with mental health problems in South Ayrshire were particularly likely to be under-served. Other problems highlighted were that some patients needed more emotional support when accessing services but this was rarely available and there was an absence of some services altogether in South Ayrshire such as an out of hours Mental Health Officer, bereavement counselling and support for women who had been raped.

Access to services was the only issue that might be related to inequalities highlighted in the recommendations. It was taken up on the grounds that there were specific services that were available elsewhere but not in South Ayrshire, rather than as a general principle that all services should be accessible to all who needed them. Particularly notable was that evidence for deprivation, increased risk factors for mental health problems and the need for more support for patients to access services, were clearly presented in the report but neither the recommendations or steering group discussions picked up on these. For example, more research might have been required to link the higher levels of need in some areas for more services, but the recommendations focused on a small selection of services that were thought to be required to be provided equally across South Ayrshire, despite some evidence in the report that mental health needs might be variable across the area.

Reflections of strategic staff on the needs assessment

Interviews with strategic staff are discussed in full in the following section, but reported here are comments on the needs assessment made by some respondents who had been involved. None of the respondents appeared to be too hopeful that the needs assessment would contribute hugely to addressing the many problems they believed hampered effective mental health service provision at that time, despite that two respondents had been instrumental in driving the needs assessment process. One respondent explained that needs assessments in general had potential for driving change in practice:

> *"I mean while you are doing data collection, I can use it, I can use it to inform and I can use it to influence and it begins to make a difference in terms of where resources go* […]. *So it's how much can we shift and can we shape the future direction and if people see that you can use information to do that and evidence to do that then they should be more willing to record, collect, collate, analyse and develop."* P23

However, this particular needs assessment did not appear to have enough power to influence changes in service provision. One issue was that there had been a bewildering array of strategic groups for mental health services at the time of the study and their lines of accountability and influence had become opaque. This issue is discussed in more detail in Section 3 below but respondents' accounts suggested that there was no clear route for this needs assessment into Board-wide strategic decision-making processes. A respondent whose role on the Needs Assessment Steering Group was to represent a partner agency, described feeling on the periphery of the needs assessment because it had become very focused on NHS service provision, and there were other groups looking at mental health in which the respondent had a more central role.

There was some disappointment that the needs assessment did not provide enough about inequalities. For example, the final report was criticised for not being as "*punchy*" (P26) as hoped with less than expected on health inequalities or groups such as homeless people or people with acquired brain injury, and that it would have had to be more sophisticated to pick up on detail about socio-economic factors. The process was thought by one respondent not to have had enough focus on health inequalities at the beginning. However, some others were more positive, believing that it had highlighted some gaps where more focus or further exploration was required. One of the respondents who had not been directly involved in the needs assessment (and was interviewed before it had reported), expected that it would find that the biggest needs in South Ayrshire would be around the elderly and addictions particularly in areas of

deprivation and in the rural areas. Another respondent thought that it would help to highlight problems with access to services.

On the whole, the responses from strategic staff suggested that the needs assessment process was less useful that had been expected, and in particular that issues of inequality might have been developed more fully. Worthy of note was that most of these respondents were involved in the process but spoke as if they did not believe that they had the opportunity to influence the needs assessment in ways they might have wanted. For example, despite their apparently influential roles at senior levels in the CHP and NHS Board, none of the respondents talked about using the needs assessment themselves to develop further work or to help drive change. One of the steering group members explained that once the report was finalised it would then be up to the CHP Clinical Governance Group to decide how to take the recommendations forward.

Summary of the needs assessment process

The needs assessment began and was approved of as a population wide proposal which included an exploration of the population most at risk of mild to moderate mental health problems as a result of social and economic disadvantage, as well as two other groups of people suffering mental health problems. The aims changed to exclude the former group and focus on the other two groups, relating to those with diagnosed severe and enduring mental illness and who were therefore already known to the mental heath system. The literature review and needs assessment final reports highlighted social inequalities including socio-economic status and poor education as being related to poor mental health, but the main recommendations from the needs assessment did not include any mention of social or mental health inequalities. Instead, the recommendations focused on the ways in which the system could be improved in relation to data collection, planning mental health services and staffing levels. Therefore, it can be concluded that inequalities in mental health and the potential impact of social inequalities on mental health within South Ayrshire, were described by the needs assessment process but not acted upon.

Section 3: Interpretation and application of inequalities in mental health at strategic level within the CHP

Introduction

At the outset of the study I assumed that inequalities in mental health would be discussed at Needs Assessment Steering Group meetings. As the study progressed I found that inequalities were not usually a subject for discussion within the mental health strategic groups included in the observation process. A more proactive attempt to gather data on understanding of inequalities in mental health at a strategic level was evidently required. Therefore, one to one interviews were arranged with five steering group members and two additional senior staff who had some influence in the CHP, in order to explore the ways in which strategic staff interpreted and applied an understanding of inequalities in health and inequalities in mental health. The two additional strategic staff were included at the suggestion of other respondents as they were thought to be particularly influential in relation to inequalities and direction of the CHP. The seven senior respondents are collectively referred to here as strategic staff.

A summary of the coding scheme for interviews with strategic staff is given in Table 5.2, where findings from the interviews are reported under the three main headings of Core Roles, Reflections on Practice and Inequalities. In order to trace sources of quotes from the interviews while maintaining anonymity, the identifier allocated to transcripts on importing them to the ATLAS.ti programme is used in the thesis. Identifiers are numbers, preceded by the letter P. Where my speech was included in quotes, I am identified by my initials of PC.

Table 5.2 Coding scheme for interviews with strategic officers

Theme	*Sub-theme 1*	*Sub-theme 2*
Core roles	1. Discipline	Psychology Community Care Psychiatry Public Health (x2) General practice Health Services Management
	2. Core activities	Management Strategy Practice General practice Mental health practice Member of Steering Group CHP/Council focus NHS Board-wide
	3. Roles in mental health	Service provision Strategy Prevention Research LHCC/CHP roles
Reflections on practice	1. Mental health conditions in primary care	Severe to enduring Mild to moderate Older people and substance abuse
	2. Problems with mental health services	Criticism of services and providers Gaps in services Overwhelmed services Lack of development Limitations of services available
	3. What could be done to improve mental health services	Tackling causes and prevention Thinking and working differently Organisational change
	Reflections on needs assessment	[reported in Chapter 4]
Inequalities	1. Definitions	Individuals Communities Rich/poor gap Societal factors Organisational issues People most at risk
	2. Information	Mental health Health inequalities Inequalities in mental health
	3. Practice	Own role in health inequalities Problems in reducing inequalities in mental health What could be done for health inequalities

Core Roles

The core roles of respondents were discussed early in the interviews in order to clarify their activities and beliefs in relation to mental health before going on to explore their perspectives on inequalities and are presented under Disciplines, Core activities and Roles in mental health.

1. Disciplines

The disciplines represented in these interviews were as follows: psychology, community care, psychiatry, public health (x2), general practice and health services management. Respondents' roles and reflections are reported below under the headings of Core activities and Roles in mental health.

2. Core activities

Steering Group members interviewed were a combination of practitioners, managers and strategic officers and some held responsibilities for all three arenas within their posts. The other two officers interviewed also had strategic and managerial roles. Some participants worked directly for or were aligned with the CHP and others had Board-wide roles with some link or influence within South Ayrshire CHP. Two were mental health specialists and five had generalist roles although all five generalists had remits that included some element of mental health which was either directly through patient contact or through managing staff with mental health remits. A summary of the combination of roles is presented in Table 5.3.

Table 5.3 Roles and responsibilities of strategic officers

Respondent Role	P5	P19	P23	P25	P26	P24	P27
Manager		✓	✓	✓	✓	✓	✓
Strategy Role	✓	✓		✓	✓	✓	✓
Practitioner	✓	✓	✓				
Generalist (including mental health)	✓			✓	✓	✓	✓
Mental health specialist		✓	✓				
Member of Steering Group	✓	✓	✓	✓	✓		
CHP/ Council area only	✓		✓	✓			
Board-wide remit			✓		✓	✓	✓

3. Roles in mental health

Respondents' roles in mental health were explored in order to identify the level of influence they might have in driving action on mental health or on inequalities in health within the CHP. As a group, they had influence within and outside the CHP, and their reach extended from direct contact service users to the NHS Board. Their roles are reported under the headings of service provision, developing and implementing strategy, prevention and research, and roles in governance or managing staff in the LHCC or CHP.

Service provision: Three steering group members had direct service provision roles as senior practitioners. Between them they provided clinical assessment and medical and psychological interventions to primary care and mental health service patients, covering severe and enduring and mild to moderate illnesses. They also engaged in liaison between primary care and mental health services, and two of the three managed small teams of consultants.

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Developing and implementing strategy: Respondents chaired or participated in a number of strategic groups that focused on or included mental health, including: a mental health strategy implementation group; a multi-disciplinary group reviewing mental health services as a whole; a group tasked with retraction of services for people with a Learning Disability; implementation of the most recent Mental Health Act; a joint health and social service group to look at supporting people with mental health problems and others in the community; and a multi-agency mental health and well-being advisory group. One respondent said that:

> *"there has been a plethora of groupings really that have been looking at mental health services"* P25

Prevention and research: One respondent managed a team of staff who did not have mental health in their titles but provided some input to schools around confidence and self-esteem, and also had a staff team member who was responsible for implementing the framework for mental health and young people. This respondent was also involved in reviewing a mental health promotion strategy.

One respondent intended to use the methodology and epidemiology from the CHP needs assessment across the whole NHS Board area for further mental health needs assessments and other mental health activity already underway including working on the link between alcohol and brain damage.

LHCC/CHP roles: In addition to the service provision roles of three practitioners on the steering group, two other respondents had direct links with South Ayrshire CHP through managing staff who worked in or with the CHP. Another steering group member's links with the CHP was through a Joint Futures Steering Group which was looking at services for older people, mental health and learning disability. Only one respondent did not have direct links with CHPs although her work was expected to influence their practice and planning.

Reflections on Practice

Respondents' perspectives on planning and delivery of local mental health services were sought to identify whether inequalities were taken into account from their perspectives. They were asked specifically about their roles and the mental health conditions that are dealt with in primary care, but all respondents also offered other reflections on mental health services particularly in relation to problems in their planning and delivery. Some ideas for improving services and improving mental health were also

suggested. Reflections on practice are reported under the headings of mental health conditions in primary care, problems addressing mental health and what could be done for mental health.

1. Mental health conditions in primary care

Strategic staff who also worked as practitioners tended to provide lists of conditions, or discussed specific problems they had direct experience of in practice. Those without practitioner roles offered more reflective accounts about a smaller number of mental health problems, including exploring causal factors. Categories were assigned to mental health problems discussed as severe and enduring, mild to moderate and elderly people/substance abuse.

Severe and enduring: Respondents described some severe and enduring problems as being an issue for primary care. In this category were patients with complex problems such as schizophrenia combined with substance misuse, people with brain injuries as a result of alcohol and violence or neglect, or people with acquired brain injuries.

Mild to moderate: Mild to moderate problems were mentioned by most respondents, including that anxiety and depression were the most common problems to go the GP about, and mothers with postnatal depression being picked up at a family centre where there was a nurse working. One respondent described mild or moderate disorders as those that will respond better to particular interventions:

> *"if we are talking about anxiety disorders and that level of severity and then there is the kind of more moderate or mild ones that will respond better to psychological interventions or to changes in life circumstances".* P26

Another respondent said that mild to moderate conditions were not really mild and the issue was about presentation:

> *"people with psychological needs who don't meet the criteria for requiring multi-disciplinary case management. So they don't have the same sorts of severe and enduring mental health problems* […]. *I think they are sometimes thought of as the people with mild to moderate problems although that's not really true – it's about the way in which it presents itself."*
> P23

Elderly people/Substance misuse: One respondent believed that one of the biggest needs relating to mental health in South Ayrshire in the years to come will be related to elderly people with addictions with both of these issues related to deprivation and to rurality:

> *"I think in South Ayrshire one of the biggest, or two of the biggest needs will be elderly and also probably addictions because a lot of addictions has come in to South Ayrshire* […] *they have an elderly population and an increasing number of their elderly population. They also have a major problem with addiction in massive areas of deprivation,* […] *and one particular in Ayr is grossly deprived, but they also have a lot of rural deprivation."* P27

2. Problems with mental health services

As mentioned above, problems with mental health services were unprompted in the interview but mentioned by all of the respondents. It should be noted here that some respondents also remarked on the successes of certain local services for example a local register of people with learning disabilities, the drug misuse service run by a voluntary organisation on behalf of the NHS and new training on the recovery model for mental health demonstrating that despite problems, their perspective on services was not entirely negative. Polarised views were picked up within the group on a number of issues including seeing the same services from very different angles. For example, one respondent emphasised a lack of attention on services for patients with severe and enduring mental health problems while another believed that the system coped well with these:

> *"P 19: The Board does not prioritise mental health issues.*
>
> *PC: Who would you say suffers most from mental health services not being prioritized?*
>
> *P 19: Oh people who, people with severe mental illnesses will be hurt most, people who won't complain. GPs tend to respond to complaints, but certain patients, for example psychotic patients are unlikely to be able to complain and demand a service."* P19

> *"We do look at mental illness and we do have a fairly good robust treatment programme and the GPs do recognise and identify and treat and they link into the CMHTs and it all seems to gel together and particularly if we are looking at the very severe end, the severe and enduring stuff, then that does seem to be coped with quite well."* P26

Other issues highlighted as being problematic are described below under the headings of: criticism of services and providers, gaps in services, overwhelmed services, lack of development, and limitations of services available.

Criticism of services and providers: Three aspects of mental health services drew criticism from respondents. These could be described as direct service provision, data collection and use of information, and strategic leadership.

(i) Direct service provision: GPs were criticised for appearing to see mental health patients as difficult and time consuming and primary care staff in general were thought by others to lack confidence in dealing with mental health problems. One respondent had been unable to get GPs on board for a suicide review process. The fact that mental health was not covered adequately by the Quality and Outcomes Framework was one reason suggested for difficulties encountered in involving GPs in mental health services.

One respondent believed that mental health can be used as a political football with involvement of drug companies:

> *"In some practices mental health is used as political football,* […] *and there is a problem with the training in primary care in that for mental health it is generally drug sponsored which means that sometimes guidelines are not enacted on, for example, for depression etc. Drug companies pay for speakers, but the NHS pays for GPs to attend, em, that kind of training and there doesn't appear to be much appetite in the NHS for changing that, although in the CHP some senior CHP members are quite keen to change it."* P19

(ii) Data collection and use of information: Concerns were raised by one respondent about data on mental health, such as hospital admission figures not being collected accurately and other data being collected but not used. Consequently the respondent believed that information could not be used to support changes in services and in addition, there were plans being produced that were proposing actions with no clear evidence base:

"there is a lack of epidemiology in there, but there are actions being identified as, you know, the right ones to take, but on what basis they're being put forward is unclear so perhaps the route of the planning is deficient to some extent." P26

(iii) Strategic level: A number of respondents expressed concern about lack of leadership for mental health and well-being at all levels Board-wide and within the CHP. For example, there was said to be a lack of clarity about service provision for patients, with a multitude of possible entry points into mental health services. This was difficult for planners who were not involved in frontline services to understand, and prevented services being joined up at strategic level. There was concern expressed that organisational structures were focused on financial priorities rather than on clinical governance, and that entrenched professional boundaries were hindering integrated care management.

Gaps in services: Most respondents identified that there were major gaps in psychological services and services for children and adolescents, both of which had also been highlighted in the mental health needs assessment:

"We are definitely short of psychological services of all sorts and the waiting list for psychology is just totally unrealistic. People do not have problems 18 months from now they have problems now. I'm sure that would be of great benefit, and child and adolescent services are virtually non-existent." P5

Other services highlighted as having gaps were Cognitive Behavioural Therapy and addictions. The addiction substitution service which had been developed alongside primary care was praised by one respondent. However, problems were mentioned relating to addiction services in general, including that addiction reduction services were needed but unavailable. In addition, dual diagnosis with mental health often led to referral into addiction services, which was not always appropriate.

Overwhelmed services: Secondary and tertiary mental health services were said by some respondents to be overwhelmed by patients who might be more appropriately dealt with at primary care level. This was said to have resulted in community psychiatric nurses doing less work with people with mild to moderate problems, such as relaxation and counselling, because of the high level of severe mental illness that they had to deal with. In addition, some community mental health teams were thought to be understaffed, adding to the pressure within the mental health system. One respondent was concerned that patients with mental health problems needed to be referred to someone who can

spend time with them, but this was often not an option as waiting lists for psychologists were too long.

Lack of development: Two respondents were concerned that the NHS Board had not prioritised mental health in recent years. For example, a five year plan for mental health services produced in 1999 was only funded for one year, and the report from a mental health service re-design from four years ago had only been made available recently. Another respondent believed that mental health care and treatment has taken precedence over developmental work:

> *"We had a big focus on the mental health care and treatment not surprisingly, but that did stop us progressing the other agendas because everybody's energy had to go onto that and that really meant that we were at a stand still for the development work, you know."* P26

Limitations of services available: Some respondents believed that there was a lack of opportunity or resources to carry out preventive action for mental health, such as communicating information about health promotion or access to services to people with sensory impairment, or offering stress management sessions. One respondent was direct in his criticism of current health promotion efforts:

> *"Oh we're not good at that.* [prevention] *Somebody going in with a quasi uniform or this view, I'm telling you what you should be doing – you shouldn't be eating that fried mars bar. So what, get stuffed I'll eat that if I want that's all I can afford, rather than going in and saying, well okay you're having that, but we could get you something much better for you and having that sort of approach."* P27

There was a feeling among some respondents that the current services were unable to meet the needs of patients with complex needs for example,

> *"in a simple uncomplicated depression that [recovery] is something that you can see, whereas it is much more difficult when there are 1001 problems to solve as well of the socio/relationship type."* P5

Two other respondents highlighted difficulties for current services for meeting complex needs including when a patient had a mental illness as well as physical problems such as Hepatitis B or Hepatitis C. One respondent was concerned that areas of deprivation did not get the best treatment for mental health, as people with chronic problems often didn't seek help. Another respondent was also concerned that complex issues around a

mental illness posed a problem for the CHP and its partner agencies, as well as for individual practitioners:

> *"Again criminal justice, there is an overlap there of people that are offending who's problems are very multifaceted, you know, so you've got addiction problems, mental health issues, poverty issues, offending issues, and it's all very, very complex, you know, unpicking that and it's just, in terms of how the CHP responds to mental health issues then it's how broad do you make it and in some ways you have to kind of narrow, narrow down the, you know, the range really, so that in fact we're not, we cant deal with everybody. In some ways I think that has been the difficulty in trying to work out exactly what the definition of mental health issues are."* P25

In summary, a picture emerged of an apparent lack of strategic leadership for mental health services. A complex system existed between mental health services and primary care with little clarity as to which problems should be dealt with by whom. Both primary care and mental health services appeared to be unhappy with the other's efforts, and polarised and disparate views were expressed for many important issues in delivery of mental health services to very vulnerable patients. Services for people with mental health problems appeared to be under-funded and unable to deal with patients with dual diagnosis or complex circumstances, or to be able to take preventive action.

3. What could be done to improve mental health services

As well as identifying problems, strategic staff also made suggestions for practice that could be developed to improve mental health or mental health services. Suggestions tended to be general rather than specific, and no respondents talked about what they would or could do themselves, or within their teams. Instead, suggestions were offered for services in general or for staff outside their own jurisdiction. Suggestions for improvements are presented under the themes of tackling causes and prevention, thinking and working differently, and organisational change.

Tackling causes and prevention: Four respondents made suggestions for actions to tackle causes of mental health problems including: helping with relationship problems, getting people off drugs or helping them to control their lifestyles, helping with problem-solving for patients with minor ailments, and supporting families to help children. One respondent believed that if domestic violence were tackled other elements of mental illness would also be addressed:

> *"I mean the East has looked at domestic violence and the links between domestic violence and mental health and domestic violence and alcohol and how that, if you tackle the domestic violence you will help to tackle the other elements or you allow the other elements to be addressed."* P26

Four respondents mentioned that prevention should be adopted in general by services with two believing that primary care had an important role since GPs were usually the first point of contact for patients with a mental health problem. Another respondent believed that prevention should be seen as everyone's business, but that it was sometimes assumed to be only within the realm of the health promotion department.

Thinking and working differently: There were a number of suggestions made for primary care to work differently including that GPs should consult with communities and user groups, and that there should be more support available for staff who were prepared to champion the cause for mental health. Most of the other suggestions made were for stronger adherence to protocols and guidance documents, or for establishing recently introduced models of working such as the recovery model or tiered, flexible treatment.

Organisational change: Some respondents made suggestions for changes at organisational level to improve mental health, such as a complete overhaul of mental health services including leadership, strategy, management and delivery, although changes should be based on a profile of patients. Interestingly, this might happen as another respondent described plans that had just recently been agreed for a new financial framework for continuing care and discharge planning, reviews of clinical practice and the overall mental health strategy, and a mini review of mental health services. It was suggested that this process might help to bring some synergy to mental health services that some respondents believed was missing, despite an apparent industry of action within the services, for example:

> *"There has been a lot of work with addiction services, there is a lot of work with the home detox teams and there is a lot of work with the other team home crisis teams. There is also now a liaison service which links in with A & E which has direct links in with in fact with primary care. So there is a lot going on in mental health, but you will always get the impression it's not totally coordinated, they are all doing a wee bit here and a wee bit there and doing very well, but if you actually put it all together the synergy in that would be fantastic and you're losing that synergy".*P27

Inequalities

Respondents' views on health inequalities and inequalities in mental health and what might be improved were explored in the interviews. Findings are reported under Definitions of health inequalities, Information, and Practice.

1. Definitions of health inequalities

The themes emerging for definitions of health inequalities, first identified in the policy analysis reported in Chapter 4, were applied to strategic staff data in order to compare definitions given by strategic officers with the definitions given in policy documents. The same themes were also used to analyse data from frontline professionals, and a comparison of all three sets of data for definitions is given Table 6.4 at the end of Chapter 6. A question asking respondents who they thought might be most at risk of mental health problems was used in the interviews in order to explore respondents' definitions in more depth. The themes for definitions are reported under the headings of Individuals, Communities, Rich/poor gap, Societal factors, Organisational factors, and People most at risk of mental health problems.

Individuals: No respondents described definitions for health inequalities that were related to individual mechanisms such as behaviour or choice.

Communities: Two respondents talked about deprivation and environment as being linked to health inequalities. In addition, another respondent strongly associated area deprivation and geography with addiction:

> *"I think this (mental health) needs assessment in South Ayrshire will be very similar because (a) they have an elderly population and an increasing number of their elderly population they also have a major problem with addiction in massive areas of deprivation and they have major areas of deprivation in North Ayrshire, but South Ayrshire also has deprivation and one particular is KA6 in Ayr is grossly deprived, but they also have a lot of rural deprivation."* P27

Rich/poor gap: Most respondents linked health inequalities to demonstrations of differences in health between different socio-economic groups, or as being linked to poverty. One respondent highlighted that the most common way of looking at inequalities was through geography because data was available, but that this was only

one way of looking at it. Another respondent identified that people with mental health problems differed according to social class and other demographic differences

Societal factors: One respondent described social circumstances including life opportunities, poverty and housing as being linked to health inequalities. Two respondents highlighted that different population groups had differences in health status. One of them also said that there were some measures that could be used to describe differences in health relating to gender, ethnic minority and sexual orientation, but data was of variable quality and did not always answer the relevant questions about health inequalities.

Organisational factors: Four respondents linked health inequalities to access to health services, particularly when people from deprived areas were less likely to attend appointments. Another respondent pointed out that there was evidence that someone with a mental health problem would have unequal access to other health care, and another believed that the challenge for the NHS was to find ways to engage with the 10 to 15% of people with the highest morbidity rate. This respondent also made some suggestions as to why people from deprived areas might not access services:

> *"if you send out ten appointments to somebody who lives in KA1 to come and get their blood pressure checked and their cholesterol checked nine out of ten will come and do it. If you send it to KA6 you'd be lucky if you get two out of ten to come. Now, they have their own reasons for that (a) they might not be able to afford the bus fares (b) they might not have somebody to look after the weans (c) they may be that drunk they don't know what's going on (d) they may be worried in case somebody catches them because they are on bail or whatever and there is all these issues, so we have to have a different method of being able to actually engage."* P27

People most at risk of mental health problems: All respondents believed that socio-economic factors increased the risk of mental health problems although two noted that cause and effect were difficult to entangle. Only one felt that socio-economic factors were less problematic than other risk factors such as bereavement, childbirth, family history or illegal drug use. However there was evidence from some of the interviews that respondents had not always thought through the issue for example:

> *"PC: Who do you think are most at risk of developing mental health problems in South Ayrshire?*
>
> *P24:   Oh* [pause] *I don't know if I could really say. I mean definitely I think people living in deprivation, but I think certain target groups as well."*
> P24

In summary, strategic staff tended to define inequalities in health in much the same way as did the policy documents in the analysis reported in Chapter 4. Most described health inequalities as being linked to observable differences between socio-economic groups, and that some social circumstances might be linked to health inequalities. However, definitions tended to be patchy in that few respondents used definitions that spanned all possibilities. While all respondents mentioned poverty or geographical deprivation (although few mentioned both), only one mentioned social factors of gender, ethnicity and sexual orientation. None mentioned age as a risk factor as highlighted in the needs assessment. There was evidence that some respondents had not thought through that some people might be more at risk of mental health problems than others.

2. Information

Information on mental health: Information on mental health was thought by some respondents to be accessible if required, while others believed that there was not enough information available for planning. For example, two respondents believed that GPs and other frontline staff knew the issues around mental health, but that this information was drawn from knowledge of the GP's particular client group and therefore had limited use for understanding of the wider population. However, another respondent who was experienced in data analysis, was clear that epidemiology data was limited in relation to mental health:

> *"We have got lots of addiction statistics in terms of people coming into mental health,* […] *so we've got the addictive stuff and the physical harm and it's trying to marry those two elements together to say this is the total picture. And we get differences according to age, we get differences according to where people are coming from and we get the gender difference.* […] *So yes, I would love to do something similar to mental health. I just don't think that we have the data sets to do it and I think NMHIP* [the national mental health information programme] *would agree."*
> P26

Information on health inequalities: Again, respondents said that they would have to seek out information on health inequalities if required. Profiles had been carried out nationally and locally linking inequalities in health to deprivation across South Ayrshire, including one carried out within one or two years of the interviews. However, only one respondent mentioned the local profile. Another respondent stated that they sought out information on health inequalities from journals, the internet, and through meetings and presentations.

Information on inequalities in mental health: Once again, respondents said that they would have to seek out specific information relating to inequalities in mental health:

> *"PC: Do you get any information specifically about inequalities in mental health?*
>
> *P25:   No, not really.*
>
> *PC: You would have to seek out?*
>
> *P25:   No, we'd have to seek it out.   There is nothing that is done ordinarily that helps to kind of raise those kinds of issues locally, we'd have to go and look for it."* P25

Some respondents felt that more should be done about information for inequalities and inequalities in mental health. One respondent believed that more needed to be done to understand health needs in general, and suggested that statisticians should be brought together with public health practitioners and doctors:

> "*The demographics plus also the local information, plus also what are the actual killers out there. What is it that is going on?"* P27

3. Practice

Own role in health inequalities: Three respondents stated that they carried out action on health inequalities, such as to fund or manage practical interventions, advocate for health inequalities in strategic groups, and contribute to strategy development. One intervention described was a welfare benefit advice initiative in a primary care setting for patients with mental health problems. Advocacy for health inequalities and for voluntary sector roles in addressing drugs and alcohol, was taken forward by another respondent, within the CHP Board and other local strategic groups. One respondent had

responsibility for strategy development which at the time of the study, included a strategy for health inequalities which was currently in draft form, and to ensure that health inequalities were represented in other strategies. It could be concluded from this that there were influential individuals potentially contributing to debates about aspects of inequalities in mental health at senior levels within the CHP.

Problems in reducing inequalities in mental health: As suggested previously, some respondents believed that there was not enough information on which to base planning for reducing inequalities in mental health. For example, one respondent suggested that there was no capacity within the service for finding out about the patients who didn't use services, or for looking at areas where they might not be doing enough. Other respondents mentioned the lack of epidemiology, or that the data that was available was of variable quality.

Another challenge for reducing inequalities in mental health was that articulate people or the "*worried well*" (P27) were the patients who were most likely to be able to access services rather than those with higher levels of vulnerability, and the challenge for CHPs would be to divert resources to areas of greatest need.

The third issue was raised as a problem throughout the interviews and this was the emphasis on acute services which acted to de-prioritise mental health services as it fell between the higher profiles of acute and primary care services.

What could be done for health inequalities: Already mentioned was the need for clarity of vision at strategic level and an understanding of roles and responsibilities across the system. New resources were said to be required to be ring-fenced for the system to deal with inequalities in health. Better information from epidemiology and from patient profiling was also thought to be required in order to gain a population perspective and to see how health inequalities affected different population groups. Some respondents suggested that there was a need to raise awareness of issues relating to inequalities among clinicians and in general:

> *"I mean obviously, you know, poverty is not just about money it's about other things as well, it's about lack of opportunity and different expectations. Yes I think it is about raising awareness and looking at more national research and looking locally at what needs to be done within our own area."* P25

Summary for interviews with strategic officers

Most respondents believed that health inequalities were related to poverty or deprivation, and some respondents also linked geographical deprivation to high levels of addiction, or to patients being less likely to attend NHS appointments. There was evidence that some respondents had not thought through who might be at most risk of developing mental health problems, while others worked to advocate for inequalities issues within strategic groups related to the Community Health Partnership (CHP). Findings relating to definitions and actions generally reflected perspectives found in the policy analysis reported in Chapter 4. This is perhaps unsurprising, as respondents were all senior strategic staff whose roles were generally to manage the implementation of elements of national policy. Problems with mental health service provision were highlighted by all respondents, particularly in relation to lack of leadership; the apparently disparate and confusing nature of mental health services offered to patients; and the lack of capacity within the service to deal with the volume of patients or the complexity of patients' mental health problems. While all of the respondents at strategic level appeared to be influential within or in partnership with the CHP, they did not articulate their perspectives on health inequalities within the needs assessment process.

Summary of key findings from observation of the mental health needs assessment

The needs assessment observation included an appraisal of the local strategic context resulting from national policy drivers and local priorities; the dynamics of the needs assessment itself; and additional exploration with key individuals in order to identify where a focus on inequalities might be located within the CHP structure.

The appraisal of local strategy documents demonstrated that the strategic context in South Ayrshire did not include emphasis on addressing inequalities in mental health in any documents. Health inequalities in general were also absent from most local strategies with the exception of the Local Health Plan and an early draft of a health inequalities strategy. There had been one attempt at a local level to explore the link between health outcomes and deprivation which had been inconclusive. There was some evidence that future documents might focus more on health inequalities with one plan proposing the challenging suggestion that health services might inadvertently work to increase inequalities.

The mental health needs assessment did not include objectives for inequalities other than to describe mental health epidemiology in relation to socio-economic factors. This

was despite that the original need assessment proposal had been strongly orientated to include inequalities issues, and that one of the original authors was involved in the process. The final literature review and needs assessment reports provided evidence from data analysis and previous research that some areas in South Ayrshire might contain people who are at greater risk of mental health problems than others, therefore causing potential variation in needs for mental health services across the area. However, recommendations in the final needs assessment report and the steering group discussions did not pick up on these issues, either for re-shaping services or for suggesting further exploration. Terminology relating to mental health problems used in the final reports showed similar inconsistencies as in other research and policy documents, demonstrating some of the inherent difficulties in defining mental health problems.

Some individual steering group members believed that social circumstances were linked to mental health problems, but this was not raised at any meetings nor included in any other element of the needs assessment. However, respondents believed that there was not enough information about inequalities or about mental health to fully understand mental health needs, or to use as the basis for sound planning of services. They also appeared to believe that they would be unable to influence their own or other's service developments with the reports' findings. However, the needs assessment did not appear to be linked directly into other local or Board-wide strategic mental health and well-being groups, reflecting some of the problems highlighted by respondents of lack of clarity of leadership, accountability and decision-making for mental health services.

In conclusion, the observation of a mental health needs assessment demonstrated that inequalities in mental health were not fully understood or prioritised for exploration by the CHP. While some individuals with influence within or on the CHP held personal beliefs about links between social circumstances and mental health, these ideas were not contributed to the needs assessment process.

Chapter 6

Results III

Frontline professionals' interpretations of inequalities in mental health

Introduction

Chapter 6 presents the results from an exploration of mental health and primary care frontline professionals' interpretations of inequalities in mental health as a policy issue. It draws on interviews with 21 frontline staff working in primary care and mental health, representing the second community of meaning within the implementing agency, and the third community of meaning within this study. Results were also linked with the analyses of policy documents and interviews with strategic staff, in particular the definitions given for health inequalities. The summary of combined data for definitions is given at the end of this chapter in Table 6.4.

As described previously in Chapter 3 Section 2, respondents are labelled in the results as either generalists or mental health specialists. Those labelled here as generalists were staff whose roles included first contacts with patients who may or may not have a mental health problem, although their roles might also include providing a service to patients referred to them. Those described as mental health specialists provided a mental health service to patients as a result of referral into their service. Three topics of "Core Roles", "Inequalities" and "Tom" were identified from the interview questions to divide data for analysis. "Tom" refers to responses to the vignette presented in the interview and represents the fourth community of meaning in the study. Results for Tom are presented in Chapter 7. Results for "Core roles" and "Inequalities" are presented in this chapter in two sections followed by a summary of the combined findings for definitions given by policymakers, strategic officers and frontline professionals. Reporting of quotes from respondents follows the format described in Chapter 5 for interviews with strategic officers.

Section 1: Core Roles

Information about respondent's core roles was important to identify the breadth and scope of their roles, provide context for understanding their approaches to practice which would be explored further through responses to the vignette, and to clarify their

understanding of mental health conditions. The coding scheme for Core Roles is presented in Table 6.1. Results are then presented for each theme and sub-theme under the main headings given in the table of; Context, Practice in mental health, and Reflections on practice.

Table 6.1 Coding scheme for core roles of primary care and mental health professionals

Theme	*Sub-theme 1*	*Sub-theme 2*
Context	**1. Discipline**	Mental health specialists Generalists
	2. Practice demographics	South Ayrshire South Ayrshire plus some cross boundary All Ayrshire GP Practices Area descriptors
	3. Years in Practice	
	4. Additional previous experience	
	5. Additional Practice	
Practice in mental health	**1. Core Activities**	Referrals in Assessments Interventions Signposting or referring on Liaison Other practice-related roles
	2. Local services available	Mental health services Community resources
Reflections on practice	**1. Mental health conditions in primary care**	Severe and enduring Mild to moderate Elderly people Substance misuse Mental health problems resulting from physical problems Carers Difficult to categorise/not coping
	2. Prevention	
	3. Problems with mental health services	Criticism of services and service providers Gaps in services Overwhelmed services Lack of development Limitations of services available
	4. What could be done to improve mental health services	Specialist referral Connecting people Earlier identification and access Thinking and working Differently

Context

The context for respondents' core roles was explored as background to aid understanding of their approaches to practice. There were nine mental health specialists and 12 primary care generalists interviewed. Mental health specialists tended to cover larger geographical areas than the generalists, who were mostly based in GP practices. All respondents worked within or had responsibilities that included South Ayrshire Community Health Partnership, working across deprived and affluent areas and most respondents covering a mix of rural and urban areas. All respondents held professional qualifications with between four and 30 years in practice since qualifying. Some respondents had held their current or similar posts for many years and over a third had previous experience in different arenas including addictions and social services. The context and core roles are summarised in Table 6.2

Table 6.2 Context for frontline professionals' core roles

Mental Health Specialists	Generalists
1. Discipline	
Community Psychiatric Nurse Project Manager (former Occupational Therapist) Primary Care Mental Health Worker (2) (former Psychiatric Nurse and Health Visitor) Physiotherapist Occupational Therapist Psychiatrist Psychologist Social Worker (4 male and 5 female)	GPs (3) District Nurses (3) Health Visitors (2) Practice Nurses (2) Pharmacy Advisor Homeless Persons Co-ordinator (3 male and 9 female)
2. Practice Demographics: bases	
South Ayrshire 4 South Ayrshire plus some cross boundary 2 All Ayrshire 1 GP Practices (across 2 practices) 1	South Ayrshire 2 GP Practices 10
3. Area descriptors	
All mental health specialists covered large geographical patches that included urban and rural areas and a mix of deprived and affluent communities.	6 generalists covered a mix of urban and rural, 5 rural only and 1 urban only. All generalists covered areas from across the spectrum from deprived to affluent although three worked mostly in more deprived areas and two covered less deprived areas.
4. Years in Practice	
Total since qualifying: Average 14.7 years Range 4 to 17 years Time in current post: Average 4 years Range 2 months to 9 years.	Total since qualifying: Average 16 years Range 8 to 30 years Time in current post: Average 8.5 years Range 6 months to 25 years.
5. Additional Previous Experience	
Addictions Social services Strategy implementation post (secondment) Health visitor	Addictions (3) Social services

Practice in Mental Health

1. Core Activities

The core activities of generalists and mental health specialists with patients with mental health problems are summarised below, under the headings of Referring in, Assessment, Intervention, Liaison, and Other roles.

Referrals in: Mental health problems were often identified as a side issue by generalists when they were seeing patients for other reasons, with the exception of GPs who had patients self-referring or referred to them for mental health problems. Referrals to mental health specialists were reported to be through formal routes from GPs to Primary Care Mental Health Workers (being piloted in a small number of GP surgeries), or more frequently to the Community Mental Health Team (CMHT), comprising community psychiatric nurses (although not all held the community qualification), occupational therapists and social workers. Referral to the team also provided access to psychology (although with a long waiting list), psychiatry and physiotherapy. Patients were referred to the CMHT as a whole rather than a particular team member, and would be given a general assessment by one of the team members before being assigned to the appropriate part of the service.

Assessments for mental health problems might be carried out by any of the generalists as part of core lifestage assessments, for example, with mothers in the postnatal period, with elderly people, or when a patient was suspected of having mental health problems. Validated assessment schemes such as the Edinburgh Post Natal Depression Score, locally developed tools including one created to identify depression in elderly people, and a personally-devised system, were all used. However, assessment tools were sometimes considered as only one aspect of making an assessment. For example a feeling that all is not well would be taken seriously:

> *"yeah I know it's a well validated, you know em validated and everything, but you will get girls that will score nothing and your gut feeling is that it would be a lot higher*[…]. *It depends what I know about the family"*.
> Generalist P8

Building relationships with patients was regarded as an important component of ensuring early detection of mental health problems. For example, respondents described situations when they had spent time building trust with patients or carers, or in one case with another member of staff, using empathy, exploration to find out more information,

drawing on other team members' knowledge, and offering support to a patient until they were ready to agree to act on the practitioners' concerns.

In contrast, mental health specialists usually carried out assessments using validated and established assessment tools with additional exploration of symptoms. Assessment tools mentioned included the Hospital Anxiety and Depression Score (HADS), Patient Health Questionnaire, Work and Social Adjustment Scale and Canadian Occupational Performance Measure. Some of the respondents would see patients who had already been assessed by others, in which case they used the report from that assessment as the basis for further exploration. The assessment tools were mostly used at the first or second appointment to assess the patient's needs for referral on or for intervention although one participant used four scoring systems at the first appointment and repeated them at the last appointment following four structured intervention sessions to identify any changes in the patient's mental well-being. Some respondents stated that they also used the assessments to stimulate discussion, and to help the patient understand better their mental state. For example, the HADS was used in this way:

> *"it often was good because you're able to say well look anxiety is the major thing here it isn't low mood, but low mood, there's a wee bit of low mood and that was generally very enlightening for folk to see, because obviously they were sometimes not clear whether they were anxious or stressed, but some of their responses would indicate that hey you are struggling with that. So it's further encouraging them to decide that they needed to do something about it"* Mental Health Specialist P7

Interventions from generalists once a mental health problem had been identified might include listening, prescribing, treating, referring or a complex set of actions involving many partners to solve a social dilemma. An example of the latter was where one respondent wanted to encourage a patient to take up a place at a day centre. This involved negotiating with the patient and the carer when one was keen and the other reluctant, organising transport, cancelling or re-organising other home based services, ensuring the patient can get help to get dressed on time on the day in question, as well as other logistical concerns. Direct intervention for mental health problems was occasionally offered as part of a primary care generalist role, including structured stress management, support for carers, support to resolve social issues, and prescribing or monitoring pharmaceutical treatment:

> *"In fact one of the gratifying things we do is to have someone come in here who is really quite depressed and we have known before and you know this is a totally different person and within two or three weeks you can see them just suddenly coming back again".* Generalist, P5

There was some overlap suggested with interventions by mental health specialists within the new model of primary care mental health, but generally they were distinct from primary care. Mental health specialists' interventions were usually in the form of structured, pre-set sessions lasting between four and eight weeks or in fortnightly appointments. These sessions could be therapy oriented or for guided self-help followed by review then discharge, or referral either back to the referring GP or on to a more specialist service. Some of the mental health specialists described their service within the stepped or tiered approach. One respondent explained the tiered approach as starting with community level with information and general health and well-being messages or through voluntary organisations or clinicians for support such as a book prescription scheme or lifestyle coaching. The next tier was for moderate symptoms of depression which could be dealt with by the Community Mental Health Team (CMHT) or the new primary care mental health workers. Patients with moderate to severe problems would be referred for assessment through the psychology services.

Signposting or referring on by generalists could be to a GP for further referral to NHS mental health specialists, referring to social services, or referring or signposting to voluntary sector organisations. However, generalists were clear that if they suspected that a patient might have a mental health problem, they would refer them to their GP in addition to other routes for help if appropriate. Most of the generalists also emphasised that building links with specialist mental health services was important in order that they could learn about specific mental illnesses, clarify their own limits of knowledge about mental health problems, and be in a position to negotiate a position of shared care after referral if necessary. Another element was to know what mental health services might offer their patients.

Mental health specialists would refer patients on to other services, including those in the NHS and in the voluntary sector, for specialised or social support. Most mental health specialists also talked about building relationships with other service providers such as the GP or other members of the CMHT in order to agree treatment, or at least to ensure that the GP was aware of the treatment the patient was receiving. Mental health specialists often appeared keen to maintain patients within a primary care service or to divert patients away from mental health services:

> *"you go along with government philosophy and local philosophy, you know, about not stigmatising people with regards to mental health needs and diverting them away from mainstream mental health services"*. Mental Health Specialist, P3

Voluntary sector organisations particularly those providing specialist services such as counselling or help with alcohol problems, appeared to be used regularly and valued highly by both generalists and mental health specialists. However, some were concerned that the funding problems suffered by the voluntary sector meant that they were not always assured that the organisations would be available.

Liaison was a core part of both generalists and mental health specialists' work. For example, respondents worked to co-ordinate care across generalist and specialist input; engaged in formal partnership working, such as in carrying out single shared assessments; worked in joint funded posts; or developed informal partnerships or networks, for example:

> *"it's communications, who you know, networking I suppose you would call it* […]. *I made a point of going out and shadowing them, phoning them up and going to see them and, you know, I get on really well with social workers that are in our area because I know them all, you know, I know that if I phone them up and I ask them for something that they will give it to me, you know, because they know that I'm not just doing it to be bolshy.* […] *I think it's a communication thing and if you scratch my back it means I'll scratch yours further and it works, it works for me."* Generalist, P6.

Mental health specialists also talked about liaising with other services in order to improve access to services, to teach generalists more about mental health, to share learning and practice, and to augment a medical model of treating mental health problems with a social model.

Other practice-related roles included management responsibilities in addition to clinical roles, either in managing small teams, or membership of strategic working groups or LHCC or CHP governance groups. Some respondents also participated in teaching or advising other staff, trainees or staff from other statutory or voluntary organisations.

2. Local Services Available

Both mental health specialists and generalists listed a large number of mental health services and resources available in their areas to which they would refer or signpost patients for support for mental health problems. Not all services were available in all local areas or GP practices and that was true of primary care mental health services as well as services outwith the NHS. Taken together patients in South Ayrshire potentially had access to some of the following services:

Mainstream mental health services included: lifestyle advice, book prescription scheme with reference group advising on library service, Cognitive Behavioural Therapy (CBT), Doing Well by People with Depression primary care mental health workers in a rural practice, self-help material, exercise for depression referral scheme, health visitor offering stress management sessions, welfare benefits in primary care, family support and counselling through social work, dual diagnosis team, child and adolescent mental health services within psychology, substance misuse team, smoking cessation through health visitor and practice nurse, travel passes available to patients of the CPN in a rural area, free access to keep fit and swimming for mothers attending the CPN, Joint Futures-funded integrated care team, and care pathways for patients in psychiatry.

Community Resources included: Citizen Advice Bureaux, a database created by primary care of voluntary organisations through a group called Working Together, counselling, family mediation, carers support organisations including the Princes Trust and others, Scottish Association for Mental Health, community education with childcare, Rape Crisis (funding had just been withdrawn in the area but services in a neighbouring area could be accessed), respite care, addictions services managed by Turning Point (formerly the Bridge Project), family support services, exercise class for over 60s (Class Diamonds), innovative ways of providing information in the community such as through a GP receptionist and a hairdressing shop, mother and toddler groups, youth club, church groups, alcohol counselling services including Ayr Council on Alcohol and Alcoholics Anonymous, rural phone-up bus service, lunch club and "good community spirit".

Reflections on Practice

1. Mental Health Conditions in Primary Care

The terms "mild to moderate" and "severe and enduring" were used by most respondents to describe two discrete categories of patients. Four of the mental health specialists stated that they dealt with patients with mild to moderate problems, three

dealt with patients suffering severe and enduring conditions and two dealt with patients from both categories. Generalists could potentially be dealing with patients from both categories at any one time, but some generalists would see some severe mental health conditions only very rarely. Most respondents from generalists and mental health specialists considered that primary care was the right arena to deal with mild to moderate conditions for example using SIGN (Scottish Intercollegiate Guidance Network) guidelines for managing anxiety and depression, and for co-management with psychiatric services of patients with problems such as schizophrenia and bi-polar disorder.

In direct response to my question in the interview asking respondents to name the mental health problems they saw in primary care, a typology emerged as; severe and enduring conditions, mild to moderate conditions, specific problems relating to being elderly, mental health issues for carers, mental health problems resulting from physical problems and mental illness relating to substance abuse. Many respondents also talked about conditions that were difficult to categorise, for example, whether they might be due to unhappiness or to mental illness. The same typology was applied to data from interviews with strategic staff. Responses differed between strategic staff and frontline professionals although the group of frontline staff was much larger than the group of strategic staff, and therefore potentially covered a much broader range of experience in mental health services. Categories emerging from frontline professionals descriptions are explained below.

Severe and enduring conditions: Schizophrenia, bi-polar disorder, personality disorder, post traumatic stress disorders, obsessive compulsive disorder, hyper manic conditions, self-harming and severe depression were all described by respondents as being severe and enduring conditions dealt with in primary care. New cases in this category were rare encountered by generalists with only an occasional presentation of a new acute psychotic illness. Patients with these conditions were instead longer term, thought by generalists to be well controlled and were usually co-managed with CPNs. Some generalists might see some patients with severe and enduring conditions but did not manage their care and usually only saw them when they were providing their service for another reason, for example, after the birth of a baby of for a district nursing issue.

Mild to moderate: This term was generally used to describe anxiety and depression although the latter was thought to be experienced either as severe or more manageable problems. Most respondents appeared to aim to manage these conditions outwith psychiatric services as much as possible in order to reduce stigma and reduce the need for travelling to, or being added to, a waiting list for specialist services. In addition mental health specialists in particular believed that these conditions could be managed in

primary care if caught at an early stage but they also recognised the increasing demands on primary care in general, and the time required to manage mental health conditions effectively. Most generalists thought of anxiety and depression as being very common across the population, and much more common ("*by a huge factor*" Generalist, P1) than severe and enduring problems. One generalist was shocked to see so many people with depression:

> *"I think my biggest shock, I always worked in secondary care, and my biggest shock coming into primary care was how many problem titles we have with depression.* […] *I couldn't believe that almost everybody, you know, that came in the door at some point had had a problem with depression."* Generalist, P13

Elderly people: Some generalists identified mental health problems relating to being elderly were more common now, including dementia and confused states relating to physical problems such as urinary tract infections and chest infections. CPNs were thought to be unlikely to keep these types of patients on their books, instead referring them back to generalists.

Substance misuse: Respondents identified a common ground between substance abuse and underlying mental health problems. For example, a respondent remarked that most homeless people were likely to have mental health problems together with alcohol or drug addiction. Two respondents suggested that people involved in drug abuse and alcohol addiction might now constitute the biggest group within their patients suffering mental health problems for example:

> *"you scarcely see someone with a mental health problem who isn't also mixed in with drugs, drugs is involved with it all and I'm sure it's getting more and more common"* Generalist, P5

One respondent offered possible reasons for people affected by substance abuse having mental health problems, suggesting that low educational attainment might be the underlying reason for some patients, but more importantly, there was often a strong history of abuse.

Mental health problems as a result of physical problems: Generalists mentioned mental health problems in relation to a number of physical conditions, for example anxiety developing with high blood pressure. One respondent believed there to be a strong link between physical and mental health:

> *"people get anxiety and stressed out, if they are ill or if their relatives are ill,*
> *people with terminal illnesses, things like that".* Generalist, P6

Carers: Carers were thought to be commonly referred to mental health specialists because of anxiety and depression. This included young people who were caring for parents with mental health or substance abuse problems, as well as parents who were caring for children with mental health problems. It was also suggested that carers would be unable to look after the person they are caring for if their own mental health needs were not identified and met, for example,

> *"It's also about identifying mental health needs of the family, carer, the*
> *parent because we recognise that that's a huge issue and clearly they will*
> *be disabled or disarmed in a way to follow through with the young person if*
> *they are having difficulties, if they have got problems themselves."* Mental
> Health Specialist P7.

Difficult to categorise/ not coping: Generalists and mental health specialists talked about seeing a large number of patients struggling to respond to difficulties in their lives including coping with work stress, family stress, neighbours, financial pressures, grief reactions, relationships and children, and some believed that unhappiness and depression were hard to distinguish between. In addition, two respondents felt that they were seeing more abuse of women by their partners and one felt that some of the mental health problems he was seeing stemmed from similar relationship problems at work:

> *"I mean so much of what we see is relationship problems. We see the wrong side*
> *of a relationship, I mean, we see the normal wife usually, a bastard husband and,*
> *um, or equally at work, I mean, we see the hard done by employees of vindictive*
> *bullies and, you know, that is quite a common situation."* Generalist, P5

As mentioned above the emerging typology was applied to strategic staff's accounts of mental health conditions in primary care and some differences were detected. For example, the link between physical and mental health, mental health needs of carers and difficulty coping were not raised by strategic staff. Strategic staff also provided more reflective accounts of a small number of issues while frontline professionals tended to list all the conditions they had seen in primary care. The main similarity was that both used the terms "severe and enduring" and "mild to moderate" to categorise different types of mental health problems.

2. Prevention

Primary prevention in general was regarded somewhat suspiciously by some respondents as being difficult to do and lacking clarity as to whether it really was part of their role for example,

> *"When I first started* […] *I thought it was all about primary prevention, but it's not, it's all secondary prevention so people have already developed whatever they are going to have and you are trying to stop it getting worse, which does work, but it's, I always say oh why can't we do the primary one, but you can't because people are generally quite happy in their lifestyles, what they're doing, what they're eating and their exercise wise and they're going along fine, there's no really issues until they have their heart attack or until asthma, you know, obstructive, chronic obstructive pulmonary disease, all those kind of things. It is difficult".* Generalist, P9

Prevention activity for mental health was mentioned only by one generalist and one mental health specialist, and both focused prevention towards specific activity. The generalist took on a role of ensuring that carers did not become too stressed and would organise practical support for them such as respite services. The specialist provided training for generalists in understanding mental health problems in order to support their preventative role. Other generalists and mental health specialists spoke about prevention activity and mental health promotion as being important. However, respondents reported that both primary care and mental health services were overwhelmed by dealing with their main roles in dealing with illness and there was no time or support for either service to engage in preventive activities. One generalist who held a strategic role as well as a practice role was clear that he did not take a preventive approach to either mental health problems or their risk factors, in an exchange exploring the mental health problems and risk factors dealt with in primary care:

> *"PC do you have any kind of planning process or information, either that you provide or that you get that might be around preventing, or what I'm trying to say is, working on the risk factors..*
>
> *P1: Eh no, is the short answer. Are we taking a population-based approach to the management of stress or anxiety or troublesome life events, no. We deal with them as they present to us."* Generalist, P1

3. Problems with mental health services

While I did not include a specific question in the interviews about problems or barriers encountered in providing mental health services, frontline professionals, in common with strategic staff as discussed in Chapter 5, raised a large number of problems while they described their core roles, or while they reflected on their practice. The problems highlighted are described here under the headings of; Criticism of services and service providers, Overwhelmed services, Gaps in service provision, and Lack of opportunities for development.

Criticism of services and service providers: Mental health services were seen as falling between the higher profiles of primary care and acute services, and were believed by some of the mental health specialists to have been given a lower priority than primary care by the NHS Board. In addition, primary care services attracted some criticism from some of the generalists as well as mental health specialists. In particular, the GPs' Quality and Outcomes Framework did not prioritise mental health sufficiently resulting in GPs being able to decide legitimately not to take on mental health problems. Within mental health services, some mental health specialists believed that severe and enduring mental health illness had been prioritised over mild to moderate conditions.

Primary care practice was also criticised for failing to provide basic lifestyle advice or talking therapies as a first line of treatment. Concern was expressed by some mental health specialists that primary care staff might be lacking in confidence about how to deal with mental health problems, believing that primary care thought mental health patients to be too time-consuming or difficult to deal with, for example,

> *"I think there may well be practitioners out there that are very physically chronic disease management driven and it's not that they don't acknowledge mental health, but they don't want to go there because it will unearth, it will open a can of worms that they maybe don't have the time or skill or desire to deal with".* Mental Health Specialist, P7

Interestingly, some generalists also criticised primary care responses to mental health problems, including criticism of their own service, for example, in not knowing how to deal with things or why certain decisions had been made:

> *"I feel, probably wrongly but I feel that the mental health team withdraw*
> *quickly. Once they're referred and they're taken on to their caseload and*
> *they're giving the appropriate treatment or counselling or both or whatever*
> *it may be there comes a time when they have to discharge them from their*
> *caseload and sometimes, and its just my perception, I think, are they ready*
> *to be discharged? But that's my lack of knowledge of mental health*
> *obviously".* Generalist, P2

In addition, two generalists pointed out that a presenting mental health problem could be relatively easy to deal with, but the social and relationship problems that surrounded a mental health condition posed major problems for primary care staff who might feel that they lack enough knowledge or resources to deal with them. Other problems encountered in primary care included difficulties in dealing with drug users and chronic mental health problems. In addition, the focus for primary care on physical problems and "*projectitis*" (Generalist, P 14), when services providing basic social support such as befriending or gardening skills were only funded for a short time, thereby letting vulnerable clients down when funding was withdrawn.

Gaps in services: Mental health specialists and generalists identified many gaps in services including for children and adolescents, anger management, Rape Crisis, methadone, information for service users, transport to services, spending time with patients, uneven distribution of services (with more services thought to be available in deprived areas), and not enough mainstream or voluntary sector services for people with mental health problems.

Overwhelmed services: Both primary care and mental health services were believed by the mental health specialists to be overwhelmed. Primary care was thought to lack capacity for general staff including GPs, health visitors or practice nurses to focus on mental health. This resulted in missed opportunities to refer or signpost patients to community-based or lifestyle-oriented interventions, or to deal with the complexity of mental health-related social or relationship problems. Instead, they were thought to be likely to prescribe medication too quickly or refer patients directly into specialist mental health services, sometimes inappropriately. Concern was also expressed about a lack of resources for cognitive behavioural therapy (CBT) services in primary care. The community mental health teams were thought to be understaffed, and the new primary care mental health services available in some GP practices were already building up waiting lists despite running for only a few months at the time of the study. Clearly both primary care and mental health services were described as being overwhelmed, but criticism was generally ascribed to the volume of patients with mental health problems or

to time constraints within the services, rather than criticism of the service providers themselves.

Lack of development: Some of the mental health specialists expressed a desire to engage in development of new services or mental health promotion activity but they believed that there was a lack of time and funding to do this.

Limitations of services available: Even when respondents spoke in positive terms about services available, a large number of responses highlighted limitations within service provision. One of the key issues was access to services which manifested in various ways. For example, if a primary care professional aligned to a GP practice came across a member of a patient's family with a mental health problem, they would only be able to act if the family member were also a registered patient with that GP practice. Another issue already alluded to above was that voluntary sector services were often popular choices for referral, but the uncertainty of availability through reliance on volunteers or due to short term funding was frustrating for referrers and for service users. For example,

> *"I remember phoning Cruise for a lady that had, just could nae get over a bereavement for her husband and I remember phoning and it took me the whole afternoon to get through to somebody who would eventually speak to me from Cruise in Glasgow, but they had nobody in this area at that time".* Generalist P6

A number of generalist respondents were concerned about the very strict line around the areas that were labelled deprived and therefore eligible for additional social funding:

> *"I know in Ayr the KA8 area is supposedly an area of deprivation, but I think there is one street where that KA8 becomes KA9, on one side is KA8 and the other side is KA9, but it's exactly the same type of housing and exactly the same type of people that are on both sides. On one side these people are, it's actually caused inequality because on one side of the street they are getting extra help and the other side are not because they are KA9 so therefore they are 'affluent'."* Generalist P12

Travel was a major issue related to access for some of the respondents, particularly for those in rural areas with evidence of services being used less when re-located to more central positions. Lack of transport affected patients attending services, and staff or volunteers who might not be able to afford the time or transport costs to visit patients in outlying areas:

> *"The outlying villages is a problem, you know, you'll get them* [volunteers for befriending] *possibly more than likely in the town centre, but as soon as you go out to Barrhill or the smaller areas, you know, you're limited. You know, you get few people who are able to travel out that far then you've got the travelling distance out there and the time to get out there as well".*
> Generalist P21

Another limitation of services was believed to be over-reliance on medication which one respondent believed might be beneficial for the mental health problem but could leave patients unable to cope with other aspects of their lives:

> *"I think people suffer at the hands of some of the medication. The medication they get, it just leaves them, you know, in a haze all the time. You get folk in and you think, "Oh for heavens sake". I mean you're having to deal with depression, you're dealing with anxiety and aye maybe this medication is supposed to help, but at the end of the day it has made it much more difficult for me to cope just with every day things."* Mental Health Specialist P10

4. What could be done to improve mental health services

Most of the respondents had ideas about how mental health services might be improved. Four themes were identified from responses and are reported below as: Prevent inappropriate specialist referral; Create more opportunity for people to connect with others; Ensure earlier identification of problems and access to help; and Thinking and working differently.

Prevent inappropriate specialist referral: Mental health specialists wanted to ensure greater awareness and basic skills for mental health in primary care, in order that knowledge and skills for dealing with or referring on for mental health problems would be better understood. Improved access to more primary care-based mental health services would prevent primary care patients having psychiatric records, and perhaps lead to more low key responses to mental health problems. For example,

> *"So maybe there's a job to convince people in primary care that perhaps they are the most appropriate people to deal with it.* […] *If we can be sort of accessible so that somebody doesn't, you know, need to sit down with a complicated flow chart every time, you know, to think it through, but actually has a good kind of sense of where their own competences lie, you know, one can feel confident that yeah what I do need to do with this lady is to encourage her to join the local mother and toddlers group and maybe getting the health visitor involved with that and maybe a relaxation class and you know, or, no, is this somebody who's developing a depression which clearly hasn't responded to, you know, x number of antidepressants and the depression treatment guidelines tell me I need to refer on."* Mental Health Specialist P23

While mental health specialists thought that primary care staff could provide a service that helped to normalise mental health problems rather than turn to specialist interventions too soon, generalists expressed preference for more specialists to be more easily accessible such as psychologists working in the GP surgery.

More opportunity for people to connect: Echoing the point above about seeking simple rather than complicated solutions, there were suggestions that more basic human contact from services and within the community might help to reduce mental health problems in the population. For example, one respondent believed that social support and collective activity from community facilities including local churches has been lost in recent years resulting in social isolation. Simple activities were suggested to enable people with mental health problems to connect with others such as local businesses taking on people with a mental health problem or more community networks offering basic support such as walking groups. For example,

> *"Not everybody needs a therapist, not everybody needs a counsellor, not everybody needs a clinical psychologist, but often what people are looking for is someone to just connect with and to be allowed to be"* Mental Health Specialist P4.

Earlier identification and access: Recognition of early symptoms followed by early proactive involvement was suggested by mental health specialists as being particularly important. Access to some services was thought by a few respondents to be better in urban, deprived areas due to additional funding being available, but some suggestions were made as to where better access might be achieved. These included bereavement counselling offered in funeral directors offices, directories of services with information about referral pathways and more triaging systems as follows:

> *"if the GPs have got somebody they can basically slot in and say right go and see this person, this specialist and then she's then triaging and then there's a leaflet on the Doing Well Project or a booklet and it's a kind of self help thing, the person can work through. She can then refer on to psychological services if she feels needs that as well or, you know, the quick intervention stuff. So we need kind of more services like that I feel".*
> Generalist P11

Thinking and working differently: A number of suggestions were made for new approaches or support for previously piloted projects such as: occupational therapists working more closely with health visitors to work with young mothers with chaotic lifestyles; a need to work with NICE, SIGN and QIS guidelines; clear sets of procedures for counselling services; more regular updates for primary care from mental health services; training primary care staff to deal with mild to moderate conditions; and providing training in mental health for pharmacists as potential first contact staff. Some suggestions were also made regarding working differently with patients, particularly in taking a holistic perspective with a patient rather than just dealing with the presenting problem,

> *"not just seeing the person as the problem, but what are the issues that are impacting on that person and taking that into account. That's about the stuff, you know, the social stresses, the life stresses that can be harmful to them".* Mental Health Specialist P23

One respondent despaired of being able to improve the circumstances of people suffering from mental health problems but clearly retained his sense of humour and made a unique, tongue-in-cheek suggestion:

> *"I think some of the problems will always be there. I think women will always marry the wrong men. When you get rid of that one they then go and…how often do we see it. Without saying to them never, never get married again without coming to see me first."* Generalist P5

Summary for core roles

Primary care generalists and mental health specialists both regularly worked across service boundaries in order to share the care of patients or to achieve access to services for patients with complex needs. However, their approaches to patients were quite different, with mental health specialists using validated, established assessment tools

and pre-set systems for interventions while generalists were more likely to use personal or locally-developed mental health assessment frameworks. Mental health specialists tended to manage the treatment of severe and enduring conditions, while generalists dealt with mild to moderate problems. Generalists' interventions were occasionally direct, structured interventions similar to those provided by mental health specialists, but were more likely to draw on a range of inputs including solving social dilemmas. However, prevention of mental health problems was not regarded as part of either groups' core roles. Most respondents from both groups were aware of a range of statutory, voluntary and community services in order to put in place treatment or support for patients with mental health problems. Some respondents from both groups believed that difficulties in coping with adverse life circumstances, such as abusive relationships at home and work, grief and financial pressures, meant that it was difficult to draw a line between unhappiness and depression in some cases. Generalists wanted better access to mental health specialists without waiting lists. On the contrary, mental health specialists wanted primary care to develop more capacity to treat patients, believing that in many cases "low level" input for supported lifestyle and well-being advice might avert patients from specialist services.

Section 2: Inequalities

Introduction

Section 2 reports the results from exploration of frontline professionals' understanding of inequalities and inequalities in mental health. The results relating to Inequalities are summarised in the coding scheme in Table 6.3 and are described in full under the headings of definitions, impact of inequalities on mental health, information and practice.

Table 6.3 Coding scheme for inequalities for frontline professionals

Inequalities		
Theme	*Sub-theme 1*	*Sub-theme 2*
Definitions	Individuals	
	Communities	Deprivation Geography
	Rich/poor gap	Social divide
	Societal factors	Social circumstances Social exclusion Discrimination Gender
	Organisational factors	
	People most at risk	
Impact of inequalities on mental health	A "downhill spiral" in mental health Inequalities in mental health care Stigma	
Information	Mental health Inequalities Inequalities in mental health	
Practice	Own role in health inequalities Partnership working Problems reducing inequalities in mental health What could be done for health inequalities	

Definitions

Respondents were asked to describe what the terms health inequalities and inequalities in mental health meant to them. Some respondents found these questions difficult. For example, some expressed concern over whether they had given me the "right" answer, and others stated that they did not know much about inequalities. In order to explore the question in a different way I also asked respondents to tell me who they thought might be most at risk of developing mental health problems. In instances when respondents appeared to lack confidence about discussing inequalities, they often made observations

from practice that shed more light on their perspectives than was achieved by asking direct questions about theoretical understanding. For example,

> *"PC: Are there any patients who are more likely to be depressed than others do you think?*
>
> *P2: Em, are there any patients more likely to be more depressed than others. I feel I can't answer that. No I really don't know that*
>
> *PC: You can't predict it? Maybe from a particular area or in a particular situation at home?*
>
> *P2: Well obviously highly stressed situations at home, they would be more prone to, yes, definitely. If there was a highly stressed situation for instance a carer who seemed to have a lot on their plate or had lots of other things going on in their life"* Generalist, P2

Most respondents discussed inequalities in health in general rather than specifically talking about inequalities in mental health except when answering the question about risk of mental health problems.

The same themes from the policy analysis and from analysis of data from interviews with strategic staff were used again here to capture definitions for inequalities given by professionals. This enabled me to compare national policies, strategic officers and frontline professionals for understanding of inequalities in health and in mental health. A summary of combined definitions given by policies, strategic staff and frontline professionals is given in Section 3 at the end of this chapter. Definitions are reported under the headings of Individuals, Communities, Rich/poor gap, Societal factors, Organisational factors, and People most at risk of mental health problems.

Individuals

No respondents mentioned that health inequalities were related to individual mechanisms such as behaviour or choice.

Communities

Around half of respondents mentioned differences between communities but expressed these differences in a variety of ways, including that the gap between deprived and affluent communities was increasing and that health in the deprived communities was not getting better. Also mentioned by one respondent was that there was a clear link between social deprivation and mental health, and another had observed a link between social deprivation and patients not attending arranged mental health service appointments. Geography was mentioned by one mental health specialist as one of many factors contributing to inequalities along with gender and access to services, and four respondents believe that there were inequalities between rural areas and towns. Some respondents noted differences between the urban postcode sectors KA7 and KA8 where KA8 was described as a poorer area, deprived to the extent that it was eligible for regeneration funding.

Rich/poor gap

One generalist recognised differences between geographical areas but felt that more information was required to identify differences between individuals than only to rely on geography:

> *"I'm not sure that it's terribly easy to say how you would define people* […]. *There are substantial numbers of people within the KA8 postcode area who are quite happy to come and have their cervical smears done and quite a lot of people within the KA7 who don't. Therefore for primary care general practice I think it has to be addressed on an individual level."*
> Generalist, P1

Four respondents understood inequalities to mean a social divide with an increasing gap apparent between upper and lower social classes but there was uncertainty as to whether that was also true for mental health:

> *"I think the general consensus is that although the health needs of the population or that the health of the population is generally improving, the gap between the rich and the poor is widening and nobody seems to know why that is, although generally things are better. Um, I don't know if that's true of mental health problems as well."* Generalist P6

Societal factors

Some respondents talked about combinations of societal factors and, echoing the findings from the policy analysis reported in Chapter 4, different combinations of factors were used to describe the complexity of the problem of health inequalities. Societal factors mentioned as relating to inequalities included ***social circumstances*** such as lack of employment, low incomes, poor housing and lack of social contact in rural areas. ***Social exclusion*** was mentioned as one of many factors that had an impact on mental health in combination with access to services, gender, geography and education, as suggested here:

> *"It's about social inclusion and exclusion. It's about, I suppose it's about education, it's very clearly about education, it's about people accessing and having the right supports to access education to enable them to feel empowered to access health care when they need it, particularly around mental health"*. Mental Health Specialist, P7

One mental health specialist was very aware of the impact of stigma on well-being arising from ***discrimination*** against people who were already in the mental health system which could further affect their well-being. ***Gender*** was the only diversity issue mentioned by respondents in relation to inequalities, but of the four respondents who mentioned it, their concern was about the difference between the mental health problems experienced by men and women rather than discrimination in society. Three respondents (two female and one male) gave examples of differences between men and women in relation to mental health without using the term "gender". A fourth respondent (female) included gender as part of a list of factors that contributed to inequality but without providing further explanation. Differences between men and women were identified in the variations between male and female suicide rates, homelessness, talking about mental health, domestic abuse, and women struggling to meet their own and their family needs, for example:

> *"…a lot of women who are juggling, they're trying to work, they're trying to do their best by their kids, teenagers or whatever, they're trying to support their husband who is working all the hours and can't change his job because there isn't anything else or he's not working and they have their own health problems it may be menopausal and they're just trying to keep everything, you know, under control and I think a lot of them struggle. A lot of them struggle and it will come out in things like well women reviews or if they have they'll maybe come with problems with periods you know, but when they explain what's going on in their life sometimes you're thinking that's the least of your things, but it's what brings them in the door."*
> Generalist, P13

I prompted some of the respondents further on gender if they had described differences between mental health problems in men and women. One mental health specialist appeared to agree that gender should be taken on board but did not comment as to what role gender might play:

> *"We must understand relationships and how those relationships might link to socio-economic inequalities round gender".* Mental Health Specialist,P23

Another respondent, unprompted by me as she had not mentioned male/female differences, was curious as to whether I had found gender "*cropping up*" in the study. She suddenly changed tack at the end of a response to a question where she had been describing examples of practice that might contribute to reducing inequalities:

> "P17:   East Ayrshire have the what's called the chip van.
>
> PC: I've heard of that, yeah.
>
> P17:   and that's that, do you know it would be good to see something like that em, you know, really, kind of going round with a whole lot of different information. So I think from that respect, yeah there is that kind of inequality there. Inequalities some of the other, I mean, some of the things that have cropped up has it been about gender or, yeah, has it?
>
> PC: Mm huh. Is that something that's …
>
> P17:   (Cutting in) Not, you know, not that I can think of off the top of my head, it's never really been much although again in the kind of rural areas the majority of my referrals are for women, you know, and I don't know if that's kind of more about historically men aren't, you know, as willing to go and discuss their feelings and things like that" Mental Health Specialist, P17

Other diversity issues were not used in definitions and were generally absent from discussions. Two respondents mentioned disability in that they stated that there were no mental health services in South Ayrshire for patients with learning disability. Ethnicity was mentioned only once by one respondent who was making the point that ethnicity was not an issue for her client group in that, "*we don't have a lot of ethnic groups here*" (Generalist, P11).

Organisational factors

All respondents with only two exceptions believed that inequalities in health were characterised by unequal access to healthcare. Many mentioned access as their first response in the discussion about health inequalities, for example

> *"my main use of inequalities in health as a term for guiding us, is on the inequalities in access to healthcare".* Generalist, P1

The reasons for unequal access included rural areas having less accessible services than urban areas with the problem of poor transport highlighted by almost half of all respondents for example,

> *"they have centralised everything again. So, as I say, the clinic I used to*
> *go up to in New Cumnock, they have got to go to Cumnock which is about*
> *8-10 miles away, and they have got to go on the bus, you know, whereas*
> *you could turn up in your slippers before, which was what happened often*
> *when they came, you know."* Mental Health Specialist, P10

Some respondents were concerned that concentrating additional resources for services only in the poorer areas disadvantaged those people living in affluent areas who were struggling to cope. Other reasons given for unequal access to services were lack of good information about services, lack of education or inability to read health information, and people's inclination or ability to use the system. For example, having a mental health problem in itself might lead to discrimination or being unable to articulate need:

> *"Generally people that are more outspoken will get things done than people*
> *that aren't, I would think".* Generalist, P9

People most at risk of mental health problems

As found for strategic staff and reported in Chapter 5, there was evidence that many respondents had not thought through this issue before. About half of the respondents stated that they did not know who might be most at risk and would not hazard a guess. Others responded likewise, then went on to speculate tentatively as to who might be at risk with carers being mentioned in most of these speculations. An interesting finding was that some respondents began to contradict themselves as they spoke. Three clear examples are given below of respondents' contradictory thinking about risk factors as they appeared to have internalised the message from the national campaign *See Me,* then changed their minds with or without prompting:

Quote 1

"PC: Who do you think are most at risk of getting mental health problems in the first place?

P22:   Gosh, anybody.

PC: Right.

P22:   Well if you look at the stats of 1 in 4 that the See Me Campaign would suggest that mental health difficulties will affect 1 in 4 people in any given lunchtime or year, that's how you count it.

PC: So that's one in any four people then?

P22:   Yeah, but then if, it depends again (pause), but yeah you could point to poverty, poor housing, marital break-up, discord in the family, coping with teenage children, looking after the elderly parent or relative, all sorts of things that could bring stresses and pressures."
Mental Health Specialist, P22

Quote 2

"Depression seems to hit any age group and any sort of class group, possibly those with less education attainment have lower coping skills, but we see professional people as well as blue collar workers presenting with mental health problems. Certainly those jobs or environments put greater stress on the person who will, or appear to, predispose to greater risk of mental health problems and so those who are chronically unemployed or those whose job is enormously demanding beyond their capacity to do it or those who are going through a period of family disruption or significant life events of any sort with greater risk. I don't think it's just an educational thing or an equalities issue. I think it can cross all groups, and as I said, maybe there was with the greater…the more unequal, maybe those who have less resource or less ability to deal with it." Generalist, P14

Quote 3

"I think everybody is at risk of mental health problems. I think, depending on your circumstances, then, you know, "there but for the grace of God go I", but I think people, obviously poverty is an issue, deprivation all these sort of things. […] I don't think there is anybody that's not at risk given the right set of circumstances, but aye there are obviously people who are more at risk than others." Mental Health Specialist, P10

As alluded to in Quote 1 above, a discussion emerged from these four respondents of cause and effect between poverty and mental illness. Poverty, along with poor housing, relationship problems and other factors, was suggested as acting as a precipitating factor in mental illness in people who are already vulnerable. Another respondent suggested a different relationship between poverty and mental illness, with severe mental illness resulting in being less economically successful which in turn led to more patients with mental health problems living in deprived areas. Two other respondents also noted that there was a link between mental illness and socio-economic group but that cause and effect were difficult to prove. However, one respondent who was a member of the Mental Health Needs Assessment Steering Group as well as being a senior practitioner thought social factors were less important than individual factors in mental health:

"family history; bereavement; childbirth; elderly; physical problems; people who misuse cannabis and other illicit substances; non compliant patients, ie, patients who don't take their drugs; patients who do not engage well with the services; divorce. Also with the most severe mental illnesses, genetic factors are important. There is also family environment with less severe illnesses, poverty, social circumstances, lack of finances, but these are less problematic." Mental Health Specialist, P19.

Impact of inequalities on mental health

As noted above, not all respondents believed there to be links between social inequalities and mental health. Those that made a link spoke about the apparent increase in mental health problems in the population, and the impact of health care and social factors on patients who were already vulnerable as a result of developing a mental health problem. Impacts of inequalities on the population and patients are described here under headings of A "downhill spiral", Inequalities in mental health care, and Stigma.

A "downhill spiral" in mental health

There was a general feeling among some of the respondents that mental health problems were worsening. One respondent put it down to a "*sign of the times* […] *people live a more stressful life than they used to*" (Generalist, P6). Some respondents felt that depression in particular was increasing as they were seeing more depressed people for example:

> P13:   *I couldn't believe that almost everybody, you know, that came in the door at some point had had a problem with depression.*

> PC: *Right, right.*

> P13:   *And I found that very, very interesting and then I started thinking well why, you know, and an awful lot of it was down to family issues, family pressures, financial pressures, grief reaction and various things like that, but I was astonished. I honestly did not understand how many people were affected with that.* Generalist, P13.

One respondent described a "downhill spiral",

> *"obviously there is more, there are more mental health problems in deprived areas related to all sorts of, you know, drug abuse, natural selection I suppose or whatever, people drift into the downhill spiral."* Generalist, P5

Another respondent painted a bleak picture of the potential for turning this around:

> *"the opportunity to break out the system and how much are you perpetuating it by the work that we do and the systems that exist. You could develop that then into how do people get financially supported, that's the benefit system by and large. There are very few people of the 300 plus people on my teams caseload, workload, you could count on the one hand if any of those people have a job."* Mental Health Specialist, P22

Inequalities in mental health care

One respondent had carried out a small study investigating the reasons why some patients did not attend appointments for his own service. The respondent concluded that people who did not attend appointments were more likely to come from deprived areas and have greater health needs, but that staff were unable to follow up with defaulting patients as they already had long waiting lists for their services. Other respondents believed that not attending was part of the difficulty in dealing with mental health problems:

> *"Mental health patients tend to be difficult to get to take up the healthcare opportunities on offer, it doesn't really matter where they live – it's the nature of the disease to a large extent."* Generalist, P1

Further inequalities were noted within the system including for older people with mental health problems because of the current focus on young people, and services for severe and enduring mental health problems were thought to be better funded and organised than those for patients with mild to moderate conditions. In addition, mental health services in general were thought to be of less a priority than acute health services and as already noted, some respondents were concerned that people with severe and enduring problems would be less likely to be able to articulate their needs or make complaints about lack of services.

Stigma

Two thirds of the respondents were concerned with stigma and the impact it can have on patients. They believed that patients could feel that they were being "labelled", not just in having a mental illness diagnosis or a psychiatric case record but also as being inadequate in some way for example,

> *"She wouldn't like to think of herself as being, as having a mental problem, it's a stigma thing. She's a lady perhaps in her late 70's so there's the stigma thing comes in again, no I don't have a mental problem type of thing. Cause I think the GP has, to be fair, tried to enlist the help of a psychiatric nurse to go in and see her, but she wont have it because, psychiatric, no. I don't want to go to the Ailsa and it's all this stigma thing coming in for that generation."* Generalist P12

Most reported that stigma prevented people seeking help or if they had sought help it prevented people taking up treatment. One respondent believed that the discrimination and prejudice that patients suffer because of having a mental health problem further damages their well-being.

Stigma was suggested as causing particular difficulties when difference from the norm is more obvious, such as for people in higher social classes or in rural areas where anonymity was more difficult to achieve. National stigma campaigns were mentioned by two respondents as helping to raise awareness but have not managed to solve the problem. Most of the respondents concerned about stigma were keen to find different ways of providing their services in order to normalise mental health problems as much as possible. For example, one respondent suggested that more was needed for prevention of mental health problems and the answer did not just lie within health services:

> *"But you want to have things there that help to prevent people becoming ill, but, you know, you don't want to have it under that sort of illness umbrella. It needs to be something else and I don't know whether it would be through community education, if that's the kind of way to go with some of these things."* Mental Health Specialist, P10

Respondents generally spoke highly of the current new initiatives that brought more open access to first line mental health services in GP surgeries rather than having to attend appointments at a psychiatric hospital. This had the dual role of reducing the likelihood of people knowing that patients were attending for a mental health appointment, and also that there were opportunities to start treatment with the least invasive options:

> *"For me, I would not want to necessarily go with a huge label of being depressed immediately. I reckon I would probably be looking at something like the lifestyle pack with them […].What we are trying to do is to give people the least amount of intervention and that's not least in terms of cost or capacity or anything like that it's about what do you require, you know. If you had a sprained ankle we wouldn't necessarily put you in a stooky from your foot to your groin. We would give you Brufen and tell you to put some ice on it and rest it for a while and see if that's enough and I don't think we necessarily in mental health do that, kind of triage almost, well enough."* Mental Health Specialist, P4

Information

Sources of information were explored to uncover the factors that influenced respondents' understanding of inequalities in mental health. Respondents' knowledge of sources of information for mental health, inequalities and inequalities in mental health were sought. Results are presented under each of these three themes.

Information on mental health

No hard information such as relating to prevalence of mental health problems was offered by any of the respondents. Respondents who wanted to access information on mental health had to seek it out independently, and only one respondent had joined a national mental health email information service. Some respondents were only interested in information that they believed to be directly relevant to them:

> *"Well I do (receive information on mental health), there's a lot of studies going on and you do get updates. I suppose the CPNs will have a lot more information coming their way and also it's retaining it, I mean, you get 150 e-mails every day and 6 documents to read, you know what I mean. You don't retain it if it's not relevant to you."* Generalist, P6

A small number of respondents accessed mental health information from training, some of which was offered locally for example for depression, although there might be years between such training opportunities. There were other training programmes, conferences and networking events where they could develop knowledge and skills such as for new drugs or SPIRIT Training (for providing Cognitive Behavioural Therapy), or opportunities to share experience.

Two respondents were familiar with routine sources of mental health information but complained about the inadequacy of the information they did receive. Both felt that they knew the patients and the areas better than could be described through collated data:

> *"P5:   Well we get an annual report.*
>
> *PC: Right, but if you were wanting to look underneath it, like you say, to identify something that isn't there or if you were wanting to look at, you know something specific that has arisen in the practice, I mean is it easy enough to access data?*
>
> *P5:   Um, I don't find this information useful because my gut instinct is I know several streets that I could go and say have you got a mental health problem, bring it out."* Generalist, P5

One respondent stated that the kind of information that would be useful would be clearer guidance on interventions:

> *"So what we need is for somebody in a public health position to come and say, this works, this is the population for whom it works, now can you identify how many of these people you've got and then we could work out what sort of resources you would need in order to offer that service to these people."* Generalist, P1

Information on health inequalities

Generalists tended to be more knowledgeable about information on health inequalities than the mental health specialists. As was the case for information on mental health as reported above, respondents accessed information on health inequalities only for specific purposes, and had to seek it out rather than be provided with it routinely. Respondents who did access information on health inequalities described its shortcomings rather than its usefulness. An example given was that they could access information on mortality and morbidity but not about people from rural areas having less access to services such as surgeries and transport. In addition, being told about the deprived areas in South Ayrshire was regarded as being not particularly helpful:

> *"Well, we've had very half-hearted attempts to give us profiles of the area and they all tend to fall down on this thing that they'll tell you that KA8 is a deprived area which is fairly obvious to anybody, but it doesn't really help."* Generalist, P1

Respondents who did find information about health inequalities helpful had accessed and used NHS Health Scotland Community Profiles and the local Regeneration

Outcome Agreement to highlight local health and social issues in a presentation. The *Black Report* was also mentioned by two respondents who understood that the link between deprivation and health inequalities had been established for a long time. However, another respondent felt that inequality information is not acted upon, and gave an example: the fact that people with schizophrenia die early from physical causes has been known for years, but has to date been ignored.

There was evidence that some respondents would not necessarily come across information about health inequalities at all, for example,

> *"I only came across these terms* [Depcat, health inequalities] *as coming into this post and with meeting with other public health people, but I think yes, you know, your average* [practitioner] *for example wouldn't have come across Depcat figures and things like that."* Generalist, P12

This was borne out by another generalist, who was not aware of inequalities in the area:

> *"PC: And do you think inequalities in health arise in this area, where you practice?*
>
> *P2: I don't think that I'm aware of any, I don't think that I'm aware of any. I think that in this area we seem to be to my knowledge fairly well off healthwise, certainly when you compare it to down South, we seem to be fairly well off.*
>
> *PC: You mean South of…?*
>
> *P2: South of the Border, England.*
>
> *PC: How do you know that? I mean, have you come across reports, do you read about it…?*
>
> *P2: I read about it, I watch the news, interested in health aspects, I watch the television, documents, I read, nursing journals and that seems to be the perception I have, whether its right or not, or wrong, but that's my perception. I don't feel that there seems to be a lot of differences in Scotland, there are some obviously but possibly, I don't feel that there are as many as there are between England and Scotland. I don't really come across many difficulties."* Generalist, P2

Information on inequalities in mental health

While generalists tended to be more articulate than mental health specialists on the subject of information for inequalities in health, the reverse was true for inequalities in mental health. Six mental health specialists commented on aspects of inequalities in mental health for example:

> *"You usually find the people with the most severe and most enduring needs are much poorer and I think the majority have started off that way. You know, you get some people who, you know, have come from wealth or whatever and they have problems, but I think the majority with enduring needs, certainly there is a poverty aspect in their background."* Mental Health Specialist, P10

Three out of the four generalists who commented on inequalities in mental health appeared to be more hesitant as to whether inequalities in mental health existed. Examples of this from generalists included,

> *"PC: Do you see any evidence of inequalities in mental health?*
>
> *P12:   That's a difficult one. Cause there are, I think there is mental health issues no matter what your income is, they may be different, but…* [pause] *That's a difficult one. The team at (hospital), the whole team are very good on the whole at monitoring and looking after their patients, you know, regardless of the area that they're from. That is a difficult one I'm not sure how to answer that one."* Generalist, p12

Practice relating to inequalities in mental health

Own role in health inequalities

Few respondents explicitly identified areas of their own practice that would be relevant to reducing inequalities in mental health. Respondents generally believed that action to address inequalities in health and in mental health was outwith their areas of expertise, or that addressing social issues was not an area that the NHS could participate in:

> *"I think a lot of people are much better placed* [to address inequalities], *I mean, I'm very happy to give my opinion as to how their proposals will fit in with what I know of primary care. I don't think I really have the expertise to start telling them how they should do it."* Generalist, P5

Partnership working

Two thirds of respondents talked of working in partnership with a range of organisations in order to deliver a more effective, integrated core service by linking health professionals within the NHS with social care services, or to connect health services with voluntary sector providers. The other reason which was described by fewer respondents was to widen support out from a clinical perspective to engage with a holistic approach to a patient's needs beyond immediate health and social care issues for example:

> *"There does need to be more involvement from the voluntary sector in mental health issues at a local level.* […] *Voluntary services and community people tend to be involved at local level, including with issues that are not necessarily to do with health and clearly we need a multidisciplinary carer/user/voluntary organisation involved in order to deal with the whole problem at a local level."* Mental Health Specialist, P19

Problems reducing inequalities in mental health

Five respondents commented on problems that existed within the services regarding reducing inequalities in mental health. For example, planned services should be based on mental health need which was potentially different from just providing additional funding for deprived areas:

> *"I don't think anybody says where the socio-economic black spots are where we should, you know, target our resources I think it happens at the level of, you know, where's the greatest need, where should we be targeting our resources, you know, where is greatest number of referrals, you know, and whatever."* Mental Health Specialist, P23

On a similar theme of having too little knowledge to plan services, two respondents believed there was not enough knowledge about interventions that would reduce inequalities in mental health, while another felt that there was not enough knowledge about the patients and no capacity to gain that knowledge:

> *"We see the ones that come, we don't see the ones that don't come and that is always, that is the problem isn't it, I suppose is that how do you count the people who haven't used the service. […] We are a reactive service, we sit here waiting for people to throw stuff at us and they throw quite enough that we can just about cope with it and, in fact, rather more than we can cope with and we have our own stresses and strains so it's very difficult for us to start looking at where we might not be doing enough."*
> Generalist, P5

What could be done for health inequalities

About half of the respondents had ideas about action that could be taken to address health inequalities. Some of the ideas were for the respondents themselves to work differently or potentially to work differently in the future, such as to be non-judgemental or to work better with others, for example, doing preventive work with schools on raising awareness about domestic violence or drugs. Some respondents had recommendations for others rather than themselves to take on either in a general, non-specific sense, for example:

> *"But certainly if there was back up or supports, but it would have to be in the community to make people realise what the issues were for them and they knew that when they came to their GP there was a certain path they could follow. So it would be like developing a whole new scheme I think for them to realise their issues, get them seen to and be followed up with. Maybe sounds a bit iffy, but it's maybe something new that needs to be looked at."* Generalist, P9.

In addition, there were quite specific ideas suggested such as the Health Board or GPs re-distributing services to favour deprived areas, or increasing primary care professionals' knowledge about mental health issues so that they did not refer too quickly to secondary services.

Summary for inequalities

Many respondents appeared to be uncomfortable about discussing inequalities, and it is suggested that this might be due to having previously given little consideration to inequalities in relation to their work. The main definition for inequalities in health was

given by a large majority of respondents as being access to health services. Some respondents discussed a relationship between social factors and health including linking social factors with mental health, but the range of factors they included was limited and did not reflect the interpretation found in research literature or in Scottish policy documents. Respondents demonstrated contradictory ideas of risk by appearing to have internalised the *See Me* message that everyone in the population was at equal risk, while at the same time suggesting that certain social factors increased the risk of mental health problems. However, one respondent, who held an influential strategic role in addition to a service provision post, expressed the view that social factors were less important than individual factors in increasing risk of mental health problems.

An issue that was raised by many respondents was that of the need to "normalise" treatment for people with mental health problems in order to reduce stigma and provide less invasive treatments. No respondents believed themselves to have a role to play in reducing inequalities in mental health. Instead, they saw the answers lying in social interventions while they appeared to be more concerned with trying to provide health services to an increasing number of people with mental health problems with a reducing staff complement.

Summary of key issues for frontline professionals

Data was analysed separately for the two groups of frontline professional staff in order to identify whether there were differences in their approaches. Patients seen by both groups were different, with mental health specialists more likely to specialise further into working with either patients with mild to moderate problems or severe and enduring conditions, while generalists could potentially be treating both types of patients at any one time. However, generalists were more likely to see patients with mild to moderate problems as those with severe and enduring conditions were seen on only rare occasions or for routine checks. Mental health specialists were more likely to use validated assessment tools but both groups of staff also used subjective perspectives in addition to structured tools. Generalists' interventions were more likely to include solving social dilemmas that might prevent patients attending services such as accessing transport. However, mental health specialists were more likely to describe social issues such as education and poverty as being linked to mental health problems.

In discussing their core roles, some respondents believed that where patients had difficulties in coping with adverse life circumstances such as abusive relationships at home or work, grief or financial pressures meant that on occasions, unhappiness and depression were difficult to distinguish. Responses to these problems were generally to

propose that services should be improved in order to pick up mental health issues at earlier stages, to treat problems with less invasive techniques before supplying medication, or to increase access to specialists. While some of the respondents recognised the part that social factors might play in contributing to mental health problems, few believed they had a role to play in addressing them. This was despite that they already worked in partnerships with organisations that were concerned with social issues including other health, social, voluntary and community based services. An anomaly was found in that the anti-stigma message of everyone being at equal risk of mental health problems appearing to have influenced respondents' beliefs about risk, but at the same time they could vividly described patient's circumstances which they believed might put them at greater risk of developing mental health problems.

An additional, interesting result was found from combining the definitions given for inequalities in health from the policy analysis, interviews with strategic staff and interviews with frontline professionals. Results are collated in Table 6.4 below and it can be seen from this that definitions given are very different, particularly between policies and frontline professionals. A striking difference was that access to services was almost universally used as the main definition for inequalities in health by frontline professionals, commonly used by strategic staff but used only once by one policy document. In contrast, poverty or economic factors were used most often in policy documents and by all strategic staff (after prompting), but only rarely (and only on prompting) by frontline professionals. One similarity between all three levels was that there were definitions given that suggested that observable differences rather than fairness was the underlying assumption of the term health inequalities. Evidence from this, together with other evidence from the interviews such as a lack of access to good information about inequalities, suggested that the frontline staff were not generally influenced by the policies or other national documents, but instead focused on their experience in practice for their understanding of inequalities in health.

Table 6.4 Summary of combined data for definitions of health inequalities

Policy appraisal	Interviews with strategic staff	Interviews with frontline professionals
14 different definitions - lifestyle/behaviour , deprivation, differences between individuals, disability, discrimination, environment, ethnicity, gender, geography, opportunity gap, personal choice, rich/poor gap, social circumstances, economics, social injustice.	13 definitions: deprivation, geography, differences between social groups, poverty, combination of social circumstances (poverty, housing, opportunities), gender, ethnicity, sexual orientation, access to services NB: Five said access. Four definitions were added to initial nine when asked who was most at risk – socio-economic factors, poor housing, relationships, biology.	15 definitions: deprivation, geography, combination of social circumstances (poverty, housing, unemployment), social class, differences in lifestyles, social exclusion, discrimination, gender, access to services. NB: six definitions added to initial nine when asked who was most at risk – poor housing, carer, relationships, biology, unemployment, poverty
Definitions cited between 1 and 6 times. Economics/poverty cited most often	Most definitions were given by either one or two respondents except all said socio-economic on prompting and 5 out of 7 said access	Most definitions were given by either one or two respondents with the exception of access with almost all (19 out of 21) using access as their main definition.
24 actions suggested	3 actions suggested	5 actions suggested

Chapter 7

Results IV

Tom: A service user's experience

Introduction

Chapter 7 presents the results of responses of frontline professionals to a vignette about a patient called Tom. The vignette was introduced in order to explore models of working adopted by respondents and the impact on a patient that a focus on inequalities in mental health might have in assessment, diagnosis and treatment of a mental health problem. As described in Chapter 3, Section 1, the vignette was used in interviews with frontline primary care and mental health professionals to gather data for the fourth "community of meaning" in the interpretive policy analysis. As noted previously, this focused on the experience a service user might expect from a consultation with frontline primary care and mental health professionals through an exploration of the approaches taken by professionals and not the actual perspectives of service users.

The vignette was as follows:

> Tom is 48. He is divorced, he shares the care of his two teenage children with his ex-wife and he cares for his elderly mother who doesn't live with him since his father died two years ago. He presents as a newly registered patient or newly referred patient with sleeping difficulties, intermittent back pain and frequent headaches. He smokes and he drinks two or three glasses of beer or wine on some days and more at the weekends. He has had no contact with the NHS since a sports injury 5 years ago.

All respondents were presented with the same vignette. Questions were asked as prompts to explore why the respondent might be seeing Tom, the investigations and assessments they might do, and the treatment and follow up procedures proposed.

A summary of the coding scheme for Tom is given in Table 7.1 and the results described in full below under the headings of initial response to Tom, topics explored by respondents and practice relating to Tom.

Table 7.1 Coding scheme for Tom from interviews with primary care and mental health professionals

Tom		
Theme	*Sub-theme 1*	*Sub-theme 2*
Initial response to Tom	1. First reaction to Tom	Sleeping difficulties Reasons for referral Social circumstances Routine assessment What Tom wants
	2. Aim of first enquiry	
	3. First investigation	
Topics explored by respondents	1. Physical Symptoms	Back pain Headache Difficulty sleeping Other physical Contact with NHS
	2. Lifestyle	Smoking Alcohol Diet Daily living skills
	3. Mental Well-being	Psychological symptoms Link between physical and psychological Bereavement Tom as a carer Exploration of social circumstances
Practice in relation to Tom	1. Assessment	Mental health assessment tool
	2. Interventions	Deciding on treatment Follow up Help with Tom's circumstances
	3. Signposting and referring on	What is available Referral for mental health Referral outwith service Referral to GP
	4. Reflections on practice	Own role with Tom What should be available for Tom Limitations of help available

Initial response to Tom

The initial response to Tom was of interest to identify the issues that the respondents brought to the top of their mind on hearing Tom's story. This was thought to help signify the issues that respondents thought they might make most impact on or possibly what they might think was most significant for Tom. However, all respondents were also encouraged to explore in more detail how they might react to Tom and this stimulated some very informative, reflective accounts. Initial responses are described under the headings of first reaction to Tom, first investigation and aim of first enquiry.

1. First reaction to Tom

The first reactions to Tom were quite variable, as might be expected with the range of disciplines represented in the interviews. Respondents from different disciplines would see Tom for different reasons. A small number said that they probably would not see Tom routinely but might have come into contact with him through association, such as while visiting his mother. However, all respondents rose to the challenge and some began their response to the vignette by first constructing a story that would lead them to meeting Tom in some form of clinical situation.

Nine respondents out of the 18 who were presented with the vignette focused initially on Tom's ***sleeping difficulties,*** with three generalists linking them to backpain and headaches. The other six respondents (three each from the generalists and mental health specialists) linked sleeping difficulties to potential underlying depression, stress or anxiety. For example,

> *"I mean I think it sounds like there's a possible underlying anxiety if he's had sleeping difficulties. It's jumping out at me right in the middle of the paragraph."* Mental Health Specialist P7

Three generalists focused on issues that Tom might have been referred for depending on the ***reason for referral*** such as back pain, smoking cessation or help with caring for his mother. Only three respondents, all mental health specialists, focused first on Tom's ***social circumstances*** such as his relationship with his family or how he coped with caring responsibilities. Two respondents (one generalist and one mental health specialist) suggested that they would first apply their ***routine assessment*** procedures to Tom.

> *"I would generally see this person and I have four assessments to go through with them at my first contact".* Mental Health Specialist, P17

One generalist would first find out **what Tom wanted** as he suspected that he might want a repeat prescription or a sick line.

> *"Ah, the first question is what he's wanting, what's he looking for. We may well get a number of people with this sort of presentation who are long term unemployed, long term sickness benefit and the back pain, headaches is their ticket to their benefits."* Generalist, P14

2. Aim of first enquiry

Not all respondents gave an aim for their first enquiry. Those that did wanted to check first whether there was a physical explanation for his symptoms or whether they were related to underlying mental health problems, or to get the best history possible in order to point him in the right direction.

3. First investigation

As suggested above, some respondents indicated that they would apply their routine assessment procedures to Tom immediately before speculating what Tom's needs might be but they took different approaches to assessment. For example, one generalist would investigate Tom's ability to carry out activities of daily living and one of the mental health specialists would use a range of mental health assessment tools. Another generalist would also use a formal assessment of health needs after an initial less formal discussion. Less formalised but routine assessments of general physical and mental health would be carried out by two mental health specialists as their first investigations.

> *"We would ask general things, just how he is feeling and if he did sort of come up with the difficulties that he's had, the problems that he has had, how long they had been going on and things that might have brought that about"* Mental Health Specialist, P10

Sleeping difficulties would be focused on as part of a physical examination alongside Tom's backpain and headaches by some respondents while others would begin with an exploration of sleeping difficulties as possible symptoms of underlying depression, stress or anxiety.

> *"Tell me about the back pain to try to get a feel for what it was and the sleeping difficulty -was that a result of the back pain or is it because he doesn't sleep is it he's anxious, is he depressed."* Generalist, P1

Three mental health specialists and one generalist would start their investigations by exploring Tom's social circumstances and how he coped with them and one mental health specialist would focus on whether Tom needed support for his caring role.

> *"what I would be looking at, I guess, is whether or not he needs support in terms of caring so there is obviously links with things like the carer's centre and a lot of the carer's centres in the local areas have, I'm not sure whether in the south they do, but they have often advice and support, they have information and I know for sure in the north they have a sort of stress management initiative attached to it where they can get sort of relaxation."*
> Mental Health Specialist, P4

Only one respondent, a generalist, reported that they would start by investigating the issue that Tom perceived was the main problem.

Approaches to the first investigations were equally variable among both groups of respondents. No patterns emerged as to whether one group or the other would be more likely to focus immediately on Tom's physical, mental health or social needs, or whether either group would look first to Tom's perspective or to formal assessments to provide the lead for the consultation.

Topics explored by respondents

A number of health topics were explored unprompted with Tom and they are reported below under Physical symptoms, Lifestyle and Mental well-being.

1. Physical Symptoms

Back pain: Most generalists indicated that they would ask about Tom's back pain along with the other presenting physical symptoms. Three would explore the reason for the pain by asking whether it was due to a sports injury or for a sick line or whether it was due to stress or depression. The mental health specialists mostly assumed that the backpain would have been investigated or treated by the GP, but all who mentioned it

suspected that it was linked to Tom's mental state and would in any case explore it further.

Headache: The mental health specialists rarely mentioned Tom's headaches but when they did they again assumed that the GP had already dealt with it. Five of the generalists focused on Tom's headache with most of them linking it to the back pain and sleeping difficulties for further investigation, as well it being a possible link to stress or depression:

> *"Sleeping difficulties and the back pain and the headaches, that could be to do with depression. He may well be depressed and this is how it's manifesting itself."* Generalist P6

Difficulty sleeping: Sleeping difficulties were connected to back pain and headache by five generalists as described above, but they also attracted an additional two generalists who would further investigate difficulty sleeping as a symptom in its own right. Four of the generalists were concerned that Tom's sleeping difficulties could be due to depression although another two said that they would look for underlying causes which they did not specify. One generalist postulated that the sleeping difficulties might be linked to Tom's drinking. In a similar vein four mental health specialists said that they would explore a possible link with underlying stress or anxiety or offer help with sleep routines.

Other physical conditions: Other investigations of physical conditions that generalists said they might ask about included blood pressure, an eye test to investigate headaches, exploration of Tom's cardiac history. One of the mental health specialists would also check for upset stomach, hyperventilation, chest pain and increased heart beat. One generalist would take the opportunity to carry out a full MOT-type general health check:

> *"Certainly I mean from the health promotion point of view I would possibly even get him into a kind of male kind of general health check just to get him a MOT type thing. He's age 48 maybe worthwhile just doing a male screening, you know, general health".* Generalist, P21

Contact with NHS: Only one generalist and one mental health specialist considered that Tom's lack of contact with the NHS might be significant. The mental health specialist felt that Tom had done well to have got to age 48 without having contact with mental health services, and the generalist regarded Tom's contact at this stage as indicative that his concerns should be taken seriously:

> "*I mean obviously he is a man who doesn't usually trouble the doctor at all
> so - something is up as they say,*" Generalist P5.

In summary, about half of the generalist respondents suggested that they might investigate Tom's physical symptoms as possibly being linked to mental health problems. Most of the mental health specialists assumed that the physical problems would have been dealt with before Tom was referred to them.

2. Lifestyle

Most respondents picked up on aspects of Tom's lifestyle. Some made suggestions for Tom to get help, some would explore further and others would acknowledge Tom's lifestyle choices but not necessarily act on them.

Smoking: Only one generalist did not pick up on Tom's smoking although he did talk about smoking cessation services at other points in the interview. Five respondents would offer advice on smoking although one appeared to be unconvinced as to whether this was the right thing to do:

> "*I suspect he will probably say that it was the problems of his lifestyle that
> were troubling him and we would want to look at that and obviously with
> sleeping problems wonder if he was depressed and run a few questions
> across him. What else would we do? We would have a go at him about his
> smoking, probably.*" Generalist P5

Three generalists suggested that they would explore Tom's feelings about smoking first before deciding on action, and two would defer smoking cessation interventions until other problems were addressed. Three generalists also believed that smoking was likely to be linked to or indicative of Tom's mental health issues. Only one mental health specialist would offer referral to smoking cessation classes if Tom wanted that although three others noted that he smoked without offering further comment.

Alcohol: Two thirds of all respondents focused on Tom's alcohol intake and one third of them regarded his drinking as unproblematic at face value, including some joking that Tom drank less than them or their colleagues,

> "*if he only drinks two or three glasses of beer or wine on some days, that's
> less than I do!*" Generalist, P1

Many of the respondents assumed that Tom was under-reporting alcohol intake including some who believed that it was not an issue for him. Some would explore this further to identify Tom's reasons for drinking, whether it had increased, and whether it had an impact on his everyday life. Seven respondents speculated possible reasons for Tom's drinking including boredom, stress, as a coping mechanism, to relax or as a social activity. Some would only explore further if Tom indicated to them that drinking was a problem for him.

Diet: Only two respondents would have asked about diet, one generalist as part of a routine health promotion assessment and one mental health specialist as part of a broader lifestyle coaching approach to mental health in a primary care mental health initiative. The latter respondent made a clear link between diet and mental health:

> *"You know, if you don't have particularly good money, you don't have particularly good cooking skills and you go to the chip shop or McDonalds for your tea every night then, you know, the messages about healthy eating and all those things could be completely lost because that individual doesn't have the capacity to make those changes and also the sort of socialisation part of it and about going out and being involved, particularly those with severe mental illness."* Mental Health Specialist P4

Daily living skills: Two respondents would investigate the impact of Tom's symptoms on his activities of daily living including on his ability to care for his mother.

3. Mental well-being

Psychological symptoms: Nine respondents mentioned psychological symptoms with explorations ranging from wondering whether, "*maybe things are getting on top of him*" (Generalist, P6) to carrying out full mood or anxiety based assessments. Explorations would include looking for underlying causes for Tom's physical symptoms related to stress, anxiety or depression, and one respondent would explore whether he had been having suicidal or morbid thoughts.

Link between physical and psychological: Most respondents talked about Tom's physical and psychological symptoms being intertwined with each other and with Tom's circumstances. For example a typical comment was as follows:

> *"Some of the symptomatology he presents with, sleeping difficulties, headaches could be related to depressive illness, could be related to difficulty in coping with the situation he finds himself in."* Generalist, P14

One mental health specialist also believed that Tom's symptoms, underlying causes and circumstances should be understood together in order to provide some human support in response,

> *"I'm assuming he is depressed. He may not be at all, you know. Um, he may be suffering from stress or he may have something completely unrelated that has absolutely nothing to do with that and for me what I think it's about, is about people being aware of some of the things that can impact on peoples health be it medical, be it mental health, be it whatever, and to have a general awareness of that* […] *and to also feel comfortable enough with their own basic skills to be able to support them as a human being."* Mental Health Specialist, P4

Bereavement: Bereavement was seen as a potential source of unhappiness for Tom by less than a third of respondents and one other respondent thought that it might be an issue for Tom's mother, and consequently Tom through his caring role. Two mental health specialists would ask Tom about the relationship he had with his dad but others would consider referring him for bereavement counselling.

Tom as a carer: About half of the respondents saw some significance in Tom's role as a carer. Most saw this role in relation to caring for his mother which could mean that Tom could be referred to one of a number of local voluntary organisations for support. Two generalists highlighted that sharing the care of two teenage children might also be a potential source of stress. particularly if Tom's relationship with their mother was problematic. One mental health specialist was concerned that he had many patients referred to him for anxiety and depression as a result of having difficulties coping with caring roles. One respondent felt that Tom's caring role had to be explored from various angles:

> *"it doesn't say if Tom works, you know, but who cares for the children. Teenagers, are they 12, 13, you know. What are you classing as a teenager? Obviously if they were really young they do need some sort of, you know, kind of childcare. He may need more help for his elderly mother, but it depends how dependant she is. She might be elderly, but self caring and quite able, you know."* Generalist, P8

Exploration of social circumstances: Tom's social circumstances would be explored by around half of both generalists and mental health specialists. Most gave a list of factors that they thought might be issues for Tom, although none explained how they would explore these issues. Work and children were mentioned most often, by six respondents. However, work was mentioned in relation to the potential for industrial injury or being unhappy in the workplace, and no-one discussed work or other activity in relation to income or to social contact. Tom's relationship with his ex-wife and his mum's grieving for his dad were also considered by some. Other issues mentioned included finding out who he lived with now, why he was in contact with the NHS at this time and what medication he was on. Some of the respondents who would explore Tom's circumstances talked about looking at a range of aspects of Tom's life, for example,

> *"I mean obviously we are talking about his father dying and there's been issue around that, teenage children, divorce and then go on to look at things like hobbies, interests, personal time, if he can relax, relaxation and stuff. Social life, you know, who he lives with, you know, if he does go out, if he has friends, if he has sort of interests like that."* Mental Health Specialist P10

Despite poverty and deprivation being raised by some of the respondents in the theoretical accounts of definitions of inequalities, neither factor was raised as something they might explore with Tom.

Practice relating to Tom

1. Assessment

Mental health assessment tool: Most of the mental health specialists described their use of validated and established mental health assessment tools including the Hospital Anxiety and Depression Score (HADS), Patient Health Questionnaire, Work and Social Adjustment Scale and Canadian Occupational Performance Measure. They generally would use the tools together with additional exploration of symptoms and they would use them to assess Tom if he was referred to them. Some generalists also used mental health assessment tools in their core roles but they tended to be specific to their core client groups such as for postnatal depression or depression in the elderly. Most generalists therefore did not have a method that they would use routinely for assessing Tom's mental health, although it was clear that if they suspected a mental health

problem they would refer Tom to his GP. Only one generalist said that he would carry out a mental health assessment albeit of his own design:

> *"if I decided there was a psychological component to it at least I would then try, using my own personalised scheme to work out whether it was likely to be something that would benefit from some psychological treatments or whether it was what we used to call endogenous depression – depression that might respond to anti-depressant therapy."* Generalist P1

2. Interventions

Deciding on treatment: Most of the mental health specialists had particular programmes that they could work through with Tom. Depending on the outcomes of his assessments and their core roles, Tom might be offered anxiety management, self-help based depression programmes and sleep programmes. Some generalists as well as most of these mental health specialists suggested that they would take the least invasive option first. For example, one generalist would consider referring Tom for stress management in the first instance before referring him to the GP for medication or further referral. Another would not want to rush Tom into taking anti-depressants:

> *"Look at his lifestyle see if he can solve these problems and resolve his sleeping difficulties that way rather than… I don't think we would be rushing in with tablets unless we decided that he really was depressed in which case we might think, at least, probably not the first visit, but we would try and get him back fairly soon and see if he still comes over like that and then possibly an antidepressant."* Generalist P5

Follow up: Tom would probably be referred back to the GP by most generalists to report progress or for further referral if necessary. In contrast, mental health specialists would take Tom through their programme to the end before referring on to other colleagues in the mental health specialist teams, to other parts of the NHS for physical needs or to outside agencies for further specialist services or social support. In addition, Tom might be offered help to care for his mother by either providing support directly to her or by supporting Tom in his role.

Help with Tom's circumstances: Four generalists suggested help with Tom's circumstances with three suggesting help with his mother and one proposing to help him sort out his problems. None of the mental health specialists suggested helping Tom with his social circumstances.

3. Signposting and referring on

What is available: Chapter 6, Section 1 detailed services available locally where patients might be referred. These lists included some services that were also mentioned in the vignette response, often in relation to prompting, as options to consider for Tom. In particular, the main options for Tom appeared to be support for him as a carer for his mother, alcohol counselling or lifestyle help. Only two respondents felt that there were enough services available locally to meet Tom's needs while others thought services might be adequate if he was referred to the right person depending on what his needs were. Other respondents felt that services to meet any mental health needs were severely lacking, particularly for substance misuse, homelessness and psychology. Services within primary care that respondents mentioned that Tom might be referred to included:

Men's drop in psychology service for lifestyle advice, book prescription scheme, CBT, Doing Well by People with Depression primary care mental health workers in a rural practice, self-help material, exercise for depression referral scheme, health visitor offering stress management sessions, welfare benefits in primary care, family support and counselling through social work, social work for carers support, dual diagnosis team, child and adolescent mental health services within psychology for Tom's children if required, substance misuse team, and smoking cessation through a health visitor or a practice nurse.

Community and voluntary sector services suggested that might help Tom or his mother included:

Citizen Advice Bureaux, counselling, family mediation, carers support organisations including the Princes Trust and others, Scottish Association for Mental Health, bereavement support, community education, Meals on Wheels, respite care, addictions services managed by Turning Point (formerly the Bridge Project), family support services, youth club, church groups, alcohol counselling services including Ayr Council on Alcohol and Alcoholics Anonymous, rural phone-up bus service, lunch club and "good community spirit".

Referral for mental health: Generalists had a number of options for Tom if he was found to have mental health problems. Non-GPs could refer Tom to his GP and he would then be referred on to a mental health team if required. Two GP practices also had a *Doing Well by People with Depression* project to whom GPs could refer patients and non-GPs could refer through the GPs. This project would offer Tom early screening for mental health problems and provide general lifestyle and self-help advice.

Alternatively Tom could be referred to the community mental health team for assessment and triage or the GP could specify whether a CPN, psychiatrist, OT or social worker would be preferable. Limitations of services for mental health needs were described above in this chapter, Section 1, and some respondents discussed limitations of the psychology services in relation to Tom as well as to services in general in that they would not refer Tom for psychology services even if he needed them as the waiting list was too long:

> *"PC: Are there the services in place to meet the needs that Tom might have?*
>
> *GP 1: Em, no. We have quite a good voluntary and social work supported carers supporting system which is quite good and he would do quite well with if that's what he needed. If he needs psychological services the waiting list is interminable and means that a direct referral to psychology is pointless and the best thing we can do is to refer these people to the mental health team who may have something approaching the psychological interventions that you want."* Generalist P1

Referral outwith own service: Most respondents mentioned the potential for referring Tom to voluntary and community based services such as those listed above. There appeared to be three different types of services. First there were local branches of well-established national voluntary organisations which offered services for caring support and addictions. Some of these services were directly commissioned by health or social care to provide services in conjunction with mainstream professional interventions. The second category included local organisations that might not be directly funded for particular patients but would take referrals from mainstream services as well as self-referrals. The third type identified was informal local groups such as church groups, self-help or activity groups set up and run by the local community or by health and social care staff such as exercise groups and post-natal depression groups. Despite different levels of formality of structure between them, all three types had the common problem that their funding was generally short-term and unstable. At the same time there was a feeling among some respondents that not enough was being made of the voluntary sector services available and that it was difficult to find ways of ensuring communication that would enable referrals to be made:

"I think a system by which the voluntary sector was given if you like the NHS stamp of approval would be quite useful. I mean, we know of certain voluntary organisations where we've had good results in the past and we feel they are fairly respectable and could be good places to refer people to but there are lots of others about which I don't really know very much at all so I wouldn't bother referring to them". Generalist, P1

"One of the kind of big issues, particularly with the community and voluntary sector is the issue of, um, if I refer someone to this organisation are they fly by night, will they disappear, will their funding run out and their shop shut up and they were actually closed a year ago because a GP doesn't have time to go out and check up on every voluntary organisation. So I think that's an issue from the community and voluntary sector to look at in terms of how do we organise ourselves, how do we organise ourselves in such a way that a GP will feel comfortable in referring themselves to us. So I think that's one issue that would have to happen for primary care to feel more comfortable in doing that." Mental Health Specialist P4

Referral to GP: As suggested previously, all the non-GP generalists would not hesitate to refer Tom to his GP if they suspected he had some form of mental health problem. In addition, mental health specialists were likely to enter into a dialogue with the referring GP either to keep each other informed about treatment or investigations undertaken, for example for backpain, or to work together to find a solution to Tom's problems.

4. Reflections on practice with Tom

Own role with Tom: Generalists' hands-on roles with Tom were described as being to offer him the chance to talk, "*as talking to me can be beneficial in itself*" (Generalist, P1), try to sort out his problems, give him advice and encourage him to go to the doctor, offer him smoking cessation, take his blood pressure, measure his cholesterol, liaise with other service providers, prescribe analgesia for backpain or organise services for his mother. Five generalists would at some point in the consultation seek Tom's perspective either on what he thought his problem was or what changes he would like to make, for example:

"I would listen to what he said but I mean I think that's one of the first things. Most patients will tell you what's wrong with them." Generalist, P5

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Mental health specialists' hands on roles included mental health assessment, anxiety management, provide self-help materials for depression, prioritising and problem-solving, relaxation techniques, stress management, back maintenance, help with healthy lifestyle, talking through coping strategies, skills development and dealing with teenagers. Around half of the mental health specialists stated that they would ask Tom for his perspective on his priorities for the consultations.

In addition to their hands on role, generalists would refer Tom on for specialist mental health services, services for his mother, help with physical symptoms, bereavement counselling and help with lifestyle (for mental health). Mental health specialists would refer on for relaxation and carers support.

What should be available for Tom: As mentioned above, there was a feeling that there were not enough services available for Tom. One generalist was frustrated that there was a lack of well defined treatments that have been proven to be beneficial and also that there was not enough information about the treatments that were available. Another generalist believed that there were a lot of services "*out there*" (Generalist, P21), but they were too difficult to keep track of and more help with referral would be useful:

> *"A directory of what's out there, you know, would be helpful from statutory to voluntary services. I know they are changing all the time, but an up-to-date directory, you know, of what's out there would be great for me, as a professional. I'd probably have an idea of, you know, referral pathways, you know, for different situations and if it's like a mental health, a referral pathway who to contact, when to contact them, you know, when would you see this as being a problem sort of thing, you know, what to do beforehand before you refer, you know, to eliminate the ones that are not, you know, appropriate. A guideline when to refer and when not to refer and a pathway on how to work through the referral process".* Generalist, P21

The need for more information about what might be locally available was echoed by other respondents. Another big issue was the need for more sustainable counselling services, with the examples of Rape Crisis and the Bridge Project being closed at short notice leaving vulnerable patients who had started counselling with nowhere to go.

Limitations of help available: Limitations of services available have already been mentioned in the previous chapter but some limitations were also mentioned specifically with regard to Tom. These included that: if Tom's mother was not registered with his GP practice she would not have been able to access their services; Tom's problems could not be dealt with in the short timeslots available to some health professionals, therefore

they would have to deal with what they could in the limited time available and hope that he would come back later; waiting times for psychology were too long, and even if this were the most appropriate service for Tom he would have to be referred outside local health services; some services that Tom might want to access such as bereavement counselling, substance misuse and anger management were either very stretched or not available locally therefore incurring costs in time, for transport and occasionally for non-NHS services; and if Tom had come to live in a rural area for the first time he might find issues of isolation or dissatisfaction adding to his existing troubles.

Summary for Tom

Other aspects of the interviews with frontline professionals reported in the previous chapter focused on respondents' accounts of their usual roles and their interpretations of inequalities in mental health. The vignette provided further insight into the potential impact of respondents' services on a patient and whether an interpretation of inequalities influenced the service provided. The first issue was whether Tom would have been suspected as having a mental health problem. All the mental health specialists would have had Tom referred into their service through primary care and therefore they would assume that he had been assessed for mental and physical health problems before coming to them. Around half of the generalists thought that Tom's physical symptoms might be linked to mental health problems and would warrant further investigation.

Just over half of the respondents from both groups said that they would explore Tom's circumstances but, with one exception, the only circumstance they would offer help with was caring for Tom's mother. Tom would already have been referred for help with smoking cessation, alcohol counselling or other lifestyle advice which would probably have been available "in-house". On prompting, some respondents were aware of community services available such as welfare benefits advice, but no respondents discussed enquiring about Tom's income or other social issues such as housing or education. This was significant as some respondents included these issues as being related to mental health in the theoretical discussions about definitions of inequalities. However, while respondents did not demonstrate a strong leaning towards looking at causal factors and prevention, most respondents suggested that they would explore beyond physical symptoms or health service interventions for responding to Tom's problems.

In conclusion, Tom's visit to primary care might or might not lead to exploration of his mental health. His physical problems and mental health problems, if identified, would lead to referral to counselling or lifestyle help if available in his area, or to specialist

mental health services. Within mental health services he would be likely to receive a pre-set psychological intervention with or without medication and with or without lifestyle advice. Tom might be asked about some of his social circumstances in some services but the findings here suggested that respondents would offer a limited exploration, and few demonstrated that a link would be made between Tom's social circumstances and potential mental health problems.

Chapter 8

Discussion

Introduction

This chapter collates and discusses the main findings from the analyses set out in the previous chapters. The results from each of the four communities of meaning – policies, local strategic planning, frontline professional's interpretations and practice with a service user - were considered separately and in combination. Chapter 8 discusses the findings from the study in relation to the research questions and previous research, and includes discussion of the study's limitations and a personal reflection. The discussion is presented under the headings of Main findings, Summary of answers to the research questions, Limitations of the study, What does this study add to what is already known?, and Reflection.

Main Findings

The main findings are discussed below under each of the research questions.

1. **What are the expectations from policy on primary care organisations to reduce and prevent inequalities in mental health?**

Previous policy research concluded that very little evidence is used explicitly within policies for health inequalities although some ideas or concepts might be incorporated (Macintyre *et al*, 2001; Exworthy *et al*, 2003; Petticrew *et al*, 2004; Mackenzie *et al*, 2006; Smith, 2006). The policy analysis in this study also found a lack of a clear use of evidence in policies relating to health inequalities. However, some evidence was occasionally mentioned in general terms such as in claiming the existence of a widening health gap or a link between health and life circumstances. Specific research conclusions and identifiable sources were usually missing with only one exception found in *Towards a Healthier Scotland* (Scottish Executive, 1999) where a review, rather than a primary data source was referred to.

A degree of confusion and a great deal of disjunction between definitions and actions to address inequalities in health was evident in the health and social policy documents appraised in the study. As described in Chapter 4, 34 citations of 14 definitions and 24

types of actions cited a total of 85 times were identified to address health inequalities across the nine policy documents. Proposed actions did not always follow the definitions given in the documents. For example only three definitions from two documents were found that described health inequalities as being linked to personal behaviour, but 24 actions across six documents were given for actions on individual behaviour change. In contrast, 14 definitions regarding societal factors in seven documents were followed by only eight actions across six documents. A strong message came from 35 actions being proposed for organisations to address health inequalities such as improving access to services (two citations) or better data management (five citations) but no definitions were given that linked health inequalities to organisational factors.

Where actions were proposed for primary care to address inequalities in health the intentions were often unclear such as in the *Community Health Partnership Statutory Guidance* (Scottish Executive, 2004d). This document stressed the importance of inequalities in health but the only guidance offered was to recommend that CHPs should meet the needs of the whole population in order to reduce inequalities. Other polices stating that health inequalities were an overarching aim for the NHS and the Scottish Executive were also unclear and inconsistent about their definitions of health inequalities and about the actions that should be taken to address them. *Health Improvement in Scotland: the Challenge* (Scottish Executive, 2003) gave the NHS and other agencies a steer towards prioritising improving mental health and to a lesser extent acknowledging inequalities in mental health. This was the only document that suggested the existence of inequalities in mental health but fell short of proposing actions. Recommended actions in the policy documents generally specified only the high level structures such as the NHS, local authority, local partners or the public sector. The exception to this was the *Community Health Partnership Statutory Guidance* (Scottish Executive, 2004) which focused mostly on Community Health Partnerships (CHPs) and Community Planning Partnerships, and *Delivering for Health* (Scottish Executive, 2005) which specified CHPs and GPs for implementing most of its actions for improving service delivery.

The health inequalities target introduced in *Building a Better Scotland: Spending Proposals 2005-2008* (Scottish Executive, 2004a) used smoking, suicide in young people and physical health indicators to measure progress in reducing the health gap. It is argued that these indicators sometimes relied on separately-funded initiatives rather than mainstream services suggesting a lower priority than other issues such as waiting times. Similarly, *Delivering for Health* (Scottish Executive, 2005) identified the main role for primary care in health inequalities would be to pilot an anticipatory care initiative which intended to become mainstream sometime in the future (Scottish Executive, 2005).

It is argued that the role of primary care in addressing inequalities might have been narrowed rather than enhanced by *Delivering for Health.* Its stated role for primary care in reducing health inequalities was to focus on interventions favouring biomedical control of risk factors and behaviour change at an individual level while moving "upstream" actions to others including the less accountable partnership arrangements. It was interesting to note that *Delivering for Health* provided more hard evidence of the link between social circumstances and health than any other document in the policy appraisal and included an intention to tackle determinants of ill-health. However it used the evidence as a demonstration of differences between individuals and communities rather than to argue that the circumstances might be a causal factor in ill-health. It proposed to strengthen poor communities by targeting services at individuals in the communities rather than tackling the circumstances around the individuals. In addition, *Delivering for Health* made very little mention of mental health although that might have been in anticipation of a promised future mental health strategy. Prevention of mental health problems was not included in specific recommendations for primary care or in performance assessment for either CHPs or general practice in any of the policy documents which arguably gave it less priority than other aspects of service delivery and development that were being assessed.

The policy appraisal found disjunction within and between Scottish national policies for defining and addressing inequalities in health and inequalities in mental health, and the use of the term "inequalities" described observable differences rather than issues of unfairness. Policies acknowledged the need to reduce health inequalities including by tackling social inequalities but there was no narrative or action that might link contributory factors and outcomes, or that linked NHS activity with action on wider social circumstances. In particular, there was a lack of specific guidance for primary care. The disjunction was mirrored in local strategic development and in primary care practice, both of which are discussed below.

2. **What is meant by "primary care" and who are the key practitioners within primary care involved in work on inequalities in mental health?**

Guidance was sought from local documents and key contacts in South Ayrshire Community Health Partnership (CHP) for suggestions of who should be approached for inclusion in the study. This approach enabled the CHP to define the key practitioners for primary care mental health and inequalities in mental health, rather than identification being researcher-led. Initial meetings with individuals led to a meeting with all the heads of services in the CHP and this group in turn provided contact details of staff throughout the CHP who they thought would be appropriate to include. Further potential contacts

emerged as a result of suggestions by respondents or contacts who did not want to take part but offered to help in identifying alternative participants. I understood from this process that there were GPs and primary care staff including nurses, health visitors, physiotherapists, dieticians, speech therapists and others to whom patients might self-refer or confide in for first line help for mental health problems. Patients might then be referred on through their GPs for specialist mental health interventions to the Community Mental Health Team (CMHT) and from there into other services if required. The CMHT and other mental health services were also employed through the CHP (and previously the Local Health Care Co-operative). Despite that they had separate management structures from the primary care staff, it was clear that they worked closely with GPs and others in primary care to share information and care for many of their patients. There was a strong emphasis from most participants on "normalising" a patient's experience of mental health services by bringing services closer to the patients and preventing hospitalisation or even hospital-based appointments as much as possible. This was in line with current guidelines for mental health services which aimed to move away from institutionalised psychiatry in order to reduce stigma and aid recovery (Scottish Executive, 2005b; NICE, 2005; Stewart, 2006).

Some GP surgeries in the area at the time of the study were piloting the use of different types of primary care mental health workers with primary care teams rather than within mental health structures. The close working relationships between primary care, the mainstream Community Mental Health Teams (CMHTs) and the new primary care mental health services meant that boundaries appeared to be increasingly blurred between primary care and mental health, and between the NHS and local authority staff within CMHTs. This suggested that the services a patient might expect for a mental health problem could in some cases be potentially indistinguishable from any other primary care service, and might be delivered by staff employed and experienced in primary care rather than in mental health. Within the study it was important to draw lines around the different services in order to be able to explore a primary care role and whether it differed in any way from a mental health role. The issue that emerged to explain the different roles was that some staff had first line contact with patients with mental health problems either through self-referral or by being "picked up" as having a mental health problem requiring attention while others had patients referred to them. The terms "generalists" and "specialists" distinguished them accurately for the purposes of the study. The respondents themselves might not have agreed with these titles as some of the "generalists" had roles that might otherwise be described as specialists for any other purpose such as in working with homeless people or in pharmacy.

Practitioner roles in reducing inequalities in mental health were difficult to identify from both generalists and specialists, as frontline professionals were often unclear about the

significance or even existence of inequalities in mental health. The study was based on the assumption that inequalities in mental health might be prevented or reduced through improving a patient's or the population's social circumstances (Hannah and Halliday, 2002; Taylor *et al*, 2007), as has been suggested for inequalities in health in general (Whitehead and Dahlgren, 2006). For frontline practitioners and planners to contribute to this, it is argued that they and their organisation would first require to have an understanding of who might be most at risk of mental health problems arising from adverse social circumstances. Neither frontline professionals nor the primary care organisation in the study demonstrated understanding of the impact of social circumstances on mental health, or that had they thought through potential risk factors. It is argued that national policy could be partially implicated in this as it had provided a misleading message that everyone was at equal risk of having mental health problems (*See Me* website, n.d.). The lack of evaluated interventions (Millward *et al*, 2004) could also be partially implicated in the lack of focus on inequalities in mental health within the CHP. Attempts had been made in Scotland through the *National Programme for Mental health and Well-Being* (Scottish Executive, 2004) and *Doing Well by People with Depression* (Morrison *et al*, 2007) to raise awareness of interventions to improve mental health and well-being. However, the *National Programme* was not mentioned by any respondents and *Doing Well by People with Depression* was mentioned only by the two respondents who had been directly employed through the initiative.

Mental health specialist staff demonstrated more awareness than generalists of the potential for poverty to have an adverse effect on their patients either as a cause or a consequence of mental illness. Despite this, none of the respondents proposed to take an active role in enquiring about Tom's (the vignette patient) financial or other circumstances and only one of the generalists thought that they might help Tom with his social circumstances although three more would have offered some help in caring for his mother. Links between poverty and mental health were discussed by most of the strategic staff but were not taken into account by the Needs Assessment Steering Group. The Steering Group also missed opportunities to use information presented to them in the commissioned literature review that highlighted the existence of inequalities in mental health and the link between adverse social circumstances and mental health problems in South Ayrshire.

3. **What information is available to the primary care organisation about the patterns of mental health and health inequalities in their area?**

Frontline professionals and strategic staff described the mental health problems they saw in practice under the categories of "severe and enduring" and "mild to moderate".

The former category included complex problems such as schizophrenia or obsessive-compulsive disorder together with other longer-term conditions that were described as being often well-controlled and usually managed by the psychiatric services. The "mild to moderate" category included conditions that were shorter-term, managed predominantly in primary care if caught at an early stage, and were much more common than those in the former category. Frontline professionals tended to offer lists of mental health conditions that they had seen in practice when asked which mental health problems they saw in primary care, although their lists differed from each other to some extent. Strategic staff tended to offer more considered discussion of a small number of conditions rather than lists, perhaps due in some cases to their distance from practice. Both sets of respondents agreed that anxiety and depression as the main conditions described under the heading of "mild to moderate" were much more common than those described as "severe and enduring". Thus respondent's categorisation of mental illness generally corresponded to that found in the literature described in Chapter 1, Section 2 and was notable for a similar lack of consistent, clearly defined, distinct categories. Confusion in terminology relating to mental health was a theme running through all elements of the study of research papers, policy documents, the needs assessment literature review, the needs assessment report and accounts of respondents.

Respondents appeared to have developed their categorisations for mental health problems in response to patients they saw in practice. The two categories of "mild to moderate" and "severe and enduring" were named as such by all respondents without exception suggesting a well-established shared language. These terms were not found in the format used by respondents in either the research literature or the main mental health policy documents, that is, the *Framework for Mental Health Services* (Scottish Executive, 1997) or *Delivering for Mental Health* (Scottish Executive, 2006), neither of which used the term "mild to moderate". The well-established nature of the respondents' terms suggested that they had derived from an influential source but it remained elusive to this study despite a great deal of searching.

There were a number of sources of routine data for mental health and for inequalities that staff in general practice and primary care organisations could access if required. At the time of the study national mental health data for Scotland were collected and collated by the Mental Health Programme in Information and Statistics Scotland (Information and Statistics Division, 2007). Information and Statistics Scotland (known as ISD) had an accessible website which included contact details for staff who advised on the Programme. Mental Health Programme staff from ISD were credited in the South Ayrshire Mental Health Needs Assessment with providing an analysis of patients with severe and enduring mental illness which they carried out at the request of the independent researchers. The Mental Health Programme also ran a national project

called the "Improving Mental Health Information Project" which engaged with health service staff around the country to improve the collection and reporting of mental health data. They provided a monthly email newsletter to which anyone could subscribe. In addition to health service data, Community Profiles (NHS Scotland, 2004) were available for all LHCC areas across Scotland during the study period, and South Ayrshire's profile was drawn on for this study in Chapter 5, Section 1, and by the needs assessment research team to provide context for the area. Community Profiles used a number of health and well-being indicators drawn from a wide range of routinely collected data sources and surveys, and they demonstrated inequalities within and between defined geographical areas for health and social circumstances. Mental health information in the profiles included some mental health conditions and related health service use, and area deprivation was linked with higher prevalence of diagnosed conditions, hospital admissions and suicide.

Local information on health and on health inequalities to a limited extent was available in reports and strategies written by Ayrshire and Arran NHS Board, the LHCC or CHP and South Ayrshire Council. The main source of published and accessible information for Ayrshire and Arran at the time of the data collection period (2002-2006) was the annual NHS Director of Public Health Report published in 2004. This had separate sections for mental health and for inequalities but made no reference to links between the two. Another data analysis produced by the council for internal use concluded that there was no link between deprivation and prevalence of mental health conditions or between deprivation and hospital admission for drug and alcohol conditions. This assertion contradicted much of the published research evidence including the Community Profiles (NHS Scotland, 2004) but may have been the result of geographical boundaries that were too small to provide good population data.

The mental health strategies produced by the NHS, local authority and multi-agency partnerships tended to be written in response to requests relating to legislative or service directives from the Scottish Executive. None featured inequalities in mental health, although some of their service changes were linked to better access to services for the most vulnerable patients such as those affected by homelessness or drug and alcohol abuse. One mention was made in relation to inequalities in mental health in South Ayrshire's Local Health Plan which was written in 2004 and promised that an equity audit for mental health would be carried out. However, this had not yet been enacted by Spring 2007. An unpublished and unfinished draft health inequalities strategy stated that people living in deprived areas were more at risk of mental health problems, but one of the strategic staff interviewed believed that the strategy would not be finalised for quite some time.

As already mentioned above, the literature review carried out prior to the commissioned needs assessment and to a lesser extent the needs assessment itself, gathered and presented information that linked social inequality with physical and mental health problems in South Ayrshire. In addition, the needs assessment included an analysis carried out specifically for it by ISD of "severe and/or enduring mental illness" (their term). This analysis concluded that 508 patients between the ages of 16 and 65 had severe and/or enduring mental illness in 2006. It is argued that if South Ayrshire followed the general population prevalence for anxiety and depression as outlined in Chapter 1, Section 2 (which are assumed here to constitute the largest proportion of the "mild to moderate" category described by respondents), there could potentially be somewhere between 11,000 and 16,000 adults with mild to moderate mental health problems in South Ayrshire at any one time with as many as 28,000 (25% of the population) being affected at some point over their lifetime. The potential prevalence of "mild to moderate" mental health problems was not described or discussed in any of the local documentation or by the needs assessment process.

4. **What information is available to the primary care organisation about interventions that primary care can implement to reduce and prevent inequalities in mental health?**

There is a lack of intervention research reported for health inequalities in general (Millward *et al*, 2003) but there are numerous evaluations of small projects available in the grey literature. Some of these had been brought together for mental health and were argued to be relevant to intervention planning as they had been shown to help people albeit on a small scale (Mentality, 2002). The *National Programme for Mental Health and Well-Being* published Mentality's paper on its website in 2004. In addition, authors of the paper provided workshops around Scotland for primary care, local authority and voluntary sector practitioners over the time of the study period (I attended one in 2004) in order to raise the profile of their potential roles in improving mental health and well-being. In addition, a national conference in Scotland called "Equal Minds" was funded by the *National Programme for Mental Health and Well-Being* in 2004 in order to stimulate discussion about inequalities in mental health. All of this demonstrates that over the study period there was some information available about interventions for primary care to improve mental health and the beginnings of national debate about inequalities in mental health. All of this would have been available to the CHP but discussion of this was absent from participants' accounts as well as from most local and national policy and strategy documents.

5. **How are inequalities in mental health incorporated into primary care strategy and planning within the primary care organisation?**

Chapter 5 provided details of the investigation of whether South Ayrshire CHP incorporated inequalities in mental health into local strategy documents, their mental health needs assessment, or other planning processes. Information and evidence about inequalities in mental health were provided for the mental health needs assessment in the commissioned literature review and in the introduction to the needs assessment final report. However, the report's discussion and recommendations did not include any reference to inequalities in mental health. While other local strategy or information documents included very little about inequalities, one made reference to the potential for health services to increase the inequalities gap. Issues relating to the measurement of inequalities in mental health or the impact of social inequalities on mental health were not taken up by any substructure of the CHP over the period of the study.

6. **How do primary care professional staff access and interpret information about inequalities in mental health from research and policy?**

As mentioned under question 3 above, neither frontline professional nor strategic staff appeared to receive or seek out information about inequalities in health or inequalities in mental health on a routine basis. Many reported that this type of information was not directly related to their roles. The few respondents who did believe that it was relevant suggested that it was incomplete or otherwise not helpful enough to them to enable them to use it for planning purposes. Only one respondent from the frontline professionals (a "generalist") mentioned receiving information from the ISD Mental Health Programme (Information and Statistics Division, 2007) as a result of signing up to their email newsletter. Apart from this, none of the frontline professionals mentioned national data sources or local reports providing them with information about the health of the Ayrshire population. Four respondents described postcode sector KA 8 as being deprived, although only two of them mentioned this in relation to differences between KA 8 and KA 7. The sectors were separated by the River Ayr flowing through Ayr town centre and both respondents described the north of the river as being deprived and the south being affluent.

The type of knowledge of inequalities demonstrated by many respondents and the inconsistencies in their discussions suggested that they tended to draw most of their understanding and information about health inequalities from experience in practice or from the general media rather than from research or policy. This was strongly suggested in their definitions where the most common one given was "access to services", which

was less apparent in research and policy than definitions relating to social or economic factors. Many respondents illustrated their thoughts on access to services by giving examples of patients who had experienced difficulties in obtaining or getting to appointments or services. It is argued that participants would have been more likely to link inequalities with poverty, area deprivation or other social circumstances had they taken their definitions from research or policies as these were much more in evidence in both arenas than was the issue of access to services. As noted above, access to services did not appear as a definition in any of the policy documents although two actions were included among the 33 actions proposed for addressing health inequalities through organisational change. Respondents' accounts were also generally lacking in references to equality and diversity issues which had begun to appear in policy documents over the study period although these remained less apparent in other national and local data sources.

The media was mentioned as a source of information by one respondent who stated that she accessed information about health inequalities in newspapers and by another who quoted the *See Me* campaign figure of one person in four being at risk of mental health problems. However, three other respondents also believed that everyone was at equal risk of developing mental health problems while the remaining respondents declined to answer the question of who might be at most risk. Again it is argued that research was not the source of information for practitioners while the media clearly influenced at least some of the respondents.

7. **How do primary care professional staff apply an understanding of inequalities in mental health in practice?**

Inconsistencies and hesitations were apparent in many of the respondents' accounts of their understanding of inequalities in mental health and even where there was an understanding of inequalities in mental health there were gaps in applying this to practice. The answers to this question are drawn from responses to the vignette with comparisons made between these responses and respondents' definitions of health inequalities and links made between social factors and mental health. For practice relating to mental health in general, respondents demonstrated variability in assessing, investigating and diagnosing Tom with a mental health problem. As noted previously, the terms used to describe mental health problems provided a confused picture. Respondents appeared to be comfortable in using the two categories of "severe to enduring" and "mild to moderate", although the latter did not appear in research, information or policy documents. Most of the mental health specialists used a validated assessment tool to reach a diagnosis. In contrast, generalists either did not use a tool or

they used their own system which might explain at least some of the variability in their responses to Tom in the vignette. Formal processes for assessment were found in the literature and policy review to be favoured by the World Health Organisation (2001) and Scottish mental health guidelines (NICE, SIGN). However, formalised assessment processes were found in one Scottish study to have played only a small part in diagnosing depression in women, with social and moral reasoning being more important parts of the process for patients and for GPs (Maxwell, 2005). In the present study, exploration of Tom's social circumstances was mostly limited to his relationship with family members who appeared in the vignette. Other circumstances such as poverty and education were missing from these explorations, even for respondents who had included these issues in their definitions of health inequalities.

Responses to the vignette illustrated respondents' approaches to day-to-day practice in identifying and treating mental health problems. In particular, the extent to which participants used a social model or biomedical model was explored through the vignette in order to identify ways in which social inequalities might be tackled. A social model would entail looking "upstream" at causes of ill-health and tackling social determinants of health such as poverty, housing and discrimination (Whitehead, 1995) and a biomedical model would favour a clear diagnosis, an expertly-designed treatment proven to work for that specific diagnosis and would ignore the social context of disease (McKeown, 1976; Tudor Hart, 1988). A strong bias towards a biomedical model was detected for two respondents and a similarly strong bias towards a social model was detected for another two respondents. The biomedical model saw the causes of Tom's problems lying exclusively within him and the treatment would be medication and/or talking therapy, offered by a professional to a prescribed model. A social model was suggested through speculation by respondents of some causes of Tom's problems perhaps arising from in his relationships or roles with others. Consequently the solutions would include helping him with these circumstances such as by offering support for his mother. A further two respondents demonstrated a more holistic approach than was detected for others although arguably not fully signed up to a social model. Their approaches took a broad perspective, notably focusing on issues that would help Tom cope with or challenge his circumstances such as gaining employment or offering counselling for problem drinking but they generally saw the answer to Tom's problems as lying in the one-to-one services that were accessible locally.

The remaining frontline professionals and strategic staff tended to use a combination of biomedical and social models of health to assess, understand or treat a patient with potential mental health problems. Respondents did not generally articulate the model used for their approach although one proactively defended their use of a medical model. While a few others talked about exploring patients' social circumstances with them they

did not describe their practice as being aligned with a social model. The two respondents conforming to a biomedical model were senior, experienced staff with membership of LHCC/CHP committees including one with an influential role on the Needs Assessment Steering Group. In contrast, both respondents demonstrating alignment to a social model of health were frontline staff with full-time roles in working directly with patients and one was working on a time-limited project. Respondents adhering to both models believed that more attention was required to be paid to the most vulnerable of their patients.

Inconsistencies were identified between definitions used for inequalities and issues that they might follow up in practice. For example in the discussions about understanding health inequalities, around half of the frontline professionals mentioned some aspects of social circumstances that might impact on health such as social deprivation, unemployment, income and the gap between rich and poor. In response to the vignette, just over half of the respondents thought that Tom's social circumstances might be issues for him. However the circumstances referred to in relation to Tom were not identified as income or social deprivation as suggested in some of the theoretical discussions, but relationships with family members and Tom's possible caring role. Employment was mentioned in vignette responses but in relation to being unhappy at work or for the possibility of industrial injury, rather than as a potential source of income.

Similar inconsistencies arose in the strategic staffs' accounts where all of them mentioned poverty as a cause or consequence of mental illness, but only one described taking a corresponding action which was to support a project offering welfare benefits advice to mental health service patients. In addition, despite the influence that most of these respondents had on CHP strategy, the conclusions of the mental health needs assessment made no mention of poverty or any other social problem and were clearly driven by a biomedical model. The demonstration of inconsistencies between respondent's theoretical understanding of inequalities in mental health and application to practice mirrors the disjunction found in policy documents between definitions and proposed actions.

General Practitioners were the lynchpin for Tom's mental health problems either for diagnosis and treatment or for referring into specialist services. This might create an assumption that treatment and support routes were likely to be driven by a biomedical model. However, many of the frontline professionals including the GPs suggested that they would have referred Tom to voluntary or community organisations for counselling, lifestyle advice, self-help or for help with caring for his mother, in addition to treatment that could have been provided by themselves or specialist mental health services.

The voluntary sector was seen as important in providing general support for Tom and there was some suggestion that they could deal with Tom's social circumstances better than primary care. At the same time a sense of dissatisfaction with some voluntary services was expressed as a result of recent cuts in funding or a perceived lack of clarity of services provided. Services provided by the voluntary agencies that were mentioned most often appeared to be those that backed up the biomedical or psychological treatments offered in primary care, such as providing addictions services, bereavement counselling, home support or stress management many of which were likely to be directly commissioned by health or social services. There were very few mentions of other voluntary or community-led services which might provide social support for patients although, according to a local voluntary sector database project, there were a number of community based initiatives including gardening schemes, walking groups and others. In the light of this it is argued that instead of the voluntary sector being the source of a social model of health it was in some cases subject to the same overall dominance of the biomedical model, with services designed to help individual patients cope with their circumstances rather than being aimed at changing their circumstances. For example, if poverty was taken as an issue for Tom, services might respond in one of two ways. First, an approach that would fit with a biomedical model would be to provide stress management so that Tom might learn to cope with living in poverty. Alternatively, a social model approach would include finding a way for Tom to maximise his income, such as through welfare benefits advice or help into employment. A social model might also include advocacy for the reduction of poverty or to improve housing or the local physical environment with structures including campaign groups as well as groups and committees within the service.

Most respondents suggested that they would be reluctant to have Tom prescribed medication at an early stage, instead taking the least invasive approach which was generally to offer set programmes for stress management or self-help for depression. After the programmes, Tom would then be referred back to the GP for medication or further referral if required. While pharmaceutical interventions were not the first choice, the usual alternative was to be offered a pre-programmed, evidence-based, expert-led intervention with the option of a prescription. It is argued that this model fitted into a biomedical model with or without medication. Very few respondents said that they would offer to provide or find help for Tom's social circumstances including those who said they would explore them during his assessment. In addition, staff could not find time to participate in or develop preventive action, funding was being withdrawn for the voluntary sector services which did provide social support, and a patient-led approach was rarely seen in response to the vignette. On balance, a biomedical approach appeared to dominate primary care mental health services, and knowledge about

existence or causes of inequalities in mental health were generally not applied to practice.

8. **What are the factors that help and that hinder primary care professionals to contribute to the reduction and prevention of inequalities in mental health?**

None of the frontline professionals explicitly described action that they could or did take to address inequalities in mental health. However there were some general suggestions for activity that might help, such as improving access to services, better information about interventions, and raising awareness of domestic violence, drugs and alcohol with schoolchildren. Most believed that work to reduce or prevent inequalities was not a role for the NHS although some suggested that working in partnership with others might help to enable a holistic approach beyond patients' immediate health and social needs. The voluntary sector was usually suggested as the key agency for developing a holistic approach but this process was described as a general aspiration rather than as a description of work that was actually happening. It is argued that addressing inequalities in mental health was seen by frontline professionals as being different from their day-to-day work and something that they did not have the time to do as they were already overstretched with their core roles.

Three of the strategic staff did provide concrete examples of action for reducing and preventing inequalities in mental health which were: to provide funding for a welfare benefit advice project for mental health service patients; development of a health inequalities strategy; and advocacy for inequalities in general within CHPs and strategic groups. It is argued that these actions were not discussed within frontline professionals' accounts or in local strategy, suggesting that there were organisational barriers that prevented these actions impacting effectively on general CHP strategy and on practice. Strategic staff also believed that there was inadequate information available on which to base good planning for inequalities in mental health and to ensure that services were accessible to those most in need. The main issue that strategic staff believed hindered developments was that mental health services were regarded by the NHS Board as less of a priority than acute and primary care services. This was illustrated in part by the uncoordinated and confusing spread of semi-autonomous mental health groups developing overlapping strategies that were on occasions not implemented.

An approach suggested by a social model of health for contributing to reducing health inequalities would include ensuring that the voice of the powerless is heard (Whitehead and Dahlgren, 2006), and it is argued that for primary care and other CHP staff this

might be achieved using a patient-led approach. There were two manifestations identified in respondents' accounts of a lack or existence of a patient-led approach. The lack was expressed by mental health specialists where some were concerned that patients who did not present at appointments were likely to be particularly vulnerable. No respondents had taken steps to follow up such patients and there did not appear to be an expectation that anyone within the service would do this. One respondent had conducted a small piece of research on such patients and concluded that most of them lived in deprived areas. It is argued that this is an example of a service-centred rather than a patient-led approach in that the service has not responded to known, vulnerable patients with unmet needs. Instead, the service-dictated needs were prioritised of having professionals unable to leave their bases despite knowing that some patients had difficulties in accessing services there.

On the other hand, a patient-led approach was in evidence when Tom was given some control of the direction of the consultation. Only one respondent suggested that finding out what Tom wanted from the consultation would be an appropriate first step. However, rather than intending to give Tom control of the consultation they were keen to identify quickly whether the patient was there primarily and possibly inappropriately for a prescription or sick line. Four respondents reported a more participative approach by starting their investigations with an exploration of Tom's circumstances and how he coped with them, while most others suggested that they would begin by applying their routine assessments before making decisions about Tom's needs. A participative approach focusing on social circumstances rather than dealing only and primarily with presenting symptoms would fit with a social model as discussed above and might enable professionals to more easily identify and address issues relating to inequalities. However, it is argued that respondent's lack of debate about inequalities together with apparent lack of knowledge about patients who might be most at risk of mental health problems, were the main barriers to primary care contributing to addressing health inequalities.

9. **What more needs to be done by primary care to contribute to reducing or preventing inequalities in mental health?**

As already noted, policy and research lacked descriptions of interventions that primary care can implement to reduce inequalities in mental health (Millward *et al*, 2003). Of major immediate concern is research carried out in recent years in the West of Scotland that demonstrated that primary care did not serve vulnerable population groups well (Stirling *et al*, 2001; McAlister *et al*, 2004) and therefore could potentially contribute to the increase in health inequalities. Processes that have been proposed as contributing

to reducing inequalities included working in partnership with other agencies to develop broad multi-disciplinary approaches (Arblaster *et al*, 1996), and increasing access to services through concerted effort to engage with vulnerable population groups (Baker and Middleton, 2004). There is also strong evidence emerging that suggests that improving childhood socio-economic status improves health in later life (Poulton *et al*, 2002). The main actions for health and social policies have focused on targeted behavioural change and improving access to employment as actions that primary care might take to contribute to reducing health inequalities. It could be argued that all of the above suggestions (with the exception of improving childhood socio-economic status) appeared in some respondents' accounts. However, examples of practice given were often aspirational or they described work going on elsewhere rather than suggesting a set of strategic and concrete actions for themselves. For example, access to employment was mentioned by only one respondent and partnership working appeared to be concerned with integrating health and social services rather than developing broad approaches to addressing health inequalities.

Access to services was strongly believed by respondents to be an issue at the heart of inequality in health. There were a small number of accounts of this being acted upon directly by frontline professionals at an individual level. Those accounts described complex processes of working through a range of problems, often negotiating with staff in a number of organisations or services, and success usually depending on good relationships between the respondent and the other service providers. Access to mental health services was raised in the mental health needs assessment for some specific services for people with severe and enduring mental health problems, and at practice level through a small pilot project that aimed to improve access to services in primary care for people with mild to moderate problems. It is argued that the principles of access to services in general, including for the most vulnerable and unsupported people, had not been taken on at strategic level.

There was no guidance available from national policy or local strategy for specific action such as focusing on the most vulnerable patients or those most at risk of developing mental health problems, and it is argued that this would need to be in place in some form in order for primary care to contribute to reducing or preventing inequalities in mental health. The CHP did not take on evidence of uneven distribution of risk factors for mental health problems or seek out recommendations from research that might contribute to reducing health inequalities. Some individual respondents appeared to hold the view that social circumstances might impact on or be linked to mental health, but they had not taken the next step of translating evidence into practice.

Summary of answers to the research questions

1. What are the expectations from policy on primary care organisations to reduce and prevent inequalities in mental health?

Disjunction was found within and between Scottish national policies for defining and addressing inequalities in health and inequalities in mental health. Policies were unclear about specific guidance for primary care but appeared to steer primary care towards a biomedical focus on individuals while moving upstream activity to tackle social determinants of health towards local authorities or less accountable partnership organisations. Policy documents emphasised the importance of addressing inequality but the disjunctions presented a confused picture, and clouded policies' expectations for primary care in reducing and preventing inequalities in mental health.

2. What is meant by "primary care" and who are the key practitioners within primary care involved in work on inequalities in mental health?

Community mental health services were managed alongside primary care services and there were strong links between primary care and mental health services in the CHP under study. The boundaries between primary care and mental health were being broken down through the development of new primary care mental health services and close referral links between them. Any primary care professional might be in a position to identify a patient who is experiencing mental health problems. Knowledge of inequalities in mental health was weak for both primary care generalists and mental health specialists, and was not discipline-specific. Mental health specialists appeared to be more aware of the potential for poverty to impact on the mental health of their patients but did not propose a role in addressing this or other social factors that might impact on mental health. While individuals working at strategic level demonstrated more awareness of a link between social factors and mental health, none of them influenced the mental health needs assessment process with this perspective. Therefore, while all disciplines within primary care mental health services had potential to address inequalities in mental health, virtually no-one did.

3. What information is available to the primary care organisation about the patterns of mental health and health inequalities in their area?

In addition to the array of definitions given for health inequalities within Scottish policy documents there was also confusion in terminology describing mental health problems. One exception to this was an unaccountable consistency among respondents in using terms such as "mild to moderate" in ways that did not appear in policies or research papers. However, it was impossible to trace where the organisation or individual professionals accessed information relating to the terms used and this suggested that information came from a diverse range of sources. There was little evidence that data collected nationally or locally on mental health or inequalities in health was promoted to primary care professionals who described accessing such information only rarely and when specifically required for personal interest or professional use. Information on patterns of mental health and health inequalities were made available to the mental health needs assessment but was not used to shape recommendations.

4. What information is available to the primary care organisation about interventions that primary care can implement to reduce and prevent inequalities in mental health?

A limited amount of information appeared to be available to the primary care organisation on interventions nationally or locally, but the most likely source of accessible information at the time of the study would be through the *National Programme for Mental Health and Well-Being*. Particular effort had been made by the *National Programme* to package results of small evaluations for primary care staff to encourage implementation and to start to raise the debate about prevention of mental health problems and about inequalities in mental health.

5. How are inequalities in mental health incorporated into primary care strategy and planning within the primary care organisation?

Issues relating to the measurement of inequalities in mental health, mental health outcomes of social inequalities or links between mental health and social inequalities were not taken up by the mental health needs assessment or other local strategic processes.

6. How do primary care professional staff access and interpret information about inequalities in mental health from research and policy?

It is argued that information about inequalities in mental health was generally accessed through experience in practice. Evidence was found that related respondents' understanding of elements of inequalities in mental health to a media campaign and to experience rather than to research and policy.

7. How do primary care professional staff apply an understanding of inequalities in mental health in practice?

Inequalities in health were generally understood by primary care and mental health frontline professionals as being unequal access to services. While respondents did not always articulate an understanding about inequalities in mental health, the vignette helped to explore whether respondents used a social model or biomedical approach to mental health problems. Respondents subscribing to a biomedical approach as well as those following a social model identified that vulnerable patients were not being followed up when they did not attend appointments. No respondents proposed action to redress this even when asked directly what they might do about inequalities in mental health. In addition, patients' social circumstances would be ignored with very few exceptions, including by some who held the theoretical perspective that social circumstances might impact on mental health.

8. What are the factors that help and that hinder primary care professionals to contribute to the reduction and prevention of inequalities in mental health?

Most respondents believed that work to reduce inequalities was not a role for the NHS. However, respondents who suggested that they would take a participative approach to consulting, thereby enabling the patient to identify or prioritise issues raised at their appointment, appeared to be the ones who would also stimulate discussion about a patient's social circumstances. It is argued that the main hindrance to addressing inequalities in mental health was the lack of information available to and taken up by frontline staff about the link between social factors and risk of developing mental health problems. Its absence meant that inequalities in mental health had not been defined as a problem for this group of staff.

9. What more needs to be done by primary care to contribute to reducing or preventing inequalities in mental health?

Access to services was believed by respondents to be an important issue in health inequalities and has been demonstrated elsewhere to be worse for people living in deprived areas. Policies and local strategies did not pick up on access and none of the respondents proposed to take action to improve access including for specific patients who they suspected were particularly vulnerable. Therefore it is argued that more needs to be done to define inequalities in mental health as a problem for primary care in order that the CHP develops action in response.

Limitations of the study

Interpretive policy analysis

Yanow's (1999) main argument for taking an interpretive approach to policy analysis was that stakeholders' interpretations of policy rather than the policies themselves drove change on the ground, and all communities of meaning involved in a policy intervention had a part to play in shaping its implementation. The communities of meaning identified for this study were policy documents, strategic staff, frontline professionals and on the ground services, with data for the latter community of meaning gathered though eliciting professionals' responses to Tom in the vignette. The alternative to the vignette was considered to have been to explore service users' perspectives on inequalities in mental health which would have reflected a full adoption of Yanow's framework as well as enhancing the study by including all the stakeholder communities for policy objectives on health inequalities. While Yanow's framework was only partially applied to this study, it is argued that even in its truncated form it provided the means for a rich exploration of the links between national policy, local strategy and professional practice.

With the benefit of hindsight, the service users' perspectives on health inequalities would also have provided further insight into the link between policy and practice as well as into a lay understanding of inequalities in mental health. It would have been particularly beneficial to the further exploration of the issue of "access to services" which emerged very clearly from the data from frontline and strategic staff. One barrier to including service users' perspectives was that there could have been difficulties in recruiting service users defined as people at potential risk of mental health problems as well as those who had been diagnosed. The community level study population could then have been all adults within the boundaries of the CHP or to be more accurate, up to 16,000 unknown adults within South Ayrshire. Apart from the contentious issue of identifying

individual adults at risk from a population estimate of risk, the population would have been too broad to ensure that recruits were matched with identifiable service providers, which would have been desirable to maintain the link between policy, strategy and local service provision. An alternative strategy might have been to recruit people as representatives of the general CHP population rather than as service users. In any case the vignette would still have been included as it proved to be valuable in harnessing insights into day-to-practice as well as to specific pre-planned issues.

Breadth of the study

For the purposes of the study I took the perspective proposed by Muntaner *et al* (2000) and Fryers *et al* (2005) that most factors relating to inequalities in mental health would be likely to follow inequalities in physical health, in particular the pathways between poor social circumstances and poor health. This meant that generic discussions of inequalities in health in the policy documents could be broadly interpreted as covering inequalities in mental health and therefore could be included in the study. However this perspective also meant that all policies have the potential to impact on health inequalities although not necessarily developed with reducing health inequalities in mind (Exworthy *et al*, 2003), such as those related to business, industry and culture. In addition, policies at UK and European levels can impact on Scotland including reserved issues such as welfare benefits or regulation of health professions, and their inclusion would have provided additional dimensions and insight.

An alternative approach would have been to narrow down the policies to be included and to have chosen a particular intervention of relevance to primary care mental health such as the introduction of cognitive behavioural therapy, or the role of primary care in addressing inequalities in mental health through anticipatory care. Using this approach the study might have identified more specific implications for policy implementation and might have identified some generalisable lessons for other services.

Strengths

The strengths of the study are argued to lie in the interpretive, multilevel approach to policy analysis which enabled an exploration of the relationship between policy, strategy and practice. The focus on a complex policy objective, acknowledged by the policies themselves to be problematic, highlighted areas of disjunction between defining the problem and action in both policy and practice. In addition, by exploring the concept of inequalities in mental health rather than a specific service development the study

exposed the complexity of implementing interventions on an issue that is not yet clearly understood by key actors.

What does this study add to what is already known?

Interpretations of policy objectives

Methods of reviewing policies are more often concerned with economic analysis or evaluation of implementation of policy objectives than the perspectives of actors involved in their implementation (Yanow, 1999). Interpretive policy analysis shed light on the different levels of interpretation and engagement within a primary care organisation that can impact on implementation of a policy objective. In particular, the comparison between policy and practice identified an anomaly between tackling health inequalities being clearly stated as a policy objective, and its lack of definition and implementation through strategy and practice.

Disjunction within and between policies

The study confirmed previous findings (eg Exworthy *et al*, 2003; Smith, 2007) that Scottish Executive policies appeared to have taken on some of the key messages from the *Black Report* (Townsend *et al*, 1980) and the *Acheson Report* (1998), if not the detail. In addition, the study demonstrated disjunction across policies in definitions used to explain health inequalities and between definitions and actions proposed within individual policies. Further disjunction was found between practice and policies where primary care and mental health professionals almost universally defined inequalities in terms of access to services. This contrasted with poverty, area deprivation and other social circumstances which dominated the definitions given by research, policy and profiling information. Rather than research and policy impacting on professionals, respondents had either looked to their own practice or taken on the message of a general mental health media campaign.

Dominance of the biomedical model

The literature review identified two distinct models for health and illness as a biomedical and a social model. The study confirmed that the primary care mental health culture is dominated by a biomedical model and unlikely to be conducive to recommendations based on a social model. The study also identified that Scottish Executive policy

appeared to have embraced both models where descriptions or definitions of health inequalities favoured a social model, while action for primary care generally recommended a biomedical approach or organisational change. Recommendations for reducing inequalities in health or mental health were not specific. Respondents who articulated an understanding of a social model of health at the same time applied a biomedical model to practice and to strategy.

Patient's variable experience of services

Definitions of mental health problems in research and information lacked consistent, clearly defined categories. The study suggested that this was reflected among respondents who described different lists of conditions seen in a primary care mental health setting. Different validated and informal assessment tools were used by frontline professionals and these were often added to by personal knowledge but with limited exploration of the patients' social circumstances. As a result, a patient may or may not be understood as being at risk of mental health problems and may or may not be investigated or receive an offer of help when first presenting. Consequently, different courses of action might be suggested depending on who the patient consulted or was referred on to.

Service-centred model

Barriers to accessing primary care services were previously shown to exist for certain population groups including patients living in poorer areas. This study demonstrated that professionals themselves recognised that they were unable to provide a service to patients who did not attend arranged appointments even when they knew that the patient might be particularly vulnerable. However at the time of the study neither the organisation nor individual professionals offered a service that followed up vulnerable people who had not attended an arranged appointment.

Reflection

Reflection on research process

Reflecting on the research process as a whole, it was perhaps ambitious to attempt to gather a depth of data for four dimensions (although from three sources) and analyse them as separate entities before bringing them together. Gathering data from fewer

dimensions might have allowed more in-depth exploration of a narrower range of issues. For example, inclusion of service users' views has already been discussed as being desirable, interviewing more frontline professionals might have enabled further insight into differences between disciplines, deeper exploration around the vignette might have strengthened the findings on understanding the links between social factors and mental health, and more in depth enquiry around the needs assessment might have found other channels within the CHP for addressing inequalities in mental health. Repeating the process in other CHPs would have provided more insight into other possibilities for interpretation of policy around inequalities and would have increased the generalisability of some of the conclusions.

One issue that threatened part of the data collection was the risk of the needs assessment being abandoned or of being postponed for a future date outside my timescale. I had no control over the process in part due to being based outside the CHP and had limited ability to pick up on informal actions or discussion around the needs assessment taking place between steering group meetings. Another potential problem I had no control over was the re-organisation of the LHCC/CHP which might have affected any part of the data collection or even the CHP's willingness for me to be studying them at a time of change and uncertainty. Fortunately re-organisation did not directly affect the study to a great extent but I was always aware of the potential for change to happen.

Any policy research is at risk of major policy changes occurring quickly but taking steps to anticipate changes and build timescales for data collection and analysis in relation to this knowledge would be important. Ensuring buy-in from the guardians of the data sources is also extremely important and building contingency plans where there is risk involved would be one way of protecting the study from too great a diversion once it is underway.

In relation to data collection, the vignette might have been used in different ways to elicit values and attitudes relating to inequality. For example, vignettes concerning different patients might be used with groups of respondents where one group might receive a vignette about a woman, another featuring a man, or patients might differ with regard to income levels or ethnic backgrounds. Findings from the groups might then be compared to identify whether certain social inequalities result in different approaches, although this method would have required many more respondents to identify significant differences.

Another issue with the vignette was that it included the underpinning assumptions, taken from the policy review described in Chapter 1, that promoting positive mental health should be part of mental health service provision and that primary care staff should be

taking opportunities to promote health within all consultations as far as possible. It certainly was the case that mental health and primary care staff alike picked up on health promotion issues that could be dealt with through health and social services, that is, smoking cessation and alcohol. On the other hand, few picked up on the hint that Tom might be open to exercise, and no-one picked up on exploring whether Tom had a good or poor income or had high or low levels of control at work or at home despite that many of these factors were well-documented in the literature as being important in physical and mental well-being. The conclusion from this was that respondents were often not familiar enough with the wider factors that are important in contributing to physical and mental illness to include them in an assessment of a patient. However, a small number of respondents demonstrated in other parts of their interviews that on prompting, they would enter into a discussion about social factors and mental health. This suggests that prompts in the vignette on factors such as income, employment and life satisfaction might have yielded more in-depth exploration on these and their impact on mental health and inequalities. Consequently, findings from the vignette alone cannot provide conclusive proof that respondents did not understand the impact of social factors on mental health, but it highlighted that social factors were at least not at the front of their minds and that further prompting would be required to explore these issues in more depth.

The strongest conclusions from the study were arguably those arising from the links (and disjunctions) between policy, local strategy and practice, reflecting the aims for interpretive policy analysis of learning from the combination of different perspectives on a policy issue. The depth of data collected from the implementing agency communities of meaning in isolation was not extensive enough to arrive at conclusions that could be generalisable outside the South Ayrshire context, although each level has provided some issues that could be explored further within other contexts. Conclusions and recommendations for further action are the subjects for Chapter 9.

Reflection on findings

Policy processes generally appear to assume that objectives will be implemented as stated. Interpretive policy analysis illuminated that a wide variety of interpretations can be made on a policy objective throughout an organisation. All of these interpretations can influence the ways in which an objective is carried through several strands of service provision. The end result as demonstrated in this study was a very different experience for patients depending on where they accessed the service, with respondents acting on personal perspectives which may or may not take account of the policy objective. In the case of health inequalities there were also conflicting

organisational perspectives which created further potential for variations in service provision for people with mental health problems. An example in the study was that some patients appeared to have access to interventions additional to mainstream health and social services such as welfare benefits advice or carer support, while others were likely to be offered only psychological or medical interventions.

It was perhaps surprising that promotion of mental health came into respondents' views very rarely and usually only for those respondents whose jobs specifically included promoting positive mental health, such as those from *Doing Well by People with Depression* projects and occupational therapy. It is argued that this result reflected the ambiguity of policy objectives for incorporating positive mental health and well-being into a biomedical service agenda together with respondents often feeling that their services were overwhelmed and that line managers were not pushing staff to engage in mental health promotion. The results from this study suggested that promoting health and well-being and service delivery for illness remain distinct aims for policy and practice, reflected by the split of the *National Programme for Mental Health and Well-Being* from mental health services policy. A biomedical model of diagnosis and treatment was found to dominate in primary care mental health policy and practice, while a social model promoting positive mental health and well-being remained on the periphery of service provision.

The study suggested that most respondents at practice level failed to factor in addressing inequalities to their encounters with patients. The small number who did followed a social model of practice such as working with the patient and local agencies to organise help to deal with adverse social circumstances or to actively seek out those patients who might be most at risk of developing, or having difficulty recovering from, mental health problems. Most respondents at strategic level demonstrated a surprising double standard of individually regarding social inequalities as risk factors for mental health problems but collectively failing to incorporate inequalities into the needs assessment. This was despite research and information being presented to the Needs Assessment Steering Group that made links between local social circumstances and higher risk of mental health problems. Instead, the group accepted a biomedical model for the development, process and conclusion of the needs assessment reflecting acceptance of the dominant biomedical culture within primary care mental health services. The duality between beliefs and actions in this group not only mirrored the disjunction found in policy documents but also echoed Bourdieu's concept of habitus (Williams, 1995), where individuals take on behaviours that fit with their chosen societal group rather than act alone.

These findings might have been less surprising if the policy documents did not have health inequalities as a policy intention with actions proposed for health and social services to contribute to reducing the health gap. However, closer inspection of the policy statements and their actions identified that four of the documents in the policy appraisal were vague about implementation of proposed actions for addressing health inequalities while the remaining five admitted that reducing health inequalities would be problematic. Actions that had more specific implementation plans tended to assume that improving individual health status through population behaviour change programmes would eventually reduce the health inequality gap, such as those in *Improving Health in Scotland: the Challenge* and *Closing the Opportunity Gap,* but this approach runs contrary to much of the evidence (eg Acheson, 1998; Gwatkin, 2003). Certainly, there were no individual or organisational imperatives to prioritise inequalities or other preventive activity within primary care mental health services during the study period despite the introduction of national targets and indicators.

Despite a lack of imperatives to drive action on health inequalities, a small number of respondents at practice and strategic levels were clearly sensitive to inequalities issues. This was arguably not as a result of interpreting policy, strategy or research but had its roots in personal experience. Respondents' almost universal identification of access to services as their main definition of health inequalities demonstrated that evidence from day-to-day practice was an important source of knowledge and understanding. Access to services was not the most visible definition in either policy or accessible research resources.

Another important source of information identified in the study was from the general media with some respondents quoting or alluding to the *See Me* statistic (*See Me* Website, n.d) that one in four people would suffer a mental health problem at some point in their lives. Two arguments are made here challenging the appropriateness of using this statistic in Scotland. First, it has been used in a high profile Scottish media campaign despite the source of the statistic being omitted from the *See Me* website. It is likely however that the source was the World Health Organisation (2001) which estimated that 25% of the world's population will have a mental illness at some time in their lives. It is argued that this might not accurately reflect the Scottish position, as the world's population, and some of the countries included in the WHO's research, includes many politically unstable countries whose populations are subject to lifetimes of absolute poverty, war, violence and displacement. That is not to trivialise mental health problems in the Scottish population as the figure for Scotland might be only slightly less if following UK trends (Singleton *et al*, 2000), but one in five might have presented a more accurate picture although arguably slightly less media friendly than one in four.

The second argument against the *See Me* statistic is that among the most pressing mental health issues for Scotland is currently not only the widespread prevalence but the differences in people's experience of mental health and mental illness depending on social status. For example, leading causes of health inequalities in Scotland are now believed to be mental health problems relating to drug and alcohol abuse and suicide which disproportionately affect people living with social disadvantage (Leyland *et al*, 2007). However even highly qualified and experienced professionals in the study had taken on the *See Me* message that apparently any one of us could develop a mental health problem. This runs contrary to conclusions from research and information that risk factors and access to help are distributed unequally across the population with educated, affluent people less likely to be affected. While the *See Me* website includes an article suggesting that the campaign has contributed to a reduction in stigmatising people with mental health problems it is argued that it might inadvertently have also contributed to the inaccurate assumption among professionals that everyone is at equal risk of developing mental health problems.

It is argued that the biomedical dominance of primary care mental health services reflects the Scottish Executive's approach to governing Scotland and builds on traditional NHS values. The approach is supported within primary care and by other structures including media campaigns such as illustrated above, and continues through voluntary sector organisations where their funding is increasingly dependent on their adherence to a service model rather than a community based approach. Inequalities in mental health has even less of a profile in policy and practice than health inequalities in general, but it is argued that, if the profile of health inequalities was raised, a higher profile for inequalities in mental health would follow.

Policies admitted that addressing health inequalities was problematic and this study has demonstrated some of the reasons why. First, health inequalities has not yet become enough of a "policy problem" (Exworthy *et al*, 2003) to enable the co-ordinated, cross-government approach that research suggests would be required. This might arguably be due at least in part to the incongruence of reducing health inequalities at the same time as having a national focus on accelerating economic growth in addition to the absence of evaluated, effective policy interventions. In the event of a co-ordinated approach being developed, it might be demonstrated in the first instance by policies rationalising and clarifying their definitions of health inequalities, social inequalities in health and inequalities in mental health.

Second, targets and performance measures need to be based on actions that can be implemented, but the lack of intervention research and absence of clarity of policy

expectations on primary care for addressing health inequalities means that implementing organisations have no solid base from which to develop local organisational imperatives.

The third reason is directly related to the first and second above. Service planners and frontline staff had no professional reason to be concerned about health inequalities as they received no information, training, directives or support from within the organisation. Health inequalities were simply not discussed as work. In addition, the main role of the majority of primary care mental health services is to diagnose and treat individuals, while an understanding of health inequalities or inequalities in mental health requires attention to a population. In this study, a minority of strategic staff had a remit that included population health, with most of the strategic staff's main roles being in direct, one-to-one practice or practice management. Ideas and actions that would fit research findings for addressing inequalities in health including a social model were articulated by some respondents despite the unsupportive policy context. In the light of this it is argued that there is a base of knowledge and skills within the service which could be built on and further developed should national policies shift towards a social model.

The fourth and final reason identified in the study for health inequalities and inequalities in mental health being problematic for policy is that in addition to these not yet becoming policy problems neither are they media problems or issues raised explicitly by patients. It is argued that only when the media and patients clamour for attention to inequalities will service providers be required to act.

Chapter 9

Conclusion and recommendations

In conclusion, the study has highlighted some issues to be taken into consideration by policy, planning and practice. The conclusion and recommendations are presented under the headings of: Summary of key findings and conclusions in relation to the aim, Generalisability, Implications for policy, planning and practice, and Recommendations.

Summary of key findings and conclusions in relation to the aim

The aim of the study was to identify the contribution that a primary care organisation makes to reducing and preventing inequalities in mental health. It began by exploring the policy expectations on primary care for inequalities in mental health through an in-depth appraisal of a broad range of polices. A primary care organisation was identified, and key actors at strategic and practice levels were recruited to inform the study about local strategy and practice in reducing and preventing inequalities in mental health. The ways in which frontline professionals, strategic staff and the organisation defined and approached inequalities in mental health were explored, and conclusions reached are described below.

Policy appraisal

Evidence from elsewhere had suggested that inequalities in mental health followed the patterns of other aspects of health inequalities but they were barely mentioned in policy documents. Documents included in the appraisal expressed aspirations that all of the public sector would contribute to reducing and preventing health inequalities with tackling health inequalities described in some as an overarching aim. In contrast to this aspiration the documents provided a disjointed picture of definitions for inequalities and similarly disjointed lists of proposed actions which often did not flow from definitions and occasionally ran contrary to research evidence. The disjunction in the policy documents clouded their overall interpretation of inequalities in health and prevented identification of a clear set of expectations for primary care in addressing inequalities in mental health. In addition the most recent policy documents for primary care and health improvement appeared to be moving more closely to a biomedical model than the social model which would be required for reducing inequalities in health.

Local strategic level

A primary care organisation was identified and key actors at strategic and practice levels in the organisation most likely to contribute to reducing and preventing inequalities in mental health were recruited into the study. At a strategic level senior staff were identified who were involved in managing, developing and reviewing services that might impact on the primary care role in inequalities in mental health. Respondents were drawn from primary care, acute mental health services, community mental health services, parent structures for the primary care organisation and local partnership agencies. There were a large number of strategic working groups developing and reviewing mental health services at the time of the study and a new group was set up to carry out a primary care mental health needs assessment for the primary care organisation. The context, process and outcome of the needs assessment were observed in order to identify how the organisation might incorporate inequalities into mental health services planning. It can be concluded from the observation that inequalities were not considered in the mental health needs assessment despite information and evidence being made available to the needs assessment steering group and also despite some group members' individual perspectives that social inequalities can impact on mental health. This was broadly in line with most other local strategic processes as very few local documents had highlighted inequalities in health, and none had discussed inequalities in mental health. While some individuals in influential positions were sensitive to inequalities issues, the culture of the organisation appeared to be less conducive to taking action to reduce or prevent inequalities in health.

Practice level

Frontline professionals from most disciplines in primary care and mental health teams were suggested by senior managers in the primary care organisation for inclusion in the study. A selection of 21 staff from 14 disciplines was recruited for interview and their roles explored in relation to inequalities. Their understanding of and approaches taken to inequalities were identified by asking about their definitions of health inequalities and who they thought might be most at risk of developing mental health problems. They were also invited to describe their day-to-day work through eliciting their responses to a vignette regarding a patient called Tom, who presented with a series of vague symptoms and clues about his life which may or may not signal risk of developing mental health problems. The vignette was given to all respondents working at practice level. It proved to be a useful tool in providing further insight into the professionals' core practice and the variety of ways in which primary care and mental health services might respond to the same patient.

Neither sensitivity nor resistance to inequalities were obviously discipline-specific. Respondents who were most articulate about inequalities or had the most ideas about how to respond to them were from different disciplines with varying levels of experience while those least convinced about their roles in inequalities were also from a range of different disciplines. In addition, respondents from the same disciplines demonstrated different levels of sensitivity to inequalities issues. Clearly there were too few individuals from each discipline included in the study to reach a firm conclusion as to the most important disciplines in primary care mental health in addressing inequalities in mental health, and further investigation of this is would be required. However, the study suggested that any primary care or mental health discipline could potentially contribute in some way to reducing inequalities in mental health.

Frontline professionals and strategic staff almost universally understood health inequalities to mean differential access to services, but were generally unclear about identifying who might be most at risk of developing mental health problems. Some respondents discussed social factors that they thought might impact on mental health but responses to the vignette suggested that most respondents would not follow up on addressing a patient's social circumstances. Instead they would work within a biomedical model, drawing mostly from professionally-developed tools. There were a few exceptions to this. Actions described by those respondents who suggested they would follow up on social issues included working with others outwith health and social services to meet a patient's social needs such as reducing isolation; helping to maximise income; or improving family relationships.

Definitions given for health inequalities or inequalities in mental health differed between policy, planning and practice. In addition, there were inconsistencies between respondent's theoretical understanding of inequalities in mental health and application to practice which mirrored the disjunction between definitions and proposed actions in policy documents. Polices suggested that poverty, area deprivation and other social circumstances were important issues that defined health inequalities, but individual lifestyles and organisational change were emphasised more strongly as areas for action. Local strategy as observed through the mental health needs assessment suggested that general access to services and social circumstances were believed to exist but were not prioritised. Instead, actions proposed by the needs assessment focused only on access to some specific services that were already available albeit differentially across the area. At practice level access to services was the main definition of health inequalities and identified as a current problem for practice, but no frontline respondents proposed action to improve access. Certain definitions offered throughout all levels in the interpretive policy analysis suggested that the emphasis was on observable differences between groups rather than a notion of unfairness.

There was a great deal of inconsistency identified in defining mental health problems. This was demonstrated by the bewildering array of terms used in research, policy and practice, the different assessment methods used in primary care mental health services, and the different approaches to diagnosis by individual professionals. In addition there was a general lack of routine information for mental health and for health inequalities, but relevant information and research evidence that was available was rarely accessed by respondents, particularly those working directly with patients. Most respondents drew on day-to-day practice or public media rather than research or policy for their understanding of prevalence of mental health problems and of health inequalities.

Conclusion

In conclusion, the contribution that the primary care organisation in the study made to reducing and preventing inequalities in mental health appeared to be at an early stage. Inequalities in mental health was only beginning to appear in policy documents at the time of the study and it is argued that there was not enough information in policy or public domains for it to be defined and acted upon as a policy problem. It is argued that inequalities in mental health might begin to become more visible as mental health problems attract further policy attention and the health gap between rich and poor in Scotland continues to increase.

Study findings suggested that the culture of the primary care organisation was not conducive to driving change on inequalities in mental health, and the study exposed the complexity of implementing action on an issue that was not clearly understood by key actors. A biomedical model was found to dominate in primary care mental health services and was assumed to provide patients with quality controlled, evidence based, individual-focused interventions. The variations found in respondents' approaches to Tom questions these assumptions but the model was also found to fit with current political direction for Scotland's growth and development. This suggests that there are more powerful influences acting on a primary care mental health culture than could be achieved by a handful of articulate professionals. However, if a social model of health is assumed to be a more effective approach in reducing inequalities, the dominance of a biomedical model might also act to prevent action being taken to reduce inequalities.

Consequently, a biomedical model used alone in primary care mental health services could contribute to widening the health gap as a result of acting mainly in the interests of patients who are amenable to a biomedical intervention. Those patients not suitable for this type of treatment such as those who cannot attend appointments or whose other circumstances are too complex to enable them to adhere to a medical intervention, are

less amenable and therefore less likely to receive a service. Nevertheless some individual respondents within planning and practice described working round organisational barriers to improve social circumstances of their patients as an additional input into improving their health and functioning. It is argued that these activities and gaps represent areas ripe for development for addressing inequalities. They demonstrate that some of the building blocks are already in place for the primary care organisation to respond to policy leadership on inequalities in mental health should that time come.

Generalisability

The study explored the responses of one primary care organisation to inequalities in mental health using qualitative methods and therefore its findings cannot be generalised to other organisations. However, certain findings might raise questions or insights for further exploration or development in similar organisations, or for policy. For example, the disjunction found in defining inequalities in health between policy, planning and practice might contribute to an explanation of why policy objectives for inequalities in health are problematic to implement. Alternatively, if taken as symptoms of a problem rather than explanations some findings might suggest a focus for further policy development for example, in building on the unequivocal concern amongst frontline professionals about access to services for vulnerable patients. Other findings supported general social concepts such as the importance of culture in influencing individual actions in this case within the primary care organisation rather than general society. The study also supported previous research and commentary such as the influence of evidence on policy, the concern about access and follow up in primary care, and the dominance of the biomedical model in improving health as well as in healthcare.

Implications for policy, planning and practice

Policy

Tackling health inequalities is promoted as an important overarching aim for much of health and social policy. In the absence of a co-ordinated, concerted effort the study suggested a lack of effective processes in place to implement change. Previous research evidence demonstrated that inequalities in mental health followed similar patterns to other health inequalities and had many of the same links with social circumstances and social status, but policy in Scotland does not currently offer this perspective. Work at a national level is required to develop health inequalities and

inequalities in mental health into genuine "policy problems", amenable to interventions and resourced as appropriate. An area that might be ripe for early intervention is that of improving access to health and social services for the most vulnerable patients as a general principle rather than as a series of specialist services or short-term initiatives. Previous research identified that the NHS has fallen down in this respect to date, but concerns expressed by many of the respondents in this study suggested that a policy drive to improve access to patients already within the system might gain support from senior and professional staff. In addition, it is argued that policy initiatives should have a responsibility to present accurate information, as the study demonstrated that they can be an important source of information for service providers and planners as well as for the general public.

Planning

Information on inequalities in health and inequalities in mental health was available to the primary care organisation but either not sought out or alternatively, believed by service planners to be of limited use. However, information from research evidence regarding social inequalities and mental health was formally presented in the needs assessment but not acted upon. Perhaps related to this ambivalence, information about inequalities discussed in interviews including by some senior, experienced professionals was inaccurate. Study findings suggested that the biomedical culture of the primary care organisation in general did not support a move to address inequalities in mental health and could potentially contribute to widening the health gap. Information should be made more easily accessible and in useable formats to encourage planners to use it within local health and social care structures.

Practice

Some respondents at practice and planning levels demonstrated that they were sensitive to the potential impact of social inequalities on mental health. This was not universal which added to the variability of services a patient with non-specific problems might encounter depending on which service he presented to. However, despite the confused policy context and a lack of local strategic direction some staff did act to help patients cope with adverse social circumstances and to work to improve their circumstances. This suggests that primary care mental health services might have the potential to contribute to reducing and preventing inequalities in mental health, which could be strengthened with better information and the support from policy and management to do so.

Recommendations

As suggested above the study has identified some questions for further research or development, as follows:

1. The disjunction found within polices, between policies and between policies and practice was of major concern. Work needs to be done to bring information to the policy arena that influences all policies that state an interest in inequalities in health to move in the same direction. In particular, the incongruence for health and social services between the national drive towards accelerated economic growth and the reduction of inequalities in health needs to be addressed or at least debated in order to influence change at policy level.

2. The use of information for national campaigns should be accurate and relevant to Scotland, and attention should be given to the potential influence on inequalities. The next phase of the *National Programme for Mental Health and Well-Being* should include inequalities in mental health as a central objective. It should work to improve information available to service providers and the general public about risk factors for, and inequalities in, mental health problems. In addition, targeted information that would contribute to service providers anticipating risk of mental health problems and planning accordingly, should be made available and accessible to planners and frontline professionals. Interim results from the study were submitted to the review process for the *National Programme* (Appendix 9) in order to highlight the impact of the *See Me* campaign on some respondents' understanding of risk factors for mental health problems.

3. At practice level the concern expressed by many respondents about the vulnerability of patients not presenting at arranged appointments raised a question as to why professionals were unable to provide a service they appeared to believe should be provided. This suggests that access might be improved for such patients by enabling staff who know the patients and their circumstances to provide a slightly different service than they do at present. For example, this might include following up patients who did not attend or being obliged to explore a patients social circumstances, and then working with other agencies to address social needs as well as to meet biomedical or psychological needs.

4. At planning level the finding that there were organisational barriers hindering strategic staff who believed individually that social circumstances were important but could not bring these beliefs to strategy or practice, was intriguing. Individually these respondents were very senior and appeared to have influence within the primary care organisation.

Yet they were unable to act on their own knowledge about inequalities, instead silently allowing a biomedical model to dominate and consequently prevent a social model of health influencing strategic development. The role of the individual actor versus organisational culture in the field of inequalities in health would be a timely question to research as the focus on the health inequalities gap and the role of the NHS sharpens.

5. An issue that was peripheral to the main findings but potentially important for future service development was the role of the voluntary sector in supporting a social model of health. Services offered by voluntary sector organisations appeared to be thought of as providing a social model or at least social support to patients. However, it was argued from study findings that voluntary sector services available to the patient in the vignette were instead supporting the services' biomedical model of care. The changing role of the voluntary sector would be a useful research question to consider within the context of inequalities in mental health, particularly in the light of less funding being available from mainstream services at the same time as the services believing that they can rely on the voluntary sector as a source of social support.

6. Interpretive policy analysis offered an approach that uncovered problem areas between policy, planning and practice. The perspective from service users or the general population on primary care's role in inequalities in mental health might have been a useful addition to the findings here. Should a very different perspective have been found, further disjunction would have been highlighted in practice for addressing inequalities. On the other hand a similar perspective between service users and any of the other levels might have provided insight into accessible sources of information about inequalities and how they are used. Interpretive policy analysis proved its benefit to this thesis and repeating its successful application either by extending the study to explore a service user perspective on the questions asked here or to a different policy objective would help to gain further insight into inequalities in mental health as well as establish interpretive policy analysis as a useful tool for exploring and troubleshooting policy problems.

7. Finally, the primary care role in reducing and preventing inequalities in mental health remains unclear. Scotland is in the early stages of developing effective mechanisms to address health inequalities in general and the study has identified some key issues for policy development to take into consideration. In particular, the time might be right for establishing health inequalities and inequalities in mental health as real policy problems rather than as troublesome policy aspirations. While the NHS might be uncomfortable about health inequalities being resistant to biomedical interventions, there might now be adequate evidence to enable health inequalities and inequalities in mental health to be amenable to some practical policy interventions.

Chapter 10

Outputs from the Thesis

Three types of products have arisen from the work represented in the thesis. The first was a secondment to the Scottish Executive resulting in two papers, the second was the inclusion of interim findings in presentations based on or incorporating work from the thesis and the third was a book chapter. All three outputs are described below.

Secondment

While working in Health Scotland I was invited to take a part-time secondment to the Health Improvement Division in the Scottish Executive from July to December 2004. My main role was to contribute to the development of a proposed guidance document for the NHS on tackling health inequalities. I was asked to collate evidence and examples of practice that would help to clarify the potential role for the NHS. The final paper had to take into account some of the health improvement dimensions of health department policies as well as to provide a brief overview of literature and practice.

While on the secondment and following submission of the above paper I was also asked to prepare a briefing paper on food and health inequalities for the first meeting of a new food policy group.

Presentations

Three presentations have been carried out and one abstract accepted for a forthcoming presentation (at the time of writing) using work carried out for the thesis. The first presentation was to the Chief Scientist Office Research Conference, "Evidence, Policy, Practice, 2004" in which I outlined the initial literature review and plans for data collection.

The second and third presentations were carried out in my capacity as Public Health Programme Manager at Glasgow Centre for Population Health, where I drew on interim findings from the study to contribute to the Community Health Partnership Programme. In particular the early findings added to local explorations of the ways in which Community Health Partnerships were developing action on health inequalities and some findings were presented along with other work. The first presentation was made to the

Glasgow Healthier Futures Forum comprising a large audience of public and voluntary sector staff and the second presentation was to the 2006 Scottish Annual Public Health Conference comprising an audience of public health specialists, practitioners and researchers from across Scotland.

An abstract was accepted for the Scottish Annual Public Health Conference in November 2007 to present an overview of the study.

Book chapter

During the lifetime of the study I was invited to write a chapter for the second edition of a textbook, *Community Public Health in Policy and Practice* edited by Professor Sarah Cowley, King's College, London and due to be published in October 2007. Having contributed to the previous edition of the book on the development of public health nursing in the UK, I was asked to write a chapter on the theme of "collaborating for health" but could bring in any aspect I wanted in order to reflect some of the Scottish policy context relevant to public health in the community. I asked a colleague from the University of Glasgow Business School to contribute a management perspective on partnerships and wrote about the development of Community Health Partnerships and other collaborative initiatives in Scotland which I was also exploring for the literature review for the study. The reference for the chapter is as follows:

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Development of the research questions

The initial literature review identified questions and opinions about primary care roles in addressing inequalities in mental health but there was a dearth of research that tested these ideas. In addition practice perspectives on inequalities in mental health for primary care were largely absent from the reviewed literature but were required in order that research questions could be developed for the study that might have relevance for current Scottish primary care practice. To this end, discussions were set up with key informants to explore practice perspectives from a wide range of stakeholder groups in Scotland including primary care and mental health professionals and managers, public health, academics, policy makers and the voluntary sector. The key informants' roles were as follows:

- Senior academic researcher
- Local Health Care Cooperative (LHCC) General Manager
- General Practitioner (GP)
- Director of Public Health
- Scottish Executive Health Improvement Planner
- Scottish Executive Senior Civil Servant in the Primary Care Division
- Primary Care Trust Inequalities Manager
- Senior Social Worker in Mental Health
- Director of a voluntary sector mental health organisation
- LHCC Public Health Practitioner.

Key informants were recruited through existing networks and the discussions took place in the form of short, face-to-face meetings using open ended questions to elicit their understanding of inequalities and mental health and the roles that primary care might play in addressing these. Discussions were recorded in written notes taken at the meetings and analysed for recurrent and related themes. Themes were then collated under the three headings of primary care culture, actions relating to inequalities in mental health and the need for change. The results were as follows:

Primary care culture

- Inequalities were not core to primary care as a clinical focus takes priority
- Mental and physical health were generally understood to be addressed through different service routes
- GPs were sometimes thought of as being resistant to working differently (such as opposing the new public health emphasis in nursing) and appeared to be disengaged with the wider population beyond their practices and with changes in primary care management
- LHCCs were thought to be dominated by GPs' priorities and as general practice is demand-led both LHCCs and GPs tended not to focus on inequalities
- Understanding and dealing with social determinants of mental health problems was described as "too difficult" for the NHS and it was easier to focus on physical problems
- Public health departments might not focus on wider inequalities in mental health but they targeted some of their mental health and other work on vulnerable population groups
- Primary care often had to pick up on gaps in unequally distributed mental health services but in general people with severe and enduring mental health problems were thought of as being well-catered for
- Primary care management's priorities (one participant described them as "preoccupations") were the interface between primary and secondary care and access issues. However a rapid change in focus was sometimes stimulated by crises for example child deaths.

Actions relating to inequalities in mental health

- Some vulnerable population groups were recognised as requiring targeted action for mental health for example homeless people, people with alcohol problems and children
- Community based projects including SIP-funded initiatives had some wider primary care support (that is mostly from primary care staff other than GPs) and were thought to offer the potential for mental health promotion activity
- "*Things that work well rely on connections between for example health visitors, midwives and community psychiatric nurses or between primary care and the wider community*"- quote from a participant
- Senior managers in primary care were now expected to participate in inequalities work as a result of new accountability structures
- Emotional and mental health issues were more readily recognised within some core services (such as sexual health services) as demonstrated by increased demand for and referral to counselling services. However there was concern at the lack of evidence for counselling.

Need for change

- Need more patient-centeredness and public involvement, which was thought might link mental and physical problems
- Need more planning for mental health based on population needs assessment, epidemiology etc,
- Need structures to link evidence with practice
- Need more strategic thinking across projects and boundaries to ensure core issues around inequality are understood in relation to professional roles within primary care
- Responses to inequality in health were likely to be different from service delivery as the former required a population approach and the latter an individual one. There was a need to be explicit about which approach was being taken in order to identify relevant key partners and training or support required by practitioners.

Conclusion

Primary care structures at that time did not appear to be designing services around inequalities in mental health or inequalities in health in general but there was some support from most of the key informants who worked outwith primary care for primary care to have a greater role particularly in relation to working between primary care and the wider community. On the other hand informants working within or closely with primary care appeared to be more cautious about primary care taking on a greater role in inequalities. They expressed the concern that work on inequalities in mental health would be unlikely to gain support from GPs in a climate where there appeared to be a lack of funding in general within primary care and specifically in relation to mental health services. The forthcoming new contract for GPs at the time was thought to compound problems in focusing on health inequalities. Informants suggested that more effort was required to link evidence with practice and public health with primary care in relation to both planning and service delivery. There was thought to be potential for making more of community based resources such as offered by voluntary sector organisations, but it was also argued that too much reliance on others might result in primary care failing to take responsibility for this work.

The informal exploration of current issues in practice and planning for primary care's roles in inequalities in mental health demonstrated that while policies had an overarching aim to tackle inequalities there was not an obvious locus or starting point within primary care. The structures around primary care could envisage a role for primary care but managers and clinicians within primary care appeared to have other priorities. At the same time informants from all perspectives had given examples of practice where

primary care staff were engaged in work that appeared to be relevant to inequalities in mental health. I had uncovered a confused picture which did not rule out a role for primary care in inequalities in mental health but lacked clarity at all levels from community based activity through to policy. Research questions were subsequently devised to guide exploration of all dimensions of primary care roles in inequalities in mental health. The research questions are listed in Chapter 2.

Ethics approval letters

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> Ayrshire & Arran Local Research
> Ethics Committee
> Ayrshire & Arran General Hospitals
> Division
> Crosshouse Hospital
> Crosshouse
> KILMARNOCK
> KA2 0BE

20 October 2004

Ms Pauline M Craig
Public Health Project Manager
NHS Health Scotland
Clifton House
Clifton Place
Glasgow
G3 7LS

Dear Ms Craig

Full title of study: An exploration of the role of primary care in reducing and preventing inequalities in mental health
REC reference number: 04/S0201/49

The Research Ethics Committee reviewed the above application at the meeting held on 6 October 2004.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion to the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the following research site:

Site: South Ayrshire LHCC
Principal Investigator: Pauline Craig*

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document Type: Application
Version:
Dated: 20/09/2004
Date Received: 23/09/2004

Document Type: Investigator CV
Version:
Dated: 23/09/2004
Date Received: 23/09/2004

Document Type: Protocol
Version:
Dated: 23/09/2004
Date Received: 23/09/2004

Document Type: Letters of Invitation to Participants
Version:
Dated: 23/09/2004
Date Received: 23/09/2004

Document Type: Participant Information Sheet
Version:
Dated: 23/09/2004
Date Received: 23/09/2004

Document Type: Interview Schedule
Version:
Dated: 23/09/2004
Date Received: 23/09/2004

Management approval

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

We shall notify the research sponsor, South Ayrshire LHCC and the Medicines and Health-Care Products Regulatory Agency that the study has a favourable ethical opinion.

Statement of compliance *(from 1 May 2004)*

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 04/S0201/49 **Please quote this number on all correspondence**

Yours sincerely

pp Susan Butterly

Fr M McManus
Chairman

Enclosures   List of names and professions of members who were present at the meeting
              and those who submitted written comments

List of Names and Professions of Members who were Present at the Meeting or who Submitted Written Comments

Dr David Price, Lay Representative
Mr Raymond Thomson, Lay Representative
Mr Stuart Hislop, Consultant Maxillofacial Surgeon
Mr John McGuffie, Pharmacist
Dr Rani Sinnak, Consultant Psychologist
Ms Jodi Binning, Podiatry Co-Ordinator
Mr John Mitchell, Lay Representative
Ms Tina McMichael, Health Improvement Officer
Rev Sheila Mitchell, Lay Representative
Dr William McAlpine, General Practitioner
Dr David Watts, General Practitioner

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KLB/AM

24 November 2004

Ms Pauline M Craig
Public Health Project Manager
NHS health Scotland
Clifton House
Clifton Place
Glasgow G3 7LS

Dear Ms Craig

An exploration of the role of primary care in reducing and preventing inequalities in mental health (04PC40)

Thank you for returning the Data Protection Checklist. I confirm that the Ayrshire and Arran Community Health Division R&D Committee have granted Management Approval for the above study to go ahead.

The terms of approval state that the investigator authorised to undertake this study within Ayrshire & Arran Community Health Division is: -

-   Ms Pauline M Craig, NHS Health Scotland

Regular reports of the study require to be submitted. Your first report should be submitted to myself in 6 months time and subsequently at yearly intervals until the work is completed.

In addition approval is granted subject to the following conditions: -

-   All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care.

-   If any amendments are to be made to this study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and Division must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The Division's Complaints procedure should be accessed if any complaints arise regarding the project and the R&D Office must be informed.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

If I can be of any further assistance please do not hesitate to contact me. On behalf of the committee, I wish you every success with the project.

Yours sincerely

Karen L Bell

Dr Karen L Bell
R&D Manager on behalf of R&D Committee

Identifying a study site

A primary care organisation was required for data collection in order to explore identifiable influences from national and local policies and strategies and the internal response to inequalities in mental health. At the outset of the study, Local Health Care Cooperatives (LHCCs) were the smallest primary care structures in Scotland with some devolved managerial responsibilities for developing local strategies and the forthcoming development of Community Health Partnerships (CHPs) had been announced in policy but not yet enacted. Therefore an LHCC was recruited but due to the passage of time most of the data collection took place within the new CHP structure. Fortunately the recruited LHCC was one which retained almost exactly the same boundaries and many similar sub-structures as it evolved into the new CHP and the changeover did not affect the data collection in any way.

The study required an LHCC in which staff might be conversant with the concept of inequalities in health, for example, where differences between population groups might be most evident. LHCCs that included a mix of clearly deprived and clearly affluent communities or a sizeable proportion of black and minority ethnic groups were sought for the study rather than those that covered mostly affluent areas, mostly deprived areas or had a large part of the population living within the mid range of deprivation quintiles. To identify LHCCs which might come within the criteria, a list of postcode sector areas across Scotland which had been grouped into defined community areas relating approximately to LHCC and/or evolving CHP boundaries was obtained from NHS Health Scotland (David Walsh, personal communication 2004). The postcode sectors for each defined community area had been sorted into quintiles using Carstairs deprivation scores calculated by ISD from unemployment, social class, car ownership and overcrowding variables.

The list was examined to identify defined community areas relating to LHCCs with a balance of deprived and affluent postcode sectors as well as a substantial proportion of postcode sectors in each of the first and fifth quintiles in order to maximise the visibility of inequality in the study site. On initial examination, when quintiles one and five were considered there were only three defined community areas/LHCCs across Scotland that met this criteria. Widening the net in order to ensure recruitment was important at this stage particularly as primary care was about to undergo reorganisation which potentially could have made recruitment difficult. When quintiles one and two were taken together and balanced against the number of postcode sectors in quintile five, ten areas provided both a substantial proportion and a balance between relatively affluent and deprived sectors. A further three areas with less postcode sectors but demonstrating a balance of affluent and deprived areas or a substantial black and minority ethnic population were added to the shortlist. Two of the original areas were now excluded as one was more heavily weighted towards affluent postcode sectors than others and recruitment of staff working across both affluent and deprived quintiles might have been difficult to ensure in these areas. The other excluded area was my own area of residence where I was also registered with a GP and known professionally and personally among local primary care staff, potentially introducing a source of bias that would not have applied to any other area.

The final list of defined community areas identified as potential data collection sites is summarised in Figure 1 below.

Figure 1. Potential data collection sites

Defined Community Areas (DCAs)	Numbers of postcode sectors in each group of Quintiles		
	Affluent (quintiles 1&2)	Medium (quintiles 3&4)	Deprived (quintile 5)
Aberdeen Central	4	5	3
Dundee City	7	4	11
East Ayrshire	9	9	5
Inverclyde	5	1	7
Nithsdale	6	1	4
North Ayrshire	6	11	10
Paisley and Levern Valley	3	7	5
South Ayrshire	7	7	4
Camglen	2	5	1
Greater Shawlands	1	2	3
Hamilton	3	7	2

The LHCCs/CHPs relating to the defined community areas were contacted initially through the LHCC Public Health Practitioners network with whom I had a working relationship through my employment. Public Health Practitioners (PHPs) at that time had a role within primary care related to population health improvement and many had some involvement with inequalities and/or mental health. I wrote to all eleven PHPs giving a brief outline of the research and requesting further contact if interested in exploring potential involvement in the study. PHPs from four areas responded positively, one being a lead PHP who suggested that any of the three Ayrshire LHCCs might be interested. Three PHPs responded to say that their LHCCs were currently focused on reorganisation issues and would not be in a position to take on the research at that time. Two PHPs did not respond with subsequent information explaining that one had left their post and one was on extended leave. Two of the LHCCs who responded agreed to meet me and following further discussions with both, South Ayrshire LHCC invited me to be involved with a planned mental health needs assessment which promised to yield mutual benefit from my involvement.

Topic guide for interviews with strategic staff

What is your role (including scope and reach, employment base)?

What is your role with mental health?

What is your interest in or role with the Mental Health Needs Assessment Steering Group?

What does the phrase "inequalities in health" mean to you?

Do inequalities in health exist in South Ayrshire?

Are there inequalities in mental health?

Who is most at risk of developing mental health problems?

How do you access information on inequalities in health and inequalities in mental health?

Do you have to seek this information out?

What can primary care do about inequalities in health and inequalities in mental health?

What helps primary care in this?

What hinders primary care in this?

Topic guide for interviews with primary care and mental health professionals

Demographic details relating to the post:
Title
Profession and grade
Length of time in current post
Previous relevant experience
Postcode sectors/areas covered
Main patient group (eg GP list, geographical, CHP-wide etc).
Nature of post

Vignette
Explain that the same vignette is being presented to participants from all professions being interviewed and it is designed to find out ***different ways that professionals might respond to a patient and to introduce some issues for further exploration.***

Tom, aged 48, divorced, shares care of two teenage children with ex-wife, cares for his elderly mother (not living with him) since his father died two years ago, presents as a newly registered patient with sleeping difficulties, intermittent back pain and frequent headaches. Smokes, drinks two or three glasses of beer or wine some days, sometimes more at weekends. Has had no contact with the NHS since a sports injury to an ankle five years ago.

Questions on vignette
- Why do you think he might have come/been referred to you?
- What initial investigations or enquiry would you make?
- What further investigations would you suggest?
- What initial treatment or advice would you recommend?
- What follow-up would you suggest?
- Are current services in place to meet Tom's needs?
- What more could be developed locally for patients in Tom's situation?
- Is there anything else you would want to know about Tom?

Further enquiry

What would you say were the current priorities for (your discipline) and where do you get that information from?

What do you understand by the term "inequalities in health"?

Are there inequalities in health in this area, in South Ayrshire or across Scotland? What about social inequalities? Are health inequalities and social inequalities linked?

How do you know about them?

What mental health problems do you/primary care staff deal with?

Do inequalities in mental health exist? What form do they take?

What inequalities in mental health are there in this area? How do you know about them?

Who do you think might be most at risk from developing mental health problems?

Is there a difference between people who suffer severe and enduring and mild to moderate problems?

What do you do as part of your work that might reduce or prevent inequalities in mental health?

What **is** done or **could** be done to reduce or prevent inequalities in mental health – with individual patients, together with colleagues or teams, within the local community, across the CHP, or in partnership with others outwith the CHP/NHS?

Where do your suggestions come from and how do you know that these things would work?

What else could **you** do? If nothing, why not?

What prevents primary care from reducing inequalities in mental health? And what helps?

**The role of primary care in addressing inequalities in mental health:
a PhD study**

Participant Information Sheet

Background to the study
It is clear that Scotland has high levels of inequality in health and high levels of mental health problems. Neither academic research nor routine NHS data collection has focused fully on inequalities in mental health, but there is increasing evidence that there are similar social gradients for mental health problems as there are for general health. However, to date there are no guidelines in Scotland for practice in primary care for either general health inequalities, inequality in mental health, or mental health promotion. Therefore there is little clarity as to what interventions primary care is delivering, or could develop, to reduce and prevent inequalities in mental health.

Aim and data collection
The aim of the study is to explore the contribution that a primary care organisation might make to reducing and preventing inequalities in mental health.

The question will be pursued through three avenues including data collection within South Ayrshire CHP. The first will be semi structured interviews with between 20 and 30 individuals from all (or most) of the professional disciplines within the CHP, and the second will be to observe, record and analyse the development and production of a CHP mental health needs assessment. The third will be to analyse relevant documentation including the academic literature, local and national policies, strategies, project proposals, data sources and other papers relating to the CHP role in addressing inequalities in mental health.

The timescale for the data collection will be from February 2005 to September 2006 and ethics approval was granted by the Ayrshire and Arran Local Research Ethics Committee in October 2004.

Why South Ayrshire CHP?
I wanted to work with an LHCC/CHP that covered a geographical area which included a balance of affluent and deprived postcode sectors, as there might then be an opportunity to identify clear differences between sectors within a single CHP. I first identified 12 such LHCCs across Scotland and initially approached them through the Public Health Practitioners. I offered my role as in either facilitating a process or researching the issue with staff, or a combination of both. South Ayrshire was one of two LHCCs who were keen to work with me. My main contact within the LHCC to set up the process was Kathleen McGuire, Lead Public Health Practitioner, and I am now being supported by Shiona Johnstone, Lead PHP and Fiona Smith, PHP.

Interviews
The interviews and observation are designed to explore the ways in which primary care professionals interpret and respond to inequalities in mental health within both practice and planning activities. A vignette, or scenario, will be given at the interview and participants invited to answer some questions on it in order to identify the ways in which different professionals might respond to the same patient. Additional questions will focus on the participants' perspectives on health inequalities, mental health and primary care.

The interviews should take approximately one hour and, with the participants consent, will be audio-recorded. The recordings will only be used by the researcher for the purposes of data analysis. Direct quotes from some respondents will be used, again with their consent for the purposes of illuminating points in the analysis, adopting the usual

conventions for anonymising respondents' comments, such as using numbers rather than initials or discipline.

Other data collection
A mental health needs assessment in South Ayrshire CHP is being planned to begin early in 2005 and this presents an opportunity to observe how the CHP incorporates inequalities into a mental health planning process. Data collection from this process will include observation of steering group and working group meetings, document analysis of minutes of meetings, draft papers and final needs assessment document (This might also include some additional interviews depending on issues arising throughout the process). Agreement for this has already been granted by the CHP group who are overseeing the development of the needs assessment. In addition, a wider document analysis will identify the range of policies, strategies, protocols, evidence and routine data available to primary care staff that would support work on addressing inequalities in mental health.

The researcher
I am carrying out this research on a part-time basis towards a PhD at the University of Glasgow, supervised by Professor Phil Hanlon, Division of Public Health and Health Policy and Professor Jill Morrison, Division of General Practice and Primary Care. I currently work as a Public Health Programme Manager at the Glasgow Centre for Population Health and have a professional background that includes health visiting, community development, health services research and health policy development. Please contact me directly if you would like to discuss any aspect of the research study, as follows:

Pauline Craig
Public Health Programme Manager
Glasgow Centre for Population Health
Level 6
39 St Vincent Place   Tel: 0141 221 9439
Glasgow G1 2ER   email:pauline.craig@drs.glasgow.gov.uk

Meaning making: from coding to analysis

The process of extracting meaning from data that had been sorted under code headings was summarised in Chapter 3, Section 3 and is explained in more detail here. Having sorted the data to the stage of achieving stable code headings I embarked on the process of examining the respondents perspectives under the headings that I had imposed on them. Taking quotes within each code heading in turn I copied the lists of quotes from ATLAS.ti into word files code by code. I then began to draw out their meaning or meanings by summarising or paraphrasing the points made in each quote before making further links between these summaries.To illustrate this process the extract below in Figure 1 was taken from the code for "Mental health assessment tool" and contained quotes from generalists only:

Figure 1. Extract from lists of quotations from one code

P 1: Int 1 transcript.doc - 1:14 [using my own personalised sche..] (40:40) (Pauline) Codes: [Mental health assessment tool] No memos using my own personalised scheme to work out whether it was likely to be something that would benefit from some psychological treatments or whether it was what we used to call endogenous depression	GP1 – use own personalized scheme GP1 - to identify need for psychology or different treatment
P 2: Int 2 transcript.doc - 2:29 [PC: what about people with dep..] (75:77) (Pauline) Codes: [Mental health assessment tool] No memos PC: what about people with depression, do you pick them up? DN1: We can do, we use a screening tool for the elderly to pick up depression so we could pick them up from there	DN1- locally developed screening tool for the elderly (? validated) DN1 - to pick up depression
P 8: Interview 8 HV2.doc - 8:22 [We use that….we recommend 6 we..] (165:165) (Pauline) Codes: [Mental health assessment tool] No memos We use that….we recommend 6 weeks and again at 3 months, and we use that to try and pick up. I'm not saying that all, you know, yeah I know it's a well validated, you know em validated and everything, but you will get girls that will score nothing and your gut feeling is that it would be that it would be a lot higher.	HV2 – EPNDS HV2 - although validated, some women might score nothing but gut feeling would be that it should be a lot higher
P12: Interview 12 - CPA.doc - 12:18 [CPA: Yeah, aye, just to let yo..] (93:97) (Pauline) Codes: [Mental health assessment tool] No memos CPA: Yeah, aye, just to let you see the sort of tool that we use. I know with the depression one there is a tool and it would have a sort of some key questions to ask to make sure that you ask them and what their responses, almost a flow chart type of thing. PC: Yes, uh huh. CPA: Just to kind of guide the pharmacist.	CPA – model scheme for depression will have an assessment tool to guide the pharmacist

It can be seen from this that more than one meaning could be applied to a quote, and alternatively more than one quote could be summarised in one meaning. I then transferred these summaries to new word files to bring together themes from both staff groups as shown below:

Mental health assessment tool

MH Specialists
DPM – Patient Health Questionnaire. 9 questions
DPM - to elucidate mild depression and lifestyle advice
HV1/PMHW – HADS scale
HV1/PMHW - to identify for the patient whether they were anxious or stressed and help them decide to do something about it
PCMHW/CPN – Patient Health Questionnaire, Core assessment, HADS and Social Adjustment Scale.
PCMHW/CPN – Useful to stimulate discussion as well as do assessment as no past psychiatric notes will be available. Go through assessments again at the last session to compare with first session and note any improvement
OT – Canadian Occupational Performance Measure
OT - to look at personal care, eating, functional mobility, leisure, vocational work and physical health. Client identifies their priorities

Generalists
GP1 – use own personalized scheme
GP1 - to identify need for psychology or other treatment
DN1- screening tool for the elderly (? validated)
DN1 - to pick up depression
DN2 – mini mental scale used with the elderly
HV2 – EPDS
HV2 - although validated, some women might score nothing but gut feeling would be that it should be a lot higher
CPA – model scheme for depression will have an assessment tool
CPA - to guide the pharmacist
HV3- EPDS.
HV3 - Useful in conjunction with the relationship with the mother. Useful for getting mums to open up and explore their own feelings. Can be difficult to admit to yourself or someone else that you're not coping. Can lead to referral to CPN or GP if major problems unearthed

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to gain additional insight into the topics under scrutiny.

Three main topics had been identified in the interviews with frontline professional staff of Core Roles, Inequalities and Tom. The process of merging and splitting codes is illustrated here for Core Roles but was applied in the same way to the other two headings.

Core Roles

18 codes from the total of 73 were initially identified as relating to respondents' core roles. As mentioned above a small number of these codes were prescribed from interview questions in order to gather some "hard" data about respondents, such as years in practice or the population covered by the respondents. Within core roles, the three major themes emerged of Context, Practice and Reflection on Practice.

Under **Context,** the codes were:

- Practice demographics
- Years in Practice
- Additional previous Experience
- Additional Practice
- LHCC/CHP roles.

Under **Practice**, the codes were:

- Core Roles
- Own role in mental health
- Mental health assessment tool
- Mental health conditions in primary care
- What is available
- Partnership working.

Under **Reflection on practice**, codes included were:

- Carers and mental health
- Travel to services
- What could be done for mental health
- Prevention
- Problems with prevention
- Problems addressing mental health
- Limitations of help available.

Some of these codes were merged with others and then these in turn were split into new sub-codes. Some codes were moved from one theme to another for example "Prevention" started under practice but most of the respondents' comments on prevention related to the difficulties in doing it rather than explaining practice being carried out. Therefore it fitted better under "Reflection on practice" than under "Practice". In addition some codes were moved from one topic to another and occasionally decisions were taken to share codes across topics. For example "Travel to services" provided themes relating to the "Inequalities" topic as well as to "Limitations of help available". The latter was initially set up as a code relating to "Tom" but respondents moved in and out of talking about Tom and talking about their usual practice therefore this code had relevance to themes within "Core Roles" and "Tom". Through this process the final themes and sub-themes were identified to explain the core roles of the respondents as illustrated in the coding structure in Table 1.

Table 1 Final coding scheme for the Core Roles of primary care and mental health professionals

1. Core Roles		
Theme	*Sub-theme 1*	*Sub-theme 2*
Context	**Discipline**	Mental health specialists Generalists
	Practice demographics	South Ayrshire South Ayrshire plus some cross boundary All Ayrshire GP Practices Area descriptors
	Years in Practice	
	Additional previous experience	
	Additional Practice	
Practice in mental health	**Core Activities**	Referrals in Assessments Interventions Signposting or referring on Liaison Other practice-related roles
	Local services available	Mental health services Community resources
Reflections on practice	**Mental health conditions in primary care**	Severe and enduring Mild to moderate Elderly people Substance misuse Mental health problems resulting from physical problems Carers Difficult to categorise/not coping
	Prevention	
	Problems addressing mental health	Criticism of services and service providers Gaps in services Overwhelmed services Lack of development Limitations of services available
	What could be done for mental health	Specialist referral Connecting people Earlier identification and access Thinking and working differently

A similar process was carried out to identify themes relating to Tom and to Inequalities from the interview data from frontline professionals. Data from the policy analysis and interviews with strategic officers were analysed using a similar process.

Process of the mental health needs assessment

The process of the mental health needs assessment is described here in full with key points summarised in Chapter 5, Section 2.

History and development of the needs assessment

The needs assessment had first been proposed in June 2003 by a Specialist Registrar in Public Health Medicine. The outline proposal was taken up by the Lead Public Health Practitioner in South Ayrshire LHCC whose health improvement team had mental health as one of their priorities but final decisions as to the focus they should be taking were still to be made. Together they had outlined a draft paper to scope the needs assessment as a project to be taken forward. The project aimed to assess mental health and health care needs of adults aged 16 and over in South Ayrshire using epidemiological, corporate and comparative methods in order to enable setting of priorities and targeting of services to those areas which were least well resourced. It aimed to identify needs of the three categories of people outlined in a report previously produced by the Scottish Needs Assessment Programme (Donaghy *et al*, 1997) as follows:

- The public at higher risk through life events or through being socially or economically disadvantaged
- The mentally unwell who have psychopathology but are not chronically disabled
- Those with major disabilities as a result of chronic mental health disorders.

Drivers for change were noted in the scoping paper as being evidence of health inequalities where people with enduring mental health problems had poorer physical health and poorer access to health services, that the demography was changing with increasing numbers of elderly people and less people of working age and that there were information sources available including recent guidelines and standards that highlighted best practice for mental health services.

The Lead PHP had previously gained approval in principle to carry out the needs assessment from a group described in the draft project proposal as the South Ayrshire Mental Health Project Group. However this group had been subsequently disbanded and the needs assessment process had to be re-started and was approved this time through a new group called the "Joint South Ayrshire Adult Mental Health Strategies Implementation Group". The group had been set up by the Patient Services Manager for Adult Mental Health Services in order to bring together health and social care professionals and mangers who were working on developing and implementing different mental health strategies, services and legislation and it would report to the South Ayrshire Joint Future Steering Group. The new group aimed to create a:

> *"more joined up process in the planning and delivery of the adult mental health agenda in South Ayrshire*" (minutes from meeting of the Joint South Ayrshire Adult Mental Health Strategies Implementation Group, 19/10/04).

The first and, as it turned out, only meeting of this group took place on 19th October 2004. The agenda included a slot for the Lead PHP to propose her needs assessment together with an opportunity for me to describe my research study for which I had already received ethics approval two weeks previously. The meeting identified that there were a myriad of strategic groups looking at aspects of mental health in place within South Ayrshire, across Ayrshire and Arran NHS Board and within the Ayrshire Councils and few if any members of the group had an overview of all that was going on. Frustration was expressed at the meeting that there appeared to be a lack of connection between top down imperatives such as the new national legislation and local developmental activity.

The two main actions agreed from the meeting were that information should be gathered from the group about all the adult mental health initiatives, projects and processes in place in South Ayrshire and that the needs assessment should go ahead as proposed by the Lead PHP with my involvement as observer which was also agreed unopposed. The group agreed that a Needs Assessment Steering Group should be set up with some participants at the meeting volunteering to join and others being proposed in their absence. They also agreed that the needs assessment could build on some of the re-design work already underway which had included involvement and perspectives from service users and carers which would mean that it did not need to repeat exploration of service users' and carers' perspectives. Instead the needs assessment should focus on demography, epidemiology and a literature review. The new Steering Group were asked to further shape the proposal in the light of this discussion but that the proposal should first involve the LHCC Management Team. A date was agreed for the next meeting of the whole Joint Adult Mental Health Strategies Implementation Group but was subsequently cancelled.

Delays in setting up the Needs Assessment Steering Group were caused by changes in personnel including that of the Lead PHP moving on and a new acting Lead PHP being appointed. At the same time some uncertainty crept in to the LHCC staff regarding establishment of the LHCC as a Community Health Partnership. The delays resulted in the needs assessment finally gaining approval from the LHCC/CHP Management Team almost one year after it had been agreed at the initial meeting of the Joint Adult Mental Health Strategies Implementation Group and almost two years after it had first been proposed.

The first meeting of the Needs Assessment Steering Group was organised for 26th September 2005. The meeting was chaired by the Patient Services Manager and attended by the acting Lead PHP, a seconded PHP (who was to take over the project management role), a Consultant in Public Health Medicine who had prepared the initial proposal as a Specialist Registrar, a Consultant Psychiatrist, a Health Improvement Officer and an Evaluation Officer. The main focus for the meeting was to finalise the proposal before taking it to the CHP Clinical Governance Group for funding.
The main issues discussed were the links between the proposed needs assessment and other related local activity, the parameters of the needs assessment and the process itself including who else should be involved.

The main actions agreed were as follows:

Links with other activity

Related activity from the previous mental health re-design process should be incorporated in the needs assessment. In particular the perspectives of users and carers which had been gathered already should be incorporated rather than attempting to repeat this process in order to prevent consultation fatigue among local service users.

Parameters of the needs assessment

The aim was agreed to be to back up existing services from a sound evidence base by assimilating existing information and assessing service provision against user and carer needs. The Consultant Psychiatrist proposed that the group described as the "public at high risk" from the original proposal should be taken out of the needs assessment on the grounds that existing data covers people already in the system most of whom are affected by moderate to severe mental illnesses. The group agreed that inclusion of the "public at high risk" group would mean too large a piece of work and that it would be important at this stage to "put something on the table" which could then be added to at a later date. It was agreed that the two categories of people to be included would be adults aged 16-65 who were mentally unwell and who suffered major problems. Both primary and secondary care should be explored including referral patterns, prescribing patterns and geographical variations. Older people and people with addictions should be

excluded as these populations are covered by NHS Board-wide services and the South Ayrshire CHP could not make decisions on its own about these services. Forensic services and children were dealt with through other strategy routes and therefore should also be excluded. Dual diagnosis of mental health along with substance misuse, older people and learning disability should be acknowledged as an important issue but not included on the grounds of being too complex to explore within this process.

The proposal to exclude the group of people "at high risk of mental health problems through being socially or economically disadvantaged" was agreed virtually unopposed with the exception of one attempt to explore needs relating to social circumstances and *Choose Life* as people at risk of suicide would not necessarily come within included categories. This issue was lost in favour of agreement that looking at one aspect of mental health at a time would be preferred and that the first should be services for adults with severe and enduring mental health problems. Concern was expressed that CHP clinical leads might be difficult to engage in the process if a drive towards equitable primary care service provision across social circumstances were to be focused on as this might be construed as a threat to GPs current pattern of providing services.

Needs assessment process

The meeting agreed that the CHP Clinical Governance Group was to act as the reporting group and be approached for funding to commission a researcher to gather data for the Needs Assessment Steering Group. The NHS Board-wide Mental Health and Well-being Advisory Group should also be informed of the process. The CHP Clinical Governance Group was meeting the following day and the group agreed that a one page outline of the proposal should go to them to request funding of £20,000 for a six-month needs assessment process. Ethical approval was thought not to be necessary as users and carers would probably not be required to be approached if information collected for a previous re-design process was still relevant. The Steering Group at this point was believed to lack membership from clinical leads including lead GPs, representatives from implementation of the Mental Health Act and from work relating to the National Programme for Mental Health and Well-being. The group agreed that additional members were to be identified through the CHP clinical governance lead groups.

As part of the observation of the mental health needs assessment I attended an initial, exploratory, pre-steering group meeting on 19th October 2004 and every full meeting of the Steering Group thereafter with one exception, meeting on 26th September 2005, 2nd November 2005, 30th January 2006, 6th July 2006 and 19th September 2006. This paper details the data drawn from attendance at the meeting, minutes and papers produced by the Needs Assessment Steering Group.

Progress of the mental health needs assessment steering group

The second meeting of the Mental Health Needs Assessment Steering Group took place on 2nd November 2005. The core group had now been identified and most gaps filled with attendance at the meeting comprising:

- Patient Services Manager
- Acting Lead Public Health Practitioner
- Seconded Public Health Practitioner (project manager)
- Evaluation officer, NHS Board
- Planning Officer, NHS Board
- General Practitioner
- Consultant in Public Health Medicine
- Pharmacist
- Clinical Psychologist
- Prescribing Advisor
- Consultant Psychiatrist (not in attendance)

The aim of the meeting was to finalise the focus for the needs assessment, other key individuals to be included and how to proceed.

The Clinical Governance Committee had approved funding of £20,000 for the needs assessment but required more information about intended outcomes and how it might influence service provision. This information was required for the next Clinical Governance meeting to be held at the end of November.

The main discussion concerned availability of information for assessing needs and difficulties in accessing relevant information. For example some of the difficulties identified at the meeting included the following:

- prescribing data could not be broken down into age groups and anti-depressants can be prescribed for a range of symptoms not just mental health problems
- GP registers required patients to consent to have their details included and not all patients consent
- there was no routine information collected about non-pharmaceutical interventions
- different interpretations of coding for mental illness was apparent between clinicians for example in deciding where unhappiness ends and mental illness begins
- dual and multiple diagnoses were all recorded therefore some patients would be recorded several times.

The range of services holding data on patients who were mentally unwell was discussed and included GP, health visitor and midwives scoring systems, psychiatrists, psychologists, local authority advocacy, housing, education, NHS 24 (which records conditions, referrals and support offered), Copeline (a voluntary sector initiative), and other voluntary sector organisations, such as the volunteer centre, local befriending service, Breathing Space and Samaritans. In addition the need for services that might be limited or unavailable should also be identified such as forensic services, anger management, eating disorders, personality disorder and self harm and the issue of diversity and race equality should be taken into consideration. The meeting agreed that some of these issues would have to be identified through a literature review.

Qualitative information was also thought to be required including users and carers views from previous research being potentially relevant. Additional data collection might also be sought through one-to-one interviews with some service providers to map services and explore service issues. The meeting agreed that two processes would be commissioned separately, first, a literature review and following that, the needs assessment itself.

Actions agreed from the meeting were that a brief for a literature review would be developed as soon as possible in order to commission immediately and a brief would also be developed to commission researchers to carry out the needs assessment to begin in early January.

Recruitment and management of commissioned researchers

Following the November meeting, draft invitations to tender for commissioning researchers for the literature review and the needs assessment were produced and circulated by email to the Steering Group for comment. Both processes are described below.

Literature Review

Four research teams submitted bids to carry out the literature review and one was chosen following email discussion between four steering group members. It was to be carried out over a six-week period at a cost of £3000. The brief asked for the following to be the focus for the literature review:

- Severe and enduring mental illness including schizophrenia
- Psychotic illnesses – depression, hypomania, manic depression
- Anorexia and bulimia nervosa
- Anxiety
- Mental illness in young people age 16-18
- Suicide and deliberate self-harm.

The following questions were to be asked:

- Incidence and prevalence
- Epidemiological and associated characteristics of the disease groups (eg demography, socio-economic deprivation)
- Evidence-based interventions for effective management
- Role of primary care in their management

Needs Assessment

The invitation to tender for the needs assessment was placed on the Health Scotland website. The research brief described the two target populations for the needs assessment as:

10. The mentally unwell (those with significant psychopathology but without chronic disabling characteristics) such as depressive episode, phobias, panic disorder, anxiety, mixed anxiety/depressive disorder

11. Those with major disabilities as a result of severe and enduring mental health disorders – serious persistent or intermittent psychological disturbance with at least one of the following – psychotic diagnosis, organic illness or injury, previous compulsory admissions, long period in hospital, serious risk of self-harm, limited social skills, requiring home support for community living.

The objectives were as follows:

- To gather and interpret routine and survey data applicable to the population with mental health needs, national or local
- To gather information on services in South Ayrhsire currently available to mental health service users
- To gather views of the users on whether their needs are being met (much of this available from a 2002 review)
- To gather views of the service providers on local health needs and services
- To use the above to identify priority health needs to be addressed.

Three survey methods were proposed to be employed:

- Epidemiological – prevalence and incidence data from local and national surveys and sources
- Corporate – views of service providers, users and carers to look at identified, met and unmet needs
- Comparative – collecting data on provision of mental health services in South Ayrshire and where relevant, Scotland, eg from SKIPPER 3, prescribing data, ISD, GPASS.

Four organisations submitted tenders for the needs assessment, and all four were invited for interview on 11th January 2006 where a team of researchers were successfully recruited.

Following the set-up meeting for the needs assessment researchers on 30th January 2006 the next meeting of the full Steering Group took place in July 2006 in order to receive the first draft report of the needs assessment from the commissioned research team. At this meeting the researchers explained the process they had undertaken to identify needs and other initial findings. They then ran part of the meeting as a focus group in order to consult with Steering Group members to identify and further explore key issues in order to shape the final recommendations of the report. The meeting was not well attended by Steering Group members with only two core members and another two attendees deputising for core members but was regarded as a useful meeting by all in attendance as it had provided an opportunity to discuss the needs assessment in detail.

The main items discussed at the July meeting included:

Data issues: there was a lack of consistency in recording including that some patients were recorded on some databases and others not, guidelines for diagnostic criteria for GP returns had just been agreed but it would be some months before data returns would reflect those, databases for different services had different diagnostic criteria and some databases did not record patients' postcodes.

Strategic planning structures for mental health: a bewildering array of multi-agency and single-agency, pan-Ayrshire and South Ayrshire groups were identified as being in place with remits to develop and implement strategy for mental health services. There appeared to be a lack of clear leadership for mental health across Ayrshire and Arran including a lack of clinical leadership. Symptoms of the problems highlighted by the commissioned research team included that the 5 year Mental Health Strategy produced in 1999 was funded for only one year and that the main Mental Health and Well-Being Advisory Group was set up to provide the "vision" but had become caught up in operational issues. Joint groups between health and social care services were designing jointly funded processes but there were tensions in funding and decision-making where some issues were relevant to all three Ayrshire CHPs while other issues were more local. In addition there were practice-related issues such as roll-out of single shared assessments that were regarded as potentially problematic. Consequently the pan-Ayrshire picture was thought to be important to be taken into account when looking at South Ayrshire.

At the end of that meeting I asked the researchers about inequalities in mental health as there was very little mention of these in their draft report and was not discussed at any point in the meeting. They replied that they had identified some information and that they would flesh it out for the final report but did not specify what they had found at this point.

The final meeting of the Steering Group took place on 19th September 2006. By this time the Patient Services Manager had taken ill, was on long-term sick leave and was planning to take early retirement without returning. (I was extremely sorry to receive this news as she had been very helpful and encouraging to me, had been a driving force in seeing through the needs assessment process and was a warm, open and energetic presence at meetings). Participants in this meeting who had attended at least one of the previous meetings were:

- Seconded Public Health Practitioner
- Consultant in Public Health Medicine
- Planning Officer, NHS Board
- Pharmacist
- Clinical Psychologist.

The meeting was also attended by others who had been on the email list but had not attended meetings:

- Community Care Manager from South Ayrshire Council
- Acting Patient Services Manager
- Choose Life Development Officer.

Steering Group members had been asked to comment on the draft paper which had been amended following the previous meeting in July and this meeting intended to finalise the needs assessment report. To this end the researcher gave a comprehensive presentation of the main findings and opened the discussion in the Group. The key issues presented at the meeting were as follows:

Data: Health Scotland's Health and Well-Being Profiles identified a range of indicators relevant to the needs assessment and ISD had provided additional analyses in order to estimate prevalence and incidence of mental health problems in South Ayrshire. Two databases holding local service use data were also examined which were GPASS for general practice and FACE for mental health services. While these and other current systems did not allow easy transfer of data between them there were proposals in place to enable more consistency within and between service use databases. The data exploration concluded that sections of the population were more vulnerable to mental illness.

Planning processes: the researchers found that there was confusion among mental health service providers about strategic issues and which groups were responsible for making decisions about the range of mental health issues. There was a lack of a clear strategic plan and they proposed a need for a pan- Ayrshire and Arran plan with a South Ayrshire dimension.

Service providers: the researchers gathered some data from service providers through one-to-one interviews and they found that there was a great deal of desire for improvements in mental health services. They talked about wanting to work in a joined up way between health, social work and the voluntary sector in order to improve their clients life circumstances and support people into meaningful ways of life with comprehensive support packages. However they were restricted from working in this way due to lack of time and funding. The issue of rural access to services was raised particularly about provision of out of hours cover as this did not exist at that time.

Patient information: there had been a resource directory but it was out of date and service providers did not always know about all the services or patients forgot about services they had been told about.

Views of users and carers: an additional three interviews with service users had been carried out by the needs assessment research team in order to enhance information from the 2002 service re-design users and carers consultation. Views were similar to those of the service providers in that they identified needs for a 24 hour crisis centre, more CPNs, better information and better hospital/community links.

Main recommendations proposed: There were three main groups of recommendations proposed as follows: to improve statistics and data across services and across the NHS Board area; to produce a mental health plan for the NHS Board area in conjunction with the local authorities which should be linked to a South Ayrshire implementation plan to ensure local solutions at the same time as consistency across the Board area; and that specific needs identified should be addressed regarding information, staffing and resource levels and 24 hour cover.

Issues and questions raised by the Steering Group broadly agreed with the researchers findings. One participant suggested that the Group should match up the findings from the literature review on expected prevalence for the UK with ISD's figures for South Ayrshire, and another suggested that the methodology should be contributed to the new

Board-wide Review group that had recently been set up. The report was to go to the CHP Clinical Governance Committee following which the Steering Group should meet again to finalise actions and progress recommendations. The Group agreed that they would comment on the draft paper within 2 weeks after which it was to be taken to the Clinical Governance Committee.