Table of Evidence on Equality Issues- Key Documents

See also www.equality.scot.nhs.uk

Is Britain Fairer? The state of equality and human rights 2015. Equality and Human Rights Commission. October 2015. http://www.equalityhumanrights.com/sites/default/files/uploads/IBF/Final-reports/EHRC_IBF_MainReport_acc.pdf
Challenges include: • Self-reported health status for some people with specific characteristics (for example, Gypsies and Travellers and disabled people) was worse (in the 2011 Census); lower life expectancy for people with serious mental illness or a learning disability, Gypsies and Travellers and homeless people. • Worse end of life outcomes for people in more disadvantaged socioeconomic positions. • Legal safeguards provided by the Human Rights Act 1998 to prevent inhuman or degrading treatment were not as widely used as they should have been; a number of inquiries highlighted serious flaws (and sometimes abuse) in the care of vulnerable patients, such as those with learning disabilities, older people and patients with dementia. • Care of prisoners with mental health needs was inconsistent across prisons. • Some people, such as transgender people, Gypsies and Travellers, homeless people and migrant communities, experienced problems accessing healthcare services. A number of disadvantages were associated with mental health: • People with some forms of serious mental health conditions had shortened life expectancy.

- While there is evidence that stigmatising attitudes to mental health slightly decreased in England and Wales, there was little change in Scotland.
- People with both serious and common mental health conditions had higher unemployment rates.
- The suicide rate increased in both England and Wales. There was a fall in Scotland, although Scotland continued to have the highest suicide rate within Britain), with middle-aged men at highest risk.

What works to reduce prejudice and discrimination? A review of the evidence. Scottish Government. Maureen McBride, Scottish Centre for Crime and Justice Research. October 2015

http://www.gov.scot/Resource/0048/00487370.pdf

Key lessons in reducing discrimination

1. Aim for a broad commitment to reducing prejudice, not one-shot Interventions

Are specific anti-prejudice initiatives (e.g. anti-sectarian, anti-racist, anti-homophobic etc.) better than a catch-all focus on prejudice? This has not yet been subject to sufficient testing, but since prejudices towards different groups appear to have different developmental trajectories, there is value in treating these as different problems, with potentially different causes and solutions that require reflection and sensitive intervention designs.

There should be a broad prejudice reduction framework with flexibility which allows for a focus on specific forms where necessary and regional and local sensitivity.

Evidence suggests that one-off activities make less impact; better results come from sustained activities over a period of time. Some short-term projects may still be effective, however these should be part of a wider

framework that emphasises long-term education and opportunities for long-term contact with the potential for cross-group friendships.

Interventions should take place within a broader context of commitment to diversity in terms of institutional and cultural change. For example, there is perhaps less of a priority for organisations holding diversity training courses when groups such as women, ethnic minorities, or people with disabilities, are significantly underrepresented in senior positions within their workforce.

2. Certain techniques more effective than others

Interventions should be based on social-psychological theories and key lessons from the literature: those that are not rooted in these tend to be less effective. Techniques based on an overly simplistic or idealised notion of what should work can be counterproductive, especially if not applied with care.

For example, despite good intentions, direct attempts at persuading people to recognise and change their attitudes have been known to be ineffective and often have unintentional negative effects. Diversity training in particular risks backfiring by reinforcing minority ethnic stereotypes, essentialising group categories, and drawing attention to difference and inequality.

Certain techniques are known to be much more successful with less risk of negative impacts. Interventions which facilitate positive intergroup contact, or are based on principles of perspective-taking or empathy-induction are considered to be effective. In education, cooperative learning and the use of curriculum which embeds positive messages of intergroup contact are also promising.

3. Handle issues sensitively

Rather than instructing what types of behaviours, language, or attitudes are wrong something that is often

subjective and contested – teaching skills and disposition, such as critical thinking and empathy, is likely to be more effective.

Acknowledging and discussing historical events may be helpful in terms of breaking down existing barriers and challenging the residual prejudice apparently stemming from historical conflict and poor relations.

The backlash effects discussed above emphasise the importance of knowing the area and of carefully designing programmes and initiatives. The literature strongly supports the principle of peer engagement, suggesting that change is best affected from within peer groups where possible. This could involve participants who previously took part in programmes helping to shape and facilitate future initiatives. The credibility of the messenger is highly important.

4. Key lessons – Scotland

A clear caveat is that we need to be wary about what conclusions can be drawn from what works in more problematic settings that will be relevant or appropriate to Scotland. Many of the key prejudice-reduction interventions have taken place in areas in which ethnic or other prejudice results in or is exacerbated by overt conflict, or at least has done in recent times. This has not been the case in Scotland, so although these may involve useful strategies that could help to influence prejudice-reduction initiatives more broadly, direct application may not be appropriate.

High levels of contact does not necessarily remove the existence of stereotyping or discrimination: the example of gender relations highlights this. In terms of Catholic/Protestant relations, people are very integrated in terms of families and other relationships. However, the research shows that perceptions of continued existence of sectarianism in Scotland are extremely high.

People have to be willing to confront and challenge their prejudices: it is very difficult to compel someone to change against their will. Yet we have established that most people do not recognise themselves as prejudiced, and this is particularly complex given that the attitudinal research on sectarianism shows that people tended to think of sectarianism as happening elsewhere - not in their local area/community and not themselves personally. There may therefore be a lack of willingness among people to engage.

It is important to be mindful of not facilitating the reproduction of particular assumptions or stereotypes. Dramatic interpretations of the issue - for instance, hard-hitting messages or media clips - could risk alienating sections of the audience who would not recognise overt violence as a feature of their lives or communities.

Variations in the Experiences of Inpatients in Scotland: Analysis of the 2010 Scottish Inpatient Survey. Boyd, G. & Hodgkiss, F.

http://www.gov.scot/Publications/2011/08/29131615/0

Females are generally less likely than males to report a positive experience.

There are many differences in the experiences of patients of **different religions or beliefs** compared to Christian patients. However the experience of Church of Scotland patients, Roman Catholics and other Christians were very similar. (Patients answering “none” for religion were generally less likely to report a positive experience than Christian patients. For 49 questions they were less to report a positive experience.) Patients with other non-Christian religions and belief systems were less likely to report a positive experience than Christian patients for 21 of the questions.

There are some differences in the experience of patients reporting different **sexual orientation**. There are no obvious patterns in the answers and there is little than can be inferred from them. It is possible that there will be

a greater proportion of lesbian / gay / bisexual patients out of the total not answering the question than answering the question.

Patients whose day-to-day activities were limited a lot because of a **health problem or disability** are less likely to report a positive experience in some areas. (One possible reason for the difference is that this group is likely to have additional care needs that may be more difficult to meet.)

Patients with **translation, interpreting and communication support needs** are generally less likely to report a positive experience than others. (Patients requiring an interpreter or any other help to communicate were generally less positive than others. For 40 questions they were less likely to
report a positive experience and they were never more likely to report a positive experience. Three questions particularly stand out where those requiring an interpreter or any other help to communicate were less positive:
• I understood what my medicines were for
• I was confident I could look after myself when I left hospital
• I understood what was happening to me)
• There are differences in the experiences of patients with different disability status.

Patients with **deafness or a severe hearing impairment** were less likely to report a positive experience for 7 questions and more likely for one question although this was about being bothered by noise. These patients were less likely to report a positive experience of their time in A&E with being told what
was happening in a way they could understand a problem

Patients with **visual impairment** were less likely to know how and when to take their medicines and less confident of
being able to look after themselves when they got home.

Patients with a **learning disability** were less likely to answer positively about being involved in decisions about their care. This difference may be because family and hospital staff are likely to be more involved in these decisions.

Social Integration: A Wake Up Call. The Social Integration Commission.

http://socialintegrationcommission.org.uk/a-wake-up-call-social-integration-commission.pdf

This report focuses on three main areas:
1. Why a failure to tackle a lack of social integration will inhibit our ability as a country to deal with some of the major social and economic challenges facing the UK.
2. The specific costs in relation to employment, recruitment and career progression, and community health and wellbeing, where the consequences of a lack of social integration are already evident today.
3. The positive outcomes of social integration on our perceptions of others and levels of trust.

Workforce Diversity
Smart Metrics Equality and Diversity Monitoring, Findlay, P. 2014

http://www.equalitiesinhealth.org/Link-Files/Smart-metrics.pdf.pdf

The report recommends that:

- NHS GGC needs to clarify its objectives for workforce data beyond meeting regulatory requirements.
- There is a need for a clear and consistent narrative connecting service data and workforce data.
- There is a need for a clearly defined business/operational case for workforce data that specifies relevant

organisational risk and opportunities.

- In setting objectives, NHS GGC should define its ambitions in workforce diversity.
- Stakeholders need to decide whether the organisation wishes to be compliant, developing or pathbreaking in workforce diversity and what each of the latter two would mean in practice.
- These objectives need to be ‘owned’ more widely than by the HR and the inequalities team
- Operational management involvement is crucial to defining the business drivers of workforce diversity.
- Establishing a clearer link between strategic, operational and workforce diversity data objectives should be used to strengthen ownership of E&D data across HR and corporate teams.
- Existing high levels of trust and commitment to fairness and inclusion provides a basis for a genuinely collaborative approach across a wider group of stakeholders to defining workforce diversity objectives.