Leicestershire Partnership NHS Trust

Equality and Human Rights Team

Leicestershire Partnership NHS Trust: CQC Mental Health Inpatient Survey 2015

A quantitative equality analysis considering ward, age, gender, and ethnicity: Summary of findings

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Table of Contents

Introduction

Aim

The present report looks at the 2015 Care Quality Commission's Mental Health Inpatient Survey. The analysis aims to identify equality issues arising from service user's responses to the survey.

The Equality Act (2010)

The Equality Act (2010) describes a 'public sector equality duty' (section 149). The 'public sector equality duty' applies to listed public authorities (including NHS Trusts) and others who exercise public functions.

149 Public sector equality duty:

(1) A public authority must, in the exercise of its functions, have due regard to the need to—

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

(2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The public sector equality duty covers people across nine protected characteristics: age; disability; gender reassignment; marriage and civil partnership*; pregnancy and maternity; race; religion or belief; sex; sexual orientation. (*Marriage or civil partnership status is only covered by the first aim of the public sector equality duty, to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act.)

Listed public authorities must publish information to demonstrate compliance with the duty imposed by section 149(1) of the Act, at least annually. The information that a listed public authority publishes in compliance with paragraph (1) must include, in particular, information relating to persons who share a relevant protected characteristic who are—

(a) its employees;

(b) other persons affected by its policies and practices.

Although, only listed public authorities with 150 or more employees need publish information on their workforce.

Regarding other persons affected by its policies and practices, the types of information that listed authorities could publish to demonstrate compliance include[1]:

- Records kept of how it has had due regard in making decisions, including any analysis undertaken and the evidence used.
- Relevant performance information, especially those relating to outcomes, for example information about levels of educational attainment for boys and girls, health outcomes for people from different ethnic minorities, and reported incidences of disability-related harassment.
- Access to and satisfaction with services, including complaints.
- Any quantitative and qualitative research undertaken, for example patient surveys and focus groups.
- Details of, and feedback from, any engagement exercises.

The present report considers the 2015 Care Quality Commission's Mental Health Inpatient Survey which covers several topic areas: introduction to the ward, about the ward, hospital staff, care and treatment, patient's rights, leaving hospital, and an overall rating.

[1] This guidance is taken from the technical guidance published by the Equality and Human Rights Commission: Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England (August 2014), page 69

A note on the anonymisation of information about service users within this report

This version of the report has been redacted and edited to allow publication on a publically accessible website. The report contains counts of numbers of service users, analysed in several tables, by their protected characteristics (e.g., age group, gender). The use of these tables to produce aggregated summaries of service user counts has the effect of anonymising much of the information and protecting the identities of individual service users. However, some analyses contain very small counts of service users in some protected characteristic groups, especially when broken down by certain domains of interest. Such small counts could, potentially, be used to identify individual service users, even after aggregation. Consequently, these small counts might be considered personal information that is protected by the Data Protection Act 1998 and other legislation. Where there is a risk that individuals could be identified from a small count, these counts have been redacted from the tables. Where the redacted count can be deduced from other counts in a table, these other counts have been redacted as well. In the present report, as a start point for the anonymisation process, counts below 10 have been redacted to mitigate the risk that individuals might be identifiable. The anonymisation process has followed guidance issued by the Information Commissioner's Office[2]. Additionally, some groups have been suppressed and excluded from the analyses at the data source (please refer to the Appendix of analytical methods: Excluded and included groups).

[2] Information Commissioner's Office: Anonymisation: managing data protection risk code of practice (November 2012)

Summary

Main findings from the analysis of the breakdowns of the 2015 CQC Mental Health Inpatient Survey are summarised below, alongside indications from the overall findings of the 2016 CQC Mental Health Inpatient Survey (breakdowns of the 2016 survey were not available at the time of writing this report).

Good practice

- For most of the topic areas covered by the survey, there were no indications that a particular protected group was disadvantaged amongst LPT's respondents (analyses were possible by age, gender, and ethnicity)

- The differing dietary requirements of inpatients (for example because of cultural or religious beliefs, a particular health condition, or through personal choice) were catered for, with equality of provision by ethnicity—indications from the 2016 survey are that the differing dietary requirements of inpatients are still being met

Areas for improvement

- Some inpatients reported sharing a sleeping area, for example a room or bay, with patients of the opposite sex (also evident in the 2016 survey). The 2015 and 2016 surveys will have covered patients who were on the wards in 2014 and 2015 respectively. All wards at LPT now offer only single sex accommodation.

- There were low levels of provision of talking therapy services, despite demand for such services, especially for older service users and White service users—however, the 2016 survey indicates that levels of provision of talking therapy services have since increased

- Although, LPT's service users were less likely to report having been detained under the Mental Health Act, Asian British service users were twice as likely as White service users to report having been detained under the Mental Health Act

- There were poor levels of knowledge amongst service users of an out-of-hours number for mental health services, especially amongst White service users / elective admissions—indications from the 2016 survey are that levels of knowledge amongst service users of an out-of-hours number for mental health services have since increased

- There were poor levels of contact with services users by a member of the mental health team since the service user left hospital, especially amongst White service users / elective admissions—indications from the 2016 survey are that levels of contact with services users by a member of the mental health team since the service user left hospital have increased

Main findings and recommendations

Data and analyses supporting the findings detailed below are provided for reference in the Appendix of analyses. Each table referred to below is hyperlinked to its occurrence in the appendix. The present report is concerned with detailed breakdowns from the 2015 CQC Mental Health Inpatient Survey. However, updates of overall national and LPT figures from the 2016 CQC Mental Health Inpatient Survey have been included alongside the detailed breakdowns from the 2015 survey (detailed breakdowns of the 2016 survey were not available at the time of writing this report).

For most of the topic areas covered by the survey, there were no indications that a particular protected group was disadvantaged amongst LPT's respondents (analyses were possible by age, gender, and ethnicity).

Dietary requirements were met for inpatients of different ethnicities

- Asian British service users were more likely to report having specific dietary requirements (for example because of cultural or religious beliefs, a particular health condition, or through personal choice, Table 1); almost all service users were able to get the specific diet that they needed from the hospital, with no statistically significant variation by ethnicity (Table 2). (2016 update: again, almost all service users were able to get the specific diet that they needed from the hospital.)

Some inpatients reported sharing a sleeping area, for example a room or bay, with patients of the opposite sex

- There was a trend for LPT's service users to be more likely to report having shared a sleeping area, for example a room or bay, with patients of the opposite sex (Table 3). (2016 update: levels of sharing a sleeping area with patients of the opposite sex remained high at LPT.) It is noted that those patients surveyed in 2016, will have been on the ward between 1st July and 31st December 2015. All wards at LPT now offer only single sex accommodation.

There were low levels of provision of talking therapy, especially for older service users and White service users

- LPT's service users were less likely to report having had talking therapy (Table 4), despite the levels of service users wanting talking therapy being similar to the national benchmark (Table 7); this issue was more likely to affect older service users (45 to 54 and 55 to 64 years old, Table 5) and White service users (Table 6). (2016 update: overall levels of those reporting having had talking therapy increased at LPT to match national levels.)

Detention under the Mental Health Act

- Although, overall, LPT's service users were less likely to report having been detained under the Mental Health Act (Table 10), Asian British service users were twice as likely as White service users to report having been detained under the Mental Health Act (Table 12). (2016 update: overall levels of those reporting having been detained under the Mental Health Act increased at LPT to above national levels.)

There was poor knowledge of an out-of-hours number for mental health services – primarily affecting White service users / elective admissions

- LPT's service users were less likely to report having the number of someone from their local NHS mental health service that they could phone out of office hours (Table 13). This issue primarily affected White service users (Table 16), reflecting that the issue also primarily affected elective admissions as opposed to emergency admissions (Table 14) and that White people were less likely to have been admitted as an emergency (Table 17). (2016 update: levels of knowledge amongst LPT's respondents of an out-of-hours number for mental health services have increased since the 2015 survey.)

There were poor levels of contact with service users after leaving hospital by a member of the mental health team – primarily affecting White service users / elective admissions

- LPT's service users were less likely to report having been contacted by a member of the mental health team since leaving hospital (Table 18). This issue primarily affected White service users (Table 21), reflecting that the issue also primarily affected elective admissions as opposed to emergency admissions (Table 19) and that White people were less likely to have been admitted as an emergency (Table 17). (2016 update: levels of contact with respondents since leaving hospital have increased at LPT to match national levels.)

Appendix of analyses

A key to the colour coding in the tables of analysis can be found in Table 26.

Dietary requirements

- Compared to LPT overall, Asian British service users (Table 1) were more likely to report having specific dietary requirements (for example because of cultural or religious beliefs, a particular health condition, or through personal choice – 69% of Asian British service users vs 19% of White service users).

- Most service users (90%) were able to get the specific diet that they needed from the hospital, with no statistically significant variation by ethnicity in dietary needs being met (Table 2). (2016 update: 91% of respondents at LPT were able to get the specific diet that they needed from the hospital.)

Table 1: Q8. Do you have a specific diet, for example because of your cultural or religious beliefs, because you have a particular health condition, or through personal choice? Analysed by ethnicity (detailed groups), compared against LPT overall

Ethnicity (detail)	% Yes*
LPT Overall	28.43% (29/102)
Asian or Asian British	68.75% (11/16)
White	19.48% (15/77)

* % calculated out of the total responding "yes" or "no"

Table 2: Q9. Were you able to get the specific diet that you needed from the hospital? Analysed by ethnicity (detailed groups), compared against LPT overall

Ethnicity (detail)	% Yes*
LPT Overall	90.00% (27/30)
Asian or Asian British	83.33% (10/12)
White	93.33% (14/15)

* % calculated out of the total responding "yes" or "no"

Sharing a sleeping area, for example a room or bay, with patients of the opposite sex

- Compared to the national benchmark, there was a trend (although not to a statistically significant degree) for LPT's service users to be more likely to report having shared a sleeping area, for example a room or bay, with patients of the opposite sex (9% nationally vs 15% at LPT, Table 3). (2016 update: levels of sharing a sleeping area with patients of the opposite sex remained high at LPT: 7% nationally vs 16% at LPT).

- It is noted that those patients surveyed in 2016, will have been on the ward between 1st July and 31st December 2015. Since this time, work has been undertaken at Leicestershire Partnership NHS Trust so that all wards offer only single sex accommodation.

Table 3: Q4. During your most recent stay, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex? LPT Overall compared against the National Benchmark

Area	% Yes*
National	8.88% (103/1160)
LPT Overall	14.68% (16/109)

* % calculated out of the total responding "yes" or "no"

Provision of talking therapy

- Compared to the national benchmark, LPT's service users were less likely to report having had talking therapy (28% nationally vs 13% at LPT, Table 4), despite similar levels of service users wanting talking therapy (50% nationally vs 44% at LPT, Table 7).

- There was a trend (although not statistically significant) for older service users (45 to 54 and 55 to 64 years old, Table 5) and for White service users (Table 6) to be less likely to report having had talking therapy, despite similar levels of service users wanting talking therapy by age group (Table 8) and ethnicity (Table 9). (2016 update: overall levels of provision of talking therapies were higher than in 2015—32% nationally vs 32% at LPT—with a slight increase in levels of demand—56% nationally vs 49% at LPT.)

Table 4: Q29. During your stay in hospital, did you have talking therapy? LPT Overall compared against the National Benchmark

Area	% Yes*
National	28.21% (319/1131)
LPT Overall	12.50% (13/104)

* % calculated out of the total responding "yes" or "no"

Table 5: Q29. During your stay in hospital, did you have talking therapy? Analysed by age group (years), compared against LPT overall

Age Group (years)	% Yes*
LPT Overall	12.50% (13/104)
25-34	23.08% (3/13)
35-44	14.81% (4/27)
45-54	6.45% (2/31)
55-64	7.69% (2/26)

* % calculated out of the total responding "yes" or "no"

Table 6: Q29. During your stay in hospital, did you have talking therapy? Analysed by ethnicity (detailed), compared against LPT overall

Ethnicity (detailed)	% Yes*
LPT Overall	12.50% (13/104)
Asian or Asian British	29.41% (5/17)
White	7.69% (6/78)

* % calculated out of the total responding "yes" or "no"

Table 7: Q28. During your stay in hospital, did you ever want talking therapy? LPT Overall compared against the National Benchmark

Area	% Yes*
National	49.74% (565/1136)
LPT Overall	43.93% (47/107)

* % calculated out of the total responding "yes" or "no"

Table 8: Q28. During your stay in hospital, did you ever want talking therapy? Analysed by age group (years), compared against LPT overall

Age Group (years)	% Yes*
LPT Overall	43.93% (47/107)
25-34	38.46% (5/13)
35-44	44.83% (13/29)
45-54	35.48% (11/31)
55-64	48.15% (13/27)

* % calculated out of the total responding "yes" or "no"

Table 9: Q28. During your stay in hospital, did you ever want talking therapy? Analysed by ethnicity (detailed), compared against LPT overall

Ethnicity (detailed)	% Yes*
LPT Overall	43.93% (47/107)
Asian or Asian British	56.25% (9/16)
White	43.90% (36/82)

* % calculated out of the total responding "yes" or "no"

Detention under the Mental Health Act

- Compared to the national benchmark, LPT's service users were less likely to report having been detained under the Mental Health Act (59% nationally vs 35% at LPT, Table 10), with the majority of those detained under the Mental Health Act being involuntary admissions (82% involuntary vs 17% voluntary, Table 11).

- Although not a statistically significant trend, Asian British people were twice as likely as White people to report having been detained under the Mental Health Act (60% Asian British vs 30% White, Table 12). This finding may be related to a noted underrepresentation of Asian British people amongst users of mental health services at LPT (in 15/16 and in previous years too). Those Asian British people who do present to mental health services may have a greater tendency to do so in an emergency situation, with severe illness requiring detention under the Mental Health Act – perhaps reflecting greater barriers to and greater stigma associated with accessing mental health services for Asian British people. (2016 update: levels of detention under the Mental Health Act amongst respondents at LPT have since increased to above national levels—55% nationally vs 61% at LPT.)

Table 10: Q35. At any time during your most recent admission were you detained (sectioned) under the Mental Health Act? LPT Overall compared against the National Benchmark

Area	% Yes*
National	59.04% (624/1057)
LPT Overall	35.42% (34/96)

* % calculated out of the total responding "yes" or "no"

Table 11: Q35. At any time during your most recent admission were you detained (sectioned) under the Mental Health Act? Analysed by legal status on admission, compared against LPT overall

Legal status on admission	% Yes*
LPT Overall	35.42% (34/96)
Informal	17.39% (12/69)
Involuntary	81.82% (18/22)

* % calculated out of the total responding "yes" or "no"

Table 12: Q35. At any time during your most recent admission were you detained (sectioned) under the Mental Health Act? Analysed by ethnicity (detailed), compared against LPT overall

Ethnicity (detailed)	% Yes*
LPT Overall	35.42% (34/96)
Asian or Asian British	60.00% (9/15)
White	30.14% (22/73)

* % calculated out of the total responding "yes" or "no"

Out-of-hours contact telephone number

- Compared to the national benchmark, LPT's service users were less likely to report having the number of someone from their local NHS mental health service that they could phone out of office hours (73% nationally vs 57% at LPT, Table 13). Within LPT, this issue primarily affected elective admissions as opposed to emergency admissions (17% of elective admissions vs 66% of those admitted in an emergency, Table 14) with a greater (although not statistically significant) tendency to affect Aston ward (38% of those on Aston Ward compared to 57% for LPT overall, Table 15).

- White service users were less likely than Asian British service users to report having the number of someone from their local NHS mental health service that they could phone out of office hours (although not to a statistically significant degree, 57% of White service users vs 67% of Asian British service users, Table 16), reflecting that White people were less likely to have been admitted as an emergency (77% of White service users vs 88% of Asian British Service users, Table 17). (2016 update: overall levels of knowledge amongst LPT's respondents of an out-of-hours number for mental health services have since increased at LPT, but remain lower than the national benchmark—73% nationally vs 64% at LPT.)

Table 13: Q43. Do you have the number of someone from your local NHS mental health service that you can phone out of office hours? LPT Overall compared against the National Benchmark

Area	% Yes*
National	72.66% (768/1057)
LPT Overall	56.84% (54/95)

* % calculated out of the total responding "yes" or "no"

Table 14: Q43. Do you have the number of someone from your local NHS mental health service that you can phone out of office hours? Analysed by admission type, compared against LPT overall

Admission type	% Yes*
LPT Overall	56.84% (54/95)
Elective	16.67% (3/18)
Emergency	66.23% (51/77)

* % calculated out of the total responding "yes" or "no"

Table 15: Q43. Do you have the number of someone from your local NHS mental health service that you can phone out of office hours? Analysed by ward name, compared against LPT overall

Ward name	% Yes*
LPT Overall	56.84% (54/95)
Ashby	64.71% (11/17)
Aston	37.93% (11/29)
Bosworth	75.00% (9/12)
Heather	58.33% (7/12)
Thornton	66.67% (8/12)

* % calculated out of the total responding "yes" or "no"

Table 16: Q43. Do you have the number of someone from your local NHS mental health service that you can phone out of office hours? Analysed by ethnicity (detailed), compared against LPT overall

Ethnicity (detailed)	% Yes*
LPT Overall	56.84% (54/95)
Asian or Asian British	66.67% (10/15)
White	56.94% (41/72)

* % calculated out of the total responding "yes" or "no"

Table 17: Emergency admissions analysed by ethnicity (detailed)

Ethnicity (detailed)	% emergency admissions*
LPT Overall	81.13% (86/106)
Asian or Asian British	88.24% (15/17)
White	77.22% (61/79)

* % calculated out of the total number of "elective" and "emergency" admissions

Contact with the hospital since leaving

- Compared to the national benchmark, LPT's service users were less likely to report having been contacted by a member of the mental health team since leaving hospital (84% nationally vs 73% at LPT, Table 18). Within LPT, this issue primarily affected elective admissions as opposed to emergency admissions (18% of elective admissions vs 84% of those admitted in an emergency, Table 19) with a greater tendency to affect Aston ward (43% on Aston Ward vs 73% for LPT overall, Table 20).

- Compared to LPT overall, White service users were less likely than Asian British service users to report having been contacted by a member of the mental health team since leaving hospital (although not to a statistically significant degree, 70% White vs 82% Asian British, Table 21), reflecting that White people were less likely to have been admitted as an emergency (77% of White service users vs 88% of Asian British Service users, Table 17). (2016 update: overall levels of contact with respondents since leaving hospital have since increased at LPT to match national levels—82% nationally vs 84% at LPT.)

Table 18: Q45. Have you been contacted by a member of the mental health team since you left hospital? LPT Overall compared against the National Benchmark

Area	% Yes*
National	84.07% (934/1111)
LPT Overall	72.55% (74/102)

* % calculated out of the total responding "yes" or "no"

Table 19: Q45. Have you been contacted by a member of the mental health team since you left hospital? Analysed by admission type, compared against LPT overall

Admission type	% Yes*
LPT Overall	72.55% (74/102)
Elective	17.65% (3/17)
Emergency	83.53% (71/85)

* % calculated out of the total responding "yes" or "no"

Table 20: Q45. Have you been contacted by a member of the mental health team since you left hospital? Analysed by ward name, compared against LPT overall

Ward name	% Yes*
LPT Overall	72.55% (74/102)
Ashby	89.47% (17/19)
Aston	42.86% (12/28)
Bosworth	83.33% (10/12)
Heather	84.62% (11/13)
Thornton	85.71% (12/14)

* % calculated out of the total responding "yes" or "no"

Table 21: Q45. Have you been contacted by a member of the mental health team since you left hospital? Analysed by ethnicity (detailed), compared against LPT overall

Ethnicity (detailed)	% Yes*
LPT Overall	72.55% (74/102)
Asian or Asian British	82.35% (14/17)
White	70.13% (54/77)

* % calculated out of the total responding “yes” or “no”

Appendix of analytical methods

Excluded and included groups

Data available from the Care Quality Commission's 2015 Mental Health Inpatient Survey, through Quality Health's reporting portal (Survey Online Analysis & Reporting - S.O.L.A.R.) were analysed against national and LPT-wide benchmarks as appropriate, in terms of ward and the available protected characteristic breakdowns: age group, gender, and ethnicity (although only statistically significant findings and findings that provide context are considered in the present report). Within each breakdown, Quality Health excludes subgroups with small numbers of respondents to reduce the risk that individuals can be identified from the analyses. The excluded and included groups for the age group, gender, ethnicity, and ward breakdowns are given in Table 22, Table 23, and Table 24, and Table 25 respectively.

Table 22: Excluded and included groups for the age group breakdown

Excluded group (number in group)	Included group (number in group)
16-24 (R)	National (1180) My Organisation (111) 25-34 (14) 35-44 (30) 45-54 (32) 55-64 (28)

R-Redacted

Table 23: Excluded and included groups for the gender breakdown

Excluded group (number in group)	Included group (number in group)
	National (1180) My Organisation (111) Female (65) Male (46)

R-Redacted

Table 24: Excluded and included groups for the ethnicity breakdown

Excluded group (number in group)	Included group (number in group)
Black or Black British (R) Mixed (R) Missing (R)	National (1180) My Organisation (111) Asian or Asian British (18) White (84)

R-Redacted

Table 25: Excluded and included groups for the ward breakdown

Excluded group (number in group)	Included group (number in group)
Beaumont (R) Belvoir Unit (R) Watermead (R)	Ashby (21) Aston (32) Bosworth (13) Heather (15) Thornton (14)

R-Redacted

Analysis of questions with yes or no response categories

For comparisons between LPT's respondents and the national benchmark, respondents were grouped according to whether they responded "yes" or "no." The odds of responding "yes" were calculated for the national benchmark and for LPT overall, and were compared using an odds ratio. Statistically significant deviations from even odds of responding "yes" are flagged in the results tables (α = .05). Please refer to Table 26 for a key to the colour coding used in these tables of analysis.

For comparisons with the LPT overall benchmark, LPT's respondents were analysed into breakdown groups (e.g., by age band, gender or service) and also grouped according to whether they responded "yes" or "no." The odds of responding "yes" were calculated for each breakdown group and compared to the odds of responding "yes" for those not in the breakdown group using an odds ratio. Statistically significant deviations from even odds of responding "yes" are flagged in the results tables (α = .05, Bonferroni correction applied for multiple comparisons).

Analysis of questions with multiple response categories

For questions with multiple response categories, the distributions of respondents across response categories were analysed into breakdown groups (e.g., by age band, gender or unit) and compared with the distribution of respondents across response categories in the benchmark (either the national distribution or the distribution for LPT overall, by breakdown group). Please refer to Table 26 for a key to the colour coding used in these tables of analysis.

Overrepresentation or underrepresentation of a breakdown group (e.g., a specific age band) in a certain response category was assessed relative to its level of representation in the benchmark for that response category (Chi-Squared Test or Fisher's Exact Tests, α = .05, followed by *post-hoc* analyses of standardised residuals with the Bonferroni correction applied). Statistically significant deviations from proportional representation are flagged in the results tables.

Table 26: Key to interpreting tables of results

Reference benchmark (national benchmark or LPT overall)
Significantly better than the reference benchmark (all those not in the subgroup), to a large degree
Significantly better than the reference benchmark (all those not in the subgroup), to a medium degree
Significantly better than the reference benchmark (all those not in the subgroup), to a small degree
Not significantly different from the reference benchmark (all those not in the subgroup)
Significantly worse than the reference benchmark (all those not in the subgroup), to a small degree
Significantly worse than the reference benchmark (all those not in the subgroup), to a medium degree
Significantly worse than the reference benchmark (all those not in the subgroup), to a large degree

(Essentially, greens indicate more positive outcomes and yellows/oranges/reds indicate more negative outcomes.)