Gloucestershire Adult Mental Health and Wellbeing Needs Assessment

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1   Executive summary

Introduction, mental health concept and policy context

The requirement for an adult mental health needs assessment was identified as a part of the development of a new local Mental Health and Wellbeing strategy and commissioning plans. The key objectives are to understand how the mental health needs of Gloucestershire residents aged 18 years and over, current and future prevalence of mental wellbeing and mental illness and service provision in Gloucestershire align with each other and to highlight inequalities emerging from the lack of or inadequate alignment. Recommendations are made at the end of each section and then categorised at the end of the document (Chapter 11).

The sources of data include a wide range from nationally published indicators to locally collated data from service providers. However, there are limitations in drawing conclusions based on this data, due to their quality and gaps.

Mental health is more than just the absence of illness, and neither mental nor physical health can exist alone. The essence of mental wellbeing is the fulfilment of personal and social goals and contribution to the community. Mental illness can be defined as the presence of clinically specified symptoms or behaviours obstructing emotional, cognitive and social function.

There are many national and local policies covering all aspects of mental health and wellbeing. The local *Gloucestershire Mental Health & Wellbeing Strategy, Crisis Concordat Action Plan, Suicide Prevention Strategy and Sustainability & Transformation Plan* are aligned with the objectives of the national strategies: *No health without mental health***,** *Mental Health Crisis Care Concordat programme, Preventing suicide in England* and the *Five Year Forward View for Mental Health.* The main focus of these policies is to ensure that the effective prevention is in place and to improve the services and practices to make sure people get the help they need.

Gloucestershire Population Profile

Gloucestershire has a lower percentage of adults aged under 49 years and a higher percentage of adults aged over 50 years than the English average. There are more females than males over 50 years old, and nearly twice as many females as males aged over 85 years.

Between 2014 and 2025 the adult population will increase by 8.2%; the population aged over 75 years will increase rapidly, however there will be fewer people aged between 20 and 24 and between 40 and 54 years. Gloucester is predicted to have the highest increase in number of people; Tewkesbury will have the highest increase in proportion of population; and Forest of Dean will have the smallest increase in number and proportion.

These key points have potential implications for social isolation, loneliness, bereavement, living with long term conditions and disabilities, carers' responsibilities and suicide prevention, and suggest an opportunity to "design in" environments that promote good mental health.

Determinants of mental health and wellbeing

Mental health and wellbeing depends on individual protective factors (such as resilience, inclusion, control and participation), influenced by factors ranging from population characteristics (such as age, gender, ethnicity), the socioeconomic circumstances in which people find themselves, to wider determinants of health (such as physical security, environment, meaningful activity, good quality food, leisure, education) and by equity. These determinants may protect or put at risk mental health and wellbeing.

Overall Gloucestershire is a relatively affluent county; however, there are 13 neighbourhoods with high levels of deprivation - this has increased by five since 2010.

With the exception of the rate of people living alone and the rate of hospital admissions for alcohol, Gloucestershire performs better than the national average and similar or better than the regional average for the key determinants of mental health, such as population characteristics and social and economic factors. However, there are specific population groups, who are more vulnerable to poor mental health.

Vulnerable groups

Evidence suggests that the following groups can be at the higher risk of having poor mental health:

- People with a learning disability or autism
- People with a physical disability or life limiting illness
- People who have suffered domestic abuse and sexual violence
- People with substance misuse problems
- Care leavers
- Homeless people
- People within black and minority ethnic communities
- Gypsy and Travellers

- People who are unemployed
- People who are in financial debt
- Carers
- Refugee and asylum seekers
- People who are lesbian, gay, bisexual or transgender (LGBT)
- People with dementia
- Members of the Armed Forces Community
- Adults who are in contact with the criminal justice system

In Gloucestershire, the prevalence of most of these groups (where prevalence could be measured and compared with the national equivalent) was lower or similar than the national average. Some of the groups have a higher prevalence within individual districts of the county. For example, compared with the national average, the rate of asylum seekers receiving support in Gloucester is higher than the national average.

A higher occurrence of mental ill health within these groups is associated with a range of risk factors such as trauma, discrimination, isolation or culturally unsuitable or inaccessible mental health treatment.

Mental and emotional wellbeing in Gloucestershire

The national mental wellbeing survey measures people's outlook on life satisfaction, feeling worthwhile, happy and anxious. Self-reported emotional wellbeing scores of Gloucestershire's residents are in line with the English average, but amongst the lowest (highest in case of anxiety levels) as compared with their statistical neighbours. Gloucestershire also rates as one of the worst among statistical neighbours in terms of the proportion of people who rate their personal well-being at the lowest levels.

The effect of stigma and discrimination on mental and emotional wellbeing is an important factor. A survey from nearly a decade ago highlighted that in general Gloucestershire residents are more tolerant, supportive and understanding towards people with mental health problems and better informed about mental health than the country as a whole.

Out of Gloucestershire's top 20 areas with residents most likely to experience social isolation, 9 are in Gloucester, 7 in Cheltenham, 2 in Cotswold and 1 in Tewkesbury and Stroud each. Local adult carers feel more socially isolated than those living in England, South West and the nearest statistical Local Authorities.

An evaluation of the social prescribing scheme in Gloucestershire highlighted that nearly half of patients were referred for concerns relating to mental health and wellbeing.

Mental health conditions among the Gloucestershire population

The prevalence of most Common Mental Health Disorders (CMHDs) in Gloucestershire is similar to the national average, with the prevalence of depressive disorder being lower than the national average and one of the lowest within the region and 10 most similar CCGs. It is predicted, that by 2021 the prevalence of mixed anxiety and depressive disorder and of generalised anxiety disorder will decrease slightly, while the prevalence of the reminder of disorders will stay at similar levels. The hospital admission rate in Gloucestershire for depression and for neuroses is lower than the national average.

The prevalence of people with severe mental illness on GP practice registers in Gloucestershire is lower than the national and regional average. The A&E attendance rate for a psychiatric disorder is significantly lower than the national average, but one of the highest rates within the region.

The local audit on mental health conditions within Primary Care highlighted that 3.3% of the population registered with GPs were diagnosed with a mental illness. Of those, 65% were diagnoses of anxiety. There is a clear relationship between surgeries in the most deprived areas of Gloucester city and a higher proportion of patients with mental health issues, based on the audit's results, although this correlation is not found elsewhere in the county.

The emergency hospital admission rate for self-harm in Gloucestershire is higher than the national average and the highest among nearest statistical neighbours. Females and younger people are at higher risk. Many admissions are repeat admissions, especially among females. There is a strong association between the highest rates of self-harm admissions and areas of highest deprivation in Gloucester and Cheltenham. However, there is no such correlation in other districts. The most frequent methods of self-harm amongst those admitted were self-poisoning and laceration. Note,

these findings are based only on reported self-harm events, which are severe enough to warrant hospital admission and do not represent the real prevalence of self-harm.

The overall Gloucestershire mortality rate from suicide is similar to the national, regional and statistical neighbours' rate. In line with the national figures, male suicide rates are higher than female rates. The most concerning suicide rates occurred for males aged 35-64 – for whom the rate is higher than the national rate and the highest among statistical neighbours. There is no data on local rates of female suicide by age, due to small numbers.

Mental Health Services

In Gloucestershire the services providing help in all areas of mental health and wellbeing range from commissioned and non-commissioned voluntary organisations; primary care, e.g. GP services; through to the specialist mental health and learning disability services provided by 2gether NHS Foundation Trust.

Section 136

Section 136 of the Mental Health Act allows police to remove a person with a mental disorder in need of immediate care to a Place of Safety (POS), if this person poses a risk to others or themselves. Locally, section 136 detentions are more likely to occur out of hours; around a third of detentions are of intoxicated patients, around 68% of all detentions require support from specialist mental health services and 11% do not require any follow up. There has been a significant upward trend in the number of detentions at the time of writing, although pilot projects to reduce this number have subsequently been implemented. A high proportion of repeat detentions are accounted for by a minority of users.

Sections 2, 3, 4

Sections 2, 3, and 4 of the Mental Health Act define conditions under which a person is detained in hospital due to establishing or treatment of mental health disorder. Out of all detentions, section 2 is most likely to occur, while section 4 is rarely used. Local detentions under sections 2 and 3 show that young adults (aged 20-29), older people (70-89) and people of Black/ African/ Caribbean/ Black British ethnicity are overrepresented.

2gether NHS Foundation Trust services

The majority of the 2gether NHS Foundation Trust's services are provided within the community. Four inpatient care units provide assessment, treatment and/ or recovery for patients with acute mental health needs.

Service data provided for this needs assessment is only available for the numbers of events or bed days (one event represents a single occurrence that happened in a service) and therefore the analysis of referrals or activities by unique individuals is not included. The activities within the services and mental health acute hospitals demonstrate various trends over the years, however most of the services experienced significant increase in activities at the beginning of 2017/18.

<u>IAPT</u>

One of the biggest services delivered by 2gether is Improving Access to Psychological Therapies (IAPT) programme, also referred to as 'Let's Talk'. This service offers talking therapies for people with mild to moderate anxiety and/or depression, as well as other mental health conditions.

Changes in the IAPT referral system contributed to a decrease in activities, such as referrals, entering and completion rates - these rates were lower in Gloucestershire than the national average for the first half of 2016/17. The average waiting time to enter treatment is higher than in England; however the national target of 75% of all new referrals to begin the treatment within 6 weeks is often met. The recovery national target of 50% is not achieved, although the recovery rate has shown significant improvement since the beginning of 2016.

The numbers of referrals to IAPT are lowest for the most deprived areas, which is opposite to the national trend. Additionally people living in these areas are less likely to enter the treatment and complete a course of treatment than in other areas, with the outcomes of their treatment also being lower.

<u>Other services</u>

Within the Gloucestershire Mental Health and Wellbeing Service, people living with an ongoing functional mental illness can be supported by: one to one support, peer development, use of 'safe spaces' and participating in the community activities. The majority of services users have a single relationship status. One of the main service challenges is an underrepresentation of service users from Black and Ethnic Minorities groups.

The Gloucestershire Self-Harm helpline offers support with coping strategies and exploring self-harm through a call, text or web chat. Service user numbers have increased with the majority of service users being female. Similarly to other mental health services, this service struggles in reaching Black and Ethnic Minority groups.

Non-commissioned Voluntary and Community Sector (VCS) counselling services are more likely to be used by females than males. The main reasons for accessing counselling are bereavement, relationship problems, depression and anxiety.

<u>Prescribing data</u>

The overall primary care prescribing spend on mental health is slightly higher in Gloucestershire than the national average. The cost of hypnotics and anxiolytics (used for treatment of several anxiety and insomnia) is also higher than national average.

Although the total number of items and cost of antidepressant drugs is the highest among all mental health prescribing drugs, the weighted cost rate is at the similar level as the England average. This is not in line with the depression prevalence, which is lower in Gloucestershire than the national average.

<u>Perceived and felt needs</u>

The perceived and felt needs of service users and other stakeholders were not gathered for the purpose of this needs assessment and the overview is based on views and feedback presented in 2gether NHS Foundation Trust reports, Healthwatch Gloucestershire summaries and a Mental Health and Wellbeing Stakeholder Event. Common themes from this feedback include:

- Accessing services, including waiting times and re-presentation
- User experience, including communication and information sharing
- Crisis service awareness, access and availability
- Joining up of services and compliments for services offered by the voluntary and community sector
- Support and information for relatives and carers
- The needs of specific groups, e.g. the armed forces.

2   Introduction

Purpose

The purpose of this adult mental health needs assessment is to understand how the current mental health service provision in Gloucestershire is aligned to local mental health needs in order to inform the local Mental Health and Wellbeing strategy and commissioning intentions. Key recommendations address potential unmet need for mental health promotion and service provision and aim to reduce health inequalities.

The main objectives of this adult needs assessment are:

- To achieve a shared understanding of the mental health needs of Gloucestershire residents aged 18 years and over, in order to inform the commissioning and provision of services

- To understand current prevalence of mental wellbeing and mental illness in Gloucestershire and consider how it may change in the future

- To describe current services and assess if they are appropriate and meet the need in Gloucestershire

- To highlight inequalities in mental health provision and areas where resource allocation and distribution do not match need for services.

Scope

This needs assessment considers the needs of and service provision for the Gloucestershire population aged 18 years and over. The equivalent needs assessment concerning children and young people was completed in 2015: *Gloucestershire's Transformation Plan for Children & Young People's Mental Health & Wellbeing*, it is available at:

https://inform.gloucestershire.gov.uk/viewpage.aspx?c=page&page=ChildrenandYoungPeople

Although the prevalence of dementia and services provided for people with dementia are out of scope in this needs assessment, the demographics of people with dementia are included, due to the higher risk of developing mental health problems.

The broad scope of this needs assessment is categorised into seven main areas:

1. Gloucestershire's population profile
2. Key determinants of mental health and wellbeing
3. Groups who are vulnerable to developing poor mental health
4. Emotional wellbeing in Gloucestershire
5. Prevalence of mental health conditions
6. Use of mental health services (statuary and voluntary)
7. Perceived and felt needs

This document complements other local needs assessments and strategies including *Therapeutic Services for Victims of Sexual Violence in Gloucestershire, Health and Well-Being of Trans People in Gloucestershire and Bristol, Personality Disorders Recommendation Report, Mental Health Crisis Care Concordat Action Plan* and *Intoxication and Mental Health Assessment.*

Data

This needs assessment is based on the data available during the process of completion. The sources of data include a wide range from the nationally published indicators to the locally collated data from service providers. Caution should be exercised when drawing conclusions from data based on the different sources. Where possible, the local indicators are compared with national, regional and statistical neighbours'[1] averages in order to benchmark the local position. The gaps and caveats regarding the quality of data are acknowledged in specific sections. In some cases, further investigation of data sources or improvement on data availability is recommended.

2.1 Concepts of mental health, mental wellbeing and mental illness

Mental health

Due to variances in values across countries, cultures, classes, and genders there is lack of consensus on the definition on mental health. The World Health Organization (WHO) proposed the definition of mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a

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[1]Gloucestershire Nearest Neighbours are based on the model of similarities between Local Authorities/ Clinical Commissioning Groups, which was built by the Charter of Public Finance Accountancy (CIFPA). More information is available at CIFPA website: https://www.cipfastats.net/resources/nearestneighbours/ Gloucestershire statistical neighbours include Warwickshire, Worcestershire, Suffolk, Somerset, North Yorkshire, Leicestershire, Staffordshire, Buckinghamshire, West Sussex, Oxfordshire, Devon, Nottinghamshire, Essex, Derbyshire and Hampshire. NHS Gloucestershire CCG nearest neighbours include NHS West Hampshire CCG, NHS Somerset CCG, NHS Wiltshire CCG, NHS Southern Derbyshire CCG, NHS Kernow CCG, NHS East and North Hertfordshire CCG, NHS Ipswich and East Suffolk CCG, NHS Mid Essex CCG, NHS Nene CCG and NHS West Kent CCG

contribution to her or his community".[2] This emphasises that mental health should be understood at the broader level, not as an absence of mental illness, but as the foundation for positive wellbeing and positive functioning for individual and for a community. Neither mental nor physical health can exist alone.

The terms 'mental health problems', 'poor mental health', 'mental ill health' and 'mental distress' are used in this needs assessment to refer to the absence of or reduced level of mental health, as distinct from a diagnosable mental illness.

Mental wellbeing

Mental wellbeing has been defined by Foresight as a "dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in the community".[3] Being productive and contributing is in the essence of mental wellbeing. Section **5.1** of this needs assessments summarise the actions on how to improve mental wellbeing.

Mental illness

The phrase 'mental illness' is used in this needs assessment to refer to "symptoms that meet the criteria for clinical problems: diagnosis of mental illness, or symptoms at sub-clinical threshold which interfere with emotional, cognitive and social function".[4] Mental illnesses can occur more or less commonly and may differ in severity. Examples include Common Mental Health Disorders (CMHD) (Section **8.1**) and severe and long-lasting mental health illnesses, such as schizophrenia (Section **8.2**).

3 Mental Health Policy Context – national and local

Mental Health & Wellbeing Strategy

The national strategy for mental health, *No health without mental health*[5], was published in 2011 and set out six shared high-level mental health objectives:
- More people will have good mental health

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[2] World Health Organization (2014) *Mental Health: A state of wellbeing,* available at: http://www.who.int/features/factfiles/mental_health/en/, accessed on 25/09/2017
[3] Foresight Mental Capital and Wellbeing Project (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, Final Project Report, The Government Office for Science, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292450/mental-capital-wellbeing-report.pdf, accessed on 25/09/17
[4] Mental Health Improvement Group NHS Health Scotland (2010*) Mental Health Improvement Terminology and Working Understandings*, available at http://www.healthscotland.com/uploads/documents/13619-Terminology%20and%20Working%20Understandings%20-%20Final.pdf, accessed on 25/09/17
[5] HM Government (2011) *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf (Accessed 3rd November 2016)

- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

In Gloucestershire, the Mental Health and Wellbeing Partnership Board developed a local strategy that was aligned with these six objectives and partners continue to deliver an action plan to meet these objectives through a range of sub groups, activity and engagement with stakeholders, including people with lived experience of mental illness.

Local partners are currently reviewing the Gloucestershire Mental Health and Wellbeing strategy in light of national and local changes (see below). It is envisaged that this will be completed in early 2018.

Mental Health Crisis Care Concordat

Closely aligned with the strategy, the national Mental Health Crisis Care Concordat programme[6] is a national agreement between services and agencies involved in the care and support of people in mental health crisis. It sets out how organisations will work better together to make sure that people get the help they need when they are having a mental health crisis and it focuses on four main areas:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well.

Gloucestershire partners – including the Gloucestershire Clinical Commissioning Group (CCG), Gloucestershire County Council (GCC), Gloucestershire Police, 2gether NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust and South Western Ambulance Services NHS Foundation Trust – have produced a local Crisis Concordat Action Plan to improve local services and practice to make sure people get the help they need in a crisis.

Suicide Prevention Strategy

The national suicide prevention strategy, *Preventing suicide in England[7],* was published in 2012 and set out two overall objectives:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

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[6] HM Government (2014) *Mental Health Crisis Care Concordat*. http://www.crisiscareconcordat.org.uk/about/ (Accessed 14th November 2016)

[7] HM Government (2012) *Preventing suicide in England: A cross-government outcomes strategy to save lives*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf (Accessed 3rd November 2016)

In Gloucestershire, the Suicide Prevention Partnership Forum (GSPPF) reviewed its Suicide Prevention Strategy in 2015, aligning its priorities with the national strategy and identifying specific local issues for attention through its suicide audit process. The Gloucestershire priorities are:

- Reduce the risk of suicide in high risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring.

New and forthcoming policy changes

In February 2016, an independent Mental Health Taskforce brought together health and care leaders, people who use services and experts in the field to create a *Five Year Forward View for Mental Health* for the NHS in England[8]. In response, NHS England published an Implementation Plan[9] in July 2016, to set out the actions required by local areas to deliver the recommendations of the Taskforce. These actions focus on improvements to services including children and young people's mental health; perinatal mental health; common mental health problems; community, acute and crisis care; secure care pathway; health and justice; and suicide prevention. The plan also includes cross-cutting actions to improve infrastructure, workforce development and other underpinning areas.

At the time of writing this needs assessment, Gloucestershire health and social care partners have developed a Sustainability & Transformation Plan (STP) to set out how the NHS funding challenge will be handled. Gloucestershire's plan sets out priorities to:

- Place greater emphasis on prevention of illness and self-care with investment to support it
- Provide more joined up care and support in people's homes and in the community
- Explore options to bring together some hospital services into 'centres of excellence' to ensure safety and quality
- Develop a 'best use of medicines' programme and priority fund the drugs and treatments that have the greatest health benefit for the population
- Develop a sustainable workforce
- Make the most of new technologies.

Gloucestershire partners with continued input from a wide range of stakeholders, including people with lived experience and their carers are in the process of reviewing and refreshing its local Mental Health & Wellbeing strategy to ensure it is aligned with these policy developments.

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[8] Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (Accessed 14th November 2016)
[9] NHS England (2016) *Implementing the Five Year Forward View for Mental Health.* https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf (Accessed 14th November 2016)

4   Gloucestershire population profile

This section provides a brief summary of Gloucestershire's population aged 18 and over. There is additional information in regards to the population's social and economic profile in Chapter 5: **Determinants of mental health and wellbeing**. For a more in depth population profile, please refer to Understanding Gloucestershire – A Joint Strategic Needs Assessment 2015.[10]

Key points in this section are:
- Gloucestershire has a lower percentage of people aged 18-49 and higher percentage of people aged 50+ compared with the English average
- The number of females is higher than males from the age bands of 50+; this difference increases with age, all age bands below 50 are evenly distributed
- There are nearly twice as many females as males aged 85+
- Gloucestershire's adult population will increase by 8.2% between 2014-2025, which indicates slower yearly average population growth than between 2010-2014
- It is predicted that between 2014-2025 there will be an increase of people aged 18-19, 25-39 and those over 55 years old, and smaller numbers of people aged 20-24 and 40-54 years old
- The highest decrease is expected for the population aged 45-49 years old, which will be 20% less in 2025 compared to 2014
- The elderly population of 75+ year olds will grow rapidly between 2014-2025, 3 times faster than between 2010-2014
- Gloucester is predicted to have the highest increase in number of population; Tewkesbury will have the highest increase in proportion of population; Forest of Dean will have the smallest increase in number and proportion
- Predicted changes in Gloucestershire's population indicate that by 2025 there will be 19,933 more 18+ year old females and 20,337 more 18+ year old males.
- The elderly population of males over 80 years old will increase by 2025 at a higher pace than females, which will result in the ratio between female and male population of that age reducing from 2:1 to 3:2

These key points have implications for social isolation, loneliness, bereavement, living with long-term conditions and disabilities, carer's responsibilities, suicide prevention, and suggest an opportunity to "design in" environments that promote good mental health.

4.1   Current population by age, sex and district

According to ONS Annual Mid-year Population Estimates, the total population aged 18+ for Gloucestershire was 487,526 in 2014, which represents a rise of approximately 18,000 (4%) people since 2010.[11] [12] The population age structure presents as:

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[10] Gloucestershire Health and Wellbeing Board (2016) *Understanding Gloucestershire, A Joint Strategic Needs Assessment 2015,* available at http://www.gloucestershire.gov.uk/inform/
[11] ONS (2015) *Annual Mid-year Population Estimates:2014,* available at www.ons.gov.uk
[12] ONS (2013) *Revised Annual Mid-year Population Estimates: 2001 to 2010*, available at www.ons.gov.uk

- 24.4% aged 18-34
- 25.2% aged 35-49
- 25.0% aged 50-64
- 13.7% aged 65-74
- 11.7% aged 75 and over.

Compared to the national average, Gloucestershire has a slightly smaller proportion of working age adults (18-64); England - 77.7% and Gloucestershire - 74.6%. Gloucestershire has a lower percentage of people aged 18-49 and higher percentage of people aged 50+ than the English average.

The proportion of females is very slightly higher than males, respectively 51% and 49% of the whole population; in 2014 there were 12,000 more females than males across all ages. The proportion of females and males of ages up to 64 ranges between 49% and 51%. However, there are more significant gender differences for older age bands. The number of females is higher from the age of 50 (51%), and the proportion of females increases with older age. The largest discrepancy is seen in the over 85 year olds, where there are nearly twice as many women than men (5,458 more females than males). The difference is largely attributable to the gender life expectancy.

4.2 Population projection

Population projections are based on the ONS mid-year population estimates and provide an indication of the future proportion and age structure of the population in relation to the year 2025.

Figure 1 shows how the Gloucestershire population may change in the future. The number of residents aged 18+ is projected to increase from 487,526 in 2014 to 527,270 in 2025 (8.2% increase), which is in line with the English average – 8.1%.[13]

Up to the year 2025 the average increase in Gloucestershire's population aged 18+ is predicted to be 0.7% yearly. This indicates that the dynamic of population growth is smaller than it was in 2010-2014, where the average yearly change was 1%.

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[13] *Subnational population projections for England: 2014-based projections*, ONS, 2016, www.ons.gov.uk

Figure 1: Gloucestershire population change 2014-2025 by 5 year age bands and sex
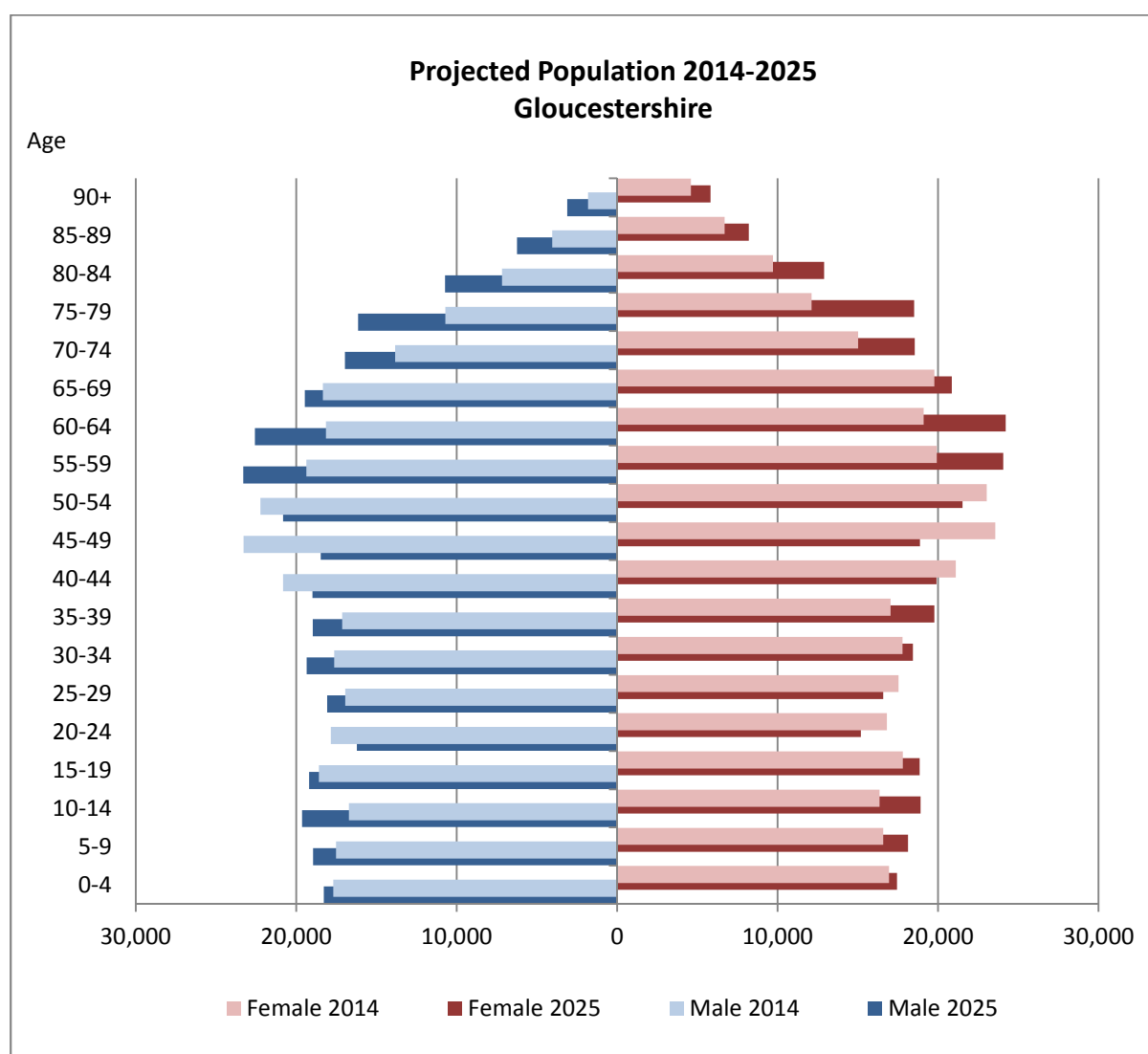
Source: ONS (2016) *Subnational population projections for England: 2014-based projections*

4.2.1   Population projection by age and sex

Figure 1 indicates that by the year 2025 a population decrease from 2014 is projected for people aged 20-24 and 40-54; there will be 3,260 fewer people aged 20-24 (-9%) and 15,480 fewer people aged 40-54 (-12%). The highest decrease is expected for the age bands 45-49, which will be -20% (9,518 fewer people).

By the year 2025 an increase from 2014 is predicted for:

- young people aged 18-19 years old; 657 more people (5%)
- people aged 25-39; 7070 more people (7%)
- people aged 55+; 51,282 more people (26%). Within this age group, the smallest increase dynamic is expected for 65-69 year olds (9%). The population of people aged over 75 shows to have the most rapid growth; projections suggest that there will be an additional 24,814

people by 2025 (44%). The average yearly growth between 2014 and 2025 (4%) will be 3 times higher as compared to the 2010-14 average yearly growth (1.3%). The growth and the dynamic of the growth of the population aged 75+ in Gloucestershire are higher than the English average (increase of 38% in 2025, yearly average 3.4%).

By 2025, there will be 19,933 (7.9%) more over 18 year olds females and 20,337 (8.6%) more over 18 year olds males than in 2014. The highest increase in numbers of females and males populations is expected for the age group of 75-79 year olds –there will be 6,389 (52.8%) more females and 5,447 (50.9%) more males. The largest decrease in numbers and proportions is predicted for males and females aged 45-49 years old – there will be 4,706 (-20%) fewer females and 4,812 (-20.7%) fewer males.

The population of females and males from most age groups will change in similar ratios. However, the exceptions are:

- The highest discrepancy in female and male projections concerns the age group of 25-29 year olds – it is predicted that the number of females in that group will decrease by 5.5% and the number of males will increase by 6.6% (Figure 1). For the following age group of 30-34 years old, the male population is predicted to increase at a higher rate than females, retrospectively 9.8% and 3.6%. As a result, by 2025 there will be more males than females in the age group 25-34 years old, as opposed to 2014.
- The numbers of females 35-39 years old will increase by 16%, while numbers of males from this age group will increase only by 10.6%.
- The population of males aged over 80 will increase at a higher rate than females. It is predicted that there will be 49.6% more males aged 80-84 (female 32.6%), 54.5% more males aged 85-89 (female 22.8%) and 71.7% more over 90 year old males (female 26.6%). This will result in the reduction of the difference between the numbers of over 85 years old females and males - as described in section 4.1 in 2014 there were nearly twice as many women as men, by 2025 it will be 1.5 times more females than males

4.2.2   Population projection by district

As indicated in Figure 2 the population will increase across Gloucestershire districts between 2014-2025. Gloucester is expected to have the highest increase in number of population, which is 9,217 (9.5%) more people. However, Tewkesbury is estimated to have the highest population proportion increase, which is 12.2% (8,365 people).

Forest of Dean's population is predicted to have the smallest number and proportion increase – there will be 3,830 more people living in this district, which is equivalent to a 5.7% of increase between 2014-2025.

Gloucester and Stroud populations will increase at a lower rate between 2014 and 2025 than it was in 2010-2014. Gloucester's average yearly increase will fall from 1.6 % in 2010-2014 to 0.9% in 2014-25; for Stroud retrospectively: 1.1% to 0.7%. In Cheltenham, Cotswold, Forest of Dean and Tewkesbury the average yearly increase will stay at a similar level for the years indicated above.

Populaton number and projections for people aged 18+ Districts

	Cheltenham	Cotswold	Forest	Gloucester	Stroud	Tewkesbury
2010	91,852	67,033	66,097	91,699	87,730	65,162
2014	93,571	68,774	67,572	97,453	91,704	68,452
2025	99,691	73,594	71,402	106,670	99,096	76,817
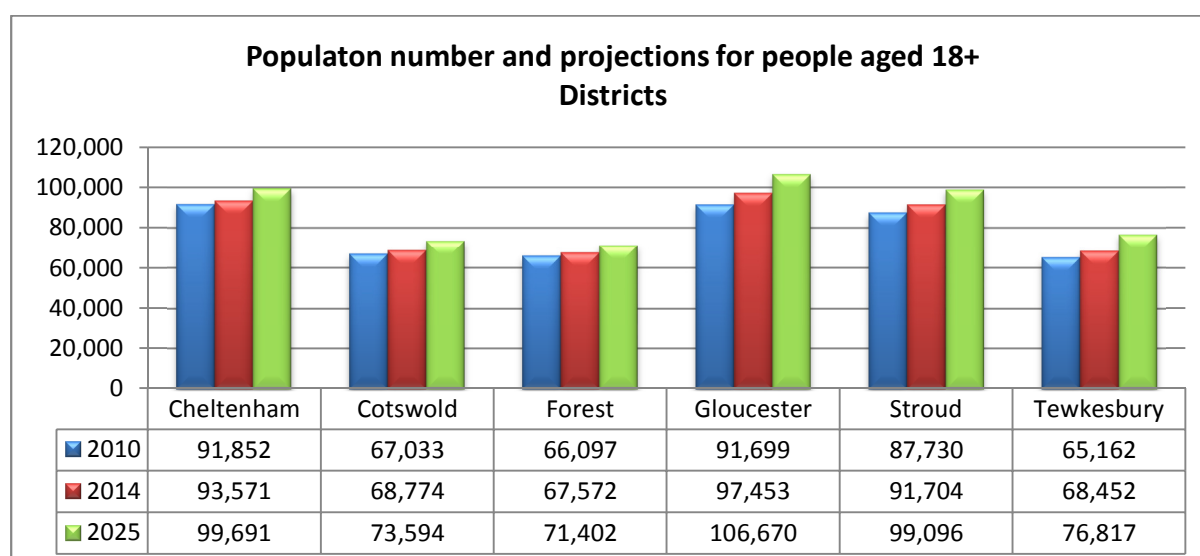
Source: ONS (2016) *Revised Annual Mid-year Population Estimates: 2001 to 2010,* ONS, 2013
Subnational population projections for England: 2014-based projections,

4.3   Population summary with regards to mental health

The changes in Gloucestershire's population may have implications on public mental health, such as:

- A growing population of older people may have an impact on social isolation and loneliness prevalence, bereavement and living with long-term conditions and disabilities - this can lead to a higher risk of experiencing poor mental health or mental illness, e.g. depression. Demand for carers will increase, especially as the growth rate of older people is proportionally larger – the number of carers is likely to rise not only within younger and middle age groups, but also within the older population. Many carers face their own health problems in addition to coping with the needs of the person they are carrying for, which increases the risk to their own health and wellbeing.[14]

- Discrepancies in projections by gender – this suggests there will be an increase in men aged 25-29 and a decrease in women in that age group – given that this is a high risk age for men for suicide, this may indicate a need for continued emphasis on reaching men in suicide prevention activity .

- A growing population will need a place to live, which creates potential for housing development – this might suggest an opportunity to "design in" environments that promote good mental health.

Chapter 4 recommendations:
The population projections suggest that we should consider:

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[14] Faculty of Public Health and Mental Health Foundation (2016) *Better Mental Health for All: A Public Health Approach to Mental Health Improvement*, available at
http://www.fph.org.uk/uploads/Better%20Mental%20Health%20For%20All%20FINAL%20low%20res.pdf

4.1.1	Promotion of good mental health in ways that best reach and are appropriate to older people, e.g. 'Keeping Active' with opportunities that can be tailored to older people (e.g. five ways to wellbeing described in Section **5.1**)
4.1.2	Ensuring training, e.g. Mental Health First Aid (MHFA), is promoted/accessible to people working with older people
4.1.3	Ensuring mental health support and services are accessible to and appropriate for older people
4.2	Engagement with local planning authorities to ensure that housing growth takes into account the wider determinants of good mental health and can create healthy living environments.

5   Determinants of mental health and wellbeing

This chapter gives an overview on factors that are considered to be associated with Mental Health and Wellbeing. The key determinants are presented in relation to Gloucestershire's demography and compared with Gloucestershire's statistical neighbours. Deprivation – a key determinant of mental wellbeing - is explored in greater detail in this section.

Key points in this section are:

- Determinants can have a protective or harmful effect on mental health and wellbeing
- Mental health and wellbeing is an outcome but also a determinant
- Gloucestershire's risks rate lower than the national average and similar or lower than the regional average for the key determinants of mental health
- Although Gloucestershire is not a deprived county, there are 13 neighbourhoods with high levels of deprivation; this is 5 more neighbourhoods than there were in 2010
- These key points illustrate the importance of considering a targeted approach in providing Mental Health services.

5.1   Summary of research/ knowledge

A comprehensive diagram (**Figure 3**) from the Mental Well-being Impact Assessment (MWIA) published by the National MWIA Collaborative captures the broad range of factors that impact on mental health and wellbeing. Mental health and wellbeing is determined by individual factors and by population characteristics, by the socioeconomic circumstances in which persons find themselves and the wider determinants of health.[15]

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[15] National MWIA Collaborative (England) (2011) *Mental Well-being Impact Assessment. A toolkit for well-being*, available at www.apho.org.uk

Figure 3: A dynamic model of mental wellbeing for assessing mental wellbeing impact

The four protective factors are influenced by population characteristics, wider determinants and the core economy. All of which are influenced by levels equity and social justice.
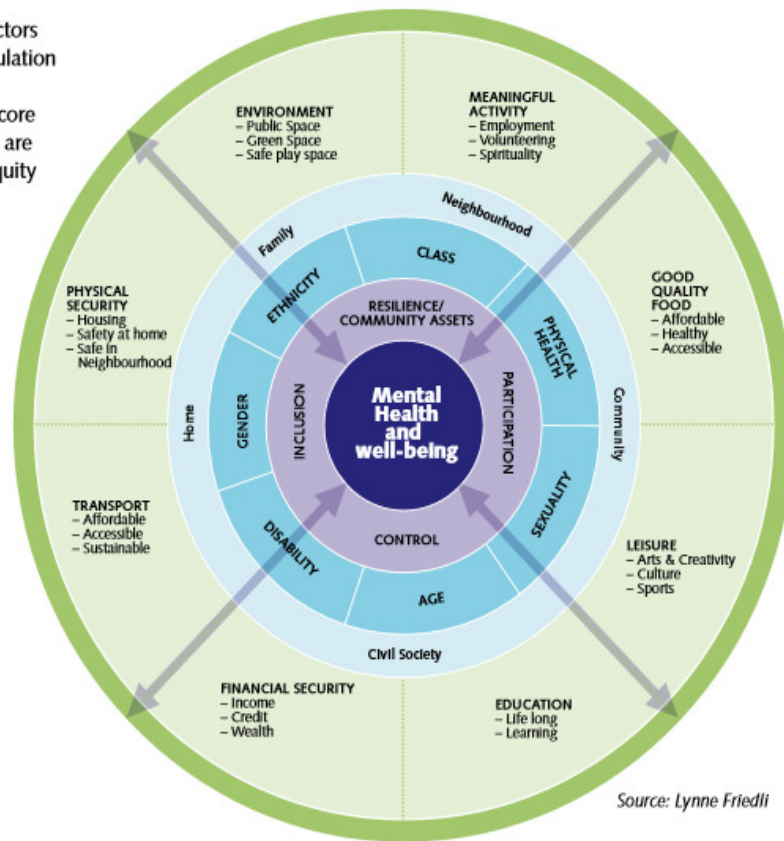
Source: Lynne Friedli

Source: National MWIA Collaborative (England) (2011) *Mental Well-being Impact Assessment. A toolkit for well-being*

Protective factors

Core protective factors which can have a significant influence on mental wellbeing are:

- Enhancing control - where individuals and communities have control over their lives. People who feel in control of their lives are more likely to feel capable of taking control of their health
- Increasing resilience and community assets - community resilience can be built by social networks, which help communities able to tackle common problems. Community assets can include: know how, tradition, safety, local democracy, social networks, sport, culture, etc.
- Facilitating participation – this is the level of people's involvement and commitment outside their household, for example volunteering and collective action.
- Promoting social inclusion – people are able to access opportunities such as employment, education, leisure.

Five ways to mental wellbeing

Evidence suggests there are five actions that people can take to improve their mental wellbeing, and reduce mental health problems. These actions, developed by the New Economics Foundation on behalf of Foresight include:

- **Connect** – investing time in building and developing connections with others, for example, family, friends, colleagues and neighbours can support and enrich everyday life.
- **Be active** – any exercise, from stepping outside, going for a walk or run, cycling, playing a game, gardening and dancing will help discover enjoyable and suitable activities, which result in 'feeling good'.
- **Take notice** – being more aware of the present moment, including feelings and thoughts, helps appreciate what matters, reaffirm life priorities and enhance self-understanding.
- **Keep learning** – setting enjoyable challenges and learning new skills enhance confidence and give a sense of achievements.
- **Give** – individuals who report a greater interest in helping others are more likely to rate themselves as happy. Participating in wider community life is rewarding and creates connections with people.[16]

Population characteristics

Population characteristics that impact on mental health and wellbeing include:

- Age – the foundations of good mental health begin in the perinatal period and early childhood. In adolescence, the protective factors include a connection to school, family, friends, chances to succeed and problem solving skills. The five main areas that influence the mental health of adults, especially in older age, are discrimination, participation, relationships, physical health and poverty.
- Gender – gender affects the risk and protective factors and the way of expressing experiences of mental distress. Females are more likely to experience depression, anxiety and self-harm (Section **8.6.1**), and are also more vulnerable to poverty, unemployment, domestic violence and sexual violence (Section **0**). Suicide, drug and alcohol use, crime and violence are more prevalent in males (Section **8.6.2**).
- Ethnicity/race – variances in levels of mental wellbeing and prevalence of mental health disorders in different ethnic and racial groups result from a combination of factors, such as socio-economic factors, racism, diagnostic bias, and cultural and ethnic differences, and the way of presenting, perceiving and interpreting mental health distresses. Different cultures may also develop different reactions of coping with psychological stressors. Section **0** explores the higher vulnerability of people from Black and Ethnic Minority groups.
- Socio-economic position and class – this refers to the position of individuals and families, in relation to others, captured by the differences in educational levels, income, occupation,

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[16] Government Office for Science (2008) *Five ways to mental wellbeing*, part of *Mental capital and wellbeing* available at https://www.gov.uk/government/publications/five-ways-to-mental-wellbeing, accessed on 24/07/17

housing or wealth. It is a major determinant of health inequalities. Socio-economic position determines the experience of dominance, hierarchy, isolation, support and inclusion.

- Disability – the mental health of people with disabilities is affected by life chances (education, employment and housing), social inclusion, support, choice, control and opportunities to be independent. More details on people with physical and learning disabilities and their mental health can be found in Sections **6.1** and **0**.
- Sexual orientation and gender identity – Lesbian, Gay, Bisexual and Transgender people are more likely to have poor mental health and are more vulnerable to experience factors that increase risk of poor mental health and wellbeing, such as bullying, discrimination and verbal assault. Section **6.13** describes the prevalence of mental ill health among this group.
- Physical health – poor physical health is a significant risk factor for poor mental health, while good mental wellbeing enhances health outcomes and recovery rates. Poor mental health is associated with poor self-management of chronic illness and a range of health damaging behaviours, such as smoking, drug and alcohol abuse, unwanted pregnancies and poor diet. The relationship between physical health and mental health is described in Section **0** .

Social relationships and the core economy[17]

Home, family, neighbourhood, community and civil society influence social relationships and the core economy. Evidence suggests that good quality social relationships throughout the lifetime are associated with protection of health and a wide range of other beneficial outcomes, the effects of which are individual and ecological. These outcomes include:

- Stress buffering,
- Access to information,
- Health behaviour/ help seeking,
- Psychological benefits,
- Functional: practical and material help,
- Access to valued resources e.g. employment opportunities,
- Improving quality of life.

Wider determinants

The wider determinants of mental health and wellbeing include:

- Physical security e.g. housing, safety at home and in the neighbourhood – this includes secure and positive environment that supports people as they progress through life. Research into the influence of housing on mental health in England indicates that 21% of English adults reported that housing had negatively affected their mental health over the period of five years. Additionally housing affordability was the most frequently referenced issue by those who experienced housing pressures having had a negative impact upon their

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[17] Core economy – this is the economy of family, neighbourhood, kith and kin. This is the productive economy activity, which takes the place outside of the market and is not measured by traditional indicators.

mental health.[18] People who are homeless are more vulnerable to experience poor mental health, as indicated in Section **0**.

- Environment e.g. green space, safe play space, quality of the built environment – access to activities in a natural environment supports mental health by improving quality of life and relaxation, recovery from stress, intellectual and creative development, sense of meaning, purpose and perspective, and social contact, including belonging and cohesion.

- Meaningful activity e.g. employment, voluntary work – employment is important for identity; it can raise self-esteem, provide a sense of fulfilment and improve social interaction. Additionally work is the main source of income. Unpaid work (for example volunteering) positively influences a sense of meaning and purpose within the context of community. In reverse, unemployment has a negative effect on mental health and wellbeing, as described in Section **0**. An example of 'meaningful activity' intervention is social prescribing, described in Section **0**.

- Good quality food e.g. affordable, accessible – healthy eating is significant for physical and mental health. It has been observed that consumption of wholefoods lowers the risk of depression, while high consumption of processed food increases this risk.[19] Additionally, sugars, caffeine, nicotine and alcohol can influence mood and mental health and wellbeing, while misuse of drugs and alcohol increases the risk of mental health problems (Section **0**).

- Leisure e.g. arts and creativity, sport, culture – leisure and physical activity improve wellbeing as they increase the feeling of competency and relaxation, distract from problems and increase social inclusiveness and support. Additionally these activities enhance wellbeing by meaningful engagement, self-expression and creativity.

- Education e.g. lifelong learning – education protects mental health across the life course; it reduces the risk of transition to depression and improves mental health. Learning during adult years also improves wellbeing, life satisfaction, optimism and health behaviours.

- Transport e.g. affordable, accessible, sustainable – increasing non-car travel (active travel), reducing traffic levels and traffic spend, and increasing use of local amenities is associated with increased social interaction between residents and quality of life.

- Financial security e.g. income, credit, assets – unemployment, job insecurity and debt increase the risk of mental disorder (Section **0**). It has been suggested that financial capability increases psychological wellbeing by 5.6% and life satisfaction by 2.5%, and reduces anxiety and depression by 15%.[20]

Equity and social justice

Research indicates that there is a direct and indirect relation of the significance of mental health to human responses to inequalities on every level. This suggests that inequality impacts on the key pathway of mental health. It has been suggested that relative deprivation is a promoter for a range

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[18] Shelter (2017) *The impact of housing problems on mental health*, available at https://england.shelter.org.uk/__data/assets/pdf_file/0005/1364063/Housing_and_mental_health_-_detailed_report.pdf, accessed on 25/07/17
[19] T.N. Akbaraly, E.J. Brunner, J.E. Ferrie, M.G. Marmot, M. Kivimaki, A. Singh-Manoux A (2009) *Dietary pattern and depressive symptoms in middle age*, The British Journal of Psychiatry, 195 (5), available at http://bjp.rcpsych.org/content/195/5/408, accessed on 25/07/17
[20] National MWIA Collaborative (England) (2011)

of negative emotional and cognitive reactions to inequality. These include conscious and unconscious behaviours affecting health, such as psychological reactions, the impact of low status on identity and social relationships and variety of damaging behaviours, which are a response to social inequalities.

These factors interact with each other in a dynamic way; they may be protective and stimulate mental health and wellbeing or detrimental, and work for or against a particular individual's mental health state and increase the possibility of mental illness (Table 1). The adverse factors impact on individuals and increase their vulnerability placing them in the groups with a higher risk of developing a mental health condition. Discrimination towards a particular group in society, for example against a person's sexual orientation, ethnic group or place of residence raises that group's exposure to social exclusion and economic adversity, thereby making the group vulnerable to a higher risk of stress, anxiety and other common mental disorders. A range of vulnerable groups are described in Chapter 6.

Table 1: Example of factors that may threaten or protect mental health

Level	Adverse factors		Protective factors
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Source: World Health Organisation, *Risk to mental health: an overview of vulnerabilities and risk factors*, 2012

Most risk factors are also correlated with each other in a cause and effect relationship. Poor mental health is an outcome of the above risk factors, but also is a determinant. For example, for people who live in poverty, the risk of mental illness is higher, and the likelihood that those living with mental illness will drift into or remain in poverty is also higher.[21] Good mental health and wellbeing or its lack influences a wide range of outcomes such as health behaviours, physical health, educational achievements, employment and earnings, relationships, crime and quality of life.

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[21] Lund C, De Silva M, Plagerson S, et al. (2011) *Poverty and mental disorders: breaking the cycle in low-income and middle-income countries*. *Lancet*, available at www.ncbi.nlm.nih.gov

5.2 Key determinants of Mental Health in relation to Gloucestershire

Table 2 provides a summary of the key mental health determinants, as identified by Public Health England (PHE), within Gloucestershire in relation to England and to the South West.

Table 2: Key determinants of mental health in relation to the demographics of Gloucestershire.

Determinants of Mental Health	Gloucestershire measure	England value, RAG*	South West value, RAG*
Population characteristics			
Long-term health problems or disability: % of population (2011)	16.7	17.6	18.4
Migrant GP registrations: Rate per 1,000 resident population (2016)	6.7	12.9	8.5
Adults with low education: % of adults that have no qualifications or level one qualifications (2011)	33.1	35.8	34.3
English Language skills: % of people who cannot speak English / speak it well (2011)	0.6	1.7	0.6
Admission episodes for alcohol-related conditions, rate per 100 000 population (Narrow) (2014/15)	669	641	638
Estimated prevalence of opiates and/or crack cocaine use: rate per 1,000 aged 15 - 64 (2011/12)	6.9	8.4	7.7
Social relationships and the core economy			
Lone parents households: % of households that have lone parents with dependent children (2011)	5.2	7.1	5.9
Relationship breakup: % of adults whose current marital status is separated or divorced (2011)	11.8	11.6	12.2
People living alone: % of all households occupied by a single person (2011)	13.0	12.8	13.3
Older people living alone: % of households occupied by a single person aged 65 or over (2011)	5.8	5.2	6.1
Children leaving care: Rate per 10,000 <18 population (2015/16)	24.0	27.2	26.3
Socioeconomic deprivation: % of people living in 20% most deprived areas (2014)	7.5	20.2	10.6
Socioeconomic deprivation: overall IMD score (2015)	15.0	21.8	0

Determinants of Mental Health	Gloucestershire measure	England value, RAG*	South West value, RAG*
Wider determinants			
Long-term unemployment: % of working age population (Aug 2016)	0.2	0.4	0.2
Unpaid carers: % of population who provide substantial unpaid care (2011)	2.0	2.4	2.4
Household overcrowding: % of households (2011)	2.7	4.8	2.9
Rented accommodation: % of all households living in rented accommodation (2011)	28.3	34.5	30.4
Domestic abuse incidents: rate per 1,000 population (2014/15)	13.0	20.4	17.6
Violent crime: violence offences (including sexual violence) per 1,000 population (2015/16)	10.1	17.2	15.0
Physical activity: % of population engaging in recommended levels of physical activity (2015)	61.5	57.0	59.2
Use of outdoor space for exercise/health: estimated % of population (Mar 2015 - Feb 2016)	15.3	17.9	17.4
Statutory homelessness: rate per 1,000 households (2015/16)	1.4	2.5	1.6

* RAG (Red, Amber or Green) - higher, average or lower risk than national average
Source: *Public Health Profiles*, Public Health England

With the exception of prevalence of percentage of people and older people living alone and rate of admission episodes for alcohol-related conditions, Gloucestershire's risks rate better for the key determinants of mental health when compared with the national average and similar or better when compared to the regional dataset. Notwithstanding, the above determinants are still an issue of concern. Further details of the indicators are explored in the following section and Chapter **6**.

Some of the powerful risk factors, for example parenting or bullying in workplaces or schools, are more difficult to measure than social factors such as income, education or marital status. For that reason, the measurable determinants represent the overall picture, but not a clear plan for interventions for the complex system of public mental health.

5.2.1   Deprivation in Gloucestershire

Deprivation underpins many of the risk factors described in Section **5.1**. A key measure of deprivation is the Indices of Multiple Deprivation (IMD), which is based on seven domains of deprivation:

- Income deprivation

- Employment deprivation
- Education, skills and training deprivation
- Health deprivation and disability
- Crime
- Barriers to housing and services
- Living Environment Deprivation.

Gloucestershire is a relatively affluent county, which is not as deprived as the national average – overall the IMD score is 15.0 compared with English average of 21.8. **Figure 4** shows the areas of Gloucestershire from the least deprived to the most deprived based on the national quintiles. According to the IMD 2015, Gloucestershire ranks 124 out of 152 upper-tier authorities, placing it in the least deprived 20% county for overall deprivation in England[22].

Figure 4: Areas in Gloucestershire by national quintile of multiple deprivations, i.e. from the most deprived 20% nationally to the least deprived 20% nationally.
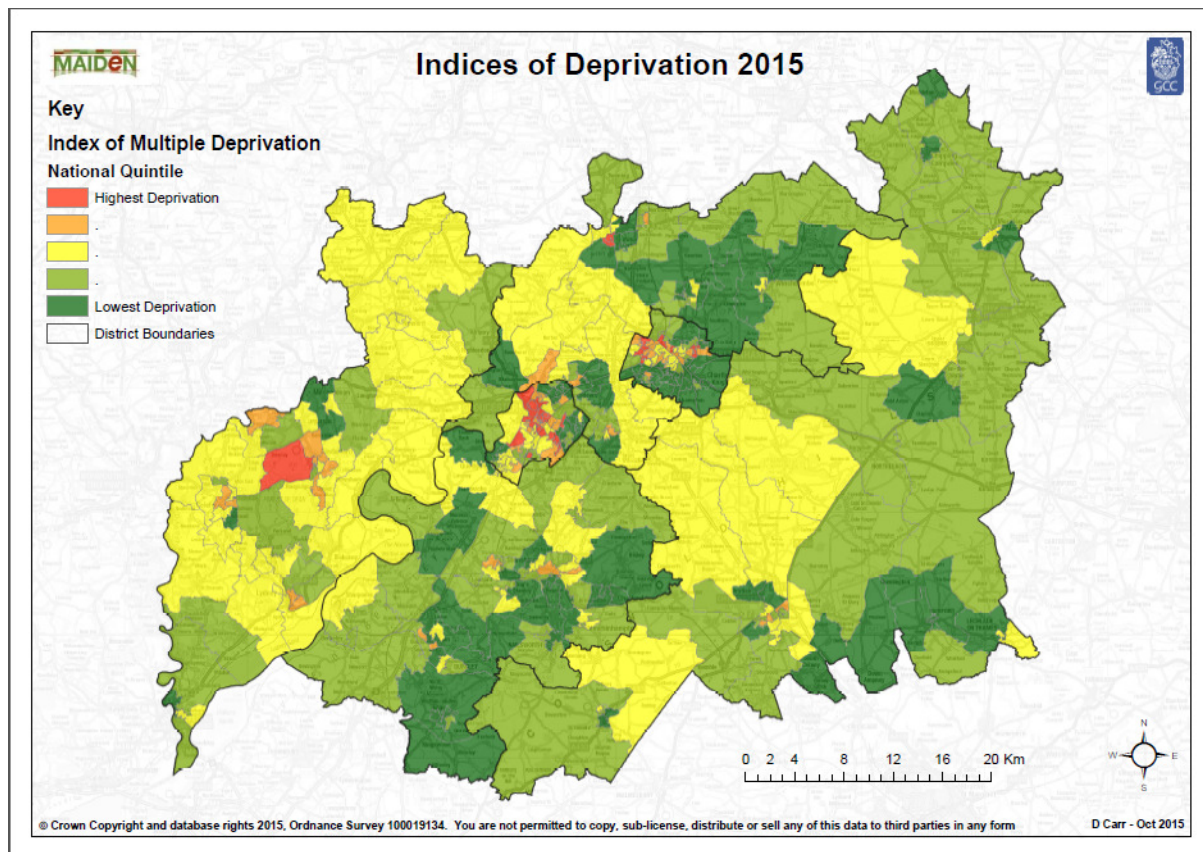
Source: *English Indices of Deprivation 2015*, Department for Communities and Local Government, 2015

However, there are pockets of high deprivation in Gloucestershire. There are 30 neighbourhoods in Gloucestershire (19 in Gloucester, 8 in Cheltenham, 2 in Tewkesbury and 1 in Forest of Dean), which

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[22] English Indices of Deprivation 2015 (2015) Department for Communities and Local Government, available at www.gov.uk,

are among 20% most deprived areas in England. Around 7.5% (46,016) of Gloucestershire's population lives in these areas.

13 neighbourhoods (Lower Super Output Areas) in the county are identified as among the most deprived 10% nationally for the IMD. This is an increase from eight areas in 2010 of five more areas. These neighbourhoods are located within Gloucester (10 out of 13) and Cheltenham (3 out of 13) districts (Table 3). They account for around 20,600 (3.4%) people in the county, including 4,700 children and young people aged 0-17, 13,300 people aged 18-64 and 2,600 older people aged 65+.

Table 3: The 13 areas of Gloucestershire in the most deprived 10% nationally

LSOAs that fall within the most deprived 10% nationally	District
Westgate 1	Gloucester
Podsmead 1	Gloucester
Matson and Robinswood 1	Gloucester
Kingsholm and Wotton 3	Gloucester
Westgate 5	Gloucester
Moreland 4	Gloucester
St Mark's 1	Cheltenham
Hesters Way 3	Cheltenham
St Paul's 2	Cheltenham
Barton and Tredworth 4	Gloucester
Matson and Robinswood 5	Gloucester
Barton and Tredworth 2	Gloucester
Westgate 4	Gloucester

Source: *English Indices of Deprivation 2015* (2015) Department for Communities and Local Government

Chapter 5 recommendation:

5.   Partners across the system should consider the impact of the wider determinants set out in this section on mental health and wellbeing to deliver a truly preventative approach to public mental health. The forthcoming National Prevention Concordat for Better Mental Health should provide a helpful framework for leadership by the Health & Wellbeing Board of this work.

6   Vulnerable groups

The factors affecting mental health and wellbeing described in Chapter **5** highlight a number of groups which, based on evidence, may be at greater risk of having poor mental health compared to the general population. The groups listed below are broadly highlighted in the literature and are of particular interest to Gloucestershire County Council and its partners:

- People with a learning disability or autism
- People with a physical disability or life limiting illness
- People who have suffered domestic abuse and sexual violence
- People with substance misuse problems
- Care leavers
- Homeless people
- People within black and minority ethnic communities
- Gypsy and Travellers
- People who are unemployed
- People who are in financial debt
- Carers
- Refugee and asylum seekers
- People who are LGBT
- People with dementia
- Members of the Armed Forces Community
- Adults who are in contact with the criminal justice system

However, it should not be concluded that individuals within these groups will experience mental health problems. Nor should it be concluded that individuals outside of these groups will not experience mental health problems.

Key points in this section are:
- People with a **learning disability** are at higher risk of developing a range of mental health problems and experience additional barriers in accessing mental health services. In Gloucestershire, this population is estimated to increase at a slower pace than the overall population trends. However, the population over 75 years old with a learning disability will increase by 50% by 2025. Tewkesbury and Gloucester's population will increase at a higher rate than the national average.
- More than 30% of people with a **long-term condition** experience mental health problems. Co-morbid mental health and physical problems result in lower quality of life and increase the cost to health care system. In Gloucestershire, there are 29,392 people living with a moderate physical disability and 8,839 people with a serious disability. These numbers will increase by 2025. Forest of Dean has the highest percentage of people living with long term illness limiting day-to-day activities.
- **Domestic abuse** leads often to the development of depression, anxiety and other mental health disorders, and may also lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse. Although the domestic violence rate recorded by the police for Gloucestershire decreased and is significantly lower than national, regional and statistical neighbours, the rate is unlikely represent the true scale of this crime, due to under-reporting. The highest reported rate is in urban districts of Gloucester. Half of the reported incidents are repeat offences.
- **Sexual Violence** victims present a significant burden of mental health implications, including, severe mental illness, risk of suicide, post-traumatic stress disorder and longer term psychological needs. Sexual offences recorded by Gloucestershire police are below the national average, yet are representing an increase of 29% compared to the previous year.

Many sexual violence crimes are unreported. As of January 2017, there were 62 women on a Gloucestershire Rape and Sexual Abuse Centre's (GRASAC) waiting list for face-to-face support, with the longest time to wait of 48 weeks. Gaps in service provision for the victims of sexual violence have been identified and are currently informing the Domestic Abuse Sexual Violence commissioning steering group strategy.

- **Substance misuse** can lead to paranoia, depression, aggression, hallucination and schizophrenia. Conversely, poor mental health can lead to developing substance misuse problems. Gloucestershire has a high rate of people admitted to hospital for alcohol related causes. This rate is the highest in Gloucester and Cheltenham. Gloucester is the only district with a higher prevalence with opiate and/ or crack cocaine users than the national and regional prevalence. People with a dual diagnosis can face additional difficulties in accessing services and treatment.

- **Care leavers** encounter additional challenges during their childhood, which can result in poorer mental health than their peers. In addition, they can experience difficulties in the transition from Child and Adolescent Mental Health Services (CAMHS) to adult services. In Gloucestershire a smaller proportion of children in leave care at the early stage (aged 16-17) than in England.

- It is estimated that 85% of **homeless people** have some form of mental health issue and that 45% have been diagnosed with a mental illness. The number of people sleeping rough in Gloucestershire in 2016 increased by 40% from 2010. The highest rates of people who are street-homeless are in Gloucester and Cheltenham.

- The highest prevalence of Common Mental Disorder by **ethnicity** is among Black and Black British women. Black women are significantly more likely to have depressive episodes, while panic disorder is more prevalent in mixed, multiple and other ethnic groups. Psychotic disorder is more common among black men than in other men's ethnic groups. African-Caribbean people are more likely to suffer severe mental illness. Black and Minority Ethnic groups make 4.6% of the Gloucestershire population, which is significantly lower than the national average; Gloucester has the highest proportion out of all Gloucestershire districts, which is still lower than the national average.

- There is not much evidence on the mental ill health prevalence among **Gypsies and Travellers**. However, the socio-economic status of this group can have a negative impact on their mental health. In Gloucestershire there are approximately 478 Gypsies and Travellers, with the highest numbers and rates in Tewkesbury.

- **Economically inactive and unemployed** people present a higher prevalence of many mental health disorders than people who work. The long-term unemployment rates in Gloucestershire have decreased over the last 3 years, with Forest of Dean presenting the lowest proportional decrease.

- Around one in two adults in **debt** present with mental ill-health. One in four people with poor mental health is also in debt. The highest numbers of people reporting debt in Gloucestershire are in Gloucester and Stroud.

- **Carers** experience poorer mental health than the whole population. Although, Gloucestershire rates of unpaid carers are lower than the national and regional average, Forest of Dean presents a higher proportion than the national and regional average.

- **Refugees and asylum seekers** experience high rates of depression, post-traumatic stress disorder (PTSD) and anxiety disorders. The rates of asylum seekers in Gloucester City are higher than the national average.

- Lesbian, gay, bisexual and transgender (**LGBT)** people experience poorer mental health than the general population. The prevalence of mental health issues varies between the LGBT groups: higher rates are observed among lesbian women, lesbian women from BME communities and bisexual people. Evidence on transgender people is limited. There is no definite data on local and national population size. Estimates suggest that in Gloucestershire

there are around 15,283 (2.5%) Lesbian, Gay and Bisexual people. Surveys on local the LGB population reported various rates from 1.5% to 8.5% of the whole population.

- People living with **dementia** are more likely to develop mental health problems, such as depression, anxiety, psychosis; people living with mental health problems, such as schizophrenia, are more likely to develop dementia. However, mental health problems are often missed in people with dementia. In Gloucestershire, there are 9,581 people living with dementia, with the highest numbers in Stroud, Cheltenham and Cotswold. This number is predicted to increase, due to an aging population.
- Studies suggest that the estimated prevalence of the CMHD among the **military population** is double, compared with a general population. Females, "other ranks"(made up of lower social classes), personnel aged between 22 and 44 and personnel previously deployed to Iraq or Afghanistan are more vulnerable to developing CMHD. However, the prevalence of self-harm and suicide is lower than among the general population.

6.1   People with a learning disability

This section presents information on the current and future population in Gloucestershire with learning disabilities and their mental health. To identify the trends within the learning disability population, a range of sources is considered. Conditions, such as autistic disorder, challenging behaviour and Down's syndrome are associated with learning disability; therefore, these conditions are investigated further in this section. Estimates made by Projecting Adult Needs and Service Information (PANSI) and statistics held by GPs, Local Authorities and NHS Gloucestershire CCG differ, as the data is based on the organisation's individual requirements.

6.1.1   Learning disability

People with learning disabilities have poorer mental health than the general population. Prevalence of psychosis, bipolar disorder, dementia, behaviour that challenges and neurodevelopmental conditions such as autism and attention deficit hyperactivity disorder is higher than in people without learning disabilities.[23] Additionally people with learning disabilities are three times more likely to experience schizophrenia as compared with the general population.[24] Estimates suggest that between 30% and 50% of adults with a learning disability experience mental health issues during their life. This is higher than the prevalence of 25% in the general population.[25] [26]

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[23] National Institute for Health and Care Excellence (NICE) (2016) *Mental health problems in people with learning disabilities: prevention, assessment and management,* available at https://www.nice.org.uk/guidance/ng54/chapter/Context, accessed on 18/11/16

[24] G. Doody, E. Johnstone, T. Sanderson, D. Owens, W. Muir (1998) *'Pfropfschizophrenie' revisited. Schizophrenia in people with mild learning disability,* British Journal of Psychiatry, 173, available at https://www.ncbi.nlm.nih.gov

[25] E. Smiley, *Epidemiology of mental health problems in adults with learning disability: an update*, Advances in Psychiatric Treatment (2005), vol. 11, available at http://apt.rcpsych.org

[26] Mental Health Foundation (2015), *Fundamental Facts about Mental Health 2015,* available at https://www.mentalhealth.org.uk
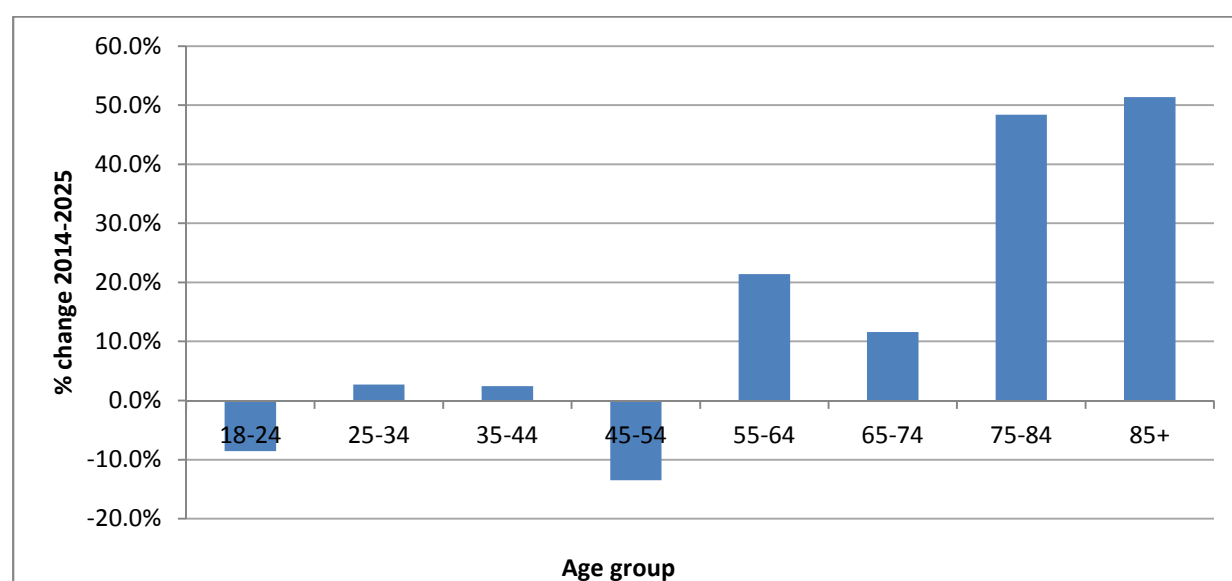
People with a learning disability are more likely to experience deprivation, poverty and other adverse life events earlier on in life. They are exposed to social exclusion, loneliness and other people's negative attitudes. These factors increase their vulnerability to mental health problems.[27]

Additionally, people with learning disabilities can experience barriers in accessing appropriate and effective mental health care. Problems with describing or expressing their distress may increase the difficulty in identifying mental health problems. Furthermore, mental health symptoms may be wrongly attributed to a person's learning disabilities, and as a consequence the mental health problems remain unrecognised and preventable distress extends.[28]

Based on PANSI estimates, there were 11,360 people over 18 year old living with a learning disability in Gloucestershire in 2014. Of these, 2,352 had a moderate or severe learning disability and were likely to be in receipt of local services. The population is predicted to increase to 12,142 people by 2025, which represents an increase of 6.9%. This is lower than the increase of the whole 18+ population (8.2%). The increase is at a similar level as the national forecast of 7.2%. As **Figure 5** illustrates, the highest increase of 50% is expected for the age group over 75 years old. Gloucestershire's population with a moderate or severe learning disability is expected to increase at a lower pace of 4% by 2025.[29]

Figure 5: People aged over 18 years old predicted to have a learning disability between 2014 and 2025 in Gloucestershire, by age group

Source: Projecting Adult Needs and Service Information (PANSI)

The highest relative increase of people with a learning disability between 2014 and 2025, is expected in Tewkesbury, which will see an increase of 9.3% (146 people). However, Gloucester's learning disability population is predicted to rise by the largest number, 207 people (9.0%). These increases are in line with the districts' overall adult population forecast – as indicated in section **4.2.2.** In the

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[27] J. Robinson, *What's the difference between a learning disability and a mental health problem*, 2016, Mencap, https://www.mencap.org.uk
[28] NICE (2016)
[29] Projecting Adult Needs and Service Information (2014) www.pansi.org.uk

whole of Gloucestershire, Tewkesbury and Gloucester show a higher than national average increase in the rate of people with a learning disability. Forest of Dean's population is forecast to grow by the lowest relative and absolute figure of 4.2% and 60 people.

Gloucestershire GPs reported a rate of 0.54% (3,403) of people of all ages living with learning disabilities known to them in 2014/15. This rate is higher than the national and regional rates (0.44% and 0.47%), second highest as compared with regional counties and third highest as compared with Gloucestershire's statistical neighbours.[30] As identified in the Building Better Lives Policy, this is partly due to the significant population of people with a learning disability having been placed in residential care or supported living in Gloucestershire by other authorities.[31]

However, the rate of adults (18-64 years old) living with a learning disability in Gloucestershire and getting long term support from the Local Authority (3.56 per 1,000; 1,295 people) is similar to England (3.73 per 1,000) and to the South West region (3.67 per 1,000) and similar as compared with statistical neighbours.[32]

A different population size is indicated by NHS Digital. At the end of August 2016, 1,810 people of all ages were in contact with NHS Gloucestershire CCG's learning disability and autism services.

The data sources described above indicate differences in numbers of people being in receipt of local services in Gloucestershire:

- 2,352 (PANSI) (18+)
- 3,403 (GP) (all ages)
- 1,295 (Gloucestershire County Council) (18-64)
- 1,810 (NHS Gloucestershire CCG) (all ages).

These variances create difficulties in accurate understanding of the local population of adult people with learning disabilities in Gloucestershire.

There is a lack of local data on mental health service accessibility by people with a learning disability. However, the research conducted by Healthwatch Gloucestershire on views and experiences of people with learning disabilities on supported living and other health and social care provision provided some feedback in regards to mental health services. Comments were made that:[33]

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[30] Public Health England, *Learning Disability Profiles*, available at https://fingertips.phe.org.uk/profile/learning-disabilities, accessed on 10/11/16
[31] Gloucestershire County Council (2014) *Building Better Lives Policy 2014-2024,* available at http://www.gloucestershire.gov.uk/buildingbetterlives, accessed on 18/11/2016
[32] Public Health England, *Learning Disability Profiles,* accessed on 10/11/16
[33] Healthwatch Gloucestershire (2016) *Views and experiences of people with learning disabilities on supported living and other health and social care provision gathered at the Gloucestershire County Council (GCC) Drop In Centres*

"The cuts to mental health services are affecting me directly. The time limit that is put on services is affecting me. The Independence Trust can only offer me a course of something that is for six months. They are a good organisation, but six months isn't long enough to make a difference, it takes longer sometimes. CLDT [Community Learning Disability Team] can only provide me something for a year, and then they sign you off."

"I've been seeing [doctor's name] from the Independence Trust for two years, for anxiety management. This has been really helpful"

While it is not possible to draw a comprehensive conclusion on people's experience in accessibility and provision of mental health services, the above feedback indicates that people with a learning disability can be satisfied with the quality of mental health help they are provided with, yet they may require this help to be provided for a longer period of time.

6.1.2 Autism

Autism is a lifelong condition, which impacts on the way a person communicates and interacts with other people, and how the person thinks about and deals with the world around them. Although autism is not a learning disability, around half of people with autism may also have a learning disability. People with autism show different degrees of severity.[34]

Evidence suggests that rates of mental health problems in adults with autism are higher than in the whole population. People with autism experience increased rates of depression, anxiety disorder, bipolar affective disorder, obsessive–compulsive disorder (OCD), psychosis, and self-harm. Additionally, some of the cognitive skills, such as poor planning, decision making, timing and motor skills that may affect people with autistic disorder can limit the ability to access mental health services. [35]

Autism appears to be more common in males than females. It is estimated, that in 2014 in Gloucestershire there were 364 females and nine times more males (3,247) with autism aged 18-64 years old in 2014. These numbers are projected to stay relatively constant between 2014 and 2025 (**Figure 6**).

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[34] The National Autistic Society (2016) "*Autism facts and history*", http://www.autism.org.uk/about/what-is/myths-facts-stats.aspx, accessed on 18/11/2016,

[35] C. Murphy, C. Wilson, D. Robertson, C. Ecker, E. Daly, N. Hammond, A. Galanopoulos, I. Dud, D. Murphy, G. McAlonan (2016*) Autism spectrum disorder in adults: diagnosis, management, and health services development*, Journal of Neuropsychiatric Disease and Treatment 12/2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940003/ accessed on 18/11/16

Figure 6: People aged 18-64 predicted to have conditions associated with learning disability, between 2014 and 2025, in Gloucestershire.
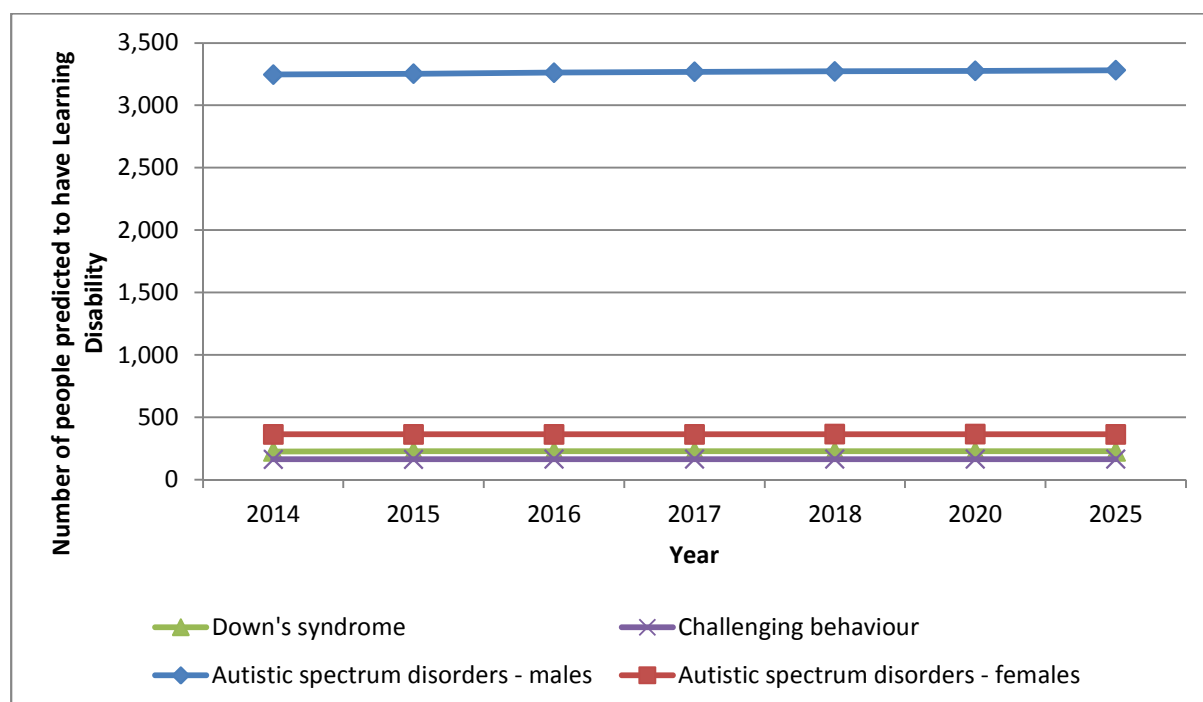
Source: Projecting Adult Needs and Service Information (PANSI)

6.1.3   Challenging behaviour

People with a learning disability, especially with a higher degree of severity are more likely to demonstrate challenging behaviour. It is estimated that between 5% and 15% of people with learning disabilities in educational, health or social care services demonstrate behaviours significantly challenging for those caring for them.[36] Additionally challenging behaviour may be a sign of wider problems, such as mental health state.[37]

Challenging behaviour may include aggression, self-injury, destructive behaviour and withdrawal. It is often a consequence from the interaction between personal and environmental factors.

As estimated by PANSI, in Gloucestershire there were 163 people showing challenging behaviour in 2014. The number is not projected to change by 2025 (**Figure 6**).

6.1.4   Down's syndrome

Learning disability is often present in people with Down's syndrome. However, the level of the disability is different for each individual.[38]

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[36] National Institute for Health and Care Excellence (2015) *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*, https://www.nice.org.uk/guidance/ng11/chapter/Introduction accessed on 18/11/16

[37] Mencap (2016) *Challenging behaviour*, https://www.mencap.org.uk/learning-disability-explained/conditions/challenging-behaviour, accessed on 18/11/16

[38] Mencap, *Down's syndrome*, https://www.mencap.org.uk/learning-disability-explained/conditions/downs-syndrome, accessed on 18/11/16

More than half of adults with Down's syndrome experience mental health issues at any point in their life. This population group is more vulnerable to mental health problems, such as:[39]

- general anxiety
- repetitive and obsessive-compulsive behaviours
- oppositional, impulsive, and inattentive behaviours
- sleep related difficulties
- depression
- autism spectrum conditions
- neuropsychological problems characterized by progressive loss of cognitive skills.

Estimates suggest that in Gloucestershire there were 226 people 18-64 years old with Down's syndrome in 2014. The population is predicted to remain stable between 2014 and 2025 (**Figure 6**).

Recommendations:

6.1.1   People with learning disabilities experience additional barriers in accessing mental health services, therefore further work may be needed to identify barriers and improve local access to mental health services.

6.1.2   Early prevention of mental health issues should be considered for the predicted rise in the older population with learning disabilities.

6.2   People with a physical disability or life limiting illness

In this section, the nature of the relationship between mental health and physical health is identified, followed by a presentation of the current and projected Gloucestershire population with physical disability and life limiting illnesses.

At least 30% of people with a long-term condition encounter a mental health problem (**Figure 7**). The recent evidence suggests that this population group is two to three times more likely to experience poor mental health than the whole population. Additionally, as presented in Section **7.1**, people with a disability rate their personal well-being distinctly lower than those without.

Common disorders occurring in people with long-term conditions are: depression, anxiety, dementia in the case of older people or cognitive decline. These and other mental health problems are strongly associated with long-term conditions such as cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and musculoskeletal disorder. Additionally, there is also evidence for co-morbidities among people with asthma, arthritis, cancer and HIV/AIDs. [40]

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[39] National Down Syndrome Society, *Mental Health Issues & Down Syndrome*, available at http://www.ndss.org/resources/health-care/associated-conditions/mental-health-issues--down-syndrome/, accessed on 18/11/16

[40] C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey, A. Galea, (2012) *Long-term conditions and mental health, The cost of co-morbidities*, The King's Fund and Centre for Mental Health, available at https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf accessed on 07/12/2016

Groups with multiple long-term conditions encounter co-morbid mental health problems most commonly. People with at least two long-term conditions are seven times more likely to have depression than the whole population.[41]

Detection of mental health problems is more difficult among people with long-term conditions. Evidence suggests that patients and practitioners have a tendency to focus only on physical symptoms during consultations.[42]

Physical and mental health is correlated with each other in a two-way relationship (**Figure 7**). Experiencing mental health problems may lead to the onset of a range of physical illnesses. For example, studies suggest, that depression increases the risk for onset of coronary artery disease and ischemic heart disease between 50% and 100%.[43]

Figure 7: The overlap between long-term conditions and mental health problems

Long term conditions: 30% of population of England (approximately 15.4 million people)

Mental health problems: 20% of population of England (approximately 10.2 million people)

30% of people with a long-term condition have a mental health problem (approximately 4.6 million people)

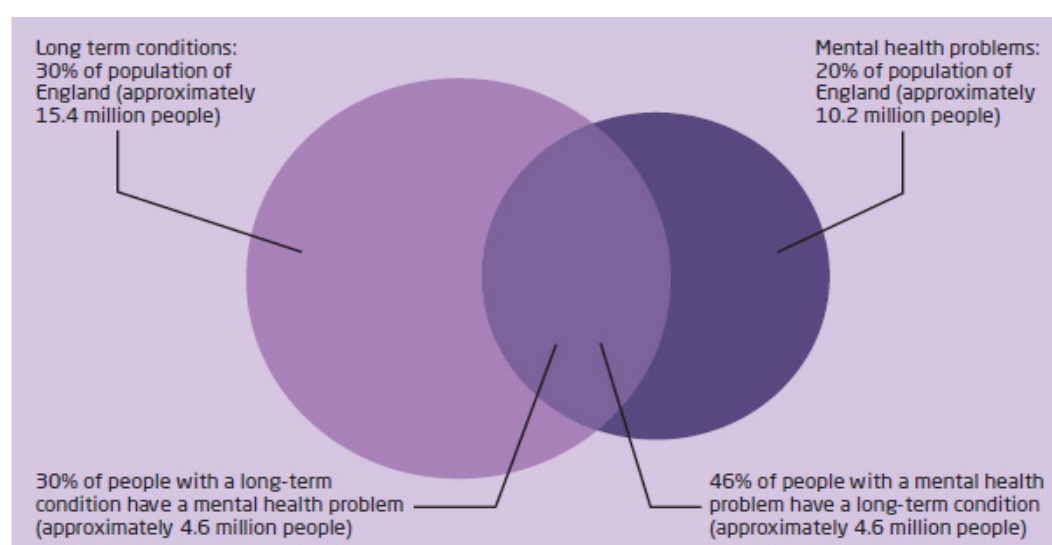46% of people with a mental health problem have a long-term condition (approximately 4.6 million people)

Source: C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey, A. Galea (2012) *Long-term conditions and mental health, The cost of co-morbidities*, The King's Fund and Centre for Mental Health

Co-morbid mental health problems result in poorer clinical outcomes of people with long-term conditions, lower quality of life and reduced ability to manage physical symptoms effectively, which consequently increase their use of health services for their physical problems. This translates to a significant rise in cost to the health care system, by 45-75 per cent for each person with a long-term condition and co-occurring mental health issues. The impact of co-morbid mental health problems on the delivery, efficiency and cost of services treating people with a long-term condition, raises the high importance/priority of good integration of mental health support and physical health services.

[41] C. Naylor et al. 2012
[42] C. Naylor et al. 2012
[43] C. Naylor et al. 2012

6.2.1 Prevalence of people living with a physical disability and/or long term limiting illness

It is estimated that in Gloucestershire in 2014 there were 29,392 people aged 18-64 years old with a moderate physical disability and 8,839 people with a serious disability (**Figure 8**). These numbers are predicted to rise respectively to 30,483 (by 3.7%) and to 9,194 (by 6.5%) by 2025, which is at a lower rate than the national increase of 5.6% of people with a moderate physical disability and 8.6% of people with a serious disability.

The highest increase of people with a moderate and serious disability is predicted for people aged 55-64 (by 21.2% for both groups), and the highest decline is predicted for age band 45-54 (by -14.6%). These trends are in line with the projection for the whole population (Section **4.2.1**).

Figure 8: People predicted to have a physical disability in Gloucestershire, by type
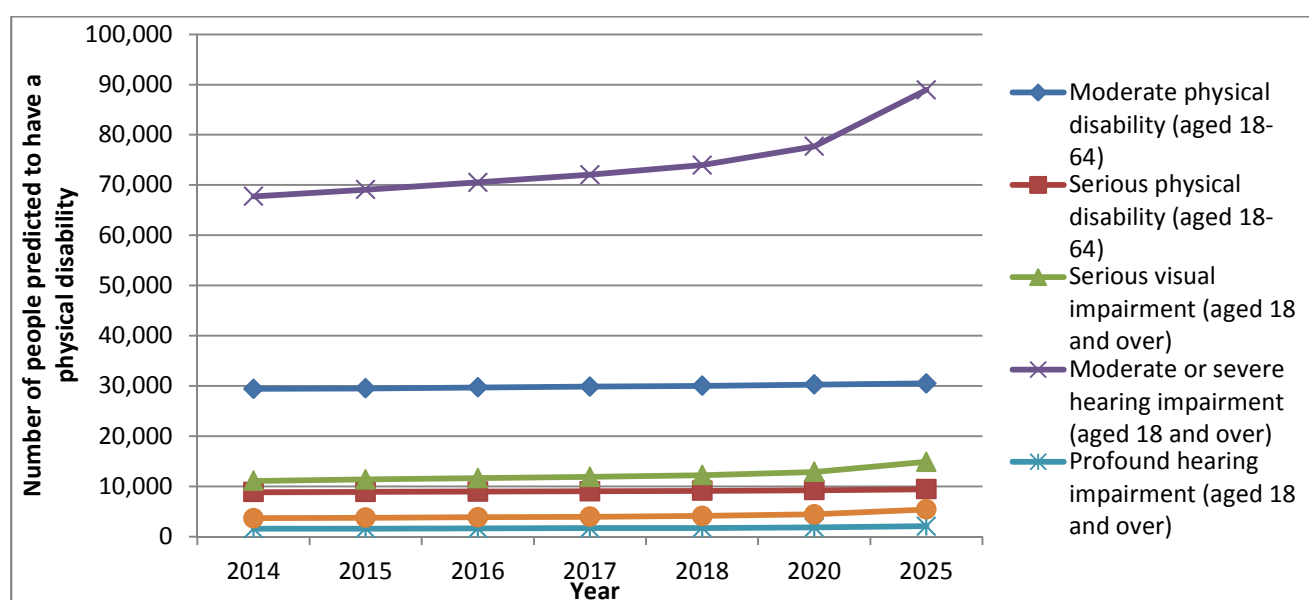
Source: Gloucestershire County Council, Data and performance team

The prevalence of other types of disabilities, particularly sensory impairment is predicted to rise at a significantly higher rate by the year of 2025 (**Figure 8**):

- Registrable eye conditions - by 47% (aged 75 and over)
- Serious visual impairment – by 34% (aged 18 and over)
- Profound hearing impairment – by 34% (aged 18 and over)
- Moderate or severe hearing impairment – by 31% (aged 18 and over).

Self-reported information on people's health, including the long term limiting illness was measured by the Censuses in 2001 and 2011. People were asked to assess whether they had a long-term illness, health problem or disability that limits their day-to-day activities, and has lasted, or is expected to last, at least 12 months. However, some questions asked in 2001 differed from that asked in 2011, which means it is not possible to make direct comparisons.

As **Figure 9** and **Figure 10** indicate, in 2011 the highest percentage of people living with long term illness limiting day-to-day activities a lot and a little or a lot was in Forest of Dean (a lot – 8.5%, a little or a lot - 19%). Additionally, Forest of Dean experienced the highest relative growth of population, whose daily activities are limited a little or a lot (by 1.7%), as compared to 2001. By contrast, Cheltenham was the only district in which this population group declined very slightly by 0.3%.

Figure 9: Persons with Long Term Limiting Illness or Disability in Gloucestershire, Day-to-day activities limited a little or a lot, by districts
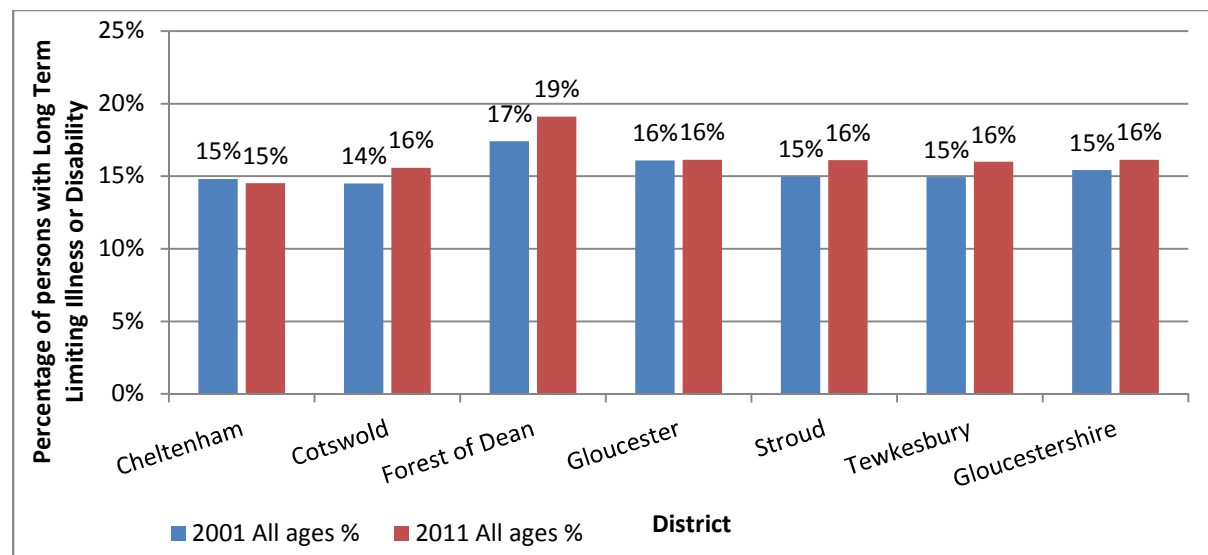
Source: NOMIS

Figure 10: Persons with Long Term Limiting Illness or Disability in Gloucestershire, Day-to-day activities limited a lot, by districts
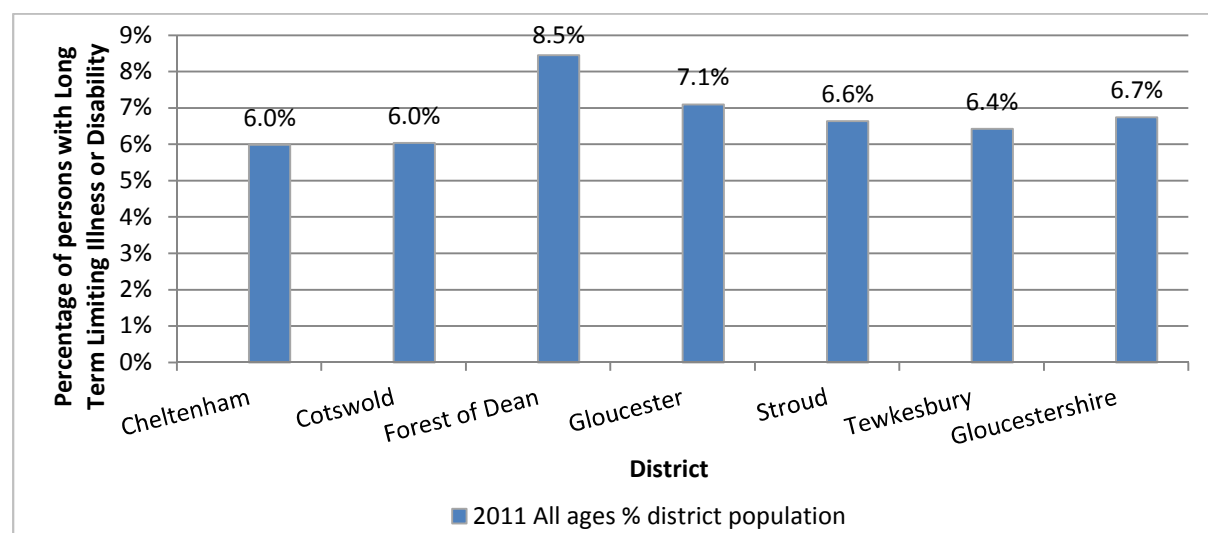
Source: NOMIS, no equivalent 2001 Census data

More females than males reported having long lasting illnesses limiting their day-to-day activities a lot in Gloucestershire in 2011: respectively 21,798 females and 17,695 males.

Nearly half of people aged over 65 years old (47%) experienced long term limiting illness. The prevalence in people aged 16-64 was 11%.

Recommendations:

6.2   There should be continued efforts to further align support for people with co-occurring long-term conditions or physical disabilities and mental health problems, including training and support for clinicians working with physical conditions to identify and signpost/refer to help for mental health problems.

6.3   People who have suffered domestic abuse and sexual violence

This section presents the characteristics of domestic violence incidents, including information on the number of victims and the mental health implications of domestic abuse and sexual violence. Particular concern is placed on the victims of sexual violence. Although sexual violence can relate to domestic abuse, it is not just within the context of domestic abuse. Sexual violence does not occur only within the context of an intimate partner or family relationship. Findings of *Therapeutic Services for Victims of Sexual Violence in Gloucestershire* Needs Assessment have been drawn on to highlight the need, demand and gaps for the specialist sexual violence therapeutic counselling services.

6.3.1   Victims of domestic abuse

Domestic abuse can have a significant impact on mental wellbeing. While men or women can be victims of domestic abuse, women are twice as likely to have experienced any domestic abuse as men.[44] Additional information about gender based violence can be found in an article written by Polly Neate, Chief Executive of Women's Aid.[45]

Research conducted by University College London (UCL) suggests, that 69% of women and 49% of men with severe mental illness reported adulthood domestic violence.[46] Domestic abuse in women is often the main factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse.[47] Women's Aid reviewed the evidence and reported that one third of all female suicide attempts are implicated by domestic violence. Women with experience of extensive abuse are about twice as likely to have an alcohol problem, three times more likely to smoke and eight times more likely to be drug dependent than women with little experience of violence and abuse – these wider determinants can have further implication on mental health and wellbeing.[48]

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[44] ONS (2016) *Intimate personal violence and partner abuse*, available at www.ons.gov.uk,

[45] P. Neate (2016) *Women's Aid responds to new statistics on female perpetrators of domestic abuse,* Women's Aid, available at https://www.womensaid.org.uk/womens-aid-responds-new-statistics-female-perpetrators-domestic-abuse/

[46] University College London (2014), *40% of women with severe mental illness are victims of rape or attempted rape,* available at https://www.ucl.ac.uk/news/news-articles/0914/040914-Mental-health-sexual-assault

[47] Women's Aid (2015*) Domestic abuse and your mental health*, available at www.womensaid.org.uk

[48] Women's Aid (2015) *The nature and impact of domestic abuse,* available at www.womensaid.org.uk

There has been little research focused on men as victims of domestic violence. According to a study conducted by University of Bristol, men experiencing or perpetrating domestic violence are linked with two to three-fold increase in mental health problems.[49]

Incidents of domestic violence recorded by the police for Gloucestershire decreased from 16.3 incidents per 1,000 population in 2010/11 to 13.0 in 2014/15. This rate is significantly lower than the national and regional average (20.4 and 17.6 respectively). Furthermore, Gloucestershire has the lowest rate in the region and among nearest statistical neighbours.[50] However, only a small proportion of domestic abuse incidents are reported to the police, due to the often sensitive nature of domestic abuse.[51] Therefore, these figures are unlikely to represent the actual information on domestic abuse.

Based on three and half years of data (April 2010-September 2013), there have been a total of 22,817 incidents recorded on the Domestic Abuse Database at Gloucestershire Constabulary. The relationship of the perpetrator to the victim for almost half of incidents is classed as an "ex-partner" and a third is classed as a "partner" (**Figure 11).** Overall, about 50% of incidents are categorised as being repeat incidents, with the highest repeat incident rate being for current partners (54%).[52]

Figure 11: Police Recorded Incidents of Domestic Abuse in Gloucestershire (based on 3 ½ years of data)
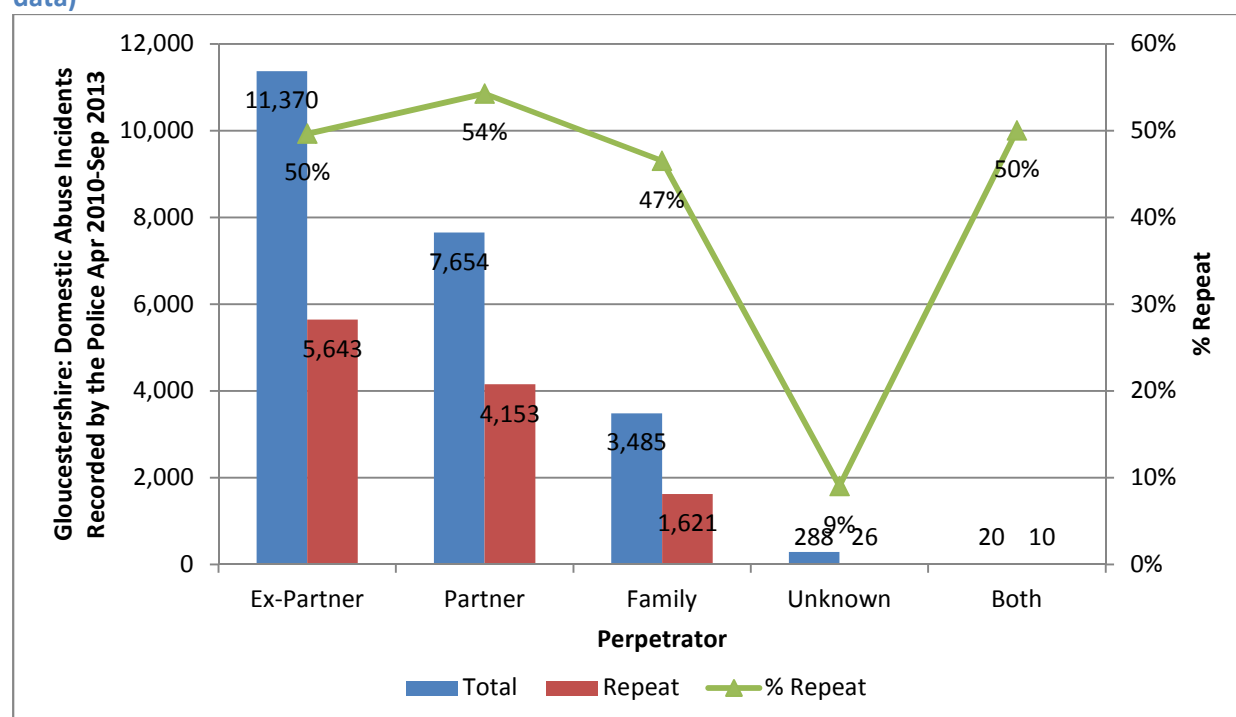
Source: D. Carr (2014) *Domestic Abuse and Violence in Gloucestershire Needs Assessment April 2010 to September 2013*, Gloucestershire County Council

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[49] M. Hester, G. Ferrari, S. K. Jones et al. (2015) *Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey,* BMJ Open, available at http://bmjopen.bmj.com,
[50] *Public Health Profiles, Co-existing substance misuse and mental health issues,* Public Health England, 2016, https://fingertips.phe.org.uk/
[51] *Focus on Violent Crime and Sexual Offences : Year ending March 2015*, ONS, 2016, www.ons.gov.uk
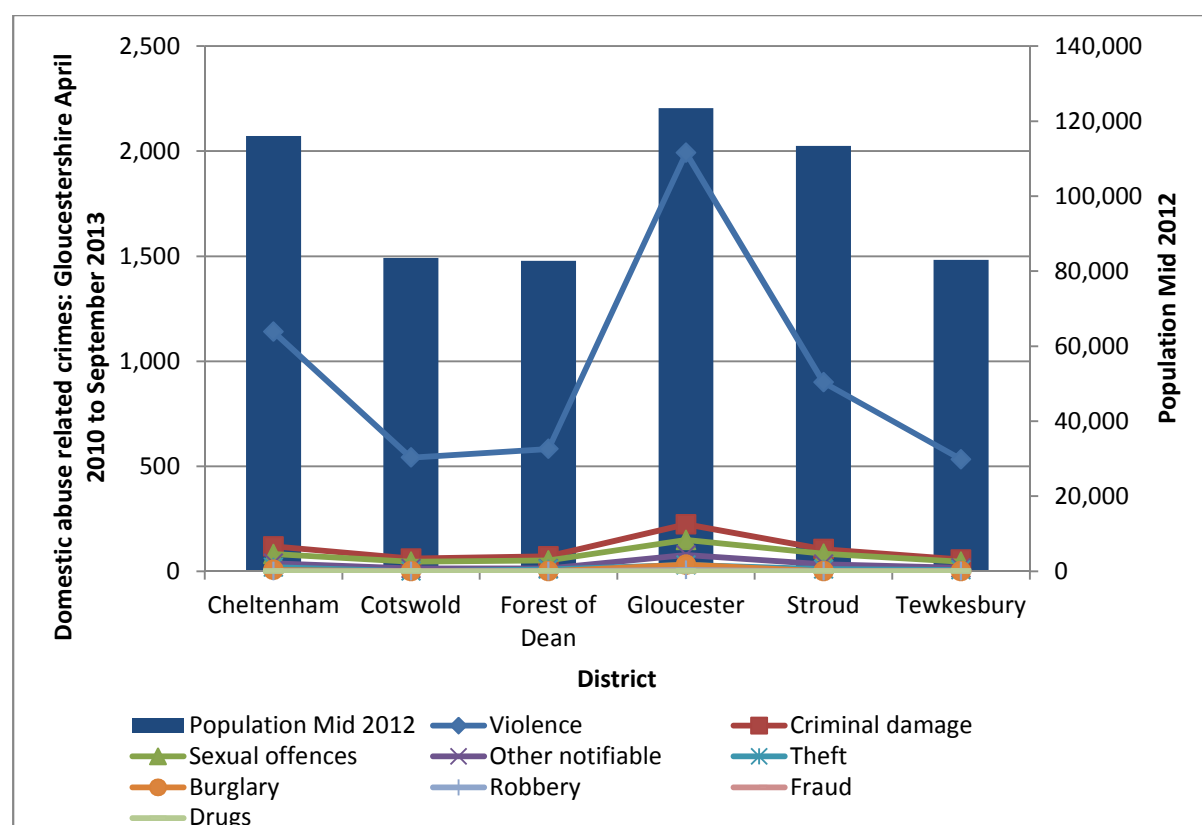[52] D. Carr, *Domestic Abuse and Violence in Gloucestershire Needs Assessment April 2010 to September 2013*, Gloucestershire County Council, 2014

There have been a total of 5,774 victims, based on three and half years of data. Although, most (4,827) victims of domestic abuse related crime appeared in the records only once, many - almost 1,000 victims - were repeat victims, with 57 being recorded five times or more.

Based on the recording officer's interpretation of the crime (**Figure 12**) eight out of ten crimes (5,710 out of 7,140) where domestic abuse is suspected to be involved are recorded as violence against the person. The other most common categories are criminal damage (635 out of 7,140) and sexual offences (458 out of 7,140). Some crimes of domestic abuse, such as fraud, drugs and robbery are less commonly reported in Gloucestershire.[53]

There is a significant variation in the recording of domestic abuse related crime by district, with the highest rate in the urban district of Gloucester (20 per 1,000 population) and lowest in Tewkesbury (8 per 1,000 population).[54] However, because of under reporting, the police figures do not represent the true scale of domestic abuse and there may be some cases, when people from close-knit rural communities may be less likely to report this type of crime.[55]

Figure 12: Domestic Abuse Related Crime in Gloucestershire (based on 3 ½ years of data)*

* There were 30 crimes out of a total 7140 that could not be allocated to a district and are not included on this chart
Source: D. Carr (2014) *Domestic Abuse and Violence in Gloucestershire Needs Assessment April 2010 to September 2013*, Gloucestershire County Council,

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[53] D. Carr, 2014,
[54] D. Carr, 2014,
[55] P. Neate, Domestic violence in rural areas (2014) Crimestoppers, available at https://blog.crimestoppers-uk.org/domestic-violence-in-rural-areas/

Mental health implications for domestic abuse victims are significant; taking into account that nearly half of the incidents are repeated, this group should be considered as a priority vulnerable group.

6.3.2 Victims of Sexual Violence
Sexual Violence has a detrimental effect on the mental health and wellbeing of the victim.

According to a UCL study, 40% of women with severe mental illness had been victims of rape or attempted rape in adulthood, of which 53% had attempted suicide. The number of men with severe mental illness, who had experienced serious sexual assault is lower - 12%. This would mean that 7% of the female population and 0.5% of the male population had suffered rape or attempted rape.[56]

Additionally one third of rape survivors are estimated to develop post-traumatic stress disorder, relationship problems and longer term psychological needs and mental illness. Sexual abuse in childhood leads to increased risk of suicide when they reach their mid-twenties.[57][58]

According to the Police Records for Gloucestershire in 2014 and 2015 there were 256 and 345 sex offences on women above the age of 18, respectively. Rape was the most common offence and made half of the overall offences. More than half of rapes were committed on women aged between 18 and 25.

The draft local Health Needs Assessment: *Therapeutic Services for Victims of Sexual Violence in Gloucestershire* (2016) includes more detail on the need and demand for mental health support services for survivors of sexual violence in Gloucestershire. The report highlighted that:

- With a rate of 1.29 per 1,000 (796) in 2015-16, sexual offences recorded by Gloucestershire police are below the national average, yet represent an increase of 29% as compared to the previous year. This increase is likely to be linked to high profile national cases of historic sexual abuse. However, figures from the self-completion survey section of the British Crime Survey suggest that only 11% of victims of sexual violence report to Police
- Local need for therapeutic services exceeds the increase in police-recorded rates of sexual offences. Gloucestershire Rape and Sexual Abuse Centre (GRASAC) experienced a 20% rise in requests for face-to-face emotional support per quarter and a 100% increase in call volume to the telephone helpline during the year 2015-16. Additionally, 62% of GRASAC service users have a diagnosis of a mental health disorder such as anxiety, depression, bi-polar disorder, personality disorder or post-traumatic stress disorder (PTSD). As of January 2017, there were 62 women on a GRASAC's waiting list for face-to-face support, with the longest time to wait of 48 weeks. Of those 62 women, 80% are adult survivors of childhood sexual abuse.
- Specialist sexual violence counselling in Gloucestershire is solely provided by Sexual Assault Referral Centres (SARC). However, a service user is signposted to Improving Access to Psychological Therapies (IAPT) if common mental health disorders are identified.

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[56] University College London, 2014
[57] NHS England (2013) *Securing Excellence in commissioning sexual assault services for people who experience sexual violence*, available at www.england.nhs.uk
[58] Domestic abuse related crimes include sexual violence; however, sexual violence is not just within the context of domestic abuse.

- Non-specialist counselling is available through third sector organisations, but access can be limited by fees and waiting period.
- Since April 2016, the SARC service has not offered counselling for victims of historic abuse that occurred more than 12 months previously and who are not eligible for pre and post-trial counselling. During 2015-16 the service received 105 referrals for individuals, who experienced historic sexual abuse. This group cannot any longer be offered services provided by SARC and would need to be referred to other services (such as GRASAC), which will create higher demand for alternative therapeutic services. Additionally, this group is particularly vulnerable to develop long-lasting psychological effects and without easy accessible counselling services and emotional support, individuals may develop more serious mental health problems
- There are concerns about engagement and access to counselling services by the following vulnerable groups: BME individuals, men, sex workers, individual with learning difficulties, and socio-economically deprived.

The recommendations from the above Needs Assessment included: improving access to and managing demand for therapeutic services and developing service pathways. Currently the Domestic Abuse & Sexual Violence (DASV) Board is in the process of considering these recommendations and discussing the best way to address the gaps in service provision for sexual violence victims.

Recommendations:

6.3.1   Investigating further training needs for services that are in contact with domestic abuse victims, e.g. mental health, suicide prevention. Commissioners should ensure that there is an awareness of mental health pathways and support and that signposting is available.

6.3.2   This adult mental health needs assessment supports the recommendations of the *Therapeutic Services for Victims of Sexual Violence in Gloucestershire* (2016): improving access to and managing demand for therapeutic services and developing service pathways for victims of sexual violence. Further, it is recommended that mental health commissioners are engaged in this process to ensure a joined up approach.

6.4   People with substance misuse problems

This chapter focuses on the mental health effects of misusing a range of substances and presents the prevalence of Gloucestershire residents with co-existing mental health and alcohol and/or drug problems. As alcohol dependence is the most common form of substance misuse, alcohol's impact on mental health function is highlighted in this section separately.[59]

Chronic misuse of any mind-altering substance is a risk factor for mental health problems. High doses of some drugs can cause long-lasting changes in the brain, which may lead to paranoia,

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[59] Mental Health Foundation, *Drugs*, available at https://www.mentalhealth.org.uk/a-to-z/d/drugs (accessed on 03/01/17)

depression, aggression, and hallucinations.[60] Amphetamine use can lead to symptoms, which can be very similar to schizophrenia. Similarly, poor mental health can lead to developing substance misuse problems. Approximately 40% of people with psychosis abuse substances at some point in their lifetime, which is double the rate seen in the general population.[61] There is an indication that people with mental health problems abuse substances as a result of their social vulnerability, self-medication or as a coping mechanism.[62]

Excessive and/or long-term intake of alcohol is linked to range of mental health issues from depression and anxiety to self-harm and suicide or later in life to psychotic mental illness and dementia.[63] The prevalence of alcohol problems among people who have died by suicide is high – a study conducted in Northern Ireland highlighted that 43% of all people who died by suicide had consumed alcohol at the time of death, and 62% of people who used mental health services and died by suicide had a history of alcohol abuse. Alcohol not only contributes to some psychiatric disorders, but is also more common among people with mental health conditions who seek to "self-medicate", or use substances for social reasons, such as improving their perceived ability to socialise.[64] Alcohol can also make existing mental health problems worse, for example, individuals who suffer from schizophrenia can suffer a relapse after drinking alcohol. Alcohol withdrawal can cause confusion, extreme anxiety and psychosis.[65]

People who have both mental health and substance misuse disorders and are receiving care from mental health services for reasons other than substance misuse are defined as people with **dual diagnosis.**[66]

People with dual diagnosis, as compared to individuals with mental health problems only, are more likely to have:

- increased likelihood of suicide
- more severe mental health problems
- homelessness and unstable housing
- increased risk of being violent
- increased risk of victimisation

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[60] Rethink Mental Illness (2016) *Drugs, alcohol and mental health - Drugs – effects*, available at https://www.rethink.org/diagnosis-treatment/conditions/drugs-alcohol-and-mental-health/drugs-effects (accessed on 03/01/17)

[61] NICE (2011) *Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings*, available at https://www.nice.org.uk/guidance/CG120/chapter/Introduction (accessed on 05/01/17)

[62] S. Banerjee, C. Clancy, I. Crome (2002) *Co-existing Problems of Mental Disorder and Substance Misuse*, available at http://www.rcpsych.ac.uk/pdf/ddippracmanual.pdf (accessed on 03/01/17)

[63] Royal College of Psychiatrists (2015) *Alcohol and Depression*, available at http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/alcoholdepression.aspx, accessed on 03/01/17

[64] Hamilton I. (2010) *Ensuring integrated treatment for people with mental health and substance use problems* 106: 11Nursing Times 106: 11, available at http://www.nursingtimes.net/roles/mental-health-nurses/ensuring-integrated-treatment-for-people-with-mental-health-and-substance-use-problems/5012894.fullarticle (accessed on 03/01/17)

[65] Royal College in Psychiatrists in Northern Ireland, *Alcohol and Mental Health – the Facts*, available at http://www.rcpsych.ac.uk/pdf/Alcohol%20and%20mental%20health%20fact%20sheet.pdf, accessed on 03/01/2017

[66] The National Drug Treatment Monitoring System (NDTMS), https://www.ndtms.net

- more contact with the criminal justice system
- family problems
- history of childhood abuse (sexual/physical)
- stigmatised as unreliable, feckless, difficult to engage, aggressive or abusive.

As a result they can experience barriers in accessing services and treatment; they can be moved around between services they need support from with no-one taking a responsibility for their care. This can lead to extensive use of emergency services and inpatient beds. They are also more likely to slip through the net of care.[67][68]

Gloucestershire Substance Misuse profile

As illustrated in **Figure 13**, based on the 2013/14 data, in Gloucestershire the most common misused substance is opiates (47.8%, 757 users), followed by opiates and crack together (37%, 586 users). This is in line with the England profile. However, in Gloucestershire the ratio of cocaine users is smaller, as compared with England – 1.6% in Gloucestershire versus 5.5% in England.[69]

Figure 13: Main substance, Gloucestershire, 2013/14
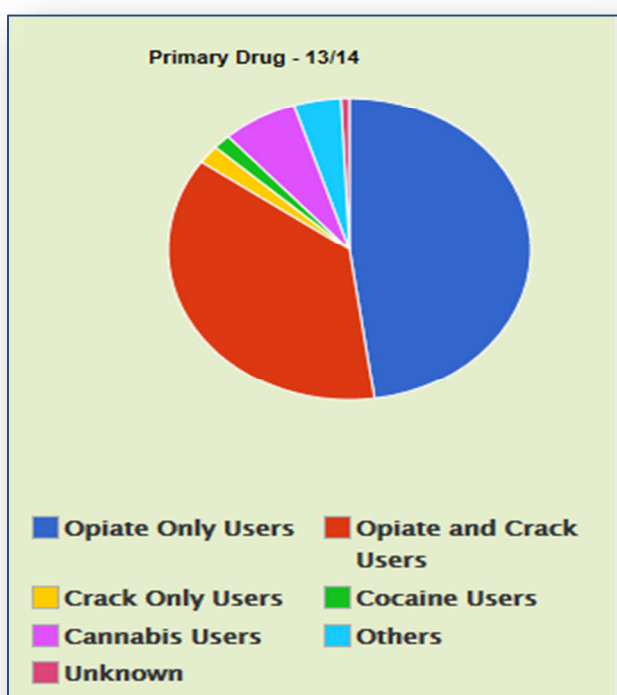
Source: The National Drug Monitoring System

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[67] S. Banerjee et al., (2002)

[68] A. Maryon-Davis (2016) *New NICE guidance on dual diagnosis is 'desperately needed',* NICE, available at https://www.nice.org.uk/news/article/new-nice-guidance-on-dual-diagnosis-is-desperately-needed (accessed on 05/01/2017)

[69] National Drug Monitoring System, available at https://www.ndtms.net/viewit/Adult/Viewer.aspx?theme=subst&shaName=Q39&level=dat&code=K14B&year=9 (accessed on 09/01/17)

In Gloucestershire during the year 2011/12, the estimated prevalence of opiate and/ or crack cocaine users per 1,000 population aged 15-64, was statistically similar to the regional and national prevalence: Gloucestershire – 6.9 (2,644 persons), South West – 7.7, England – 8.4. Gloucester was the only district with the higher prevalence of 10.2 per 1,000 population (883 persons).[70]

Gloucestershire Alcohol Profile

Gloucestershire's key indicators of alcohol profile are generally not statistically worse than the average of England and South West region (Table 4):

- Mortality rate due to alcohol specific conditions is lower than the national and regional average
- Mortality rate due to alcohol related conditions is similar to the national and regional average
- Rate of admissions to hospital, where the primary or any of the secondary diagnosis were an alcohol-related condition (broad definition) is lower than the national and regional average
- Rate of people admitted to hospital due to alcohol-specific condition is lower (better) than the national and regional average.

However, the rate of admissions to hospital, where the primary or secondary diagnosis is an alcohol-related cause (narrow definition) is worse than the national and regional average. This indicator is further analysed below.

Table 4: Key indicators of alcohol profile for Gloucestershire

| Indicator | Period | Glouc'shire | | | Region | England | England | |
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range
2.01 - Alcohol-specific mortality	2012 - 14	–	166	9.0	10.6	11.6	26.6	
4.01 - Alcohol-related mortality	2014	–	257	40.8	42.6	45.5	85.4	
10.01 - Admission episodes for alcohol-related conditions (Narrow)	2014/15	–	4,098	669	638	641	1,223	
9.01 - Admission episodes for alcohol-related conditions (Broad)	2014/15	–	10,879	1,758	1977	2139	3,571	
6.01 - Persons admitted to hospital for alcohol-specific conditions	2014/15	–	1,855	306	353	364	1,086	

Compared with benchmark ◯ Better ◯ Similar ◯ Worse   ◯ Lower ◯ Similar ◯ Higher   ◯ Not Compared

Source: Public Health England, Local Alcohol Profiles for England

Figure 14 and Figure 15 illustrate the further analysis of admissions to hospital, where the primary or secondary diagnosis is an alcohol, by gender and districts.

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[70] PHE, *Co-0ccuring substance misuse and mental health problems*, http://fingertips.phe.org.uk/drugsandmentalhealth#page/0/gid/1938132790/pat/6/par/E12000009/ati/102/are/E10000013/iid/91117/age/182/sex/4 (accessed on 10/01/17)

Nationally and locally, the numbers of admission are higher for males than females. In Gloucestershire the male standardised rate for admissions decreased over the period 2008/09 to 2014/15 and is lower than the regional and national rate: Gloucestershire – 776; South West – 784, England – 827 (per 100,000 population). However, the female hospital admissions rate is higher than the regional and national rate: for 2014/15 in Gloucestershire – 577, South West – 510, England – 474 (per 100,000 population). The similar trend in female admissions was observed for the whole 2009/10 to 2014/15 period.

Figure 15 indicates, that the highest rate of hospital admissions in 2014/15 was observed from Gloucester and Cheltenham, where the rate was higher than national and regional average. From Stroud and Tewkesbury the rate of admissions was similar as in South West and England, while from Cotswold and Forest of Dean this rate was lower.

Figure 14: Hospital admissions for alcohol-related conditions (narrow definition), all ages
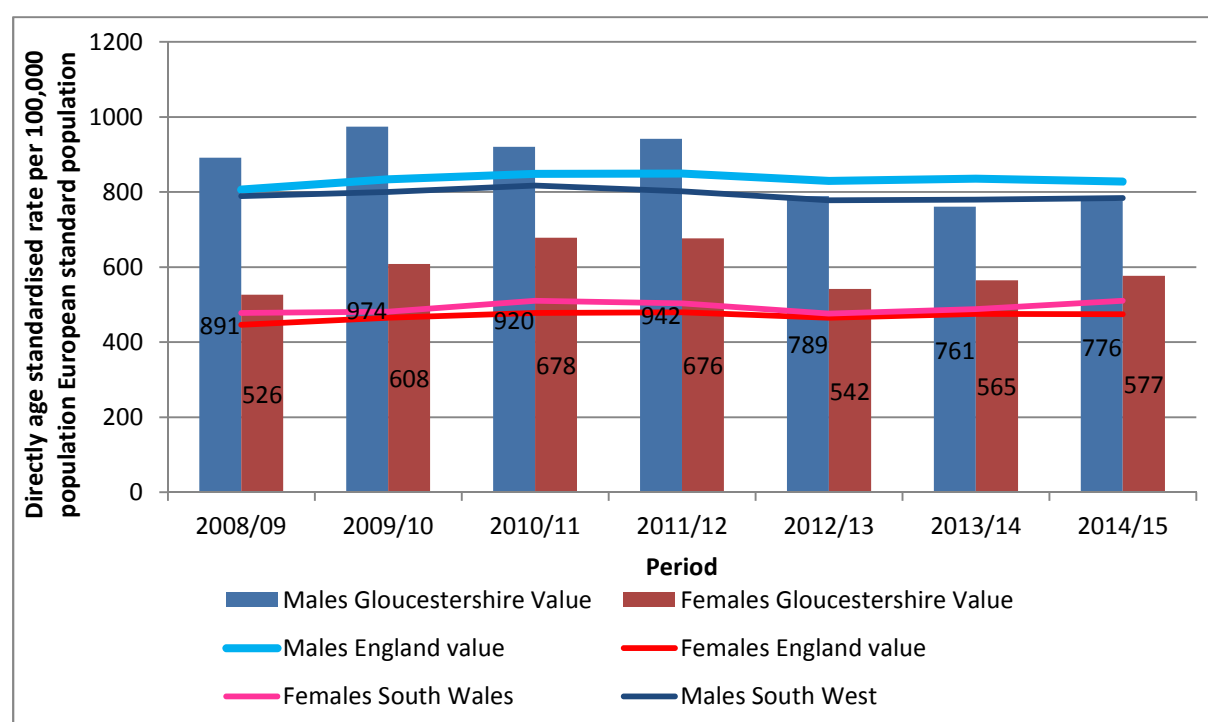
Source: Public Health England, Local Alcohol Profiles for England

Figure 15: Hospital admissions for alcohol-related conditions (narrow definition), 2014/15, all ages, by district
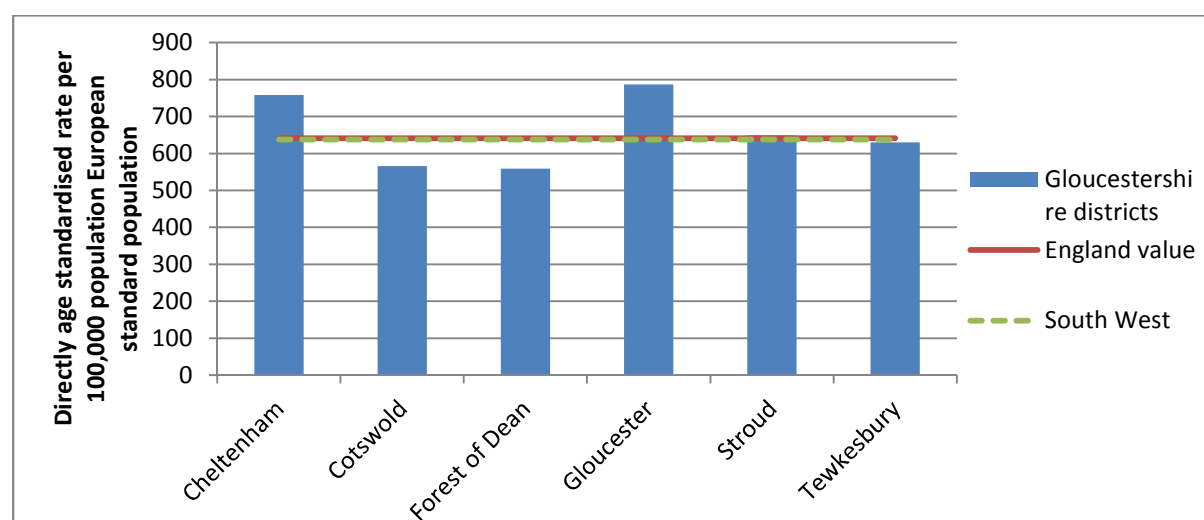
Source: Public Health England, Local Alcohol Profiles for England

Gloucestershire dual diagnosis profile

In Gloucestershire during 2015/16, 58 individuals receiving treatment for either drug or alcohol dependence were reported as having a sufficiently severe co-occurring mental health condition and to be also receiving care from Community Mental Health Teams (CMHTs) (**Table 5**). This equates to approximately 2.3% of the local substance misuse population. Additionally eight individuals were recorded as being engaged with IAPT services.

Table 5: People with dual diagnosis, 2015-16, Gloucestershire

Engaged with CMHT	Number	Percentage
Alcohol	13	1.4%
Drug	45	2.8%
Total:	58	2.3%

Source: Turning Point, Gloucestershire

These figures only partially represent the extent of mental health conditions occurring in the drug and alcohol using populations. Local data reported to Public Health England suggests that more individuals report having a co-occurring mental health condition than those who are receiving care from CMHTs. This is likely due to varying severity. Using 2015-16, 309 clients self-report having a co-occurring mental health condition (some of these individuals will be included in the treatment start and CMHT engagement figure stated above).

It is difficult to compare Gloucestershire's drug and alcohol treatment population with the national picture as there is no current national dual diagnosis prevalence estimate. However, NICE recently undertook a literature review and identified the prevalence of dual diagnosis amongst those in contact with substance misuse services. This gave wide range of prevalence estimates, between 5.7% and 38.8%; NICE advises that this estimate should be interpreted with caution.

> **Recommendations:**
>
> 6.4   Due to their multiple needs, people with a dual diagnosis of both mental health and substance misuse disorders require good communication and coordination between services they use. Mental health, substance misuse and other services, such as housing and social care, should work together to provide care and support their needs.

6.5   Care leavers

Although this needs assessment concerns adult mental health, care leavers are included due to their particularly vulnerable situation during the transition from child to adult mental health services.

A care leaver is a person who has been looked after by a local authority for a period of 13 weeks, or separate periods equivalent in total to 13 weeks, which started after the age of 14 and ended after the age of 16.[71] Children in care must leave local authority care by the age of 18. However, their transition to adulthood may start as young as 16. In contrast, half of all young people in UK still live with their parents at the age of 22.

Care leavers face many additional challenges due to their childhood experience, as compared with their peers living with parents. Based on 2012 data, the main reason for 62% of children being placed in care was abuse and neglect. About half of looked-after children encounter emotional and mental health problems. The likelihood of being exposed to deprivation and poverty is higher for children in care, as a result of low family income. The percentage of care leavers, who are not in education, employment or training (NEET) is higher than their peers: 41% of care leavers aged 19 versus 15% of all 19 years old. Only 6% of care leavers are in higher education, as opposed to one-third of all 19 years old. These challenges have a significant and lasting effect on their mental health and wellbeing and their longer-term outcomes of mental health remain worse than their peers. According to 2012 data, looked-after children and care leavers are between four and five times more likely to self-harm in adulthood.[72] Further information on children in care can be found in *Gloucestershire's Transformation Plan for Children & Young People's Mental Health & Wellbeing Needs Assessment* (available at: https://inform.gloucestershire.gov.uk/get/ShowResourceFile.aspx?ResourceID=419).

The government strategy for young people leaving care highlighted that care leavers frequently reported that they often feel that the professionals working close to them do not have an understanding of their needs, particularly in respect of mental health. They also reported that they

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[71] Department for Education (2010) *Children Act 1989: transition to adulthood for care leavers*, https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers (accessed on 11/01/2017)

[72] Department for Education, National Audit Office (2015) Care leavers' transition to adulthood, https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf (accessed on 11/01/17

experience difficulties around the transition from Child and Adolescent Mental Health Services (CAMHS) to adult services.[73]

In Gloucestershire in 2015, 90 children left care. More than three quarters (76%) of these people were aged 18 or over at the time of leaving care (**Figure 16**). 24% were aged between 16 to 17 years old. As compared with England, in Gloucestershire a smaller proportion of children leave care at the early stage (aged 16-17).

Figure 16: Children leaving care in 2015 aged 16 or over
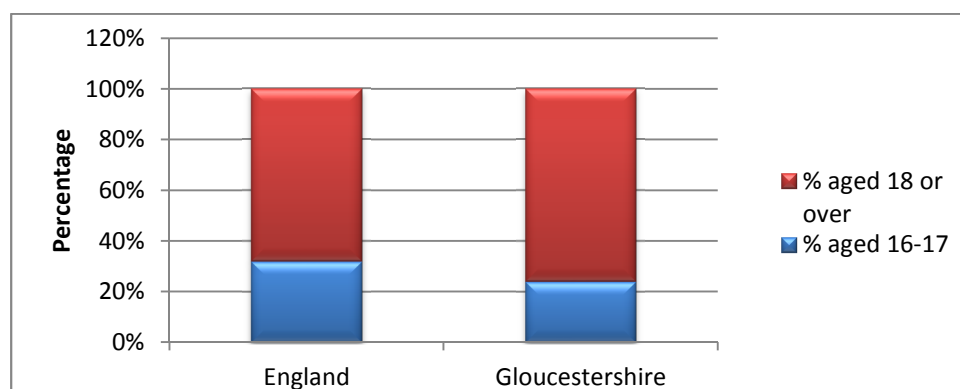
Source: Gloucestershire County Council, Data and performance team

Recommendations:

6.5.1   Care leavers should receive support and guidance about their mental health needs and how they will be met by service, before and after they turn 18.

6.5.2   Further work should be undertaken to support the skills and knowledge of those in contact with care leavers (such as health professionals, teachers, social workers) to support the care leaver's mental health.

6.6   Homeless people

This section focuses on mental health problems in the adults who are or were homeless. People can be homeless in a variety of ways: from living in temporary accommodation, such as hostels or sofa-surfing to sleeping on the street. The particular interest is focused on rough sleeping, which includes sleeping on the street, or stairwells, barns, sheds, car parks, cars, stations, etc., but exclude people living in hostels, shelters and campsites.[74]

Results from a health audit conducted between 2012 and 2014 by Homeless Link with people who had experienced homelessness indicate, that 80% of homeless people reported some form of mental

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[73] HM Government (2013) *Care Leaver Strategy*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf (accessed on 11/01/2013)
[74] Department for Communities and Local Government (2015) *Rough Sleeping Statistics Autumn 2015, England,* available at https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2015, (accessed on 16/01/2017)

health issue. 45% had been diagnosed with a mental health issue, which is nearly double that of the prevalence in the general population (25%). As illustrated in **Figure 17**, the occurrence of depression is significantly worse (around 12 fold) in homeless people than the whole population. There is also a higher proportion of people with schizophrenia, bipolar disorder and personality disorder. 12% of people have dual diagnosis, which means they experience both mental health and substance misuse disorders. People with dual diagnosis, as described in Section **0**, face further problems in accessing treatment for mental health problems. Homeless people experience additional problems, which makes them even more vulnerable and at an increased risk of poor mental health (as described in the sections above):

- 73% reported physical health problems (including long-term problems reported by 40%)
- 39% stated they take drugs or are recovering from a drug problem
- 27% reported having or recovering from an alcohol problem
- almost half reported to use drugs and/ or alcohol to deal with their mental health problems.[75]

Figure 17: Diagnosed mental health issue (general population in brackets)
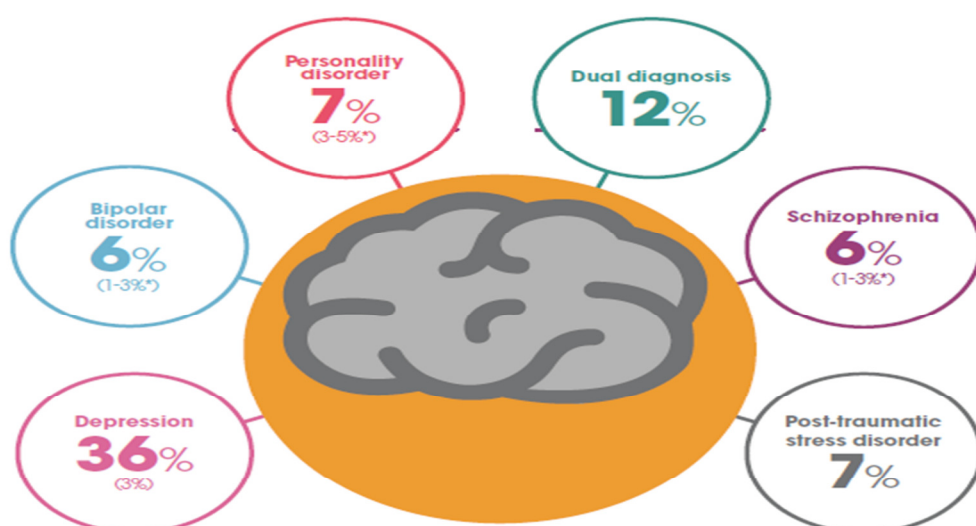
Source: Homeless Link, *The unhealthy state of homelessness, Health audit results 2014*,

The relationship between poor mental health and homelessness varies according to the type of homelessness and this association is even stronger for rough sleepers. Almost all of the clients who Gloucestershire's street homeless Outreach team work are described as having 'complex needs', i.e. a combination of mental health, physical health, drug and/or alcohol problems. Of the 142 individual clients (either current or recent rough sleepers) who the rough sleepers outreach team have worked with across the county during 6 months of January-June 2017, the primary reason each individual gave for their (most recent) homelessness was:

- Top three factors:
    o relationship breakdown: 29 people (20%);

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[75] Homeless Link (2014) *The unhealthy state of homelessness, Health audit results 2014,* available at http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf (accessed on 16/01/2017)

- o evicted from supported housing: 23 people (16%);
- o drug problems: 27 people (19%)
- • Other significant factors:
  - o other tenancy breakdown (i.e. not social housing or private tenancy): 12 people (8%);
  - o mental health problems: 10 people (7%);
  - o released from prison: 10 people (7%);
  - o alcohol problems: 8 people (6%).

Many individuals will have overlapping reasons: eviction / tenancy breakdown are often related to drug problems or financial circumstances; similarly with relationship breakdowns.

Another measure to demonstrate the prevalence of mental health and the multiple issues of rough sleepers is looking at supported needs assessed by the outreach team when they started working with the clients:

- • Mental health issues: 120 people (85%)
- • Drug issues: 90 people (63%)
- • Alcohol issues: 85 people (60%)
- • Benefits issues: 75 people (53%)
- • Offending history: 74 people (52%)
- • Physical health issues: 70 people (49%)
- • Literacy/numeracy: 36 people (25%)
- • Domestic abuse: 28 people (20%)
- • Learning disabilities: 24 people (17%).

Additionally, according to national research, rough sleepers are less likely to be registered with a GP (only 67%), than people from other types of homelessness (single homelessness in accommodation – 88%). This compares to the 98% of the adult general population registered with a GP.[76]

Healthwatch England identified that co-ordination between hospitals and housing services should be improved to enable homeless people's continued recovery after discharge. There is a risk of people being re-admitted to hospital due to not being given care and support during their recovery time. It was established that homeless people stay around 3 times longer in hospital than the general population[77]. The results from a St. Mungo's investigation[78] suggest that people are back to sleeping rough in a short time of leaving mental health inpatients care. However, this may not be a significant issue in Gloucestershire, due to the impact of Time to Heal services (TTH). This is provided by Elim

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[76] Elwell-Sutton, T., Fok J., Albanese F., Mathie H., Holland R. (2016) *Factors associated with access to care and healthcare utilization in the homeless population of England*. Journal of Public Health, available at https://ueaeprints.uea.ac.uk/57742/1/Homeless_healthcare_paper_v7_05_untracked.pdf, (accessed on 07/03/17

[77] Healthwatch England (2015) *Safely home: What happens when people leave hospital and care settings?,* Special Inquiry Findings, available at:
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf (accessed on 16/01/2017)

[78] St Mungo's (2016) *Stop the Scandal: an investigation into mental health and rough sleeping,* available at: https://www.mungos.org/publication/stop-scandal-investigation-mental-health-rough-sleeping/ accessed on 17/01/2017

Housing, with support services based in Gloucestershire Royal Hospital. TTH works with the Integrated Discharged Team to identify accommodation issues and to ensure that homeless patients are not discharged back to the street. TTH refers the patient to a GP or to the Homeless Healthcare Team and work closely with other organisations supporting homeless people.[79]

The single night snapshot of the number of people sleeping rough in England carried out between 1st of October and 30th of November 2016 stated that there were 42 rough sleepers in Gloucestershire, which equates to a rate 0.2 per 1,000 households. This indicates an increase of 40% as compared with 2010 (30 rough sleepers) and twice as many as compared with 2015 (21 rough sleepers). The highest rate per 1,000 household was observed in Gloucester (0.43) and Cheltenham (0.21), followed by Cotswold (0.16) and Stroud (0.04).There were no rough sleepers registered in Forest of Dean and Tewkesbury during this snapshot.[80] [81]

Views and experiences of homeless people and staff supporting them in Gloucestershire, along with the recommendations were captured in Healthwatch Gloucestershire's report:[82] [83]

- Support for people with a mental health problem is seen as a significant issue by the homeless people and by the front-line staff. The mental health need of vulnerable groups is considered by these stakeholders not to be met.
- Staff reported that the criteria a person needs to meet in order to receive the support from various specialists is too restrictive, which can mean that some people are falling through the gaps. Long waiting times for some therapies result in additional problems for people.
- Staff also acknowledged that there are some difficulties around access to information and advice and there is variable communication between all services that are in touch with vulnerable groups. People who are sleeping rough and people with dual diagnosis experience particular barriers in access to treatment.
- The recommendations include the reviewing of pathways for marginalised and vulnerable people needing mental health support and improving communication between organisations engaged with these groups.

Formal responses to the recommendation's report received from commissioners and providers highlighted that there are various projects in place addressing the above issues, such as the Gloucestershire Crisis Care Concordat multi-agency workforce development group, which is providing training to various organisations to improve awareness of the crisis pathway, available services, referrals pathways etc. The organisations who are in contact with homeless people expressed initial interest in participating in this training. There are also many multi-agency groups recently formed to share information and develop joint action plans. Gloucestershire Health and

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[79] ELIM HOUSING, Time To Heal, http://www.elimhousing.co.uk/health-housing (accessed on 17/01/2017)
[80] Department for Communities and Local Government (2017) *Rough Sleeping in England: autumn 2016* https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2016, accessed on 02/11/2017
[81] The figures are subject to some uncertainty. Rough sleepers may bed down at different times meaning that some may be missed. Some places of rough sleeping may be difficult or unsafe for those conducting the count to access.
[82] Healthwatch Gloucestershire (2016*) Report on access to health and social care services by marginalised and vulnerable people in Gloucester,*
[83] Feedback was provided not only by homeless people, but by general vulnerable and marginalised groups, of which significant proportion are or have been homeless) and by the front-line staff.

Wellbeing Board recently signed up to the *Charter for homeless health*, which will involve undertaking Joint Strategic Needs Assessment.

Addendum: Please note a Homeless Health Needs Assessment with more in-depth structure is planned to be completed by mid-2018.
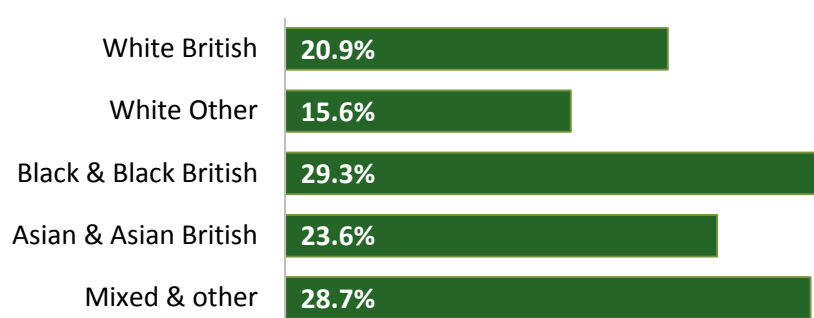

Recommendations:

6.6   Commissioners and providers, who are in contact with homeless people, should continue to improve their ways of working together, to make sure that people get help for their complex needs. Further work is needed to ensure that Gloucestershire Crisis Care Concordat Workforce Development Group will reach all groups who are in touch with homeless people. A planned Joint Strategic Needs Assessment should provide the leadership on addressing health needs, including mental health needs, and other determinants of poor mental health.

6.7   People from black and minority ethnic communities

The prevalence of mental health problems vary by different ethnic groups. Gypsies and Travellers are discussed further in Section **0** , due to their specific living conditions and needs.

The most recent survey of mental health in adult in England indicates that there is no significant variance in the prevalence of Common Mental Disorders (CMD) between ethnic groups in men, while there is in women. Non-British white women present lower than White British prevalence of CMD, while CMD are most common among Black and Black British women (**Figure 18**). Additionally this research indicated that Black women are significantly more likely to have depressive episodes, while panic disorder is more prevalent in mixed, multiple and other ethnic groups.[84]

Figure 18: Percentage of female reporting common mental disorder in the last week by ethnicity, England 2014, age-standardised

Ethnicity	Percentage
White British	20.9%
White Other	15.6%
Black & Black British	29.3%
Asian & Asian British	23.6%
Mixed & other	28.7%

Source: Health and Social Care Information Centre (2016) *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 [NS]*

Looking at the psychotic disorder variations by ethnic groups, this research indicated that there is no significant difference in prevalence among women, as there is among men (**Figure 19**).Psychotic

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[84] McManus S., Bebbington P., Jenkins R., Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. Available at: http://content.digital.nhs.uk/catalogue/PUB21748 (accessed on 23/01/17)

disorder is more common among black men (3.2%) than Asian men (1.3%), white men (0.3%) and men from mixed/other ethnic groups (no cases recorded).[85]

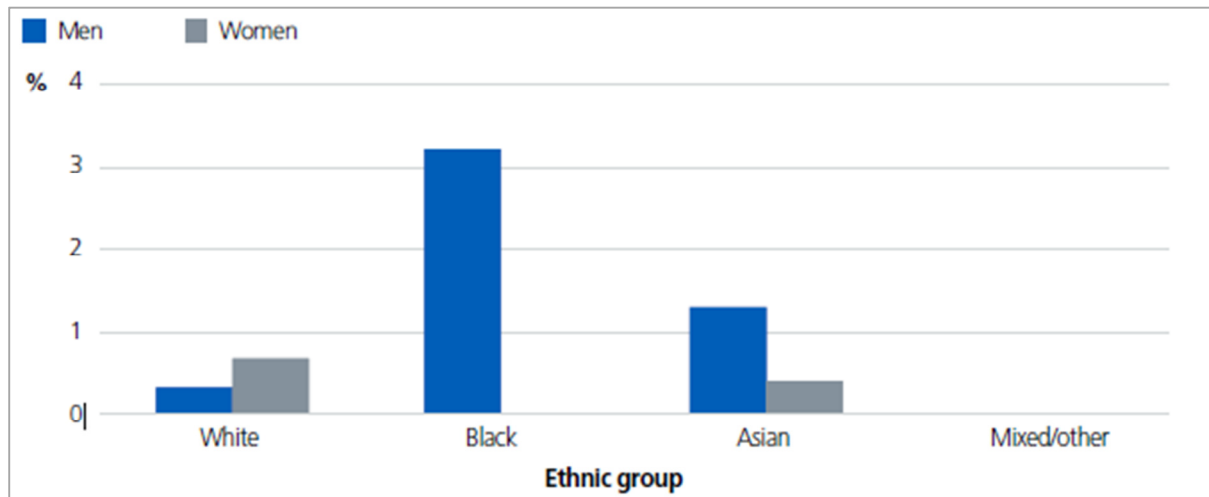**Figure 19: Psychotic disorder in the past year (2007 and 2014 combined), by ethnic group and gender**

Source: Health and Social Care Information Centre (2016), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 [NS]*

In addition, it has been suggested that, although African-Caribbean people present lower prevalence of CMD, they are more likely to suffer severe mental illness: diagnosis and admission to hospital for schizophrenia is between 3 to 5 times more common for this group. This ethnic group is also more likely to be signposted to mental health services through the courts or police, rather than via primary care, more likely to be offered medication, rather than talking treatment, and be detained under the Mental Health Act.[86]

Statistics and knowledge relating to Asian or Chinese ethnic groups are inconsistent and incomplete.

Overall, it has been suggested that people from black and minority ethnic groups within the UK are:

- More likely to be diagnosed with a mental health problem
- More likely to be admitted to hospital
- More likely to experience poor outcome from treatment
- More likely to disengage from mainstream mental health services.[87]

Suggested causes for differences in prevalence of mental health problems between ethnic groups include:

- Cultural and socio-economic factors, such as poverty or racism
- Being reluctant to engage with health services generally, which can lead to disengagements with mental health services

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[85] McManus et.al, (2016)

[86] Mental Health Foundation, Black, *Asian and minority ethnic (BAME) communities,* available at https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities, (accessed on 23/01/17)

[87] Ibid

- Approaches to mental health treatment can be culturally unsuitable
- Some ethnic groups living within close-knit family structure may feel guilt and shame when presenting with mental health problems[88]

Gloucestershire's population breakdown by broad ethnic groups is attached in the **Appendix 2**. The Gloucestershire County Council ethnicity profile indicates that the Black and Minority Ethnic population represents 4.6% (27,337 people) of the population, which is significantly lower than the England average of 14.6% (based on Census 2011). Out of that the largest proportion is made up by Asian/Asian British groups (12,433). Gloucester presents the highest proportion of Black and Minority Ethnic groups, which is nearly double the Cheltenham percentage, and around 5 times more than in the other districts (although, it is still lower than the national average). Forest of Dean has the lowest percentage of people from a Black and Ethnic Minority groups (1.5%). Non-British white people make up a higher proportion in Cheltenham than the average in Gloucestershire and England.[89]

As indicated by Public Health England only 3% of adults in contact with mental health services are from black and ethnic minorities. This is slightly lower than the overall population breakdown of 4.6%.

> **Recommendations:**
>
> 6.7   Further work should be done to identify the local evidence on differences in prevalence of mental health problem between ethnic groups, especially for women. Mental health early intervention and anti-stigma strategies should be reviewed, to ensure they are culturally appropriate and culturally customised. Mental health services should engage with organisations dealing with racial discrimination to identify and reduce the ethnic inequalities in mental health.

6.8 Gypsy and Travellers

This section reflects on the socio-economic factors and their contribution to Gypsies' and Travellers' mental health.

It has been suggested that Gypsies and Travellers experience worse mental health than the settled community. A report by the Traveller Movement concluded that the living conditions of this group considerably impact on their mental health. Living environment, accommodation insecurity, low educational achievement, economic exclusion, community isolation and discrimination have a negative influence on mental health.[90]

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[88] Ibid
[89] Gloucestershire County Council (2016) *Population Profile*, available at
https://inform.gloucestershire.gov.uk/ViewPage1.aspx?C=Resource&ResourceID=126&cookieCheck=true
(accessed on 23/01/17
[90] The Traveller Movement (2016) *Impact of insecure accommodation and the living environment on Gypsies' and Travellers' health,* available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490846/NIHB_-_Gypsy_and_Traveller_health_accs.pdf (accessed on 24/01/17)

Help-seeking and access to the health services can be also challenging for this community due to numerous factors, such as:

- primary care registration, which requires proof of identification and address
- poor literacy skills
- fear of discrimination (resulting in non-engagement and hiding ethnicity)
- over reliance on A&E services (especially mobile and/or homeless Gypsies and Travellers)
- negative perception of mental health (for example the term 'mental' is viewed with suspicion, being linked with madness)[91]
- health professionals can lack the skills, support and cultural understanding/awareness of these communities.[92]

There is not much data on the prevalence of mental health issues among the Gypsy and Traveller community in England. A small study indicated that, 39% of the study sample suffers from anxiety and depression.[93] [94] This illustrates a potential example of the mental health prevalence among this group.

According to Census 2011, in Gloucestershire there were 478 Gypsies and Travellers. As illustrated in **Figure 20** Tewkesbury presents the highest number and the highest rate of the Gypsies and Travellers over 18 years old, 187 and 28.4 respectively. The Tewkesbury rate is nearly three times higher than Gloucester's and Cotswold's rates (districts with second and third highest rates and numbers).

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[91] Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. (2004) *The Health Status of Gypsies and Travellers in England*, Sheffield, University of Sheffield, available at https://www.shef.ac.uk/polopoly_fs/1.43714!/file/GT-final-report-for-web.pdf, (accessed on 24/01/17)
[92] The Traveller Movement (2015) *Improving the health of Gypsies and Travellers*, available at http://www.travellermovement.org.uk/wp-content/uploads/2015/01/Gypsy-Traveller-Health-Briefing-2015.pdf, (accessed on 24/01/17)
[93] Based on 33 interviews with community members carried out across a dispersed sample in 5 regions of England and in Wales
[94] The Traveller Movement (2015)

Figure 20: Numbers and rates of Gypsy or Irish Travellers over 18years old, by district, 2011
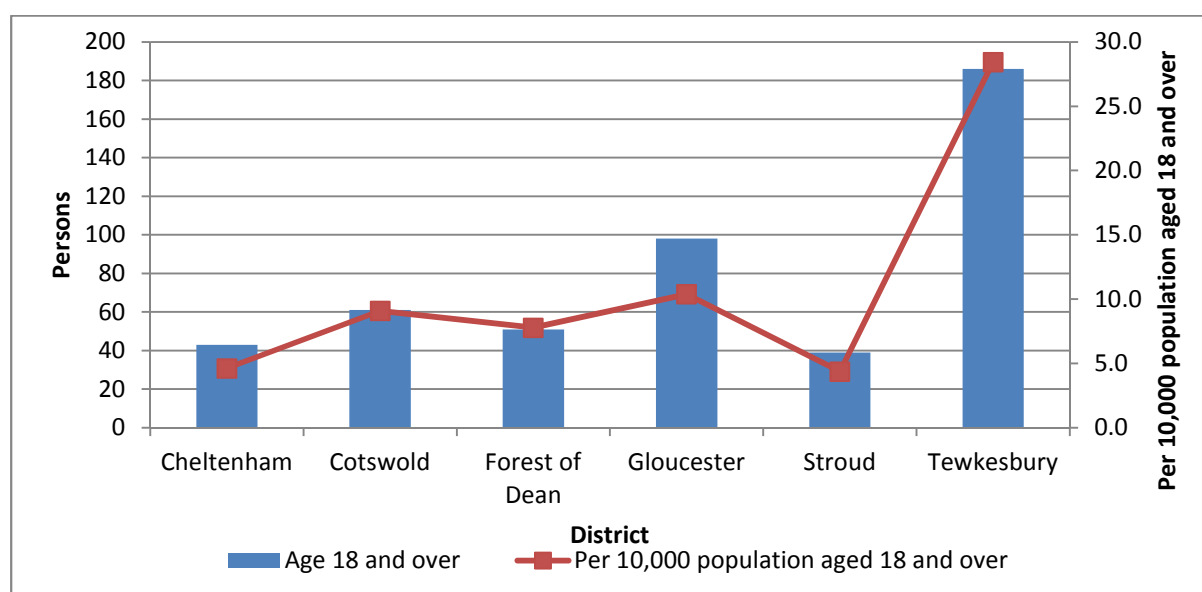
Source: Office for National Statistics, 2011

Recommendations:

6.8   Further review of literature needs to be completed to establish the relationship between mental health among the Gypsy and Traveller community. The overall small numbers in Gloucestershire suggest that there is no necessity to prioritise this group over the other vulnerable groups. However, any public communication on mental health problems and services should consider the ways to reach this group.

6.9   People who are unemployed

This section looks at mental health issues based on employment status.

As presented in Chapter **5**, unemployment is detrimental to mental health and wellbeing. A recent National Statistics publication[95] concluded that lack of work has a negative effect on a range of mental health disorders **(Table 6)**. Common Mental Health Disorders (CMHD), positive screens for Post-Traumatic Stress Disorder (PTSD), experienced trauma, psychotic disorders, suicidal thoughts and attempts, and self-harm are the most common among economically inactive people and more common among unemployed people than those in employment (based on adults aged 16-64):[96][97]

This research suggests that unemployed and economically inactive people are:

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[95] National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

[96] Unemployed classifies people out of work in the four weeks before interview, or on temporary sickness or injury, and available to start work in the two weeks after the interview. Otherwise, anyone out of work is classified as economically inactive

[97] McManus et.al, (2016)

- At least twice as likely to experience CMHD, attempt suicide and self-harm
- Around five times more likely to be screened as positive for PTSD.

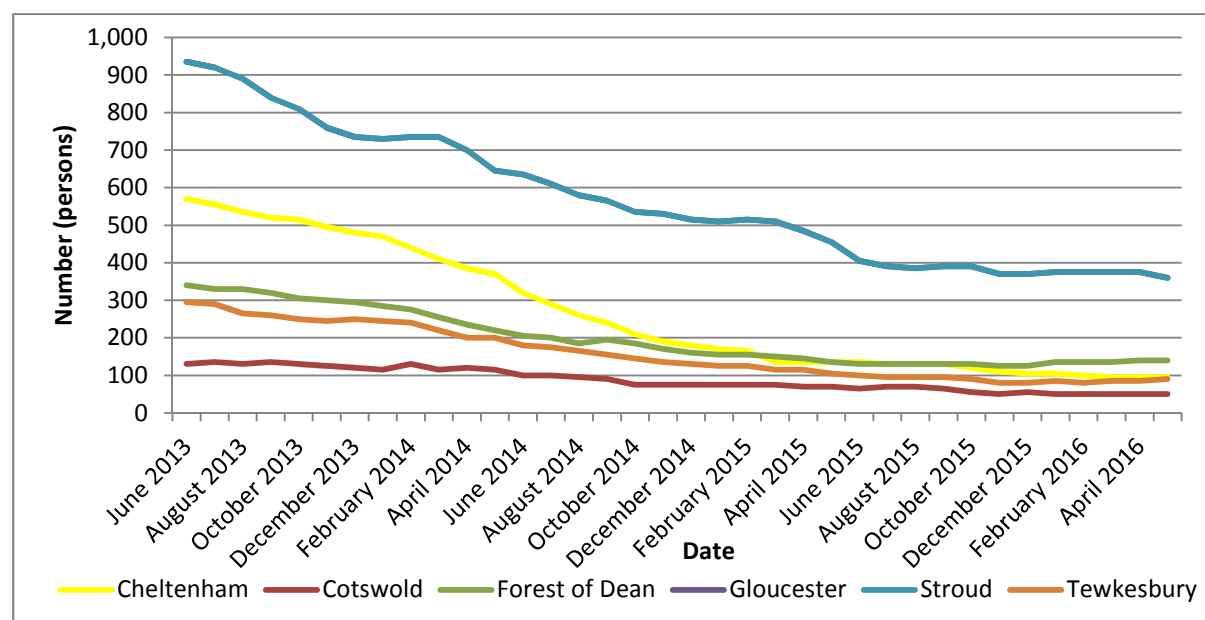**Table 6: Prevalence of mental health disorders, by employment status (adults aged 16-64; age standardised)**

Status of employment	CMHD	PTSD screen positive	Trauma experienced	Psychotic disorder	Suicide thoughts	Suicide attempts	Self-harm
Employed	14.1%	2.7%	29.7%	0.1%	20.8%	5.8%	7.6%
Unemployed	28.8%	10.0%	33.9%	0.6%	30.5%	11.3%	12.6%
Economically inactive*	33.1%	10.5%	38.2%	2.3%	34.0%	16.1%	14.6%

* The 'economically inactive' group includes students, and those looking after the home, long term sick or disabled, or retired.

Source: Health and Social Care Information Centre (2016) *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 [NS]*

In Gloucestershire in August 2016 there were 710 people in long-term unemployment (0.19% of the working age population).[98] This proportion was almost half of the national average (0.37%) and similar to the regional proportion (0.18%).[99] As captured in the **Figure 21** there is a falling trend in numbers of people claiming Job Seeker Allowance (JSA) in all districts. The highest proportional decrease was observed in Stroud and Cheltenham and the lowest in Forest of Dean. Interestingly, in 2013 the number of Cheltenham JSA's claimants was higher than in Forest of Dean, which was reversed by 2016.

Figure 21: Number of people aged 16-64 claiming Jobseeker's Allowance for over one year, by districts (2013-2016)

Source: Office for National Statistics

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[98] People in long-term unemployment are people of the working age (16-64) that have been claiming job seeker allowance for over 12 months.
[99] Public Health England, *Common Mental Health Disorders*, available at http://fingertips.phe.org.uk/common-mental-disorders#gid/8000041/ati/102 (accessed on 25/01/17)

6.10 People who are in financial debt

There are many reasons why people get into financial debt; long-term unemployment being one among the many, as described above. Experiencing poor mental health can also affect personal finances. Conversely, money difficulties can trigger mental health problems.

Research by Royal College of Psychiatrists found that in the UK one in two adults in financial debt also presents with mental ill health. These include feelings of anxiety, but also diagnosed mental health disorders. On the other hand, one in four people with poor mental health is also in debt.[100]

In Gloucestershire during the first half of the 2014 year there were 2,018 Gloucester and District Citizen Advice Bureau clients with debt issues. Out of that, the highest numbers were Gloucester (701) and Stroud residents (447), which made up half of all clients (**Figure 22**). Cheltenham's residents were the smallest client group of 137 people.

Figure 22: Gloucester & District Citizens Advice Bureau – clients with debt issues, by district, 2014-15 Quarters 1 and 2 cumulative:
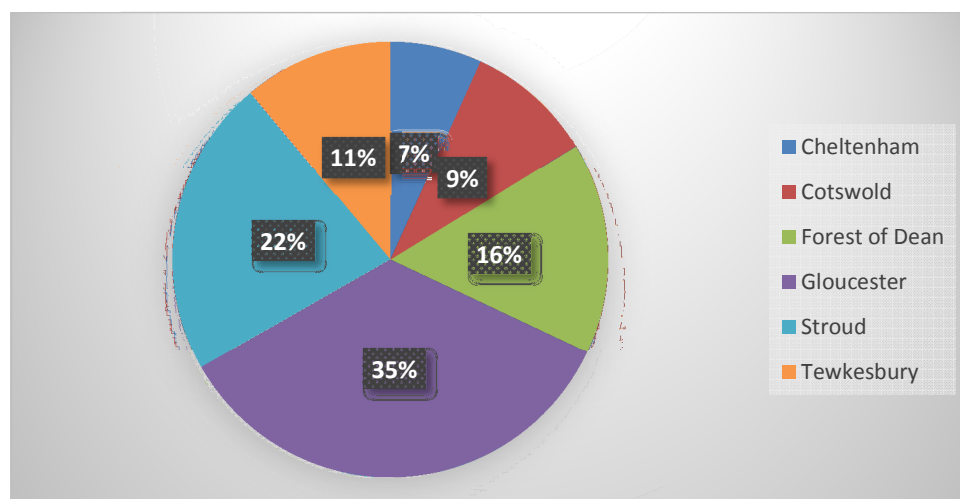
Source: Gloucester & District Citizens Advice Bureau

This data does not represent the real size of the Gloucestershire population with debt issues, as not every person in debt reports to Gloucester & District Citizen Advice Bureau.

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[100] C. Fitch, S. Hamilton, P. Basset, R. Davey (2010*) Debt and mental Health, What do we know? What shall we do?*, Royal College of Psychiatrists, available at http://www.rcpsych.ac.uk/pdf/Debt%20and%20mental%20health%20(lit%20review%20-%2009_10_18).pdf (accessed on 25/01/17)

> **Recommendations:**
>
> 6.10.1   Further work is needed to support debt services on mental health screening and referral links for people reporting debt. Mental health professionals should ensure that the patients are asked about financial difficulties and accordingly signposted to the money advice sectors; this could be achieved by working close with social prescribing services.
>
> 6.10.2   Training for debt advisors in Mental Health First Aid should be considered.

6.11 Carers

This section focuses on the mental health implications of having caring responsibilities (as distinct from people who are employed as carers). A short profile on the number of unpaid carers is included.

The role of carers is vital for the health and wellbeing of many vulnerable people with physical and/or mental health needs. However, the responsibility and challenges carers face affect their quality of life and their health, and increase the risk of mental health problems.

There is an indication that many carers experience poor mental health. Findings from Carers UK's 2015 survey highlighted that 84% of carers reported feeling more stressed, 78% more anxious and 55% stated that they suffered from depression as a result of their caring role. This is higher than reported findings from 2014 survey: 82%, 73% and 50% respectively.[101]

Within the Gloucestershire population there are around 2.05% (12,218) people providing over 50 hours of unpaid care a week, which is a smaller proportion than the national and regional average (2.37% for both). However, Forest of Dean has a higher proportion than the national average (2.65%, 2,175 people) (**Figure 23**). Cheltenham has the lowest percentage of all districts (1.66%, 1,917 people). The highest number of unpaid carers is in Gloucester (2,732 people, 2.25%).[102]

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[101] Carers UK (2015) *State of Caring 2015*, available at https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2015 (accessed on 30/01/17)
[102] Public Health England, *Public Health Profiles*, available at https://fingertips.phe.org.uk/search/carer#page/3/gid/1/pat/6/par/E12000009/ati/101/are/E07000081/iid/90411/age/1/sex/4, (accessed on 30/01/17)

Figure 23: Percentage of Gloucestershire population, who provide over 50 hours a week unpaid care, by district, 2011, all ages
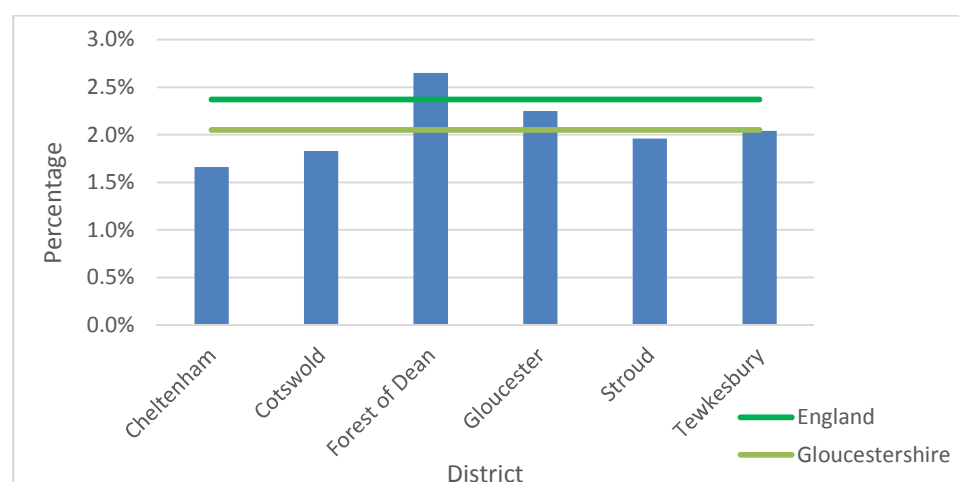
Source: Public Heath England, Public Health Profiles

A sample of local carers' views are included in Chapter **10**. Gloucestershire's carers report that they feel that they do not receive substantial support; they report feeling that they are not always listened to by professionals, taken seriously or engaged in care planning. Additionally, the requirement for improved information sharing and understanding between various organisations has been raised by Gloucestershire's carers.[103]

In Gloucestershire, 2gether NHS Foundation Trust is a member of the *Triangle of Care,* the national scheme run by the Carers Trust. This service is working closely with carers, service users and professionals. This scheme aims to promote safety and recovery for people with mental health problems and encourage their wellbeing by including and supporting their carers. Currently the Trust is evaluating how well they support carers using the Triangle of Care toolkit and improving services where there are gaps.

Recommendations:

6.11.1   Comprehensive evaluation of local carers' views would help identify their mental health needs and the ways of preventing of poor mental health; the results of the evaluation currently being carried out by 2gether NHS Foundation Trust might help to balance the reported views of carers.

6.11.2   Ensure carers' assessments include information about mental health.

6.12 Refugees and asylum seekers

Refugees and asylum seekers are more vulnerable to mental health problems due to pre-migration events, such as traumatic experiences of war or torture, and post-migration issues, such as insecure legal status, separation from family, unemployment, inadequate housing and discrimination. This

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[103] These findings are not based on comprehensive review of carers' voices. Please see details in Chapter **10**

leads to high rates of mental health disorders, particularly high rates of depression, PTSD and anxiety disorders. Additionally research on mental health service usage conducted in Leeds suggested that the prevalence of mental health needs of asylum seekers is five times higher than among the whole population, and more than 61% of asylum seekers will encounter serious mental health distress. However, this group of increased vulnerability is less likely to receive mental health support than the whole population, according to secondary healthcare data.[104]

The data on the refugee and asylum seekers population size in Gloucestershire is not consistent. According to Public Health England in 2013, in Gloucester the rate of the asylum seekers receiving support for housing and/or basic living expenses was 5.7 per 10,000 (70 people). This is higher than the national average of 3.9. The rate for Cheltenham district was supressed due to small numbers; the remaining districts' rates were zero. However, this is not a complete picture of the asylum seeker population, as it does not include the rejected applicants, who remained in the country; it also excludes the unaccompanied asylum-seeking children supported by local authority.[105]

Gloucestershire Action for Refugees and Asylum Seekers (GARAS) highlighted in their annual report 2016 that they have conducted 17,167 client consultations during 2016, which represents an increase of 204% as compared with 2015. 276 people were new clients. The countries with the highest representation were Afghanistan, Eritrea, Sudan, Iran and Syria. Counselling/ psychotherapy are among services offered by GARAS. During 2016 GARAS provided this service to 31 people, with 14 ongoing clients and 17 new. The majority of clients were of African descent.[106]

Recommendations:

6.12   Based on the higher than national rate of asylum seeker and the growing trend in the size of this population further assessment of mental health needs is recommended to inform prevention and early intervention services and identify gaps in service provision or access.

6.13 People who are lesbian, gay, bisexual or transgender (LGBT)

The prevalence of mental ill health among lesbian, gay, bisexual and/or transgender (LGBT) people is approximately 40%, which is higher than among the whole population (25%).[107] However, there are variations in prevalence for different groups of the LGBT population:

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[104] Mental Health Foundation (2016) *Fundamental Facts About Mental Health2016*, Mental Health Foundation: London, available at https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf (accessed on 30/01/2017)

[105] Public Health England, *Public Health Profiles*, available at https://fingertips.phe.org.uk/search/asylum%20seeker#page/0/gid/1/pat/6/par/E12000009/ati/101/are/E07000081/iid/90400/age/1/sex/4 (accessed on 30/01/17)

[106] Gloucestershire Action for Refugees and Asylum Seekers (2016) *2016 Annual Report*, available at http://www.garas.org.uk/Docs/annual%20report%2016.pdf (accessed on 31/01/2017)

[107] London Assembly Health Committee (2017) *LGBT+ Mental Health,* available at https://www.london.gov.uk/sites/default/files/lgbtreportfinal.pdf?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=7964640_NEWLS_HMP%202017-02-03&dm_i=21A8,4QPK0,FLXC1J,HT9BA,1 (accessed on 06/02/17)

- 42 percent of gay men
- 70 percent of lesbian women
- 90 percent of lesbian women from BME communities

encounter mental health problems at some point of their lifespan.[108]

Additionally, bisexual people experience poorer mental health than lesbian women and gay men with higher rates of self-harming, anxiety, depression and suicidality. The available evidence on transgender people is limited. A service working with this group of people in London, reported that over 50% of transgender people have contemplated or attempted suicide and over 80% suffer with depression.[109] Additionally, a local research project commissioned by Gloucestershire Care Services NHS Trust in 2013, which investigated the mental wellbeing needs of Transgender people in the Gloucestershire and Bristol area found out that:

- 15.7% of respondents indicated that they had self-harmed; however, for respondents living in Gloucester, the figure for self-harm was almost three in ten (28%)
- 61.4% of respondents reported that they had contemplated suicide; for Gloucester this proportion was slightly higher: 65.6%
- 30.0% of respondents declared that they had attempted suicide; however again, this proportion was significantly higher for people living in the Gloucester area (43%).[110] [111]

The higher prevalence of mental ill health can be related to a range of risk factors experienced by this group of people, such as homophobic, biphobic and transphobic hate crimes, discrimination and isolation. It has been suggested that the needs of this group are poorly recognised by professionals and conversely LGBT people are reluctant to express their health needs to professionals; this results in lack of data to inform commissioners. This relates not only to mental health services, but to all health and care services.[112]

There is no definitive data on LGBT population size at a national or local level. Public Heath England recently evaluated various estimates of size of LGB people and estimated that in England 2.5% of the population identify as LGB or 'other'[113], with an upper limit of 5.89%.[114] Applying this rate to all ages of the Gloucestershire population suggests that there are around 15,283 LGB or 'other than heterosexual' people. **Table 7** shows the estimates and upper estimates by district.

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[108] MIND (2016) *Lesbian, gay, bisexual, trans and queer good practice guide*, available at http://www.mind.org.uk/media/5204367/mind-lgbtqplusguide-2016-webres.pdf (accessed on 06/02/17)

[109] London Assembly Health Committee (2017)

[110] Dr G. Woods, J. Brown (2013) *Where There's a Need . . .Health and Well-Being of Trans People in Gloucestershire and Bristol,* available at: S:\Mental Health and Learning Disabilities\Mental Health\Transgender Survey\Report\Where There's a Need. . ..doc, accessed on 06/04/17

[111] These results need to be interpreted with caution given the small sample sizes

[112] London Assembly Health Committee (2017)

[113] It is not clarified who constitutes the group of 'others', however, it means other than heterosexual.

[114] Public Health England (2017) *Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England,* available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf (accessed on 06/02/17)

Table 7: Estimates of the number of Lesbian, Gay and Bisexual people living in Gloucestershire

	Estimates	Upper limit
Cheltenham	2,912	6,862
Cotswold	2,116	4,985
Forest of Dean	2,092	4,928
Gloucester	3,141	7,401
Stroud	2,877	6,779
Tewkesbury	2,145	5,053
Gloucestershire	**15,283**	**36,007**

Source: ONS (2015) *Annual Mid-year Population Estimates: 2014*; Public Health England (2017) *Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England*

Local surveys have reported considerable variation of the LGB prevalence in the population, from 1.5% to 8.5%:

- Out of 9,340 patients attending GP surgeries in Gloucestershire, **1.5**% of patients identified themselves as LGB
- Gloucestershire County Council's small scale survey indicated that **3.8%** of respondents were from LGB population
- A consultation of library users suggested that **8.5%** of respondents identified themselves as LGB[115]

Recommendations:

6.13.1   Prevention of poor mental health should include strategy on reducing stigma and discrimination against LGBT population.

6.13.2   Joined-up approach with service user representatives, such as Healthwatch, should be undertaken to improve engagement of LGBT people and understanding of barriers to accessing services.

6.13.3   Consider designing intervention and prevention campaigns targeted at LGBT population.

6.13.4   This needs assessment support the recommendations of the *Health and Well-Being of Trans People in Gloucestershire and Bristol* of better understanding the factors which impact on the mental wellbeing of Transgender people especially with regard to self-harm and suicide; and including Transgender people's mental health needs into general suicide prevention policies.

6.14 People with dementia

Although dementia is out of scope for this needs assessment, this section looks into the relationship between dementia and mental health. The projected aging population creates challenge of an increased number of people living with a comorbidity of dementia and mental ill health.

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[115] Gloucestershire County Council (2017) *Population Profile*, available at
https://inform.gloucestershire.gov.uk/viewpage.aspx?c=page&page=EqualityandDiversity (accessed on 06/02/2017)

The Mental Health Foundation completed an evidence review on the prevalence of co-existing mental health problems in people living with dementia and concluded that mental health comorbidities of dementia are often underdiagnosed, not widely researched and therefore not understood by service providers. This review highlighted that:

- Some expressions of depression and dementia overlap, which can lead to depression being undiagnosed and/ or misdiagnosed as dementia. A study suggested that 40% of people with dementia are also experiencing depression. People who have developed dementia and depression can present with greater confusion and greater memory loss, more extreme behaviour and aggressive reactions
- People with dementia are at higher risk of anxiety. However, dementia, anxiety and depression symptoms overlap, which cause difficulties in diagnosing anxiety. The studies suggest, that between 5% and 21% of people have dementia and anxiety
- There is evidence indicating that people with schizophrenia are more likely to develop dementia
- Psychosis often develops in people with dementia as a feature of the progression of the dementia.[116]

There is a lack of evidence in the literature on the care needs of those with dementia who develop a mental health issue or for those with a pre-existing mental health problem who develop dementia.

Estimates indicate that in 2017 in Gloucestershire there are 9,581 people aged over 65 living with dementia (Table 8). The highest numbers of people with dementia are in Stroud, Cheltenham and Cotswold. The numbers of people living with dementia increase with age; people aged 85-89 account for the highest proportion dementia sufferers of 25.3%.[117]

Table 8: Estimated population aged over 65 with dementia in Gloucestershire, by district, 2017

		number of people with dementia by age group					
	Total	65-69	70-74	75-79	80-84	85-89	90+
Cheltenham	1,744	76	144	235	382	461	447
Cotswold	1,643	75	156	233	369	422	388
Forest of Dean	1,408	76	151	222	322	339	299
Gloucester	1,502	76	147	222	345	383	329
Stroud	1,844	97	189	280	429	461	388
Tewkesbury	1,440	69	142	217	322	361	329
Gloucestershire	**9,581**	**469**	**929**	**1,409**	**2,169**	**2,427**	**2,180**
England	715,628	35,786	71,133	106,531	165,708	177,602	158,869

Source: Gloucestershire County Council (2017) *Population Profile*,

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[116] Mental Health Foundation (2016) *The interface between dementia and mental health,* https://www.mentalhealth.org.uk/sites/default/files/Dementia%20paper.pdf (accessed on 07/02/2017)
[117] Gloucestershire County Council (2017) *Population Profile*, available at https://inform.gloucestershire.gov.uk/viewpage.aspx?c=page&page=Population (accessed on 07/02/17)

Recommendations:

6.14   Future trends of an aging population indicate that the numbers of people living with dementia is likely to increase. Taking into account the complexity of the co-existing dementia and mental health problems it is recommended that further work is needed to investigate the mental health needs of people living with dementia. This would include the development of relationship between organisations supporting people with mental health needs and dementia.

6.15 Members of the Armed Forces Community

The Armed Forces Community, as defined by the Armed Forces Covenant, consists of "those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families". This is further defined as including the following groups: regular personnel, reservists, veterans, immediate family members of the three groups listed previously and the bereaved. Further explanations of the membership of these groups can be found in the *Armed Forces Covenant*, published by the Ministry of Defence (MOD)[118].

6.15.1 The Armed Forces Community in Gloucestershire

Gloucestershire County Council has access to some sources of data in order to identify the Armed Forces Community within the county; however it is not currently possible to confidently give accurate numbers for all of the groups defined in the Covenant.

Ministry of Defence figures for January 2016 give a total of 2330 serving personnel, including 380 civilians, based in the county. Please note, this figure lists those serving personnel based at a location within Gloucestershire, who may then reside outside of the local authority area.

Census data for 2011 lists the number of those identifying themselves as members of the Armed Forces living in the county at 2,440.

The composition of Armed Forces members based in the county is predominantly made up of members of the Army, with some communities of Royal Air Force (RAF) personnel in the east of the county, in close proximity to the large RAF establishments within Oxfordshire.

Census data from 2011 lists the number of "associated members" (spouses, partners or children) to members of the Armed Forces living in the county at 2,779. However, this figure appears intuitively low and anecdotal evidence suggests that the actual figure may be significantly higher than this.

When it comes to identifying veterans – those who have served in the past – there is currently no published data that claims to provide a definitive figure of the overall numbers within Gloucestershire. Estimates published by the Ministry of Defence, based on the Annual Population Survey, put the figure at around 47,000 for 2015.

The geographical presence of the serving Armed Forces Community in the county is made up of 8 sites (**Figure 24**). Some of these are located in particularly rural areas of the county, which is then

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[118]Ministry of Defence, *The Armed Forces Covenant*, available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

compounded by physical barriers put in place to separate those inside from the wider community. It is important in the context of this assessment to be aware of the potential impact for isolation and the implications for factors such as loneliness and access to services that this may have.

Figure 24: Armed Forces community in Gloucestershire

6.15.2 The Armed Forces Mental Health Picture

The Ministry of Defence produces an annual report on the Armed Forces mental health picture nationally. The latest report, published in June 2016, details the numbers of personnel being referred to MOD mental health services as having "risen steadily from 1.8% of UK Armed Forces personnel in 2007/08, to 3.2% in 2015/16". However, "it is unclear what proportion of this rise is due to the success of anti-stigma campaigns" and does not include members of the Armed Forces self-referring to mainstream NHS mental health services, so may be under reporting. By way of comparison, "this is lower than the rate of 3.5% within the UK general population (based on access to NHS secondary mental health services in 2014/15)."

However, it should be noted that this figure only represents the number of new assessments of mental disorders, and does not capture the percentage of those actually experiencing a condition. The most comprehensive data available for this – from the King's Centre for Military Health Research at King's College London (KCL) – estimates that "approximately double the numbers screen[ed]

positively for CMD (Common Mental Disorder) in the military population, compared to those selected from a general population study". This equates to a rate of 18.7% of respondents identifying with CMD from the military sample (both serving personnel and veterans), as opposed to 10.1% from the general population.

Both the MOD report and KCL study identified the following groups within the Armed Forces as being of interest due to higher presentations for assessment or identified levels of CMD:

- Females – this is something that is also replicated in the population as a whole
- "Other Ranks" – this group is made up of those in the lower social classes in terms of rank within the military and is correlated with those that have lower educational attainment and come from a lower socio-economic background
- Personnel aged between 20 and 44 years of age.

Other factors that appear to influence the prevalence of mental illness amongst Armed Forces personnel are previous deployment to Iraq or Afghanistan and those employed in combat roles.

It should be noted that, "there are lower suicide rates among serving personnel in all three UK services than in the general population"[119] and the same can be said for self -harm.

When it comes to veterans, the lack of records that can be used to accurately identify ex-serving members of the Armed Forces, mentioned previously, also negatively impacts on the ability to produce any definitive population wide statistics in relation to mental health. Indeed, "prior to 2003 the literature on the mental health outcomes of UK ex-Service personnel was very limited"[120].

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[119] Mental Health Foundation on behalf of the Forces in Mind Trust *(2013) The mental health of serving and ex-Service personnel: A review of the evidence and perspectives of key stakeholders*, available at https://www.mentalhealth.org.uk/sites/default/files/the-mental-health-of-serving-and-ex-service-personnel.pdf, accessed on 06/03/2017
[120] Ibid

Figure 25: Referrals rates to Combat Stress between 1994 and 2014
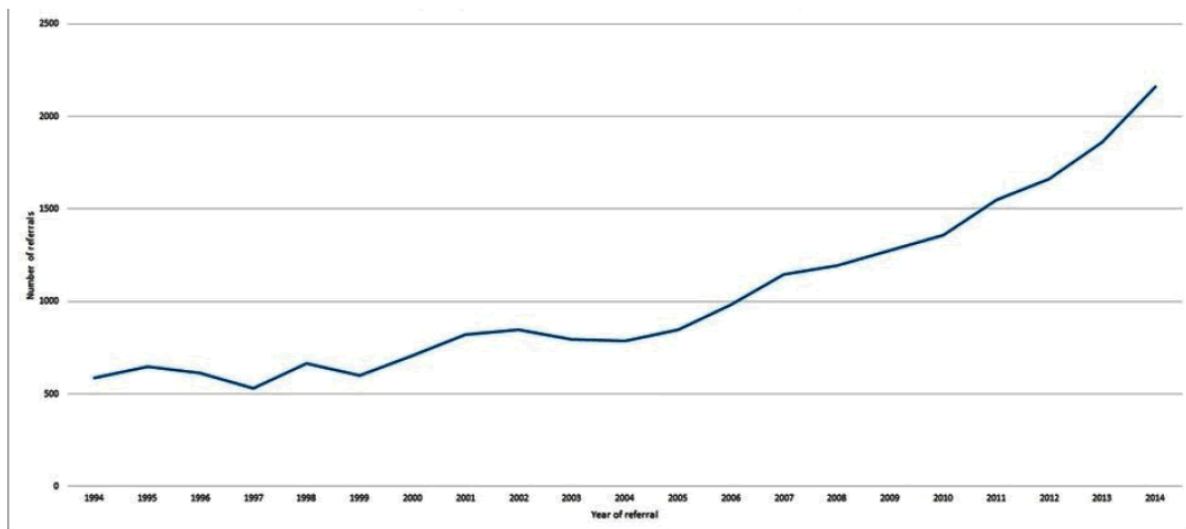
Graph 1. Referral rates to Combat Stress between 1994 and 2014.

However, the figure **above** produced by Combat Stress – a major charity that supports serving Armed Forces personnel suffering mental illness – shows an increasing number of new referrals being received. They suggest that based on these figures and the numbers of personnel involved in recent conflicts in Iraq and Afghanistan, that "over the coming years there will continue to be an upward trend in the numbers of UK veterans seeking support for mental health difficulties". This is corroborated by the work done by KCL that draws a link between the increased rates of mental illness amongst currently serving personnel and participation in these conflicts, as it is logical to assume that as this cohort joins the veteran population this trait of their service will move with them.

For service families "issues for service spouses such as sudden or extended separations, frequent moves, perceived partner in danger, and social hierarchy with the Army environment, have been well documented in the international literature".[121] It is also noted that, whilst there has been little work done on the impact of deployment on service children in the UK, studies in the USA of those deployed to Iraq or Afghanistan show that "children of deployed parents are at greater risk of psychosocial problems than their civilian counterparts".[122] Unfortunately the lack of UK specific studies that reflect the current situational pressures faced by the Armed Forces community mean that it is not possible to offer any meaningful indication of the rates at which these factors are affecting service families. It is not known to what extent either commissioned mental health services or voluntary sector organisations are currently supporting the mental health needs of Armed Forces families in Gloucestershire or whether mainstream mental health support is being provided in a way that takes in to account the specific needs of Armed Forces families

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[121] Mental Health Foundation on behalf of the Forces in Mind Trust *(2013*
[122] Ibid

Recommendations:

6.15.1   Given the higher levels of Common Mental Disorders (CMD) amongst the military population that already exist and a clear level of rising demand for mental health services amongst both serving personnel and veterans as a whole, mental health commissioners and providers should consider the impact that this may have in both the immediate and long term future.

6.15.2   Mental health commissioners and providers should consider what initiatives they could support to improve understanding of the size of certain groups of the Armed Forces Community and the scale of mental health needs, particularly when it comes to veterans and the families of serving personnel.

6.15.3   Mental Health Commissioners should consider how they could best support third sector mental health providers, who support military families and veterans, to ensure that the needs of these particular groups are met.

6.16 Adults who are in contact with the criminal justice system

People in contact with the criminal justice system are people who are in police and court custody, prison custody, probation, etc. Although there is no prison in Gloucestershire, there are people coming out of the prison custody located elsewhere and (re-)settling in the county.

These adults are commonly affected with mental health problems ranging from 39% of those in police custody and up to 90% of those in prisons. Evidence shows that there are disorders that are more prevalent in the prison population such as personality and psychotic disorders. Certain groups like BME, women, over 50s and people with comorbid disorders are over represented in prisoners with mental disorders according to reports.[123]

Although the links between crime and mental illness have not been fully investigated, there are suggestions that some pre-existing social factors (e.g. homelessness and substance misuse) are associated with increased offending.[124]

There is no comprehensive data on adults in contact with the criminal justice system in Gloucestershire. However, the rate of first time entrants to the criminal justice system in Gloucestershire in 2015 was 160.5 per 100,000 of the population (981 people, all ages). This is significantly lower than the national and regional average, 242.4 and 193.7 respectively. This was also one of the lowest proportions among the nearest statistical neighbours.[125]

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[123] National Institute for Care and Health Excellence (2017) *Mental health of adults in contact with the criminal justice system*, available at: https://www.nice.org.uk/guidance/NG66/chapter/Context, accessed on 18/04/17
[124] National Institute for Care and Health Excellence (2017)
[125] Public Health England, *Mental Health JSNA*, available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna, accessed on 13/04/2017

Chapter 6 recommendations:

6.1.1 People with **learning disabilities** experience additional barriers in accessing mental health services, therefore further work may be needed to identify barriers and improve local access to mental health services..

6.1.2 Early prevention of mental health issues should be considered for the predicted rise in older population with **learning disabilities**.

6.2 There should be continued efforts to further align support for people with co-occurring **long-term conditions or physical disabilities** and mental health problems, including training and support for clinicians working with physical conditions to identify and signpost/refer to help for mental health problems.

6.3.1 Investigating further training needs for services that are in contact with **domestic abuse victims,** e.g. mental health, suicide prevention. Commissioners should ensure that there is an awareness of mental health pathways and support and that signposting is available.

6.3.2 This adult mental health needs assessment supports the recommendations of the *Therapeutic Services for Victims of Sexual Violence in Gloucestershire* (2016): improving access to and managing demand for therapeutic services and developing service pathways for **victims of sexual violence**. Further, it is recommended that mental health commissioners are engaged in this process to ensure a joined up approach.

6.4 Due to their multiple needs, people with a **dual diagnosis** of both mental health and substance misuse disorders require good communication and coordination between services they use. Mental health, substance misuse and other services, such as housing and social care, should work together to provide care and support their needs.

6.5.1 **Care leavers** should receive support and guidance about their mental health needs and how they will be met by service, before and after they turn 18.

6.5.2 Further work should be undertaken to support the skills and knowledge of those in contact with **care leavers** (such as health professionals, teachers, social workers) to support the care leaver's mental health.

6.6 Commissioners and providers, who are in contact with **homeless people**, should continue to improve their ways of working together, to make sure that people get help for their complex needs. Further work is needed to ensure that Gloucestershire Crisis Care Concordat Workforce Development Group will reach all groups who are in touch with homeless people. A planned Joint Strategic Needs Assessment should provide the leadership on addressing health needs, including mental health needs, and other determinants of poor mental health.

6.7 Further work should be done to identify the local evidence on differences in prevalence of mental health problem between **ethnic groups**, especially for women. Mental health early intervention and anti-stigma strategies should be reviewed, to ensure they are culturally appropriate and culturally customised. Mental health services should engage with organisations dealing with racial discrimination to identify and reduce the ethnic inequalities in mental health.

6.8 Further review of literature needs to be completed to establish the relationship between mental health among the **Gypsy and Traveller community**. The overall small numbers in Gloucestershire suggest that there is no necessity to prioritise this group over the other vulnerable groups. However, any public communication on mental health problems and services should consider the ways to reach this group.

6.9 Although the local trends for the number of **long-term unemployed people** are decreasing and are below the national average, this group is particularly vulnerable to experiencing poor

mental health and therefore it is one of the highest priority among all vulnerable groups. Further investigation into the Gloucestershire profile of economically inactive people is required to understand the "size" of their mental health needs.

6.10.1   Further work is needed to support debt services on mental health screening and referral links for **people reporting debt**. Mental health professionals should ensure that the patients are asked about financial difficulties and accordingly signposted to the money advice sectors; this could be achieved by working close with social prescribing services.

6.10.2   Training for debt advisors in Mental Health First Aid should be considered.

6.11.1   Comprehensive evaluation of local **carers'** views would help identify their mental health needs and the ways of preventing of poor mental health; the results of the evaluation currently being carried out by 2gether NHS Foundation Trust might help to balance the reported views of carers.

6.11.2   Ensure **carers' assessm**ents include information about mental health.

6.12   Based on the higher than national rate of **asylum seeker** and the growing trend in the size of this population further assessment of mental health needs is recommended to inform prevention and early intervention services and identify gaps in service provision or access.

6.13.1   Prevention of poor mental health should include strategy on reducing stigma and discrimination against **LGBT** population.

6.13.2   Joined-up approach with service user representatives, such as Healthwatch, should be undertaken to improve engagement of **LGBT** people and understanding of barriers to accessing services.

6.13.3   Consider designing intervention and prevention campaigns targeted at **LGBT** population.

6.13.4   This needs assessment support the recommendations of the *Health and Well-Being of Trans People in Gloucestershire and Bristol* of better understanding the factors which impact on the mental wellbeing of **Transgender people** especially with regard to self-harm and suicide; and including Transgender people's mental health needs into general suicide prevention policies.

6.14   Future trends of an aging population indicate that the numbers of people living with **dementia** is likely to increase. Taking into account the complexity of the co-existing dementia and mental health problems it is recommended that further work is needed to investigate the mental health needs of people living with dementia. This would include the development of relationship between organisations supporting people with mental health needs and dementia.

6.15.1   Given the higher levels of Common Mental Disorders (CMD) amongst the **military population** that already exist and a clear level of rising demand for mental health services amongst both serving personnel and Veterans as a whole, mental health commissioners and providers should consider the impact that this may have in both the immediate and long term future.

6.15.2   Mental health commissioners and providers should consider what initiatives they could support to improve understanding of the size of certain groups of the **Armed Forces** Community and the scale of mental health needs, particularly when it comes to Veterans and the families of serving personnel.

6.15.3   Mental Health Commissioners should consider how they could best support third sector mental health providers, who support military **families and Veterans**, to ensure that the needs of these particular groups are met.

7 Mental and emotional wellbeing in Gloucestershire

Key points in this section are:
- Gloucestershire's residents' scores for life satisfaction, feeling worthwhile, happy and anxious levels are similar to the national average. However, the Gloucestershire average score of personal well-being for all these categories is one of the lowest compared to statistical neighbours. Additionally, Gloucestershire has one of the highest proportions among statistical neighbours of people with low life satisfaction, low happiness levels and high anxiety scores.
- Some groups present with lower well-being rates than the relatively content UK population: women report higher anxiety; people with a disability, some ethnic minority groups and people from some religious backgrounds are more likely to report lower well-being. These variances could be associated with the numbers of factors, including socio-economic status.
- Social isolation is more prevalent across certain groups, including older people, people with a disability or with long-term conditions, unemployed adults, carers, ethnic minority groups and LGBT populations. In Gloucestershire, the areas with the highest prevalence of social isolation are in Gloucester and Cheltenham. Gloucestershire's adult carers report they feel more socially isolated than those living in England, South West and the nearest statistical Local Authority areas.
- Nationally, public attitudes towards people with mental health problems are improving and people are more confident they know what it means to have good mental wellbeing. Gloucestershire residents are more tolerant, understanding and better informed than the country as a whole. However, these findings are based on the survey undertaken nearly a decade ago.
- An evaluation of the social prescribing scheme in Gloucestershire highlighted the significant improvement in the wellbeing score of service users; reduction in the GP appointments and emergency admission. Nearly half of referrals were for mental health and well-being.

7.1 Self-reported well-being

This section looks into personal well-being as reported by the population on a local and national level over five financial years; and describes how personal well-being varies by gender, disability, ethnicity and religion on a national level.

The personal well-being data is part of a wider Measuring National Well-being programme, which aims to look at what matters most to people in the UK. The estimates of personal well-being for local authorities are available from the financial year 2011/2012.

The Office for National Statistics (ONS) Measures of National Well-being programme aims to measure and estimate the national overall progress in wellbeing. It is based on 10 aspects of life that people say matter to their wellbeing; these include personal wellbeing, people's relationships, people's health, what they do, where they live, personal finance, the economy, education and skills,

governance and the environment.[126] However, the research indicates that health, employment and relationship status have the strongest association with personal well-being.[127]

The four personal well-being questions listed below are directed to a large sample of UK population aged over 16:

- overall, how satisfied are you with your life nowadays?
- overall, to what extent do you feel the things you do in your life are worthwhile?
- overall, how happy did you feel yesterday?
- overall, how anxious did you feel yesterday?

People are asked to respond on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely". The estimates were calculated based on the average ratings and using the thresholds presented in **Table 9**.

Table 9: Labelling of thresholds of personal well-being

Life satisfaction, worthwhile and happiness scores		Anxiety scores	
Response on a 10 point scale	Label	Response on a 10 point scale	Label
0 – 4	Low	0 – 1	Very low
5 – 6	Medium	2 – 3	Low
7 – 8	High	4 – 5	Medium
9 – 10	Very high	6 – 10	High

Source: Office for National Statistics (2016) Personal well-being in the UK: local authority update, 2015 to 2016

Life satisfaction

As indicated by **Figure 26** the reported average life satisfaction score for Gloucestershire over the five years was similar to the national average, and although the score was static for three years, it has risen in 2015/16 in line with the national trend. However, when comparing with statistical neighbours, Gloucestershire estimates of personal well-being are one of the lowest (**Figure 27**).[128]

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[126] Office for National Statistics (2016) *Personal well-being in the UK: local authority update, 2015 to 2016* available at:
https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/localauthorityupdate2015to2016#how-do-people-rate-their-personal-well-being-in-your-area, accessed on 22/03/2017
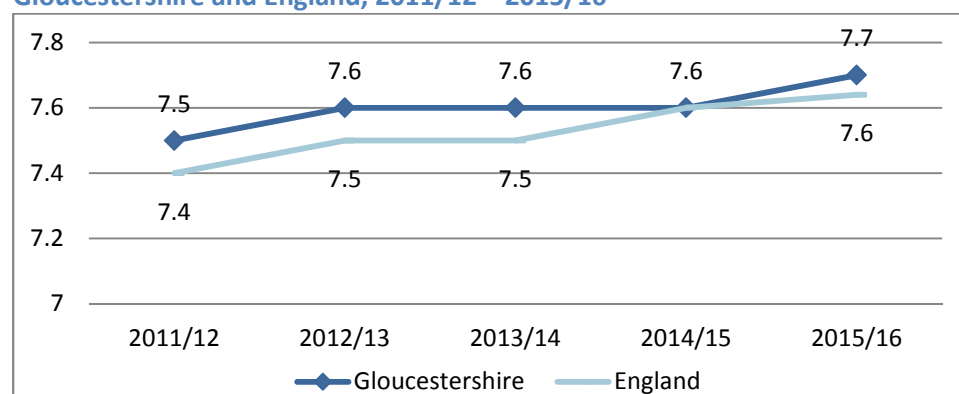
[127] Office for National Statistics (2013) *Measuring National Well-being – What matters most to Personal Well-being?*, available at:
http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/what-matters-most-to-personal-well-being-in-the-uk-/index.html, accessed on 22/03/2017

[128] Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*, available at:
https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/headlineestimatesofpersonalwellbeing, accessed on 22/03/17

Figure 26: How satisfied are you with your life nowadays (average score out of 10); Gloucestershire and England, 2011/12 – 2015/16*

Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*
sample size: 2011/12 – 800, 2012/13 – 800, 2013/14 – 790, 2014/15 – 860, 2015-16 - 900

Figure 27: How satisfied are you with your life nowadays (average score out of 10); Gloucestershire and statistical neighbours, 2015/16
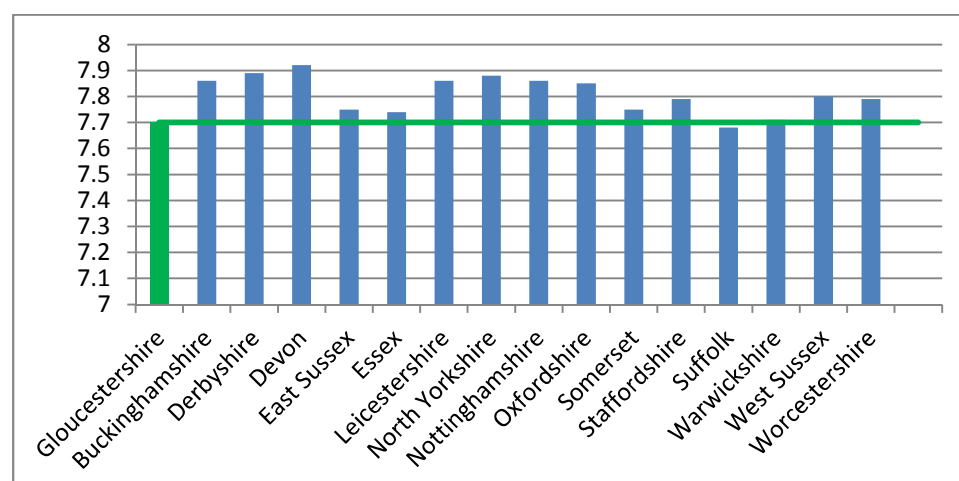
Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*

Proportion of the population who reported low scores for life satisfaction

In 2015/16, there was an insufficient sample size to enable to define the proportion of people who reported a low score of life satisfaction in Gloucestershire. In previous years, the proportion of people with low satisfaction scores was lower than the national average, however in 2014/15 this proportion exceeded the national average (Gloucestershire 5.1%, England 4.7%). Gloucestershire has one of the highest proportions of people with a low satisfaction score among the statistical neighbours in 2014/15.

Worthwhile

Having initially been slightly higher than the national average for England, scores for feeling worthwhile for Gloucestershire residents have fluctuated and now are on a similar level to England

(**Figure 28**). In comparison with statistical neighbours, Gloucestershire residents' average score was second lowest in 2015/16 (**Figure 29**).

Figure 28: To what extent do you feel the things you do in life are worthwhile (average score out of 10); Gloucestershire and England; 2011/12 - 2015/16*
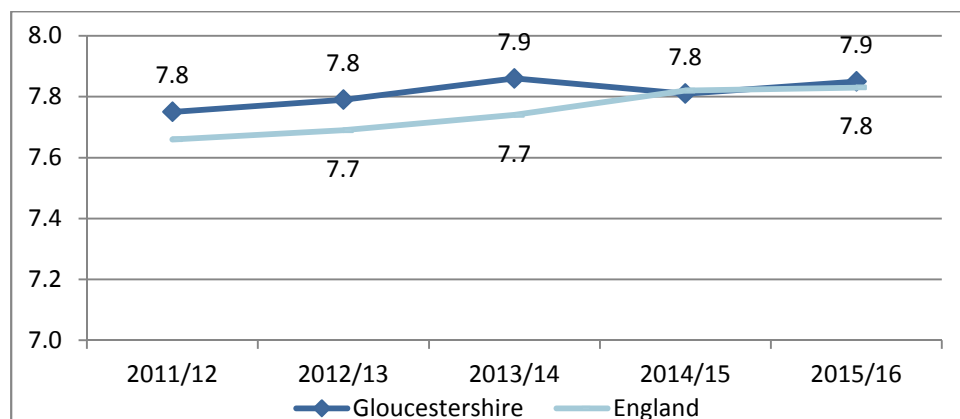
Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*
sample size: 2011/12 – 800, 2012/13 – 800, 2013/14 – 790, 2014/15 – 860, 2015-16 - 900

Figure 29: To what extent do you feel the things you do in life are worthwhile (average score out of 10); Gloucestershire and statistical neighbours, 2015/16
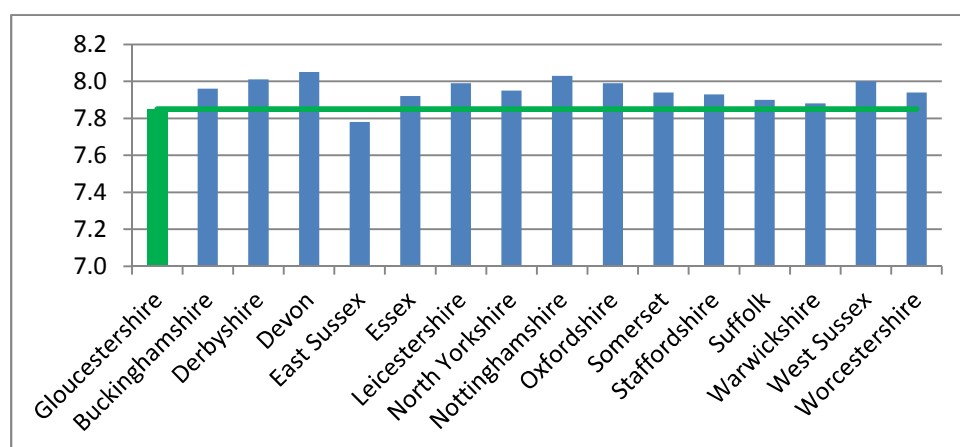
Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*

Proportion of people who reported low scores of feeling worthwhile

In 2015/16 the sample of Gloucestershire respondents with a low worthwhile score was too small to use. In 2014/15 there was a larger proportion of Gloucestershire residents with low worthwhile scores than in England: Gloucestershire – 4.2%; England – 3.6%. The comparison with the statistical neighbours has not been completed for this indicator, as the data for many Local Authorities was not available.

Happiness

Self-reported levels of happiness in Gloucestershire have fluctuated between 2011/12 and 2015/16 and now are slightly below, yet still similar to the national average (**Figure 30**). Gloucestershire has the lowest average score for happiness out of all of the statistical neighbours (**Figure 31**).

Figure 30: How happy did you feel yesterday (average score out of 10); Gloucestershire and England, 2011/12 – 2015/16*

Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*
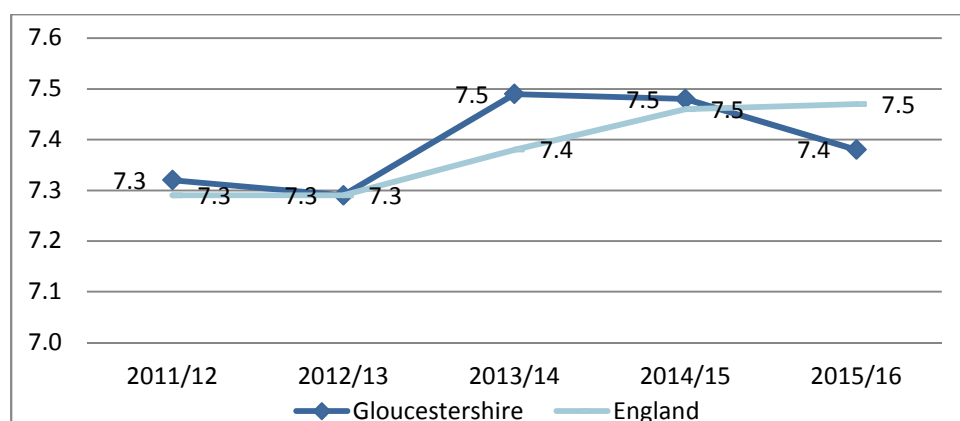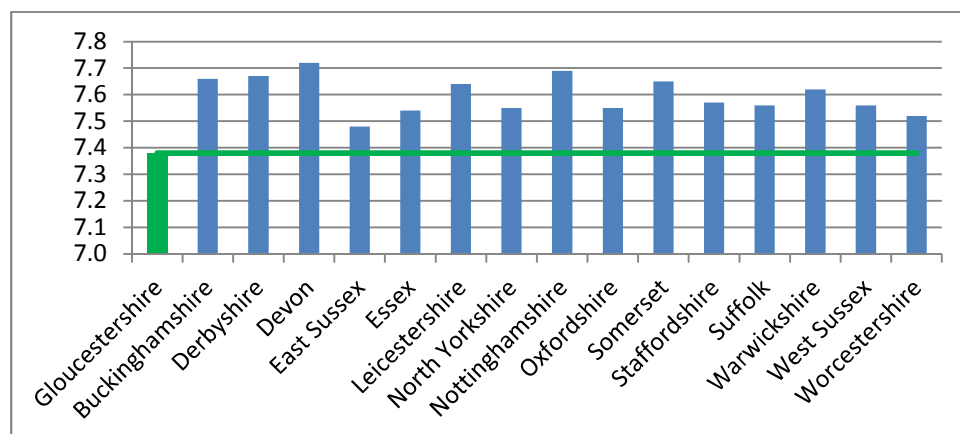*sample size: 2011/12 – 800, 2012/13 – 800, 2013/14 – 800, 2014/15 – 860, 2015-16 - 900*

Figure 31: How happy did you feel yesterday (average score out of 10); Gloucestershire and statistical neighbours, 2015/16

Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*

Proportion of people who reported low scores of happiness

The proportion of people who reported a low happiness score in Gloucestershire was similar to the national average in 2015/16: Gloucestershire - 9.1%, England – 8.8%. However, in comparison with the statistical neighbours this proportion was the second highest.

Anxiety

Reported levels of anxiety among Gloucestershire residents were slightly lower than the national average during 2011/12 and 2012/13. However, while there was a decrease in reported levels of anxiety in England, the Gloucestershire scores remained static between 2013/14 and 2015/16 (**Figure 32**). Additionally, Gloucestershire has one of the highest mean scores for feeling anxious among statistical neighbours in 2015/16 (**Figure 33**).

Figure 32: How anxious did you feel yesterday (average score out of 10), Gloucestershire and England; 2011/12 – 2015/16*
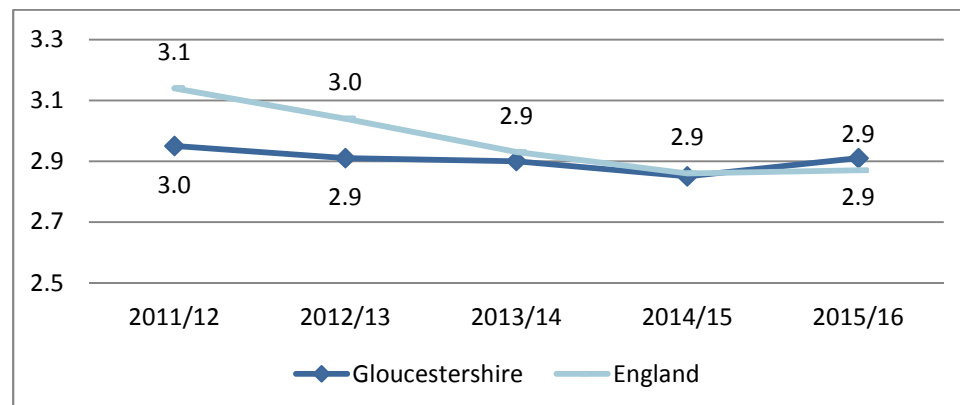
Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*
*sample size: 2011/12 – 800, 2012/13 – 800, 2013/14 – 800, 2014/15 – 860, 2015-16 - 900

Figure 33: How anxious did you feel yesterday (average score out of 10), Gloucestershire and statistical neighbours, 2015/16

Source: Office for National Statistics (2016) *Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, April 2015 to March 2016*
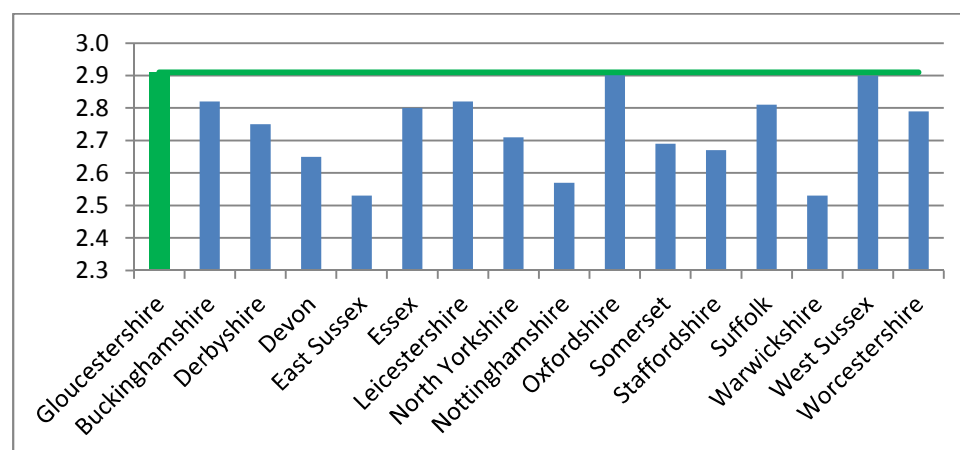
Proportion of people who reported high scores of anxiety

The proportion of people reporting a high score of anxiety in Gloucestershire was 19.2%, which is similar to the national average of 19.4% and very slightly higher than the regional average of 18.5%. This proportion is among the five highest within the nearest statistical neighbours.

Personal wellbeing by groups with protected characteristics

Although, based on the mean scores for the four measures of personal well-being, people in the UK are reasonably content, there are significant variances among different groups with protected characteristics. Note: these data are not available at a county level so the following analysis is based on UK data only.

Gender

Based on a dataset covering 3 years (2011 – 2014), females are reported to have very slightly higher rates of personal well-being:

- slightly higher levels of life satisfaction (7.5 for female versus 7.4 for male);
- feeling more worthwhile (7.8 for female versus 7.6 for male);
- slightly higher levels of happiness (7.4 for female versus 7.3 for male)

However, their anxiety rates are higher than males (3.1 versus 2.9).[129]

Disability

As indicated by **Figure 34** there are significant differences in personal well-being between people who consider themselves as disabled and those without a disability. People who are disabled reported lower levels of life satisfaction, feeling worthwhile and happiness; and they are more likely to feel anxious. Additionally, as described in Sections **6.1** and **0** people with a learning disability and physical disability or life limiting illness are more likely to experience poor mental health than the general population.

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[129] Office for National Office (2015) How Does Personal Well-being Vary by Sex, Disability, Ethnicity and Religion?, available at: http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171776_400162.pdf, accessed on 22/03/17

Figure 34: Average personal well-being ratings: by disability, 2011 to 2014, United Kingdom
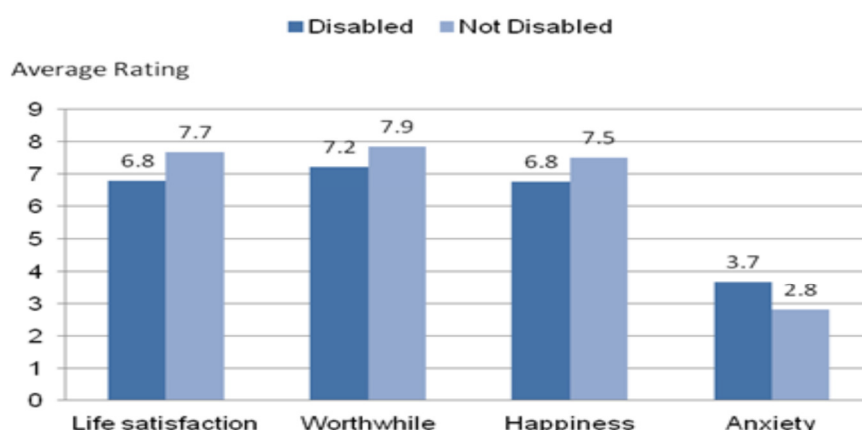
Source: Office for National Statistics (2015) *How Does Personal Well-being Vary by Sex, Disability, Ethnicity and Religion?*

Ethnicity

There are significant differences in personal well-being between the people from different ethnic groups.

The ethnic groups, which reported the lowest average levels of the life satisfaction, are:

- Black ethnic group – least satisfied with their lives; average score 6.8 out of 10 (UK average 7.5)
- Mixed/multiple ethnic group – 7.1 out of 10
- Arab ethnic group – 7.2 out of 10

Average ratings show that the ethnic groups who consider that the things they do in life are less worthwhile:

- Arab ethnic group – 7.4 out of 10 (UK average 7.7)
- Other ethnic group – 7.5 out of 10
- Chinese ethnic group – 7.5 out of 10

The lowest mean levels of happiness were reported by the Arab ethnic group and the Black ethnic groups, 7.0 and 7.1 respectively (UK average 7.3).

The ethnic groups, who reported feeling most anxious were the Arab ethnic group and the Mixed/multiple ethnic group, 3.6 and 3.4 respectively as compared with the UK average of 3.0.[130]

Religion

There are distinct differences in ratings between people from different religious affiliation across all four measured categories: life satisfaction, worthwhile, happiness and anxiety. People who identify as Muslim were one of the groups with the lowest average well-being scores. People who identify with no religion are the least likely to feel worthwhile and happy. Conversely, they are also less likely to feel anxious as compared with people from other religion affiliation. Buddhists are also among the groups who are least satisfied with their life and least likely to feel that the things they do in life are

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[130] Ibid

worthwhile. Alongside the Muslim population, Jewish people, Hindus and those answering that they identified with any other religion (not specified) reported the highest average scores for anxiety.

As described above for some groups with protected characteristics, personal well-being ratings are lower than for others. It has been suggested that these differences can be associated with the circumstances or socio-economic characteristics that are common within these groups. As previously mentioned health, employment and relationship status have the strongest association with the measure of personal well-being; therefore, if people from various groups are more likely to have low self-reported health, be unemployed, or single, this would also contribute to the variation in personal well-being ratings.[131]

Recommendations:

7.1.1   Ensure that efforts to improve mental wellbeing are appropriately targeted by gender, ethnicity, disability and religious affiliation.

7.1.2   In order to improve local personal well-being, promotion of well-being programmes, such as "5 ways to well-being" and mindfulness should be continued and, where possible, enhanced. Campaigns should be undertaken in ways and places relevant to the equality groups, especially people who are disabled and people from ethnic and religious minority groups.

7.1.3   Work on the wider determinants of wellbeing should focus on health, employment and relationship status.

7.2   Stigma and discrimination

People with mental health problems experience social stigma and discrimination associated with mental ill health, which has a further negative effect on their life. The effects of stigma and discrimination can make mental health problems worse as well as cause a delay in seeking help and treatment, and make recovery harder. Nearly nine out of ten people with poor mental health reported the negative effect of stigma and discrimination. Stereotypical views include, for instance, a perception that people with mental health problems are more likely to be violent and dangerous. This has a negative impact on social inclusion including employment, housing and relationship prospects.[132]

The Time to Change national charity conducts "The National Attitudes to Mental Illness" survey among adults in England. The most recent report for 2013 indicated that public attitudes towards people with mental health problems has significantly improved since 2011: an estimated two million people (4.8%) improved their attitudes nationally. There is an overall shift to more tolerant attitudes and greater recognition that people should not be discriminated against on the grounds of their mental health. This report highlighted a significant improvement in following behaviours among the general public since 2011:

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[131] Ibid
[132] Mental health Foundation, Stigma and Discrimination, available at https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination, accessed on 28/03/2017

- Working with someone with mental health problems – 7% rise in willingness (69% to 76%)
- Continuing a relationship with a friend with a mental health problem – 6% rise (82% to 88%)
- Living nearby with someone with a mental health problem - 5% rise (72% to 77%)
- Living with someone with a mental health problem – 5% rise (57% to 62%)[133]

One of the areas for development is improving attitudes about one's own mental health – nearly half of the population reported that they would feel uncomfortable talking to an employer about their mental health.

Additionally, the findings from NatCen's British Social Attitudes survey commissioned by PHE in 2015 highlighted that nine in ten people are confident in understanding what it means to have "good mental health". Reports emphasise that people recognise different factors influencing their mental health and wellbeing, and the things they can do to improve it. However, those living in deprived areas or who have experienced poor mental health are less likely to feel in control of the things that affect their mental wellbeing. Even though the perception of workplace prejudice has improved over time, there is still the view of a minority that someone with a mental health problem would be less likely to be promoted than others.[134]

Stigma and discrimination in Gloucestershire

According to a local survey of attitudes to mental health and mental illness in 2008, Gloucestershire residents were more tolerant, understanding and better informed than the country as a whole. The survey included home interviews with over 2,000 Gloucestershire residents, using the national questionnaire to ensure accurate comparison with the national data.

The results summarised four main factors that indicated that local residents are more tolerant and supportive than the average English population:

- Fear and exclusion, which measured people's views of the personal effects of being exposed to people with mental illness and the need to isolate them from position of power and trust and influence – 70% positive replies versus 68% at the national level
- Understanding mental illness and expressing tolerance and active support for those with the illness – 92% supportive views locally compared with 84% nationally
- Integration – people's perception on involving and including people with mental health problems into the community and supporting them to obtain the same rights as everyone else – 58% locally compared with 54% nationally
- The causes of mental illness - perceptions of the causes of mental illness and the extent to which people can overcome the problems themselves, 58% of positive attitudes locally versus 54% nationally.

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[133] Time to Change (2014) Attitudes to Mental Health Illness 2013 Research Report, available at http://www.time-to-change.org.uk/sites/default/files/121168_Attitudes_to_mental_illness_2013_report.pdf, accessed on 28/03/17

[134] Public Health England (2016) *British Social Attitudes, Attitudes to mental health problems and mental wellbeing,* available on: http://bsa.natcen.ac.uk/latest-report/british-social-attitudes-33/mental-health.aspx?_ga=1.25414974.2069454732.1462541675, accessed on 28/03/17

This survey highlighted two areas, where Gloucestershire resident's attitudes were marginally less supportive than the national population:

- 'Less emphasis should be placed on protecting the public from people with mental illness' – positive support was given by only 21% of local people; compared with 29% nationally
- 'Mental illness is an illness like any other' – this statement received 68% of supportive answer compared with 74% of the whole nation.

These attitudes were similar within the Gloucestershire districts, with Forest of Dean marginally less likely to be tolerant of mental illness than the other areas while Cheltenham being more likely to be tolerant.

Looking at demographics, the groups who expressed less supportive attitudes were:
- People aged over 55
- DE social groups[135]
- Single/ widowed/ divorced respondents
- Those with no children in the household
- Retired people.

One of the reasons for Gloucestershire residents being more supportive of mental illness could be a consequence of significantly greater likelihood of seeing or hearing about mental health problems in the media; 62% of local residents saw or heard about mental health illness in the last few years versus 45% nationally. The most frequent mentioned source from all publicity was newspapers, second most common: TV news and third most common: TV soaps/plays. However, the highest positive impact was made by TV soaps/plays.

There is about a five year gap between the latest local and national survey report regarding public attitudes to mental illness. The national survey results suggest that these attitudes have improved year on year.

Recommendations:

7.2   A refresh of the local attitudes to mental health illness survey is recommended to review whether positive attitudes increased in line with the national data. This would also evaluate, whether the actions to decrease stigma and discrimination in Gloucestershire have been successful. It is recommended that the survey sample has adequate representation from the groups and areas identified to have less supportive attitudes. Any further actions to tackle stigma should emphasise mental health and wellbeing within the workplace.

7.3   Social isolation

This section looks into the impact of social isolation on an individual's mental health and wellbeing. The local estimated prevalence of social isolation is included.

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[135] Semi-skilled and unskilled manual occupations, unemployed and lowest grade occupations

As described in Chapter **5**, social isolation is one of the determinants of mental health. Social isolation is defined as the lack of relationships with family and friends on an individual level and with community and society on a wider level.[136] The quality and quantity of these relationships influences people's health behaviours, including both physical and mental health. Although anyone can be affected by social isolation, this factor is more common in later stages of life. A recent study indicated that there is a higher prevalence of becoming isolated for older men; 14% of older men reported experiencing moderate to high social isolation versus 11% of older females. Older men experience less contact with their children and with their friends than older women.[137]

Some groups are particularly vulnerable to becoming socially isolated. These groups include: children and young people experiencing bullying, new mothers, people with a disability or with long-term conditions, unemployed adults, carers, retired people, ethnic minority groups and LGBT populations.

Factors such as: socio-economic status, age, gender, ethnicity, physical and mental disability and long-term health conditions, and life events influence the risk of becoming socially isolated. For example, barriers associated with social disadvantage status, housing problems and language barriers among ethnic minorities may contribute to increased risk of social isolation. The PHE report on *Reducing social isolation across the lifecourse* (which includes councils' experience and views on social isolation), highlighted that the absence of good health and community care accommodating local cultural differences resulted in social isolation and a significant increase in depression rates in minority groups within the Sutton Council area.[138]

Social Isolation in Gloucestershire

The map below (**Figure 35**) highlights the Gloucestershire areas with residents most likely to experience social isolation. A total of 16 variables[139] were combined to create the mapped Isolation Index. The Isolation Index values were split into five quintiles ranging from the least vulnerable to the most vulnerable and represented as shading of Lower Super Output Areas (LSOA). Values falling in the worst quintile (i.e. most vulnerable) were reassessed in terms of four isolation variables and one contentment variable and mapped at individual household level.

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[136] Mental Health Foundation (2010*) The Lonely Society?,* available at
https://www.mentalhealth.org.uk/sites/default/files/the_lonely_society_report.pdf, accessed on 27/03/2017
[137] Public Health England, UCL Institute of Health Equity (2015*) Local action on health inequalities Reducing social isolation across the lifecourse,* available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf, accessed on 27/03/17
[138] Ibid

[139] Including: older households, low income households, single person households, qualifications, mental health, no access to car, no access to internet, 4 isolation variables (rarely talk to neighbours, no one will listen, no one will help in crisis, no one to be relaxed with), and the contentment variable (i.e. not satisfied with social life)

Figure 35 : Gloucestershire social isolation prevalence, 2013
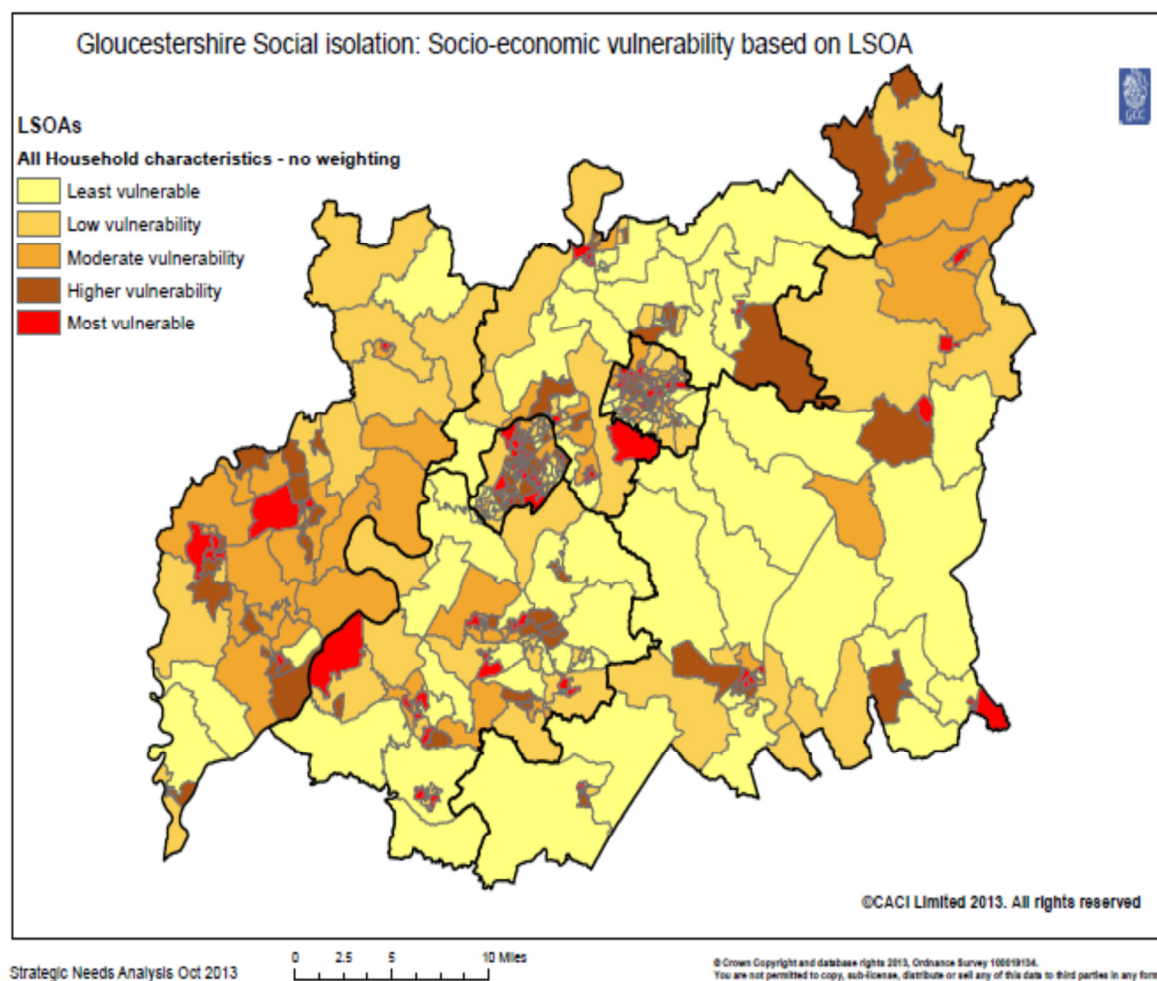
Source: GCC, Data and Performance Team

Out of the top 20 most vulnerable areas (**Table 10**), 9 are in Gloucester, 7 in Cheltenham, 2 in Cotswold and 1 in Tewkesbury and Stroud each.

Table 10: Top 20 most prevalent with social isolation LSOAs, Gloucestershire, 2013

Within Ward	District
Matson and Robinswood	Gloucester
St Mark's	Cheltenham
Podsmead	Gloucester
Cirencester Watermoor	Cotswold
Westgate	Gloucester
Tewkesbury Prior's Park	Tewkesbury
Hesters Way	Cheltenham
Tuffley	Gloucester
Kingsholm and Wotton	Gloucester
Westgate	Gloucester
Matson and Robinswood	Gloucester
Hesters Way	Cheltenham

Cirencester Park	Cotswold
Barton and Tredworth	Gloucester
Hesters Way	Cheltenham
St Paul's	Cheltenham
Oakley	Cheltenham
Dursley	Stroud
Barton and Tredworth	Gloucester
St Peter's	Cheltenham

Source: GCC, Data and Performance Team

Additionally, social isolation was measured for social care users and for carers locally. In Gloucestershire, the percentage of adult social care users who have as much social contact as they would like was 48.2% in 2015/16, which is similar to the national and regional average (45.4% and 46.6% respectively) as well as one of the highest values as compared with the statistical neighbours. However, the percentage of adult carers who have as much social contact as they would like was 26.8% in 2014/15, which is significantly lower than the national and regional average (38.5% and 36.4% respectively). It is the lowest percentage in the South West region and second lowest as compared with the nearest statistical Local Authorities.

Recommendations:

7.3.1   Continue existing community based initiatives and services provided by the public, private and charitable sectors dedicated to reducing social isolation. Consider developing additional community based initiatives.

7.3.2   Target those at risk of social isolation, especially in the most prevalent areas. Involve those at risk in designing and delivering solutions that address social isolation and inequalities.

7.4   Social prescribing

Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people who do not necessarily require a medical intervention to a range of local, non-clinical services. This is a growing trend around the country to manage the increase in demand for primary care services. This service aims to support people with a wide range of social, emotional or practical needs, and help to improve people's mental health and wellbeing. Service users include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care. The problems that can be supported by social prescribing include issues related to mental health and well-being, such as: loneliness, low level mental health problems, healthy living and coping with caring responsibilities.[140] The opportunities may include: arts, creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help,

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[140] The Kings Fund (2017) *What is social prescribing?*, available at:
https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing, accessed on 29/03/2017

as well as support for a wide range of problems including: employment, benefits, housing, debt, legal advice and parenting problems.

In Gloucestershire, social prescribing pilot is jointly commissioned by Gloucestershire Clinical Commissioning Group and Gloucestershire County Council through the Community Wellbeing Service, delivered by five different providers across the county. Hub coordinators accept referrals from all GP Practices in the county, from staff in the county's 21 Integrated Community Teams (ICTs) and staff from community hospitals.

Social prescribing was introduced as a pilot in the county in 2014 and has been fully operational across the county since April 2015. A recent independent evaluation of the scheme in Gloucestershire undertaken by University of the West of England and Gloucestershire Clinical Commissioning Group, highlighted a number of key findings:

- 2,047 patients were referred over the period (until August 2016), which makes it one of the largest services in the country in terms of referral numbers
- 48% of all referrals were for mental health and wellbeing
- 60.2% of service users were female (1,138 females)
- 33% of service users were aged 75+; the median age group was 56-65 years old
- 29.2% self-reported that they were disabled
- 81% accepted the referral
- GPs were the largest referral source (88%)
- The average time a case was live was 103 days; the mean number of recorded contact made by a prescriber with a patient was five.[141]

The objectives of this evaluation included:

- Assessment of improvement in mental wellbeing (using the short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)) among service users
- Assessment of whether people receiving a social prescription have reduced the number of visits to primary care
- Assessment of the use of outpatient, hospitals, social care and day care services by the patients referred to social prescribing, before and after referral
- A cost analysis of the social prescribing service.

To assess the service impact on mental wellbeing, WEMWBS was used at the start of the intervention and after some period of time (which should be 12 weeks). 41% of service users (844 people) completed WEMWBS at baseline. Scores on the scale ranged from 7 through to 34, with a mean score of 18.51. The scores were distributed across the three well-being domains: 'low', 'moderate' and 'high' mental wellbeing (Table 11). Compared with the English average, the data suggest that those referred to the social prescribing service in Gloucestershire have very low levels of reported personal wellbeing. 399 (19.4% of all patients) followed up with a WEMWBS score, however not all follow ups were made at 12 weeks (for some there was no completion date). As presented in Table 11 there was a statistically significant increase in reported short WEMWBS scores

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[141] Dr R. H. Kimberlee (2016) *Social Prescribing Service: Evaluation Report,* Gloucestershire Clinical Commissioning Group, University of the West of England

from baseline (median = 18.51) to follow up (median = 22.37), which resulted in the mean increase in mental health scores of around 3.86. There was a significant improvement across all three domains of well-being, with the people reporting moderate well-being nearly doubling.[142]

Table 11: England and Gloucestershire Baseline and Gloucestershire Follow-up WEMWBSs scores of social prescribing patients

	Mean WEMWBS score	Low well-being	Moderate well-being	High well-being	Base
England population*	28	16.8%	62.8%	20.4%	18,500
CCG Social Prescribing baseline	19	79%	20.5%	0.5%	844
CCG Social Prescribing follow up	22	60%	38%	2%	399

Source: Dr Richard H. Kimberlee (2016) *Social Prescribing Service: Evaluation Report,* Gloucestershire Clinical Commissioning Group, University of the West of England

There was also some noticeable impact on number of visits in primary care; however, the data is limited:

- GP appointments reduced by 21% in the six months after referral
- GP home visits reduced by 26% in the six months after referral

These findings suggest that social prescribing in Gloucestershire has a key role to play in improving residents' mental wellbeing and reducing the use of primary care for low level mental health issues.

Recommendations:

7.4.1   Promotion of social prescribing among Gloucestershire residents is recommended.

7.4.2   Partners should ensure that services that support mental health and wellbeing and those services addressing the wider determinants of mental health, provided by both the public and voluntary sector, are known about and shared for the use of social prescribers.

Chapter 7 recommendations:

7.1.1   Ensure that efforts to improve mental wellbeing are appropriately targeted by gender, ethnicity, disability and religious affiliation.

7.1.2   In order to improve local personal well-being, promotion of well-being programmes, such as "5 ways to well-being" and mindfulness should be continued and, where possible, enhanced. Campaigns should be undertaken in ways and places relevant to the equality groups, especially people who are disabled and people from ethnic and religious minority groups.

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[142] Ibid

7.1.3   Work on the wider determinants of wellbeing should focus on health, employment and relationship status.

7.2   A refresh of the local attitudes to mental health illness survey is recommended to review whether positive attitudes increased in line with the national data. This would also evaluate, whether the actions to decrease stigma and discrimination in Gloucestershire have been successful. It is recommended that the survey sample has adequate representation from the groups and areas identified to have less supportive attitudes. Any further actions to tackle stigma should emphasise mental health and wellbeing within the workplace.

7.3.1   Continue existing community based initiatives and services provided by the public, private and charitable sectors dedicated to reducing social isolation. Consider developing additional community based initiatives.

7.3.2   Target those at risk of social isolation, especially in the most prevalent areas. Involve those at risk in designing and delivering solutions that address social isolation and inequalities.

7.4.1   Promotion of social prescribing among Gloucestershire residents is recommended.

7.4.2   Partners should ensure that services that support mental health and wellbeing and those services addressing the wider determinants of mental health, provided by both the public and voluntary sector, are known about and shared for the use of social prescribers.

8   Mental health conditions among the Gloucestershire population

This chapter defines the prevalence of some key common mental health conditions and severe mental illnesses in Gloucestershire. Additionally, self-harm and suicide are included; although those who self-harm or attempt suicide may not have a mental health illness, these behaviours are associated with poor mental health and often used in public health as an indicator of mental health.

Key points in this section are:
- In Gloucestershire most of the prevalence of **Common Mental Health Disorders** (CMHDs) is similar to the national average, with the rate of depressive disorders being lower than the national average and one of the lowest within the region and 10 most similar CCGs. This is complemented by a lower than national average hospital admissions rate for depression in Gloucestershire. Additionally, the emergency admission rate for neuroses is significantly lower than the national average and one of the lowest among the statistical neighbours.
- Projections suggest that the prevalence of **CMHDs** in Gloucestershire will decrease or stay at the same level by 2021. However, the number of people with disorders will increase marginally. Nationally, the prevalence will increase for some CMHDs and stay at the same level for the others.
- National research suggests that around 85% of older people with depression receive no help from NHS services.
- In Gloucestershire the prevalence of people with Severe Mental Illness on the GP practice register is lower than the national and regional average equivalent; however, it is more than double the estimated prevalence (which is based on the Adult Psychiatric Morbidity Survey

(APMS)). Attendances for psychiatric conditions at Emergency Departments in Gloucestershire are lower than the national average, however Gloucestershire has one of the highest rates within the region. The emergency hospital admission rate for schizophrenia is lower than the national average, but higher than the regional average.

- Primary care audits indicate that anxiety accounts for 65% of Gloucestershire's adult GP registered population diagnosed with a mental health condition - this is 2.12% of the total GP registered population. However, this is much lower than the estimated national prevalence, which may suggest an under-diagnosis of anxiety within General Practice.
- All other conditions (personality disorder, schizophrenia, bipolar and self-harm) account for 1.16% of the total GP registered population
- North and South Cotswolds have a significantly higher proportion of people diagnosed with anxiety and a lower proportion of personality disorder and schizophrenia. Tewkesbury has a higher proportion of people diagnosed with personality disorder.
- There is a clear relationship between surgeries in the most deprived areas and a higher proportion of patients with mental health issues registered to these GPs in Gloucester - five highest levels of mental health diagnosing surgeries are in deprived areas
- Within Gloucestershire, there are 15 areas where the ratio of people with mental health illnesses severe enough to need hospital treatment is higher than the national average. The five areas with the highest Mental Illness Needs Index are located within Gloucester.
- The hospital emergency admission rate for intentional self-harm in Gloucestershire is higher than the national average and the highest among nearest statistical neighbours. Females and younger people are at higher risk. Many admissions are repeat admissions, especially among females. The top ten wards with the highest admissions are from Gloucester districts, Stroud and Cheltenham. There is a strong association between the highest rates of self-harm admissions and areas of highest deprivation in Gloucester and Cheltenham. However, there is no such correlation in other districts.
- In Gloucestershire the most concerning suicide rates are among males aged 35-64 – for this group, suicide rates are higher than the national rate and the highest compared with the nearest statistical neighbours. However, the suicide rate of males aged 10-34, although similar to the national and regional average, is one of the highest within the region and as compared to the statistical neighbours.

8.1 Prevalence of Common Mental Health Disorders

This section focuses on the prevalence of Common Mental Health Disorders (CMHD) in Gloucestershire, which comprise different types of depression and anxiety (including mixed depression and anxiety, panic disorders, obsessive-compulsive disorder, phobias and post-traumatic stress disorder).

The data for this section are obtained from Public Health England Profiles. The data are presented by Gloucestershire County Council (GCC) and by Gloucestershire Clinical Commissioning Group (CCG) area. For the GCC area, the data are presented as an estimation of the numbers likely to be diagnosed and the quality of the data is rated as having some or significant concern (because it is based on a 1993 modelling exercise uplifted by changes in population, in socio-demographic factors and on potential changes in the prevalence of common mental health disorders).[143] The CCG data

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[143] Public Health England, *Common Mental Health Disorders,* available at https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/, accessed on 07/03/207

are based on the GP recorded prevalence (of robust quality) and on GP patients' survey (data rated as having some concerns).

Based on the survey of the mental health of people living in England in 2014, one in six adults had a common mental disorder.[144] It has been suggested that the estimated prevalence of CMHD in the Gloucestershire CCG area is 15.6% (Table 13). Long-term mental health problems are reported by 4.6% of adults, who responded to the GP Patients Survey; this is slightly lower than the national average of 5.2%.

Nationally and locally, mixed anxiety and depressive disorder is the most common CMHD. It is estimated that in 2012 there were 41,183 people aged 16-74 (9.4%) in Gloucestershire area, which is slightly higher than the estimated national average of 8.9% (Table 12). The number of Gloucestershire residents with mixed anxiety and depressive disorder is estimated to grow to 41,744 people in 2021, which in relation to the population represents a decrease to 9.2%; the national prevalence will increase to 9.3% by 2021.[145]

The prevalence of generalised anxiety disorder is also one of the highest among CMHDs (4.2% of population, 18,404 people), which is similar to the national average (4.5%). It is estimated that the number of people with generalised anxiety disorder will increase marginally to 18,683 by 2021. However, this represents a small decrease in the prevalence - to 4.1%. Nationally this prevalence will increase to 4.7%.

The local prevalence of depressive episodes (excluding mixed anxiety and depressive disorders) in 2012 was half of the national average (1.3% versus 2.5%). By the year 2021, the number of people will increase from 5,684 to 5,973, but the prevalence will stay at similar level.

The numbers and prevalence of all phobias, obsessive compulsive disorder and panic disorder are estimated to stay at similar level by 2021, locally and nationally.

Table 12: Projection of some Common Mental Health Disorders in Gloucestershire, 2012 - 2021
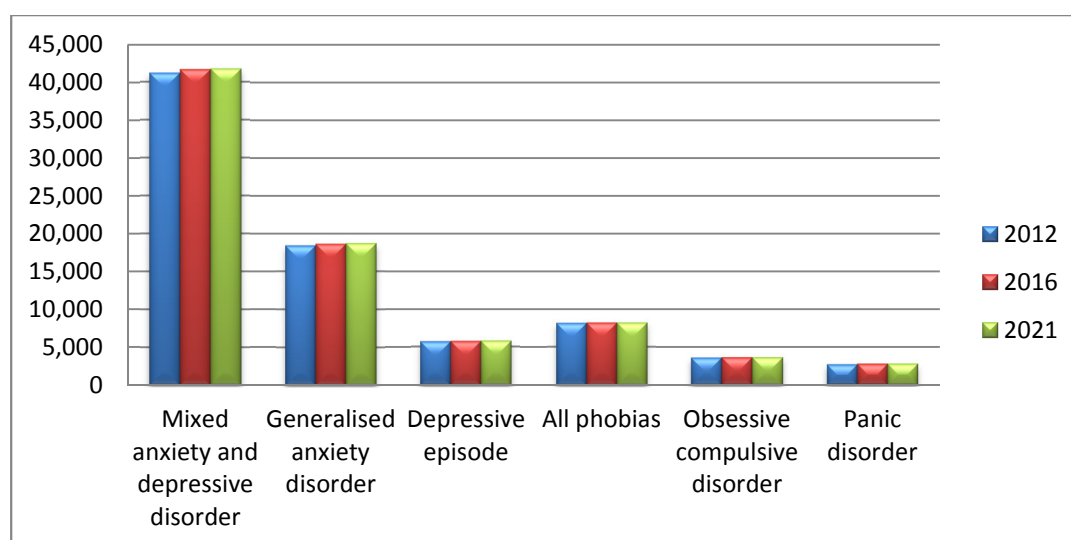
Source: Public Health England, *Common Mental Health Disorders*

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[144] McManus et.al, (2016)
[145] Public Health England, *Common Mental Health Disorders*

Additionally, estimates suggest that eating disorders are one of the most common CMHDs, with the prevalence of 6.7% (29,335 people aged over 16); which is similar to the national level.[146]

Estimated prevalence of PSTD in Gloucestershire in 2012 was 3.1% (13,505 people aged over 16), which is similar to the national level of 3.0%.[147]

GCCG records for 2015/16 (**Table 13**) show that the percentage of patients over 18 years old with depression recorded on the patients disease register (QOF) is 7.7% (39,157 people), which is lower than the England average, regional and statistical neighbours. This prevalence had decreased from 9.4% in 2011/12. This could mean that either there is a lower prevalence or fewer people have been diagnosed with depression in Gloucestershire.

Out of 39,157 patients registered with depression, 6,684 were newly diagnosed (recorded on practice disease register for the first time in 2015/16). This represents the prevalence of 1.3% of patients over 18 and is very slightly lower than the national average of 1.4%.

Based on the GP patient survey, 10.7% of adult respondents reported suffering from depression or anxiety. This is significantly lower than the national average of 12.7%. Again, this could mean fewer people are reporting depression.

Table 13: Common Mental Health Disorders in NHS Gloucestershire CCG

Recent trends: (in development) — Could not be calculated | Increasing / Getting worse | Increasing / Getting better | Decreasing / Getting worse | Decreasing / Getting better | No significant change | Increasing | Decreasing

Data quality: Significant concerns | Some concerns | Robust

Compared with benchmark: Lower | Similar | Higher | Not Compared

| Indicator | Period | Gloucestershire | | | Region England | England | | England |
		Recent Trend	Count	Value	Value	Value	Lowest	Range
Estimated prevalence of common mental health disorders: % of population aged 16-74	2014/15	—	68,653	15.6%*	15.8%*	15.6%*	10.3%	
Depression recorded prevalence (QOF): % of practice register aged 18+	2015/16	↓	39,157	7.7%	8.4%	8.3%	4.5%	
Depression recorded incidence (QOF): % of practice register aged 18+	2015/16	—	6,684	1.3%	1.4%*	1.4%	0.6%	
Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+)	2015/16	→	382	4.6%	4.9%*	5.2%	2.2%	
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2015/16	—	943	10.7%	11.8%*	12.7%	7.8%	

Source: Public Health England, *Common Mental Health Disorders*,

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[146] Ibid
[147] Ibid

The above statistics describe different categories of CMHD and the different methodologies of measurement make them hard to compare. Overall, the data indicate that most of the prevalence and incidence of CMHD are similar to national averages, with the prevalence rate for depression (estimated and registered) being lower.

Although there is no data on the population age breakdown of depression rates, national estimates provided by Age UK suggest that 22% of males and 28% of females aged over 65 live with depression.[148] A report by the Royal College of Psychiatrists indicates that 85% of older people with depression receive no treatment and that only 6% of older people are referred to mental health services compared to 50% for younger people.[149]

Hospital admissions

The hospital admissions rate for depression in Gloucestershire between the period 2009/10 and 2011/12 was 24.4 per 100,000 of the population aged over 15. This is significantly lower than the national average of 32.1 and similar to the regional average of 25.6.

The emergency admission rate for neuroses[150] in Gloucestershire in 2012/13 was 12.0 per 100,000 of the population aged 15-74, which is significantly lower than the national average of 21.7 and it is also one of the lowest among the statistical neighbours (regional rate was not measured).

8.2 Prevalence of severe mental illness

There is no consistency of definition of Severe Mental Illness (SMI). In practice, SMIs include a range of diagnoses such as severe non-psychotic disorders, psychosis and cognitive impairment.

The data in this section are based on Public Health England profiles. There is some concern about the quality of the estimated data, while GP recorded data is considered robust.

In Gloucestershire in 2015/16, 0.77% of people (4,902 people) on the GP practice register were recorded on the QOF register for mental health (schizophrenia, bipolar disorder or other psychoses or on lithium therapy) (**Figure 36**).This is lower than the national and regional average, 0.9% and 0.82% respectively. Although the SMI prevalence slightly increased from 0.72% in 2012/13 (by approximately 150 people each year), this increase was in line with the national and regional trend.

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[148] Age UK (2016) *Hidden in plain sight. The unmet mental health needs of older people,* available at http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/health-and-wellbeing/Hidden_in_plain_sight_older_peoples_mental_health.pdf?dtrk=true, accessed on 13/03/17
[149] Royal College of Psychiatrists, *The need to tackle age discrimination in mental health A compendium of evidence,* available at https://www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20-%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf, accessed on 13/03/2017
[150] Neuroses is defined as a mild mental disorder characterized by excessive anxiety, insecurity, or obsession.

Figure 36: Severe mental illness recorded prevalence (QOF) in Gloucestershire: % of practice register (all ages)
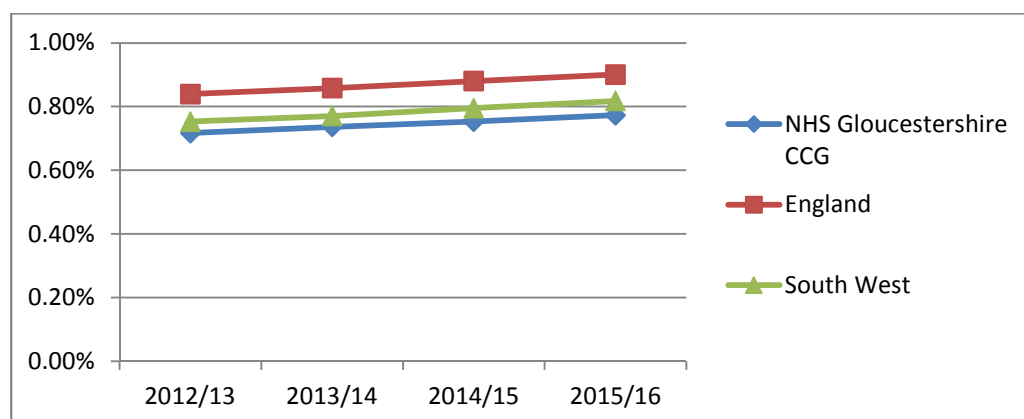
Source: Public Health England, *Severe Mental Illness*,

The estimated prevalence of psychotic disorder in Gloucestershire in 2012 was 0.35% of population aged over 16 years old (1,720). This is similar to the national (0.40%) and regional (0.33%) average. This prevalence is based on applying rates from the APMS to the local population and weighting for mental health "need". The sample for this is relatively small and insufficient to capture accurate prevalence across different groups. Therefore, it may not show the true local prevalence.[151]

Based on the above indicators, the ratio of people who are registered with GPs and are on the QOF register for mental health to the estimated prevalence of psychotic disorder in the population aged 16+ (based on APMS) was 2.15[152], which is similar to the England average of 2.22. This means that there are twice as many people registered with GPs and presenting with SMI, than the estimate suggests.

Hospital admission

In Gloucestershire, the rate of attendance at Accident and Emergency Departments for a psychiatric disorder in Gloucestershire in 2012/13 was 132.4 per 100,000 population. This rate is significantly lower than the national average; however, it is one of the highest rates within the region.[153]

The emergency hospital admission rate as a result of schizophrenia and delusion for 2009/10 and 2011/12 was 41.0 per 100,000 population aged over 18. This is lower than the national average of 57.0, but higher than the regional average of 33.0.[154] It should be noted that these available data are very out of date.

8.3 Audit based prevalence of mental health conditions in Primary Care
This section draws on results from an audit of mental health conditions within Primary Care conducted by Gloucestershire CCG.

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[151] Public Health England, Sever Mental Illness, available at https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness, accessed on 14/03/2017
[152] This is expressed as a ratio which divides the QOF prevalence by the estimated prevalence.
[153] Public Health England, Sever Mental Illness
[154] Ibid

According to the 2013 audit, 3.3% (20,511) of the local population (registered with 85 Gloucestershire GPs) were diagnosed with a mental illness (Table 14).[155]

Table 14 Gloucestershire practice population with a Mental Health condition, 2013

MH condition	Total practice population registered with condition (across 85 practices)	Percentage of registered patients (%)
Anxiety	13,280	2.12
Personality disorder	2,663	0.43
Schizophrenia	2,197	0.35
Bipolar	1,355	0.22
Self-harm	1,016	0.16
Total	**20,511**	**3.30**

Source: NHS GCCG

Anxiety accounts for 65% of the GP registered population of adults diagnosed with a mental health condition **(Figure 37).** This is 2.12% of the total registered population (13,280). Significantly higher estimated prevalence of mixed anxiety and depressive disorder (9.4%) and generalised anxiety disorder (4.2%) suggest that there is under diagnosis of anxiety in General Practice. All other recorded conditions - personality disorder, schizophrenia, bipolar and self-harm - account for 1.16% of (7,231) the total GP registered population.

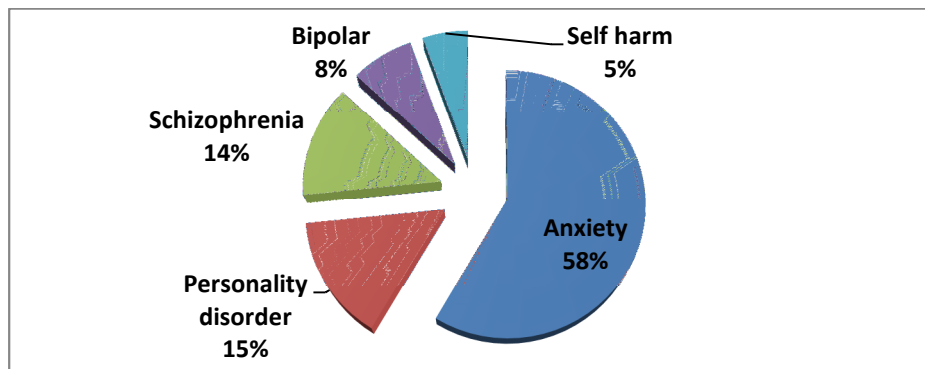**Figure 37: Prevalence of Mental Health conditions across Gloucestershire**
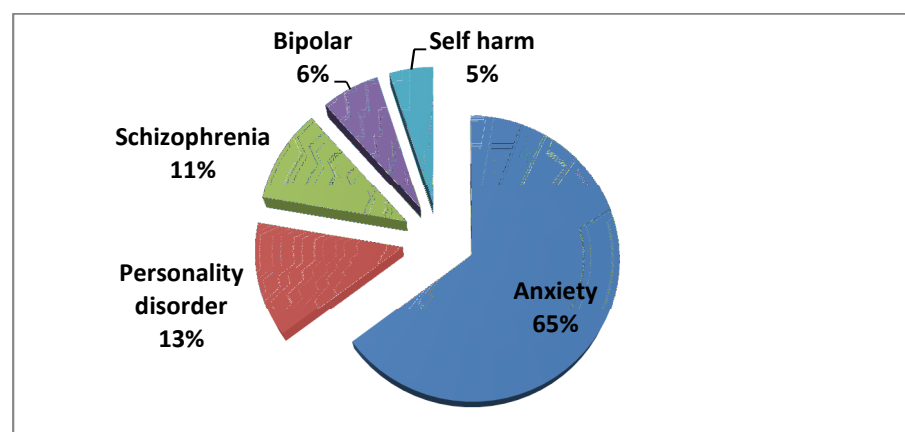
Source: NHS GCCG

Similar trends are seen across all localities **(Figure 38, Figure 39, Figure 40, Figure 41, Figure 42, Figure 43, Figure 44)**. However, South and North Cotswolds present with a significantly higher proportion of people diagnosed with anxiety (74% and 72%) and a lower proportion of personality disorder (9% and 8%) and schizophrenia (6% in both localities). Cheltenham has the lowest proportion of anxiety (58%). Tewkesbury shows a higher proportion of people diagnosed with personality disorder (19%).

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[155] Data are from 2013, a small number of surgeries no longer exist; however, it is assumed that the population has remained the same.

Figure 38: Prevalence of Mental Health conditions across Cheltenham

Source: NHS Gloucestershire CCG

Figure 39: Prevalence of Mental Health conditions across South Cotswold
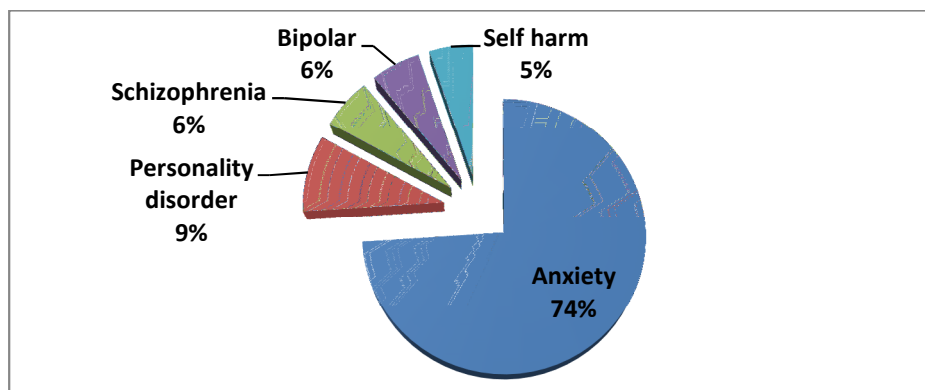
Source: NHS Gloucestershire CCG

Figure 40: Prevalence of Mental Health conditions across North Cotswold

Source: NHS Gloucestershire CCG

Figure 41: Prevalence of Mental Health conditions across Forest of Dean

Source: NHS Gloucestershire CCG

Figure 42: Prevalence of Mental Health conditions across Gloucester
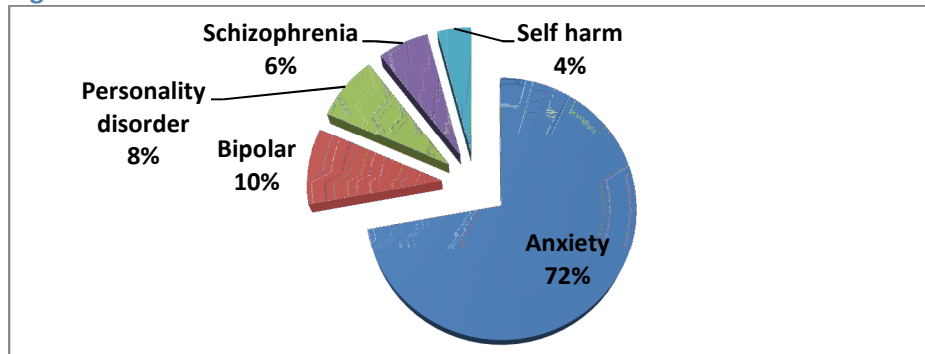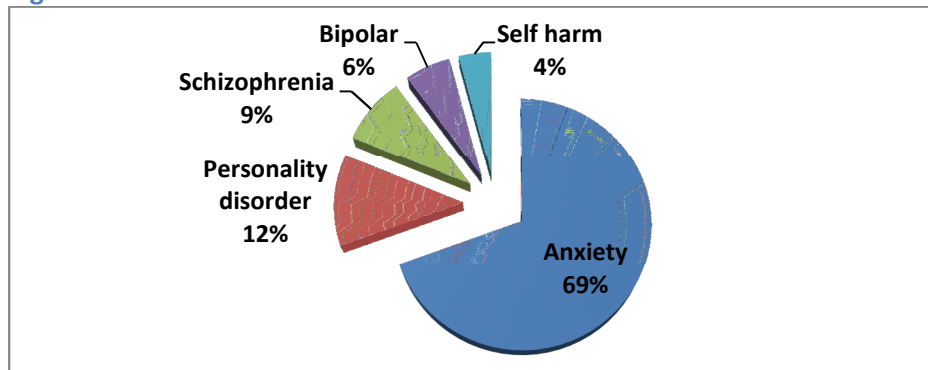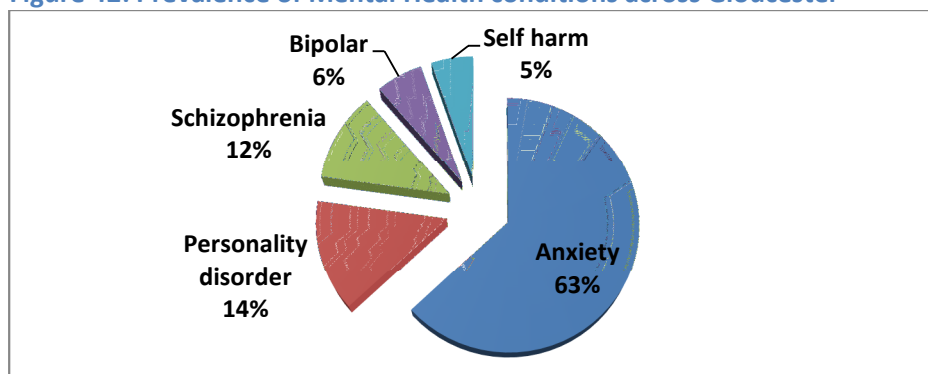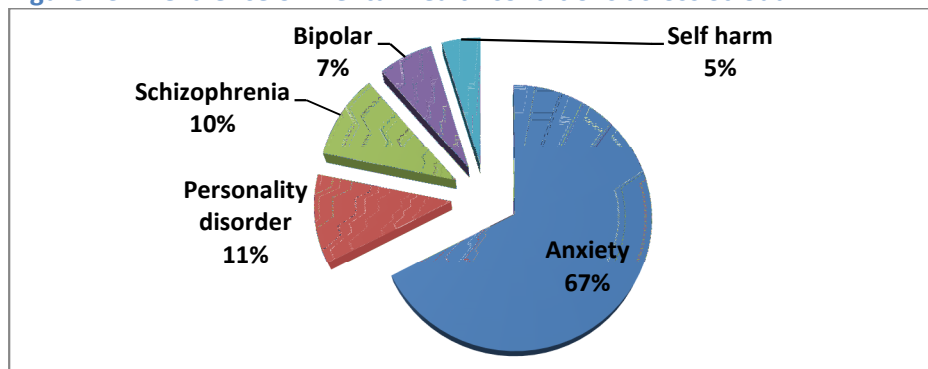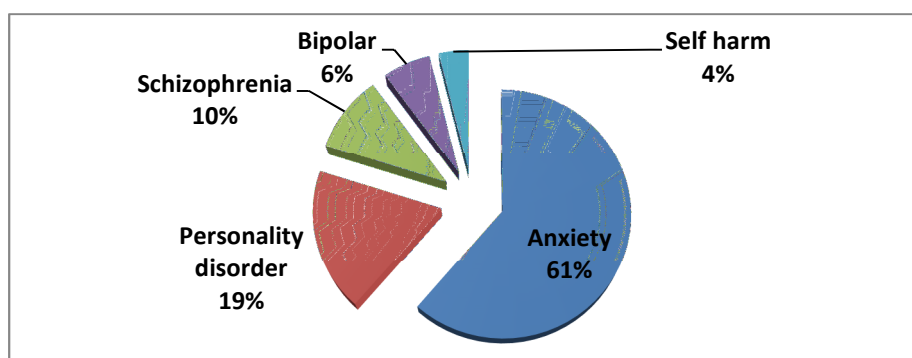

Source: NHS Gloucestershire CCG

Figure 43: Prevalence of Mental Health conditions across Stroud

Source: NHS Gloucestershire CCG

Figure 44: Prevalence of Mental Health conditions across Tewkesbury

Source: NHS Gloucestershire CCG

The above prevalence rates do not reflect the whole picture but are an indication. Accessing primary care services can be more difficult for many of groups of people with particularly high needs for mental health support, including homeless people, refugees and asylum seekers or Gypsies and Travellers. For example, nationally only 67% of rough sleepers are registered with a GP, compared with 98% of the whole population.[156]

The audit data was also used to examine the correlation between prevalence of mental health conditions and deprivation. Initial findings show that in Gloucester there is a clear relationship between surgeries in the most deprived areas and a higher proportion of patients with mental health issues registered to these GPs (Table 15). Five of the surgeries with the highest levels of mental illness diagnoses are in deprived areas.

Table 15 Gloucester GPs in order by the percentage of people diagnosed with Mental Health conditions, most deprived areas highlighted in blue

Surgery name	Percentage of patients with diagnosed Mental Health condition (%)
London Road Medical Practice (GL1 3HH)	1.73
Park Health Centre (GL1 1XR)	1.44
Kingsholm Surgery (GL1 3EN)	1.38
Bartongate Surgery (GL1 4HR)	1.19
Matson Lane Surgery (GL4 6DX)	1.07
Heathville Road Surgery	1
Gloucester Health Access Centre	0.78
College Yard & Highnam (GL1 2RE)	0.74
Hadwen Medical Practice	0.66
Rosebank Surgery	0.64
Barnwood Medical Practice	0.61
Hucclecote Surgery	0.6
Pavillion Family Doctors	0.58
Churchdown Surgery	0.51
Longlevens Surgery	0.47
Brockworth Surgery	0.47
Saintbridge Surgery	0.42
Cheltenham Road Surgery	0.37
Quedgeley Medical Centre	0.37

Source: NHS Gloucestershire CCG

However, in Cheltenham the town centre surgeries have a higher number of patients registered with a mental health condition (Table 16). The reason for this is not clear. It is possible that patients are travelling to a more centrally located surgery. The total number of patients with a mental health

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[156] Elwell-Sutton et al. (2016)

diagnosis registered in some of the most deprived areas of Cheltenham is relatively low (Springbank Surgery and Crescent Bakery Surgery).

Table 16: Cheltenham GPs in order by the percentage of people diagnosed with Mental Health conditions, most deprived areas highlighted in blue

Surgery name	Percentage of patients with diagnosed Mental Health condition (%)
Royal Well Surgery (GL50 4DP)	1.29
Overton Park Surgery (GL50 3BP)	1.14
Corinthian Surgery (GL50 4DP)	1.1
St Catherine's Surgery (GL50 4DP)	1.07
Berkeley Place Surgery (High Street, GL52 6DA)	1.06
Crescent Bakery Surgery (GL50 3PN)	1.03
Portland Practice (GL50 4DP)	0.95
Yorkleigh Surgery (GL50 3ED)	0.87
St George's Surgery (GL50 4DP)	0.79
Leckhampton Surgery	0.69
Royal Crescent Surgery	0.67
Springbank Surgery (GL51 0LG)	0.6
Sevenposts Surgery	0.57
Winchcombe Medical Practice	0.57
Stoke Road Surgery	0.54
Sixways Clinic	0.52
Underwood Surgery (GL50 3EQ)	0.51

Source: NHS GCCG

Recommendations:

8.3.1   There should be a focus on early intervention for anxiety, especially in Cotswold district and on mental health promotion in high deprivation areas, especially in Gloucester.

8.3.2   A refresh of the audit of mental health conditions within Primary Care should be undertaken, expanded by including the specification of the population characteristics. This would help identify whether people from vulnerable groups are reporting mental health conditions.

8.4   Personality disorder

A rapid review of the epidemiological data on personality disorder conducted by the GCC Public Health Team estimated that in Gloucestershire there are approximately more than 22,000 adults with a personality disorder. The estimated number of people with personality disorder would be between 10% and 25% of patients in primary care, which equates to 762 and 1,905 patients per Gloucestershire practice, though many will not have a formal diagnosis.[157] There is a significant

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[157] GCC (2016) *Personality disorders- rapid review of the data and evidence on 'need'*

difference between these estimates and the prevalence of patients with personality disorder according to the primary care audit described above (prevalence of 0.43%, 2,663 of all people registered with GP). This would suggest that the majority of people with personality disorder do not seek help for their condition within primary care and/ or the diagnosis is not made.

Additionally, this review highlighted that:

- There are groups who are at higher risk of developing personality disorders, such as: prisoners, people with substance misuse issues, and people with mental health disorders. Additionally, people from lower socio-economic status are more likely to develop personality disorders.
- People with personality disorders frequently use primary care services and are more likely to be admitted to hospital, although the personality disorder may not be the primary reason. People from this group experience other health and behavioural problems, such as: substance misuse, other mental health disorders, higher risk of suicide, accidents and self-harm.
- People with personality disorder present with higher mortality and morbidity rates, which are associated with a number of factors such as: unhealthy lifestyle behaviours, physical consequences of psychotropic medication and problems accessing healthcare.

The recommendations based on this review included: raising awareness and education for all services around personality disorder and for GPs; further investigation into whether having diagnosis earlier helps clinicians and patients; development of a screening tool to rule out personality disorder early on in the pathway; raising awareness and improving access to services for people from vulnerable and hard to reach groups, such as: black and ethnic minority groups, people with a learning disability, self-harming individuals, drug and alcohol patients, Crisis House users, people with complex and severe personality disorder.[158]

Recommendations:

8.4   This Needs Assessment supports the recommendations from: *Personality Disorders Recommendation Report.* Further, it is recommended that mental health commissioners and other commissioners (e.g. substance misuse or housing) are engaged in this process to ensure a joined up approach.

8.5   Local survey

This section looks into the Mental Health Needs Index 2000 (MINI 2000). This Index is derived from population and deprivation data relating to 1998. Although this relates to the period of around 15 years ago, this is the most relevant data available at a ward level. The MINI 2000 was developed by the Centre for Public Mental Health.[159]

[158] NHS GCCG (2016) *Personality Disorders Recommendations Report*
[159] G. Glover, Centre for Public Mental Health, Durham University, 2004, accessed through GCC Data and Performance Team

The MINI 2000 provides estimates on mental illness of adults (ages 16-59) severe enough to need hospital treatment, by ward and district. The mental health need, measured as a rate of hospital admission is mathematically correlated with the number of population characteristics likely to indicate need for access to services, such as deprivation; proportion of economically active adults who are unemployed; proportion of adults living in households not self-contained, etc. The MINI 2000 provides a ratio of predicted admission need compared to the England average. A needs index of 0.8 suggests that there will be 20% less illness in an area than in the country as a whole, an index of 1.2 suggests 20% more.

The map below indicates Gloucestershire's areas with residents most likely to suffer from mental health illness severe enough to be admitted to hospital.

Figure 45: Gloucestershire areas, with prevalence of people with mental illnesses severe enough to need hospital treatment
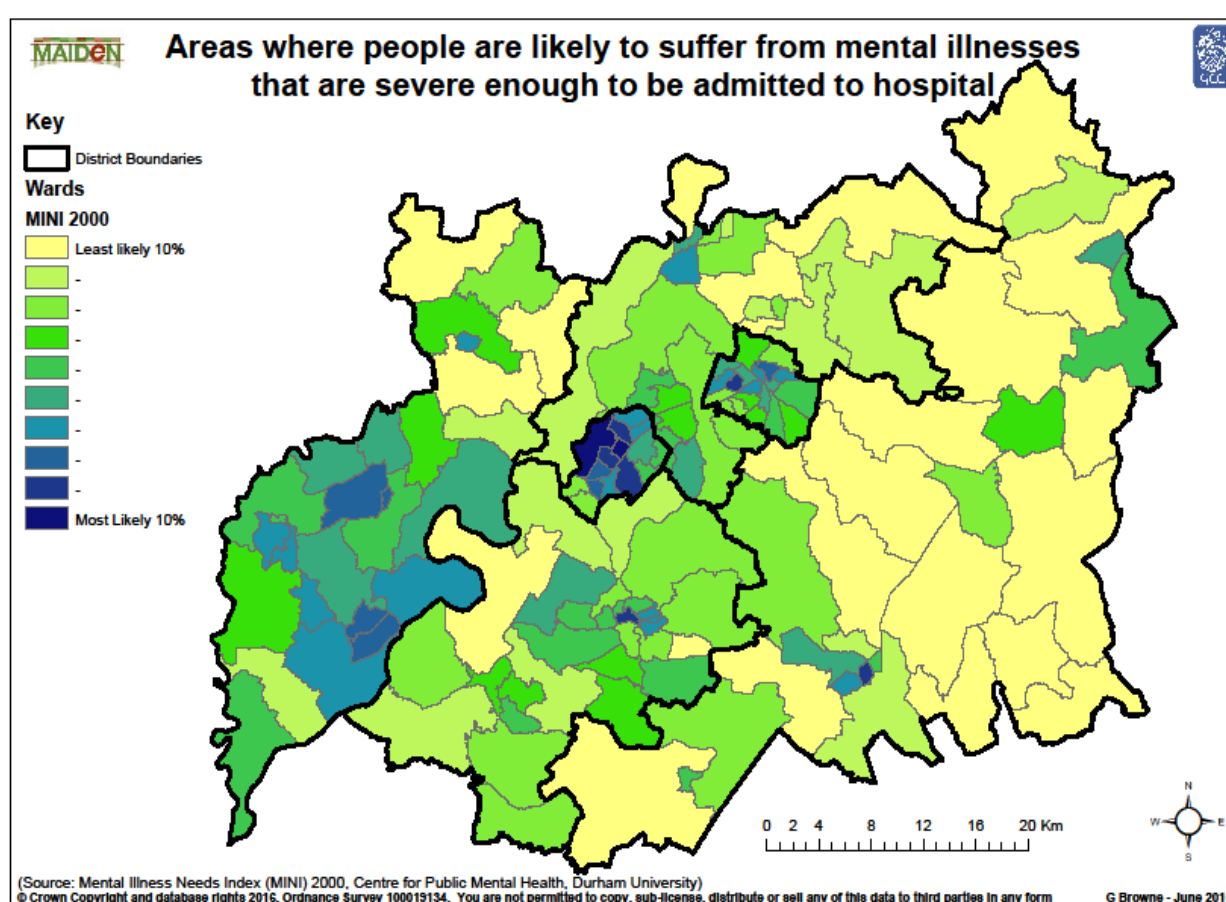
Source: MINI 2000, Centre for Public Mental Health, Durham University (2004)

In Gloucestershire there were 15 areas with a higher prevalence of predicted hospital admission than the national average (**Table 17).** Out of those, seven wards were located within Gloucester, four within Forest of Dean, two within Cheltenham, and one each within Stroud and Cotswold. The index for all Tewkesbury wards is similar to or lower than the English average. The five areas with the highest MINI 2000 ratio, were located in Gloucester.[160]

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[160] Ibid

Table 17: Gloucestershire wards with the ratio of predicted hospital admission for severe mental illness higher than England average

Ward Name	District	MINI2000	Qnt10
Westgate	Gloucester	1.6	10
Barton and Tredworth	Gloucester	1.5	10
Matson and Robinswood	Gloucester	1.4	9
Moreland	Gloucester	1.3	9
Kingsholm and Wotton	Gloucester	1.3	9
Central	Stroud	1.2	9
St Mark's	Cheltenham	1.2	9
Cirencester Watermoor	Cotswold	1.2	9
Cinderford East	Forest of Dean	1.2	8
Cinderford West	Forest of Dean	1.2	8
Grange	Gloucester	1.2	8
Podsmead	Gloucester	1.1	8
Lydney East	Forest of Dean	1.1	8
Lydney North	Forest of Dean	1.1	8
Pittville	Cheltenham	1.1	8

Source: MINI 2000, Centre for Public Mental Health, Durham University (2004)

The above prediction should be interpreted with caution, due to being significantly out of date.

8.6 Associated behaviours

8.6.1 Self-harm

Hospital admission rates for self-harm in Gloucestershire are higher than in England, therefore this topic is explored in detail in this section.

The Royal College of Psychiatrists define self-harm as: "an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent". Some self-harm acts are carried out with the intention of suicide; however, many people who self-harm are not intentionally seeking to end their life.[161] By self-harming people look for ways to cope or express their feelings and emotion, which become unbearable; some people may feel a temporary relief from the emotional pain. Although self-harm is not a primary disorder, individuals with borderline personality disorder, depression and eating disorders present higher rates of self-harm.[162] Additionally, circumstances such as: difficulties at home, past trauma (including abuse, neglect or loss), social or economic deprivation, and substance misuse together with some level of mental disorder can lead to self-harm.[163]

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[161] Royal College of Psychiatrists (2010) *Self-harm, suicide and risk: a summary*, London, available at https://www.rcpsych.ac.uk/pdf/PS03-2010x.pdf, accessed on 15/02/17
[162] Mental Health Foundation, *Self-harm*, available at https://www.mentalhealth.org.uk/a-to-z/s/self-harm, accessed on 15/02/17
[163] Royal College of Psychiatrists (2010)

There are higher incidents of self-harm among some vulnerable groups described in Chapter **6**, such as: victims of domestic abuse, people with autism, people with substance misuse problem, care-leavers, economically inactive people, unemployed people, LGBT people and asylum seekers.

The local prevalence of self-harm presented below is based on Hospital Episode Statistics. These data do not represent the real prevalence of self-harm, only self-harm events reported and severe enough to warrant hospital admission. This section does not cover self-reported or estimated prevalence of self-harm in the community, which is understood to be greater than those individuals who attend and are admitted to hospital.

The hospital emergency admission rate for intentional self-harm in Gloucestershire (all ages) between 2010/11 and 2014/15 was 126.3 per 100,000 people, which was higher than the national average of 100.0 and the highest among nearest statistical neighbours.[164]

<u>By year</u>

In Gloucestershire in 2015/16 the crude rate of hospital admissions (primary and secondary diagnosis, all ages)[165] and unique individuals admitted for self-harm was 194.3 and 134.3 per 100,000 people respectively. The number of hospital admissions and numbers of individuals increased between 2012/2013 and 2015/2016, from 1,069 admissions and 742 unique individuals in 2012/13 to 1,199 admissions and 829 unique individuals in 2015/16 (**Figure 46**). However, in relation to 2014/15 these numbers have decreased in 2015/16. **Figure 46** indicates that there is a significant number of the individuals who were repeatedly admitted to hospital for self-harm – in each year at least 30% were repeat admissions.

Figure 46: The difference between number of hospital admissions and number of unique individuals admitted in Gloucestershire, by year, all ages
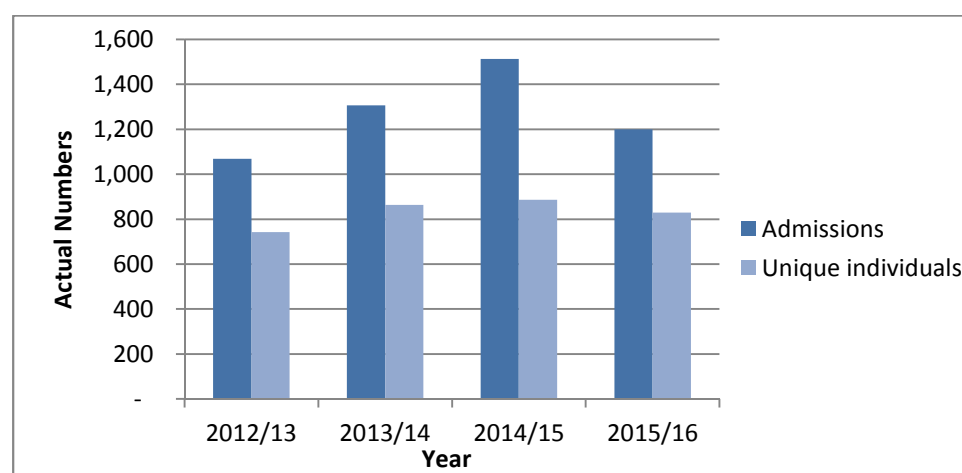
Source: GCC, Data and Performance Team

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[164] Public Health England, *Mental Health JSNA*, available at https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA/data, (accessed on 15/02/17)
[165] Primary diagnosis means that this is the main reason why the patient was admitted to hospital, and secondary diagnosis means that the patient has been admitted for another primary reason but the self-harm has been also diagnosed.

As indicated in **Figure 47** there are higher rates of hospital admission and individuals who self-harm among females than males (all ages). Additionally, females are more likely to be admitted for self-harm more than once.

Figure 47: The difference between number of hospital admissions and number of unique individuals admitted in Gloucestershire, by year and gender, all ages
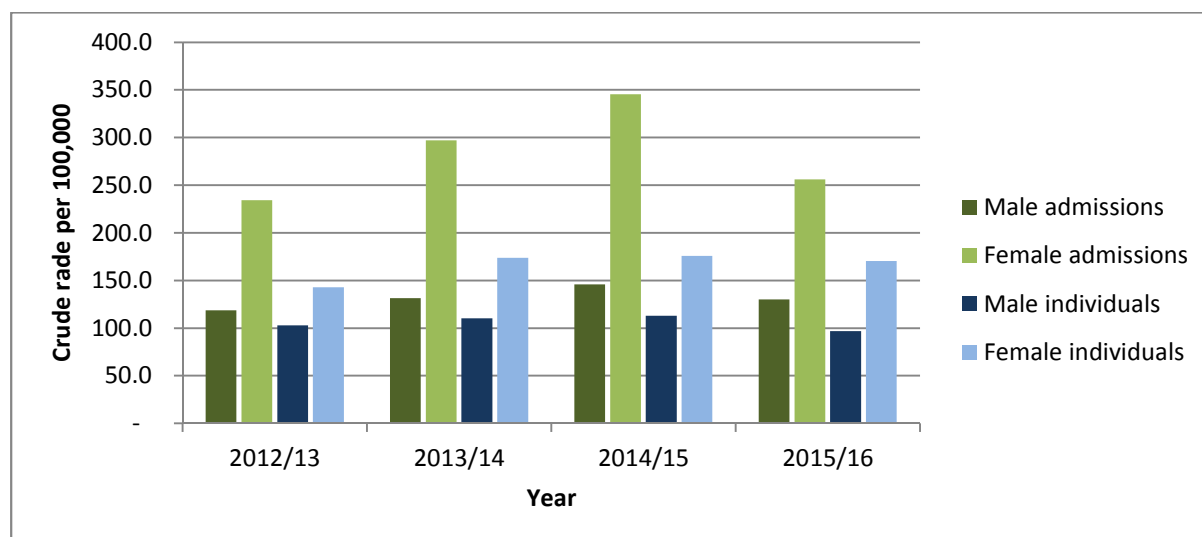

Source: GCC, Data and Performance Team

By age

Figure 48 illustrates the percentage of hospital admission numbers for self-harm by adult age groups. There is no significant difference between age-band proportion of numbers of admissions and numbers of unique individuals. Overall, the numbers of admission increasing with lower age bands, which may indicate that people of younger age are more likely to self-harm, or self-harm more severely or be admitted to hospital.

Figure 48: Self-harm hospital admissions and individuals admitted in Gloucestershire, by age groups
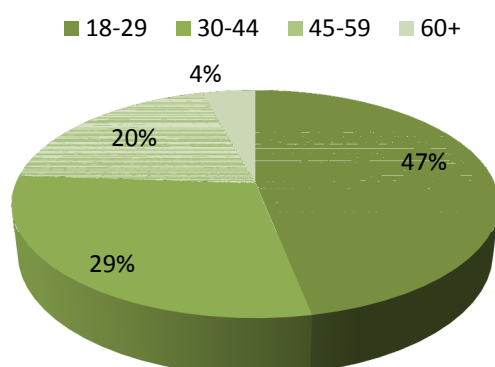
Source: GCC, Data and Performance Team

Based on the period from April 2012/13 to September 2016/17, the ten Gloucestershire wards with the highest numbers of admissions for self-harm accounted for 31% of admissions from all 140 wards (Table 18). Six out of the ten wards with the highest numbers of admissions are in Gloucester district, three in Stroud and one in Cheltenham.

**Table 18: The 10 wards with highest numbers of self-harm hospital admissions in Gloucestershire, by ward, April 2012/13 to September 2016/17**

Ward	Number of admissions	District
Kingsholm and Wotton	317	Gloucester
Westgate	295	Gloucester
Chalford	194	Stroud
Barton and Tredworth	182	Gloucester
Moreland	151	Gloucester
Barnwood	145	Gloucester
Matson and Robinswood	145	Gloucester
St Paul's	117	Cheltenham
Valley	117	Stroud
Central	111	Stroud
Total	**1774**	

Source: GCC, Data and Performance Team

The map below (Figure 49) presents the areas with the highest rates of self-harm admissions per 100,000 population. As illustrated, around half of Gloucester city is 'hot' (i.e. top 10%) or 'warm' (next 25%) (hot: parts of Matson and Robinswood, Podsmead, Moreland, Barton and Tredworth, Kingsholm and Wotton, Westgate, Elmbridge, Abbeydale, Barnwood, Coney Hill). In Stroud the highest rates are shown to be around central Stroud's wards: Trinity, Slade, Valley, Farmhill and Paganhill, Stonehouse and Chalford. There are no 'hot' areas in Forest of Dean, very little in Tewkesbury (north of Prior's Park). In Cotswold the 'hot' and 'warm' areas are in the majority located in the south (parts of Kempsford-Lechlade, The Beeches, St. Michael's, New Mills, Watermoor, Four Acres, Chesterton, Siddington and Cerney Rural), in Cheltenham – from central to north (part of Lansdown, St. Mark's, St. Peter's and Hesters Way wards).

Figure 49: Hot, Warm and Cool map based on the rate of population who were admitted to hospital for self-harm*
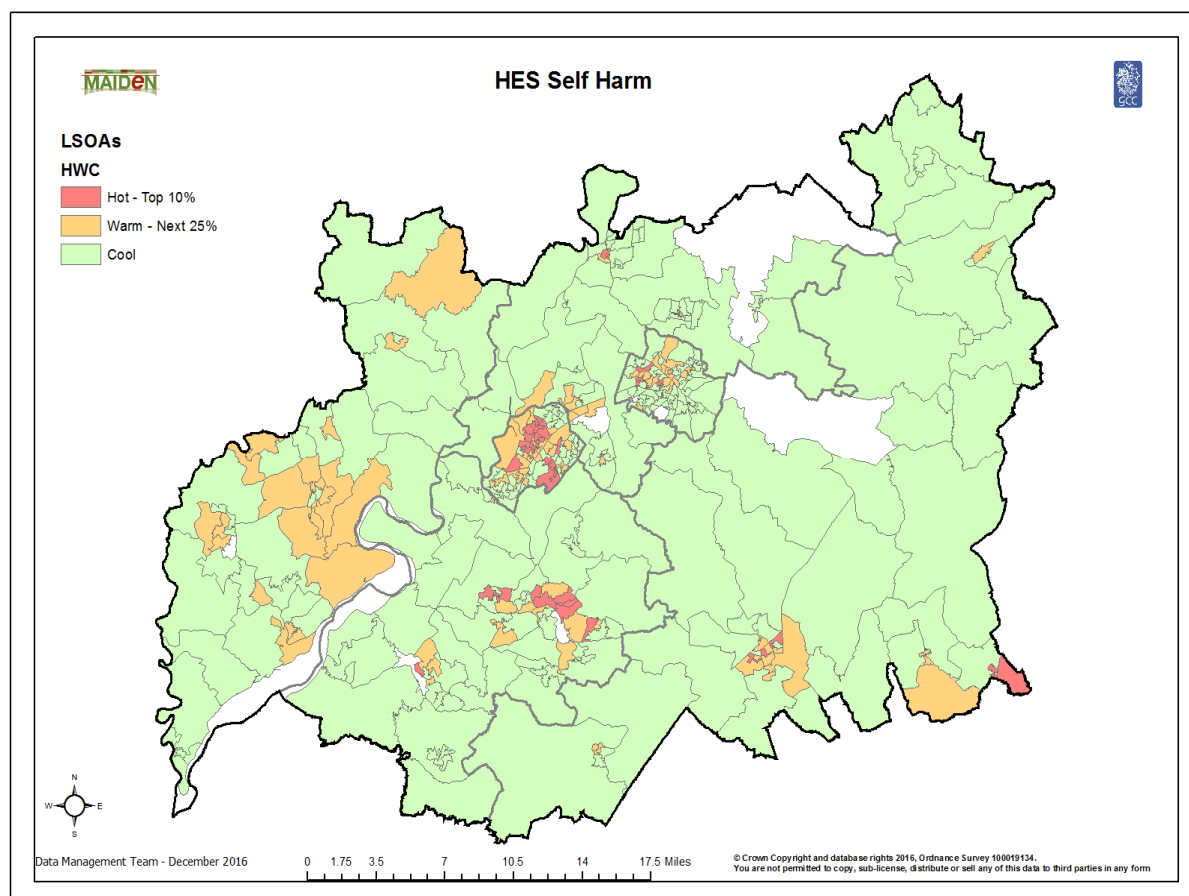
Source: GCC, Data and Performance Team
*The white areas are LSOAs with no data. No one who lived in those areas were admitted to A&E for Self Harm during that period.

By deprivation

An analysis of the numbers of hospital admissions and individuals admitted for self-harm in Gloucestershire between 2012/13 and the first half of 2016/17, shows that the highest number of hospital admissions for self-harm are linked with neighbourhoods located not in the least or most deprived areas (Table 19) However, there were more admissions and individuals admitted from the 20% least deprived areas than from the 20% most deprived.

Table 19 Self-harm hospital admissions and unique patients linked to quintile of deprivation (1- least deprived – 5- most deprived)

IMD2015Quintile	Admissions	Unique Patients
1 - Least Deprived	1,250	684
2	832	561
3	1,390	842
4	1,074	647
5 - Most Deprived	1,090	585

Source: GCC, Data and Performance Team

Analysis of the rates of admissions per 100,000 head of population and the county deprivation, captured by the maps below (**Figure 50** and **Figure 51**) shows that there is a strong association between the highest rates of self-harm admissions and areas of highest deprivation in Gloucester and Cheltenham. However, there is no such correlation in other districts, for example in Cotswold district, those from the two least deprived quintiles are at a higher risk of hospital admissions for self-harm. This possibly could be due to deprivation being more hidden or about access to hospital.

Figure 50: Map of deprivation plotted against rates of admissions for self-harm in Gloucestershire, 2012/13 to September 2016/17
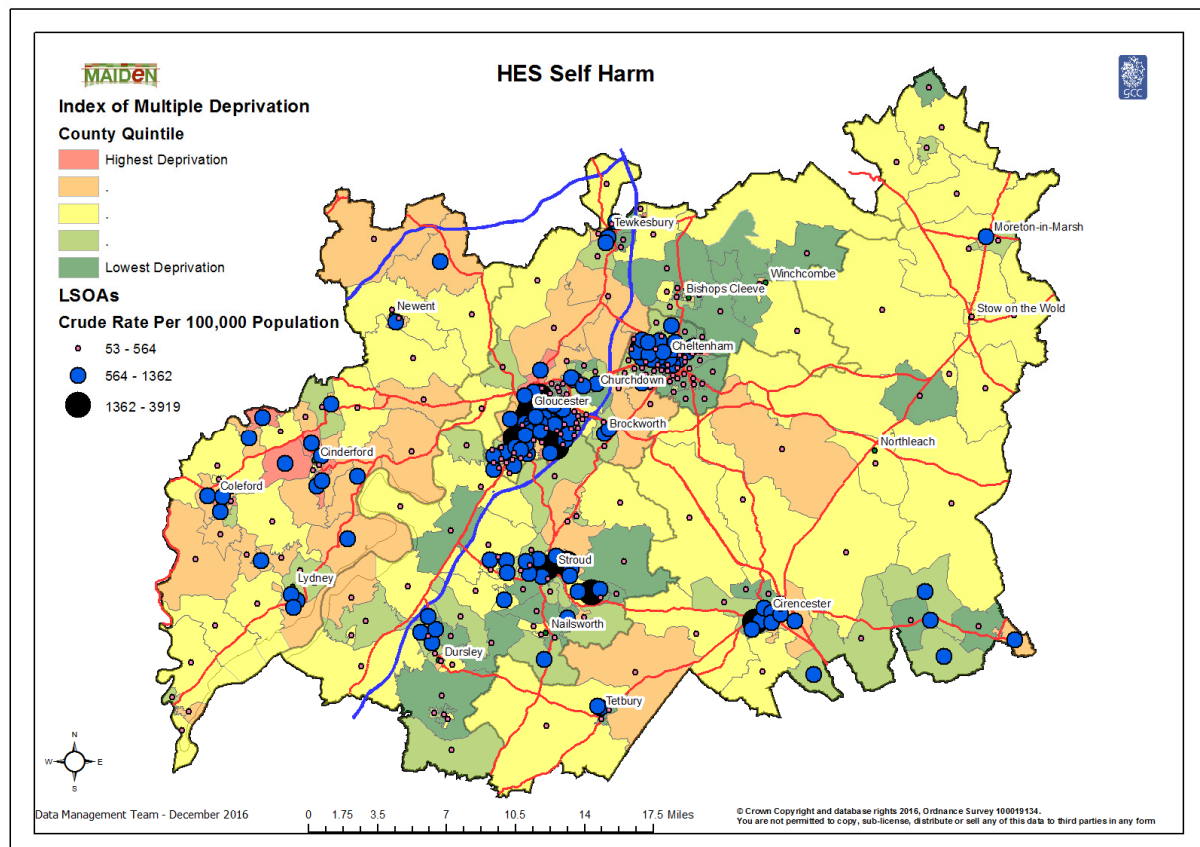
Source: GCC, Data and Performance Team

Figure 51 Map of deprivation plotted against rates of admissions for self-harm in Gloucester and Cheltenham, 2012/13 to September 2016/17
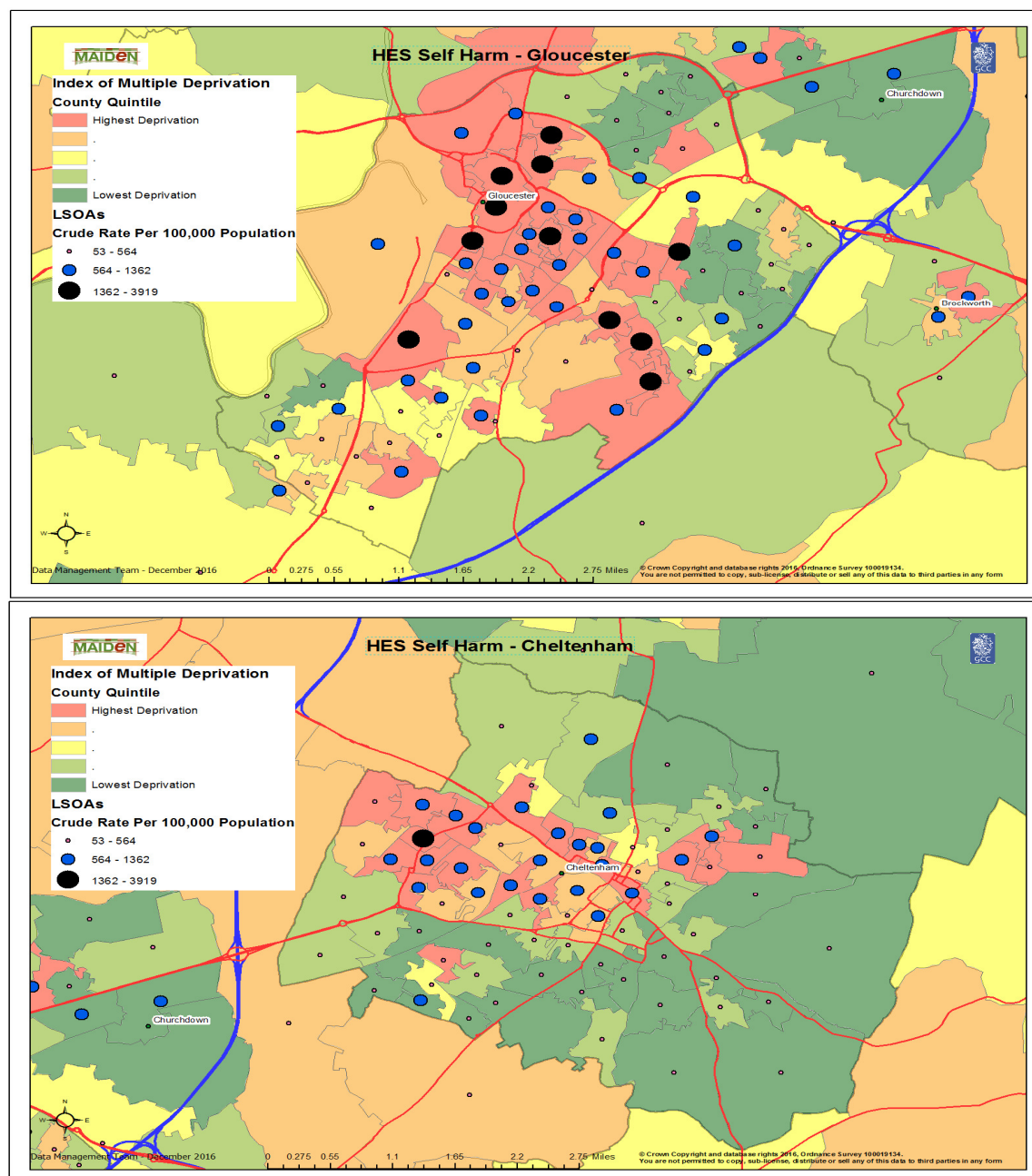
Source: GCC, Data and Performance Team

By primary cause

Based on the four and half years of hospital admissions data the most frequent method of self-harm leading to admission was self-poisoning (**Table 20**). Self-poisoning was the reason for nearly 50% of all self-harm admissions. One in four admissions was caused by laceration (a deep cut or tear in skin or flesh). Other coding is less precise, e.g. psychiatric condition (7%).

Table 20: Most frequent reason of self-harm hospital admissions in Gloucestershire, 2012/13 – September 2016/17

A&E Diagnosis	Admissions
Poisoning (including overdose)	2674
Laceration	1416
Psychiatric conditions	369
Diagnosis not classifiable	363
NULL	345
Contusion/abrasion	93
Foreign body	85
Burns and scalds	79
Soft tissue inflammation	52
Dislocation/fracture/joint injury/amputation	48
Head injury	34

The majority of the admissions in Gloucestershire were through the Emergency Department (84%). 16% presented at one of the acute hospitals (not Emergency Department) or a Minor Injury Unit.

Recommendations:

8.6.1.1 Work in partnership with hospital trust and groups at higher risk of self-harm to gain further understanding of Gloucestershire's high admission rates and repeat admissions.

8.6.1.2 Promote help seeking within community services, such as Self-Harm Helpline, especially among people living in the most deprived areas of Gloucester and Cheltenham.

8.6.1.3 This needs assessment supports the action in the recently developed *Mental Health Crisis Care Concordat Action Plan* to develop a vision and actions based on a strategic framework for developing an all age self-harm evidence based care pathway.

8.6.2 Suicide

Suicide prevention is a global, national and local priority. Although suicide is not a mental health disorder, mental illnesses increase the risk of suicide.

Suicide can be defined as an act of deliberately killing oneself.[166] Deaths by suspected suicide are reported to coroners and certified by them after an inquest. The risk factors for people taking their own life include:

- gender – males are more likely to end their own life than females
- age – the highest prevalence of suicide is among 35-49 years old
- mental illness

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[166] WHO, *Suicide*, available at http://www.who.int/topics/suicide/en/ (accessed on 22/02/17)

- the treatment and care people receive after a suicide attempt
- physical disability or painful illness
- substance misuse.[167]

Additionally, a combination of stressful events can contribute to increasing an individual's vulnerability to suicide. These events include:

- the loss of a job
- debt
- living alone, becoming socially excluded or isolated
- bereavement
- family breakdown and conflict including divorce and family mental health problems
- imprisonment.

The Gloucestershire Suicide Profile provided by Public Health England (**Appendix 3**) indicates that overall Gloucestershire has a mortality rate from suicide and injury of undetermined intent that is similar to national, regional and statistical neighbours; Gloucestershire 10.6, national 10.1, regional 11.0 (age standardised rate per 100,000 population, 2013-15). Male suicide rates (ages above 10) are higher than female: 17.1 (136 deaths) versus 4.3 (35 deaths); male rates are similar to the national and regional average and to the rates of nearest statistical neighbours; female rates are similar to the national rates and the rates of statistical neighbours; but lower than the regional average.[168]

However, there are some differences when comparing the data within specific age groups. The five years average suicide rate for males aged 35-64 is higher than the national average (25.6 compared with 20.8), and the highest as compared with the nearest statistical neighbours. The mortality rate from suicide for 10-34 years old male (rate 13.4), although similar to the national and regional average, is one of the highest within the region, and compared to statistical neighbours. Suicide rates for males aged over 65 (13.7) are similar to national, regional and statistical neighbours rates.[169]

There are no data on local rates of female suicide by age, due to small numbers.

Locally, the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) is responsible for developing and delivering a suicide prevention strategy and action plan. Their strategy is built on the National Strategy, regional reports and on results from local suicide audits. The local audits are usually conducted every three years and an audit covering deaths recorded between 2013 and 2015 has been recently published. Further recommendations will be established by the GSPPF in early 2018 and this Needs Assessment supports them.

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[167] HM Government (2012) *Preventing suicide in England; A cross-government outcomes strategy to save lives,* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf (accessed on 22/02/2017)

[168] Public Health England, *Suicide Prevention Profile,* https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000009/ati/102/are/E10000013/iid/91393/age/269/sex/2, accessed on 01/03/17

[169] Ibid

Recommendations:

8.6.2.1 Training in mental health awareness and suicide prevention should be targeted and available to all working with high risk groups.

8.6.2.2 Suicide prevention methods should be reviewed by their cost effectiveness and considered for investment.

8.6.2.3 Further work with local planners and developers should be undertaken to decrease risks of suicide opportunities.

Chapter 8 Recommendations:

8.3.1   There should be a focus on early intervention for anxiety, especially in Cotswold district and on mental health promotion in high deprivation areas, especially in Gloucester.

8.3.2   A refresh of the audit of mental health conditions within Primary Care should be undertaken, expanded by including the specification of the population characteristics. This would help identify whether people from vulnerable groups are reporting mental health conditions

8.4   This Needs Assessment supports the recommendations from: *Personality Disorders Recommendation Report*. It is recommended that mental health commissioners and other commissioners (e.g. substance misuse or housing) are engaged in this process to ensure a joined up approach.

8.6.1.1 Work in partnership with hospital trust and groups at higher risk of self-harm to gain further understanding of Gloucestershire's high admission rates and repeat admissions.

8.6.1.2 Promote help seeking within community services, such as Self-Harm Helpline, especially among people living in the most deprived areas of Gloucester and Cheltenham.

8.6.1.3 This needs assessment supports the action in the recently developed *Mental Health Crisis Care Concordat Action Plan* to develop a vision and actions based on a strategic framework for developing an all age self-harm evidence based care pathway.

8.6.2.1 Training in mental health awareness and suicide prevention should be targeted and available to all working with high risk groups.

8.6.2.2 Suicide prevention methods should be reviewed by their cost effectiveness and considered for investment.

8.6.2.3 Further work with local planners and developers should be undertaken to decrease risks of suicide opportunities.

9 Mental Health Services

Key points in this section are:

- The Gloucestershire rate of assessment under **Section 136** is increasing and is higher than the national average. Detentions are most likely to occur out of hours; the average time spent in the Place of Safety is increasing. 68% of all detentions require support from specialist mental health services, although the proportion of informal admissions is declining. The number of detainees with a predominant condition of adult personality disorder or with the dominant condition of substance misuse disorders are increasing. There were a total of 18 people, who accounted for 103 detentions during a half year period. There are areas in Gloucestershire (GL1 – mainly Gloucester and GL5 - Stroud), where the number of detentions are double the number of distinct patients, suggesting higher numbers of repeat detentions from these areas.

- Approximately half of assessments performed by Approved Mental Health Professionals (AMHPs) lead to detention under the Mental Health Act. More than half of all detentions are made under **section 2**; around 30-40% are made under **section 3**; detentions under **section 4** are marginal.

- Detentions under **section 2 and 3** increased by 100% between 2012/13 and 2015/16, and then decreased in 2016/17. There is an over representation of people aged 20-29 and 70-89 as well as people from Black/ African/Caribbean/ Black British ethnicity groups among all detainees.

- Between 2014/15 and 2016/17 there was a decrease in the numbers of events (one event represents a single occurrence that happened in a service) within several services provided by **2gether NHS Foundation Trust** including the Recovery Service, Crisis Resolution and Home Treatment Team (CRHTT), Later Life Community Mental Health, Working Age Emergency Department Liaison in Cheltenham General Hospital, Older People Mental Health Liaison within Gloucestershire Royal Hospital, Gloucestershire Recovery in Psychosis and Eating Disorder Day Treatment Team. An increase in activity was observed within the Working Age Emergency Department Liaison within Gloucestershire Royal Hospital, Older People Community Liaison, Older People Mental Health Liaison within Cheltenham Hospital, Eating Disorder Community Team, Dual Diagnosis and Criminal Justice Liaison Service.

- Between 2014/15 and 2016/17 the number of bed days within the **acute mental health hospital** (Wotton Lawn) increased for Dean Ward (admissions of female residents from Cheltenham and Tewkesbury), stayed at similar levels for Abbey (admission for Stroud and Cotswold residents) and Kingsholm (male residents of Cheltenham and Tewkesbury) and decreased for Priory Ward (admission for Gloucester residents).

- The number of bed days within the Charlton Lane Inpatient Services (older people with functional mental health problems and people with dementia) increased between 2014/15 and 2016/17 within Chestnut and Mulberry wards (specialised in mental health needs) and decreased for Willow Ward (specialising in dementia care).

- Based on the **Mental Health Services Data Set (MHSDS)** quarter 2 2016/17, in Gloucestershire there is a smaller proportion of people in contact with specialist mental health services and a smaller proportion of people on Care Programme Approach (CPA) than

in England. However, people in contact with specialist mental health services are less likely to be on CPA and more likely to have an open hospital spell. Additionally, there is a higher proportion of Gloucestershire residents detained under the Mental Health Act, as compared with the 10 most similar CCGs.

- **Gloucestershire Mental Health and Wellbeing Service** provides support for people living with an ongoing functional mental health problem within the community to prevent periods of illness (438 people as of September 2016). This service is progressing well by emphasising community support for social inclusion (Bridge Builder component of the service, 85% of clients engaged), by support of the peers with lived experience and by development of safe spaces.

- The number of **Gloucestershire Self-Harm Helpline** service users is increasing. The majority of service users who have an experience of self-harm are White British females, aged between 18 and 35. 59% of callers and 44% of people who contacted services by text reported being under mental health services, and respectively 38% and 26% reported recent use of statutory services. The service claimed to prevent/ reduce self-harming and/ or suicidal intent in 200 calls and 134 texts to the helpline in 2015/16.

- **Families in Mind** service in 2015-16 provided support for 14 individuals who all demonstrated an improvement in mental wellbeing

- **IAPT activity rates** - rates of referral, entering and completion of treatment significantly decreased in the first half of 2016/17 in relation to 2015/16, when they were above the national average. As a result, these rates are now lower than the national average, with the referral and entering treatments rates being one of the lowest amongst the ten most similar CCGs.

- The average **IAPT waiting times** are significantly higher in Gloucestershire than in England, and the highest amongst most similar CCGs. There is lower than national percentage of referrals that waited less than six weeks for first IAPT treatment and it is the lowest value among most similar CCGs. However, this proportion was within national target of 75% during most of the period January 2015 – September 2016. Further investment has been made since these figures to improve activity and waiting times.

- The **IAPT recovery rate** across all types of mental health conditions is lower than the national average and is below the national target of 50%. From the beginning of 2016, this rate has significantly increased. The recovery rates by primary conditions are lower for depression than for anxiety and stress related disorders. The **Reliable improvement** rate for 2015/16 was the lowest amongst all CCGs in England; however, since the beginning of 2016/17 this proportion has significantly increased, yet remains below the national average.

- Females and patients aged 65 and over are more likely to move to **recovery**. There is a significantly higher proportion of heterosexual people who move to recovery than those, who are lesbian, gay or bisexual.

- The numbers of referrals to IAPT are lowest for the **most deprived** areas of the county. Additionally, people living in these areas are less likely to enter treatment and are less likely to complete a course of treatment than other areas. The outcomes of treatment (recovery rates, reliable improvement and reliable recovery) are lower for those living in the most deprived areas.

- The Gloucestershire CCG **spend on specialist mental health** is lower than the national

average but it is similar to spend among Gloucestershire's most similar CCGs. The Primary Care prescribing spend is higher than the national average and the 4th highest among 10 most similar CCGs. Additionally, the overall Gloucestershire CCG Mental Health spend is lower but with a slightly better outcome than the respective national averages.

- Out of all **mental health prescribed drugs**, the weighted cost of GP prescribing for hypnotics and anxiolytics in Gloucestershire is higher than the national average, which is also the highest among 10 most similar CCGs. The actual prescribing numbers and actual cost is the highest for antidepressant drugs, although the weighted rate shows a decreasing trend; the weighted rate is at the similar level as the England average.
- Females are more likely to use **non-NHS counselling services** than males. The main reasons for accessing counselling are bereavement, relationship problems, depression and anxiety. GPs are the main source of referrals.

9.1 Mental Health Act - Section 136

Key points:

The Gloucestershire rate of assessment under Section 136 is increasing, this rate is higher than the national average. The detentions are most likely to occur out of hours; the average time spend in the Place of Safety is increasing. 68% of all detentions require support from specialist mental health services, although the proportion of informal admissions is declining. The number of detainees with predominant condition of adult personality disorder or with the dominant condition of substance misuse disorders are increasing. There were a total of 18 people, who accounted for 103 detentions during a half year period. There are areas in Gloucestershire (GL1 – mainly Gloucester and GL5 - Stroud), where the number of detentions are double the number of distinct patients, suggesting higher numbers of repeat detentions from these areas.

Section 136 is an emergency power which allows for the removal by the police of a person in a public place to a designated Place of Safety, if that person appears to be experiencing mental disorder and is in need of immediate care and control, or if the Police Officer believes it is necessary in the interests of that person or for the protection of others. In Gloucestershire, there are two places locally agreed as Places of Safety (POS), which are the Maxwell Suite (opened in 2009) and Police Custody. When the Policing and Crime Act 2017 is implemented police custody will no longer be able to be used for people 17 years and under, and their use for adults will be further restricted to people who present a risk of serious injury/death or risk to others. Once in a POS, detainees are assessed by a medical practitioner and an Approved Mental Health Professional (AMHP); arrangements should be made for their ongoing care.[170]

In the five years (February 2009 - December 2013) following the opening of the Maxwell Suite, the use of Section 136 increased by more than 60%. There was a mean of 30.8 detentions per month (ranged 12-39). A recent report from 2gether NHS Foundation Trust (2gether NHSFT) Information

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[170] D. Pugh, J. Laidlaw (2015) *Section 135 and 136: Running a health-based place of safety in Gloucestershire*

Department stated that in 2014/15 in Gloucestershire the rate of Section 136 assessments was 48.8 per 100,000 population, which was slightly higher than the national average of 44.2. In 2015/16, this rate increased to 50.7 locally and 45.5 nationally.

The analysis of detentions under Section 136 in the Maxwell Suite undertaken by 2gether NHSFT highlighted an increase in activity between 2014 and 2016 (**Figure 52**) (the locations are based on localities covered by the Crisis Teams). From the beginning of 2014 to the end of 2016 the number of detentions in the Maxwell Suite POS increased by 68%, while detentions assessed by the Stroud team increased five-fold. There was a mean of 38.7 detentions per month (ranged 26-64.3). This increase can be partially associated with the strong policy direction of moving away from using police cells as a POS for people with mental health conditions. However, the report highlighted that work is currently being undertaken to identify the reasons for the significant upward trend.

Figure 52: Numbers of detentions under section 136 in Maxwell Suite, 2014-2016
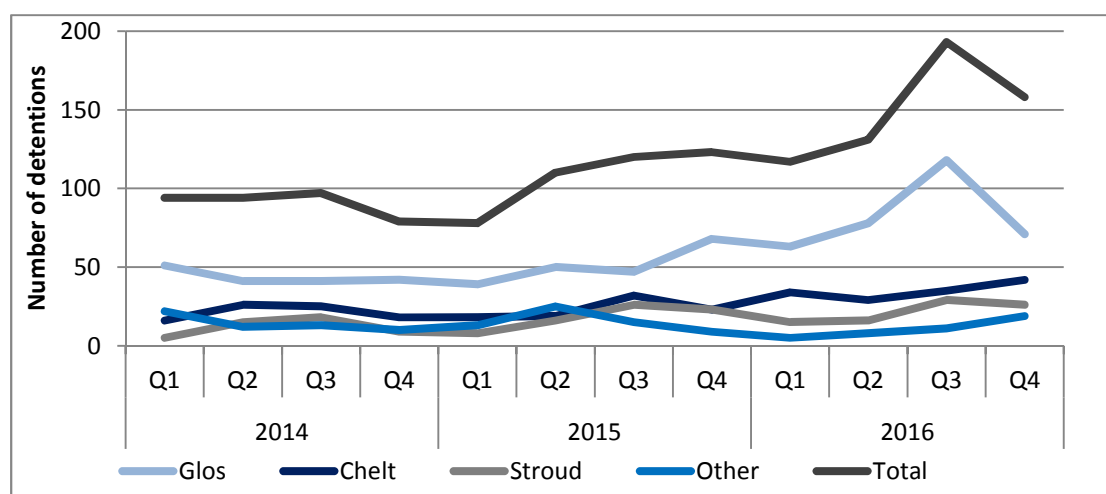
Source: 2gether NHS Foundation Trust, *S136 Place of Safety Briefing,* L. Trewin, M. Griffiths

Additionally this report highlighted:
- An increase in the average length of time an individual remains within the Maxwell Suite from 3.18 hours to 4.07 hours between first quarter of 2014 and fourth quarter 2016
- There were slightly more females admitted to the Maxwell Suite than males: 52% versus 48% during the year 2016
- In 2016, 27% detentions (161) were of intoxicated patients; 95 females (59%) and 66 males (41%),
- Nearly half of detentions (289 out of 599) in 2016 occurred out of hours (5pm-9am), additionally 29% of detentions occurred on weekends; only 22% of detentions occurred during working days between 9am and 5pm, when alternative support is available.

At the time of writing, a number of pilot projects are underway to reduce the number of detentions under Section 136.

The Maxwell Suite has capacity to detain up to two people over 18 years old under Section 136. However, if the detainee is aged 17 or under, the professionals assess if an adult can be

accommodated in this POS at the same time. In practice, this often means the reduction of the accommodation capacity to one occupant and the transfer of the adult detainees to a police cell.[171]

Previous research highlighted that between 2009 and 2013 there were 120 young people aged 17 and under detained in Maxwell Suite; in the years 2013, 2014, 2015 and 2016 the numbers were 27, 19, 25 and 28 respectively. This equates to 6% of total section 136 detentions in 2015, and to 5% in 2016. In 2016, Gloucestershire has been successful in a bid for a dedicated Children and Young People Place of Safety. The benefits of that include not only improvement of the health-based POS for Children and Young People and elimination of use police cells by the young detainees, but also increased capacity in the Maxwell Suite for adults and subsequent reduction in use of police cells as a POS for adults. [172]

When the Maxwell Suite is full, police cells are used as a Place of Safety. Additionally, the local policy states that police cells can be used as a POS when a detainee is unmanageably violent or when the arresting officer is concerned that the person may become unmanageably violent.[173] In 2015, 6.9% of detentions were taken to the police cells before transfer to the Maxwell Suite. However, between April and June 2016, only 2% of all detentions went to police cells before transferring to the Maxwell Suite. The *Intoxication and Mental Health Assessment* report, which looked into the need for a safe place for detainees who are subject to mental health assessment and are too intoxicated to be assessed, concluded that the number of detainees with such need is relatively small so it is not justified to commission a bespoke facility to meet this need. It further concluded that the Maxwell Suite provides the most appropriate POS for the majority of the section 136 detentions with the two main exceptions of the Emergency Department and the police cells at Waterwells. The Emergency Department is used for detainees with serious physical condition/s requiring urgent treatment including extreme intoxication requiring medical treatment.[174]

The table below (Table 21) shows the outcomes for those sectioned under 136 of the Mental Health Act (MHA) in 2016. 22% (131) of detentions resulted in admission to hospital: 8% (45) of informal admissions to psychiatric inpatient care, 13% (79) admissions under section 2 and 1% admissions under section 3.[175] This is a decrease from the period of February 2009 - December 2013, when 28.2% of detainees were admitted (14.2% informal, 14% formal). Combining figures for formal and informal admission into psychiatric inpatient care with detainees who were discharged to community mental health team, 68% of all detentions required support from specialist mental health services. 11% of people were discharged without follow up from primary and secondary care or a third party provider. This reinforces conclusions based on an analysis of section 136 in Gloucestershire between February 2009 and December 2013, which stated that local use of Section 136 raises important questions about "appropriate use of scarce mental health resources" given that

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[171] D. Pugh, K. Gluck (2017) *Contingency Process in Absence of AMHP or S136 Place of Safety at the Maxwell Suite,* Draft version 0.7

[172] Appendix 3 to Gloucestershire Places of Safety Children and Young People Application form

[173] Multi-agency (2017) *Mental Health Act 20017, Section 136, Policy procedure and guidance (general return 2017*)

[174] NHS Gloucestershire Clinical Commissioning Group (2016) *Intoxication and Mental Health Assessment*, D. Pugh

[175] Section 2 and section 3 are discussed in detail in Chapter 9.2

only 14% required further detentions under section 2 and 3, and one in three detentions did not require any specialist mental health follow-up.[176]

Table 21: Outcomes of 136 assessments, Maxwell Suite, 2016 *

Outcome	Detentions
Admitted to psychiatric inpatient care:	
Informal admission	8%
Section 2	13%
Section 3	1%
Total	*22%*
Discharged to community psychiatric team follow-up:	
2gether Community Service	25%
Crisis Team/MHARS	17%
Children and Young People Services	4%
Total	*46%*
Other follow-up	
GP	13%
3rd Party Care Provider	4%
Total	*17%*
Discharged with no follow-up	11%
Other	3%

Source: 2gether NHS Foundation Trust, *S136 Place of Safety Briefing,* L. Trewin, M. Griffiths
* The numbers for outcomes: 'Mental Capacity Act', General hospital Emergency Department under and not under MHA, Police Custody under and not under MHA were less than 5 (including zero), the data have been suppressed and are not included.

The most prevalent apparent mental health condition in 2016 for individuals requiring detention under Section 136 was Disorders of Adult Behavioural and Personality (37%) (**Table 22**); the proportion of which was significantly higher than in 2015 (25%).[177] The occurrence of substance misuse (including alcohol) was a dominant reason in 107 detentions (18%), which increased as compared with 2015 (14%). Additionally, only in 1% cases there was no psychiatric condition to record, while in 2015 this proportion was significantly higher – 18%.

Table 22: Apparent Dominant Mental Health Condition, detention under Section 136, 2016

Apparent Dominant MH Condition	Detentions	%
Disorders of Adult Behaviour & Personality	222	37%
Disorders due to Substance Misuse (including Alcohol)	107	18%
Schizophrenia, Schizotypal & Delusional Disorder	64	11%
Mood Affective Disorder	56	9%
Neurotic, Stress Related & Somatoform Disorders	33	6%

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[176] D. Pugh, J. Laidlaw (2015)
[177] Data provided by 2gether NHS Foundation Trust

Apparent Dominant MH Condition	Detentions	%
Problems in relationship with spouse or partner	26	4%
Nothing to record	21	4%
Disorders of Child Adolescence	15	3%
Problems related to Housing/Financial circumstances	14	2%
Other	13	2%
Behavioural Syndrome	7	1%
Mental Retardation	7	1%
No Psychiatric condition to note	7	1%
Disorders of Psychological Development	6	1%

Source: 2gether NHS Foundation Trust, *S136 Place of Safety Briefing,* L. Trewin, M. Griffiths
* The numbers for Mental Health condition: Organic Mental Disorder, were less than 5 and the data have been suppressed and are not included.

In the period between April and July of 2016, 7% of detainees were conveyed by the South Western Ambulance Service, which represents a slight decrease as compared to the same quarter of 2015 (9%). The Section 136 policy, procedure and guidance were reviewed in June 2015 to place a renewed emphasis on ambulances as the preferred method of transport for people subject to Section 136 in line with MHA Code of Practice Crisis Care Concordat expectations. Gloucestershire CCG is currently leading a review of MHA transport arrangements in the South West.

In the 6 months (01/08/2016 – 28/02/2017) a total of 18 people accounted for 103 detentions. Figures for April 2014 - November 2014 demonstrated that 17 individuals accounted for 25% (54 detentions) of the total 215 detentions. Of seven individuals who accounted for 35 detentions, 6 were female with a diagnosis of Emotionally Unstable Personality Disorder. Further work is being undertaken to understand if there is a correlation between these high intensity users and those accessing services at Gloucestershire Hospitals NHS Foundation Trust.

Table 23 shows the ten post codes with the highest numbers of distinct patients referred and highest referrals under Section 136 between June 2013 and May 2016 with the exclusion of out of county patients. The number of referrals from GL1 (mainly Gloucester) and GL5 (Stroud) areas is twice as high as the numbers of distinct patients, which could suggest a high number of people who have been in detention more than once during that period. Additionally, there were 170 distinct patients and 131 referrals from out of county.

Table 23: 136 Suite, Distinct Patients referred and referrals numbers by partial postcode, June 2013 – May 2016

Postcode	Distinct Patients referred
GL1	114
GL51	71
GL4	61
GL5	56
GL2	53
GL50	44
GL52	41
GL3	35
GL7	27
GL15	21

Postcode	Referrals
GL1	229
GL51	113
GL5	104
GL4	86
GL2	83
GL50	79
GL52	68
GL3	39
GL7	33
GL11	26

Source: 2gether NHS Foundation Trust

Recommendations:

9.1.1   This needs assessment supports current efforts to establish a dedicated Place of Safety for Children and Young People population aged 17 and under.

9.1.2   This needs assessment supports the conclusions and recommendations of the report into people who are too intoxicated to be assessed, that there are three POS options: Police Station if unmanageably violent (subject to the final Policing and Crime Act guidance); the Emergency Department for people with serious healthcare needs; and the Maxwell Suite. The majority should be managed safely within the Maxwell Suite, until they are fit to be assessed.

9.1.3   It is recommended that the Inter Agency Monitoring Group (IAMG) should continue to explore ways of reducing the need for use of section 136, especially in regards to repeat detentions, e.g. from specific localities.

9.2   Sections 2, 3, 4 of Mental Health Act

Key points:

Approximately half of assessments performed by Approved Mental Health Professionals lead to detention under the Mental Health Act. More than half of all detentions are made under section 2; around 30-40% are made under section 3; detentions under section 4 are marginal.

Detentions under section 2 and 3 increased by 100% between 2012/13 and 2015/16, and then decreased in 2016/17. There is an over representation of people aged 20-29 and 70-89 as well as people from Black/ African/ Caribbean/ Black British ethnicity groups among all detainees.

This chapter considers the trends of detentions under section 2, 3, and 4 of the Mental Health Act and the demographic details of people detained. The data are based on the ERIC system and should

be interpreted with caution, as not all Approved Mental Health Professional (AMHP) reports are recorded on this system.
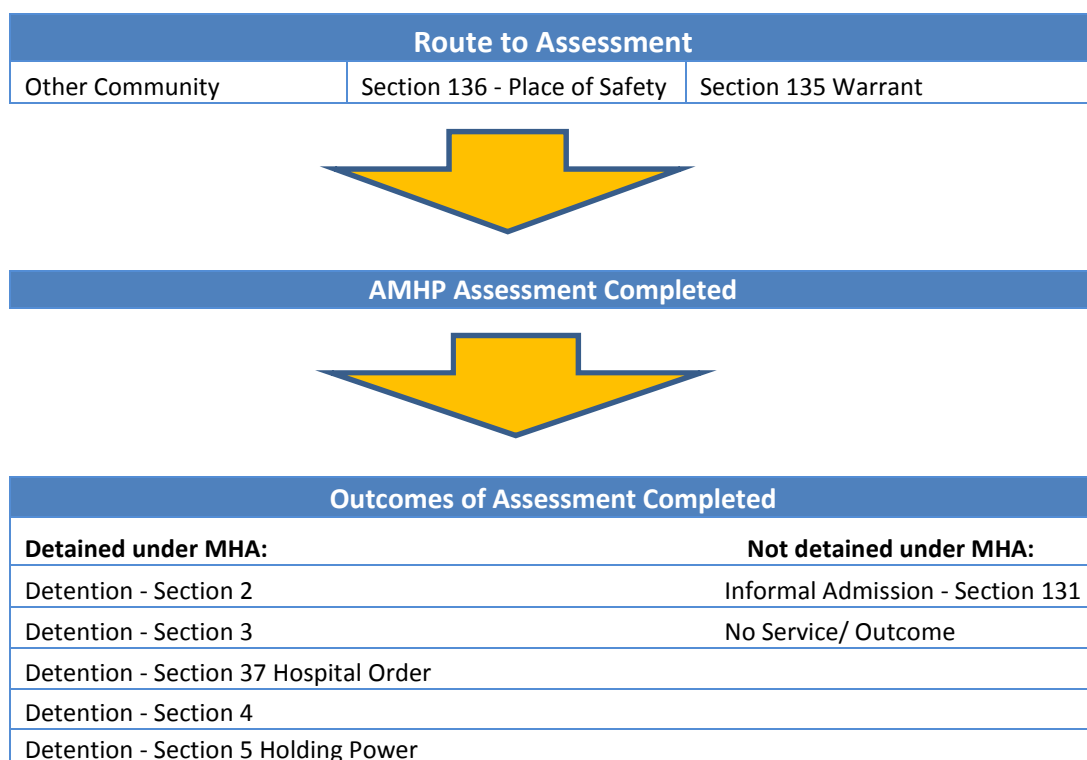
Section 2 allows a person to be held for up to 28 days and its purpose is to establish the presence of a mental disorder and begin treatment. It applies when a person has never been assessed at hospital before or if they have not been assessed at hospital for a long time. It must be implemented by an Approved Mental Health Professional (AMHP) plus two medical doctors. It is non-renewable and cannot be challenged by the nearest relative.

Section 3 allows a person to be detained within a hospital for treatment that is necessary for their health, their safety or for the protection of other people. It can apply for up to 6 months and its purpose is to treat an established mental disorder. This is also implemented by an AMHP plus two medical doctors and can be renewed if necessary. Consent is required from the nearest relative.

Section 4 is an emergency section that can be used for 72 hours and only requires an AMHP and one doctor when a person needs to be sectioned under section 2 but using section 2 would lead to an undesirable delay – meaning it may take longer than normal to carry out the section 2 assessment. A person must be admitted to hospital within 24 hours of seeing the doctor.

Figure 53 illustrates the process of possible routes to AMHP assessment under MHA and possible outcomes of these assessments. Sections 2, 3, and 4 are put in place as an outcome of section 136 (as described in the Chapter **above**), section 135 Warrant[178] or other community services.

Figure 53: Approved Mental Health Professional's Assessment routes and outcomes

Route to Assessment		
Other Community	Section 136 - Place of Safety	Section 135 Warrant

AMHP Assessment Completed

| Outcomes of Assessment Completed	
Detained under MHA:	**Not detained under MHA:**
Detention - Section 2	Informal Admission - Section 131
Detention - Section 3	No Service/ Outcome
Detention - Section 37 Hospital Order	
Detention - Section 4	
Detention - Section 5 Holding Power	

Source: From data provided by Data Management Team, GCC,   * CTO – Community Treatment Orders

[178] Section 135 MHA allows two different warrants to be issued in connection with people experiencing mental disorder on any specified premises: warrant to enter and remove to place of safety and warrant to enter and remove an absent patient.

In Gloucestershire, referrals from the community are the most common route for the all completed AMHP assessments (**Figure 54**), while the numbers of referrals from section 135 are marginal. Referrals from the community and as a result of section 136 sharply increased following the year 2013/14, with the referrals from section 136 increasing by 4.5 times by 2016/17.
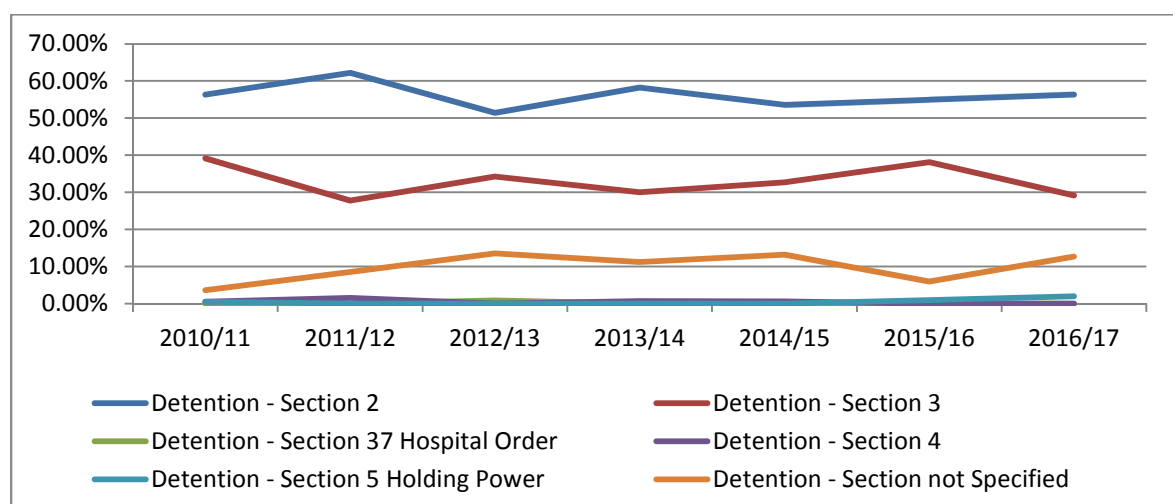
Figure 54: Route to AMPH assessments, Gloucestershire, 2010/11 – 2016/17
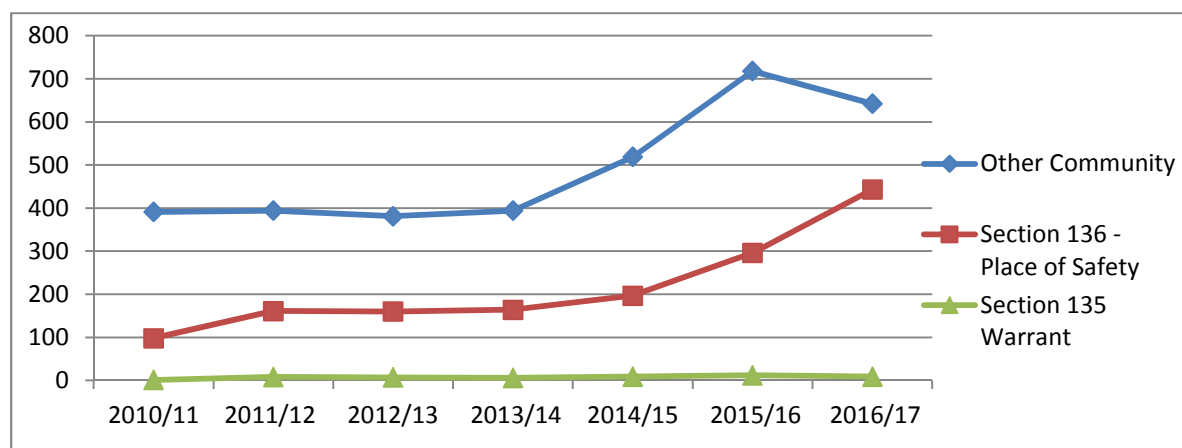
Source: Data provided by Data Management Team, GCC

Out of all AMHP assessments in Gloucestershire between 2010/11 and 2016/17, nearly half led to detentions under the MHA (ranging from 45.3% in 2012/13 to 51.8% in 2013/14). Out of all detentions, people were more likely to be detained under section 2 (more than half of all detentions) (**Figure 55**). The proportion of people detained under section 3 varied from 28% in 2011/12 to 39% in 2010/11. There were hardly any detentions under section 4 (less than five, including zero).

Figure 55: Detentions under Mental Health Act as a percentage of all detentions, Gloucestershire, per year (2010/11 – 2016/17)

Source: Data provided by Data Management Team, GCC

As illustrated by the **Figure 56** the numbers of detentions under section 2 doubled between 2010/11 and 2016/17. The number of detentions under section 3 also increased at a similar pace. However, these numbers slightly decreased in 2016/17, as compared with the year 2015/16. The number of detentions under section 4 were less than 5 for each year.

Figure 56: Numbers of detentions under section 2 and section 3 of Mental Health Act, Gloucestershire, 2010/11 – 2016/17*
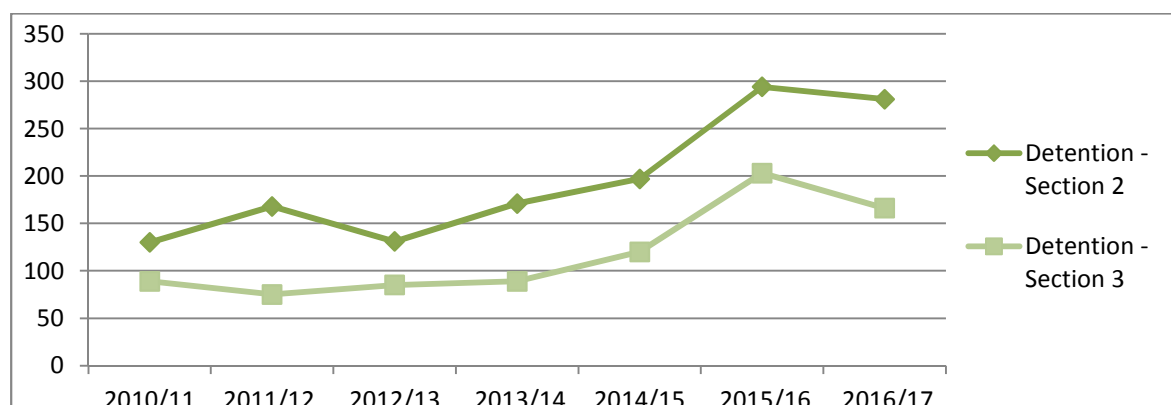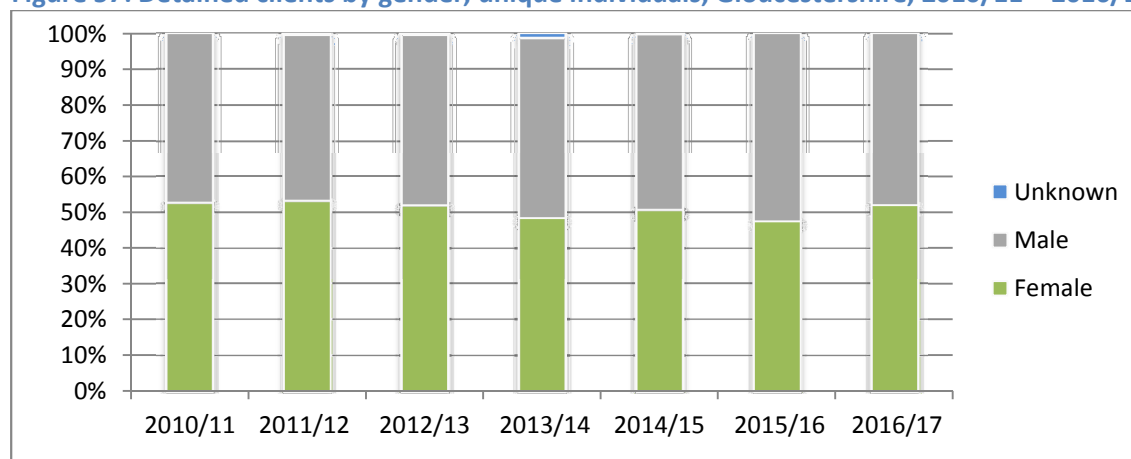

Source: Data provided by Data Management Team, GCC
*The numbers of detentions under section 4 were less than 5 and the data have been suppressed and are not included.

Demographic data

The demographic data illustrated below concern all clients detained as a result of an AMHP assessment in the period between 2010/11 and 2016/17. As the combined detentions under sections 2, 3 and 4 make up between 81% and 95% of all detentions under Mental Health Act (**Figure 55**), the data on demographics of all detentions is used to present a profile of people detained under sections 2, 3, and 4. However, this data is not exclusive to these sections.

There were slightly more females than males detained, with the exception of the years 2013/14 and 2015/16 (**Figure 57**). This proportion is in line with the ONS estimates for the years 2010 -2016, which indicate that in Gloucestershire the proportion of females is slightly higher than male (51% female versus 49% of males).[179] However, this would suggest that in 2013/14 and 2015/16 males were over represented in total detentions.

**Figure 57: Detained clients by gender, unique individuals, Gloucestershire, 2010/11 – 2016/17**

Source: Data provided by Data Management Team, GCC

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[179] ONS, *Population Estimates for UK, England and Wales, Scotland and Northern Ireland*, available at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland, accessed on 03/07/17

The age profile of detainees has changed over the years (**Figure 58**). For the first four years of the examined period, the highest numbers of the unique individuals were people aged between 40 and 49. However, the numbers of the detainees aged between 20 and 29 were increasing from the 2011/12 and this group become the highest among all age groups. In recent years (from 2013/14 onwards), the age groups 30-39 and 50-59 also increased steadily. Interestingly, in 2015/16 the number of the older age detainees (70-79) increased by 2.5 times as compared with the previous year.

Figure 58: Age breakdown of detained clients, unique individuals, Gloucestershire, 2010/11 – 2016/17
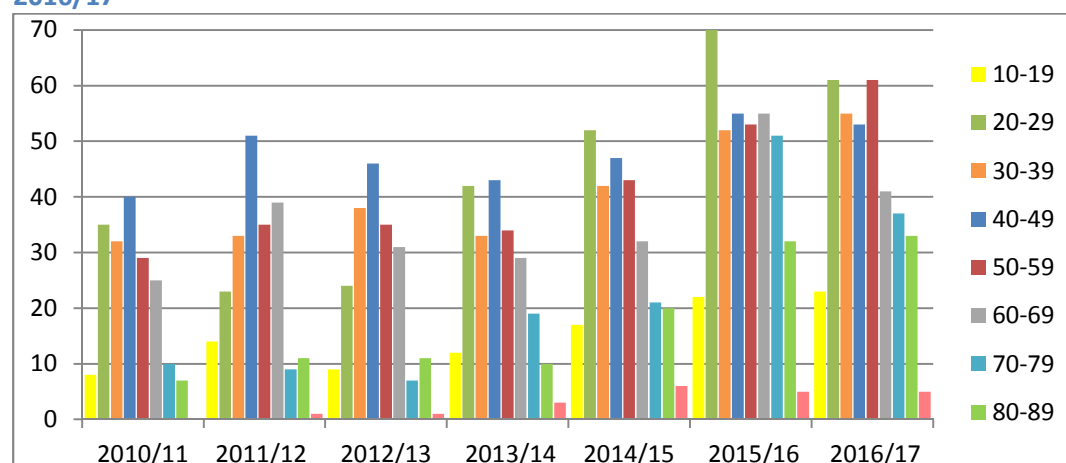
Source: Data provided by Data Management Team, GCC

The comparison of single year proportion of detentions by age with the Gloucestershire population age distribution captured by the **Figure 59**, indicates that there is a significant over representation of young adults aged 20-29 detained under the MHA. There is also a higher proportion of older people (70-79 and 80-89) detained as compared with the age distribution of population.

Figure 59: Analysis by age of those detained under MHA during 2015/16 against 2015 population estimates
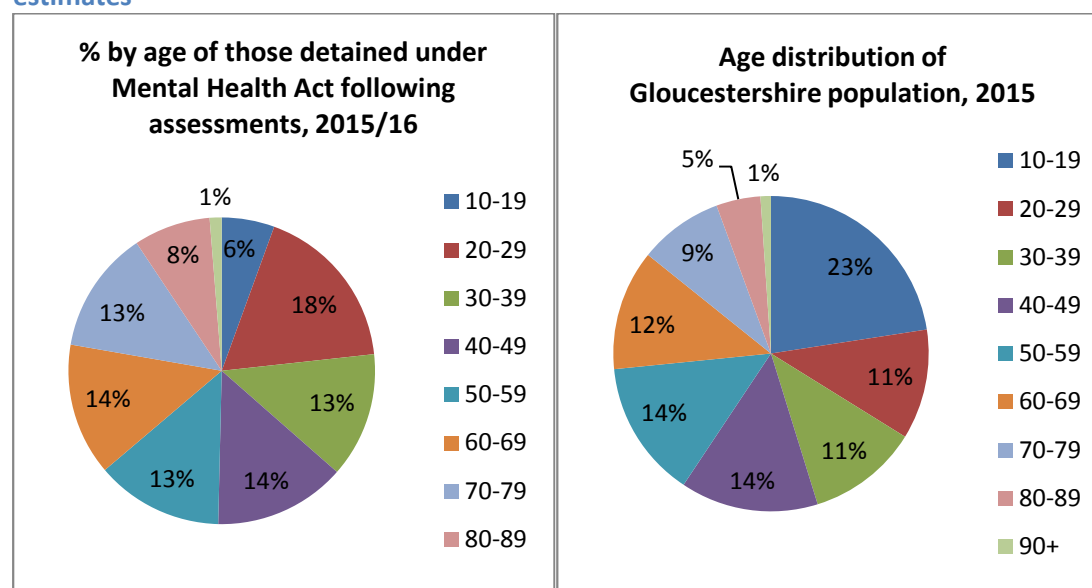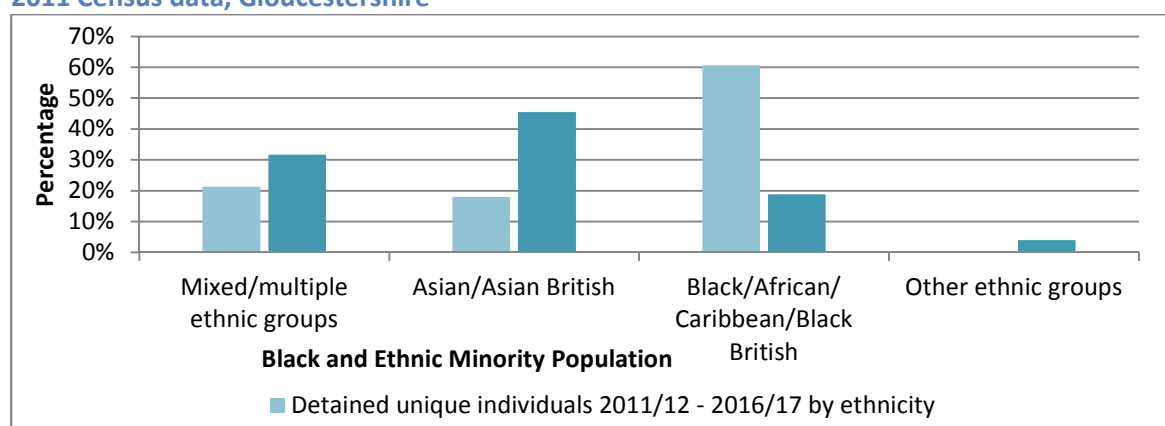

Source: Data provided by Data Management Team, GCC,
ONS, *Population estimates by single year of age and sex for local authorities in the UK, mid-2015*

Comparison of detentions under the MHA by ethnicity, using comparison data based on the 2011 Census, shows that there is a significant over-representation of people from Black and Ethnic Minority groups. 7% detentions between 2011/12 and 2016/17 were of people from BME groups, 81% of people who are White and in 12% detentions, the ethnicity was not recorded.[180] As described in Chapter **0**, the Gloucestershire population ethnicity profile is: 4.6% BME and 95.4% White.

Further break down of the detentions of people from BME backgrounds, illustrated by the **Figure 60**, shows that the people from Black/ African/ Caribbean/ Black British groups were more likely to be detained under MHA following assessment than other BME groups. As this group is third smallest amongst BME groups, the high proportion of detentions contributes to the statement noted in Chapter **0**, that African-Caribbean people are more likely to be detained under the Mental Health Act, but they present with a lower prevalence of the CMHDs.

Figure 60: Analysis by ethnicity of those detained under MHA during 2011/12 – 2016/17 against 2011 Census data, Gloucestershire

Source: Data provided by Data Management Team, GCC
GCC (2016) *Population Profile*

> **Recommendations:**
> 9.2   Ways of reducing the need for use of sections 2 and 3 should be considered, with the focus on increasing prevention and early intervention among young and older adults (20-29 and 70-89 years old), and Black/ African/ Caribbean/ Black British ethnic groups. These approaches should be culturally and age appropriate.

9.3   2gether NHS Foundation Trust services

Key points:

- Between 2014/15 and 2016/17 there was a decrease in the numbers of events (one event represents a single occurrence that happened in a service) within several services provided by 2gether NHS Foundation Trust including the Recovery Service, Crisis Resolution and Home Treatment Team (CRHTT), Later Life Community Mental Health, Working Age Emergency Department Liaison in Cheltenham General Hospital, Older People Mental Health Liaison within Gloucestershire Royal Hospital, Gloucestershire Recovery in Psychosis and Eating

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[180] *Mental Health Act Assessment Data April 2017*, Data provided by Data Management Team, Gloucestershire County Council

Disorder Day Treatment Team. An increase in activity was observed within the Working Age Emergency Department Liaison within Gloucestershire Royal Hospital, Older People Community Liaison, Older People Mental Health Liaison within Cheltenham Hospital, Eating Disorder Community Team, Dual Diagnosis and Criminal Justice Liaison Service.

- Between 2014/15 and 2016/17 the number of bed days within the acute mental health hospital (Wotton Lawn) increased for Dean Ward (admissions of female residents from Cheltenham and Tewkesbury), stayed at similar levels for Abbey (admission for Stroud and Cotswold residents) and Kingsholm (male residents of Cheltenham and Tewkesbury) and decreased for Priory Ward (admission for Gloucester residents).
- The number of bed days within the Charlton Lane Inpatient Services (older people with functional mental health problems and people with dementia) increased between 2014/15 and 2016/17 within Chestnut and Mulberry wards (specialised in mental health needs) and decreased for Willow Ward (specialising in dementia care).
- Based on the Mental Health Services Data Set (MHSDS) quarter 2 2016/17, in Gloucestershire there is a smaller proportion of people in contact with specialist mental health services and a smaller proportion of people on Care Programme Approach (CPA) than in England. However, people in contact with specialist mental health services are less likely to be on CPA and more likely to have an open hospital spell. Additionally, there is a higher proportion of Gloucestershire residents detained under the Mental Health Act, as compared with the 10 most similar CCGs.

This section describes the current specialist mental health service provision by 2gether NHS Foundation Trust (2gether NHSFT) in Gloucestershire. It is based on data provided by the 2gether NHSFT across three years (2014/15 – 2016/17) and on the Mental Health Services Data Set (MHSDS) sourced from Public Health England. Some of the services provided by the 2gether NHSFT are described in detail in Chapters: 9.1 (section 136 Maxwell Suite) and 9.7 (IAPT) and feedback from 2gether NHSFT service users is incorporated in Chapter 10.

2gether NHSFT provides specialist mental health and learning disability services for Gloucestershire residents with mental health problems, from CMHD to SMI.[181] [182] For the purpose of this Needs Assessment, only services concerning adult mental health are included.

The majority (96%) of services are provided within the community. The adult mental health community based services include a wide range of services such as: primary and intermediate mental health care teams, recovery teams, assertive outreach teams, crisis teams and liaison teams. Targeted services include IAPT, Gloucestershire Recovery in Psychosis (GRIP) (early intervention) and eating disorders.

There are four inpatient care units in the county:

- Wotton Lawn Hospital and Charlton Lane Hospital – summarised in this section
- Laurel House and Honeybourne located in Cheltenham – recovery inpatient units, used by patients with a serious mental illness, predominantly psychosis.[183]

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[181] 2gether NHS Foundation Trust also delivers services in Herefordshire, however, the range of services vary to those provided in Gloucestershire.
[182] The range of conditions covered by the Trust can be found at: https://www.2gether.nhs.uk/conditions/

The service data below are presented by events and not by referrals or unique individuals. One event represents a single occurrence that happened in a service. For example one patient may have had a few events within a particular service. Therefore, conclusions may not be drawn about numbers of individual or groups of patients. For example, trends may reflect a difference in the way in which a service is delivered or more effective treatment and support/quicker recovery.

Recovery Service

The Recovery Service is one of the main services provided by 2gether NHSFT. The local teams provide a comprehensive community rehabilitation and recovery service for people aged 18-65 with severe and enduring mental illness, who have complex needs. Service users are supported in achieving a sustainable, independent quality of life, and in being able to function in as normal a quality of life as possible.

Overall the number of events within the Recovery Service in Gloucestershire declined by 8% between 2014/15 (48,650 events) and 2016/17 (44,548 events). As illustrated by the **Figure 61** the area grouped as 'Cirencester and South Cotswold' was the only area where events increased during the captured period. The highest decrease was observed in Gloucester (17%) followed by Stroud (10%). The new data indicate, that the number of events in quarter 1 and 2 of 2017/18 in all locations exceeded the previous quarters (with the exception of quarter 2 events in Gloucester area).

Figure 61: Recovery Service – events, 2014/15 – 2016/17, Gloucestershire
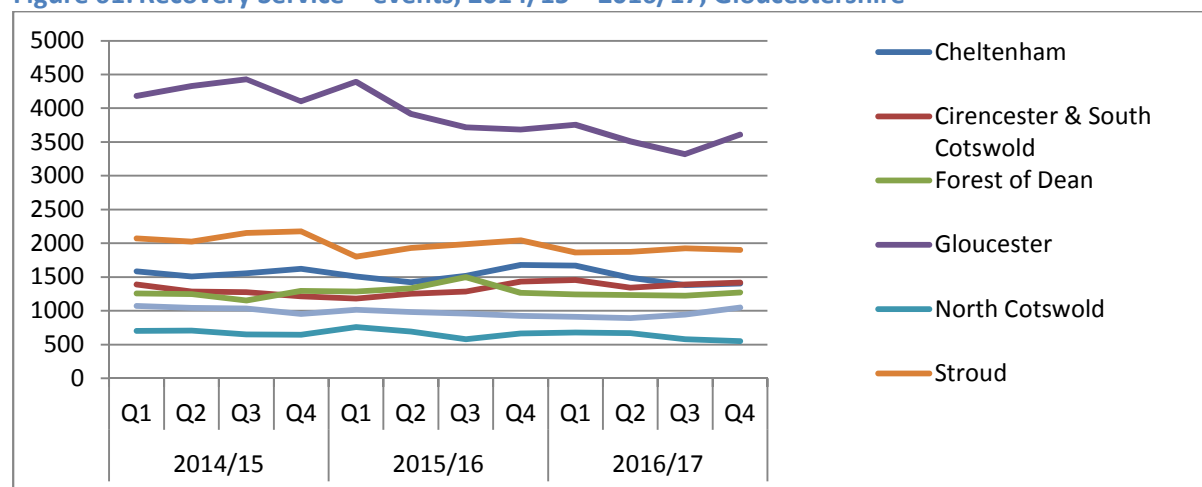
Source: Data provided by 2gether NHS Foundation Trust

Crisis Resolution and Home Treatment Team (CRHTT)

The CRHTT provides short-term intensive home and community based care for patients whose mental health illness deteriorates. Treatment includes mental health monitoring, support, education and advice, practical support and assistance with daily activities, assistance with medication management and help with adopting effective coping strategies. The service is contactable 24 hours per day with a response time of one hour. Patients can be seen within 24 hours, daily or more often,

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[183] 2gether NHS Foundation Trust, *Our teams and services*, available at: https://www.2gether.nhs.uk/our-teams-and-services/, accessed on 04/07/17

for a period of up to six weeks. The intention of the home/ community base treatment is to improve recovery and prevent hospital admissions.[184]

The numbers of events that occurred within the CRHTT service decreased by 8% between 2014/15 and 2016/17; teams located in the 'Stroud and Cotswold' locality experienced the highest decrease of 22% in the number of activities as compared with 2014/15, followed by 'Gloucester and Forest of Dean', which decreased by 14% (**Figure 62**). Although areas grouped as 'Cheltenham, Tewkesbury and North Cotswold' observed a 22% increase in events in 2015/16, the following year's activities decreased, and as a result they were at similar levels in 2016/17, as in 2014/15. According to the most recent data, the activities within CRHTT were greater in quarter 1 of 2017/18 than in the previous quarters of 2014/15 and 2016/17. At quarter 2 these activates decreased, but remained at the high level.

Figure 62: Crisis Resolution and Home Treatment Team – events, 2014/15 – 2016/17, Gloucestershire
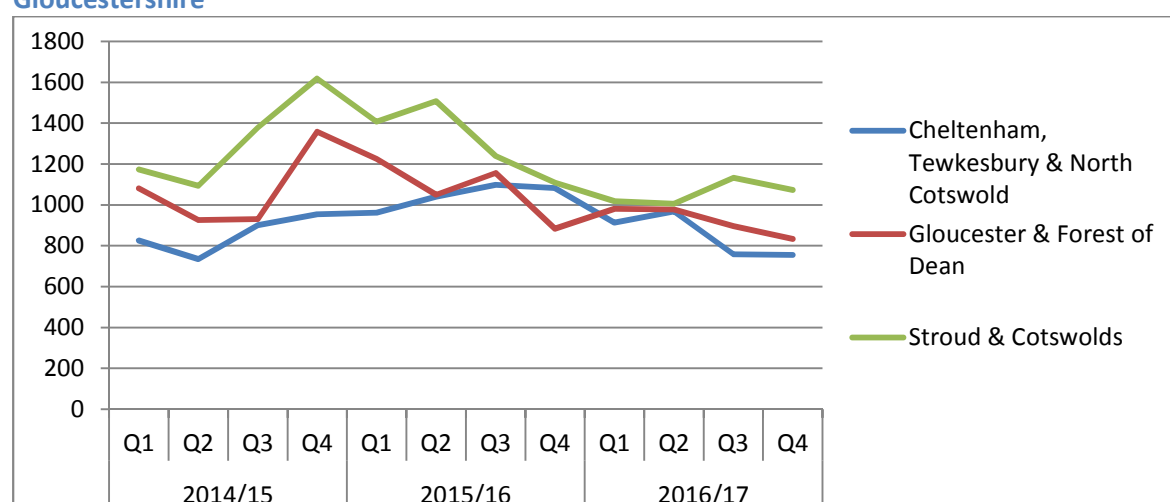
Source: Data provided by 2gether NHS Foundation Trust

2gether NHSFT is currently working with Gloucestershire's Clinical Commissioning Group to develop a new service called the Mental Health Acute Response Service (MHARS), which will replace the CRHTT. The service aims to address gaps in the urgent care pathway, identified in a service review undertaken as part of Gloucestershire's Mental Health Crisis Care Concordat. The service will:

- build working relationship with key partners - such as Gloucestershire Constabulary and South West Ambulance Service NHS Trust
- integrate more coherently with other services - MHARS Urgent Response Team will be located at the Waterwells Campus alongside police
- improve new working and cultural approaches
- ensure that people experiencing crisis are supported in a more efficient and effective way.

To ensure that any issues in existing services are reduced, the service will deliver: single point of access, sign posting, rapid access to assessment services, reduced barriers to entry, urgent crisis care

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[184] 2gether NHS Foundation Trust, *Our teams and services*, available at https://www.2gether.nhs.uk/our-teams-and-services/, accessed on 06/07/17

treatment, quick matching of needs to appropriate service, improved quality of treatment and care and help to recover from crisis and stay well.

Later Life Community Mental Health

The Later Life Community Mental Health service supports acute or complex referrals such as challenging behaviour in older people.

In 2016/17 there were fewer activities within Later Life Community Mental Health than in 2014/15 (decrease from 18,001 to 17,117). The highest decrease was observed in the area grouped as 'Cheltenham, Tewkesbury and North Cotswold' (11% decrease), followed by Gloucester (10% decrease) (**Figure 63**). Interestingly, these activities started to rise in quarter 4 of 2016/17 and (according to new figures) continued to increase to the highest levels in quarter 1 of 2017/18.

**Figure 63: Later Life Community Mental Health - events, 2014/15 – 2016/17, Gloucestershire**
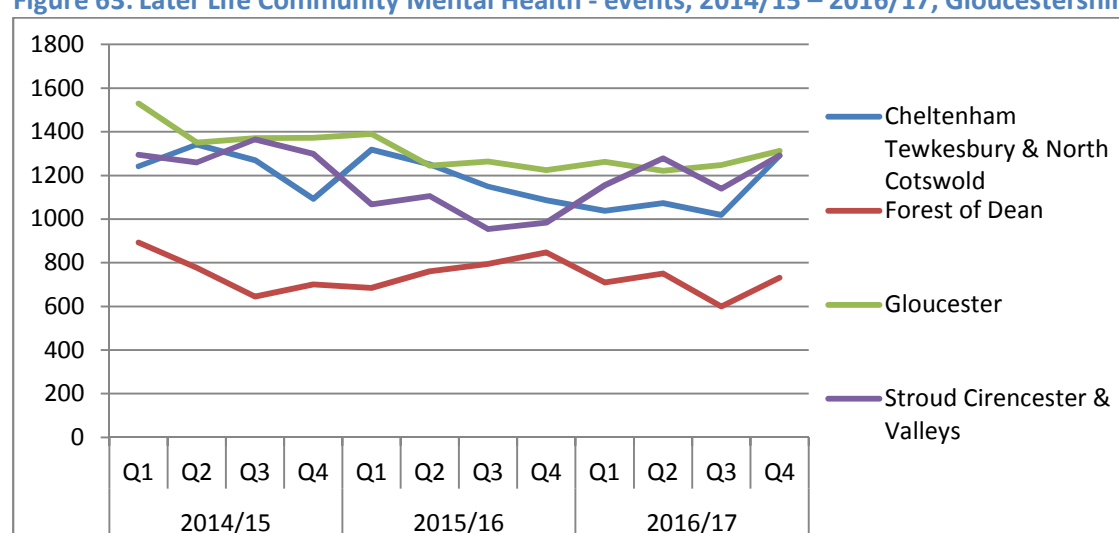
Source: Data provided by 2gether NHS Foundation Trust

Working Age Emergency Department Liaison

This Mental Health Liaison Team provides comprehensive support to patients attending the Emergency Department in Gloucestershire Royal Hospital. Assessment and support is provided for patients who present with self-injury, suicidal harm, delirium, depression, psychosis and other forms of poor mental health.

The number of yearly activities within this service remained relatively stable between 2014/15 and 2016/17, ranging between 2,673 and 2,721 events per year (**Figure 64**). The activities within Gloucestershire Royal Hospital increased from 2,095 in 2014/15 to 2149 in 2016/17 (3% increase); while in Cheltenham General Hospital the numbers slightly decreased from 581 to 572 (2% decrease). As with other services described above, the numbers of events in quarter 1 of 2017/18 exceeded the figures from previous quarters of the captured period.

Figure 64: Working Age Emergency Department Liaison - events, 2014/15 – 2016/17, numbers and trends, Gloucestershire
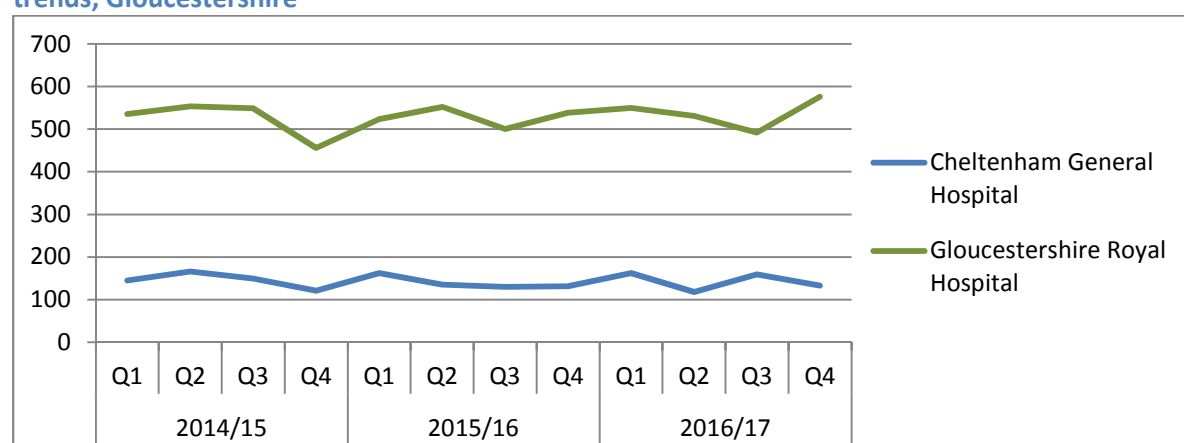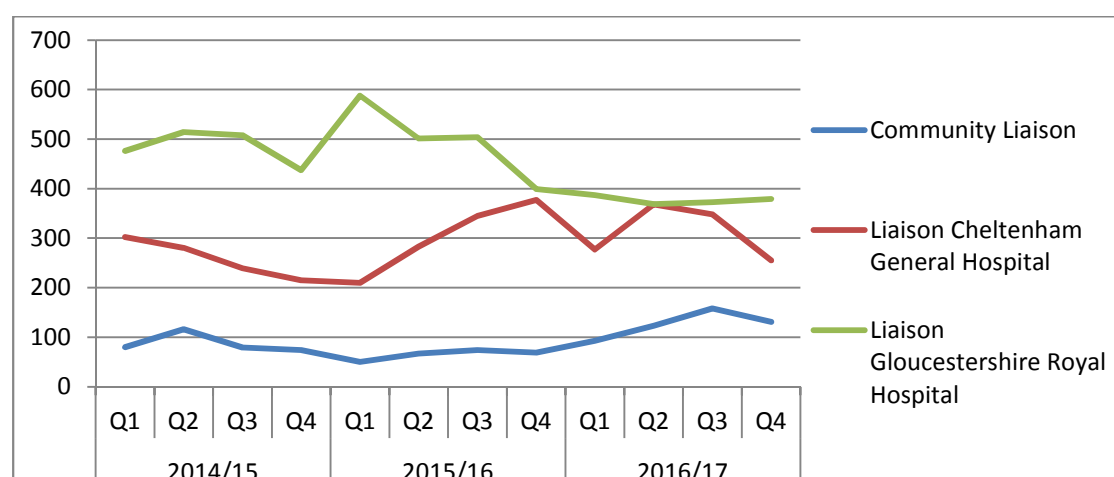

Source: Data provided by 2gether NHS Foundation Trust

Older People Mental Health Liaison

The Older People Liaison team consists of two elements: working in the Emergency Department and working on the wards with Older People with dementia, delirium, etc.

The number of events within Older People Mental Health Liaison increased by 45% between 2014/15 and 2016/17 (**Figure 65**). The increase was also observed in liaison activities in Cheltenham General Hospital (by 20%). Conversely, in Gloucestershire Royal Hospital liaison activities decreased by 22% over the captured years. For the Community Liaison and Liaison in Cheltenham General Hospital the numbers of events in the first quarter of 2017/18 was the highest as compared with the previous quarters of the captured period; the numbers of liaison activities within Gloucestershire Royal Hospital also increased, yet not to the highest level.

Figure 65: Older People Mental Health Liaison - events, 2014/15 – 2016/17, Gloucestershire
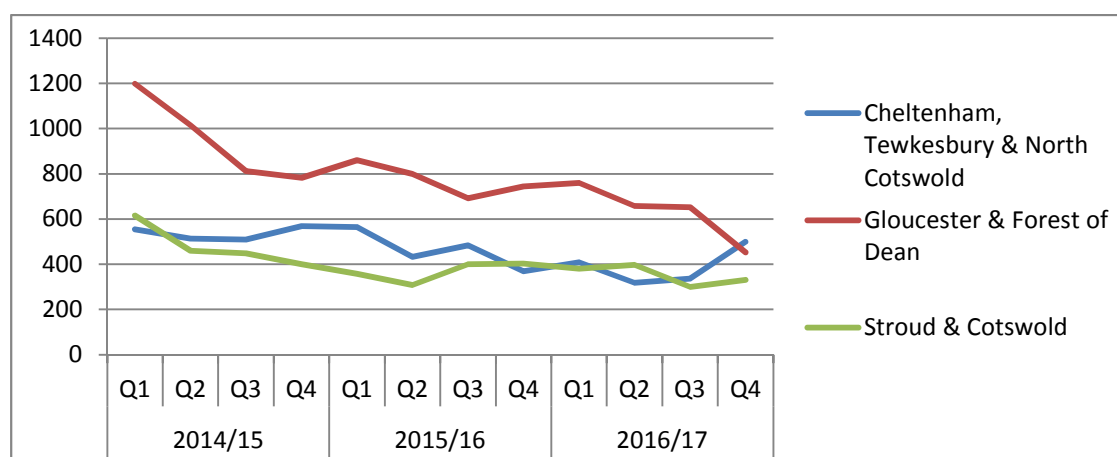

Source: Data provided by 2gether NHS Foundation Trust

Gloucestershire Recovery in Psychosis (GRIP)

GRIP is an early intervention in psychosis service, provided for young people aged between 14 and 35, who are at risk of developing or who are experiencing a first episode of psychosis. For people who are at risk of experiencing psychosis, the service provides self-help information, signposting and if required, more targeted support for between three and twelve months. Individuals who have experienced psychosis are supported in their recovery from psychotic episodes, and in reducing the chance of experiencing further episodes. This support can last for three to four years.

As illustrated by **Figure 66** the yearly numbers of events declined in all areas; the highest decrease was observed in the locality grouped as 'Gloucester and Forest of Dean' (34% decrease); the localities of 'Cheltenham, Tewkesbury and North Cotswold' and 'Stroud and Cotswold' experienced a decrease of 27%. However, the most current data indicate that in these locations the numbers of events for quarter 1 and quarter 2 of 2017/18 were higher than in any previous quarter of the captured period.

Figure 66: Gloucestershire Recovery in Psychosis Early Intervention Service - open diagnoses for referrals, 2010/11 – 2015/16, Gloucestershire
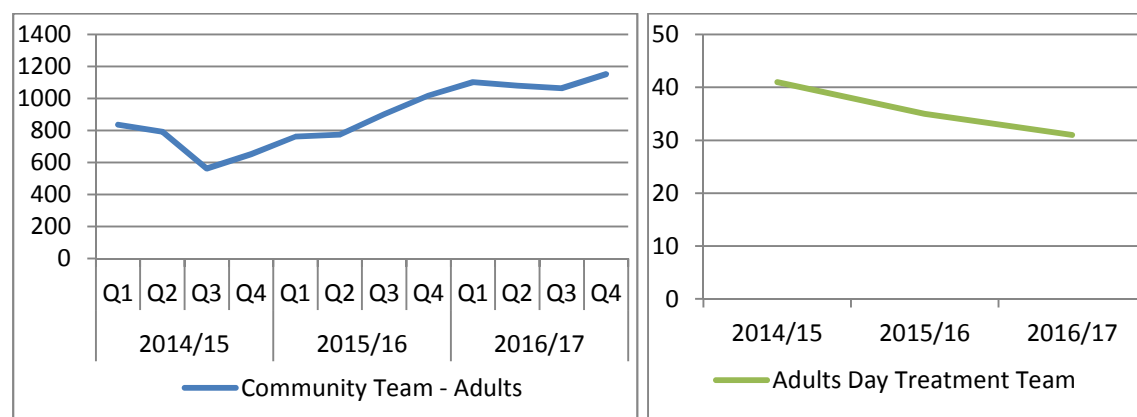

Source: Data provided by 2gether NHS Foundation Trust

Eating Disorder – Adults

This service is provided within the community. After initial assessment, the Community Team and the patient decide the type of treatment. Patients are offered a Day Treatment Programme, which aims to help individuals to stabilise their eating behaviours and to restore weight. A variety of group therapy and supported mealtimes are also offered to patients who are working towards their recovery and treatment goals. Additionally, the service provides advice and guidance to GPs to ensure that physical health is monitored.

As presented in **Figure 67** the activities of the Eating Disorder Community Team increased in 2016/17 by 55% as compared with 2014/15, while the Eating Disorder Day Treatment Team's activities declined by 24%. Furthermore, based on the most recent data, the numbers of events within the Community Team were the highest in quarter 1 and 2 of 2017/18, as compared with any previous quarter between 2014/15 and 2016/17.

Figure 67: Eating Disorders Adults –Community Team and Day Treatment, 2014/15 – 2016/17, Gloucestershire

Source: Data provided by 2gether NHS Foundation Trust
*Less than 5 (including 0), values suppressed

Dual Diagnosis activities

As described elsewhere in this needs assessment, the term 'dual diagnosis' is used in a variety of ways by people working in health and social care in the UK. In the NHS, it usually refers to the occurrence of a mental illness alongside a substance misuse condition. Some studies have used the term to refer to any co-existing mental illness, whereas others have restricted it to 'severe' mental illness.[185]

Although there is no 2gether NHSFT team dedicated to patients with dual diagnosis, there is a Substance Misuse Nurse Consultant who works with patients.

Dual Diagnosis activities fluctuated between 2014/15 and 2016/17 (**Figure 68**). There was a 61% increase in activities in 2015/16 as compared with the previous year. However, in the following year activities decreased by 21%. Overall there was an increase of 27% in 2016/17 activities as compared with 2014/15. According to most recent data, the number of events fell to the lowest level in quarter 2 of 2017/18, as compared with all quarters since 2014/15.

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[185] NICE (2016) *Guideline scope for severe mental illness and substance misuse (dual diagnosis): community health and social care services*, available at https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2

**Figure 68: Dual Diagnosis – number of events, 2014/15 – 2016/17, Gloucestershire**
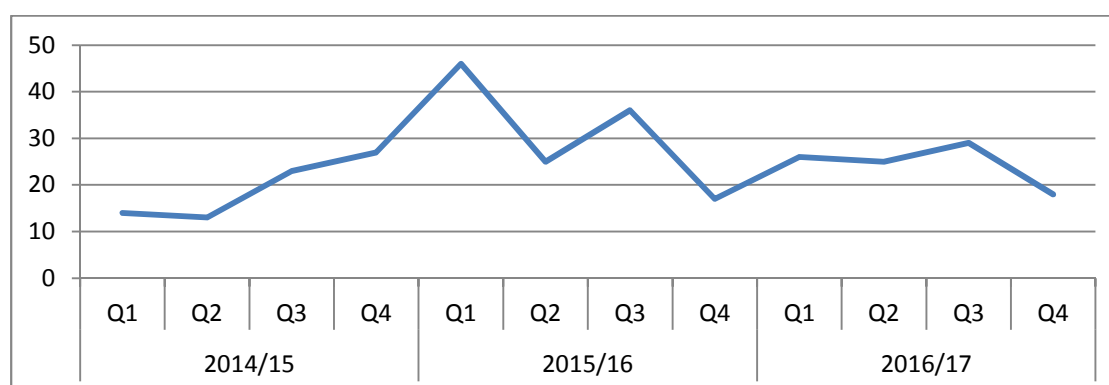
Source: Data provided by 2gether NHS Foundation Trust

Criminal Justice Liaison Service

The Criminal Justice Liaison Service supports young people from the age of 10 and adults, who are within the criminal justice system and present with mental health issues, a learning disability or substance misuse issues. The service aims to ensure that these people access appropriate services provided either by the statutory or third sector in a timely manner. The needs of people who are in police custody, or charged with an offence and appearing in front of the court are assessed and short-term interventions are provided. This is to ensure that people with mental health problems or other vulnerabilities are diverted from the criminal justice system and are supported. The service practitioners work alongside all criminal justice agencies and are present in police custody every day, during the opening hours of Cheltenham Magistrates Court and when required in Gloucester Crown Court.[186]

As illustrated by **Figure 69** the number of activities within the Criminal Justice Liaison Service remained stable between 2014/15 and 2015/16 and from quarter 2 of 2016/17 increased rapidly, resulting in overall activity doubling between 2014/15 and 2016/17. Furthermore, the most current data indicate that the number of activities in the first quarter of 2017/18 was higher than the total activities in 2016/17.

Figure 69: Criminal Justice Liaison Service – number of events, 2014/15 -2016/17, Gloucestershire
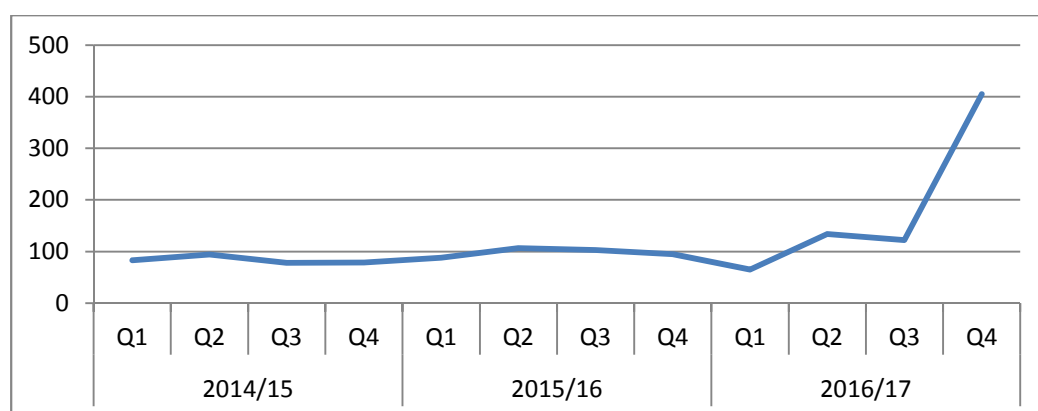
Source: Data provided by 2gether NHS Foundation Trust

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[186] 2gether NHS Foundation Trust *Our teams and services,* available at https://www.2gether.nhs.uk/our-teams-and-services/, accessed on 04/12/17.

Wotton Lawn Inpatient Services

Wotton Lawn Hospital consists of 88 beds for acute mental health, located in Gloucester.

The hospital includes:
- four admission wards:
  - Abbey Ward – 18 beds for acute admission of patients who mainly reside in Stroud and Cotswold; this ward is linked closely with Stroud's Crisis Team
  - Dean Ward – delivers acute admission care for female service users from Cheltenham and North Cotswold; this ward is allied with the Cheltenham Crisis Home Treatment Team. Additionally residents of Forest of Dean working with the Gloucester Crisis Home Treatment are admitted to this ward
  - Kingsholm Ward – 12 beds for acute admission of male patients who mainly reside in the Cheltenham and Tewkesbury region. The team work with patients and their carers to ensure an adequately quick return to day-to-day life in the patient's home
  - Priory Ward – 22 beds for service users from Gloucester. This ward is linked with the Gloucester Crisis and Home Treatment Team.
- a nurse-led psychiatric intensive care unit (Greyfriars)
- low secure unit (Montpellier Unit). This unit also integrates the Maxwell Suite (Chapter 9.1).

Patients are cared for by range of professionals such as nurses, doctors and a range of allied professionals including psychologists, art therapists, physiotherapists, occupational therapists and sports exercise therapists[187].

The quarterly numbers of bed days in Abbey and Kingsholm wards fluctuated between 2014/15 and 2016/17, yet the yearly accumulation of bed days in 2016/17 were at a similar level to 2014/15 (Figure 70). In Dean Ward the number of bed days increased each year; by 2016/17 the increase was equal to 19% as compared with 2014/15. Conversely, Priory Ward experienced a year on year decrease; in 2016/17 there were 22% fewer bed days as compared with 2014/15. The most current data suggest that the number of bed days in all these wards was considerably higher in the first and second quarter of 2017/18 than in any other quarter since 2014/15.

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[187] Ibid

Figure 70: Wotton Lawn admission ward – bed days, 2014/15 – 2016/17, Gloucestershire
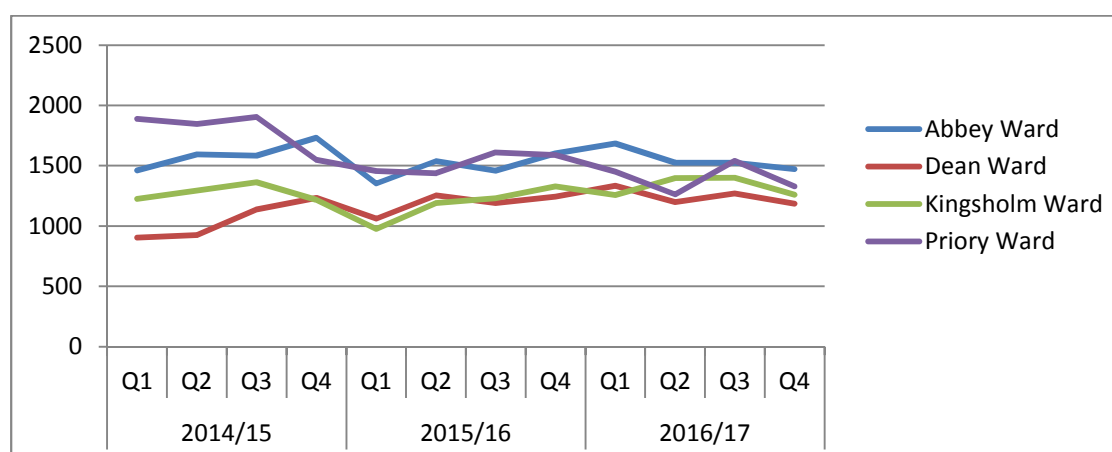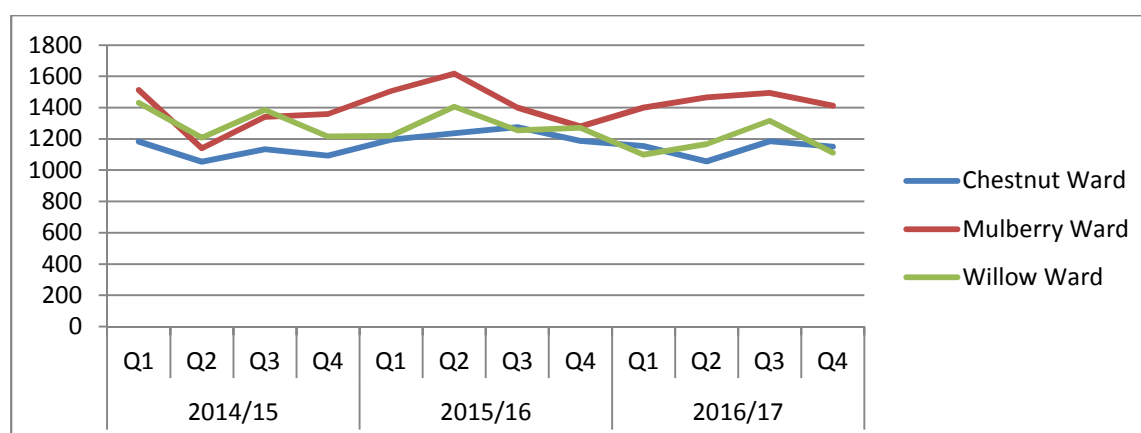

Source: Data provided by 2gether NHS Foundation Trust

Charlton Lane Inpatient Services

This hospital is situated in Cheltenham and provides specialist assessment, treatment and care for older people with functional mental health problems and people with dementia. It includes three wards: two for the assessment and treatment of specialised mental health needs (Chestnut - 14 beds and Mulberry - 18 beds) and a ward specialising in dementia care (Willow - 16 beds). There is also a family room and a therapy department with the access to arts room and physiotherapy room.[188]

The numbers of bed days within Chestnut and Mulberry wards fluctuated between 2014/15 and 2016/17 (**Figure 71**). Yearly totals of bed days within these two wards increased in 2015/16 as compared with the previous year, respectively by 10% and 8%; followed by a decrease in 2016/17, by 7% and 1%. The overall increase between 2014/15 and 2016/17 equated to 2% and 8% respectively. The numbers of bed days within Willow Ward decreased year on year, by 2% in 2015/16 and 9% in 2017/18 as compared with the relative previous years and by 10% in 2016/17 as compared with 2014/15. The data for 2017/18 indicate that the bed days in the first and second quarters exceeded the total from any captured quarters for all three wards.

Figure 71: Charlton Lane Inpatients Services – bed days, 2014/15 – 2016/17, Gloucestershire

Source: Data provided by 2gether NHS Foundation Trust

[188] Ibid

Summary of All Services

The numbers of events in most services as well as the numbers of bed days in inpatient services collectively increased in quarter 1 of 2017/18 (with the exception of Dual Diagnosis activities), with most of the figures reaching the highest levels as compared with the period between 2014/15 and 2016/17. This could imply that either more people are referred to the teams described above (more admissions in the case of inpatient services), or their treatment requires more service contact (or patient stays in inpatient hospital over the longer period of time), or there is a change in recording of the data.

Mental Health Services Data Set (MHSDS)

The MHSDS indicators are provided for the end of quarter two 2016/17 and are comparable to the national and regional figures. For the purposes of this needs assessment, only data regarding adult mental health from the MHSDS are included.[189]

As presented in **Figure 72**, the rate of people in contact with specialist mental health services in Gloucestershire at the end of quarter two 2016/17 was 1,804 people per 100,000 population, which is equivalent to 8,880 people in Gloucestershire. This is significantly lower than the national rate of 2,465, but higher than the sub-regional average of 1,437[190]. This rate is not significantly lower or higher than the 10 most similar CCGs.

Figure 72: Contact with specialist mental health services: rate per 100,000 population aged 18+ (end of quarter snapshot), 2016/17 Q2
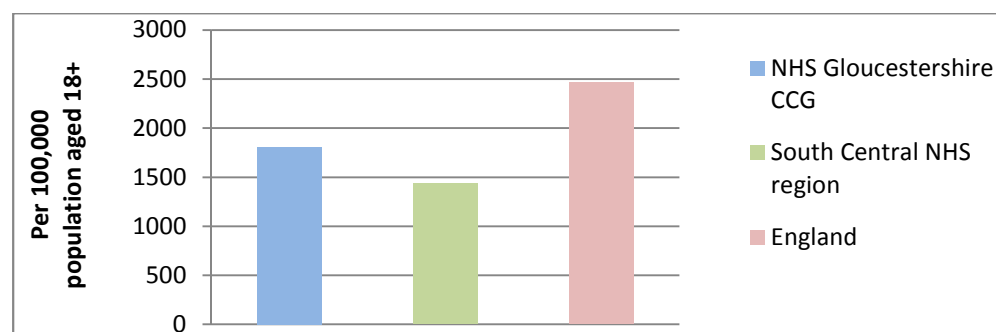
Source: Public Health England, *Severe Mental Illness*

People with mental health problems and/or a range of related complex needs, for example people who are diagnosed as having a severe mental disorder, are at risk of suicide, self-harm, or harm to others, have misused drugs or alcohol or have learning disabilities, can get help under the Care Programme Approach (CPA). CPA is the system of assessing, planning, co-ordinating and reviewing mental health specialist services.[191]

[189] MHSDS contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services.
[190] The sub-regional value is aggregated from all known lower geography values
[191] NHS Choices, available at http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx, accessed on 13/07/17

At the end of the quarter two of 2016/17 in Gloucestershire there were 1,205 people aged over 18 years old on CPA. This represents the rate of 245 people per 100,000 residents, which is significantly lower than the English and sub-region average (**Figure 74**). As compared with the 10 most similar CCGs, the Gloucestershire rate is about average.

Figure 73: People on Care Programme Approach (CPA): rate per 100,000 population aged 18+ (end of quarter snapshot), 2016/17 Q2
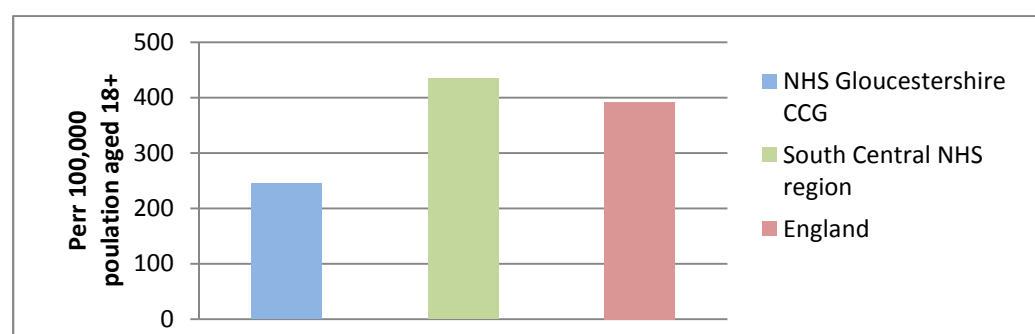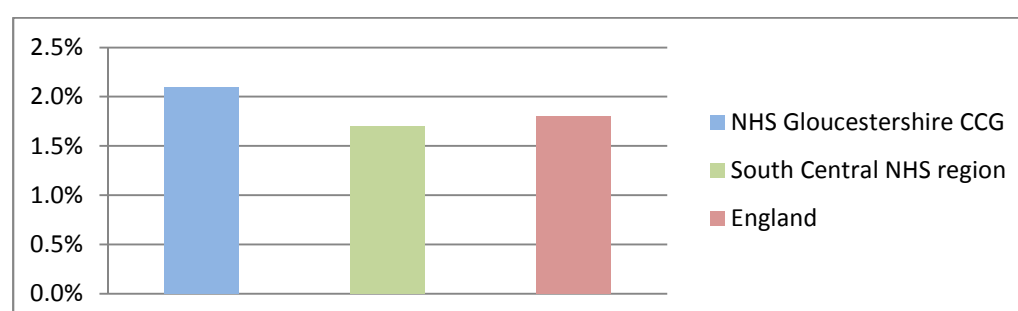

Source: Public Health England, *Severe Mental Illness*

As indicated above, out of 8,880 people in contact with specialist mental health, 1,205 were on CPA at the end of quarter two 2016/17. This equates to 13.6%, which is slightly lower than the national average of 15.9% and significantly lower than the sub-regional average of 29.3%.[192] [193]

It is important to note that approaches to allocating people on CPA varies nationally, and therefore the above data should be interpreted with caution. Additionally, people who are in contact with mental health services but who are not on CPA will receive a similar level of care as people on CPA.

Out of all people in contact with mental health services, 185 (2.1%) people were an inpatient in a psychiatric hospital (end of quarter). As illustrated by the **Figure 74** this proportion is higher than the English and sub-regional average, 1.8% and 1.7% respectively. As compared with the 10 most similar CCGs, Gloucestershire's proportion is above average.

Figure 74: Service users in hospital: % of mental health service users (end of quarter snapshot), Q2 2016/17

Source: Public Health England, *Severe Mental Illness*

In Gloucestershire, there were 165 people in contact with specialist adult mental health services, who were subject to the Mental Health Act[194] at the end of the quarter two 2016/17. This equates to

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[192] The sub-regional value is aggregated from all known lower geography values

[193] Public Health England, Severe Mental Illness, available at: http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness, accessed on 12/07/17

33.5 people per 100,000 population aged over 18 years old (**Figure 75**), which is statistically similar to the English and South-Central region. However, this rate is second highest as compared with the 10 most similar CCGs.

Figure 75: People subject to Mental Health Act: rate per 100,000 population aged 18+ (end of quarter snapshot), Q2 2016/17
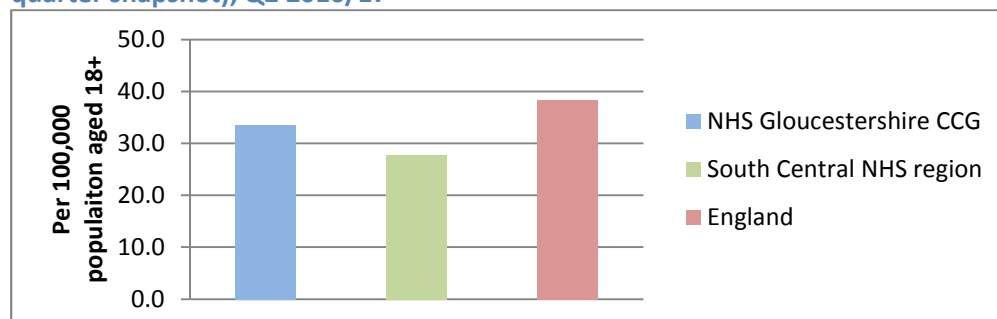
Source: Public Health England, *Severe Mental Illness*

Recommendations:

9.3   It is recommended to consider the review of lower intensity services to prevent higher rates of people admitted to psychiatric inpatient care and detained under the Mental Health Act.

9.4   The Gloucestershire Mental Health and Wellbeing Service

Key points:

The Gloucestershire Mental Health and Wellbeing Service provides support for people living with an ongoing functional mental health problem within the community to prevent periods of illness (438 people as of September 2016). This service is progressing well by emphasising community support for social inclusion (Bridge Builder component of the service, 85% of clients engaged), by support of the peers with lived experience and by development of safe spaces.

The Wellbeing Service forms part of a recovery pathway, as well as being a preventative service for people with a functional mental health problem. Its overall purpose is to improve mental wellbeing by:

- Supporting personal recovery
- Increasing social inclusion
- Increasing the control that people have over their own support
- Promoting independence.

The Wellbeing Service is provided by the Independence Trust and is commissioned by Gloucestershire County Council. The current contract runs until March 2019. The value of the contract over a five year period is around £4m.

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[194] This includes: people subject to detention, people subject to Community Treatment Order (CTO), people subject to short term holding powers under section 4, 5(2), 5(4), 135 or 136 and people subject to Guardianship but not on CTO.

The Wellbeing Service is for people who live with an ongoing functional mental health problem, who may or may not be currently receiving treatment from a clinical service. The aim is to support people to live within the community and help prevent periods of illness. People receive support in retaining their housing tenancies and employment. For individuals who have had hospital treatment as a result of their mental health condition, the service works with clinical recovery services and other community services, to help adjustment to community living after leaving hospital.

Referrals come from a wide range of services, including the 2gether NHSFT's Crisis Teams, Recovery and Intermediate Care Teams; the Autistic Diagnostic Service; housing organisations; Occupational Therapy Services; benefits agencies; GPs; Social Workers; Health Visitors, and third sector organisations. Individuals can also self-refer. There are four main components (listed below) of the service and clients can choose to engage in more than one; if the assessment finds that the service will not meet the needs of the client, they will be signposted to a more appropriate service:

- Bridge Building - one to one support from a Bridge Builder, to identify what will help in recovery, and how to access it
- Peer Development - clients who feel they are unable to access community based services/activities due to their mental ill health can access the Safe spaces within Independence Trust centres/hubs
- Safe spaces – the service provides a safe space when people need it, within each hub areas. Some of these are "Glosses" (Gloucestershire Safe and Social Environments), which are local venues that clients have nominated within the community, where they have personally experienced a supportive, caring and non-judgemental attitude towards their mental health, such as cafés, sports clubs, shops, group activity venues
- A-Z Community based activities – every 4 months, a new directory of activities is produced, detailing groups, clubs and activities which are facilitated by members of the community, peer volunteers or staff and which take place within the client's community.

Service Use

At the beginning of the current contract, April 2014, 653 people were registered with the service. Many of the clients had previously used day centre services over a long period.

In the period from April 2014 to September 2016 the service has received 1,187 new referrals rising from 69 in Quarter 1 2014, to 161 in Q2 2016. In the same period, 1,540 people exited the service. A snapshot in September 2016 shows that of the current caseload, 178 people have been using the service for less than six months; 65 have been using the service for between six months and two years; and 46 have been using the service for between two and five years. The total number of people actively engaged with the service as of September 2016 is 438. This does not include people within the wider community who access the A-Z activities, or those who have exited the service and still access activities to maintain their wellbeing.

Regular contract monitoring indicates that since the beginning of the contract, the service is progressing well in providing community-based support to people living with long term mental health problems, by:

- facilitating a shift away from building based care to a greater emphasis on community support for social inclusion, achieved by the Bridge Builder service. Monitoring shows that 85% of assessed clients chose to engage with the Bridge Building Service as of September 2016
- developing a peer support programme whereby people with lived experience support each other. The introduction of self-referrals has helped achieve this, as having clients with a range of experiences on the path to recovery makes it more feasible for a client to facilitate/co-facilitate a group, given the appropriate training
- developing a range of safe spaces across the county
- linking into the Crisis Care Concordat and development of person centred crisis plans for all clients
- developing a service for individuals on the Autistic Spectrum
- some co-location with community mental health teams
- developing a range of activities and groups outside normal working hours
- developing services for people aged 18-30. This varies in each district, with Stroud district having a discrete group of young people, whereas in other areas young people have chosen to take part in the mainstream services.

The report on the demographic profile of service users conducted by the Independence Trust for the year 2015/16 highlighted that:

- More females than males were registered with the service, 52% females versus 48% males. In the South locality (which includes Stroud, Dursley and Cirencester), the proportion of females using the service was higher (60% of females versus 40% of males). In the Central (Cheltenham and Tewkesbury) and West (Gloucester and Forest of Dean) localities there were more males than females registered with the service, respectively 53% males versus 47% females, and 51% males versus 49% females.
- The majority of service users were aged between 30 and 69. However, the services reported an increase in referrals of younger people aged between 18 and 30.
- The majority of clients were White British (94.8%). In total, 97% clients belonged to White ethnic groups, and 3% to Black and Ethnic Minority groups. As indicated in Chapter 0, 4.6% of Gloucestershire residents are from Black and Minorities Ethnic groups. Additionally, this group is more vulnerable to experience mental health illness. This suggests that Black and Ethnic Minorities are under-represented within this service.
- The service is used mainly by people whose relationship status is single (72.8%); separated and widowed people make 8% and 1.5% of clients respectively. 1 in 6 service users are married, and only 1.2% are in civil partnership. Taking into account that half of adult Gloucestershire residents are married and 33% are single (based on Census 2011), people who are single are disproportionately represented in the service user group.
- The vast majority of clients are heterosexual (95%). 2% of people identified themselves as gay or lesbian and also 2% as bisexual. The number of clients who have undergone a gender reassignment, or intend to do so, is less than five. As presented in Chapter 6.13, the estimated local population of people who are lesbian, gay or bisexual is between 1.5% and 8.5%. This would suggest that the service reaches people who are lesbian, gay or bisexual. However, taking into account the higher prevalence of mental ill health among the LGBT

population than among the whole population, the numbers of service users from the LGBT population is expected to be higher than the current 4%. Due to underreporting of the sexual orientation/ gender identity these data need to be interpreted with caution.

- Half of all clients reported that they do not have a disability, although their mental illness affects their daily life. Out of the remaining people, who consider themselves as disabled, 15% reported to have a mobility disability, 11% arthritis, 9% learning disability, 5% spinal disorders, 3% hearing, 2% fibromyalgia and also 2% sight. As indicated in Chapter **0**, 16% of Gloucestershire residents reported that their long term illness or disability limit their day-to-day activities a little or a lot (as these data relate to 2011, the comparison needs to be interpreted with caution). This could suggest that the Gloucestershire Mental Health and Wellbeing service is effective in reaching people with disabilities.

Recommendations

9.4   It is recommended that the Independence Trust and referrers should consider culturally appropriate ways of promoting access to Gloucestershire Mental Health and Wellbeing Services among people from Black and Ethnic Minorities groups, (particularly in Gloucester, where Black and Ethnic Minority groups make up the highest proportion) and among the LGBT population.

9.5   Gloucestershire Self Harm Helpline

Key points:

The number of Gloucestershire Self Harm Helpline service users is increasing. The majority of service users who have an experience of self-harm are White British females, aged between 18 and 35. 59% of callers and 44% of people who contacted services by text reported being under mental health services, and respectively 38% and 26% reported recent use of statutory services. The service claimed to prevent/ reduce self-harming and/ or suicidal intent in 200 calls and 134 texts to the helpline in 2015/16.

As outlined in Chapter **8** self-harm and suicide ideation may be considered in the wider context of increasing levels of poor mental health in the national and local population; self-harm is a behaviour rather than an illness, with a variety of causes and co-existing factors. Conversely, self-harm can also be a protective factor for suicide; a coping mechanism that prevents the person from doing something more harmful.[195]

The Gloucestershire Self Harm Helpline, commissioned by Gloucestershire County Council and provided by Rethink Mental Illness, offers a space for people to explore self-harm, discover coping strategies, and improve current mental wellbeing. The helpline call handlers will signpost and work in partnership with other agencies when appropriate. The service is accessible to people across the whole of Gloucestershire every day from 5pm to 10pm.

The aim of the service is to:

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[195] Klonsky, E. D., *The functions of deliberate self-injury: A review of the evidence.* Clinical Psychology Review, 27(2), 226-239, 2007

- Provide confidential, person centred non-medical support to children, young people and adults who are self-harming or thinking about self-harming and to those who are concerned about them
- Improve awareness and understanding and reduce stigma about self-harm within the community
- Work in partnership with primary and secondary services to provide a complementary service, that helps reduce hospital admissions
- Reduce self-harming behaviour and suicide attempts.

Service Use

It should be noted that the Gloucestershire Self Harm Helpline is a confidential service so the figures quoted below are only of those service users who shared this information with the helpline – therefore it is not a complete summary of service use.

The 2015/16 annual report for the Gloucestershire Self Harm Helpline indicates that during the year, the service handled 989 calls and 889 texts and web chats. This is 140 (15%) more calls than in 2014/15. 44 of the telephone contacts and 91 texts were from new users to the service. This growth could be attributed to an increased awareness of the service across the county, and an increase in those accessing the service for support more than once, not necessarily to an increase in the prevalence of self-harm.

97% of contacts are from those who have experience of self-harm. The others are family, friends and professionals. The majority of service users (87%) are female. The calls are mainly made from Gloucester city, where there is the densest population, although texts and web chats are handled from across the county **(Figure 76** and **Figure 77).**

Figure 76: Distribution of calls made to Self Harm helpline by district, Gloucestershire, 2015-16
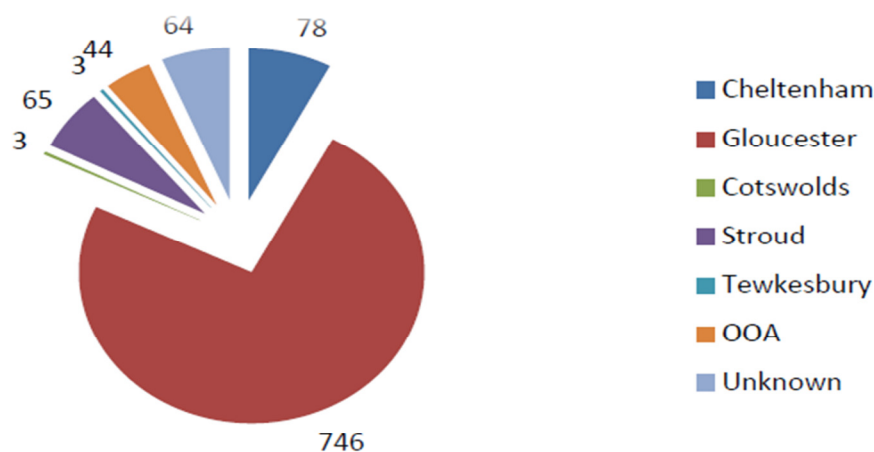
Source: Annual Report for the Gloucestershire Self Harm Helpline, April 2015 to March 2016

Figure 77: Distribution of text and web chats received by Self Harm helpline by district, Gloucestershire, 2015-16
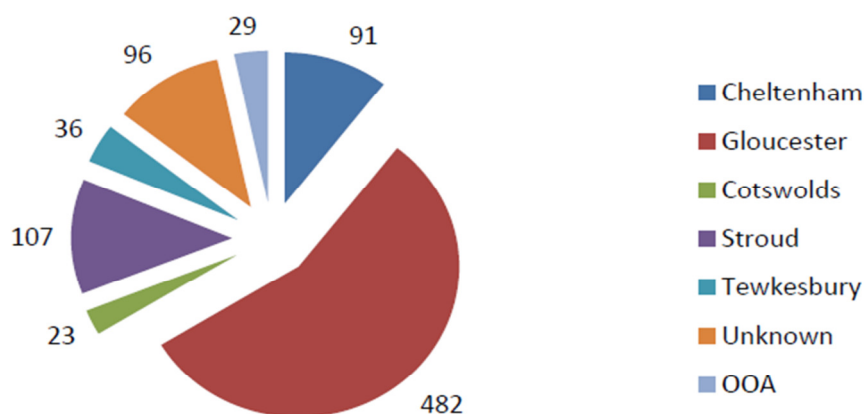
Source: Annual Report for the Gloucestershire Self Harm Helpline, April 2015 to March 2016

The vast majority of service users are White British. The service has had difficulty in reaching Black and Minority Ethnic groups, however, there are some development actions planned such as workshops with social prescribing services and meeting with social inclusion key contacts, to increase the use of the service by BME groups.

Nearly half of the callers are aged between 26 and 35, around 1 in 5 is aged 18-25 and 1 in 10 is over 66 years old. The majority of people who contacted services by text, are from the age bands 18-35, and there were less than 5 over 66 years old who texted the service.

59% of callers and 44% of people who contacted services by text reported being under the care of mental health services, and respectively 38% and 26% reported recent use of statutory services.

The service users' feedback captured in the report indicated that the service prevented self-harming and/ or suicidal intent in 200 calls and 134 texts to the helpline between April 2015 to March 2016. Below are examples of the service users' feedback. However, this information is not based on comprehensive surveys of clients, and is included only to give examples of feedback about the benefit of the service.

"It's been really helpful talking. I won't take the tablets now"

"Would have overdosed if not for helpline"

"I'm so glad I've called. It's really helped"

"I don't need to cut any more"

Recommendations:

9.5.1   This needs assessment supports the plans identified in the annual report of the Gloucestershire Self Harm Helpline to:

- Increase service promotion and networking, with a particular emphasis on men and BME groups by working with the GCC and local partners to develop effective ways to increase access of the service for these key groups.
- Increase awareness in areas such as the Cotswolds, Forest of Dean and Tewkesbury
- Promote a volunteer scheme to increase service impact and ability to attend local events for promotional purposes.

9.5.2   It is recommended, that commissioners and providers should consider:

- Promotion of the service in the areas with the highest admission rates for self-harm, such as Kingsholm and Wotton, Westgate and other wards identified in Section **8.6.1**
- Finding ways of reaching groups at higher risk of self-harm, identified in chapter **8.6.1**

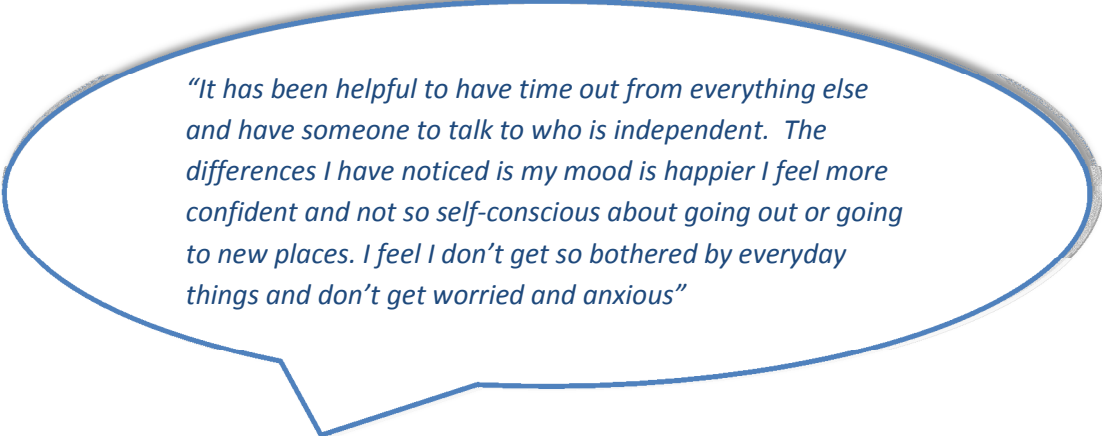## 9.6   Families in Mind

Key points:

In 2015-16, the Families in Mind service provided support for 14 individuals who all demonstrated an improvement in mental wellbeing.

Intervening early and effectively in the course of psychosis can improve clinical outcomes, limit initial problems and improve long term prospects for recovery.[196] A key component of a person's recovery is the ability to generate and mobilise social resources to build their social capital. In response to service user and carer feedback, 'volunteer buddying' provision for individuals who have a diagnosis of a psychotic illness was developed and implemented in Gloucestershire, commissioned by Gloucestershire County Council and provided by Family Lives. The service aims to promote good mental wellbeing, reduce social disability, reduce loneliness and prevent relapse for those who have psychosis. Volunteers are often people with lived experience who benefit from being able to "give" to those who are currently in need. The importance of peer support - the help and support that

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[196] NICE, *Psychosis and schizophrenia in adults: prevention and management*, 2015, www.nice.org.uk

people with lived experience of a mental illness or a learning disability are able to give to one another – is increasingly being recognised.[197]

During 2015-16, the service provided support for 14 individuals who all demonstrated an increase in satisfaction with independence, hobbies and lifestyles and improved confidence. One service user reported:

> *"It has been helpful to have time out from everything else and have someone to talk to who is independent. The differences I have noticed is my mood is happier I feel more confident and not so self-conscious about going out or going to new places. I feel I don't get so bothered by everyday things and don't get worried and anxious"*

14 volunteers were trained, 7 of whom decided not to continue with volunteer work for various reasons. The volunteer training includes the 5 ways to mental wellbeing (described in section **5.1**) which is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population.

The Families in Mind service was re-commissioned in 2017 and can now be provided to adults with any severe and enduring mental illness, not just people with psychosis. It is hoped that this will increase the reach of the service.

9.7   IAPT

Key points:

- The **IAPT activity rates** – rates of referral, entering and completion of treatment – significantly decreased in the first half of 2016/17 in relation to 2015/16, when they were above the national average. As a result, these rates are now lower than the national average, with the referral and entering treatments rates being one of the lowest amongst the ten most similar CCGs.
- The average **IAPT waiting times** are significantly higher in Gloucestershire than in England, and the highest amongst most similar CCGs. There is a lower than national percentage of referrals that waited less than six weeks for first IAPT treatment and it is the lowest value among most

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[197] Mental Health Foundation, *Peer Support in mental health and learning disability*, 2012, available at www.mentalhealth.org.uk

similar CCGs. However, this proportion was within national target of 75% during most of the period January 2015 – September 2016.

- **IAPT recovery rate** across all types of mental health conditions is lower than the national average and is below the national target of 50%. From the beginning of 2016, this rate has significantly increased. The recovery rates by primary conditions are lower for depression than for anxiety and stress related disorders. The **reliable improvement** rate for 2015/16 was the lowest amongst all CCGs in England; however, since the beginning of 2016/17 this proportion has significantly increased, yet remained below the national average.
- Females and patients aged 65 and over are more likely to move to **recovery**. There is a significantly higher proportion of heterosexual people who move to recovery than those, who are gay, lesbian or bisexual.
- The numbers of referrals are lowest for the **most deprived** areas. Additionally, people living in these areas are less likely to enter treatment and are less likely to complete a course of treatment than other areas. The outcomes of treatment (recovery rates, reliable improvement and reliable recovery) are lower for those living in the most deprived areas.

This section summarise the activity, waiting times and outcomes of the Improving Access to Psychological Therapies (IAPT) programme, also referred to as the 'Let's Talk' programme in Gloucestershire. IAPT is delivered by the NHS and offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and/or anxiety.

The IAPT service is characterised by:

- Evidence based psychological therapies,
- Routine outcome monitoring,
- Regular and outcomes focused supervision.[198]

In Gloucestershire, the IAPT service is delivered by the 2gether NHS Foundation Trust. The service offers talking therapies for people aged 18 and over, who are experiencing mild to moderate anxiety and/or depression, as well as other mental health conditions such as: panic disorder, post-traumatic stress disorder, obsessive compulsive disorder and phobias. Cognitive behavioural therapy (CBT) is used, which includes specific techniques to manage symptoms by modifying behaviours and thoughts that maintain depression and anxiety.[199]

Activities

In Gloucestershire, the rate of patients referred to IAPT services in quarter 2 2016/17 was 454 per 100,000 population aged over 18 (2,235 people) (**Figure 78**). This is lower than the national average of 768, and second lowest rate amongst statistically similar CCGs. During the second half of 2014/15 and whole 2015/16 the referral rate was above the national average, however, at the beginning of the 2016/17 this rate decreased by more than half.

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[198] NHS England, Adult Improving Access to Psychological Therapies Programme, available at https://www.england.nhs.uk/mental-health/adults/iapt/, accessed on 04/04/17
[199] Information available on the 2gether NHS Foundation Trust website, available at https://www.talk2gether.nhs.uk/, accessed on 04/04/17

Figure 78: IAPT service referrals: rate per 100,000 population aged 18+, Gloucestershire, Q2 2013/14 – Q2 2016/17
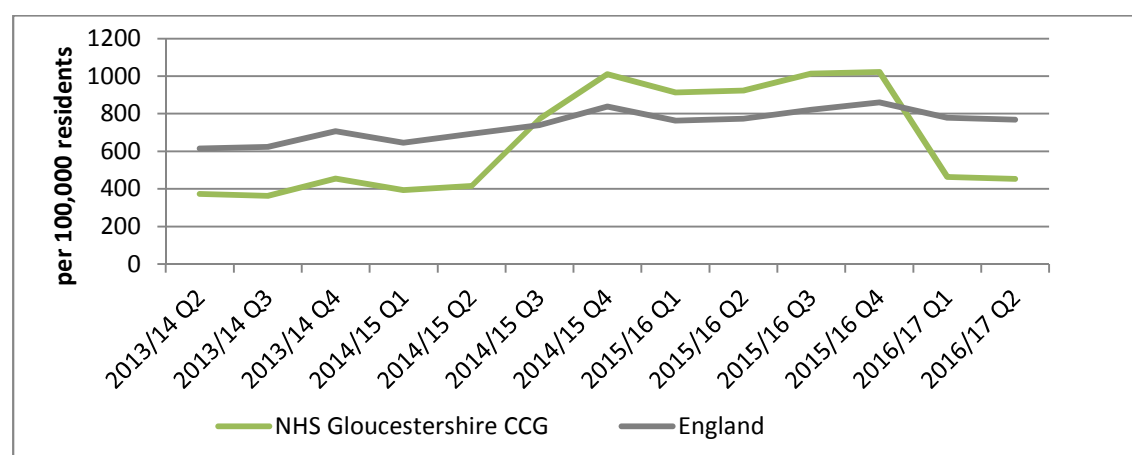
Source: Source: Public Health England, *Common Mental Health Disorders*

The rate of people entering IAPT treatment in Gloucestershire in the second quarter of 2016/17 was 196 per 100,000 over 18 years old population (965 people), which is nearly 3 times lower than the national average of 540, and the lowest as compared with the most similar CCGs.[200] This is the lowest value since Q2 2013/14 (**Figure 79**). In Gloucestershire, the rate of people entering treatment over the three year period varied between 754 and 186, when the national rate was increasing at a slow pace. Between the third quarter of the 2014/15 year and the end of 2015/16 this rate was higher than the national rate. The highest quarterly decline was observed between the last quarter of 2015/16 and first quarter of 2016/17.

Figure 79: Entering IAPT treatment: rate (quarterly) per 100,000 population aged 18+, England and Gloucestershire, Q2 2013/14 - Q2 2016/17
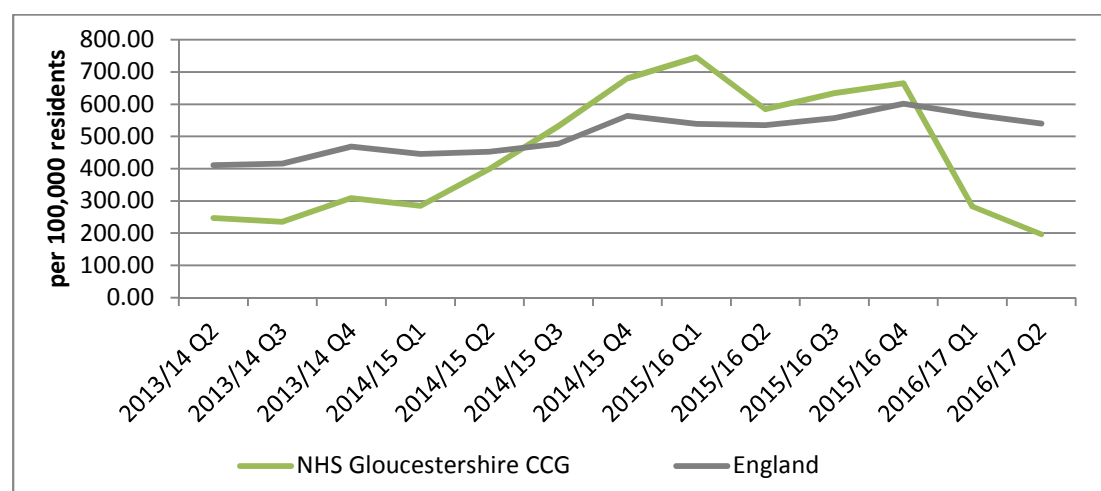
Source: Public Health England, *Mental Health JSNA*

Out of all referrals that occurred in September 2016, for 18.3% of IAPT appointments, patients did not attend and no advance warning was given (**Figure 80**). This proportion is significantly higher than the national average of 11.1% (and it has been for the previous 1.5 years); it is the highest amongst

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[200] Public Health England, *Mental JSNA,* available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA, accessed on 04/04/17

the most similar CCGs. Due to the high proportion of non-attendance, changes have been made to the booking system in Gloucestershire from November 2016. Patients now undertake a short assessment before being booked, when previously they were able to book themselves directly on to the course though the website. This is hoped to improve attendance.

Figure 80: IAPT DNAs: percentage of IAPT appointments, Gloucestershire, in month, January 2015 – September 2016
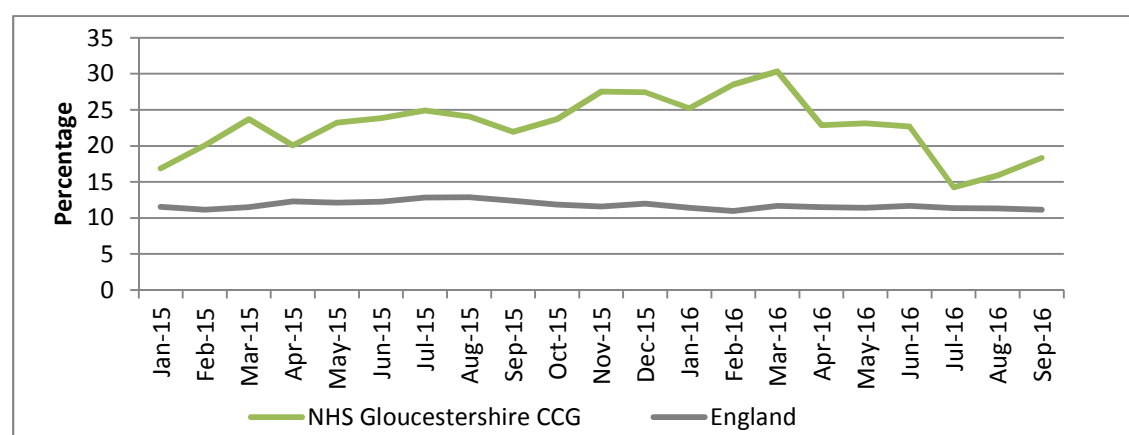
Source: Public Health England, *Mental Health JSNA*

Locally, people entering IAPT services as a proportion of those estimated to have anxiety and/or depression in the county was 9.3% in quarter 2 of 2016/17, which is significantly lower than the national average of 15.5% and the lowest among Gloucestershire's most similar CCGs. The Gloucestershire proportion has fluctuated over the period shown in **Figure 81**, and from December 2014 to February 2016 was higher than the national average. Although, as described in Sections **8.1** and **8.3,** mixed anxiety and depressive disorder, and anxiety are leading mental health issues in Gloucestershire, the low proportion of referrals indicates that there may be a need for further support for those with anxiety.

Figure 81: Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/ depression, Gloucestershire and England, April 2013 to September 2016
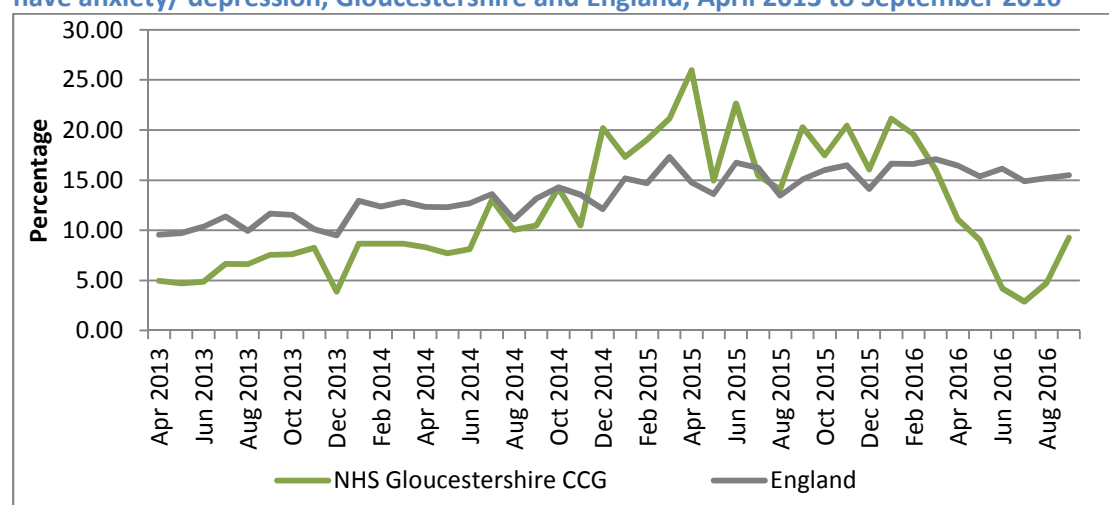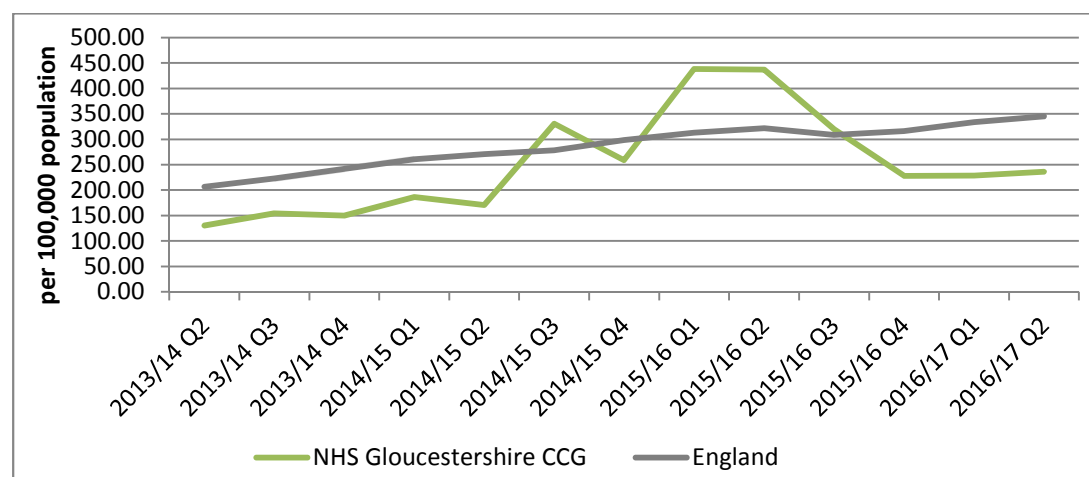

Source: Public Health England, *Mental Health JSNA*

The rate of adults who completed IAPT treatment in Gloucestershire in quarter 2 of 2016/17 was 236 (per 100,000 population), which is lower than the national average of 345 per 100,000 population (**Figure 82**). This rate was forth lowest among the 10 most similar CCGs. The completion rate was higher than the English average in Q3 2014/15 and for the first three quarters of the year 2015/16. Additionally, the Commissioning for Value report identified that increasing the proportion of patients completing IAPT treatment presents a significant opportunity for quality improvement in Gloucestershire.[201]

Figure 82: Completion of IAPT treatment: rate (quarterly) per 100,000 population aged 18+, Gloucestershire, Q2 2013/14 – Q2 2016/17

Source: Public Health England, *Mental Health JSNA*

Activity Conclusions

The rates of referral, entering and completion of IAPT treatment were above the national average during 2015-16 (completion rate was lower in Q4). However, during the first half of the 2016/17 these rates decreased, and as a result were lower than the national average, with the referral and entering treatment rates being one of the lowest amongst the ten most similar CCGs (completion rate being the fourth lowest).

The proportion of people entering IAPT services estimated to have anxiety and/or depression in Gloucestershire also significantly decreased from March 2016, and during the first half of 2016/17 was lower than the national average and the lowest amongst the most similar CCGs.

These changes are known to the local commissioner's and provider's teams and were caused by a change in the referral system. The Primary Mental Health Care Team (PMHCT) (nursing service providing a GP Practice based triage, brief intervention and signposting service to patients who present with mild to moderate mental health conditions or patients with a serious but stable mental health illness with a risk of relapse) was integrated with IAPT services from 2013/14 as the Mental Health Intermediate Care Team (MHICT). Following a review of IAPT services in 2016/17 by the NHSE IAPT Intensive Support Team, the two service elements (PCMHT and IAPT) have separate service

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[201] NHS RightCare, Public Health England (2017) *Commissioning for Value, Where to Look pack,* available at https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/south/, accessed on 04/04/17

specifications, but still operate under the title MHICT and the two elements of the service record activity data separately. The practice based nursing element (previously called PCMHT) is not designed to carry caseloads, hence caseload data is attributed to IAPT.

Additionally, data are available for referrals by ethnicity. As described in Section **0** people from Black and Minority Ethnic groups are more vulnerable to poor mental health and experience additional barriers in accessing services. In Gloucestershire, the proportion of referrals for BME patients was 5.5% in quarter 2 of 2016/17 and it has been consistent over the previous three years, ranging from 3.99% in quarter 2 2014/15 to 6.54% at the beginning of 2015/16. This is consistent with the proportion of BME population in Gloucestershire (4.6%); however, taking into account this group's higher vulnerability, it could be argued that the proportion of BME people using the IAPT services should be higher.

Waiting times

One of the IAPT service targets is that 75% of all new referrals enter treatment within 6 weeks, and 95% within 18 weeks. These are based on the waiting time between the referral date and the first attended treatment appointment, for referrals finishing a course of treatment in the year.[202]

The average wait to enter IAPT treatment in Gloucestershire in September 2016 was 62.8 days, which is significantly higher than the national average of 18.8, and it is the highest value among the 10 most similar CCGs.

The percentage of referrals that have finished a course of treatment waiting less than six weeks for first IAPT treatment in Gloucestershire in September 2016 was 71.8%, which is lower than the national average of 87.8% and the lowest value among the most similar CCGs. Although this proportion was generally above the national target (of 75%) during the period January 2015 – September 2016, the significant decrease from February 2016 resulted in the proportion of referrals waiting less than six months for first treatment being below the target in July and September 2016 (**Figure 83**). Additionally, the Commissioning for Value report identified that an increasing proportion of patients who wait less than 6 weeks for first appointment is a significant opportunity for quality improvement in Gloucestershire (based on 6 months snapshot, October 2015 – March 2016).[203]

The commissioner and provider of the IAPT service are aware of the longer waiting times in Gloucestershire and there is ongoing work to address this issue.

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[202] Department of Health, *The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016*, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf , accessed on 04/04/17

[203] NHS RightCare, Public Health England (2017)

Figure 83: Percentage of referrals that have finished course of treatment waiting <6 weeks for first treatment; Gloucestershire, January 2015 – September 2016
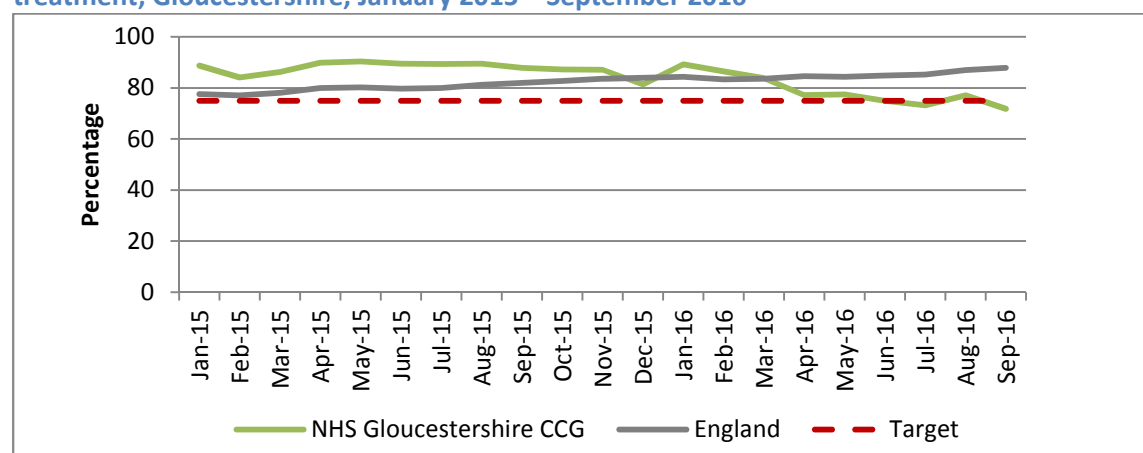
Source: Public Health England, *Common Mental Health Disorders*

The percentage of referrals that have finished a course of treatment waiting less than 18 weeks for first treatment in Gloucestershire in September 2016 was 95.3%, which indicates that the national target of 95% was achieved for this month. However, this was lower than the national average of 98.3%. Gloucestershire was the only CCG area lower than the national average among the most similar CCGs. As illustrated by the **Figure 84**, the percentage of referrals waiting less than 18 weeks reached their highest point of 100% in January 2016 and remained above the national target, with the exception of August 2016 (91.8%).
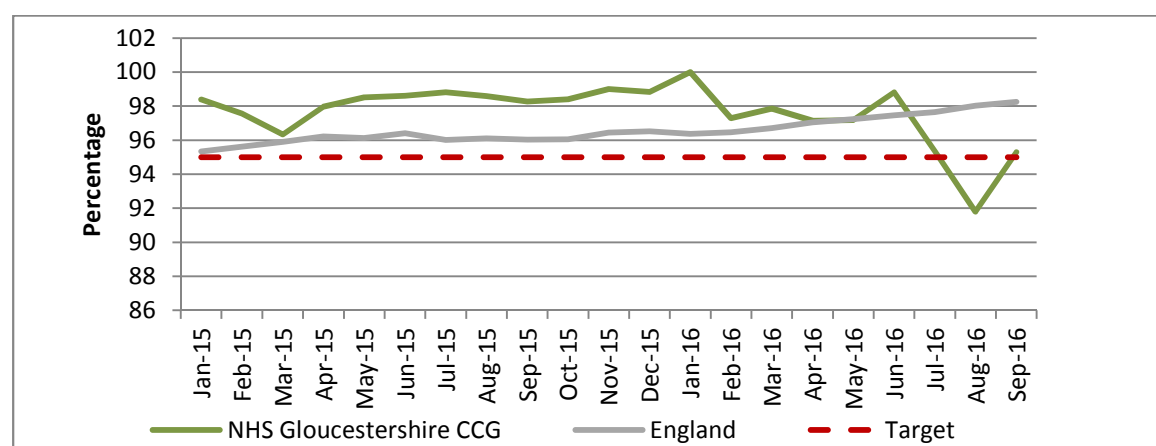
Figure 84: Percentage of referrals that have finished course of treatment waiting <18 weeks for first treatment, Gloucestershire, January 2015 – September 2016

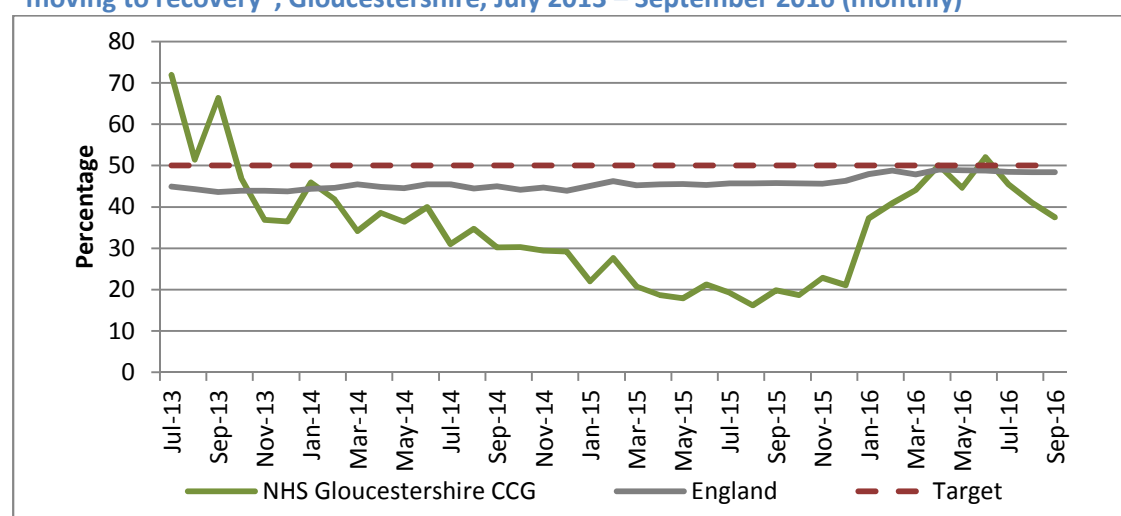Source: Public Health England, *Common Mental Health Disorders*

Outcomes

IAPT programme outcomes are measured in terms of three categories:

- Recovery – patients 'move to recovery', when they move from caseness[204] to not being at caseness; their scores need to be below the caseness threshold on both anxiety and depression measures at the end of their treatment. The national target is for 50% of eligible referrals to be moved to recovery
- Reliable improvement – referrals, which show a significant improvement in one or both conditions following a course of treatment, regardless of whether or not they were above the caseness threshold at the start of the treatment
- Reliable recovery – combined measure of reliable improvement and recovery; referrals who show both a change from being a clinical case at the beginning of the treatment to not being at caseness at the end and a reliable improvement in their condition.[205]

Recovery

Out of all people who completed IAPT treatment in Gloucestershire in September 2016 only 37.5% were "moving to recovery" **(Figure 85)**. This is below the national average of nearly 50%, and is one of the lowest rates among the most similar CCGs. However, since the beginning of 2016 the recovery rate has shown significant improvement (especially in April and June 2016 when the national target was achieved) as compared to 2015.

Figure 85: IAPT recovery: percentage of people who have completed IAPT treatment who are "moving to recovery", Gloucestershire, July 2013 – September 2016 (monthly)

Source: Public Health England, *Common Mental Health Disorders*

As indicated in the figure below **(Figure 86)**, the local recovery rates across all IAPT-relevant conditions are lower than the national average. Recovery rates for anxiety and stress-related disorders are slightly higher (31%) than for people with depression (29%), which is comparable to the national trend.

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[204] Caseness is the term that describes a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case
[205] NHS Digital (2016)

Figure 86: Recovery rate by primary problem, Gloucestershire 2015-16
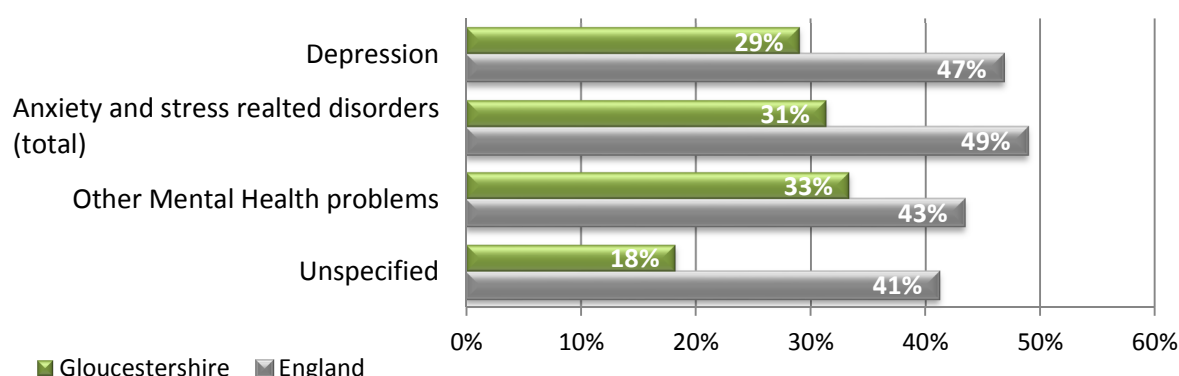
	Gloucestershire	England
Depression	29%	47%
Anxiety and stress realted disorders (total)	31%	49%
Other Mental Health problems	33%	43%
Unspecified	18%	41%

Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*
* The Gloucestershire numbers for categories of 'Other Recorded Problems' and 'Invalid Data Supplied' were less than 5 (including zero), the data have been suppressed and are not included

Figure 87 illustrates the recovery rates for specific conditions that fall within the category 'Anxiety and stress related disorders'. In Gloucestershire, the highest recovery rate is for 'Generalised Anxiety Disorder' (45.9%) and the lowest for 'Mixed anxiety and depressive disorder' (26.6%) 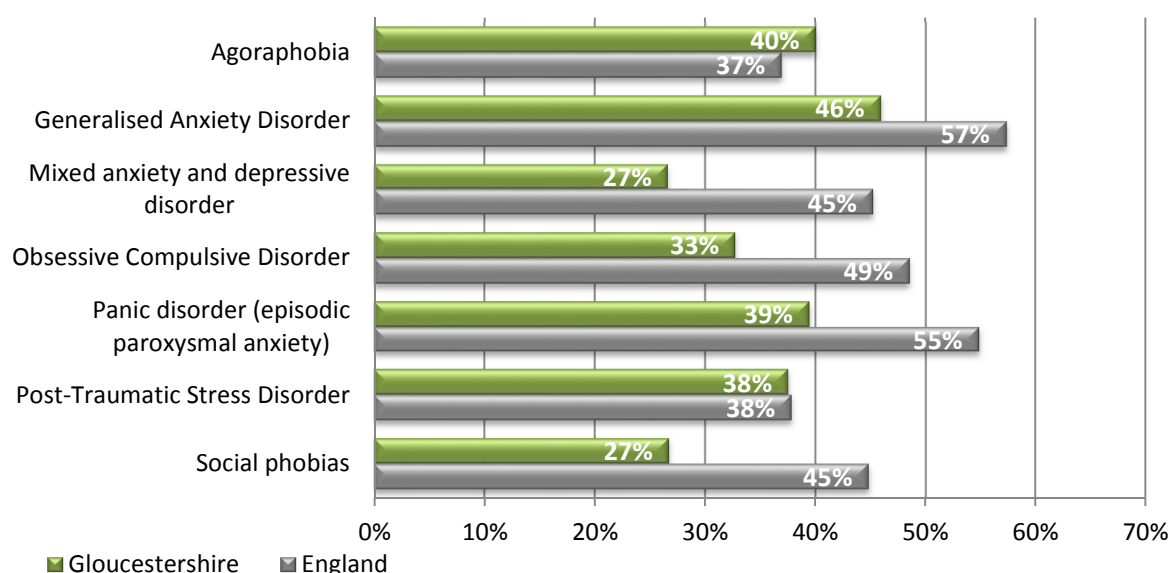and 'Social phobia' (26.7%).[206] The categories with the lowest recovery rates have the highest significant differences as compared with the national figure.

In terms of secondary problems, local recovery rates are lower than national rates, with the exception of 'Agoraphobia' (local recovery rates are higher), and 'Post-Traumatic Stress Disorder' (local and national rates are similar).

Figure 87: Recovery rate by secondary problem for those with a primary problem of anxiety, Gloucestershire 2015-16

	Gloucestershire	England
Agoraphobia	40%	37%
Generalised Anxiety Disorder	46%	57%
Mixed anxiety and depressive disorder	27%	45%
Obsessive Compulsive Disorder	33%	49%
Panic disorder (episodic paroxysmal anxiety)	39%	55%
Post-Traumatic Stress Disorder	38%	38%
Social phobias	27%	45%

Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*
* The Gloucestershire numbers for categories: 'Other anxiety and stress-related disorders' and 'Specific (isolated) phobias' were less than 5 (including zero), the data have been suppressed and are not included

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[206] Nationally, 'Specific (isolated) phobias' (not included in the figure below, due to small number in Gloucestershire) has the highest recovery rate of 64% and 'Agoraphobia' the smallest (36.9%)

Reliable improvement

At the end of IAPT treatment 60.3% of patients in Gloucestershire show a reliable improvement, lower than the national average of 64.6% (**Figure 88**); this proportion is around the middle amongst the most similar CCGS. The local rate of reliable improvement significantly decreased from quarter 3 2014/15, before improving again more recently. The overall rate for 2015/16 (35.4%) in Gloucestershire was the lowest in England.

Figure 88: IAPT reliable improvement: percentage of people who have completed IAPT treatment who achieved "reliable improvement, Gloucestershire, Q2 20103/14 – Q2 2016/17, quarterly
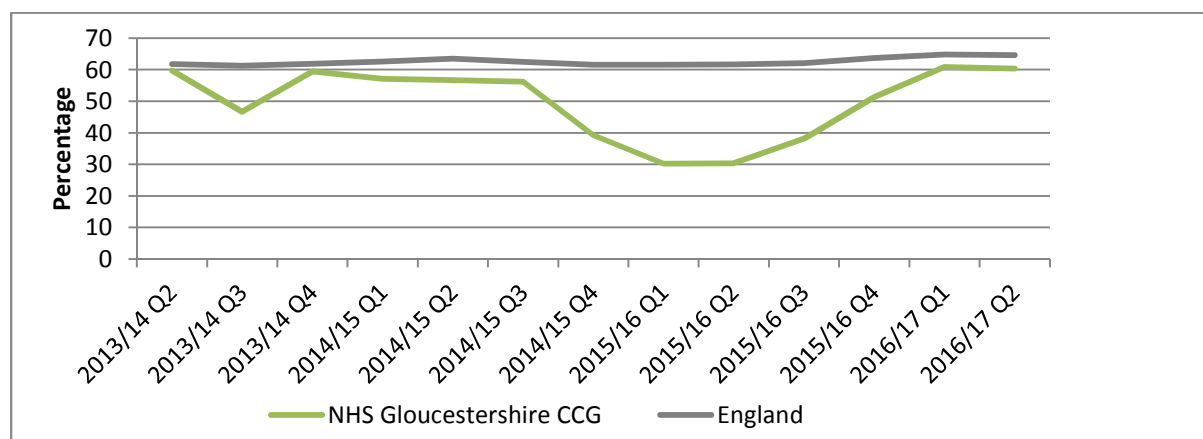
Source: Public Health England, *Common Mental Health Disorders*

Reliable recovery

Figure 89 compares recovery, reliable improvement and reliable recovery rates of the IAPT course in Gloucestershire in 2015/16. The reliable improvement rate is higher than the recovery rate, as it relates only to the scale of change not to the clinical caseness. Reliable recovery requires both: recovery and reliable improvement, therefore, it has the lowest proportion.

During 2015/16 in Gloucestershire only 21.2% of patients showed reliable improvement, which is half of the national average (44%). However, as presented above, the Gloucestershire trends of recovery and reliable improvement, after a significant decrease in 2015/16, have shown an increase in the first half of 2016/17. The proportion of patients with reliable recovery are therefore expected to show an increase when the data become available.

Figure 89: Recovery, reliable improvement and reliable recovery rates, Gloucestershire, 2015-16
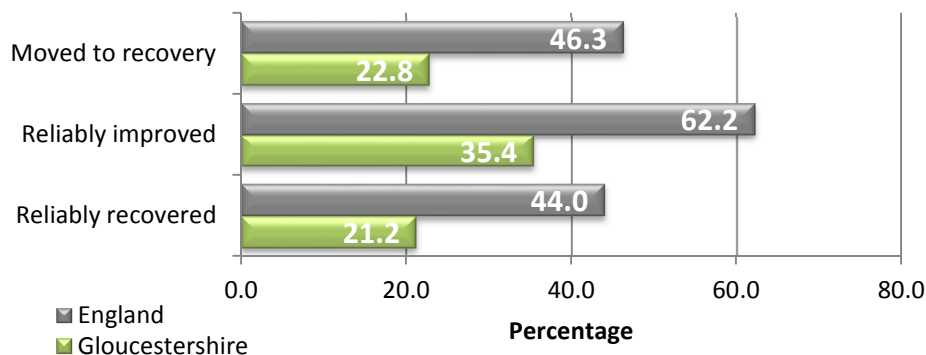
Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

Psychological therapies by patient demographics

Age and gender

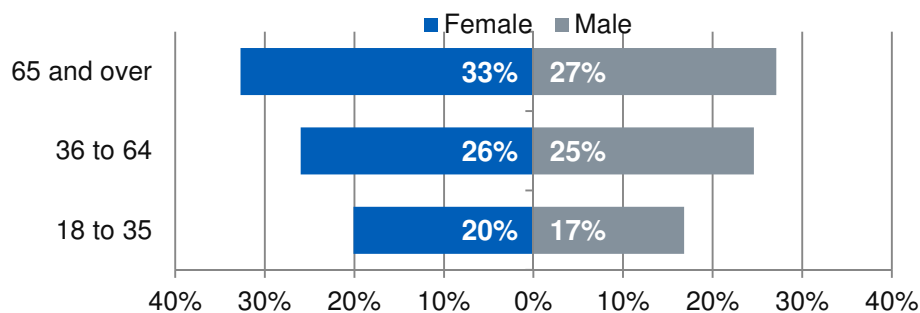**Figure 90** shows that recovery rates in Gloucestershire were slightly higher for females than males in 2015/16; nationally these rates were similar. Looking at the age groups, there is a higher proportion moving to recovery amongst those aged 65 and over than patients of working age.

Figure 90: Recovery rates by age and gender, Gloucestershire, 2015/16

Ethnicity

Locally, the numbers of patients from many ethnic groups who moved to recovery were smaller than five, as such recovery rates could not be calculated.[207]

The highest recovery rates were amongst 'Asian or Asian British –Any Other Asian Background' and 'Asian or Asian British – Indian' (44.4% and 37.8% respectively).

The recovery rates of the 'White British' ethnic group were lower than the national average (25.5% locally, 47.7% nationally).

The proportion of people from 'White – Any Other White Background' and 'Mixed – Any Other Mixed Background' who moved to recovery was similar to the proportion of people of White British ethnicity (24.4%, 28.6% respectively) similarly these rates are lower than the national average (46.6%, 40.3%).

The recovery rate of people from 'Mixed – White and Black Caribbean' ethnic group was 12.5%.

Sexual orientation

As indicated in **Figure 91**, in Gloucestershire recovery rates were highest amongst those who do not know or are not sure of their sexual orientation; nationally this group had the lowest recovery rates. There is a significantly higher proportion of heterosexual people who moved to recovery than those who are gay, lesbian or bisexual.

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[207] The recovery rates are not calculated for the following ethnic groups: 'Asian or Asian British – Bangladeshi', 'Asian or Asian British – Pakistani', 'Black or Black British – African', 'Black or Black British - Any Other Black Background', 'Black or Black British – Caribbean', 'Mixed - White and Asian', 'Mixed - White and Black African', 'Other Ethnic Groups – Chinese', 'White - Irish', 'Other Ethnic Groups - Any Other Ethnic Group'.

Figure 91: Recovery rates by sexual orientation, Gloucestershire, 2015-16
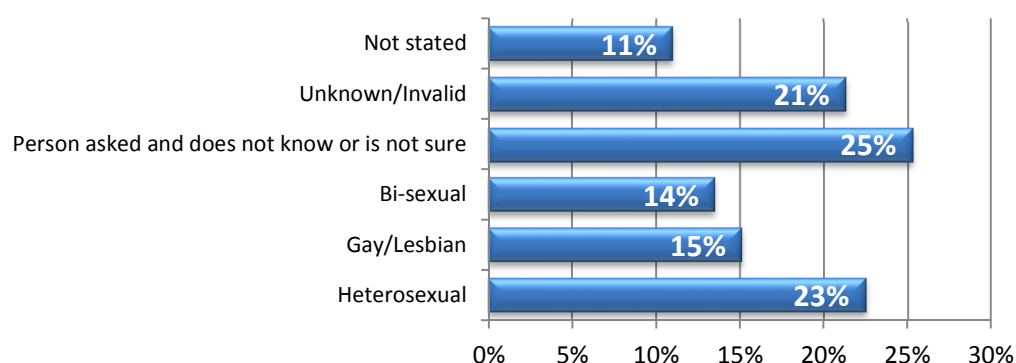
Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

Religion

In Gloucestershire the highest proportion of people who moved to recovery was for those who are Hindu (83%); however, this proportion was based on relatively small number of referrals finishing a course of treatment. The recovery rates amongst Christian people (29%) were higher than amongst those who declined to disclose (recovery rate of 27%), people with no religion (24%) and those who are Muslim (23%).

Deprivation

Nationally, the numbers of referrals received and the number of referrals which entered treatment increase as deprivation increases; additionally, patients living in the most deprived areas are less likely to finish a course of treatment than those living in the least deprived areas.[208] However, in Gloucestershire the relationship between deprivation and referrals numbers is less pronounced and in reverse as compared with the national figures for 2015/16 (**Figure 92**). The numbers of referrals are lowest in the most deprived areas.

Figure 92: Referrals received, entered treatment and finishes a course of treatment by deprivation decile, Gloucestershire, 2015/16
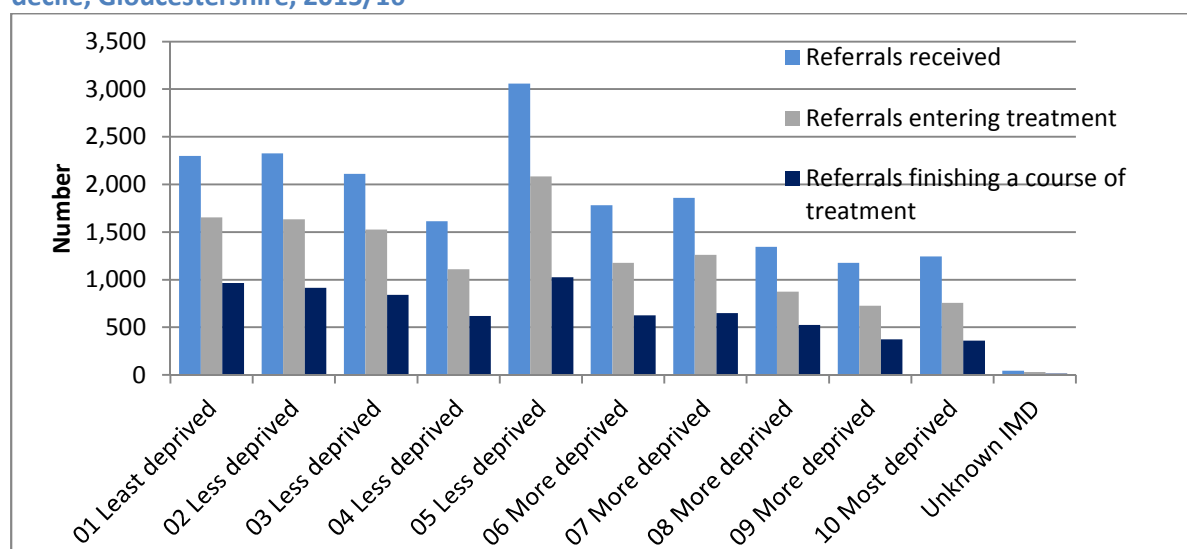
Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

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[208] NHS Digital (2016)

Additionally, people living in the most deprived areas and referred for treatment are less likely to enter treatment as compared to those living in less deprived areas (**Figure 93**). People living in the 10% most deprived areas are less likely to complete a course of treatment than other areas.

Figure 93: Proportion of referrals entering treatment in relation to received referral and proportion of referrals finishing course of treatment in relation to referral entering treatment, Gloucestershire, 2015/16

Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

**Figure 94** indicates that recovery, reliable improvement and reliable recovery rates are linked to deprivation. In Gloucestershire, in 2015/16 the percentage of patients living in the 10% most deprived areas who moved to recovery, showed reliable improvement or reliable recovery, was approximately half that of those living in the 10% least deprived areas.

Figure 94: Outcomes by deprivation decile, Gloucestershire, 2015/16
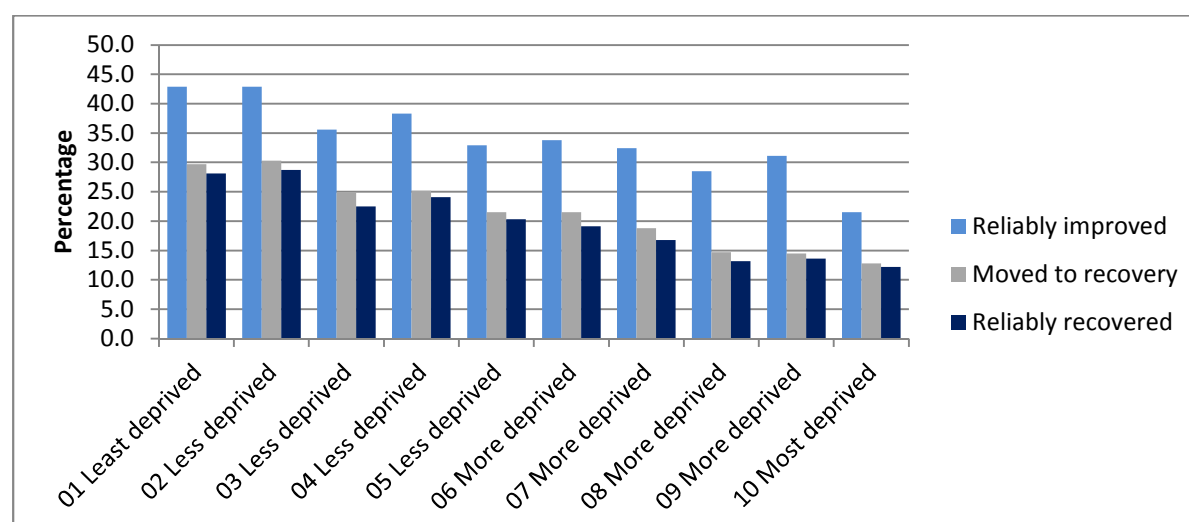
Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

Long- term health conditions

As indicated in the figure below **(Figure 95)**, the IAPT treatment outcomes for the people who have a comorbidity of depression and/or anxiety alongside physical health conditions are similar to those for the overall patient population. This is similar to the national outcomes.

Figure 95: Outcomes for patients with long-term health conditions, Gloucestershire, 2015/16
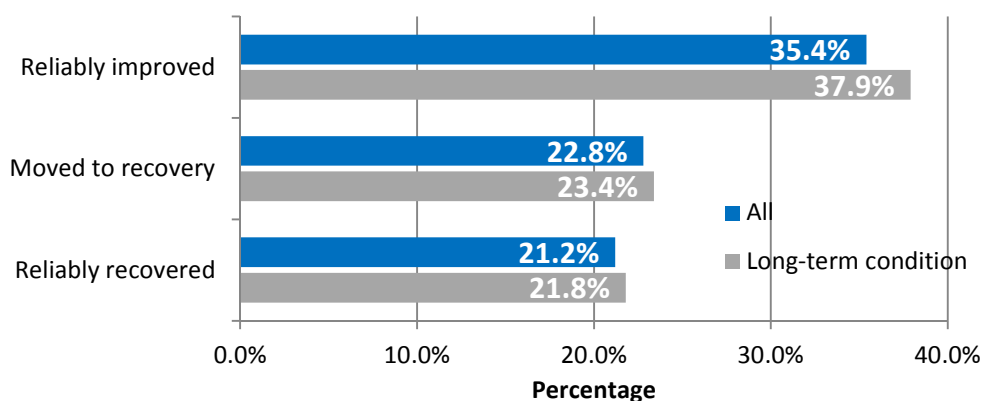
Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

Ex-British Armed Forces personnel and dependents

According to the IAPT dataset for 2015/16 in Gloucestershire, there were 295 referrals received for ex-British Armed Forces personnel or their dependants; 250 referrals entered treatment and 130 referrals finished the course of treatment. These numbers are not based on the same group referrals as each other; referral may enter treatment or end in the following year.[209]

As indicated in **Figure 96**, 33% of referrals for ex-British Armed Forces personnel or dependants moved to recovery; this is significantly higher than the overall Gloucestershire recovery rate of 23%. Other outcomes, such as reliable improvement and reliable recovery, are also significantly higher for veterans. Nationally, veterans also show higher rates in these outcomes than the overall patient population; however, the difference between groups is smaller nationally.

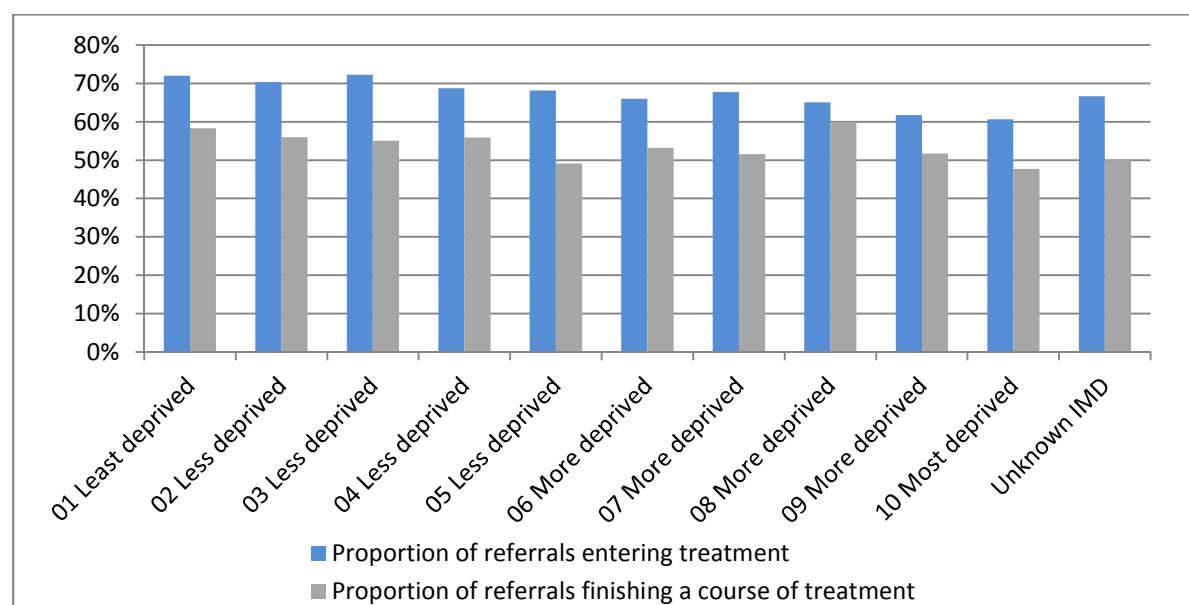**Figure 96: Outcomes for ex-British Armed Forces personnel and dependants**

Source: NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*

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[209] NHS Digital (2016)

9.8   Spend on Mental Health

Key Points:

The Gloucestershire CCG spend on specialist mental health is lower than the national average but it is similar to spend among Gloucestershire's most similar CCGs. The Primary Care prescribing spend is higher than the national average and the 4th highest among 10 most similar CCGs. Additionally, the overall lower spend on mental health by Gloucestershire CCG results in a slightly higher outcome than the respective national average.

This chapter describes the spend on mental health services in Gloucestershire across CCG specialist mental health commissioning, primary care prescribing and IAPT services. The primary care prescribing spend is described in detail in the Chapter **below**. It should be noted that some of the nationally published data are quite out of date and will not reflect any recent increase or reduction on spend. Therefore, this chapter should be read with some caution.

Of all Gloucestershire CCG spend categories, 11.3% was on specialist mental health services in 2013/14 (for all ages). This was slightly lower than the national average (12.1%) and was lower than 5 out of 10 similar CCGs. The rate of specialist mental health services spend per person in 2013/14 was £128.86, also lower than the national average of £151.07. This rate is 5th highest as compared with 10 most similar CCGs.[210]

Gloucestershire's Primary Care prescribing spend on mental health per person in 2013/14 was £13.59, which is slightly higher than the national average of £12.31 and 4th highest among 10 most similar CCGs. Additionally, the Commissioning for Value report identified an opportunity for improvement in the current spend on primary care prescribing in mental health.[211]

The total spent on Psychological Therapy Services (IAPT) for 2010/11 was £504 per 100,000 population of working age. This was higher than the national average of £487. This value is mid-ranging amongst the 10 most similar CCGs. These data are no longer published beyond 2010/11.

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[210] Public Health England, Mental Health JSNA, available at: http://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna, accessed on 04/05/17

[211] NHS RightCare, Public Health England (2017)

Understanding the relationship between spend and outcomes across key programme areas is supported by Spend and Outcome Tool (SPOT). As indicated in **Figure 97**, in 2015 Gloucestershire CCG had lower mental health spend and slightly higher outcome than the respective national average. Mental health is placed inside the dotted line - this suggests that Gloucestershire CCG spend on mental health is not highlighted as a priority for further exploration.[212]

Figure 97: Gloucestershire CCG Mental Health programme quadrant chart, 2015

Interpreting the chart:
Dot represents a programme budget category. A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.
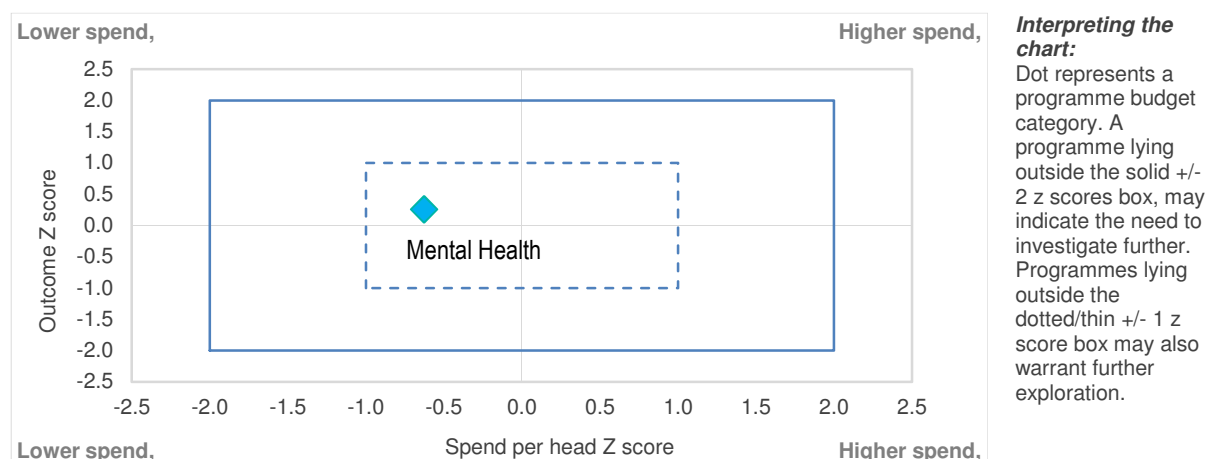
Source: Public Health England (2017) Spend and Outcome Tool

Gloucestershire County Council also funds public mental health activities (i.e. activity to promote good mental health and prevent mental illness, including suicide prevention) through its Public Health Grant. In 2016/17, this budget was £432,000. This budget funds the Gloucestershire Self-Harm Helpline, volunteer buddying for people with severe and enduring mental illness and MenTalk, an intervention with young men to tackle mental health stigma and build resilience. Training for staff across the public and voluntary sectors in Mental Health First Aid and Applied Suicide Intervention Skills was also funded.

Given the range of activities, interventions and services that support mental wellbeing – much of it taking place in communities without public funding – it is impossible to establish the true level of investment in the promotion of good mental health and prevention of mental illness or to benchmark it against other areas. From 2017, local areas are required to set out their plans for public mental health through a Prevention Concordat for Good Mental Health.

Recommendations:

9.8.1   Although the current level of overall spend on mental health by GCCG is not highlighted as requiring investigation, further exploration of spend on primary care prescribing could be an opportunity for improvement.

9.8.2   Given the data in Chapter **7.1** that shows the wellbeing of Gloucestershire residents is lower than its statistical neighbours, setting out the local response to national Prevention Concordat for Better Mental Health should be a priority for partners.

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[212] Public Health England (2017)Spend and Outcome Tool, available at https://www.gov.uk/government/publications/spend-and-outcome-tool-spot, accessed on 04/05/2017

9.9 Prescribing data

Key points:

Out of all mental health prescribed drugs, the weighted cost of GP prescribing for hypnotics and anxiolytics in Gloucestershire is higher than the national average, which is also the highest among the 10 most similar CCGs. The actual prescribing numbers and actual cost are the highest for antidepressant drugs, although the weighted rate shows a decreasing trend; the weighted rate is at the similar level as the England average.

This section looks into the cost of mental health prescribing in Primary Care as compared with the national average. The data are mainly based on the ePACT[213] system, and Public Health England profiles.

The main categories of mental health prescribed drugs described in this section are based on the British National Formulary:[214]

- **Hypnotics and Anxiolytics.** Hypnotics will sedate when given during the day and are used to treat insomnia, and should be used only when the insomnia is severe, disabling, or causing the patient extreme distress. Anxiolytics can be effective in anxiety that is severe, disabling, or causing the patient unacceptable distress. The most commonly used anxiolytics and hypnotics are benzodiazepines. These medicines can cause dependence (psychological and physical) and tolerance.

- **Drugs used in psychoses and related disorders.** These include: antipsychotic drugs (used to calm disturbed patients whatever the underlying psychopathology, which may be schizophrenia, brain damage, mania, toxic delirium, or agitated depression); antipsychotic depot injections (long acting depot injections which tend to be used when compliance with oral treatment is unreliable); and drugs used for mania and hypomania (used to control acute attacks and to prevent recurrence of episodes of mania or hypomania, used for treatment of bipolar disorder).

- **Antidepressant drugs** - effective for treating moderate to severe depression

- **CNS stimulants and drugs used for Attention Deficit Hyperactivity Disorder (ADHD)**. Usually central nervous system stimulants are prescribed for children with severe and persistent symptoms of ADHD. However, the treatment of ADHD often may need to be continued into adulthood.

- **Drugs for dementia** – not included, as dementia is outside the scope of this needs assessment.

The data in this section are weighted using STAR-PUs (Specific Therapeutic Group Age-sex weightings Related Prescribing Units). This is nationally developed weighting, which allows more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment and enables comparison of local and national

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[213] Electronic Prescribing Analysis and Cost is an application which allows authorised users at Primary Care Teams / Area Teams / Trusts and National users to electronically access prescription data
[214] NICE, *British National Formulary, Central nervous system*, available at
https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system, accessed on 31/03/17

prescribing patterns. The data are based on costs within therapeutic groups rather than all prescribing and are used only for the specific therapeutic area.[215]

Prescribing numbers of items and cost by the prescribing drug category

Hypnotics and Anxiolytics

As presented in **Table 24**, the number of prescription for Hypnotics and Anxiolytics was very similar in 2015/16 to the numbers in 2012/13; although between these years the prescription numbers have increased and then decreased. The total spend has increased by 12% in 2015/16 in relation to 2012/13.

Table 24: Hypnotics and Anxiolytics number of prescribing items and cost between 2012/13 to 2015/16, Gloucestershire

Period Name	Total Items	Total Cost
2012/13	235,645	£851,551
2013/14	243,849	£1,121,626
2014/15	245,346	£1,002,508
2015/16	237,360	£953,704

Source: NHS Gloucestershire CCG, ePACT data

Looking at the weighted cost of GP prescribing for hypnotics and anxiolytics per 1,000 STAR-PU, both the Gloucestershire and England cost is decreasing, although the Gloucestershire cost is decreasing at a slower pace than the England average **(Figure 98)**. As a result, for the first quarter of 2016/17, the local prescribing cost was significantly higher than the national average, at a level of £136.9 (per 1,000 STAR-PU) compared with £107.9 for England. Additionally, this is the highest cost among 10 most similar CCGs.[216]

Figure 98: Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly), NHS Gloucestershire CCG and England, Q1 2013/14 to Q1 2016/17, 18+
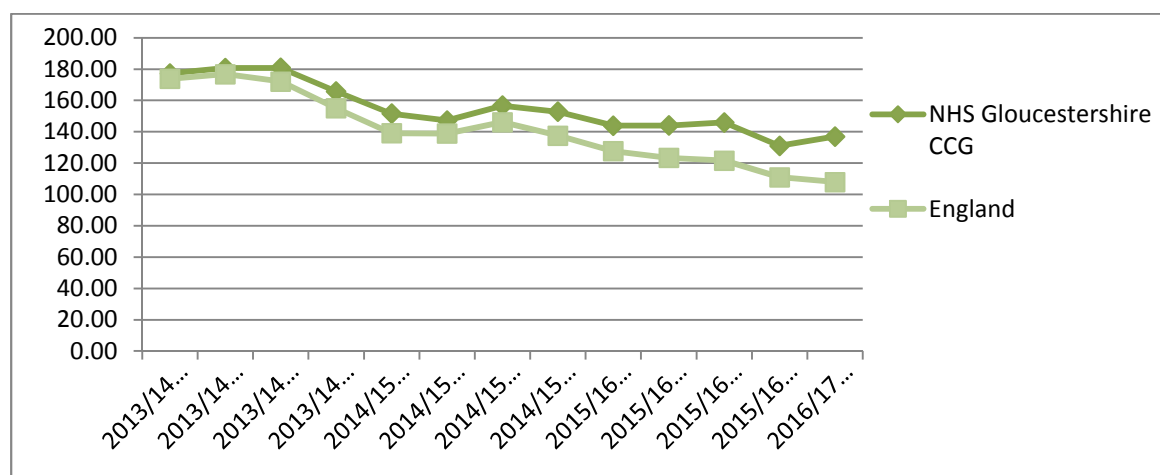
Source: Public Health England, *Mental Health JSNA*

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[215] NHS Digital, *Prescribing measures, indicators and comparators*, available at: http://content.digital.nhs.uk/prescribing/measures, accessed on 31/03/17

[216] Public Health England, *Mental Health JSNA*, available at https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA, accessed on 31/03/2017

However, as described in the section 8.1, the prevalence of anxiety disorders, which if severe enough might require the prescribing of Anxiolytics, is not significantly higher than the national average.

Drugs used in psychoses and related disorders

Although the numbers of prescribed items for drugs used in psychoses and related disorders increased in the period between 2012/13 and 2015/16 (25% increase by 2015/16), the total cost decreased by 15% during that period (**Table 25**).

Table 25: Drugs used in psychoses and related disorders, number of prescribing items and cost between 2012/13 to 2015/16, Gloucestershire

Period Name	Total Items	Total Cost
2012/2013	101,736	£1,292,590
2013/2014	111,406	£1,194,991
2014/2015	120,368	£1,308,446
2015/2016	126,966	£1,094,582

Source: NHS Gloucestershire CCG, ePACT data

As indicated by **Figure 99**, the cost of GP prescribing for psychosis and related disorders remained stable over the period 2013/14 to 2014/15 for both Gloucestershire and England. After that period, the cost has declined, which resulted in around a 40% decrease in cost by the first quarter of 2016/17 compared with the first quarter of 2013/14. The local cost continued to be below the national average and at the beginning of the 2016/17 was equal to £312, whilst the average cost for England was £388. This indicator was not weighted and is expressed as a rate per registered population.[217]

Figure 99: Cost of GP prescribing for psychoses and related disorders: Net Ingredient Cost (£) per 1,000 population, NHS Gloucestershire CCG and England, Q1 2013/14 to Q1 2016/17, all ages
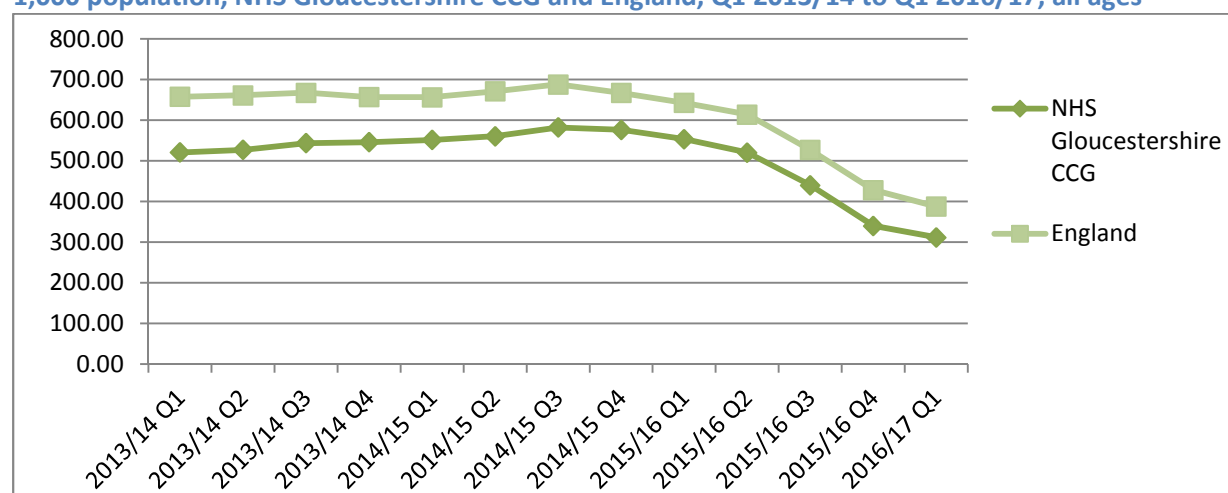
Source: Public Health England, *Mental Health JSNA*

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[217] Ibid

Antidepressant drugs

In Gloucestershire, the number of prescribed items and cost of antidepressant drugs increased during the financial years of 2012/2013 and 2015/2016 by 27% and 22% respectively (**Table 26**). This increase is opposite to the prevalence of depression recorded on the patients disease register (Chapter **8.1)**, which decreased between 2011/12 and 2015/16.

Table 26: Antidepressant drugs, number of prescribing items and cost between 2012/13 to 2015/16, Gloucestershire

Period Name	Total Items	Total Cost
2012/2013	605,839	£2,474,000
2013/2014	651,915	£2,945,840
2014/2015	716,398	£2,807,435
2015/2016	770,891	£3,028,113

Source: NHS Gloucestershire CCG, ePACT data

For antidepressant drugs, the cost per STAR-PU has declined over time for Gloucestershire and England (**Figure 100**); however, during that time there were some increases, year to year. For each period, the cost in Gloucestershire was at a similar level to the England average. However, the depression prevalence and hospital admissions rate for depression is lower in Gloucestershire than the national average (Chapter **8.1).** By the first quarter of 2016/17, the antidepressant costs in Gloucestershire and England were equal to £50.79 and £52.26 respectively. As compared with the 10 most similar CCGs, the Gloucestershire cost was amongst the CCGs with the lowest costs, which is similar to the trends of the prevalence of depressive episodes (Chapter **8.1).**[218]

Figure 100: Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU, NHS Gloucestershire CCG and England, Q1 2013/14 to Q1 2016/17, 18+

Source: Public Health England, *Mental Health JSNA*

CNS Stimulants and drugs used for ADHD

The total number of prescribed items of central nervous system stimulants and drugs used for ADHD in Gloucestershire increased by 45% in 2015/16, as compared with 2012/13 (**Table 27**). The total cost also increased over this period, however by a smaller proportion of 21%.

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[218] Ibid

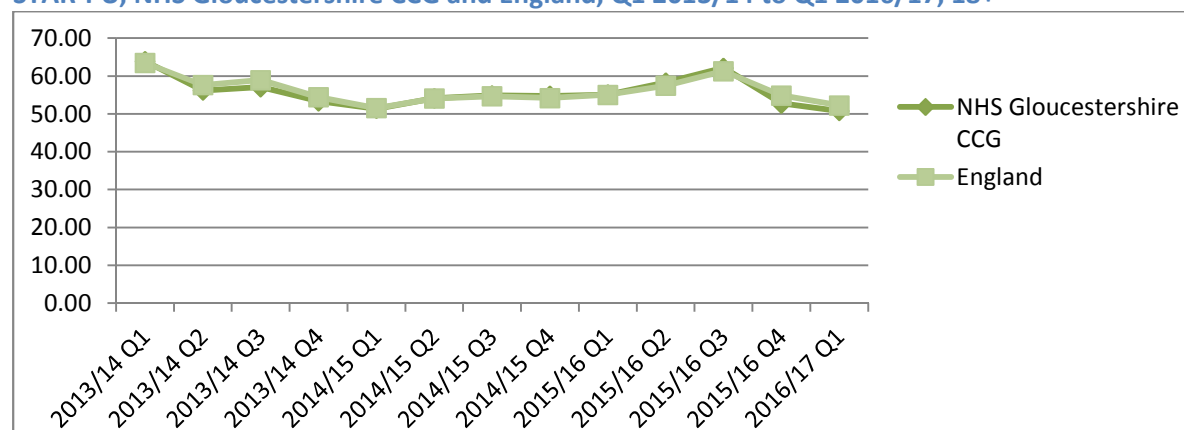**Table 27: CNS Stimulants and drugs used for ADHD, number of prescribing items and cost between 2012/13 to 2015/16, Gloucestershire**

Period Name	Total Items	Total Cost
2012/2013	6,511	£307,637
2013/2014	8,170	£367,319
2014/2015	9,194	£357,603
2015/2016	9,425	£372,474

Source: NHS Gloucestershire CCG, ePACT data

The rates are not available for this indicator; therefore, it is not possible to compare trends of local and national rates.

Looking at **Table 24** , **Table 25**, **Table 26** and **Table 27**, antidepressant drugs represented the highest number of prescribed items among all mental health prescribed drugs in Gloucestershire in 2015/16, at a level of 770,891, which was more than three times higher than second most common prescribed drugs, Hypnotics and Anxiolytics. The actual cost of antidepressant drugs was nearly three times higher than the second highest cost of psychoses drugs. However, due to data inconsistency of the prevalence of depression and anxiety it is not possible to compare prescribing data with prevalence.

Numbers of items and cost by CCG locality

As indicated by **Figure 101**, the actual numbers of prescribed mental health items ranged from 301,481 in the Gloucester CCG locality to 47,628 in the Tewkesbury CCG locality. Accordingly, Gloucester has the highest total actual prescribing cost of £1,600,991. However, the smallest actual cost was in North Cotswold (£215,806). This would suggest that in Tewkesbury there is a higher proportion of drugs prescribed from more costly groups (possibly for treating different conditions) than in North Cotswold. As there are some differences in boundaries between districts used by Gloucestershire County Council and NHS Gloucestershire Clinical Commissioning Group, it is not possible to precisely compare the localities' population numbers (by GCC districts) with the prescribing cost (by CCG localities). However, the total number of mental health related items prescribed in Forest of Dean or North and South Cotswold combined is around three times higher than Tewkesbury's figures. The Forest of Dean, Cotswold and Tewkesbury local authority district populations are of a similar size.

Figure 101: Accumulated mental health total prescribing actual items, 2015-16, by Gloucestershire district
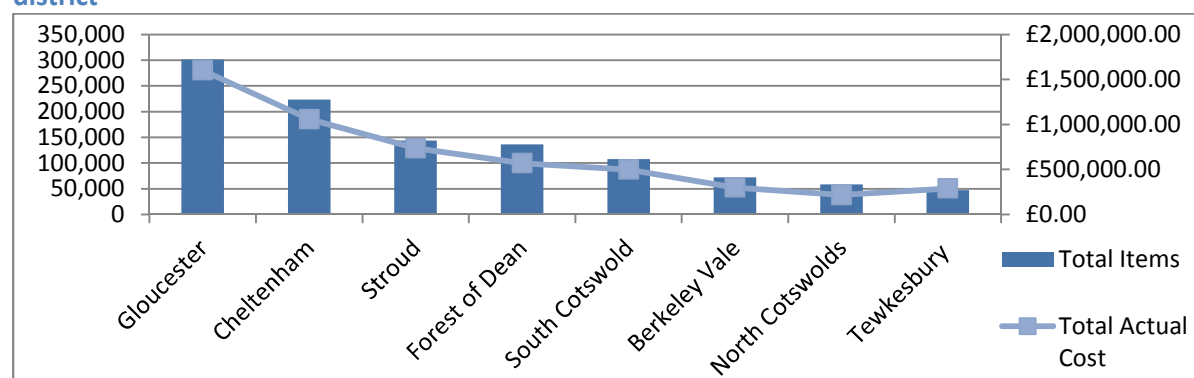
Source: NHS Gloucestershire CCG, ePACT data

9.10 Non-commissioned Voluntary and Community Sector Services

Key points:

Females are more likely to use voluntary sector counselling services than males. The main reasons for accessing counselling are bereavement, relationship problems, depression and anxiety. GPs are the main source of referrals.

There are many non-commissioned third sector or voluntary and community sector organisations, which make a valuable contribution to improving the mental health and wellbeing of Gloucestershire residents. Services provided by the main voluntary sector counselling organisations, such as Gloucestershire Counselling Service, Listening Post and Cotswold Counselling, are described in this section; the data are sourced from the service providers and are not standardised across different providers.

Gloucestershire Counselling Services

The charity Gloucestershire Counselling Services offers affordable psychodynamic counselling to those on limited income (less than 50% of all clients pay the standard fee) in venues across the county including Stroud (main office), Gloucester, Cheltenham and the Forest of Dean. Each year this service provides approximately 8,000 sessions of counselling adults and approximately 300 clients use this service each week; on average each client participates in 24 sessions; however, some clients may be seen for several years.

There are more females (60%) than males using these services. As illustrated in the figure below (**Figure 102**) 1 in 3 services users are aged between 30-39 years old, 1 in 4 aged 40-49 years old. The vast majority are from White (English/ European) background; less than 0.5% are Asian and Black African/ Caribbean (each).

Figure 102: Gloucestershire Counselling Services clients' age breakdown.
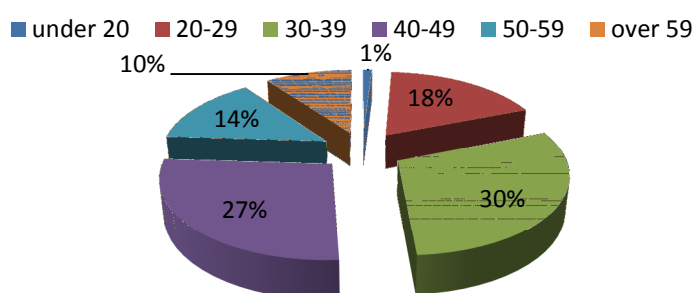
Source: Gloucestershire Counselling Services

Although, clients seek counselling for a wide range of difficulties, the most common problems are depression, anxiety and bereavement, with trauma featuring in all of these.

There is no waiting list to see a counsellor for the individual counselling, however, the demand for children and family services is high and a waiting list exists for this service.

GPs are the source of the referrals for more than half of the clients (56%); 1 in 4 clients self-refer; other self-referral sources are family members (5%) and NHS services (3%). Almost all of the clients assessed for counselling are accepted.

Based on Clinical Outcome in Routine Evaluation (CORE) data, 80% of all clients improved as a result of counselling.

Listening Post

Listening Post offers psychodynamic counselling, person centred counselling and Cognitive Behavioural Therapy for anyone over 18, regardless of financial status; there is no set fee and clients make a donation per session. There are three counselling centres in Gloucestershire: Gloucester (main office), Cheltenham and Stroud.

Approximately 450 people receive counselling support each year from the three centres. The average amount of sessions per client is 20. However, people can be within the service for up to a year, if required. The waiting time for an assessment is approximately 6 weeks, with the longest waiting time of 8 weeks in Cheltenham; 7.5 in Gloucester and 4.5 in Stroud. It might take another 8-10 weeks for a session with counsellor.

The most common difficulties presented by clients are:

- Loss and bereavement
- Emotional regulation – distressed
- Relationships
- Abuse.

Based on the CORE data for clients closing in the year 2015-16, 62% of people showed a reliable change and 42% showed a clinically significant change, with 40% showing both. Gloucester clients presented with lower outcomes for reliable improvement and clinical improvement, compared with clients in other areas (**Figure 103**).

Figure 103: Proportion of Listening Post' clients finishing in 2015-16 showing various CORE outcomes
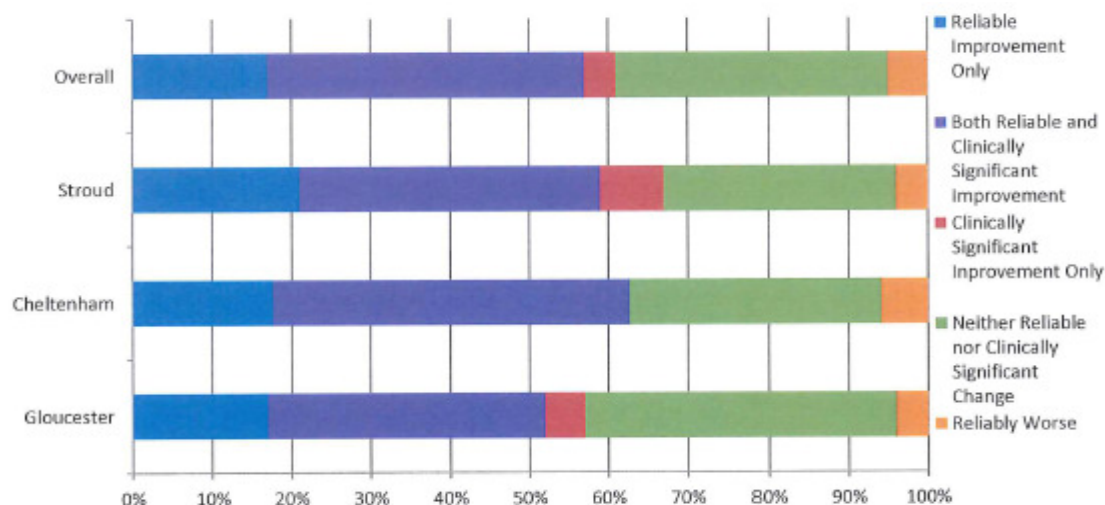
Source: Listening Post (2016) *Annual Report 2016*

The service reported an increase in referrals and requests for assessment, and increased complexity of presentation in client profile. The service also raised concern that continued growth may mean they are unable to continue to meet demand.

Cotswold Counselling

Cotswold Counselling offers counselling to adults, children and young people. There are three centres: Cirencester, Moreton-in-Marsh and Chipping Campden; for those who are housebound there is a limited service at home. In 2014/15, there were 497 new clients; of those, 342 were adults, and 8 housebound (all ages). In a year, the service provided 3,624 counselling sessions for adults and 37 sessions of home counselling. The majority of clients were females (68%). The age distribution of service user is slightly different from the clients of Gloucestershire Counselling Service (**Figure 102** and **Figure 104**). There is a higher proportion of children and young people under 20 years old, but a significantly lower proportion of 31-40 years old (this age group was the main service user of Gloucestershire Counselling Service).

Figure 104: Cotswolds Counselling client's age breakdown.
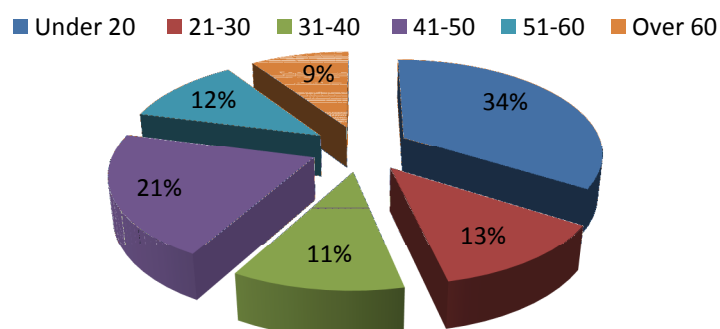
Source: Cotswold Counselling

Among adult service user the most common emotional problems are:

- Relationship breakdown (50%)
- Anxiety (10%)
- Bereavement (9%)
- Work related stress (7%)
- Depression (7%)
- Trauma (3%)
- OCD (3%).

For people who are home counselled (people either severely disabled or ill; all ages) the main issues are:

- Depression (27%)
- Relationships (20%)
- Disability/ ill health (20%)
- Agoraphobia/Panic (13%)
- Childhood abuse (13%)
- Bereavement (7%).

GPs are the main source for all types of referrals. The remaining are self-referrals, or referrals from parents, schools and youth services. A small number come from mental health services.

Information about outcomes provided by this service were not available for this needs assessment.

As indicated above, loss and bereavement is one of the common problems for counselling. The newly established Gloucestershire Bereavement Forum is an informal group of statutory, private and voluntary sector agencies, which provide bereavement support or counselling. These include specialist providers, e.g. Survivors of Bereavement by Suicide (SOBS) and Footsteps (supporting those bereaved by the death of a baby); providers of generic bereavement counselling, such as Cruse; and support within statutory services, e.g. the Acute Hospitals Trust. The purpose of the Forum is to join up support available to people who have been bereaved, share good practice and training/learning and identify gaps in provision. One of the key issues identified is the lack of awareness of the range of support available and how to access it.

Recommendations:

9.10   Investigate co-productive opportunities for commissioned and non-commissioned services (for example social prescribing and voluntary counselling services) which impact directly on mental health and wellbeing in order to prevent gaps in service or prevent a duplication. Ensure that non-commissioned services can access workforce development opportunities, such as ASIST and ensure that these service providers are invited to the quarterly events for Mental Health Stakeholders.

Chapter 9 recommendations:

9.1.1   This needs assessment supports current efforts to establish a dedicated Place of Safety for Children and Young People population aged 17 and under.

9.1.2   This needs assessment supports the conclusions and recommendations of the report into people who are too intoxicated to be assessed, that there are three POS options: Police Station if unmanageably violent (subject to the final Policing and Crime Act guidance); the Emergency Department for people with serious healthcare needs; and the Maxwell Suite. The majority should be managed safely within the Maxwell Suite, until they are fit to be assessed.

9.1.3   It is recommended that the Inter Agency Monitoring Group (IAMG) should continue to explore ways of reducing the need for use of section 136, especially in regards to repeat detentions, e.g. from specific localities.

9.2.   Ways of reducing the need for use of sections 2 and 3 should be considered, with the focus on increasing prevention and early intervention among young and older adults (20-29 and 70-89 years old), and Black/ African/ Caribbean/ Black British ethnic groups. These approaches should be culturally and age appropriate.

9.3   It is recommended to consider the review of the lower intensity services to prevent higher rates of people admitted in psychiatric hospital and detained under Mental Health Act.

9.4   It is recommended, that the Independence Trust and referrers should consider culturally appropriate ways of promoting access to Gloucestershire Mental Health and Wellbeing Services among people from Black and Ethnic Minorities groups, (particularly in Gloucester, where Black and Ethnic Minority groups make up the highest proportion) and among the LGBT population.

9.5.1   This needs assessment supports the plans identified in the annual report of the Gloucestershire Self Harm Helpline to:
- Increase service promotion and networking, with a particular emphasis on men and BME groups by working with the GCC and local partners to develop effective ways to increase access of the service for these key groups.
- Increase awareness in areas such as the Cotswolds, Forest of Dean and Tewkesbury
- Promote a volunteer scheme to increase service impact and ability to attend local events for promotional purposes.

9.5.2   It is recommended, that commissioners and providers should consider:
- Promotion of the service in the areas with the highest admission rates for self-harm, such as Kingsholm and Wotton, Westgate and other wards identified in Section **8.6.1**
- Finding ways of reaching groups at higher risk of self-harm, identified in chapter **8.6.1**

9.7.1   This needs assessment supports the ongoing work to investigate ways of improving waiting times for first IAPT treatment.

9.7.2   Further analysis is needed to better understand how people from different communities access the IAPT service and what the outcomes are for them.

9.7.3   It is recommended that improvement of referrals numbers and outcomes for people living in

the most deprived areas of Gloucestershire should be prioritised.

9.8.1   Although the current level of overall spend on mental health by GCCG is not highlighted as requiring investigation, further exploration of spend on primary care prescribing could be an opportunity for improvement.

9.8.2   Given the data in Chapter **7.1** that shows the wellbeing of Gloucestershire residents is lower than its statistical neighbours, setting out the local response to national Prevention Concordat for Better Mental Health should be a priority for partners.

9.9.1   Consider undertaking a further analysis of Hypnotics and Anxiolytics and Antidepressant prescribing data in primary care to see if people with mild anxiety or depression receive low-intensity intervention and if the Hypnotics and Anxiolytics and Antidepressant drugs are only prescribed according with the clinical criteria.

9.9.2   Further breakdown of the prescribed Antidepressants by localities is recommended.

9.10   Investigate co-productive opportunities for commissioned and non-commissioned services (for example social prescribing and voluntary counselling services) which impact directly on mental health and wellbeing in order to prevent gaps in service or prevent a duplication. Ensure that non-commissioned services can access workforce development opportunities, such as ASIST and ensure that these service providers are invited to the quarterly events for Mental Health Stakeholders.

10 Perceived and felt needs

Much of our understanding of mental health needs (and supply of and demand for services) is based on prevalence data and information about the use of services. However, we can also develop a greater depth of understanding by triangulating this with qualitative feedback provided by stakeholders about the availability and quality of services, the way in which people experience them and perceived gaps.

This chapter reviews a number of recent sources of views and feedback from stakeholders, including people who use mental health services, their carers and professionals who work for or with services:

- 2gether NHS Foundation Trust Service User Experience Reports for Q2, Q3 and Q4 2015/16 and Q1, Q2, Q3 and Q4 2016/17 (including the findings of the National Community Patient Survey 2015). **N.B. These reports cover both Gloucestershire and Herefordshire and it is not possible to attribute comments/themes to one or other county**
- Healthwatch Gloucestershire Summary of Patient and Public Feedback Reports for April – September 2015, October – December 2015 and January – March 2016 (comments on mental health services only). N.B. These reports are no longer publicly available following a change in Healthwatch provider
- Feedback from the Mental Health and Wellbeing Stakeholder Event held on 4th July 2016.

A note on the sources used

This is not a comprehensive overview of perceived and felt needs and feedback has not been gathered for the particular purpose of this needs assessment. While many stakeholder comments will refer to services provided by 2gether NHS Foundation Trust – particularly those drawn from their Service User Experience Reports – it is important to note that other comments are not always directly attributable to specific services or providers, nor is this chapter intended only to cover 2gether services. Furthermore, it is important to note that there is some crossover in the reports analysed and, whilst efforts have been made to eliminate duplicate feedback, there may be some stakeholders who have fed back the same views through a number of routes. However, there are common themes emerging from this feedback and testing of the issues with stakeholders suggests that these themes are recognisable.

Accessing Services

A commonly occurring area of feedback is a concern about waiting times, primarily for appointments for both assessments and psychological therapies (including Let's Talk). This has been reflected in past performance data and services are working with commissioners to improve waiting times, as described in Chapter 9.7.

Underpinning several comments and concerns is a general feeling that people have to "fight for services". Without exploring this further, it is not clear whether this is because there are real barriers to access; whether people's expectations about services is different to the reality of what is available to them; or both. Linked to this, there is some feedback about what happens when someone needs to access services again after discharge and a feeling that they have to go back to the start of the process with a new GP referral.

A small area of feedback relates to physical access to services, including access in rural areas or where there is a lack of public transport and the accessibility of buildings. Some stakeholders feel that services are too focused on Gloucester. However, as this needs assessment highlights, there is an argument that there is greater need in Gloucester than in other parts of the county. This suggests that there is a challenge in meeting this greater need whilst ensuring people can access services regardless of where they live.

A common theme in the feedback from the stakeholder event is a perception that there is a lack of choice in therapies commissioned and available to service users. However, there is no detail available to understand what sorts of therapies stakeholders believe are missing.

Experiencing Services

Many comments about mental health services relate to communication – both written and verbal – and the importance of this being timely, clear and jargon-free and tailored to the service user. Some feedback emphasises the importance of providing both verbal and written information, noting the importance of staff getting the tone of their communication right.

Linked to this, the importance of keeping the service user and/or their carer informed, particularly when there is a change to service contact details, their care or a delay or cancellation, or if

treatment is refused, is a clear theme. This is also the case for information about the assessment and referral process.

Several comments relate to a perception that services do not always take a person-centred approach and that it is important to emphasise this in training and development. In particular, feedback suggests that some service users feel "done to" rather than feeling involved in decision making and care planning. There is just as much emphasis in the feedback on the importance of listening as on communicating. Linked to this, some feedback refers to a concern that written records do not always reflect service users' views or experiences of a consultation.

A number of comments relate to staffing, specifically the consistency of staffing and cover when staff members are away. Some service users feel that support is only available for a fixed period of time, whether or not they feel ready for support to stop, and that there is no onward support. This is echoed by feedback from some professionals working or volunteering in the field. The potential to link more closely with voluntary sector provision to continue support for service users beyond discharge from NHS mental health services is highlighted below.

Several comments relate to transition between services or when leaving a service and an acknowledgement that services users can be particularly vulnerable at these points. The importance of better communication and focused support during transitions is highlighted, as well as the particular needs of young adults aged 16-25, who are moving between Child & Adolescent Mental Health Services (CYPS in Gloucestershire) and adult mental health services.

Crisis Services

Several comments relate to mental health crisis services and, specifically, awareness of how to contact these services, their availability and ability to access support by telephone. It is important to note that, since these comments have been made, there have been changes to crisis services and the way in which people can get in touch and access them.

However, there are also comments about the importance of earlier intervention and prevention – putting more emphasis on providing help before a person reaches a crisis point – and of being flexible about what "crisis" means to different people, including the service user and their carer, and taking these views seriously.

A small number of comments relate to a perceived lack of crisis support for people who have been drinking alcohol.

Partnerships & Information Sharing

Comments have been made by service users and their carers and professionals working or volunteering in services that there should be greater partnership working and an improved understanding between organisations, particularly between mental health services and housing services; mental health services and drug and alcohol services; and mental health and physical health professionals. This is echoed by the evidence highlighted in Chapters 0 and 0 on the relationship between mental illness and physical long-term conditions and mental illness and substance misuse. Feedback suggests that this approach should include joined-up and accessible information about what is available.

In particular, the issue of information sharing is commonly cited in feedback, with service users and their carers expressing a desire not to have to repeat their story to different professionals and for there to be consistency in the information shared both within and beyond organisations.

However, this is balanced by feedback that some service users wish to be kept informed about what information has been shared about them and a small number of comments that service users did not wish to have their information shared, e.g. with the Police or their GP.

It is also interesting to note that in feedback to Healthwatch Gloucestershire, the overwhelming majority of compliments made in relation to mental health were for services provided by voluntary and community sector organisations. Comments include an acknowledgement of the sector's role in social inclusion, preventing crisis and working in partnership with people with lived experience. However, stakeholders commonly noted that they do not know enough about what is available from voluntary and community sector partners.

These organisations play an important part in the landscape of mental health support and are clearly valued by those that use them. Commissioners and NHS providers should continue to work alongside voluntary and community sector partners to improve the understanding of and access to the range of services and support that is available. Given the feedback outlined above, that some service users feel there is no onward support after being discharged from NHS mental health services, this may be a particular area where closer alignment with voluntary and community sector services could be beneficial.

There is a particularly common theme in the feedback from the Mental Health Stakeholder Event around the role of people with lived experience of mental illness, both in informing the way services are commissioned and delivered and in providing peer support to others. Whilst the involvement of people with lived experience has been increasing in recent years, it is important to note that further work can always be done to improve this.

Relatives and Carers

There are some very common themes in the feedback relating to the experiences of relatives and carers of people with a mental illness, including:

- A perceived lack of support for relatives and carers. Chapter **0** highlights the fact that relatives and carers of people with a mental illness are at a higher risk of developing poor mental health themselves. Commissioners should consider the preventative benefits of ensuring relatives and carers can access support, whether through statutory or voluntary sector services or peer support.
- A feeling that relatives and carers are not kept informed or listened to by professionals, taken seriously or engaged in care planning, even when they know 'what works' e.g. in a crisis situation. Relatives and carers comment that this is particularly frustrating when the person they are caring for is unable, for whatever reason, to speak for themselves. Significant work has already taken place in 2gether NHS Foundation Trust through the Triangle of Care[219] approach.

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[219] The 'Triangle of Care' is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains well being (http://static.carers.org/files/caretriangle-web-5250.pdf)

However, service providers should continually review the ways in which relatives and carers are enabled to be involved in care planning.

The needs of specific groups

Some professionals highlight the need for improved guidance on how to best support people with mental health problems and learning disabilities, including a better understanding of the role of the Learning Disability Hospital Liaison Nurse team. Chapter **6.1** refers to the higher risk that people with a learning disability have of developing poor mental health and the particular issues they face.

Related to this, a small area of feedback relates to the ability to access services when an individual has other specific needs, e.g. Autism Spectrum Condition.

Healthwatch Gloucestershire highlights a small number of concerns about the support available for the armed forces community and specifically for Post Traumatic Stress Disorder (PTSD). The particular mental health needs of the armed forces community are highlighted in Chapter **6.15** but the commissioning landscape for this community is complex. However, the NHS England report, *Implementing the Five Year Forward View for Mental Health[220]*, identifies a need to develop new services, co-commissioned by Clinical Commissioning Groups and the Ministry of Defence, to respond to the particular problems and complex presentations within the armed forces community (including veterans), including for PTSD substance misuse.

In October 2016, Healthwatch Gloucestershire published a report on *Access to Health & Social Care Services by Marginalised and Vulnerable People in Gloucester[221]*. This identified that support with mental health problems is seen as a particularly significant issue amongst this group. The report recommends that a review be undertaken of the pathways for marginalised and vulnerable people needing mental health support.

Recommendations:

10.1   Commissioners and service providers should continue to seek opportunities to gain feedback about services from service users, carers and other stakeholders and, in particular, from those who are seldom heard, vulnerable or marginalised.

10.2   Consideration should be given to whether or not the pathway for services users who have been discharged but need to come back in to the service is effective.

10.3   When planning new or enhanced services, commissioners should aim to balance geographical need with ensuring people have access to the service they need, regardless of where they live.

10.4   Opportunities to improve partnership working and information sharing between professionals and organisations, including voluntary and community sector organisations, should be maximised. In particular, this relates to housing services, substance misuse services, services that support young people transitioning to adult services and services supporting people's physical health

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[220] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
[221] http://www.healthwatchgloucestershire.co.uk/News/Report_access_services_marginalised_vulnerable_Glo.aspx?page=62569

needs. It also relates to the continuity of support for service users after they have been discharged from specialist mental health services.

10.5   Consideration should be given to ensuring that workforce training and development is consistent and based on a person-centred approach and takes in to account training needs relating to appropriate sharing of information and working with carers.

10.6   Commissioners should review what support is available to carers, whether through statutory, voluntary or peer support.

10.7   Opportunities to improve understanding of how to best support people with mental health problems and learning disabilities should be considered.

10.8   Commissioners should bear in mind the feedback regarding support and NHS England plans to review mental health services for the armed forces community, particularly provision of support for PTSD.

11 Recommendations

The following recommendations are made to support the development of the local Mental Health and Wellbeing strategy. Some of these recommendations are also directed to any commissioning strategy and policy, which impacts on mental health and wellbeing of Gloucestershire residents, including beyond specialist mental health services.

The recommendations cover the areas of universal mental health promotion, targeted mental health promotion and mental health treatment and services. The recommendations also identify areas for further work or exploration.

Universal Mental Health Promotion

- The ageing population suggests that we should consider:
  - Promotion of good mental health in ways that best reach and are appropriate to older people, e.g. 'Keeping Active' with opportunities that can be tailored to older people (e.g. five ways to wellbeing described in Section 5.1) (Recommendation 4.1.1)
  - Ensuring training, e.g. Mental Health First Aid (MHFA), is promoted/accessible to people working with older people (Recommendation 4.1.2)
- Engagement with local planning authorities to ensure that housing growth takes into account the wider determinants of good mental health and can create healthy living environments (Recommendation 4.2)
- Partners across the system should consider the impact of the wider determinants set out in Section 5 on mental health and wellbeing to deliver a truly preventative approach to public mental health. The forthcoming National Prevention Concordat for Better Mental Health should provide a helpful framework for leadership by the Health & Wellbeing Board of this work. (Recommendation 5)
- Early prevention of mental health issues should be considered for the predicted rise in the older population with learning disabilities (Recommendation 6.1.2)
- Further work is needed to support debt services on mental health screening and referral links for people reporting debt. Mental health professionals should ensure that the patients are asked about financial difficulties and accordingly signposted to the money advice sectors; this could be achieved by working close with social prescribing services (Recommendation 6.10.1)
- Training for debt advisors in Mental Health First Aid should be considered (Recommendation 6.10.2)
- Ensure that efforts to improve mental wellbeing are appropriately targeted by gender, ethnicity, disability and religious affiliation (Recommendation 7.1.1)
- In order to improve local personal well-being, promotion of well-being programmes, such as "5 ways to well-being" and mindfulness should be continued and, where possible, enhanced. Campaigns should be undertaken in ways and places relevant to the equality groups, especially people who are disabled and people from ethnic and religious minority groups (Recommendation 7.1.2)
- Work on the wider determinants of wellbeing should focus on health, employment and relationship status (Recommendation 7.1.3)

- A refresh of the local attitudes to mental health illness survey is recommended to review whether positive attitudes increased in line with the national data. This would also evaluate, whether the actions to decrease stigma and discrimination in Gloucestershire have been successful. It is recommended that the survey sample has adequate representation from the groups and areas identified to have less supportive attitudes. Any further actions to tackle stigma should emphasise mental health and wellbeing within the workplace (Recommendation 7.2)
- Continue existing community based initiatives and services provided by the public, private and charitable sectors dedicated to reducing social isolation. Consider developing additional community based initiatives (Recommendation 7.3.1)
- Promotion of social prescribing among Gloucestershire residents is recommended (Recommendation 7.4.1)
- Partners should ensure that services that support mental health and wellbeing and those services addressing the wider determinants of mental health, provided by both the public and voluntary sector, are known about and shared for the use of social prescribers (Recommendation 7.4.2)
- Given the data in Chapter 7.1 that shows the wellbeing of Gloucestershire residents is lower than its statistical neighbours, setting out the local response to national Prevention Concordat for Better Mental Health should be a priority for partners (Recommendation 9.8.2)

Targeted Mental Health Promotion

- Investigating further training needs for services that are in contact with domestic abuse victims, e.g. mental health, suicide prevention. Commissioners should ensure that there is an awareness of mental health pathways and support and that signposting is available (Recommendation 6.3.1)
- Care leavers should receive support and guidance about their Mental Health needs and how they will be met by service, before and after they turn 18 (Recommendation 6.5.1)
- Further work should be undertaken to support the skills and knowledge of those in contact with care leavers (such as health professionals, teachers, social workers) to support the care leaver's mental health (Recommendation 6.5.2)
- Commissioners and providers, who are in contact with homeless people, should continue to improve their ways of working together, to make sure that people get help for their complex needs. Further work is needed to ensure that Gloucestershire Crisis Care Concordat Workforce Development Group will reach all groups who are in touch with homeless people. A planned Joint Strategic Needs Assessment should provide the leadership on addressing health needs, including mental health needs, and other determinants of poor mental health. (Recommendation 6.6)
- Further work should be done to identify the local evidence on differences in prevalence of mental health problem between ethnic groups, especially for women. Mental health early intervention and anti-stigma strategies should be reviewed, to ensure they are culturally appropriate and culturally customised. Mental health services should engage with organisations dealing with racial discrimination to identify and reduce the ethnic inequalities in mental health (Recommendation 6.7)

- Ensure carers' assessments include information about mental health (Recommendation 6.11.2)
- Prevention of poor mental health should include strategy on reducing stigma and discrimination against LGBT population (Recommendation 6.13.1)
- Joined-up approach with service user representatives, such as Healthwatch, should be undertaken to improve engagement of LGBT people and understanding of barriers to accessing services (Recommendation 6.13.2)
- Consider designing intervention and prevention campaigns targeted at LGBT population (Recommendation 6.13.3)
- This needs assessment support the recommendations of the *Health and Well-Being of Trans People in Gloucestershire and Bristol* of better understanding the factors which impact on the mental wellbeing of Transgender people especially with regard to self-harm and suicide; and including Transgender people's mental health needs into general suicide prevention policies (Recommendation 6.13.4)
- Mental health commissioners and providers should consider what initiatives they could support to improve understanding of the size of certain groups of the Armed Forces Community and the scale of mental health needs, particularly when it comes to Veterans and the families of serving personnel (Recommendation 6.16.2)
- Target those at risk of social isolation, especially in the most prevalent areas. Involve those at risk in designing and delivering solutions that address social isolation and inequalities (Recommendation 7.3.2)
- There should be a focus on early intervention for anxiety, especially in Cotswold district and on mental health promotion in high deprivation areas, especially in Gloucester (Recommendation 8.3.1)
- Promote help seeking within community services, such as Self-Harm Helpline, especially among people living in the most deprived areas of Gloucester and Cheltenham (Recommendation 8.6.1.2)
- Training in mental health awareness and suicide prevention should be targeted and available to all working with high risk groups (Recommendation 8.6.2.1)
- Suicide prevention methods should be reviewed by their cost effectiveness and considered for investment (Recommendation 8.6.2.2)
- Further work with local planners and developers should be undertaken to decrease risks of suicide opportunities (Recommendation 8.6.2.3)
- It is recommended, that commissioners and providers should consider:
  - Finding ways of reaching groups at higher risk of self-harm, identified in Section 8.6.1 (Recommendation 9.5.2)
- Commissioners should review what support is available to carers, whether through statutory, voluntary or peer support (Recommendation 10.6)

Mental Health Treatment and Services

- The ageing population suggests that we should consider:
  - Ensuring mental health support and services are accessible and appropriate for older people (Recommendation 4.1.3)

- People with learning disabilities may experience additional barriers in accessing mental health services, therefore further work is needed to identify barriers and improve local access to mental health services (Recommendation 6.1.1)
- There should be continued efforts to further align support for people with co-occurring long-term conditions or physical disabilities and mental health problems, including training and support for clinicians working with physical conditions to identify and signpost/refer to help for mental health problems (Recommendation 6.2)
- This adult mental health needs assessment supports the recommendations of the *Therapeutic Services for Victims of Sexual Violence in Gloucestershire* (2016): improving access to and managing demand for therapeutic services and developing service pathways for victims of sexual violence. Further, it is recommended that mental health commissioners are engaged in this process to ensure a joined up approach (Recommendation 6.3.2)
- Due to their multiple needs, people with a dual diagnosis of both mental health and substance misuse disorders require good communication and coordination between services they use. Mental health, substance misuse and other services, such as housing and social care, should work together to provide care and support their needs. (Recommendation 6.4)
- Given the higher levels of Common Mental Disorders (CMD) amongst the military population that already exist and a clear level of rising demand for mental health services amongst both serving personnel and Veterans as a whole, mental health commissioners and providers should consider the impact that this may have in both the immediate and long term future (Recommendation 6.16.1)
- Mental Health Commissioners should consider how they could best support third sector mental health providers, who support military families and Veterans, to ensure that the needs of these particular groups are met (Recommendation 6.16.3)
- This Needs Assessment supports the recommendations from: *Personality Disorders Recommendation Report:*

    raising awareness and education for all services around personality disorder and for GPs; further investigation whether having diagnosis earlier helps clinicians and patients; development of a screening tool to rule out personality disorder early on in the pathway; raising awareness and improving access to services for people from vulnerable and hard to reach groups, such as: black and ethnic minority groups, people with a learning disability, self-harming individuals, drug and alcohol patients, Crisis House users, people with complex and severe personality disorder.

    Further, it is recommended that mental health commissioners and other commissioners (e.g. substance misuse or housing) are engaged in this process to ensure a joined up approach (Recommendation 8.4)
- Work in partnership with hospital trust and groups at higher risk of self-harm to gain further understanding of Gloucestershire's high admission rates and repeat admissions. (Recommendation 8.6.1.1)
- This needs assessment supports the actions in the recently developed *Mental Health Crisis Care Concordat Action Plan* to develop a vision and actions based on a strategic framework for developing an all age self-harm evidence-based care pathway (Recommendation 8.6.1.3)
- This needs assessment supports current efforts to establish a dedicated Place of Safety for Children and Young People population aged 17 and under (Recommendation 9.1.1)

- This needs assessment supports the conclusions and recommendations of the report into people who are too intoxicated to be assessed, that there are three POS options: Police Station if unmanageably violent (subject to the final Policing and Crime Act guidance); the Emergency Department for people with serious healthcare needs; and the Maxwell Suite. The majority should be managed safely within the Maxwell Suite, until they are fit to be assessed (Recommendation 9.1.2)
- It is recommended that the Inter Agency Monitoring Group (IAMG) should continue to explore ways of reducing the need for use of section 136, especially in regards to repeat detentions, e.g. from specific localities (Recommendation 9.1.3)
- Ways of reducing the need for use of sections 2 and 3 should be considered, with the focus on increasing prevention and early intervention among young and older adults (20-29 and 70-89 years old), and Black/ African/ Caribbean/ Black British ethnic groups. These approaches should be culturally and age appropriate (Recommendation 9.2)
- It is recommended to consider the review of the lower intensity services to prevent higher rates of people admitted in psychiatric hospital and detained under Mental Health Act (Recommendation 9.3)
- It is recommended, that the Independence Trust and referrers should consider culturally appropriate ways of promoting access to Gloucestershire Mental Health and Wellbeing Services among people from Black and Ethnic Minorities groups, (particularly in Gloucester, where Black and Ethnic Minority groups make up the highest proportion) and among the LGBT population (Recommendation 9.4)
- This needs assessment supports the plans identified in the annual report of the Gloucestershire Self Harm Helpline to:
  - Increase service promotion and networking, with a particular emphasis on men and BME groups by working with the GCC and local partners to develop effective ways to increase access of the service for these key groups.
  - Increase awareness in areas such as the Cotswolds, Forest of Dean and Tewkesbury
  - Promote a volunteer scheme to increase service impact and ability to attend local events for promotional purposes (Recommendation 9.5.1)
- It is recommended, that commissioners and providers should consider:
  - Promotion of the service in the areas with the highest admission rates for self-harm, such as Kingsholm and Wotton, Westgate and other wards identified in Section 8.6.1
- This needs assessment supports the ongoing work to investigate ways of improving waiting times for first IAPT treatment (Recommendation 9.7.1)
- It is recommended that improvement of referrals numbers and outcomes for people living in the most deprived areas of Gloucestershire and accessing IAPT services should be prioritised (Recommendation 9.7.3)
- Investigate co-productive opportunities for commissioned and non-commissioned services (for example social prescribing and voluntary counselling services) which impact directly on mental health and wellbeing in order to prevent gaps in service or prevent a duplication. Ensure that non-commissioned services can access workforce development opportunities, such as ASIST and ensure that these service providers are invited to the quarterly events for Mental Health Stakeholders (Recommendation 9.10)

- Commissioners and service providers should continue to seek opportunities to gain feedback about services from service users, carers and other stakeholders and, in particular, from those who are seldom heard, vulnerable or marginalised (Recommendation 10.1).
- Consideration should be given to whether or not the pathway for services users who have been discharged but need to come back in to the service is effective (Recommendation 10.2).
- When planning new or enhanced services, commissioners should aim to balance geographical need with ensuring people have access to the service they need, regardless of where they live (Recommendation 10.3).
- Opportunities to improve partnership working and information sharing between professionals and organisations, including voluntary and community sector organisations, should be maximised. In particular, this relates to housing services, substance misuse services, services that support young people transitioning to adult services and services supporting people's physical health needs. It also relates to the continuity of support for service users after they have been discharged from specialist mental health services (Recommendation 10.4).
- Consideration should be given to ensuring that workforce training and development is consistent and based on a person-centred approach and takes in to account training needs relating to appropriate sharing of information and working with carers (Recommendation 10.5)
- Opportunities to improve understanding of how to best support people with mental health problems and learning disabilities should be considered (Recommendation 10.7).
- Commissioners should bear in mind the feedback regarding support and NHS England plans to review mental health services for the armed forces community, particularly provision of support for PTSD (Recommendation 10.8)

Areas for further work/exploration

- Further review of literature needs to be completed to establish the relationship between mental health among the Gypsy and Traveller community. The overall small numbers in Gloucestershire suggest that there is no necessity to prioritise this group over the other vulnerable groups. However, any public communication on mental health problems and services should consider the ways to reach this group (Recommendation 6.8)
- Locally decreasing trends of numbers of long-term unemployed people and rates lower than the national average, suggest that this group out of all vulnerable groups is not in the highest priority. However, further investigation into the Gloucestershire profile of economically inactive people is required to understand the "size "of their mental health needs (Recommendation 6.10)
- Comprehensive evaluation of local carers' views would help identify their mental health needs and the ways of preventing of poor mental health; the results of the evaluation currently being carried out by 2gether NHS Foundation Trust might help to balance the reported views of carers (Recommendation 6.11.1)
- Based on the higher than national rate of asylum seeker and the growing trend in the size of this population further assessment of mental health needs is recommended to inform prevention and early intervention services and identify gaps in service provision or access (Recommendation 6.12)
- Future trends of an aging population indicate that the numbers of people living with dementia is likely to increase. Taking into account the complexity of the co-existing dementia and mental

health problems it is recommended that further work is needed to investigate the mental health needs of people living with dementia. This would include the development of relationship between organisations supporting people with mental health needs and dementia (Recommendation 6.14)

- A refresh of the audit of mental health conditions within Primary Care should be undertaken, expanded by including the specification of the population characteristics. This would help identify whether people from vulnerable groups are reporting mental health conditions (Recommendation 8.3.2)
- Further analysis is needed to better understand how people from different communities access the IAPT service and what the outcomes are for them (Recommendations 9.7.2)
- Although the current level of overall spend on mental health by GCCG is not highlighted as requiring investigation, further exploration of spend on primary care prescribing could be an opportunity for improvement (Recommendation 9.8.1)
- Consider undertaking a further analysis of Hypnotics and Anxiolytics and Antidepressant prescribing data in primary care to see if people with mild anxiety or depression receive low-intensity intervention and if the Hypnotics and Anxiolytics and Antidepressant drugs are only prescribed according with the clinical criteria (Recommendation 9.9.1)
- Further breakdown of the prescribed Antidepressants by localities is recommended (Recommendation 9.9.2)

Appendix 1 Abbreviations

Abbreviations used throughout this document are listed in the table below:

2gether NHSFT - 2gether NHS Foundation Trust

ADHD - Attention Deficit Hyperactivity Disorder

AMHP - Approved Mental Health Professional

APMS - Adult Psychiatric Morbidity Survey

ASIST - Applied Suicide Intervention Skills Training

A&E - Accident and Emergency

BME - Black and Minority Ethnic Groups

CAMHS - Child and Adolescent Mental Health Services

CCG - Clinical Commissioning Group

CMHD - Common Mental Health Disorders

CMHT - Community Mental Health Teams

CNS - Central Nervous System

CORE - Clinical Outcome in Routine Evaluation

CRHTT - Crisis Resolution and Home Treatment Team

DASV - Domestic Abuse and Sexual Violence

GARAS - Gloucestershire Action for Refugees and Asylum Seekers

GCC - Gloucestershire County Council

GCCG - Gloucestershire Clinical Commissioning Group

GP - General Practice

GRASAC - Gloucestershire Rape and Sexual Abuse Centre

GRIP - Gloucestershire Recovery in Psychosis

GSPPF - Gloucestershire Suicide Prevention Partnership Forum

IAPT - Improving Access to Psychological Therapies

ICT - Integrated Community Teams

IMD - Indices of Multiple Deprivation

JSA - Jobseeker Allowance

KCL - King's College London

LGBT - lesbian, gay, bisexual or transgender

LSOA - Lower Super Output Areas

MHA - Mental Health Act

MHARS - Mental Health Acute Response Service

MHFA - Mental Health First Aid

MHSDS - Mental Health Services Data Set

MINI 2000 - Mental Health Needs Index 2000

MOD - Ministry of Defence

MWIA - Mental Well-being Impact Assessment

NEET - not in education, employment or training

NHS – National Health Service

NICE – The National Institute for Health and Care Excellence

OCD - obsessive–compulsive disorder

ONS - Office for National Statistics

PANSI - Projecting Adult Needs and Service Information

POS - Places of Safety

PTSD - post-traumatic stress disorder

QOF - Quality and Outcome Framework

RAF - Royal Air Force

SARC - Sexual Assault Referral Centres

SMI - Severe Mental Illness

SOBS - Survivors of Bereavement by Suicide

SPOT - Spend and Outcome Tool

STAR-PU - Specific Therapeutic Group Age-sex weightings Related Prescribing Units

STP - Sustainability and Transformation Plan

TTH - Time to Heal

UCL - University College London

UK - United Kingdom

WEMWBS - Warwick-Edinburgh Mental Wellbeing Scale

WHO - World Health Organization

Appendix 2 Gloucestershire population breakdown (tables)

Table 28 Population by broad ethnic group, Gloucestershire, 2011 [222]

	White (%)	Black and Ethnic Minority (%)
Cheltenham	94.3	5.7
Cotswold	97.8	2.2
Forest of Dean	98.5	1.5
Gloucester	89.1	10.9
Stroud	97.9	2.1
Tewkesbury	97.5	2.5
Gloucestershire	**95.4**	**4.6**
England	85.4	14.6

Table 29 Breakdown of White population, Gloucestershire, 2011[223]

	Total White	English/ Welsh/ Scottish/ Northern Irish/ British	Irish	Gypsy or Irish Traveller	Other White
Cheltenham	109,084	102,140	1,058	68	5,818
Cotswold	81,075	78,284	503	87	2,201
Forest of Dean	80,699	79,227	277	78	1,117
Gloucester	108,462	102,912	850	136	4,564
Stroud	110,426	107,026	591	57	2,752
Tewkesbury	79,901	77,010	480	305	2,106
Gloucestershire	**569,647**	**546,599**	**3,759**	**731**	**18,558**
England	45,281,142	42,279,236	517,001	54,895	2,430,010

Table 30 Breakdown of Black and Ethnic Minority population[224]

	Total Black and Ethnic Minority	Mixed/ Multiple Ethnic Group	Asian/Asian British	Black/ African/ Caribbean/ Black British	Other Ethnic Group
Cheltenham	6,648	1,878	3,675	721	374
Cotswold	1,806	698	794	229	85
Forest of Dean	1,262	528	473	199	62
Gloucester	13,226	3,565	5,839	3,486	336
Stroud	2,353	1,216	751	260	126
Tewkesbury	2,042	776	901	255	110
Gloucestershire	**27,337**	**8,661**	**12,433**	**5,150**	**1,093**
England	7,731,314	1,192,879	4,143,403	1,846,614	548,418

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[222] Gloucestershire County Council (2016) *Population Profile*,
https://inform.gloucestershire.gov.uk/ViewPage1.aspx?C=Resource&ResourceID=126&cookieCheck=true
(accessed on 23/01/17)
[223] Ibid
[224] Ibid

Appendix 3 Suicide Prevention Profile for Gloucestershire

Table 31 Gloucestershire Suicide Profile (female suicide data – the local authority level age group on female suicide data rates are reported as those for the region in within the local authority resides)

Indicator	Period	Glouc'shire			Region England	England				
		Recent Trend	Count	Value	Value	Value	Lowest	Range		Highest
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2013 - 15	–	171	10.6	11.0	10.1	5.6			17.4
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2013 - 15	–	136	17.1	16.2	15.8	8.5			27.5
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2013 - 15	–	35	4.3	6.1	4.7	-	Insufficient number of values for a spine chart		-
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	–	177	40.9	35.6	31.9	10.7			62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	–	142	65.2	52.6	50.2	16.4			101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	–	35	16.7	18.6	13.7	0.0			26.2
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male)	2011 - 15	–	59	13.4	10.8	10.5	4.5			25.3
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Female)	2011 - 15	–	153	4.0*	4.0	2.9	2.5			4.0
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2011 - 15	–	155	25.6	22.2	20.8	8.9			39.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2011 - 15	–	381	7.1*	7.1	6.0	5.0			7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2011 - 15	–	37	13.7	13.6	12.6	2.9			26.2
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2011 - 15	–	170	5.6*	5.6	4.4	3.7			5.6

Source: Public Health England, Suicide Prevention Profile, https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/1/gid/1938132828/pat/6/par/E12000009/ati/102/are/E10000013, accessed on 01/03/2017

Compared with benchmark ● Lower ○ Similar ○ Higher ○ Not Compared

Data quality: ■ Significant concerns ■ Some concerns ■ Robust

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