Gloucestershire Adult Mental Health Needs Assessment

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Produced in partnership by Gloucestershire County Council and NHS Gloucestershire Integrated Care Board

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One Gloucestershire
Transforming Care, Transforming Communities

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Thank you to all who assisted in the preparation of this report.

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Executive Summary

This Mental Health Needs Assessment (MHNA) was undertaken to better understand the needs of adults in Gloucestershire who require support for their mental health. We aimed to achieve a shared understanding of the mental health needs of Gloucestershire residents in order to inform the commissioning and provision of services. We aimed to understand the prevalence of current and projected population demographics that are associated with poor mental health, including the wider determinants of mental health.

This MHNA aims to bring together relevant reports and recommendations to support a cohesive and collaborative approach to Mental Health care in the county. Where data is not yet available, or there is potential for further work to be undertaken, recommendations will be made for further assessment and analysis to be completed. Findings from this MHNA will provide valuable insights into the needs of the population and feed directly into the strategic updates. The main theme from multiple sources was a call for the focus of future commissioning and services to be on joined up working and individualised patient care.

We developed a tool to analyse mental health service user data to better understand how different demographics move through a specific service. Due to unavoidable time frame limitations, we were not able to analyse as many services as planned but the tool remains a useful asset for further analysis. Senior project team members decided that the focus of our analysis time should be Eating Disorders, the Recovery service and Mental health attendances to Emergency Departments and Minor Injury and Illness Units (MIIU). The findings from the analysis are not included in this summary, as there remains an outstanding action to engage with the services and gather additional information (see Chapter 3 summary for the points that need further discussion with the services).

<u>Recommendations:</u>

The following recommendations are drawn from synthesising local quantitative and qualitative analysis.

Integrated approach to commissioning services for individuals needing support in multiple areas

- Mental health issues should be considered in the wider social context that a person is living in, including homelessness, substance misuse and domestic abuse.
- Joint working and co-location between mental health services and services that support those with substance misuse issues, those needing domestic abuse support services and those with wider complex needs.

Increased connectedness between Partnership boards with overlapping themes and priorities

- We need to consider how we can work together on a strategic level between partnerships to improve social connectedness and wellbeing in our communities as a form of primary prevention for social isolation, loneliness, and mental health conditions.

Consider wider determinants of health in developing mental health support

- Increased understanding of how wider determinants can have a big impact on an individual's mental health
- Commissioners and providers should continue to consider wider determinants such as employment opportunities and housing when supporting individuals' mental health

Increase understanding and awareness of mental health services (including Voluntary and Community Sector) in the county

- Consider how we can improve healthcare professionals' awareness and understanding of the range and scope of mental health services in the county, both commissioned and Voluntary and Community Sector (VCS), to improve signposting to patients
- Normalise conversations about improving wellbeing (eg 5 ways of wellbeing) and community involvement as a way of improving mental health resilience in our population (similar to Make Every Contact Count for physical health).

Preparing for changes in population demographics and addressing unmet needs:

- Commissioners and those planning or providing services need to ensure that our services are accessible to older people, and encourage engagement with preventative services for those approaching older age. They need to ensure that methods of accessing support are suitable for older ages and consider the impact of an aging population on those who will be caring for them and be proactive with signposting to mental health support for carers.

<u>Recommended further work required to greater understand our population need.</u>

- Integrate findings from the Gloucestershire Drug and Alcohol Needs Assessment 2022
- Integrate findings from the engagement work with individuals from minority ethnic communities
- Utilise the Population Health Management tool (developed in the statistical program R) for greater understanding of other mental health services in the county
- Integrate the 2021 Census findings on specific vulnerable groups which we have not had access to before (LGBTQ+ and Veterans).
- Engage with Gloucestershire Action for Refugees and Asylum Seekers (GARAS) as they have highlighted that we can better understand the needs of Gloucestershire's asylum seeker and refugee population, and the difficulties that they face in accessing mainstream services.

Chapter 1: Overview

Scope and purpose of the needs assessment

A health needs assessment aims to identify the needs of a local population in order to understand whether these needs are being met. This is an epidemiological mental health needs assessment[1] (MHNA) of the adult population of Gloucestershire and will consider the known and estimated prevalence of mental health conditions within Gloucestershire, and whether this is reflected in the population who are seeking help from our mental health services. Where the data allows, the needs assessment will also analyse the demographics of the people coming into Gloucestershire's mental health services to determine if any sub-groups within the population have unmet needs. The MHNA will also use the projected prevalence of mental health conditions, and the projected changes in Gloucestershire population demographics, to guide the planning of future service provision.

This MHNA aims to inform local Mental Health projects and strategies that are currently being undertaken or considered. It also aims to bring together relevant reports and recommendations to support a cohesive and collaborative approach to Mental Health care in the county. Where data is not yet available, or there is potential for further work to be undertaken, recommendations will be made for further assessment and analysis to be completed.

National drivers and policies

National drivers and policies have an impact on decisions and strategies at a local level. Some areas of need identified in this MHNA may already be identified nationally and have commitments in place to improve mental health care for our local population.

NHS Mental Health Implementation Plan

As part of the NHS Long Term Plan, the NHS Mental Health Implementation Plan 2019/20 – 2023/24 sets out the priorities for improving adult and older adult mental health[2]. The key commitments for adult mental health from the plan include:

- **Crisis and acute mental health:** the Long Term Plan commits to ensuring people can access a comprehensive set of crisis and acute services across the country. Gloucestershire has met the commitment to have a 24/7 mental health crisis service by 2021.
- **Crisis alternatives**: Every area has been allocated funding to invest in alternative models of crisis support, such as crisis cafes, safe havens, and crisis houses, providing an alternative to A&E or inpatient psychiatric admission.
- **Simplifying access to urgent mental health support through NHS 111:** By 2023/24, anyone seeking urgent mental health support in England will be able to do so via the simple universal 3-digit 111 number.
- **Specialist liaison mental health teams in emergency departments and general hospital wards**: to ensure that when people with mental health needs attend A&E, it is equipped to meet their mental as well as physical needs.
- **Clinically-led review of standards for urgent and emergency mental health care**: 11 pilot mental health trusts are currently testing the feasibility of introducing waiting time and quality standards for urgent mental health services.

[1] An epidemiological approach considers the epidemiology of the condition and of the current service provision. The uses of epidemiology and other methods in defining health service needs and in policy development | Health Knowledge

[2] NHS England » Adult and older adult mental health

- **Response to mental health from the Ambulance service**: In recognition of the significant role the ambulance service plays in responding to mental health calls, for the first time there will be a dedicated national investment programme to improve capacity of the ambulance service to meet mental health needs.
- **Therapeutic inpatient mental health care:** For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. It is important that care is purposeful, patient-orientated and recovery-focused from the outset, so that people have a good experience of care and do not spend more time in hospital than necessary.

The plan also encompasses a commitment to developing new and integrated models of primary and community mental health care. Key areas of focus include[3]:

- **The Community Mental Health Framework for Adults and Older Adults**: The new Community Mental Health Framework describes how the Long Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks.
- **Adult Eating Disorders Guidance**: As part of work on community based mental health care for adults, alongside work to explore the effectiveness of different approaches to integrated delivery with primary care, NHS England and NHS Improvement are working to improve availability and access to community eating disorder services for adults.
- **Early Intervention in Psychosis (EIP**): The EIP standard remains a priority of the NHS, and the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 set out continued commitment to building on successful work to date in implementing the national access and waiting time standard.
- **Improving physical health care for people with severe mental illnesses (SMI):** NHS England is leading work to reduce the premature mortality among people living with SMI.
- **Individual Placement and Support (IPS):** In order to support more people with severe mental illnesses to find and retain employment, NHS England has committed to increase access to IPS services to support 55,000 people a year by 2023/24.
- **Suicide prevention:** NHS England and Improvement is building on the progress made in the Five Year Forward View, which had already committed to reducing the suicide rate by 10% by the end of 2020/21.
- **Suicide Bereavement Support:** By 2023/24 NHSE plan that 100% of STPs will be providing suicide bereavement support services.

Covid 19 mental health and wellbeing recovery action plan[4]

The COVID-19 pandemic has had an ongoing impact on the general population's mental health. The COVID-19 mental health and wellbeing surveillance report[5] is a high-level summary of the COVID-19 pandemic's impact on the mental health and wellbeing of the population in England. They report that multiple studies revealed deteriorations in mental health and wellbeing between March and May 2020, followed by a period of improvement through July, August and September 2020 to a point where levels were comparable to before the pandemic. There was a second deterioration in population mental health and wellbeing between October 2020 and February 2021, followed by another period of recovery but not to pre-pandemic levels. Some groups have been more likely to experience poor or deteriorating mental health during this period. These include women, young adults (aged between 18 and 34), adults with pre-existing mental or physical health conditions, adults experiencing loss of income or employment, adults in deprived neighbourhoods,

[3] NHS England » Adult and older adult mental health
[4] COVID-19 mental health and wellbeing recovery action plan (publishing.service.gov.uk)
[5] 2. Important findings - GOV.UK (www.gov.uk) last updated 18/11/2021

some ethnic minority populations and those who experienced local lockdowns. In addition, those who felt lonely, felt a lack of control over their lives, who found uncertainty difficult or who were anxious about death were also more likely to experience worse or deteriorating mental health[6].

The national governments plan for mental health and wellbeing recovery include:

- Supporting the general population to take action and look after their mental wellbeing
- Preventing the onset of mental health difficulties, by taking action to address the factors which play a crucial role in shaping mental health and wellbeing outcomes for adults and children
- Supporting services to continue to expand and transform to meet the needs of people who require specialist support

Local drivers and policies

All Age Mental Health and Wellbeing Strategy for Gloucestershire[7]

The current Mental Health and Wellbeing strategy covers the period of 2018-2023, with the vision for every resident of Gloucestershire to enjoy the best possible mental health and wellbeing throughout the course of their life. The seven themes of the strategy are:

- Increase the focus on the wider factors of mental wellbeing and promote good mental health for all
- Get better at spotting the signs of mental ill health and intervening earlier
- Improve the outcomes for people experiencing mental health crisis
- Improve the wellbeing of parents, children and young people
- Continue to improve joined up approaches to reducing suicide rates across Gloucestershire
- Focus on recovery and resilience
- Ensure Gloucestershire is a mental health friendly county

The findings and recommendations from this MHNA will inform the development of the next strategy.

Interim Mental Health Strategic Update

To reflect the changing requirements of our mental health services due to the impact of Covid-19, and to prepare for the next All Age Mental Health and Wellbeing Strategy from 2023, an Interim Strategic Update was produced to review our medium-term priorities. The update encompassed feedback from local mental health stakeholders as well as experts by lived experience. Findings from this MHNA will provide valuable insights into the needs of the population and feed directly into the strategic updates.

Community Mental Health Transformation (CMHT) (2021-2023)

To reflect increasing levels of demand and complexity in the population, Mental Health partners in Gloucestershire are working together to transform our whole model of Mental Health Care and support over the next three years. Community mental health services have long played a crucial yet under-recognised role in the delivery of mental health care. They provide vital support to people with mental health closer to their homes and communities since the establishment of generic community mental health teams (CMHTs) for adults 30 years ago. However, the model of care is now in need of fundamental transformation and modernisation. This MHNA aims to feed information into the CMHT plan to support the consideration of the mental health needs of the population.

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[6]References: Modelling changes , Longitudinal analysis , First wave impact , UK household longitudinal study last updated 18/11/2021

[7] mental-health-strategy.pdf (gloucestershire.gov.uk)

Ethnic Minority Communities and Gloucestershire's Mental health Services[8]

A report was commissioned by the Gloucestershire Clinical Commissioning Group (CCG, now known as NHS Gloucestershire Integrated Care Board) to bring together available information about individuals from ethnic minority backgrounds and access to mental health services in Gloucestershire in the context of: Black Lives Matters, the 2019 report on 'The use of the Mental Health Act in Gloucestershire'[9] and the Director of Public Health's 2020 report 'Beyond Covid: Race, Health and Inequality in Gloucestershire'[10]. The Ethnic Minority Communities and Gloucestershire's Mental health Services report found that local data reflects the national position with both an overrepresentation of the ethnic minority community under compulsory powers of the MHA and underrepresentation in other services.

The 'Use of the Mental Health Act in Gloucestershire' report demonstrates the average percentage of ethnic minority admissions excluding 'White other' for Section 131 (informal), Section 2 and Section 3 and the same averages for ethnic minority communities including 'White other'. Key points are as follows:

- 6% ethnic minority admissions excluding 'White other' is above Gloucestershire's ethnic minority population at 4.6%
- 12% ethnic minority admissions including 'White other' is significantly above the ethnic minority population, including 'White other', of 8.4%
- Informal admissions in both ethnic minority groups are significantly below White admission rates of 51%
- Section 2 rates are higher in ethnic minority groups (42%) compared to White (30%).
- Community Treatment Orders (CTO) data not included in the above shows that for 2019/20 there were 12 per 100,000 population, double that of the White community amounting to 16% of CTOs.

However, there is insufficient recording of ethnicity data to draw any robust or reliable conclusions across all services. The Director of Public Health's 2020 report[10] explains that proactively reviewing and ensuring the completeness of patient ethnicity data is "a significant and much needed change that other public services should also be aiming for. While acknowledging that collecting personal data is time-intensive and has to meet the requirements of legislation, there is a clear case for mandatory equalities data in directly provided and commissioned services. At the point of collection, the reasons for collecting the data and how it will be used need to be clear and the questions and options given should be inclusive as possible, using up-to-date terms and language. This is an important step to increase response rates by building confidence in marginalised groups who may not have had the best experiences with public services."

The report authors are currently working with members of our local ethnic minority communities to ensure that the recommendations and findings from the report are a true reflection of the needs of the population. It will be looking at ethnicity and mental health at a much deeper level than covered in the scope of this MHNA, and therefore the MHNA will look to the findings and recommendations of the Ethnic Minority Communities and Gloucestershire's Mental Health Services report.

Gloucestershire Wellbeing

The Gloucestershire Wellbeing (GloW) commitment is the local response to the Public Health England's Prevention Concordant for Better Mental Health[11]. The commitment sets out what it takes to promote good mental health and wellbeing and help prevent mental illness. Organisations that sign up to GloW are asked

[8] BLM Gloucestershire MH Services report
[9] 'Use of the Mental Health Act in Gloucestershire', D Pugh, P Southam, September 2019
[10] dph-report-2020-beyond-covid-race-health-and-inequality-in-gloucestershire.pdf
[11] Prevention Concordat for Better Mental Health - GOV.UK (www.gov.uk)

to take action to promote positive change[12]. The aim is to create a countywide movement promoting good mental health for all, by focusing on all the contributing factors and taking actions that will make a difference. Many things can have an impact on a person's mental wellbeing; including housing, employment, food and social life.

Via GloW Community Grants the scheme invests in community led and based activities that address the things that contribute to our mental wellbeing and help improve our mental health, e.g. social connections and networks, physical health, and access to green spaces. Launched on 1 October 2020, the programme will run for three years and will see a total of £150,000 provided to community projects over a three-year period. It focuses on activities that promote good mental health and wellbeing, reduce isolation, and support the prevention of suicide and self-harm in those most likely to be affected.

Enabling Active Communities

Enabling Active Communities brings together a unique collaboration of 'civil society' partners[13] from across Gloucestershire. Collectively, they work together to understand and inform how systems that impact on health and wellbeing interact, and oversee a programme of work that aims to improve health and wellbeing through mobilising assets within communities, promoting equity and increasing people's control over their own health and lives. It is one of the four priority transformational programmes as part of the Integrated Care System Development programme in Gloucestershire, and they aim to deliver a Self Care and Prevention plan to close the Health and Wellbeing gap in Gloucestershire[14] .

Gloucestershire Health and Wellbeing Board

Gloucestershire Health and Wellbeing Board[15] leads on improving the co-ordination of commissioning across Health, Social Care and Public Health services and brings together elected members, leaders from the NHS, social care, Police and the voluntary and community sector to work together and support one another to improve the health and wellbeing of the local population and reduce health inequalities.

Listening to local service users:

'One Gloucestershire' is the working name given to the partnership between the county's NHS and care organisations. Their stated objectives are to 'help keep people healthy, support active communities and ensure high quality, joined up care when needed'. As part of the CMHT One Gloucestershire collated the feedback from local events, surveys and forums about mental health services and supports between 2019-2020[16]. They heard from multiple sources that there needs to be an improvement in how mental health services in Gloucestershire are connected. They summarised their findings:

- "That joined up working between services needs to be better
- Professionals need to know what services are available within the county to suit an individual's needs
- Communication needs to be clear between services with no barriers to information sharing
- Transition between services needs to be smoother and without a gap in support
- Accessing services is difficult if you have a co-existing condition or complex needs

[12] gcc_2293-glow-commitment-a4_aw.pdf (gloucestershire.gov.uk)
[13] We use 'civil society' as a collective term for the different public, private, voluntary, community and social enterprise organisations that, in this context, make up our health and social care system.
[14] 20160707 STP Overview Slides June Submission.pdf (gloucestershire.gov.uk)
[15] Gloucestershire Integrated Care System and Health and Wellbeing Partnership was established in July 2022
[16] Community Mental Health Transformation Feedback Report, Review of Scope Phase, 1st April to 30th June 2021, Noor Al-Koky and Steve Hubbard

- Holistic support for a person – their housing, finances, physical health and nutrition, employment or education"

They also heard that when developing new strategies commissioners and providers should be aiming for:

- "Person-centred services and support, 'outcome-focused' instead of 'recovery-focused'
- The voice of individuals and carers to be listened to and used to shape services
- Strategies and actions to be coproduced with those who have lived experience
- Language and terminology to be simple and clear for people to understand
- Services being open to all
- Specific support for 18 to 25 year olds
- Resources to be used effectively and efficiently"

Healthwatch reports[17]

Following an initial report exploring the view of Gloucestershire people on mental health services in the county, Healthwatch produced a series of follow up reports on specific areas including the experiences of carers, experiences of urgent mental health care in the Emergency Department and social isolation and loneliness.

The initial report on mental health services shared the following key messages:

- A lot of people talked to us about the long waiting times for the Improving Access to Psychological Therapies Service (IAPT) and Children and Young People's Services (CYPS) across the county.
- People talked about the positive support and help that their GP gave to them but understood that they were not specialists and were limited in the support that they could provide.
- Service users and carers spoke about the need for more flexibility on the number of support sessions or extra support sessions that they are given and that they were concerned that this could affect their wellbeing.
- Some people were able to access information about services and support easily, however some people struggled to know where to go to get this information. Carers especially felt that accessing professional support or advice for themselves was hard.
- People felt that the information they accessed could sometimes be conflicting and difficult to understand. It often came from many different sources.
- People talked about the difficulties in accessing support for people who were in acute crisis and that they were sometimes signposted to services that were not able to offer support for those in crisis.

Voluntary and Community Sector (VCS):

There are also a multitude of community and voluntary sector groups that support the mental health of our local population. These have been highlighted as an important source of support.

Gloucestershire VCS Alliance report

In 2020 the Gloucestershire VCS Alliance published a *State of the Sector Report*[18] to provide details to stakeholders on some of the work carried out by the Voluntary, Community and Social Enterprise (VCSE) sector over the previous 12 months. They gathered data from a database of all registered charities in

[17] Healthwatch is an independent, statutory body that was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services. Locally they obtain the views of people about their health care experiences and make reports and recommendations to local services.

[18] Glos VCS alliance report 2019/20

Gloucestershire, they surveyed 230 member organisations and conducted face-to-face interviews with senior manager representatives from 58 organisations across the sector.

In the survey, they asked organisations who they work with and support on a regular basis, and 55.9% of organisations supported the area of Mental Health. Over 25% of respondents said that they work 'all the time' with older people, people affected by poverty, people from rural areas, children and young people, and those with poor health – key groups for mental health early prevention and support.

Data sources and limitations

Mental Health Service data

A population health management (PHM) tool was developed in the statistical program R to analyse the breakdown of service users by a series of demographics. The tool examines referrals and initial assessments to a service from Gloucestershire Health and Care Foundation Trust, compared with the total population registered at Gloucestershire CCG (less the cohort concerned). This valuable tool can be used to analyse mental health service user demographics for a wide range of services, but unfortunately the scope of this MHNA was only able to analyse referral and initial assessment of two key services. The MHNA Project Group decided to focus on the Eating Disorder service and the Recovery service as two priority areas for analysis by this tool, as they were of particular interest to lead project group members. The tool remains available for future use to analyse commissioned mental health services.

Data quality is continually assessed, and as reporting practices change and data linkage increases, the data that is available to analyse becomes a truer reflection of the population that is supported by a service. For our in-depth service analysis of the Eating Disorder and Recovery teams, we have chosen the year 2020-2021 for our analysis and filtered to 18+ only; while this will exclude some patients from the analysis it will still be reflective of the cohort demographics as a whole. Although 2020/21 was a tumultuous year for our services due to the SARS-CoV-2 pandemic, the data completeness for this year was far superior to previous years (2019/20 opened with 50.7% data quality in April 2019 and 2020/21 closed with 76.8% data quality in March 2021). Our Project Group felt that data quality was the priority for the analysis.

The data quality has continued to improve and is currently at a 90% average for 2021/22, so any further in-depth service analysis undertaken will have 90% data quality.

For our key services, the analysis is performed for all ages rather than 18+, as in previous years the age was not available and this would exclude individuals from the analysis. This would lead to a false impression of increase in service usage, when the increase would reflect an improvement in data quality. There are some services that do support young people, and this needs to be taken into consideration when reviewing this data.

A limitation of this MHNA is that it is focused in depth on a limited number of services, and there will be recommendations for further analysis of other mental health services within the county.

Primary Care datasets

GPs are an important source of information, support and signposting/referral to further mental health services. However, due to the many different ways that individual GPs can 'code' different mental health conditions (coding can record the main reason for the consultation, symptoms, diagnoses, and other details) it is challenging to understand the true prevalence of mental health in GP consultations. This is a limitation of the GP dataset and without considerable liaison with GPs or a standardised way of capturing information, any rate/prevalence is likely to be an underrepresentation of the true picture. We have therefore decided to focus on referrals to secondary mental health services for treatment and support, rather than primary care datasets.

Healthwatch Gloucestershire

Healthwatch Gloucestershire is commissioned by Gloucestershire County Council to promote the interests of local people in health and social care and influence the way services are commissioned and provided. A team of staff and volunteers listen to what people like about local health services, and what could be improved. These views are then shared with the decision-making organisations, so that the voice of the community can have an impact on how they are run.

Fingertips: Public Health profiles

Fingertips is a large public health data collection. The data is organised into themed profiles, showing an overview of indicators for each theme. The data allows the user to browse indicators at different geographical levels, benchmark against the regional or national average and export data, tables and images to use locally.

Projected adult and older people population information

The latest subnational population projections available for England, published 24 March 2020, are full 2018-based and project forward the population from 2018 to 2043. Information is collected at County and District level and is projected in 5-year increments starting at 2020. This data has concentrated on 2020, 2025 and 2030. Long-term subnational population projections are an indication of the future trends in population by age and gender over the next 25 years. The assumptions used in the subnational population projections are based on past trends. They show what the population will be if recent trends continue.

These projections do not consider any policy changes, or economic, or recent global health factors that could impact the population in the future. They do not try to predict any potential demographic consequences of future political or economic changes, including the UK's withdrawal from the European Union, nor of the current Covid-19 pandemic.

Comparisons between the 18-64 and 65+ age groups was difficult for some areas, as data was not provided for both age groups for all categories. Some information was provided for gender but for not all categories and for not all age groups. Age bands were split for both the 18-64 and 65+, but these differed for the different categories.

Projecting Adult Needs and Service Information System (PANSI)

Data for 18-64 year olds is taken from PANSI data Projecting Adult Needs and Service Information System (pansi.org.uk) and was extracted in October and November 2021 by the GCC Data and Performance Team. Figures are taken from Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. Population figures have also been taken from the PANSI data for those aged 18-64 year olds.

Projecting Older People Population Information System (POPPI)

Data for those aged 65+ is taken from POPPI data Projecting Older People Population Information System (poppi.org.uk) and was extracted in October and November 2021 by the GCC Data and Performance Team. Figures are taken from Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. Population figures have also been taken from the POPPI data for those aged 65+.

Chapter 2: Population profile

Chapter summary:

The following information on the demographics of our local population and its projected changes will have implications for determining the mental health needs of our population. This is a summary of the main findings for each mental health risk factor:

Age and sex:

- A 2019 policy position paper by Age UK[19] states that 1 in 4 older people live with common mental health conditions, but only 15% of older people with mental health conditions receive help from the NHS. As the proportion of adults aged over 65 years is projected to increase to 24.5% by 2028, the number of our older citizens with unmet mental health needs will likely grow. Commissioners and service providers need to ensure that Gloucestershire's services are accessible to older people, and encourage engagement with preventative services for those approaching older age (also ensure that those who work with older people have access to training eg Mental Health First Aid (MHFA)). They also need to consider the impact of an aging population on those who will be caring for them.
- Suicide rates are higher in men, part of this is due to lower numbers of presentations to mental health services in men. It is important to ensure that mental health services in the county are accessible to men.

Ethnicity:

The Ethnic Minority Communities and Gloucestershire's Mental health Services report is an in-depth focus on ethnicity and mental health in our local population and will be the main source of recommendations for this needs assessment. For this reason ethnicity is not covered in depth here and this MHNA will defer to the focused report when it is released.

Housing:

- There is a large projected increase in population size between 2018-2043. When planning new housing developments, local planning authorities need to consider the wider determinants of good mental health and create healthy living environments.
- The numbers of people living alone are projected to increase by 2043. We need to consider how we can work togther on a strategic level between partnerships to improve social connectedness within our communities as a form of primary prevention for social isolation and lonlieness.
- Commissioners and providers should consider how they can promote an integrated approach to managing the co-dependent relationship of homelessness, mental health, substance misuse and early childhood experiences through service provision and care pathways. Mental health issues should be considered in the wider social context that a person is living in.
- Also, while the evidence suggests a high prevalence of mental health issues[20], there is a low referral rate to mental health services when a homeless person interacts with mainstream healthcare[21]. Healthcare staff should have a better understanding and awareness of the mental health services and wider support available to their patients.

[19] ppp_mental_health_england.pdf (ageuk.org.uk)

[20] Seena Fazel, John R Geddes, Margot Kushel, The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations, In The Lancet, Volume 384, Issue 9953, 2014, Pages 1529-1540, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(14)61132-

[21] "The unhealthy state of homelessness: Health audit results 2014", Homeless Link

- Homeless people recognised the importance of supportive social networks, but also reported a low level of social capital and dangers implicit in navigating homeless social networks. Commissioners and providers need to work to understand how to give homeless people access to positive and stable social networks which help to increase their social capital and to help motivate achievement of their aspirations.

Employment and deprivation:
The health consequences of unemployment have been shown to increase with duration – for mental health and life satisfaction as well as for physical health[22]. Pandemic restrictions have led to extended periods of reduced income, job loss or unemployment, and the long duration of these circumstances is a particular cause for concern. The number of Universal Credit and Job Seekers Allowance claimants in Gloucestershire is still higher than pre-pandemic levels. It is important to consider unemployment as a wider determinant of mental health.

Deprivation is about more than lack of money. It can include lack of access to resources such as adequate housing and exposure to negative stressors such as violence, crime or lack of public green space. A growing body of evidence suggests the relationship between deprivation and mental health is not just about absolute lack of resource for individuals. Populations with large differences in wealth and resource between individuals are associated with higher levels of poor health and mental health problems for the population as a whole[23].

Commissioners need to consider wider determinants of health in developing mental health support- and look at a holistic approach which also takes into account adequate housing, employment opportunities, green spaces etc. Although the population is mainly urban, we need to consider how people living in more deprived areas (eg Forest of Dean) are able to access centrally located services.

Vulnerable populations:
Domestic abuse: This MHNA defers to the Gloucestershire Domestic Abuse Strategy (2021-2024) Mental Health objectives

- Partnership investment is made available for the development of joint working and co-location between domestic abuse support services and services that support those with mental health issues, substance misuse issues and wider complex needs.
- Developing a better understanding of the role of mental health in identifying domestic abuse and improving mental health pathways to specialist support.
- The criminal justice board's female offender strategy recognises that many female offenders experience chaotic lifestyles involving substance misuse, mental health problems, and homelessness which are often the product of a life of abuse and trauma. The strategy aims to take a new approach which is locally-led, partnership-focused and evidence-based in order to address vulnerability and treat offenders as individuals with the potential to contribute positively to society.
- The national supporting families programme (formerly Troubled Families) has championed whole family and multi-agency working to support vulnerable families that are experiencing multiple disadvantages such as unemployment, domestic abuse and poor mental health.

[22] Unemployment and mental health - The Health Foundation
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652881/

Carers: Carers are an important source of support for those who have mental illness but are themselves at risk of developing common mental health conditions and feeling socially isolated. A recent Healthwatch report indicates that the local carer population feel that there is little support relating specifically to mental health carers.

Any recommendations made to prioritise social connectedness and primary prevention of mental health illness, should consider carers as a vulnerable group and mental health carers should be signposted towards tools to support their wellbeing.

<u>We need to gather more information about these local vulnerable groups:</u>
Refugees: Refugees and asylum seekers in our county are a vulnerable population with a greatly increased risk of having or developing a mental health condition. In order to fully understand the needs of this population we should engage with GARAS and the refugee/asylum seeker population.

Drugs and Alcohol Strategic review: This MHNA will be updated with the findings from the Drug and alcohol abuse strategic review that relate to mental health.

Census 2021 updates:
New information will be available for the first time on LGBTQ+ and armed forces veterans. **F**urther work may be needed depending on the findings form the Census. There will also be updated information on people living with long term health conditions.

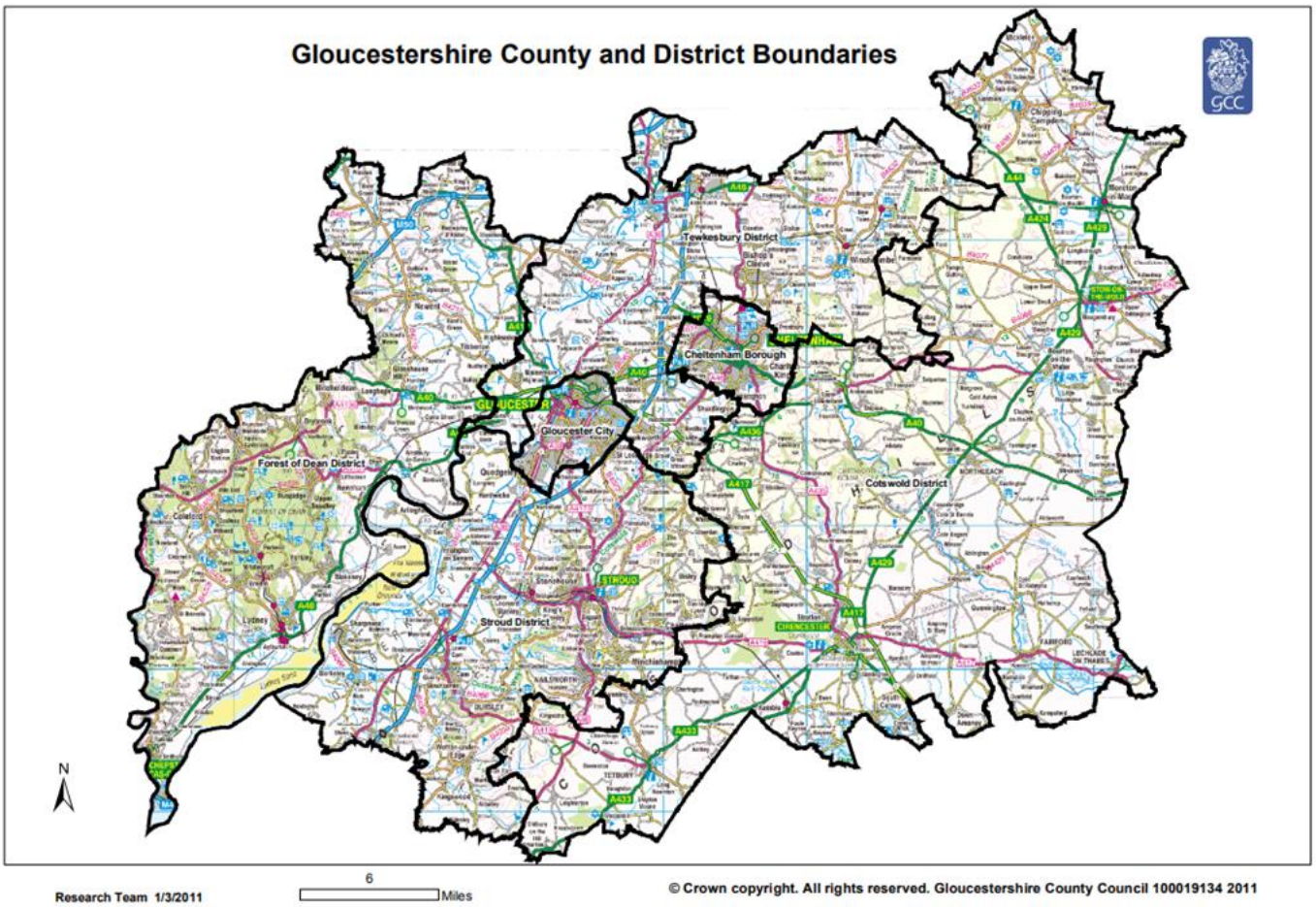
Gloucestershire population demographics:

Gloucestershire is an English county situated at the northern edge of the southwest region of the United Kingdom. It covers an area of 1,025 square miles including the largest Areas of Outstanding Natural Beauty in the country. Essentially a rural county, it has been known since Roman times for farming, forestry, and horticulture with an industrial history featuring the wool trade. Gloucester and Cheltenham are the two main urban centres of the county lying either side of the M5 and linked by the A40.

The county consists of six district councils: Gloucester City, Cheltenham, Forest of Dean, Tewkesbury, Stroud, and Cotswolds (*Figure 1*). The Severn Estuary creates a natural barrier between much of the Forest of Dean and the rest of the county, with a bridge crossing the river at Chepstow in the south and the next crossing at Gloucester City, meaning that the south of the district is geographically isolated form the rest of the county.

The district of Gloucester has the largest population in the county (2019-2020 mid-population estimate: 129,709) and the Forest of Dean has the smallest (2019-2020 mid-population estimate: 96, 624). Between, 2019-2020 Tewkesbury had one of the highest district growth rates in the UK with the main driver being internal migration[24].

Figure 1: Gloucestershire County and District boundaries



[24] Current Population of Gloucestershire (mid-2020) (gloucestershire.gov.uk)

The Projecting Adult Needs and Service Information System (PANSI)[25] estimates that 121,777 people aged 18-64 in Gloucestershire are predicted to have a mental health problem in 2020. All of the districts have a similar prevalence with almost 1 in 3 of the population predicted to have mental health problems (approx. 32,500 per 100,000 population). The number of people in Gloucestershire aged 18-64 predicted to have a mental health problem is predicted to rise by 3,328 in 2030. 70,774 are predicted to have a common mental health problem[26] and 26,923 are predicted to have two or more psychiatric disorders[27].

Socio-economic determinants of mental health in Gloucestershire:

What influences mental health?

Mental health and well-being are influenced not only by individual attributes but also the social circumstances that a person finds themselves in and the environment in which they live[28]. The All Age Mental Health & Wellbeing Strategy for Gloucestershire (2018-2023) recognised the need for increased focus on the wider influences of mental health and wellbeing (Figure 2 **Error! Reference source not found.**), and for everyone involved in working with these determinants to understand their role in addressing them.

Figure 2[29]

[25] Projecting Adult Needs and Service Information System (pansi.org.uk)

[26] Common mental disorders comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. Severe mental illness encompasses conditions that cause significant impairment for example bipolar disorder and psychotic disorders. *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (2016), NHS Digital.*

[27] Psychiatric comorbidity - or meeting the diagnostic criteria for two or more psychiatric disorders - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders included the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; antisocial and borderline personality disorders; eating disorder; posttraumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts. *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (2016), NHS Digital.*

[28] Risks to mental health: An overview of vulnerabilities and risk factors (2012) WHO

[29] mental-health-strategy.pdf (gloucestershire.gov.uk)

The demographic information about our residents is framed around some of the main risk factors for mental health so that we can better understand the mental health needs of our population (see Chapter 2: Appendix 1 *Risk factors for mental health*). Understanding the local population is vital for good needs assessment and contribution to service planning – the characteristics of the local population, and projected changes, drive demand for mental health services now and in the future[30].

Table 1 provides an overview of some of the socio-economic determinants of mental health in Gloucestershire. Many of our wider determinants of mental health, for example household overcrowding and people living in deprived areas, are better than the English average and many of the health determinants are the same or better than the English average. However, when we consider social relationships, our population has higher numbers of people living alone and separated/divorced than the English average. Table 1 looks at the whole population of Gloucestershire and will not highlight any variance at the district level or in any sup-groups of the population.

Table 1

Determinants of Mental Health	Data Period	Gloucestershire	South West	England
Health determinants				
Long-term health problems or disability: % of population	2011	16.7	18.4	17.6
Migrant GP registrations: rate per 1,000 population	2017	6.5	8.2	12.6
Admission episodes for alcohol-related conditions (Narrow): New method, rate per 100,000	2019/20	516	528	519
Estimated prevalence of opiate and/or crack cocaine use per 1,000 population	2016/17	7.3	8.3	8.9
Smoking prevalence in adults (18+) current smokers (Annual Population Survey)	2019	13.0	14.0	13.9
Percentage of adults (aged 18+) classified as overweight or obese	2019/20	61.4	62.0	62.8
Social relationships				
Lone parent households: percentage of families	2011	5.2	5.9	7.1
Relationship break up: % of adults whose current marital status is separated or divorced	2011	11.8	12.2	11.6
People living alone: % of all households occupied by a single person	2011	11.8	12.2	11.6
Older people living alone: % of households occupied by a single person aged 65 or over	2011	13.3	13.8	12.4
Unpaid Carers: percentage of population who provide substantial unpaid care	2011	2.05	2.37	2.37
Wider determinants				
Socioeconomic deprivation: % of people living in 20% most deprived areas	2014	7.5	10.6	20.2
Socioeconomic deprivation: overall IMD score	2019	14.9	18.2	21.8
Long-term unemployment rate per 1,000 working age population	2019/20	1.1	N/A	3.2
Household overcrowding: % of households	2011	2.7	2.9	4.8
Statutory homelessness: rate per 1,000 households	2017/18	1.7	1.7	2.4

[30] 3. Mental health: population factors - GOV.UK (www.gov.uk)

Homelessness- households in temporary accommodation per 1,000 households	2019/20	0.9	1.1	3.8
Domestic abuse-related incidents and crimes: rate per 1,000 population	2019/20	21.0	22.6	28.0
Violent crime: Violent offences per 1,000 population	2020/21	20.6	23.4	29.5
Use of outdoor space for exercise/health reasons: estimated prevalence % of population	March 2015-Feb 206	15.3	17.4	17.9
Percentage of physically active adults: % of adults over age 19 engaging in 150 minutes of exercise a week	2019/20	70.8	70.9	66.4
RAG (Red, Amber or Green) – higher, average, lower than national average Source: Public Health Profiles*, Public Health England				

Social isolation and loneliness

Gloucestershire's Health and Wellbeing Board have identified social isolation as an area that needs attention, so we sought to understand what social isolation and loneliness means for people living in Gloucestershire. Previous Healthwatch Gloucestershire research found that 68% of respondents living with a long-term health condition said they had felt more isolated/lonely during the Covid-19 pandemic. In September 2021 they published a report on their findings from their deeper dive into social isolation and loneliness[31].

The key messages were:

- Most people told us that they were lonely almost all of the time, frequently or sometimes.
- We identified the Covid-19 pandemic, being single, widowed or divorced, and/or having a long-term health condition, as key factors of loneliness.
- Most respondents said there aren't any opportunities to meet new people in their local area, however, many identified that there are already groups that offer the chance to connect with others. Some people highlighted issues in attending these groups including accessibility, poor transport, and a lack of groups outside of working hours.
- Some respondents identified problems with their housing providers and inadequate financial support as causes of isolation and/or loneliness.
- Many people told us they were dissatisfied with their current relationships, and some told us they have no friends in Gloucestershire (yet have friends elsewhere).
- Many people expressed that they would find it difficult to ask for help, with some identifying the cause as feeling uncomfortable or embarrassed.

This further emphasises the impact of wider determinants on mental health and wellbeing.

[31] Reports & Publications -Healthwatch Gloucestershire

Mental health risk factors:

Age

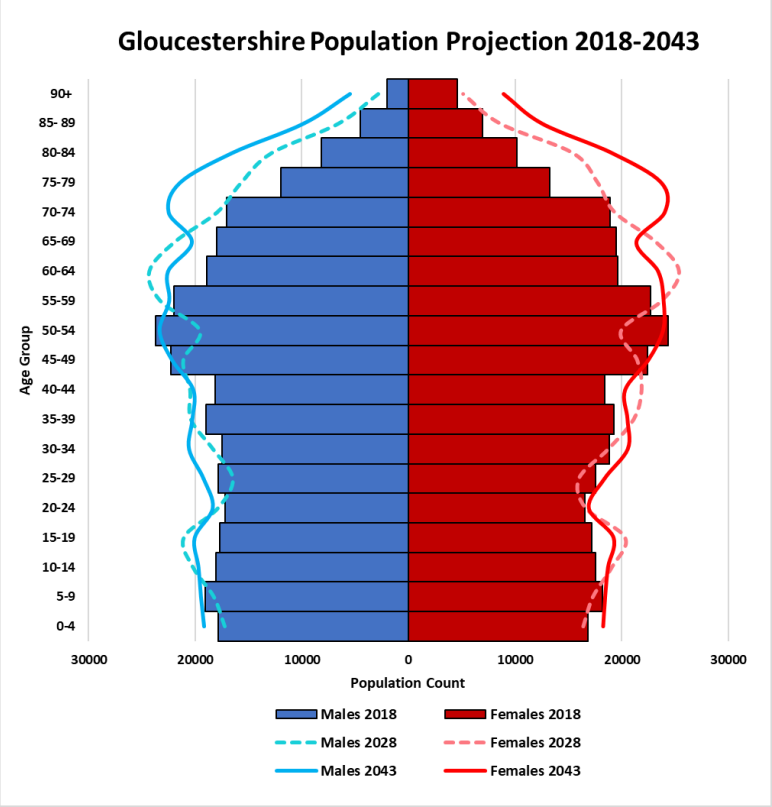
Risks to mental health manifest themselves at all stages in life[32]. In particular[33]:

- Common mental health disorders are most common in adults aged between 35-54.
- The highest incidence of psychosis is in 20-34 year olds.
- Personality disorders are increased in younger people.

In 2020, the resident population of Gloucestershire was estimated to be 640,650 people of which 22.3% were aged 0-19; 55.7% were aged 20-64; 21.76% were aged 65 and over. Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds and a higher proportion of people aged 65+ when compared to England.

The population age demographics of Gloucestershire are predicted to change (**Error! Reference source not found.**). Between 2018-2043, the proportion of the population aged 0-19 is predicted to decrease from 22.5% in 2018 to 21.9% in 2028 and 20.7% in 2043. There is also a predicted decrease in the working age population (20-64) from 56.2% in 2018 to 53.6% in 2028 and 51.4% in 2043. In contrast, the proportion of the population aged 65+ is predicted to rise from 21.3% in 2018 to 24.5% in 2028 and 27.9% in 2043. People with common mental health disorders are more likely to be aged between 35-54 years old, and the population of 35-45 year olds is projected to increase. The districts with the largest projected increase in population between 2018-2043 are Cotswold (+26.8%) and Tewkesbury (30.8%). These are both much higher than the projected population increase in England of 10.3%.

Graph 1



Data Source:2018-based Subnational Population Projections, Office for National Statistic

[32] Investing in mental health (who.int)

[33] Jenkins, Rachael and Meltzer, Howard and Jones, Peter and Brugha, Terry and Bebbington, Paul and Farrell, Michael and Crepaz-Kay, David and Knapp, Martin (2008) Mental health: future challenges. Foresight, 104-08-Fo/on. The Government Office for Science, London, UK

Sex

Mental health conditions are predicted to be more prevalent in women with 56% of 18-64 year olds predicted to have a mental health problems in 2020 being female. Gender differences occur in the rates of common mental disorders (depression, anxiety, somatic complaints). These disorders, in which women predominate, affect approximately one in three people[34].

Unipolar depression is twice as common in women, men are more than three times more likely to be diagnosed with antisocial personality disorder and no marked gender differences have been found in the rates of severe mental disorders (e.g. schizophrenia, and bipolar disorder). However, many gender-specific risk factors for common mental disorders disproportionately affect women including gender-based violence, socioeconomic disadvantage, low income, low/subordinate social status, and responsibility for the care of others[34].

However, it is also important to consider that women are more likely to present to healthcare services for mental health conditions. Often in services we see lower presentations from males, which may reflect lower prevalence but may also reflect more reticence in seeking help. We do know that suicide rates are higher in men, in 2018 the rate was 17.2 deaths per 100,000 males and 5.4 deaths per 100,000 females[35]. In 2018 three-quarters of suicide death were among men

Implications for age and sex demographics:

A 2019 policy position paper by Age UK[36] states that 1 in 4 older people live with common mental health conditions, but only 15% of older people with mental health conditions receive help from the NHS. As the proportion of adults aged over 65 years is projected to increase to 24.5% by 2028, the number of our older citizens with unmet mental health needs will likely grow. Commissioners and service providers need to ensure that Gloucestershire's services are accessible to older people, and encourage engagement with preventative services for those approaching older age (also ensure that those who work with older people have access to training eg Mental Health First Aid (MHFA)). They also need to consider the impact of an aging population on those who will be caring for them.

It is also important to ensure that mental health services in the county are accessible to men.

Ethnicity

The Department of Health and Social Care *Modernising the Mental Health Act* report[37] recognised that "profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes. We know that people of black African and Caribbean heritage are more likely than white British people to come into contact with mental health services through the criminal justice system, rather than via their GP or referral to talking therapies. Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the Mental Health Act. We know that racism experienced in everyday life compounds already poor experiences of, and outcomes from, health services."

[34] WHO/Europe | Gender and mental health
[35] Suicides in the UK - Office for National Statistics (ons.gov.uk)
[36] ppp_mental_health_england.pdf (ageuk.org.uk)
[37] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk)

In Gloucestershire, 91.6% of the population is White British (Census 2011). The 2011 Census found that 7.7% of Gloucestershire residents (46,100 people) were born outside the UK compared with a national figure of 13.4%; of this group, 40.8% were born in another European country and 22.3% were born in the Middle East or Asia[38]. More recent estimates suggest that in 2019/20 9.2% of Gloucestershire residents were born in another country[39].

With regards to ethnic origin, the 2011 Census found that 91.6% of Gloucestershire residents were White British, 2.1% were Asian/Asian British, 1.5% were from a Mixed/Multiple Ethnic group, 0.9% were Black/Black British, 0.6% were White Irish, 0.1% were of Gypsy or Irish Traveller origin, 3.1% were in an 'other White' category and 0.2% were in another ethnic group. Some 36% of the people who were not White British were born in the UK.

At district level[38]:

- Gloucester had the highest proportion of people from Black and Ethnic Minorities, at 10.9% of the total population. However, this is still considerably lower than the national figure.
- Cheltenham also had a higher proportion of people from Black and Ethnic Minorities (5.7%) than the county-wide figure.
- Forest of Dean had the lowest proportion of people from a Black and Ethnic Minority, at 1.5% of the total population.
- The proportion of people that were classified as 'other White' was higher in Cheltenham than Gloucestershire and England as a whole (5.0% compared with 3.1% for Gloucestershire and 4.6% for England).
- 42% of people who were of Gypsy/Irish Traveller origin lived in Tewkesbury district.
- At ward level Barton and Tredworth ward in Gloucester was the most ethnically diverse ward with 41.4% of its population from a Black and Minority Ethnic group and 10.3% from a white background other than White British.

The risk of psychoses for people from Black and Minority Ethnic communities and immigrants increases when they make up a smaller proportion of the area that they live in, and this could be the case in parts of Gloucestershire[71].

Implications:

The Ethnic Minority Communities and Gloucestershire's Mental health Services report is an in-depth focus on ethnicity and mental health in our local population and will be the main source of recommendations for this needs assessment. For this reason ethnicity is not covered in depth here and this MHNA will defer to the focused report.

Recommendation:

To be aware of concurrent strategic recommendations across the county including the DPH 2020 report[40]:

- Require comprehensive and good quality ethnicity data collection in all public services (directly provided and commissioned), including at death registration.

[38] equality-profile-2021.pdf (gloucestershire.gov.uk)

[39] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/populationoftheunitedkingdombycountryofborthandnationality

[40] dph-report-2020-beyond-covid-race-health-and-inequality-in-gloucestershire.pdf

- Undertake a stocktake of the BAME voluntary sector, examining further the contribution that it makes towards reducing health inequalities in Gloucestershire. Seek to build capacity and sustainability longer term within this sector

Housing

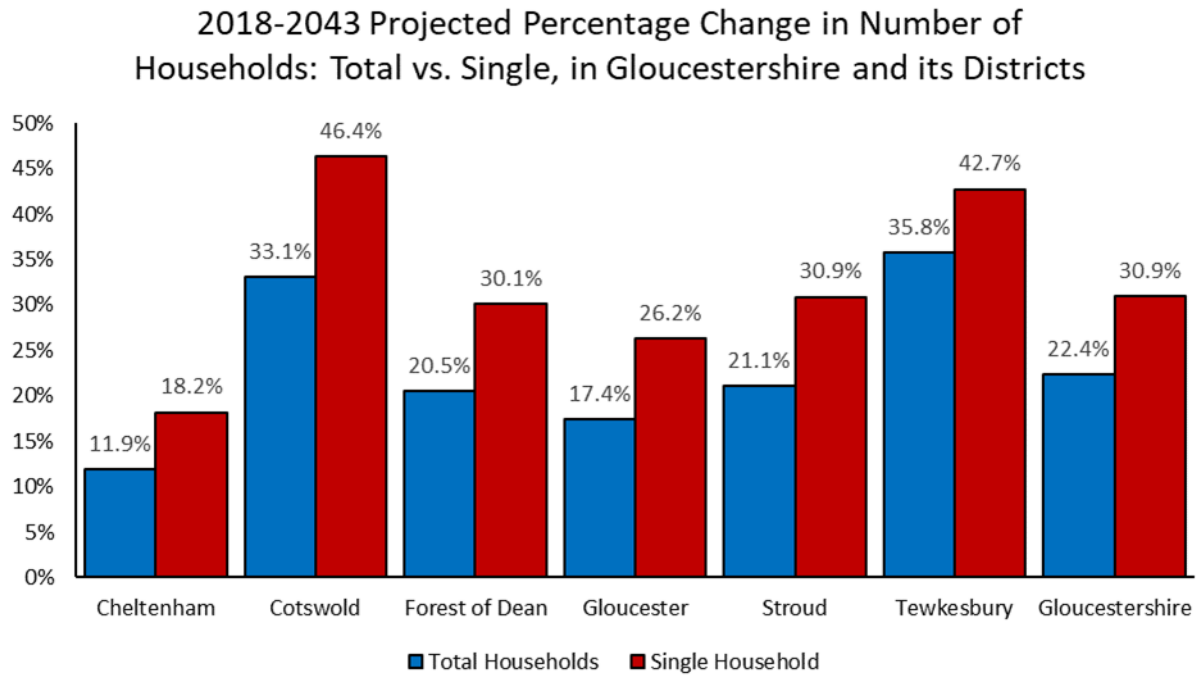
Household composition

People who live alone are at increased risk of mental health conditions. In the 2017 Annual Population Survey, one-person households had the lowest well-being of all household types[41].

Overall, the number of people living alone in the UK has increased by 4.0% over the last 10 years; in 2020 the proportion of one-person households ranged across England from 22.8% in London to 33.6% in Scotland and the North East of England[42]. Gloucestershire is at the higher end of this range with 30.6% of the population living in single households. Cheltenham has the highest proportion of people living in a single household (36.2%) and Forest of Dean the lowest (27.9%).

There is a projected 30.9% increase in the percentage change of single households from 2018-2043, this is higher than then the projected 22.4% increase in total households. The highest projected change in single households will be in the Cotswolds with an almost 50% increase, which could be due to the projected increase in the district population as well as it being an area popular with older individuals.

Graph 2



Data Source: 2018-based Household Projections, Office for National Statistics

[41] The cost of living alone - Office for National Statistics (ons.gov.uk)
[42] Families and households in the UK - Office for National Statistics (ons.gov.uk)

Homelessness

Mental health issues have a strong relationship to homelessness; poor mental health can be a cause and consequence of homelessness[43]. Mental health conditions increase the risk of, and are worsened by, homelessness as described in Fazel et al.'s 2014 UK review of epidemiology and risk factors for morbidity and mortality regarding homelessness[44]. They concluded that the most common issues amongst homeless people were drug and alcohol dependence, and the prevalence of psychosis was typically as high as that of depression (which was also normally estimated to be much higher than in the general population). While there was a wide range of estimates of prevalence of neuropsychiatric issues across the studies which they reviewed, most estimates across diagnoses (psychosis, depression, personality disorder, alcohol dependence, drug dependence, post-traumatic stress disorder, brain injury) were many times higher than the general population.

The charity 'Homeless Link' published data looking at the health of homeless people in England[45]: 80% of respondents reported some form of mental health issue and 45% had been diagnosed with a mental health issue. 17.5% of those with mental health issues would like support but are not receiving it.

In a 2017 short evaluation report[46], which sought feedback from homeless service users of accommodation-based services in Gloucestershire, the researchers found that the inability to gain access to mental health services was a key sub-theme against the background of homelessness or risk of homelessness. Homelessness or risk of homelessness creates a huge level of stress for those affected.

In 2018, a series of qualitative in-depth interviews were completed with homeless people in Gloucestershire. The homeless participants included rough sleepers, those staying in temporary accomodation, squats, 'sofa-surfing', 'survival-sex' as a means of keeping a roof over their head and people at high risk of becoming homeless. Nearly all homeless participants reported either a mental health or a physical health issue, and often both. Mental health issues were most commonly reported by participants, these included: depression; anxiety; personality disorders; and post-traumatic stress disorder. Among these depression and anxiety were the most prevalent conditions. The homeless participants also understood the role that substance misuse played in their mental health. They normally recognised that alcohol and/or drug abuse was a cause or exacerbating factor in their poor mental health. However, they also commonly talked about the role of drugs and alcohol in providing immediate short-term relief to their mental health issues.

There was a wide divergence among participants regarding the importance of social networks to help manage their mental health and wellbeing. Many of the participants with mental health issues understood the importance of social interaction and managing/maintaining social networks as a positive intervention to help manage their condition. Several reported forcing themselves to interact with others even when they lacked motivation to do so, as they knew it would be helpful to their mental state. However, participants did not tend to rely on other homeless people for social and emotional support, with few describing close relationships with other homeless people.

Access to mental health support was a priority for a large proportion of those interviewed. As detailed elsewhere in the results section there was often a co-dependency between a participant's mental health

[43] 'The Impact of Homelessness on Health – A Guide for Local Authoritiess', Local Government Association, https://www.local.gov.uk/sites/default/files/documents/22.7%20HEALTH%20AND%20HOMELESSNESS_v08_WEB_0.PDF

[44] Seena Fazel, John R Geddes, Margot Kushel, The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations, In The Lancet, Volume 384, Issue 9953, 2014, Pages 1529-1540, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(14)61132-6

[45] Homelessness and health research | Homeless Link

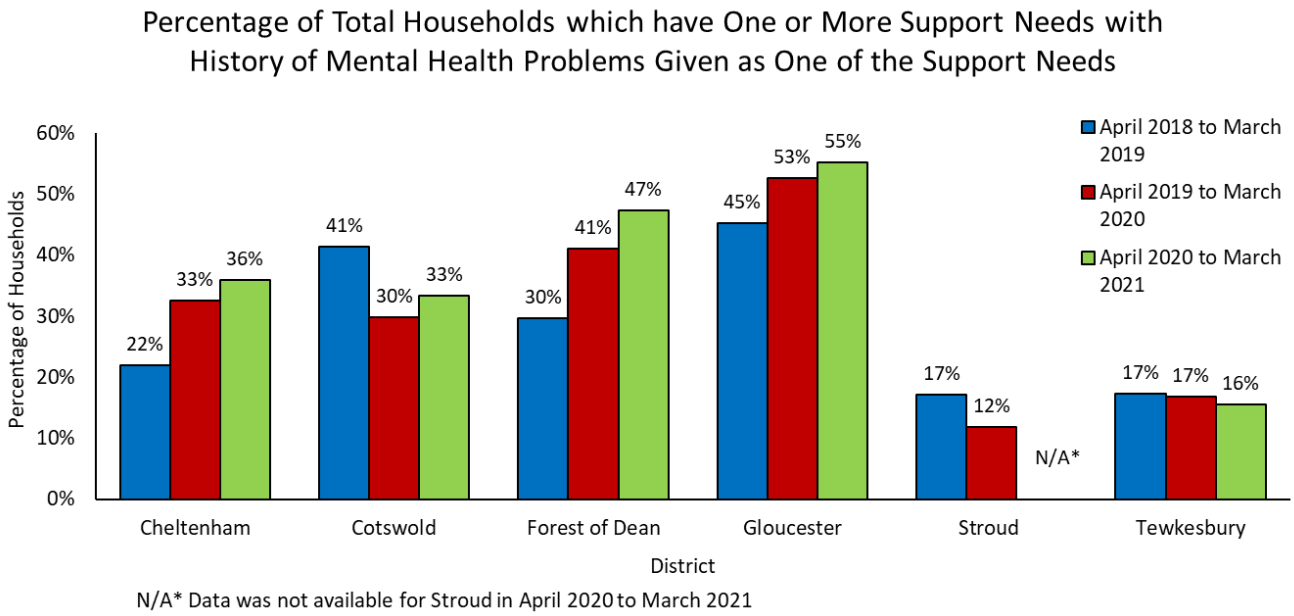
[46] Gloucestershire County Council (GCC) , 2017, SUE Project Gloucestershire – Health and Social Care Summary (unpublished)

issue and their substance misuse. Drugs and alcohol were being used to manage mental health issues, whilst also being recognised as exacerbating them. While participants understood mental health and substance misuse as part of the same problem, they felt that health services viewed them as independent issues. This was expressed as frustration by those experiencing mental health and substance misuse issues, as they were required to be 'clean' before they could access support. They felt that this left them, at least temporarily, with potentially no resources to manage their condition.

Local Authority housing assistance

If households are threatened with homelessness they can ask for help from Local Authorities to prevent them losing their home[47]. Information is gathered on the support needs of households who are receiving help from local authorities, and history of mental health needs is one of the identified support needs. The proportion of households with history of mental health needs given as one of the support needs has increased in Cheltenham, Forest of Dean and Gloucester between 2018-2021.

Graph 3



N/A* Data was not available for Stroud in April 2020 to March 2021

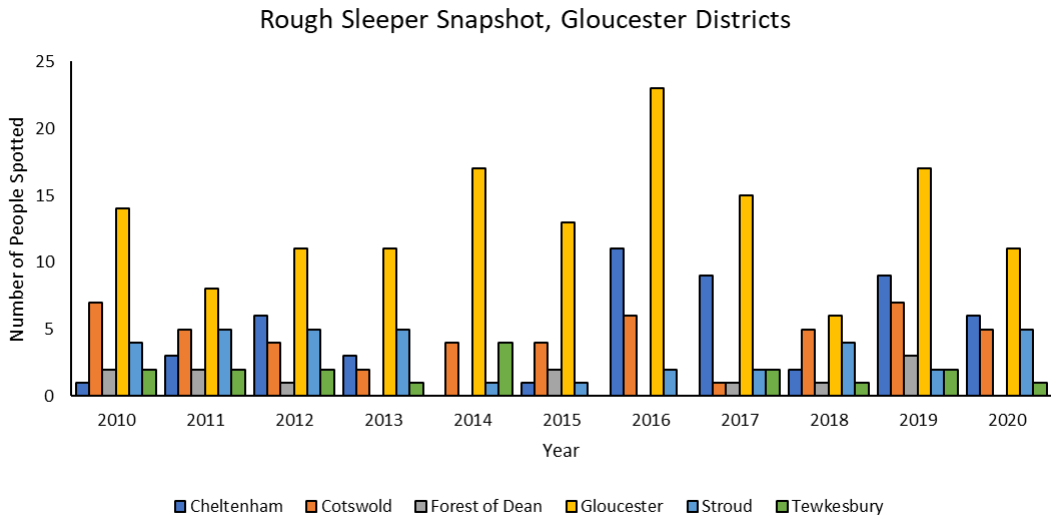
Rough sleeping

Rough sleeping is the form of homelessness most associated with health problems, and an annual rough sleeping snapshot aims to capture the number of people sleeping in open air locations, tents and make-shift shelters[48]. The highest numbers of rough sleepers each year are in Gloucester.

[47] Prevention duties include any activities aimed at preventing a household threatened with homelessness within 56 days from becoming homeless. Relief duties are owed to households that are already homeless and require help to secure settled accommodation. https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

[48] The annual rough sleeping snapshot can take place on a single date chosen by the local authority between 1 October and 30 November. The snapshot takes place in the autumn, rather than Summer where numbers are likely to be higher due to warmer temperatures, or Winter, where numbers may be lower as there are more temporary night shelters set up to ensure people do not sleep on the streets in very cold weather. The snapshot is collated by outreach workers, local charities and community groups and is independently verified by Homeless Link. This year's rough sleeping snapshot coincided with a national lockdown throughout

Graph 4



Data source: MHCLG Annual Rough Sleeping Snapshot, ONS

Implications

There is a large projected increase in population size between 2018-2043. When planning new housing developments, local planning authorities need to consider the wider determinants of good mental health and create healthy living environments.

The numbers of people living alone are projected to increase by 2043. We need to consider how we can work togther on a strategic level between partnerships to improve social connectedness within our communities as a form of primary prevention for social isolation and lonlieness.

Commissioners and providers should consider how they can promote an integrated approach to managing the co-dependent relationship of homelessness, mental health, substance misuse and early childhood experiences through service provision and care pathways. Mental health issues should be considered in the wider social context that a person is living in.

Also, while the evidence suggests a high prevalence of mental health issues[49], there is a low referral rate to mental health services when a homeless person interacts with mainstream healthcare[50]. Healthcare staff should have a better understanding and awareness of the mental health services and wider support available to their patients.

Homeless people recognised the importance of supportive social networks, but also reported a low level of social capital and dangers implicit in navigating homeless social networks. Commissioners and providers need to work to understand how to give homeless people access to positive and stable social networks which help to increase their social capital and to help motivate achievement of their aspirations.

November and many areas were in the highest tier of restrictions in October. This is likely to have impacted people's risk of rough sleeping and should be noted when comparing this year's annual snapshot figures with previous years.

[49] Seena Fazel, John R Geddes, Margot Kushel, The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations, In The Lancet, Volume 384, Issue 9953, 2014, Pages 1529-1540, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(14)61132-

[50] "The unhealthy state of homelessness: Health audit results 2014", Homeless Link

Education and employment

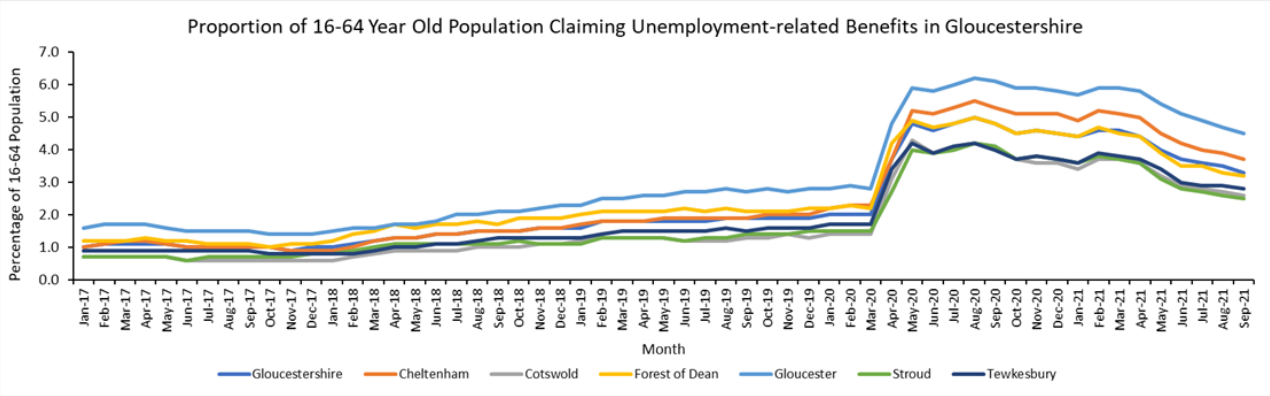
The charity 'The Health Foundation' have published a report on unemployment and mental health[51]. They explain that "unemployment – not having a job and actively seeking work – has consistently been found to have a negative impact on a range of health outcomes. There are several mechanisms by which unemployment could harm health:

- through stress and reduced self-esteem arising from the loss of the day-to-day structure of work or the stigma associated with unemployment
- as a result of financial hardship, insecurity and reduced future earnings potential, leaving people with stress (which damages health)
- from the social security system itself, which can have a negative impact on mental health through the claims process, work capability testing and job search conditions.

The health consequences of unemployment have been shown to increase with duration – for mental health and life satisfaction as well as for physical health. Pandemic restrictions have led to extended periods of reduced income, job loss or unemployment, and the long duration of these circumstances is a particular cause for concern."

Locally, we see that a spike in Universal Credit and Job Seekers Allowance claimants between March 2020 and May 2020 reflects the impact of SARS-CoV-2 health protection measures on the economy (Graph 5). The Claimant rate has decreased between May 2020 and September 2021 but remains at a higher rate than pre-pandemic.

Graph 5



Data Source: Claimant count by sex and age, ONS

Educational attainment and mental health are linked. Although the mechanism is not completely understood, there is evidence that people with common mental health conditions are more likely to have no formal educational qualification and those with psychoses[52] are more likely to have educational qualifications no higher than GCSE. The Annual Population Survey asks respondents about their educational qualifications. Between 2016 and 2019 the proportion of respondents with no qualifications was significantly lower in Gloucestershire than in England[53]. In 2020 there was no significant difference between the

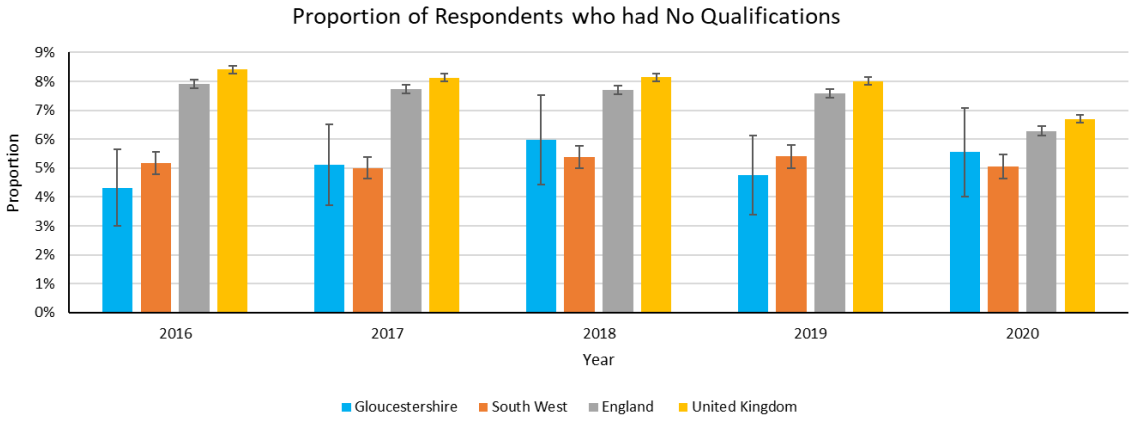
[51] Unemployment and mental health - The Health Foundation

[52] Includes affective psychoses (bipolar disorder and psychotic depression) and non-affective psychoses (schizophrenia and schizoaffective disorder)

[53] Although it is useful to see that we appear to have a low proportion of the population with no qualifications, there are inherent biases in surveys and it may be that people with no qualifications are unlikely to respond to a survey and the true number is not captured.

proportion of respondents with no qualifications in Gloucestershire and England, due to a reduction in the proportion of respondents in England who had no qualifications.

Graph 6



Implications

Number of claimants still higher than pre-pandemic levels. It is important to consider unemployment as a wider determinant of mental health.

Deprivation

Deprivation is about more than lack of money. It can include lack of access to resources such as adequate housing and exposure to negative stressors such as violence, crime or lack of public green space. A growing body of evidence suggests the relationship between deprivation and mental health is not just about absolute lack of resource for individuals. Populations with large differences in wealth and resource between individuals are associated with higher levels of poor health and mental health problems for the population as a whole[54].

Although poverty is just one aspect of deprivation, the Mental Health Foundation report on Poverty and mental health[55] states that "poverty increases the risk of mental health problems and can both be a causal factor and a consequence of ill health… Poverty produces an environment that is extremely harmful to individuals', families' and communities' mental health. The impacts of poverty are present throughout the life course (before birth and into older age) and have cumulative impacts." Nationally, the prevalence of psychotic disorders among the lowest quintile of household income is 9 times higher than in the highest, and double the level of common mental health problems between the same groups.[56]

Gloucestershire is a large county with areas of affluence and deprivation. The majority of those living in Index of Multiple Deprivation (IMD)[57] quintile 5 (Q5)[58] are based in urban areas (Graph 7). The main areas of deprivation are the urban centres of Gloucester and

[54] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652881/

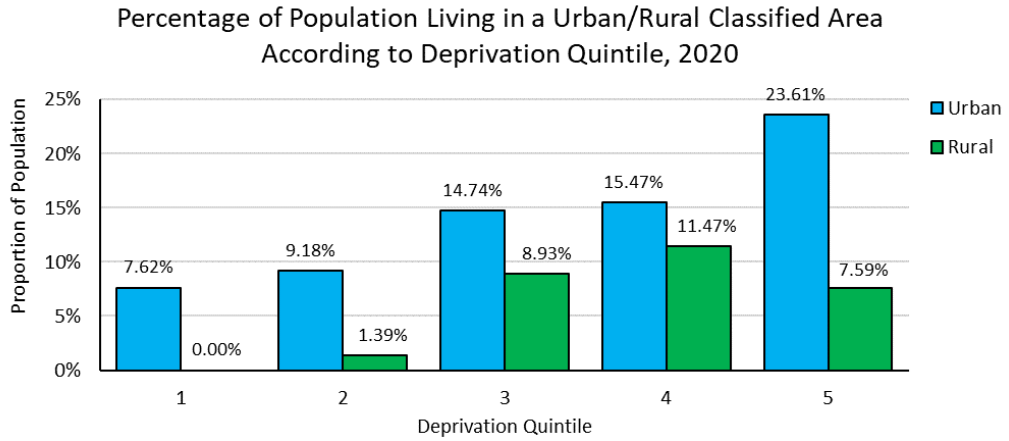
[55] Poverty and Mental Health.pdf

[56] 2. Mental health: environmental factors - GOV.UK (www.gov.uk)

[57] The English Indices of Deprivation provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas - abbreviated to LSOAs) across England, based on seven different (weighted) domains of deprivation: Income Deprivation (22.5%), Employment Deprivation (22.5%), Education, Skills and Training Deprivation (13.5%), Health Deprivation and Disability (13.5%), Crime and Disorder (9.3%), Barriers to Housing and Services (9.3%) and Living Environment Deprivation (9.3%). Combining information from the above seven domains produces an overall relative measure of deprivation, the Index of Multiple Deprivation (IMD). Each of these seven domains comprises of specific indicators. In addition, there are two supplementary indices: the Income Deprivation Affecting Children Index and the Income Deprivation Affecting Older People Index. These, together with the total IMD, total 37 indicators.

[58] A quintile is a statistical value of a data set that represents 20% of a given population, so the first quintile represents the lowest fifth of the data (1% to 20%); the second quintile represents the second fifth (21% to 40%) and so on.

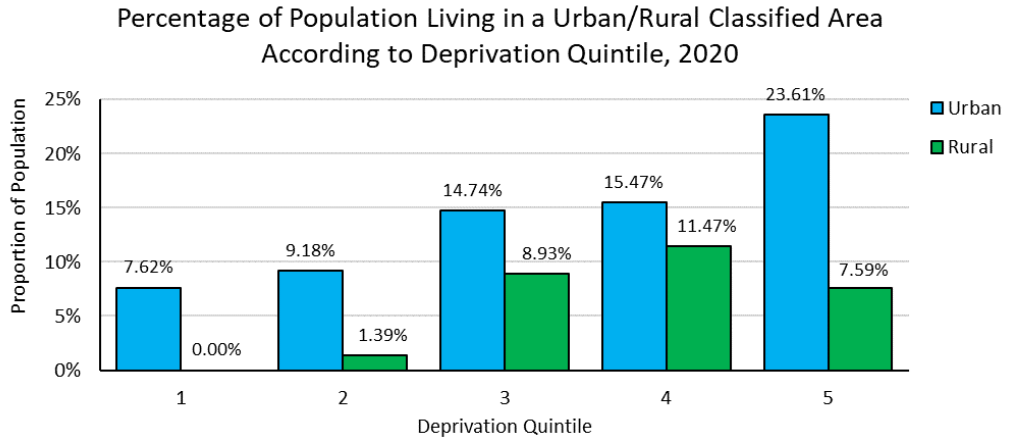
Cheltenham, but the Forest of Dean also has an area of high deprivation and has the largest proportion of residents living in Q1-Q3 and the fewest in Q5 (Graph 7:Percentage of population living in urban/rural classified area by deprivation quintile



Data sources: Mid-population Estimates, 2020; Rural/urban classification, ONS and Indices of Deprivation, 2019 MHCLG

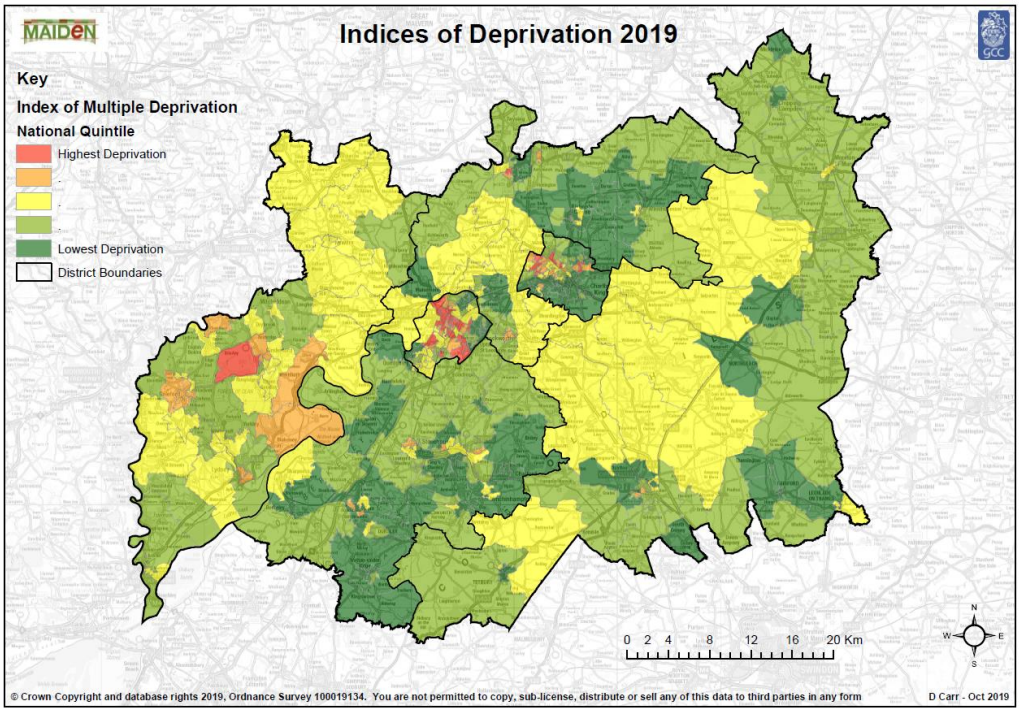
Figure 3). As deprivation is associated with poor mental health, it is important to consider the needs of the population in the Forest of Dean who may find it harder to access centrally located services.

Graph 7:Percentage of population living in urban/rural classified area by deprivation quintile



Data sources: Mid-population Estimates, 2020; Rural/urban classification, ONS and Indices of Deprivation, 2019 MHCLG

Figure 3: Gloucestershire Indices of Deprivation 2019



Implications:

Need to consider wider determinants of health in developing mental health support- and look at a holistic approach which also takes into account access to employment opportunities etc.

Although the population is mainly urban, we need to consider how people living in more deprived areas (e.g. Forest of Dean) are able to access centrally located services.

Vulnerable populations

Refugees

The Refugee Council[59] summarises the mental health support needs for refugees and asylum seekers: "People seeking safety in the UK are often deeply traumatised...Many of the people we support have lived through dreadful experiences and faced devastating losses. All have lost their homes, their livelihoods and their communities and been separated from their loved ones. Many have witnessed terrible violence, been tortured, seen family and friends killed and made perilous journeys before they finally arrive in the UK. Here in the UK, refugees also suffer acute anxiety about the complex asylum process. They worry about accommodation, money, education, access to legal advice. They fear detention, deportation, destitution and homelessness. And there is a constant concern about loved ones left behind or missing."

Gloucestershire Action for Refugees and Asylum Seekers (GARAS) offer support to those seeking asylum in Gloucestershire. They currently support over 800 people including at least 225 asylum seekers across Gloucester and Cheltenham. They help clients with a provision of psychotherapy, run by experienced therapists, particularly for those living with post traumatic stress disorder and this is partly funded by the NHS and partly by the resettlement program. GARAS find it challenging to support those with more complex psychiatric and emergency mental health needs.

[59] A charity, founded in 1951, who work with refugees and people seeking asylum in the UK.

Implications:

Refugees and asylum seekers in our county are a vulnerable population with a greatly increased risk of having or developing a mental health condition. In order to fully understand the needs of this population we should engage with GARAS and the refugee/asylum seeker population.

Domestic abuse

The impact of domestic abuse is significant and in some instances life changing or life ending in its most severe form. It can impact on an individual's health, mental health, finances, general self-esteem and wellbeing, education, employment and integration into society.

Safe Lives have conducted a range of 'spotlight' research projects that provide evidence on the experience of victims of domestic abuse who are more likely to also have care and support needs. This research highlights the following:

- Mental health problems are a common consequence of experiencing domestic abuse, both for adults and children and can in itself make a person more vulnerable to abuse. Victims of domestic abuse with mental health issues are also more likely to be experiencing multiple disadvantages than other victims of domestic abuse and this often coupled with additional complex needs such as drugs and alcohol misuse and financial difficulty. Research supports the existence of a bidirectional relationship; domestic abuse can lead to mental health difficulties, and having mental ill health can render people more vulnerable to domestic abuse. Safe Lives Insights IDVA 2017-18 dataset showed that 42% of people accessing support from a domestic abuse service had mental health problems in the past 12 months, and 17% had planned or attempted suicide. Safe Lives' Spotlights series found mental health problems are more prevalent and severe amongst certain groups of victims and survivors, with those identifying as LGBT+ and those who have a disability being more likely to have mental health needs at the point of accessing domestic abuse services[60].

Gloucestershire Domestic Abuse Needs Assessment 2021[61]

Mental health data summary:

- When entering refuge, 90% of victims were recorded as having mental health issues. Whilst it is not clear what these issues are specially, it is clear that many victims accessing refuge will experience issues with their mental health; a common impact of experiencing domestic abuse.
- 9% of all service users identified themselves as having a mental health condition. The proportion of service users reporting a mental health condition is below the Gloucestershire average.
- Data available on victim demographics applying as homeless to the district councils are available for years 2018/19 and 2019/20. Across all districts, disability is recorded across 3 categories, Physical Disability, Learning Difficulty and Mental Health. Across these categories, mental health is most significant factor recorded (Table 2).
- Referrals into Children's Social Services often flag domestic abuse coupled with mental health and alcohol/substance misuse as joint concerns, previously referred to as the 'toxic trio'. Within Gloucestershire around 12% of referrals into CSC state these 3 concerns, accounting for 753 referrals in 20/21. The percentage of referrals in 2020/21 for Forest of Dean, Gloucester and Stroud are above the countywide 3-year average.

[60] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf
[61] gloucestershire-domestic-abuse-needs-assessment-2021-final.pdf

- Independent Stalking Advocacy Caseworker (ISAC) service: Data available for the ISAC service cover the year September 2019-August 2020. In 11% of referrals, mental health was identified and in addition 4% were identified as having multiple and complex needs; a theme that has also arisen through domestic abuse and in particular in local domestic homicide reviews. The majority of victims (52%) were noted as wanting emotional support from the ISAC, with practical and safeguarding support also a high priority. Many victims also accessed the service to get support in arranging access to other services such as mental health, financial support, housing and substance misuse services.
- *Independent Domestic Abuse Advisors:* From 2021 (2 year pilot) the mental health IDVAs will have a base within Wotton Lawn and work alongside wider mental health services to provide support to victims of domestic abuse accessing mental health services, develop pathways of support and develop links between mental health services and the wider GDASS service.

Table 2

District	% of domestic abuse homeless applications where mental health was identified 2019/20	No. of domestic abuse homeless applications where mental health was identified 2019/20
Cheltenham	23%	14
Tewkesbury	13%	7
Cotswold	43%	12
Forest of Dean	26%	6
Gloucester	47%	100
Stroud	79%	55

Individuals experiencing domestic abuse who also experience additional complex needs, such as substance misuse, homelessness, poverty and mental health, are becoming a more prominent feature of domestic abuse support locally. A number of Domestic Homicide Reviews (DHRs) locally have highlighted a need to improve the local response to victims with complex needs, acknowledging that supporting these victims requires more intensive work and a trauma informed approach[62]. Gloucestershire County Council are currently reviewing the countywide response to complex needs and will consider the findings from DHRs in their ongoing work. This will be a longer-term piece of work looking to establish wider systems change and collective response to those experiencing multiple disadvantage and complex needs. There is a need to ensure domestic abuse is considered within the wider response to those with complex needs and develop specific processes to ensure victims with complex needs receive the right support at the right time and in a way that is accessible.

Implications

Relevant Objectives from the Gloucestershire Domestic Abuse Strategy (2021-2024)

- Partnership investment is made available for the development of joint working and co-location between domestic abuse support services and services that support those with mental health issues, substance misuse issues and wider complex needs.
- Developing a better understanding of the role of mental health in identifying domestic abuse and improving mental health pathways to specialist support.
- The criminal justice board's female offender strategy recognises that many female offenders experience chaotic lifestyles involving substance misuse, mental health problems, and homelessness which are often the product of a life of abuse and trauma. The strategy aims to take a new approach which is

[62] gloucestershire-domestic-abuse-needs-assessment-2021-final.pdf

locally-led, partnership-focused and evidence-based in order to address vulnerability and treat offenders as individuals with the potential to contribute positively to society.
- The national supporting families programme (formerly Troubled Families) has championed whole family and multi-agency working to support vulnerable families that are experiencing multiple disadvantages such as unemployment, domestic abuse and poor mental health.

Drug and alcohol abuse

Gloucestershire County Council are currently undertaking a Drugs and Alcohol Strategic review, that encompasses both data analysis and feedback from those with lived experience. An important part of this review will include recommendations on individuals with dual diagnosis – who have some form of addiction and at least one concurrent mental health problem. This MHNA will be updated with the findings from the Drug and alcohol abuse strategic review that relate to mental health.

There is information available from PANSI which shows the estimated numbers of people in the county who are at risk from alcohol related health problems and those who are predicted to be at risk form drugs:

- PANSI estimates show that 16,701 people (approx. 4,468 per 100,000 population) aged 18-64 in Gloucestershire are predicted to be at a higher risk of alcohol-related health problems in 2020. The Cotswold district is slightly higher than the county average at approx 4,614 per 100,000 population, the Cheltenham district is lower than the county average at 4,327 per 100,000 population. Men are at higher risk of alcohol-related health problems, with 61% of 18-64 year olds who are at higher risk being male. The split between male and female seems to be consistent throughout the county.
- PANSI estimates 12,362 people (approx. 3,307 per 100,000 population) aged 18-64 in Gloucestershire are predicted to be dependent on drugs in 2020. The Cheltenham district is the highest in the county at approx. 3,610 per 100,000 population and is predicted to increase to 3,725 per 100,000 in 2030. The Cotswold district is the lowest in the county at approx. 3,065 per 100,000. The split between male and female seems to be consistent throughout the county.

LGBTQ+

Individuals who identify as LGBTQ+ are more likely to develop common mental health conditions and also problems like self-harm and suicidal feelings. These are not caused by sexuality, but are a consequence of facing challenges such as homophobia, social isolation/exclusion and difficult experiences of 'coming out'[63]. Young LGBTQ+ adults are more likely to self-harm and 13% of those who identify as LGBTQ+ who are aged 18-24 have attempted to take their own life in the last year[64].

The office for national statistics (ONS) collected data on sexual orientation in the UK in 2019[65]. There main findings were:

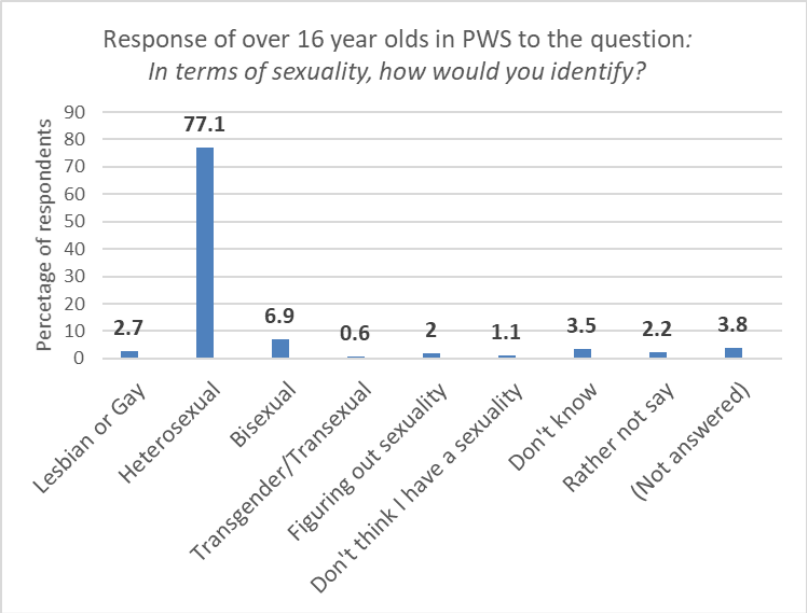
- The proportion of the UK population aged 16 years and over identifying as heterosexual or straight decreased from 94.6% in 2018 to 93.7% in 2019.
- An estimated 2.7% of the UK population aged 16 years and over identified as lesbian, gay or bisexual (LGB) in 2019, an increase from 2.2% in 2018.
- Between 2018 and 2019, the number of men identifying as LGB increased from 2.5% to 2.9% and women identifying as LGB increased from 2.0% to 2.5%.

[63] About LGBTIQ+ mental health | Mind, the mental health charity - help for mental health problems
[64] LGBT+ mental health (rethink.org)
[65] Sexual orientation, UK - Office for National Statistics (ons.gov.uk) latest release 27 May 2021 (last accessed 3/2/22)

- Younger people (aged 16 to 24 years) were most likely to identify as LGB in 2019 (6.6% of all 16 to 24 year olds, an increase from 4.4% in 2018); older people (aged 65 years and over) also showed an increase in those identifying as LGB, from 0.7% to 1.0% of this age category.

The Gloucestershire Pupil Wellbeing Survey (PWS) asks secondary and Post 16 pupils about their sexuality. In 2020, 9.6% of respondents identified as lesbian, gay or bisexual which is higher than the findings from the ONS survey (Graph 8). Gloucestershire County Council looked at the results of the PWS 2018 survey, specifically focusing on mental health[66]. They used WEMWBS[67] scores as a measure of low mental health, and found that 1 in 3 non-heterosexual young people reported low mental health in comparison to 1 in 8 heterosexual. They also found that the proportion of bi-sexual and transgender students who reported they self-harmed was 3 times higher than the proportion in the general population.

Graph 8



Implications:

Similarly to the findings in the ethnicity section of the MHNA, it is important to improve data collection about sexuality in local mental health services so that we have a better understanding of the needs of this population.

Carers

In 2019, Healthwatch Gloucestershire gathered a wide variety of feedback on many aspects of mental health services from people across the county[68]. They identified people who were caring for those who

[66] Children's Mental Wellbeing in Gloucestershire, 2018, Rowan Renow-Clarke

[67] Warwick-Edinburgh Mental Wellbeing Scales - The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 14-item scale WEMWBS has 5 response categories, summed to provide a single score. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

[68] HWG-carers-in-Covid-Report-final.pdf (healthwatchgloucestershire.co.uk)

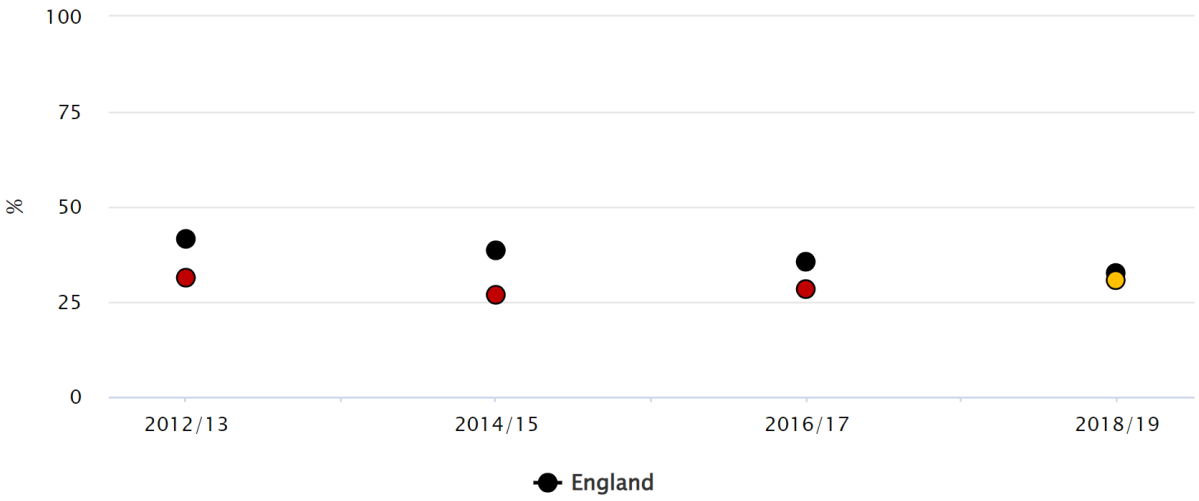
had a mental health illness and who wanted their voice heard. Carers spoke to them about what mattered most to them regarding mental health support for the person they care for. They attended support groups for carers across the county, to speak to them about their views and experiences. They engaged with over 60 carers and visited groups in each district of the county.

The key messages from the report:

- Some people were able to access information about services and support easily, however some people struggled to know where to go to get this information. Carers especially felt that accessing professional support or advice for themselves was hard.
- People felt the information they accessed could sometimes be conflicting and difficult to understand. Information often came from various sources and wasn't necessarily focussed on carer support. In particular there was little support relating to mental health carers.
- Carers felt frustrated that there are barriers to communication, with health and social care professionals not understanding what they are able to discuss about a service user with the carer.
- Carers felt they did not have enough support for themselves, short-term or long-term, and struggled to maintain their own health and wellbeing.
- Carers felt that if they are there to support the service user, it may mean there are not as many professional support services available to the person they care for.

In Gloucestershire in 2018 approx. 30% of adult carers felt that they had as much social contact as they would like. This is the first year that Gloucestershire had a similar, rather than worse, result to England but unfortunately reflects a worsening in the England trend rather than an improvement in the Gloucestershire response.

Graph 9: Percentage of adult carers in Gloucestershire who have as much social contact as they would like (18+ years) in comparison to England (2018/19)



Source: Adult Social Care Outcomes Framework (ASCOF) based on the Personal Social Services Survey of Adult Carers, NHS Digital

Implications

Carers are an important source of support for those who have mental illness but are themselves at risk of developing common mental health conditions and feeling socially isolated. A recent Healthwatch report

indicates that the local carer population feel that there is little support relating specifically to mental health carers.

Any recommendations made to prioritise social connectedness and primary prevention of mental health illness, should consider carers as a vulnerable group and mental health carers should be signposted towards tools to support their wellbeing.

Armed forces

When staff leave the armed forces, their healthcare transfers from the military to the NHS. We do not know enough about our population of veterans in the county, however for the first time the 2021 census asked people if they were a veteran of the Armed Forces. We expect this to give a much more accurate picture of the size of the population, and we will revisit this group once the Census findings are published.

Long term health conditions/Physical health

The 2011 Census showed differences in outcomes in a number of areas in Gloucestershire:

- amongst people aged 65 and over, Asian/Asian British people and Black African/Caribbean/Black British people were more likely than people from other ethnic backgrounds to have a long-term limiting illness and to be in poor health;
- people of Gypsy or Irish Traveller origin were considerably more likely to be in poor health compared with all other ethnic groups (15.9% of Gypsy/Irish Travellers compared with 4.6% of White British people).

PANSI data insights for physical health

There are predicted to be 30,803 people in Gloucestershire with Diabetes in 2020, this is expected to increase by 15% by 2030 to 35,371. Diabetes seems to be more prevalent in Males with a 56% to 44% split for females. It is most prevalent in the Stroud District, with currently 6,031 people predicted to have Diabetes, this is predicted to increase in Stroud to 6,851 by 2030. The split between males and females throughout the districts seems consistent with the county.

There are 1254 people in Gloucestershire predicted to have a longstanding health condition caused by a stroke in 2020. This is shown to be more prevalent in males than females from age 45+, however it is more prevalent in females below this age group. The predictions for 2030, don't show a significant increase for both the County or the districts.

There are 21,847 people in Gloucestershire predicted to have impaired mobility who are aged between 18-64, this is most prevalent in the people aged 55-64. This is predicted to increase to 22,782 by 2030.

Chapter 2: Appendix 1

Risk factors for mental health

The UK government office for Science commissioned a report on Mental Capital and Wellbeing: Making the most of ourselves in the 21st Century. 80 reviews were undertaken across 5 areas, and this table summarises the findings on risk factors for mental health that was brought together by the researchers in the Mental health: Future challenges report[69]. The report uses data from national surveys of psychiatric morbidity, as well as additional surveys looking at key groups e.g. prison population.

Table 3

	Common Mental Disorders: encompasses depression, anxiety, phobias and OCD. Risk factors refer to all Common mental Disorders (CMD)s unless specified	**Psychoses:** encompasses affective psychoses (bipolar disorder and psychotic depression) and non-affective psychoses (schizophrenia and schizoaffective disorder) Risk factors refer to all psychoses unless specified	**Dementia**	**Personality Disorders**
Gender	More likely to be women.	Men are twice as likely to develop non-affective psychoses than women Incidence of affective psychoses is equal.	Higher proportion of deaths attributable to dementia in women. Prevalence of young onset dementia is higher in men than in women for those aged 50-65. Late onset dementia is slightly more prevalent in women.	No difference in incidence
Age	More likely to be aged between 35-54. Less likely to be aged between 65-74	Highest incidence of psychosis in 20-34. With small secondary peak in incidence around menopause for women.	More common in older people	Increased in younger people

[69] Jenkins, Rachael and Meltzer, Howard and Jones, Peter and Brugha, Terry and Bebbington, Paul and Farrell, Michael and Crepaz-Kay, David and Knapp, Martin (2008) Mental health: future challenges. Foresight, 104-08-Fo/on. The Government Office for Science, London, UK

Household	More likely to be living as a one-person family unit, or as a lone parent	More likely to be living alone		Increased in single people
Education	More likely to have no formal educational qualification	More likely to have educational qualifications no higher than GCSE	Leaving education early[70]	
Stressful life events E.g. sexual abuse, domestic violence, homelessness	Life events are important risk factors for CMDs. Onset of CMD is 3 times higher for women reporting 6 or more life events. People in prison and homeless people have considerably higher rates than the general population.	97% of people in the survey had experiences a stressful life event		Childhood maltreatment and supervision neglect independently increase the risk of developing Personality Disorders (PD) in young adulthood
Family history		Children and siblings of individuals with schizophrenia have a 10 times increased risk compared to the general population		Strong genetic influence for emotional and fearful clusters of PD
Deprivation and employment	More likely to come from social class V. Less likely to come from Social class I	More likely to be in social class IV or V and be economically inactive. Increased rates with neighbourhood deprivation and lack of social cohesion, both in childhood neighbourhood and current neighbourhood	Less job complexity can cause poor cognitive reserve and higher risk of Dementia. Also, living in an area of deprivation means you are at higher risk of getting dementia.70	Increased in those with lower socioeconomic status and poorly educated

[70] factsheet_risk_factors_for_dementia.pdf (alzheimers.org.uk)

Social isolation	More likely to have smaller social network.	More likely to have poor social cohesion and greater social isolation. 20% of people with psychoses reported feeling close to fewer than four people.	Increased social isolation leads to poor cognitive reserve and higher risk of getting Dementia70	
Ethnicity	Higher rates in Irish and Black Caribbean	Increased risk (2-8 times higher). Risk of psychoses for BME groups and immigrants increases when they make up a smaller proportion of the area that they live in[71].	Black African, Black Caribbean and South Asian people have higher rates of vascular dementia than white Europeans[72]70	
Housing	More likely to be tenants of Local Authorities and housing Associations and to live in an urban area.	More likely to live in accommodation rented form local authority or housing association and live in an urban area.		Urban>rural
Chronic co-morbidities	More likely to have one or more physical complaints	More likely to report long-standing psychical health problems	Specific conditions can increase risk of dementia, including: cardiovascular disease, hearing loss, traumatic brain injuries, depression, learning disabilities.	

[71] The ethnic density effect in psychosis: a systematic review and multilevel meta-analysis. The British Journal of Psychiatry (2021) 219, 632–643. doi: 10.1192/bjp.2021.9

[72] Risk factors you can't change | Alzheimer's Society (alzheimers.org.uk)

Chapter 3: Services and Support in Gloucestershire:

Summary:

Important factor for consideration: Need to consider the suitability of online platforms for older age groups

Service user analysis
The service user analysis cannot be interpreted until we have engaged with the relevant services included to understand how the findings from this analysis feed into their experiences from the service.

The following is a summary of the points that need further discussion with the services:

Eating Disorder (ED) analysis:
From comparing the number of people being referred and assessed with the service with the CCG registered population, we need to investigate whether there is possible:

- Overrepresentation of white adults in both referrals and assessments
- Underrepresentation in referrals from Cotswold and Forest of dean in comparison to the CCG average population
- Increase in assessment probability for least deprived individuals
- Decrease in assessment probability for obesity (potential service gap for over-eating)
- Underrepresentation in referrals for men

It is also of interest that Stroud Trinity has a much higher rate of referrals and assessments than the rest of the county and possible reasons for this need to be discussed with the service.

Recovery service analysis:
From comparing the number of people being referred and assessed with the service with the CCG registered population, we need to investigate whether there is possible:

- Underrepresentation of Asian/Asian British in referrals
- Underrepresentation of the districts Cotswolds, Forest of Dean, Stroud and Tewkesbury
- Underrepresentation of men

Mental health attendances to Emergency Departments and Minor Injury and Illness Units (MIIU):
The main findings are as follows:

- The months with the greatest frequency of mental health attendances are in the summer.
- The gender gap in mental health attendances is increasing, with more women presenting due to mental health each year.
- Highest proportion of ED and MIIU Mental Health Attendances is in most deprived individuals
- The Forest of Dean accounted for 48.13% of MIIU mental health attendances between 2017-2021.
- The highest number of MIIU attendances due to mental health are in the 25-34 age group

Service user data analysis

Different levels of Mental Health support are available in Gloucestershire, from people seeking support within their own community to specialist inpatient care. Specialist mental health services are available for all ages, and are primarily provided by Gloucestershire Health and Care NHS Foundation Trust[73].

This chapter takes into consideration the different levels of need that an individual may have when seeing support (inspired by the Gloucestershire mental health signposting sheet[74]).

This MHNA provides a very brief overview of services that are available in the county, with an in depth look at the Eating Disorder service, the Recovery service and Mental Health attendances to Emergency Departments and Minor Injury and Illness Units (MIIUs). The service user data analysis undertaken for this MHNA is limited to data from specific services mentioned, but the authors hope that the tools developed for service user analysis in this chapter will be used in future to analyse other key mental health services within the county.

1. Individuals seeking support in their community to support their wellbeing

There are many services in the county, both commissioned and community led, to help people support their wellbeing and connect to their community. The services that work to support these individuals focus on self-management, prevention and early intervention.

There are specific services focused on different populations who require mental health support, for example Change Grow Live[75] is a drug and alcohol recovery service that can provide peer support and advice. Unfortunately, the scope of this MHNA was not able to encompass service user data analysis from all of the providers of mental health support in the county and there is no service user data for individuals seeking support in their community to support their wellbeing.

2. Individuals seeking help with anxiety, low mood or depressions (Not in immediate crisis)

For people who need more support, but who are not in crisis, there are further services available. Examples include Improving Access to Psychological Therapies (IAPT) and Community Advice, Links and Mental Health Support (CALMHS).

Community Wellbeing Service

The Community Wellbeing Service[76] works to improve quality of life of individuals and increase their knowledge, skills and confidence to enable them to take control of their wellbeing, live independently and improve their health outcomes. The service does this by providing a range of support from 'light touch' signposting to community groups or services through to holistic 1:1 support, taking into consideration the wider needs of the individual. The service is countywide and delivered by five providers who each have a local presence in one district of the County. People can be referred to the service for a variety of reasons, including: debt and finance, general health and fitness, housing and environment, loneliness, long term health conditions, mental health and wellbeing, social isolation and other (patients can be referred for more than one reason). In

[73] Welcome to the Gloucestershire Health and Care NHS Foundation Trust (ghc.nhs.uk)
[74] mental-health-signposting-sheet-final-280520.pdf (gloucestershire.gov.uk) (version 6 updated 4/2/2021)
[75] Drug & Alcohol Recovery Service - Gloucester hub (changegrowlive.org)
[76] Community Wellbeing Service - Gloucestershire County Council

2019/20, 2020/21 and 2021/22 the most common reason for referral was mental health and wellbeing (approx. 25%), followed by social isolation (approx. 16%). These were the most common reasons for referral in every district.

Qwell

Qwell was commissioned during the pandemic and is now no longer available in Gloucestershire, however data collected through this service has been considered as part of this needs assessment. Qwell is an online platform which provide early intervention support with common mental health issues, such as anxiety and stress. Users can register anonymously and no referral is required. Once registered users can access forums, self-care articles and online counselling. Throughout 2020/21 in Gloucestershire, over 75% of the Qwell logins have been made by females. Research suggests women are more likely to access mental health services than males; this trend has been seen across other services. Overall there was no clear pattern of change between the proportion of Qwell logins per age group between April 2020 and March 2021. People over the age of 60 consistently used the service less than the other age groups.

Implications:

Need to consider the suitability of online platforms for older age groups.

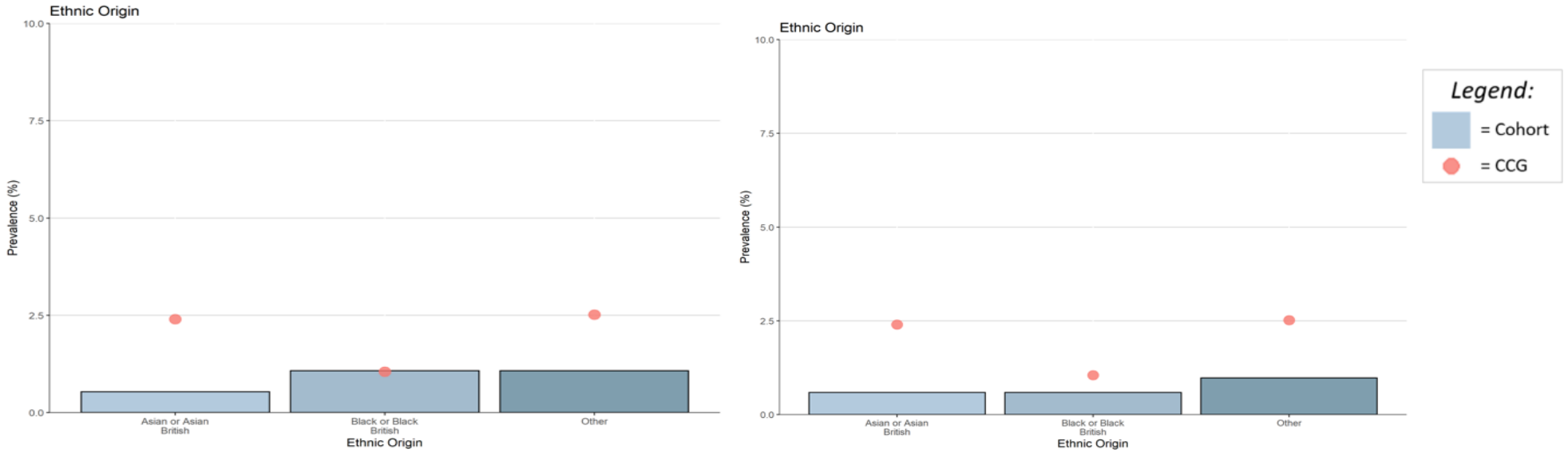
3. Individuals engaged with specialist mental health services within GHC

This section of the report contains the in-depth user analysis of key services, and the formatting of the graphs is different to other section of the MHNA. The tool examines referrals and initial assessments to the services from Gloucestershire Health and Care Foundation Trust, compared with the total population registered at Gloucestershire CCG (less the cohort concerned). The y axis usually contains the prevalence (%) of the population, with different demographic categories displayed on the x axis. Figure 4 is an example of how data from the graphs can be interpreted to reveal a possible underrepresentation or overrepresentation of a population group. On the left the prevalence of Black or Black British clients being referred into the service is very similar to the background population, however on the right the data shows that the number of Black or Black British clients having an initial assessment is below what we would expect to see.

This type of data analysis cannot be taken in isolation without wider context on known prevalence of mental health conditions within different demographic groups or knowledge about how different groups interact with service provider, and as such findings from the analysis should be used as a guide for further discussion rather than conclusive facts.

Please note all graphs which refer to 'referrals' include all referrals including repeat referrals for the same individual(s), i.e. data presented is not de-duplicated.

Figure 4: Example of graph interpretation with referrals on the left and initial assessments on the right



Eating disorder

An eating disorder is a mental health condition where you use the control of food to cope with feelings and other situations. Unhealthy eating behaviours may include eating too much or too little or worrying about your weight or body shape. The most common eating disorders are[77]:

- anorexia nervosa – trying to control your weight by not eating enough food, exercising too much, or doing both
- bulimia – losing control over how much you eat and then taking drastic action to not put on weight
- binge eating disorder (BED) – eating large portions of food until you feel uncomfortably full

The National Institute of Mental Health in the United States reports that[78]: "Eating disorders can affect people of all ages, racial/ethnic backgrounds, body weights, and genders. Eating disorders frequently appear during the teen years or young adulthood but may also develop during childhood or later in life. Researchers are finding that eating disorders are caused by a complex interaction of genetic, biological, behavioural, psychological, and social factors".

The Gloucestershire Eating Disorders service supports both Children and young people and Adults, it can be accessed via self-referral or via a GP or other healthcare professional[79]. The Community Team complete and initial assessment and determine the best course of action for each individual.

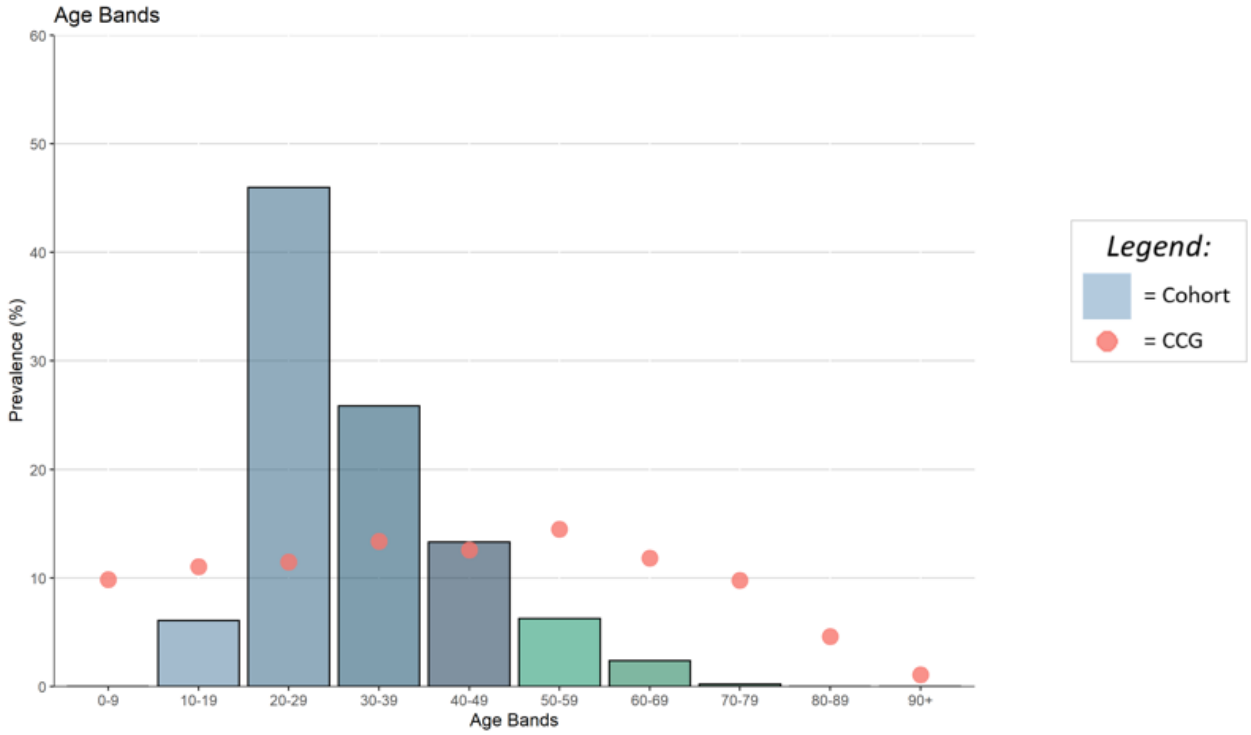
In this analysis, the eating disorder cohort includes those aged 18 and above, and covers the period 01.10.2020 – 30.09.2021. There are 186 patients in the Initial Assessment cohort and 511 in Referrals, with average ages of 28.7 and 31.8 years old respectively.

Age

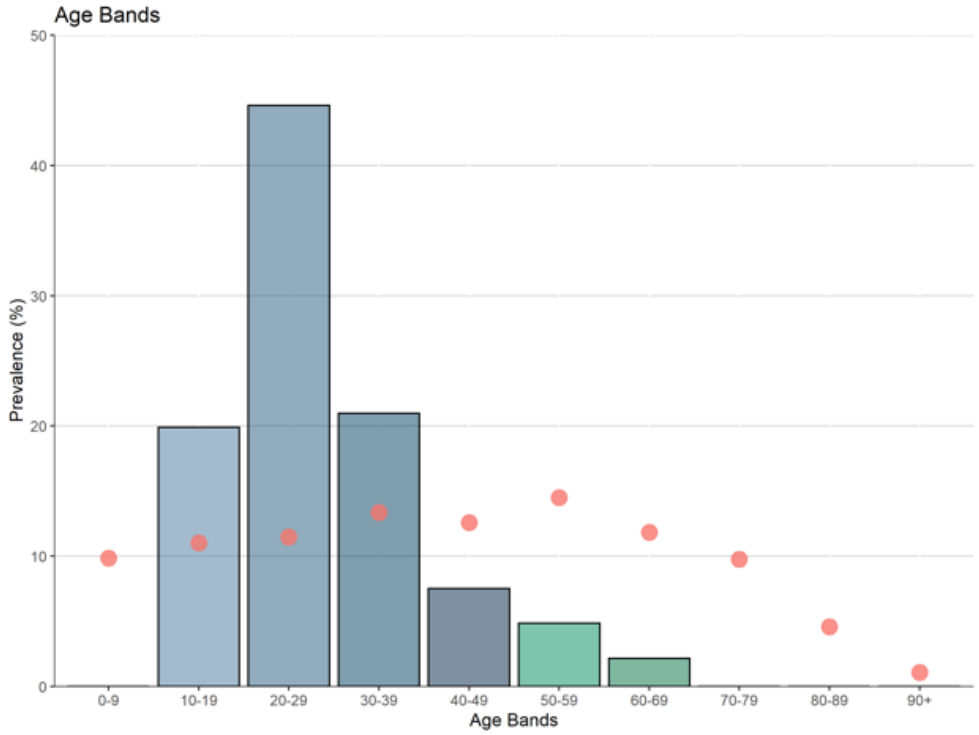
Graph 10 and Graph 11 show distribution by age bands (referrals & assessments respectively). The Eating disorder cohort has approximately half the prevalence of referrals and almost double the prevalence of assessments for the 18-19 age band vs. CCG average. This high conversion rate may indicate a high level of appropriate referrals for this age band. The 20-29 age band is fairly consistent around 45% prevalence for both referrals and assessments, more than treble the CCG average in both cases. Over the 30-39, 40-49 and 50-59 age bands we begin to observe a greater number of referrals than assessments. These are all below the CCG average for the age band, with the exception of referrals among 40-49 year olds, which is slightly above.

[77] Overview – Eating disorders - NHS (www.nhs.uk)
[78] NIMH » Eating Disorders (nih.gov)
[79] Eating Disorders > Gloucestershire Health and Care NHS Foundation Trust (ghc.nhs.uk)

Graph 10: Eating disorder Initial Assessments by Age Band – between 01/10/2020 and 30/09/2021



Graph 11: Eating disorder Referrals by Age Band - between 01/10/2020 and 30/09/2021

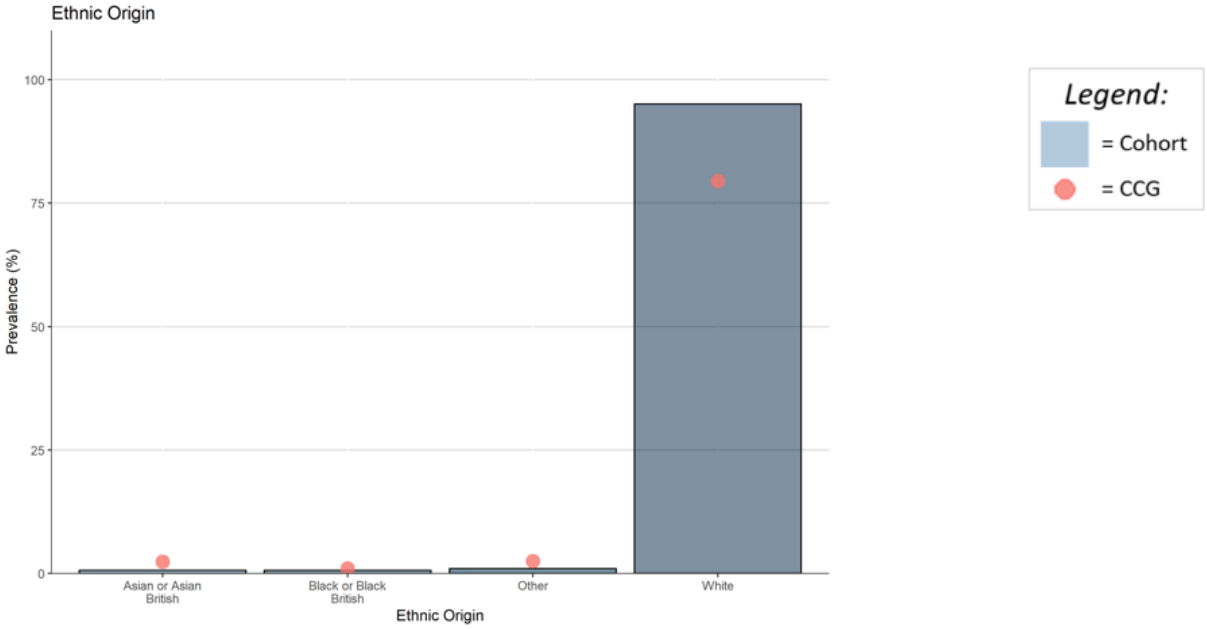


In this analysis, the eating disorder cohort includes those aged 18 and above, and covers the period 01.10.2020 – 30.09.2021. There are 186 patients in the Initial Assessment cohort and 511 in Referrals, with average ages of 28.7 and 31.8 years old respectively.

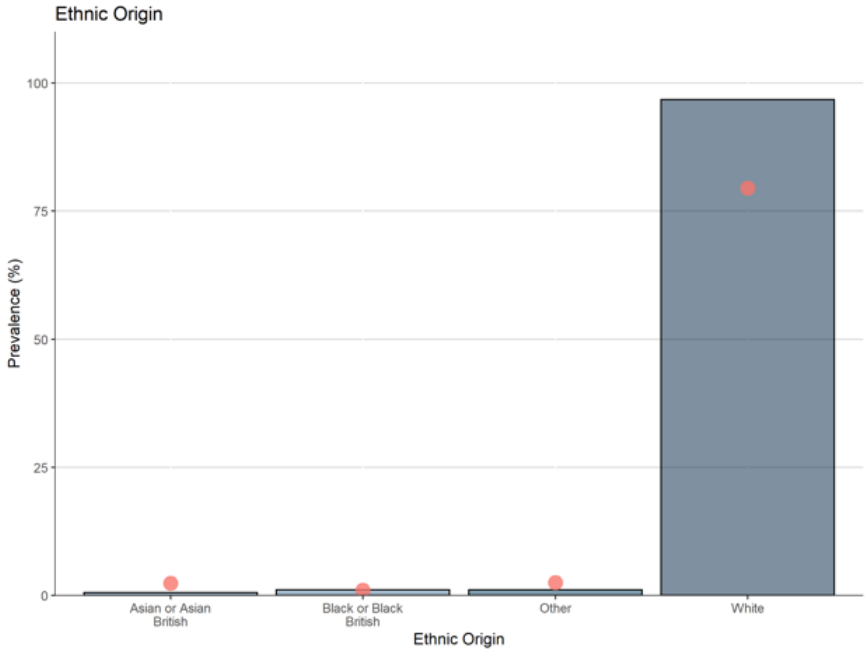
Ethnicity

Graph 12 to Graph 15 show distribution by ethnic origin. Graph 12 and Graph 13 largely illustrate the White cohort vs. others, while Graph 14 and 15 isolate 'non-White' cohorts in more detail. Immediately clear from Graph 14 and 15 is that with the exception of Initial Assessments for the 'Black or Black British' demographic, the ethnic minority cohorts are underrepresented as it falls below the CCG average on each count. It is also notable that the only demographic with a significant increase from referrals to assessments beyond the CCG average is 'Black or Black British'. This could indicate appropriate referrals from this group as a greater proportion are assessed from a smaller proportion of referrals. Graph 12 and 13 show that the only demographic with overrepresented prevalence vs. CCG average is 'White'.

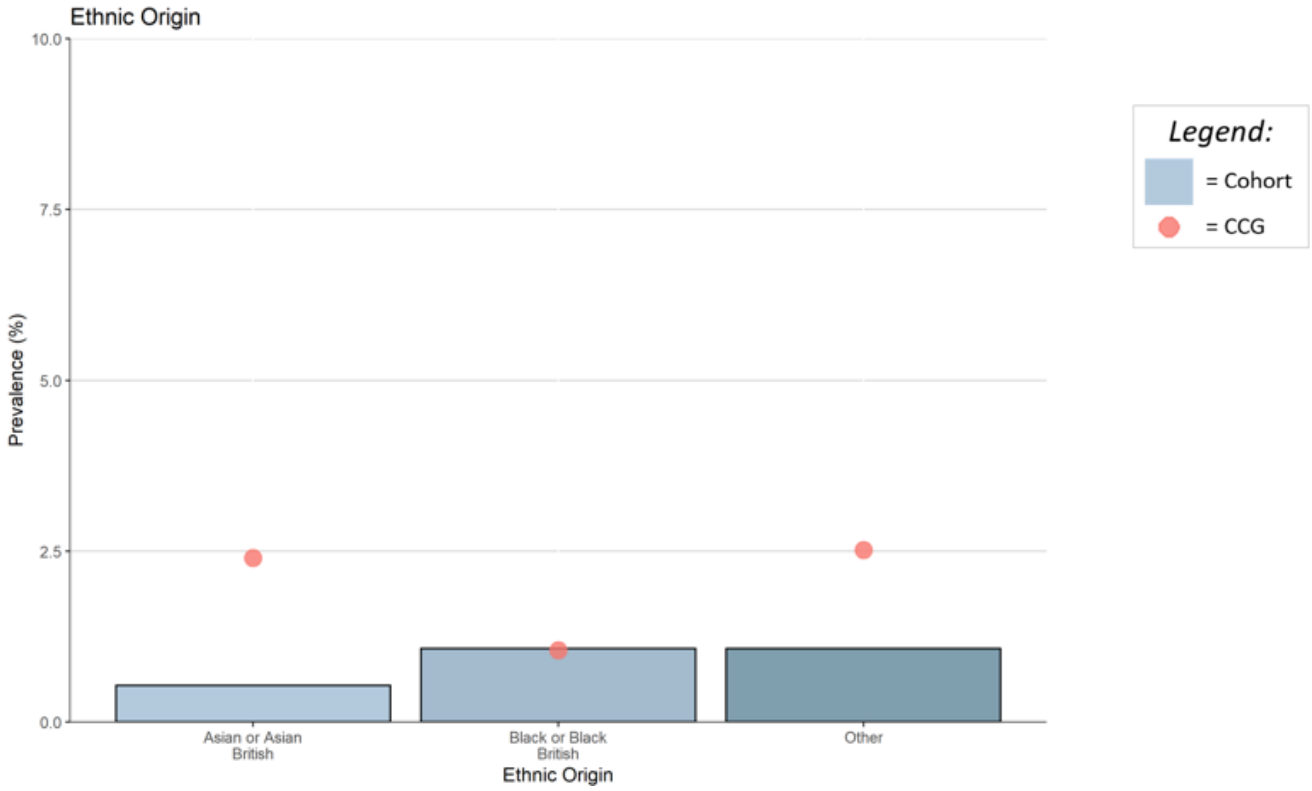
Graph 12: Eating disorder Referrals by Ethnic Origin - between 01/10/2020 and 30/09/2021



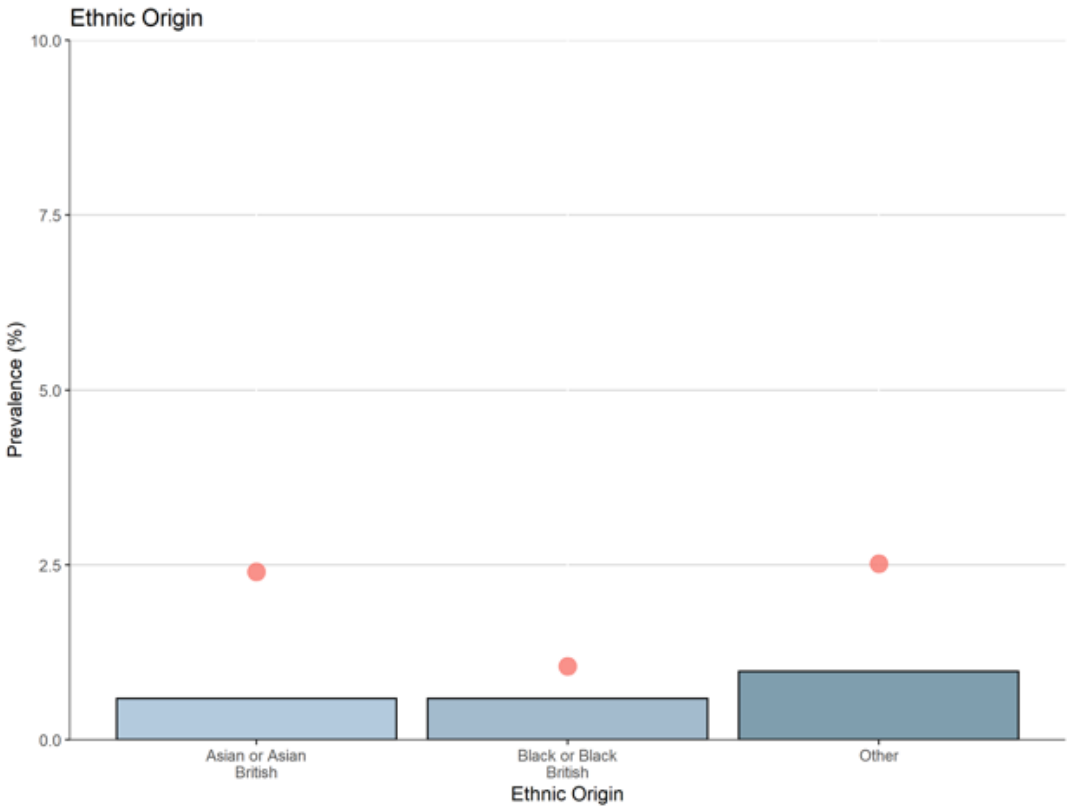
Graph 13: Eating disorder Initial Assessments by Ethnic Origin - between 01/10/2020 and 30/09/2021



Graph 14: Eating disorder Referrals by non-'White' Ethnicity - between 01/10/2020 and 30/09/2021



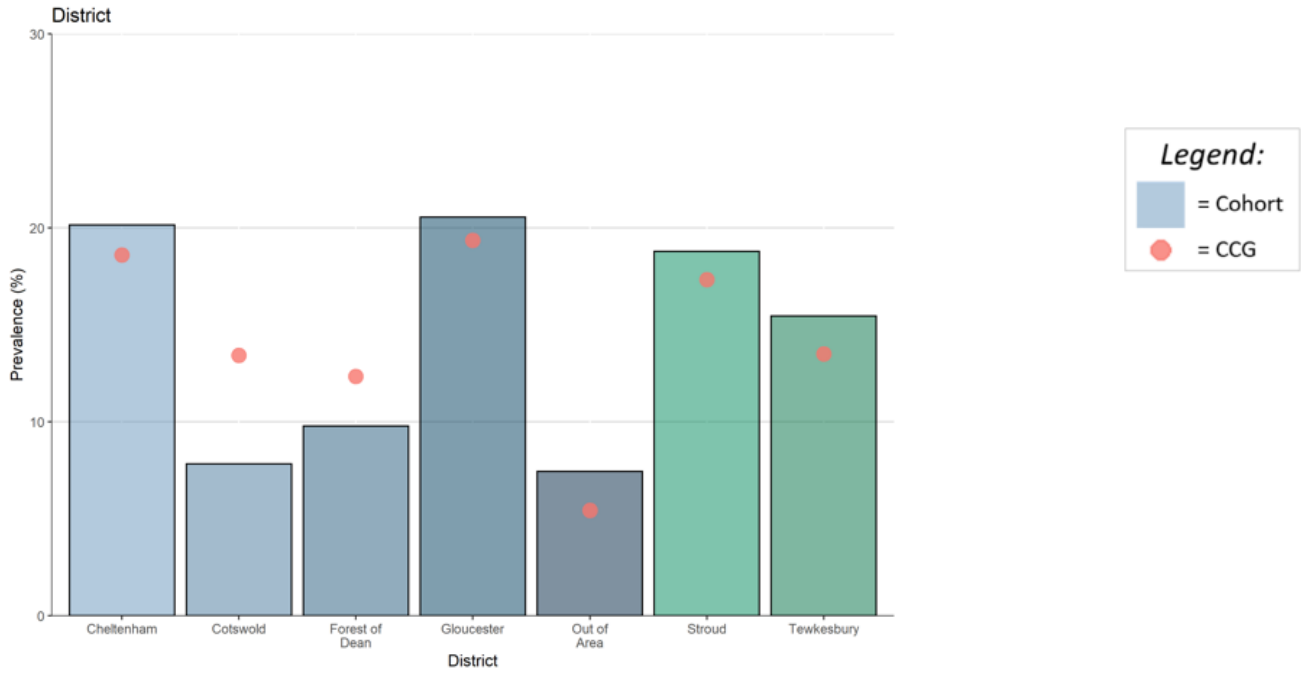
Graph 15: Eating disorder Initial Assessments by non-'White' Ethnicity - between 01/10/2020 and 30/09/2021



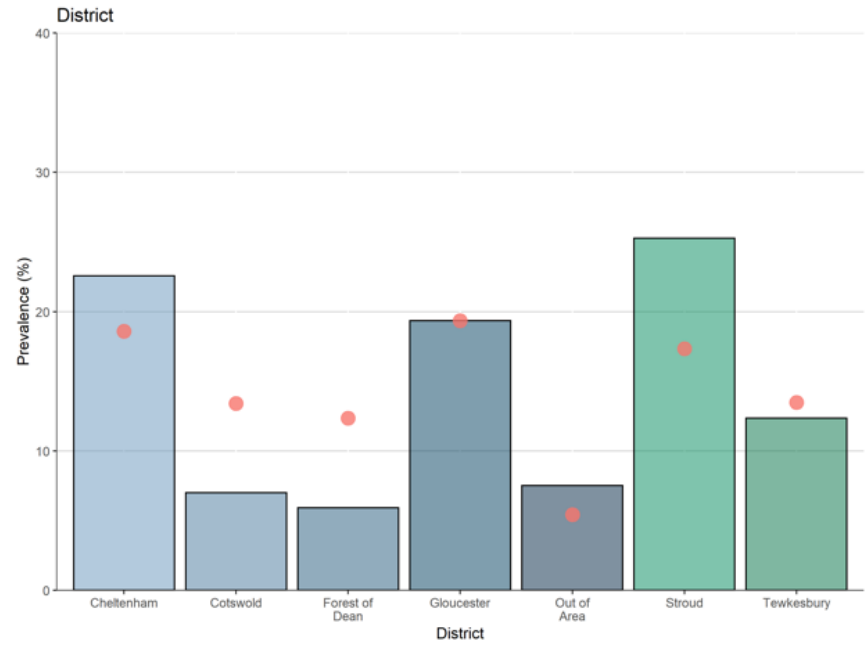
District

Graphs 16 and 17 show distribution by district. Immediately noticeable is the sizeable underrepresentation of the cohort in Cotswold & Forest of Dean (FoD) for both assessments and referrals vs the CCG average. Aside from these two districts, the cohort demonstrates a higher prevalence than the CCG average for referrals. Considering initial assessments, the cohort appears to have a higher prevalence in Cheltenham, Out of Area & Stroud, average prevalence in Gloucester and lower prevalence for Tewkesbury (as well as Cotswold & FoD as previously mentioned). This could reflection differences in population demographics in the different districts, with an older population in the FoD, or there could be challenges to referral/accessing services in Cotswold and FoD.

Graph 16: Eating disorder Referrals by District - between 01/10/2020 and 30/09/2021



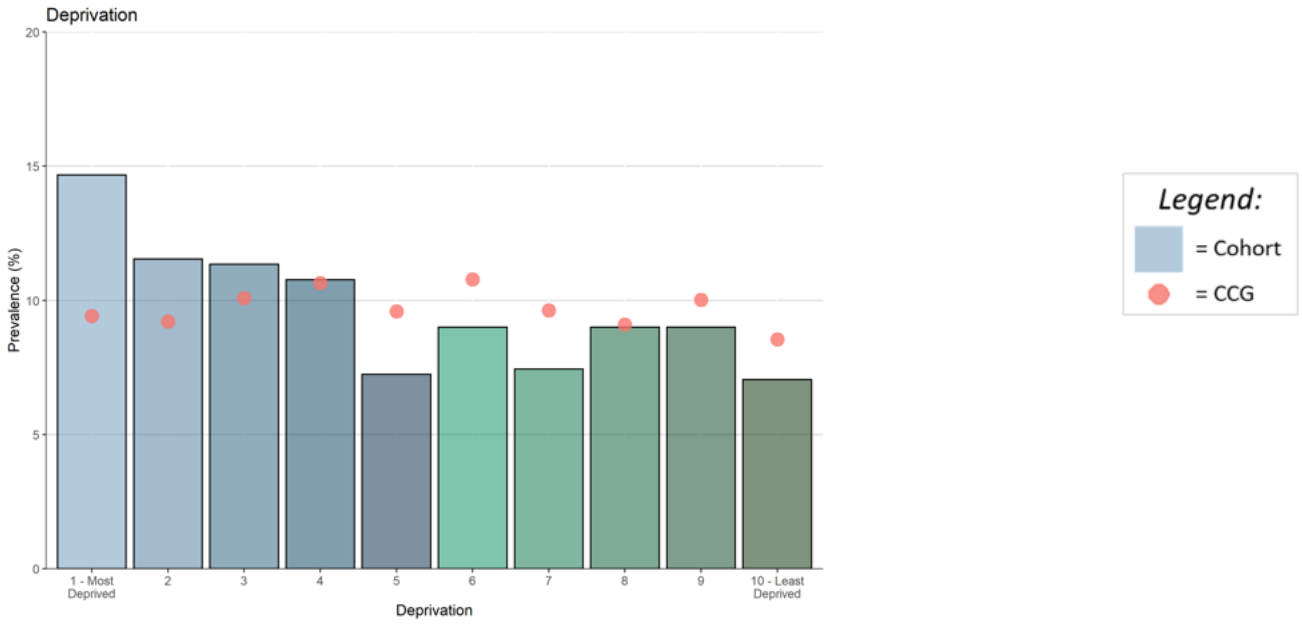
Graph 17: Eating disorder Initial Assessments by District - between 01/10/2020 and 30/09/2021



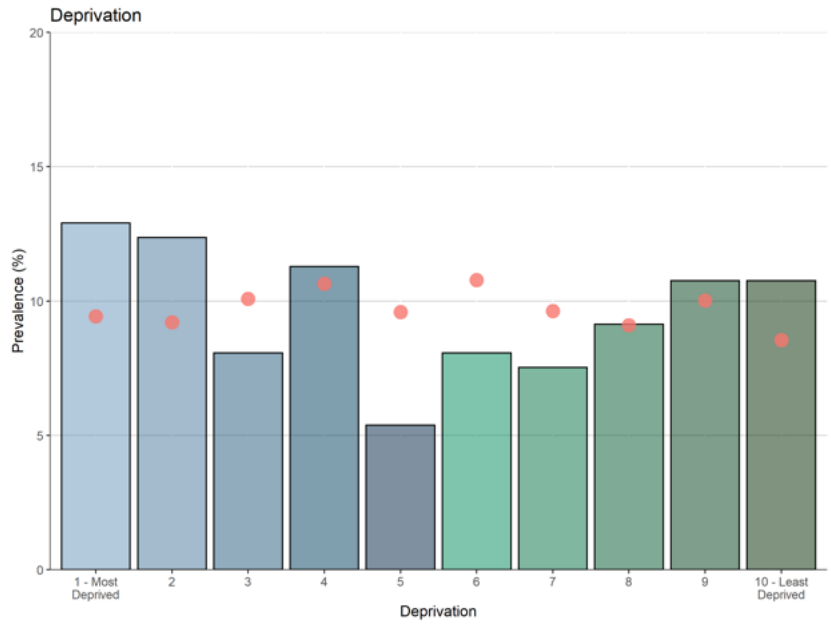
Deprivation

Graph 18 and 19 show distribution of the cohort by deprivation level. The cohort is overrepresented vs the CCG average at both ends of the deprivation scale for assessments – levels 1, 2, 4, 9 and 10 – and is overrepresented only toward the 'most deprived' end of the scale for referrals. Interestingly, in both figures the CCG data is clustered around a 10% prevalence, suggesting that deprivation level may not be an optimal indicator, however 18 shows a minor downward trend in referral prevalence from most-to-least deprived. This could indicate a higher demand for services for the most deprived deciles, but a higher possibility of a referral being assessed for the least deprived. Deprivation levels 5, 6 and 7 are underrepresented vs. CCG average for both.

Graph 18: Eating disorder Referrals by Deprivation Level - between 01/10/2020 and 30/09/2021



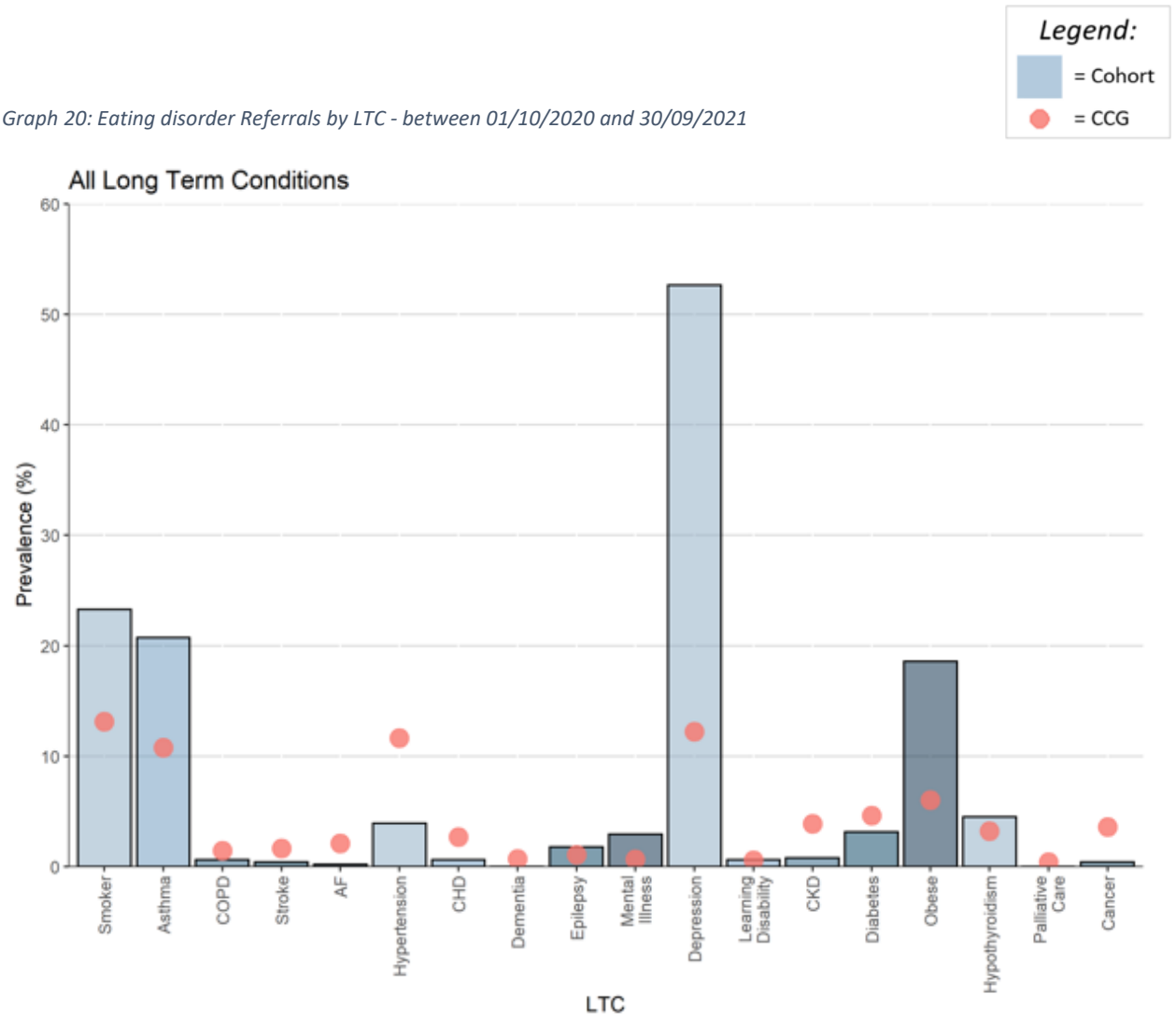
Graph 19: Eating disorder Initial Assessments by Deprivation Level - between 01/10/2020 and 30/09/2021



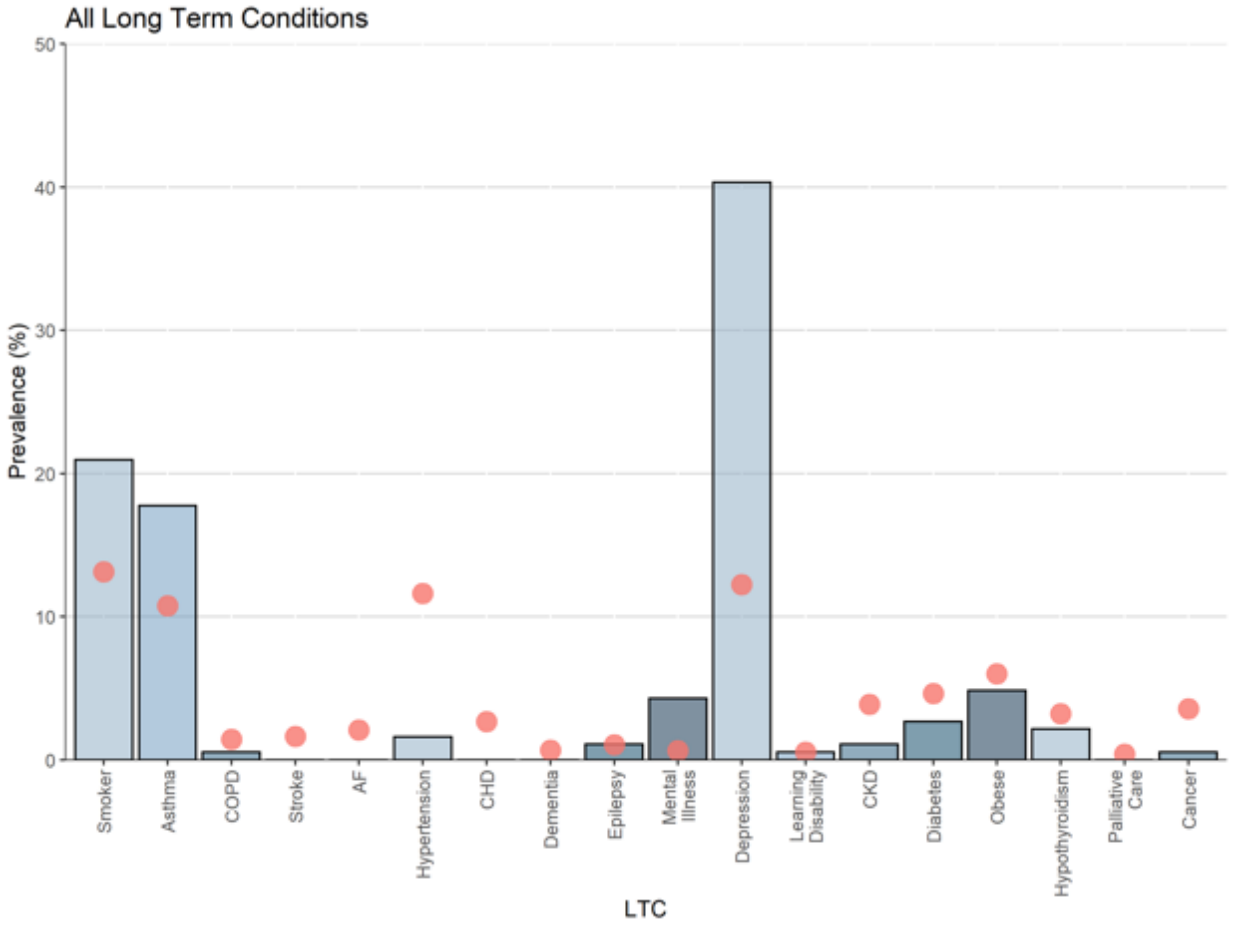
Long term conditions (LTC)

Graphs 20 and 21 show distribution by LTC. The significant overrepresentation of depression in this cohort vs. CCG average in both figures is expected due to the psychological aspect of Eating Disorders. Another notable LTC is obesity – with a higher prevalence than CCG average for referrals, and lower than average for assessments, representing a nearly 4x decrease in prevalence from the referral to assessment. This could imply a deficit in service availability for Eating Disorders connected to over-eating.

Graph 20: Eating disorder Referrals by LTC - between 01/10/2020 and 30/09/2021



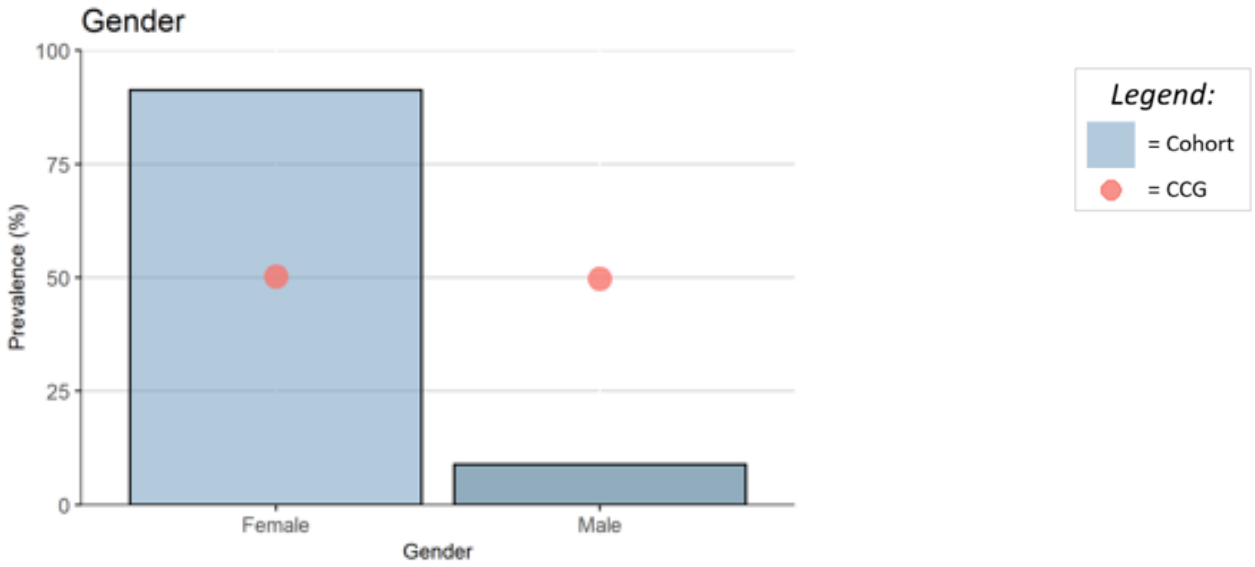
Graph 21: Eating disorder Initial Assessments by LTC - between 01/10/2020 and 30/09/2021



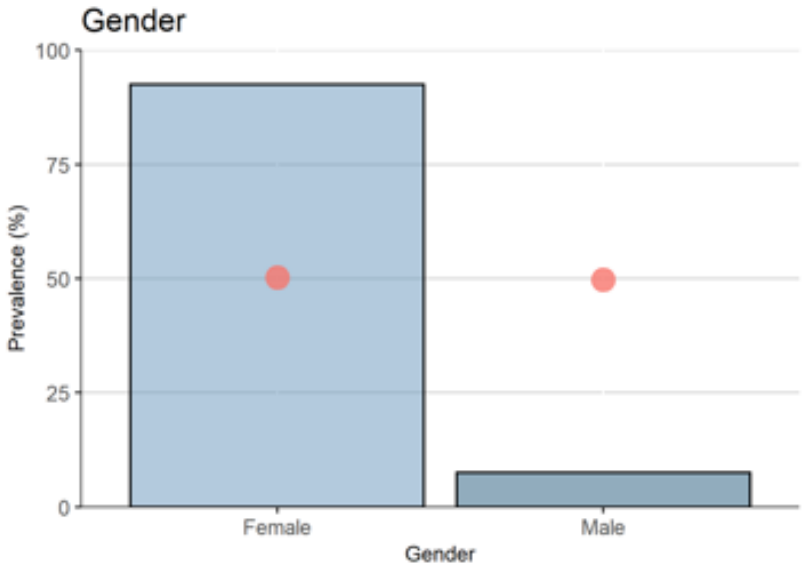
Gender

Graph 22 shows the cohort distribution by gender. It is evident from study of these figures that while the CCG population is evenly split between females and males, the cohort heavily overrepresents females and underrepresents males in both referrals and assessments vs. CCG average. We know that about 25% of those with an eating disorder are male[80] but less than 10% of those being referred into the service are male.

Graph 22: Eating disorder Referrals by Gender - between 01/10/2020 and 30/09/2021



Graph 23: Eating disorder initial assessments by Gender - between 01/10/2020 and 30/09/2021

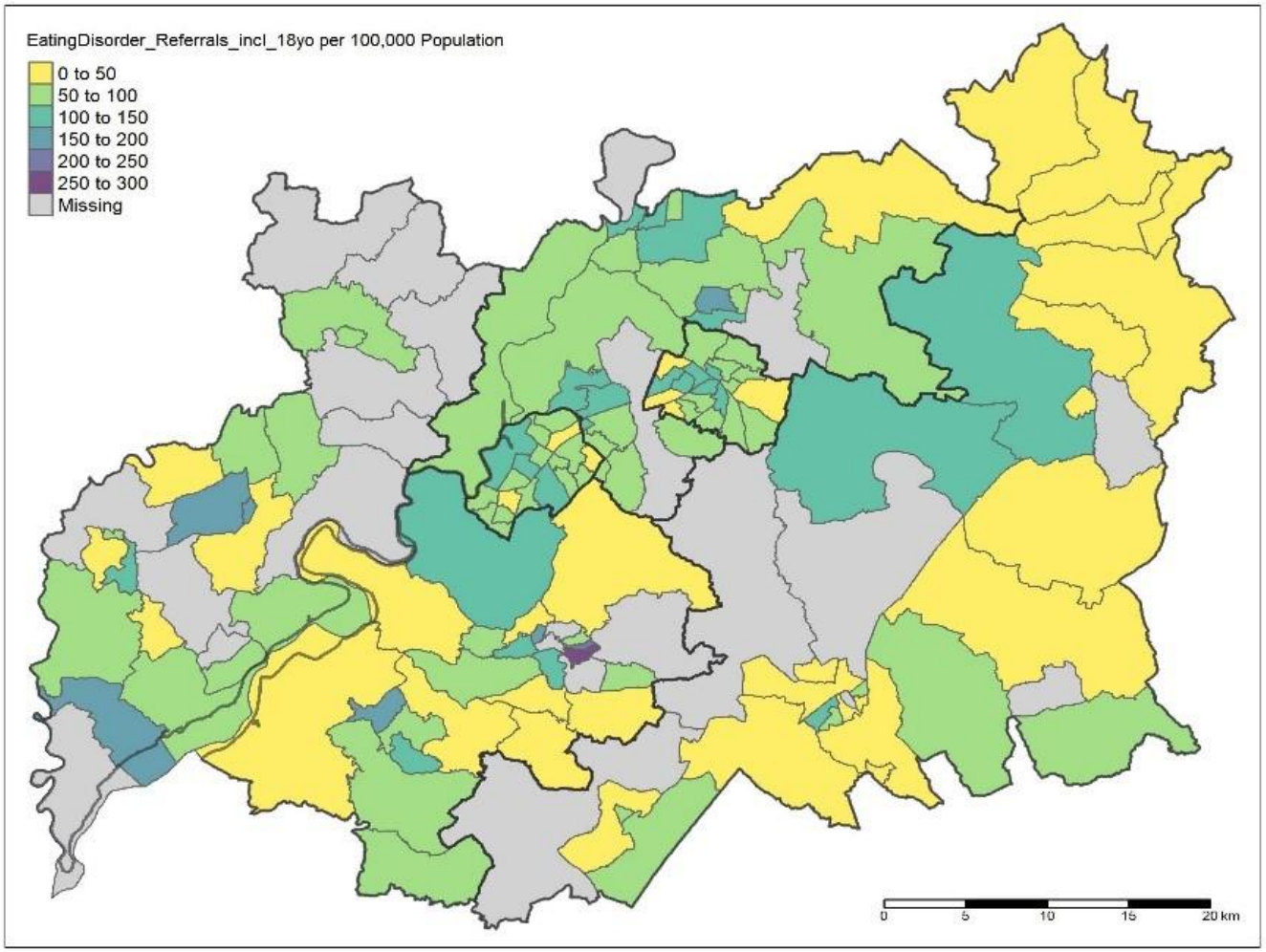


[80] Eating disorders | Mental Health Foundation

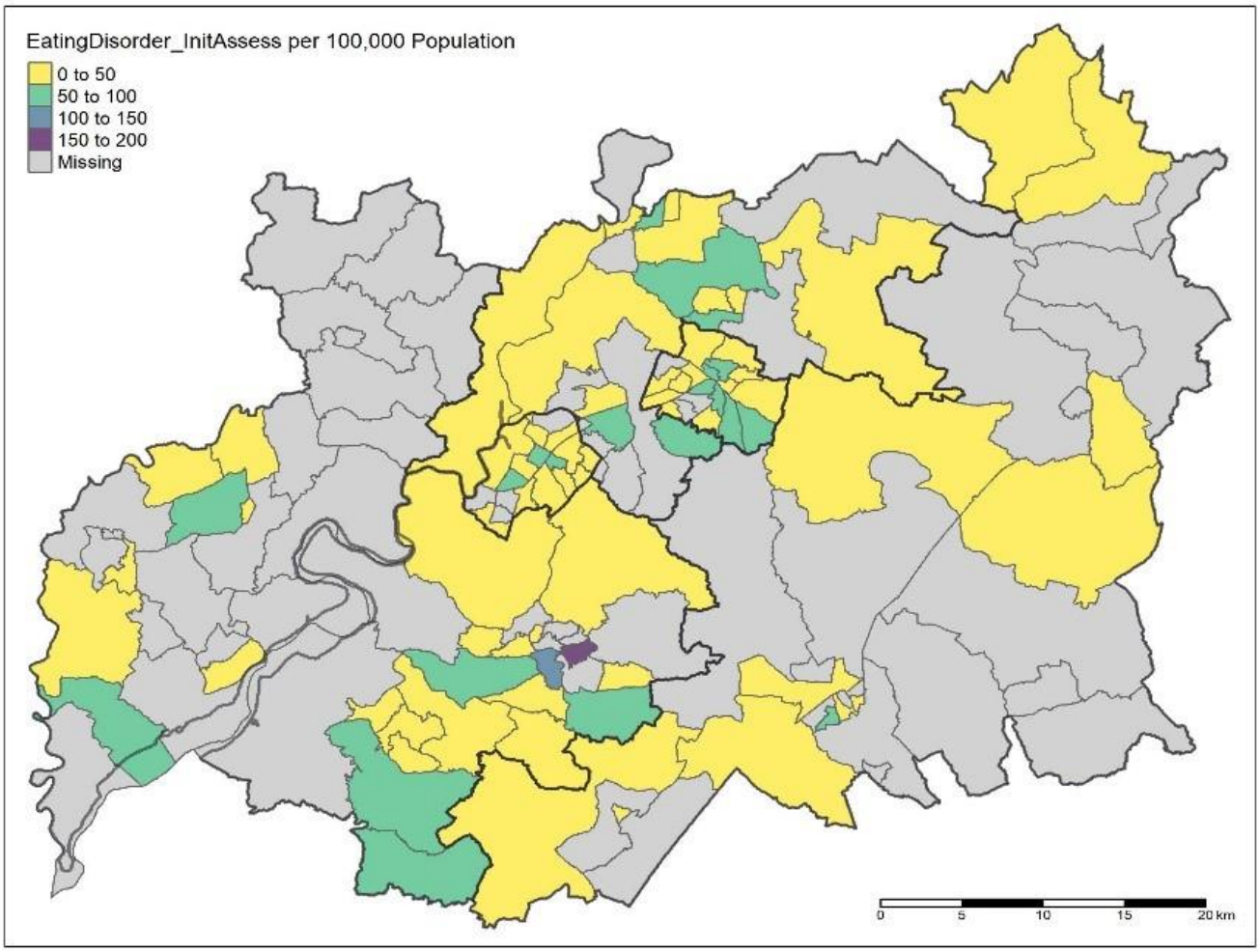
Ward maps

Graphs 24 and 25 below show the distribution of the cohort across Gloucestershire by ward for referrals and initial assessments respectively. There is an overarching pattern of a greater number of referrals vs. assessments across most wards for which data is available (although there is a greater amount of missing data for initial assessments than there is for referrals). Which could represent inappropriate referrals or poor service availability. Interestingly, one particular ward in Stroud – Stroud Trinity – has a very high number of both referrals and assessments vs the rest of Gloucestershire (ward map). The neighbouring wards of Rodborough & Minchinhampton are two of the locations which exhibit a higher prevalence of assessments than referrals, again indicating that such referrals are appropriate. There is a 7 bedded residential home located in Stroud which caters for males and females with an eating disorder, but this is not located in Stroud Trinity.

Graph 24: Eating disorder Referrals Map - between 01/10/2020 and 30/09/2021



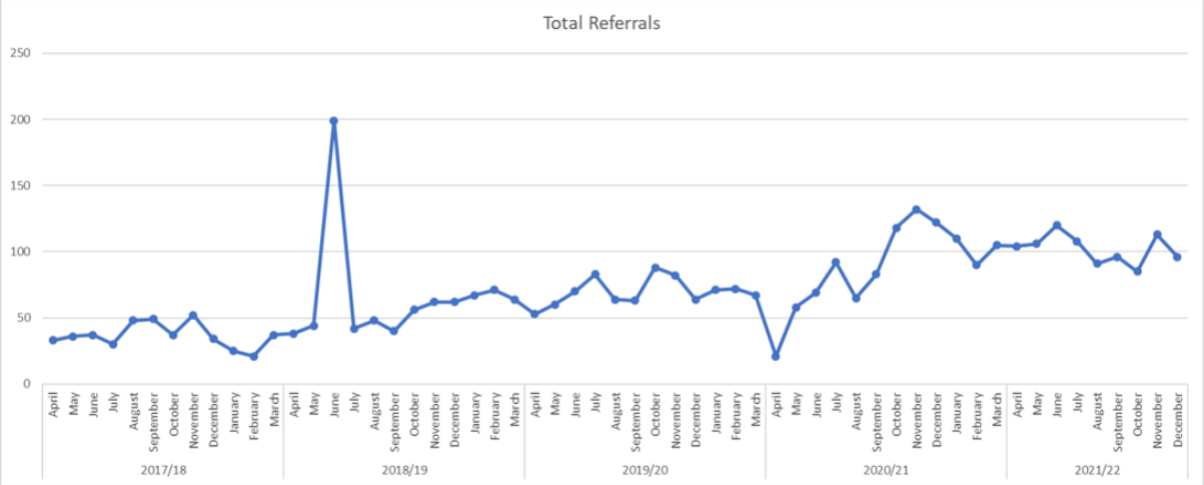
Graph 25: Eating disorder Initial Assessments Map - between 01/10/2020 and 30/09/2021



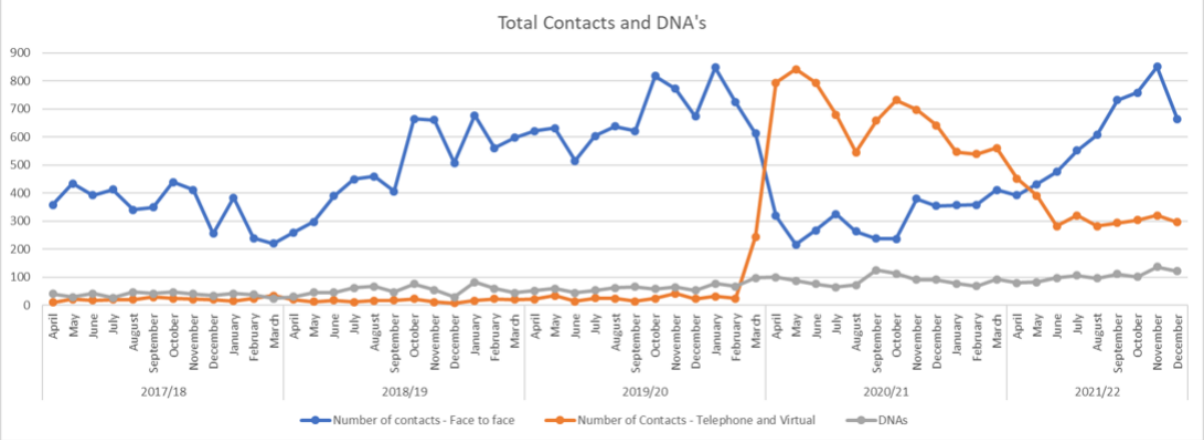
Service use over time

We also looked at service use over time. It is important to note that the Eating Disorders adults service became an all age service in June 2018 so reflects all age referrals from that date. There has been a steady increase in referrals to the Eating Disorder service each year. There has also been an increase in total contacts each year, and although face-to-face contacts are back to pre-pandemic levels the telephone and virtual contacts has remained at a much higher level than pre-pandemic. However, it is worth noting that DNAs are also steadily increasing each year.

Graph 26: Total referrals to Eating Disorder service over time 2017-2022



Graph 27: Total contacts with Eating Disorder service 2017-2022



Areas for further discussion with the service, including possible:

- Overrepresentation of white adults in both referrals and assessments
- Underrepresentation in referrals from Cotswold and forest of dean
- Increase in assessment probability for least deprived individuals
- Decrease in assessment probability for obesity (potential service gap for over-eating)
- Underrepresentation in referrals for men
- Stroud Trinity has a much higher rate of referrals than the rest of the county

Recovery

The tool compared referrals and assessments in Recovery services at Gloucestershire Health and Care NHS Foundation Trust (GHC) to the Gloucestershire's total GP registered population between 01/10/2020 and 30/09/2021.

The Recovery Team is a comprehensive community rehabilitation and recovery service for people aged 18-65 with severe and enduring mental illness, who have complex needs.
The team's aims are:

- To help service users to function as well as possible in everyday life.
- To enable service users to establish a sustainable, independent quality of life within the community.

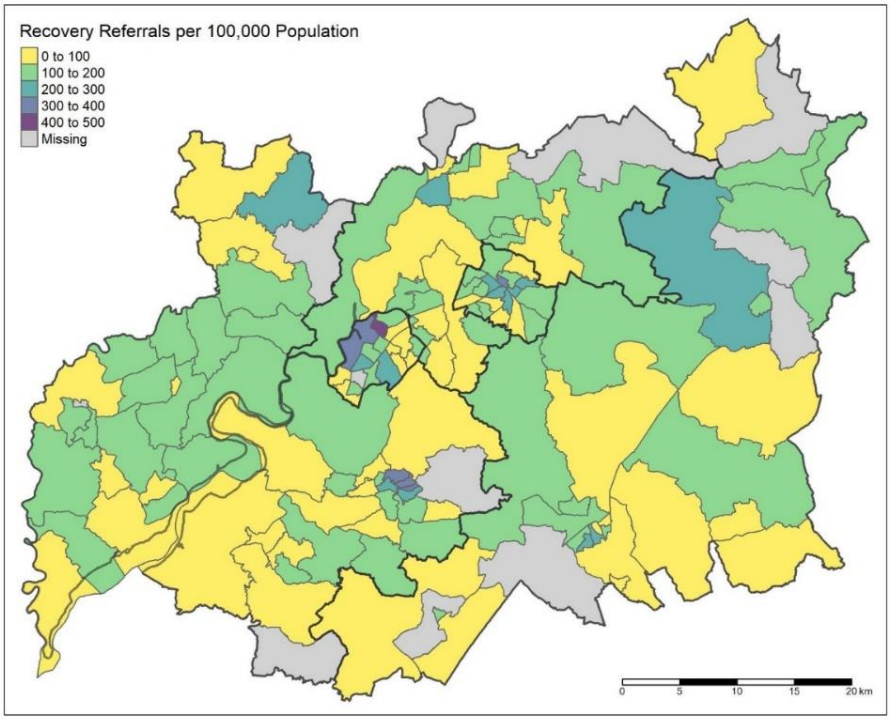
It includes outreach support in helping patients to achieve this following discharge, which is normally within six months to two years after admission.

Total number of referrals (internal and external referrals) to Recovery services in GHC included in this report are 852 with an average age of 40 years. Total number of Assessments to Recovery services in GHC included in this report are 673 with an average age of 39.7 years. This is compared against the NHS Gloucestershire Integrated Care Board (ICB) total, which is defined as the total GP registered population in Gloucestershire. At the time of running the report this population was 699,165, with an average age of 42.7 years.

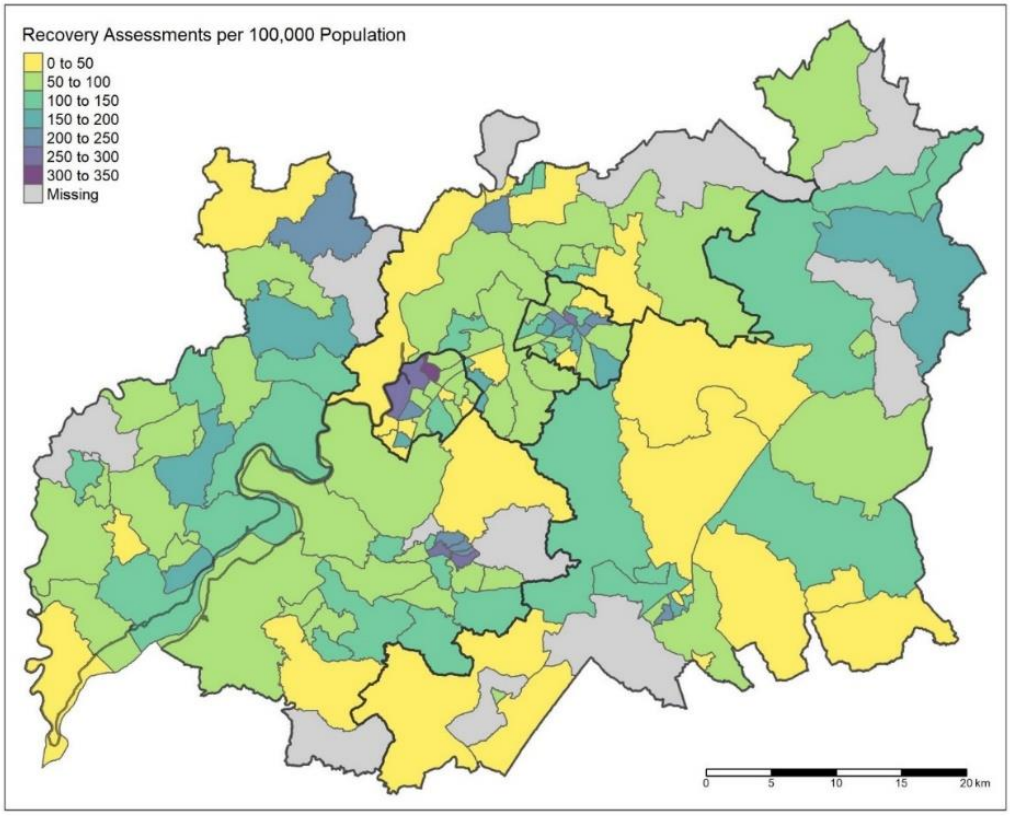
Recovery rates

The highest rate of referrals per 100,000 population to Recovery services were from more urban areas (the wards Kingsholm, Wotton lawn, Westgate, St Pauls, Stroud Uplands Ward, Stroud Valley Ward, Stroud Slade Ward) (Graph 28). The highest rate of assessments per 100,000 population to Recovery services were from wards Kingsholm and Wotton lawn, Westgate, St Pauls, Stroud Trinity Ward, Stroud Central Ward (Graph 29). The higher rates of referrals and assessments in urban areas could be due to wider determinants of poor mental health, such as deprivation and housing difficulties, being more prevalent.

Graph 28: Recovery referrals by ward – between 01/10/2020 and 30/09/2021



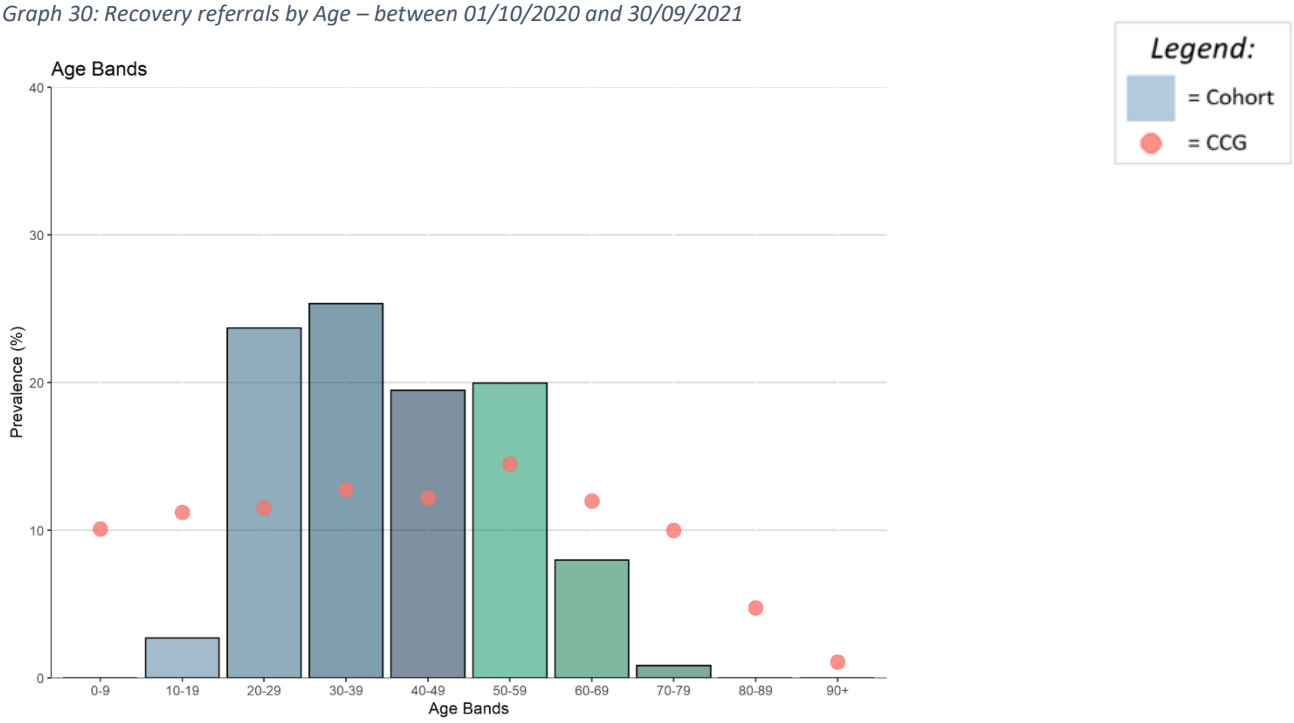
Graph 29: Recovery assessments by ward – between 01/10/2020 and 30/09/2021



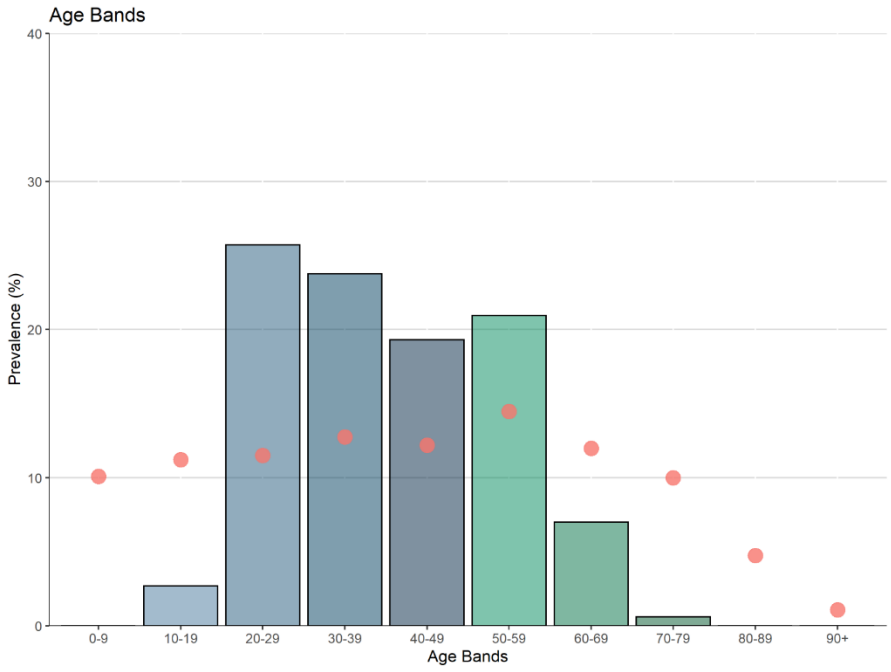
Age

The highest proportion of referrals to the service are in the 30-39 age band, and the highest number of assessments is in the 20-29 group. This could show referrals for 20-29-year olds are more appropriate than the 30-39-year group due to a higher conversion rate to assessment.

Graph 30: Recovery referrals by Age – between 01/10/2020 and 30/09/2021



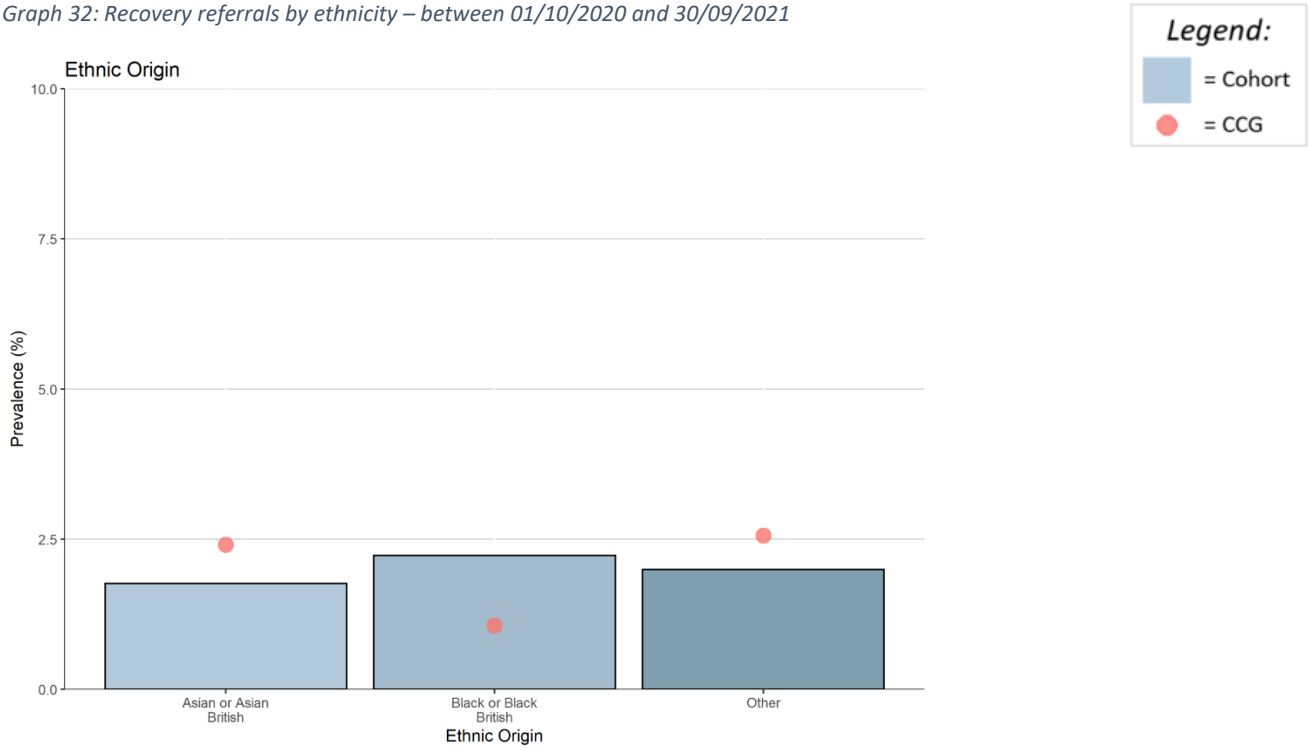
Graph 31: Recovery assessments by Age – between 01/10/2020 and 30/09/2021



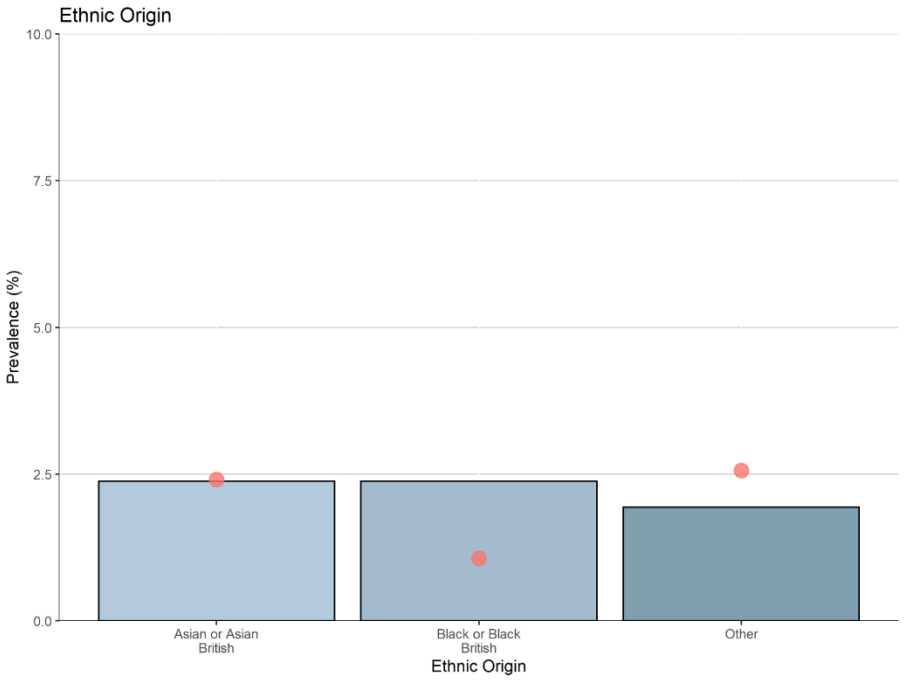
Ethnic Origin

There were a lower number of Asian/Asian British referrals to Recovery services than the CCG population (Graph 32), however Recovery assessments in this demographic is comparable to the CCG population (Graph 33). This could mean that referrals are more likely to be appropriate for this demographic, or there could be under-referring for this demographic. The Black/Black British group have a higher population in Recovery referrals and Recovery assessments compared to the CCG total population. This could be due to a higher number of people from this ethnic group being sectioned or admitted to hospital in Gloucestershire.

Graph 32: Recovery referrals by ethnicity – between 01/10/2020 and 30/09/2021



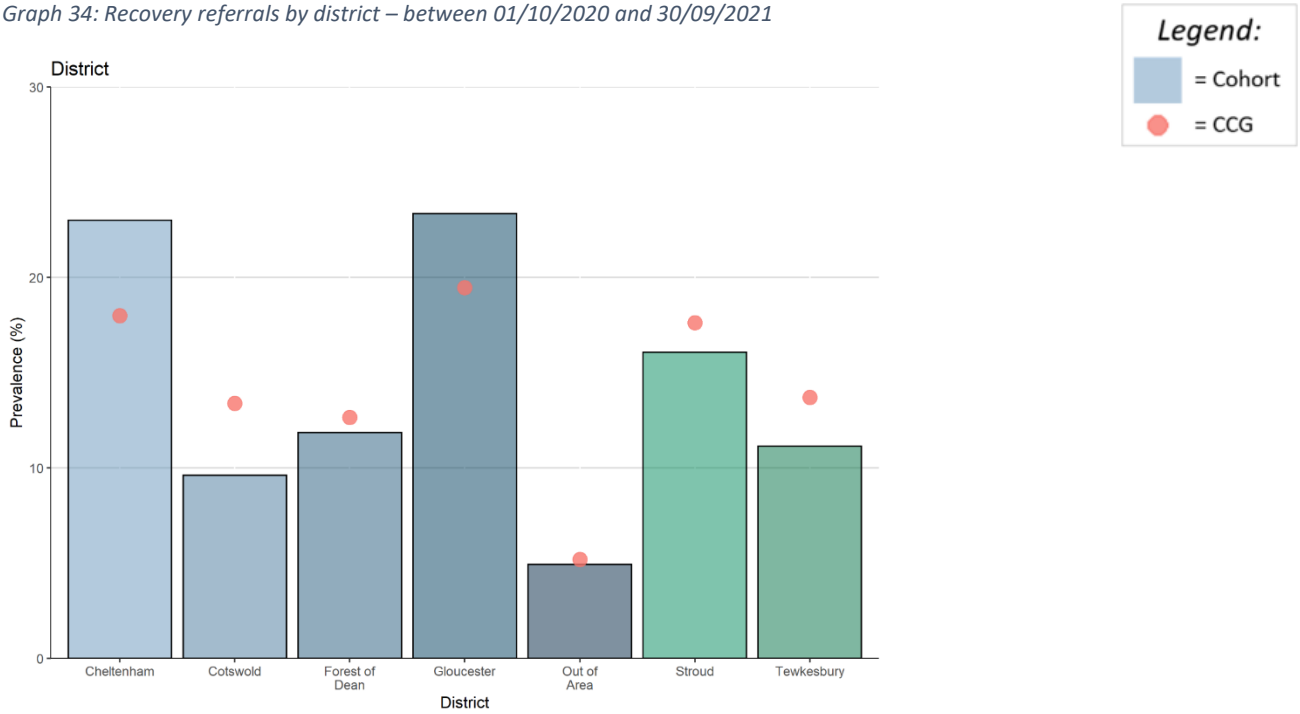
Graph 33: Recovery assessments by ethnicity – between 01/10/2020 and 30/09/2021



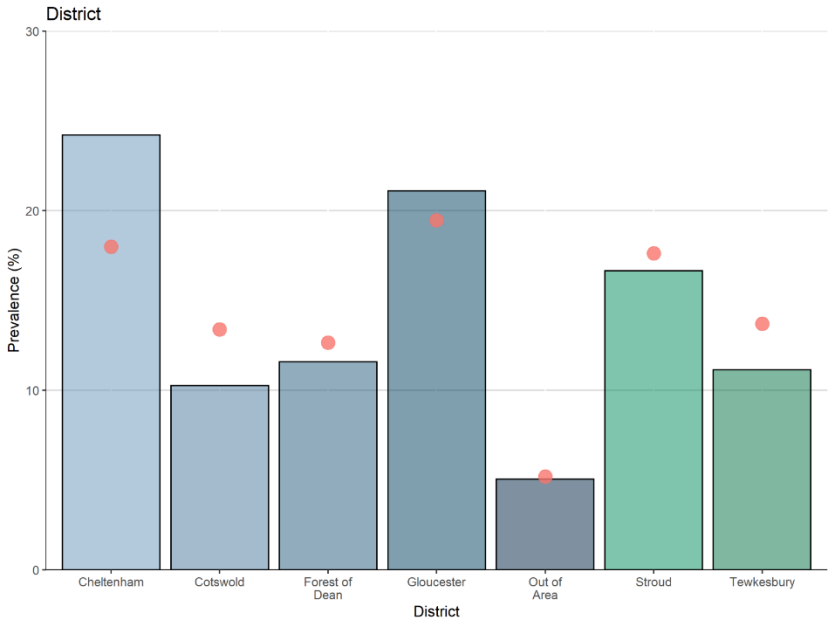
District

There was a higher number of Recovery referrals and Recovery assessments from Cheltenham and Gloucester districts than the CCG cohort. This may be due to higher proportion of younger age groups in these areas, which have higher referral and assessment rates (as shown in the age section). Recovery referrals and Recovery assessments from Cotswolds, Tewkesbury, Stroud and The Forest of Dean are lower than the CCG population. This could potentially be due to availability or awareness of Recovery services in these areas or that there is an older population in these areas which have shown to have less referrals to recovery than the CCG population (as shown in the age section).

Graph 34: Recovery referrals by district – between 01/10/2020 and 30/09/2021



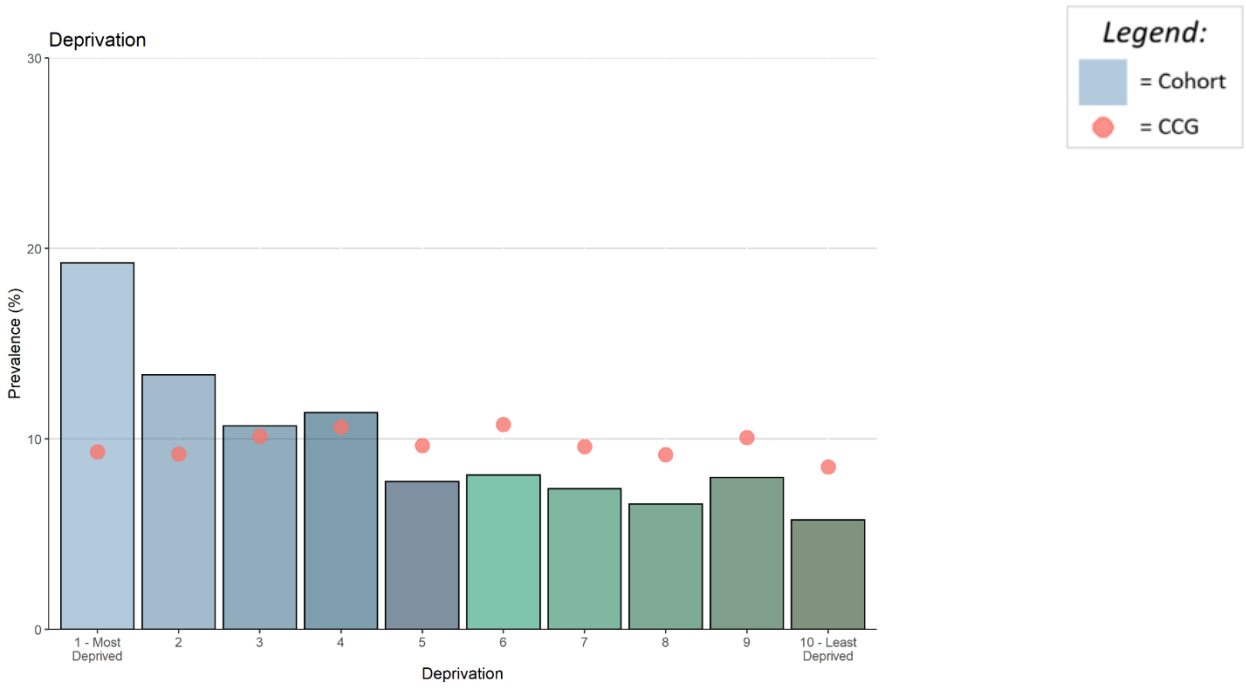
Graph 35: Recovery assessments by district – between 01/10/2020 and 30/09/2021



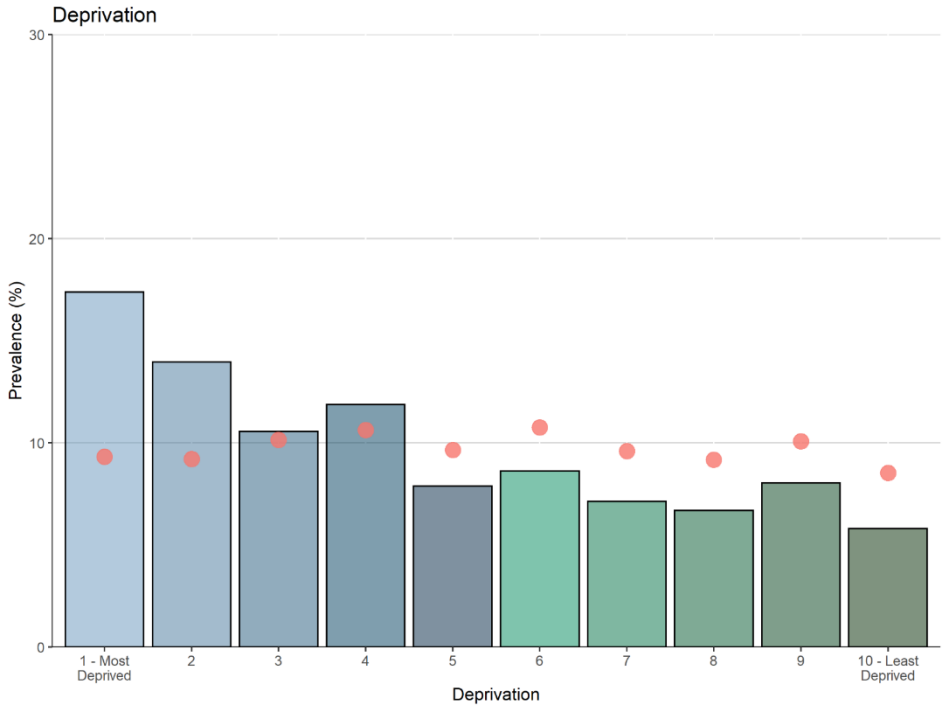
Deprivation

Recovery referrals and those having an initial assessment in Recovery were more likely to be more deprived than the CCG population (Graphs 36 and 37). Interestingly the Recovery referrals have a higher percentage prevalence of more deprived patients (those in deprivation level 1) than those in the Recovery assessments cohort.

Graph 36: Recovery referrals by deprivation decile – between 01/10/2020 and 30/09/2021



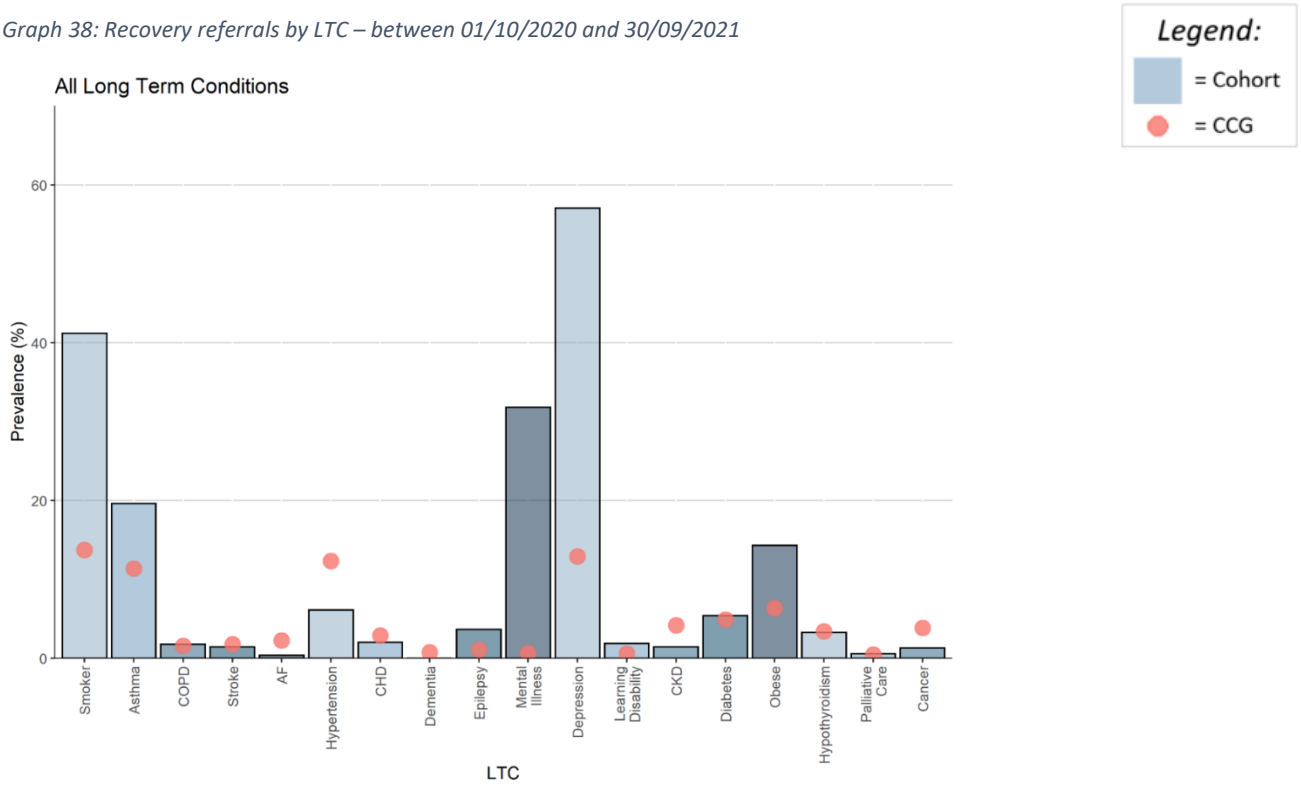
Graph 37: Recovery assessments by deprivation decile – between 01/10/2020 and 30/09/2021



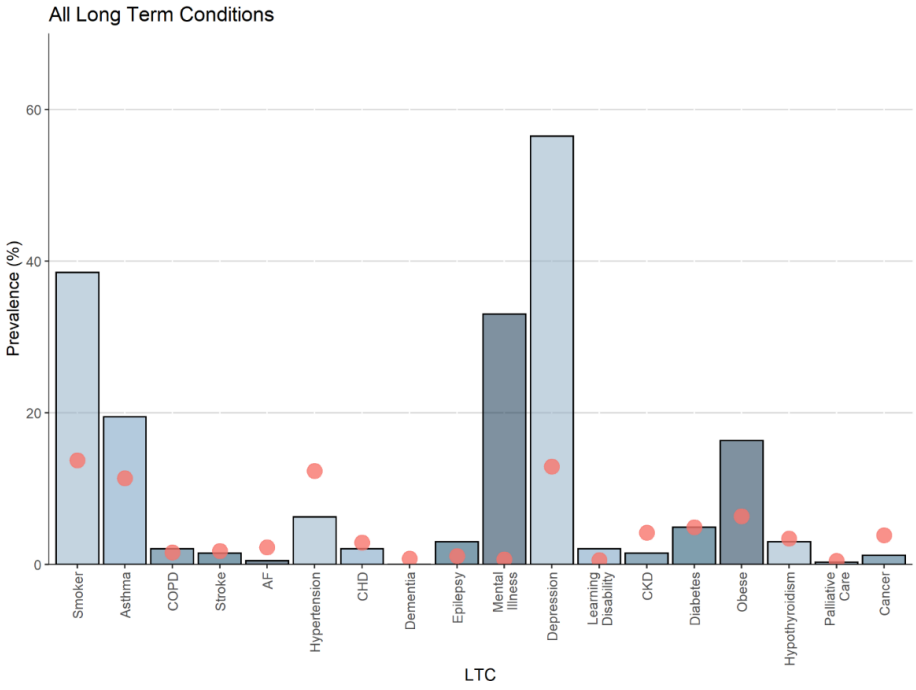
Long Term Conditions (LTC)

As mental illness is one of the long term conditions, it is not surprising that both Recovery Referrals and Assessments have a higher prevalence of LTC than the CCG population. Recovery Referrals and Recovery Assessments to GHC also have a higher prevalence of Depression, Obesity, Asthma, learning disabilities, epilepsy and smoking than the CCG population. It is important that the Recovery service recognise the link between physical and mental health, and consider the physical health issues of their clients when considering how they can live a sustainable quality of life.

Graph 38: Recovery referrals by LTC – between 01/10/2020 and 30/09/2021



Graph 39: Recovery assessments by LTC – between 01/10/2020 and 30/09/2021



Gender

Recovery Referrals and Recovery Assessments have a higher proportion of Females compared to CCG population with a similar 60%;40% split between Males and Females. This is likely due to the disproportionate difference between the number of males experiencing mental health disorders and those seeking treatment[81].

Key findings from Recovery service:

- Cotswolds, Forest of Dean, Stroud and Tewkesbury are underrepresented compared to the CCG population.
- Men are underrepresented in the service
- Asian/Asian British adults under-represented in referrals

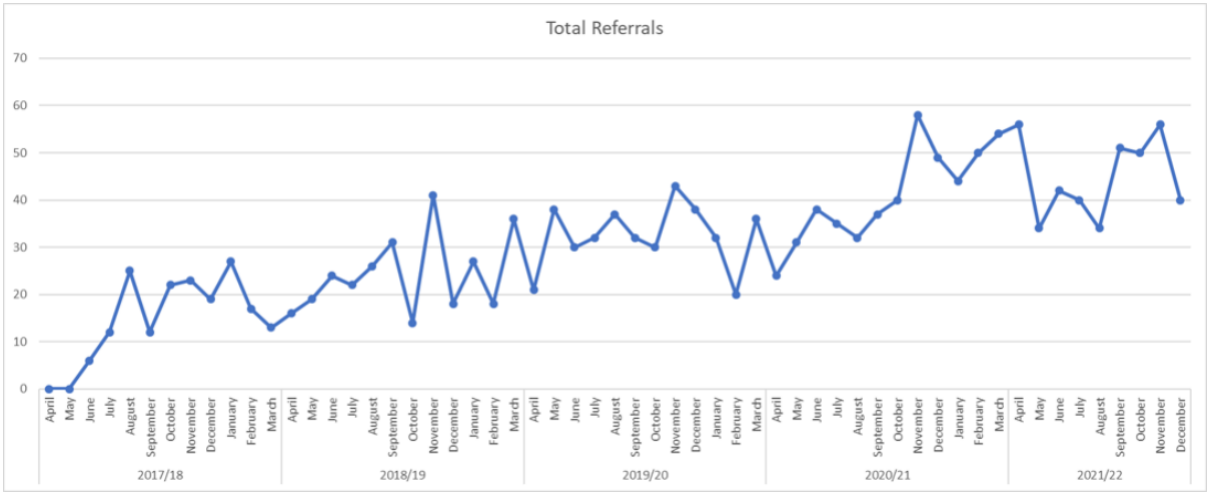
Simple analysis of Perinatal service (referrals and contacts over time)

For the perinatal service we ran a simpler analysis of number of referrals and contacts over time. There is data available to look at further services in this way.

Overall, there has been an increase in referrals to the perinatal service since being introduced, showing the increased awareness of the service and increased need. Lower overall total contacts in 2017/18 were likely due to challenges with the set-up of the service. As expected, there has been an increase in referrals and contacts following the Covid pandemic. As service numbers have increased there has also been an increase in DNA with almost 20% of total contacts being DNAs in 2021/22, compared with 10% in 2018/19.

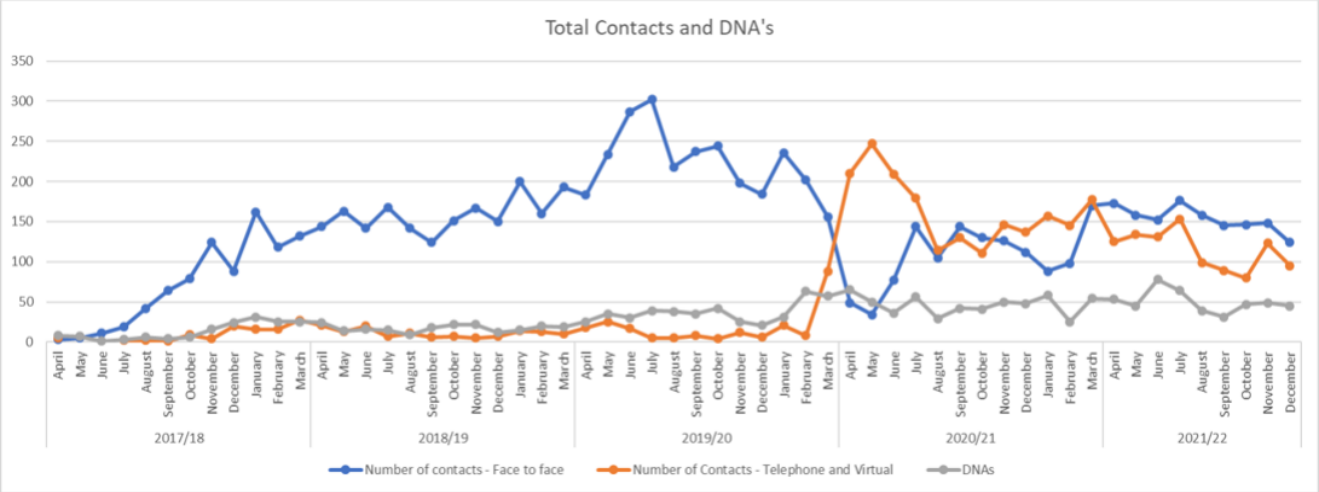
It would be useful to use our in-depth analysis tool to look at service users in the Perinatal mental health services, to ensure that the increase in service use over time has not left behind any specific population groups.

Graph 40: Total referrals to perinatal service over time 2017-2022



[81] Chatmon BN. Males and Mental Health Stigma. Am J Mens Health. 2020;14(4):1557988320949322. doi:10.1177/1557988320949322

Graph 41: Total contacts with perinatal service over time 2017-2022



4. Individuals in a high level of emotional distress or mental health crisis

Emergency Departments

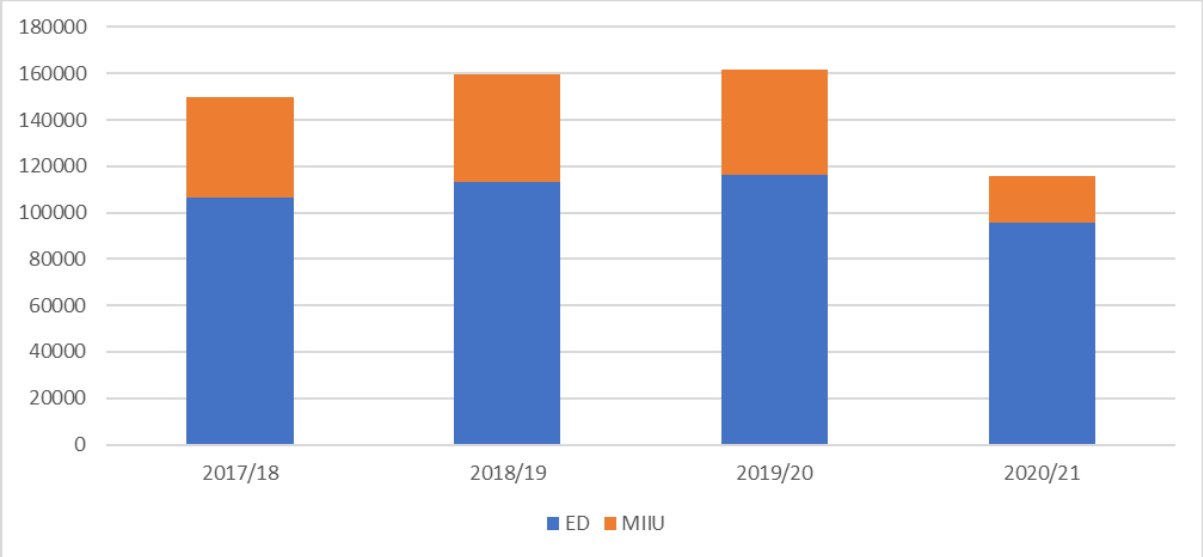
This data is for the period 01/04/2017 – 31/03/2021 and looks at Mental Health Attendances to Minor Illness and Injuries Units (MIIU) & Emergency Departments (ED), (ED encompasses only the Gloucestershire Hospitals Foundation Trust i.e. Gloucester Royal Hospital & Cheltenham General Hospital). The accuracy of hospital attendance data relies on accurate coding by healthcare professionals, and this analysis was thorough in attempting to include all possible coding entries for mental health[82].

Overall attendances:

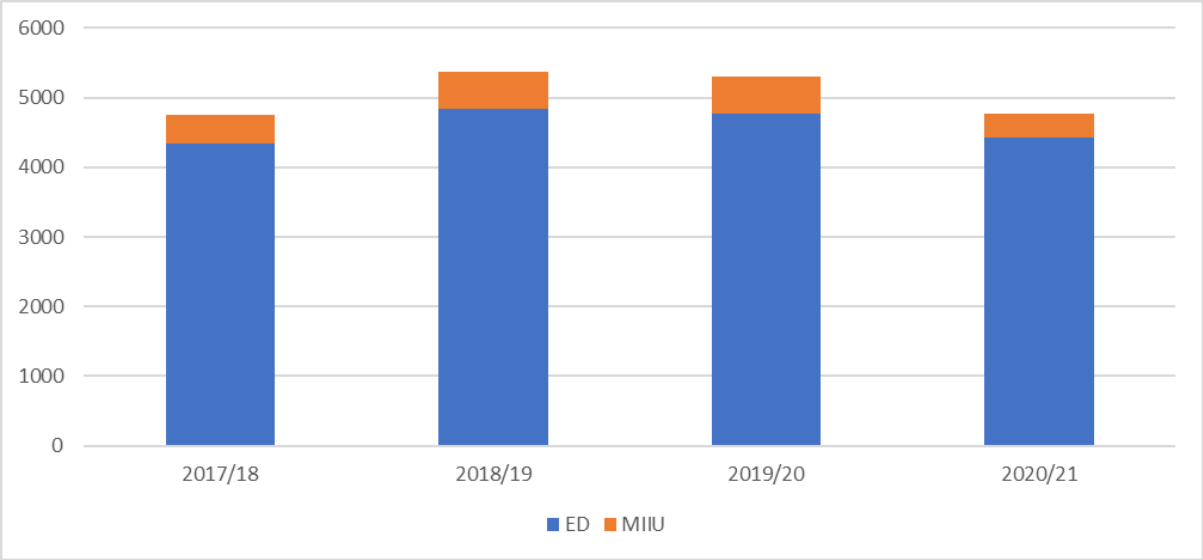
From the numbers shown in Graph 42, on average Gloucestershire has 107,870 attendances to ED & 38,861 attendances to MIIU per year; a combined average total attendance of 146,731 per year across both. *Graph* 3 shows, on average, Gloucestershire has 4,593 attendances to ED & 456 attendances to MIIU due to Mental Health (MH) reasons per year, a total of 5,049 (approx. 3.4% of total attendances). There has been a small but significant increase in the percentage of mental health attendances over time (Graph 43), increasing by 0.94% from 2017/18 to 2020/21. Due to the COVID-19 pandemic during the 2020/21 period, access to ED & MIIU for individuals may have been restricted, especially for individuals with underlying health problems who may have avoided an attendance for health reasons. This alongside lockdown restrictions and advice to remain at home may have contributed to the reduced number of total attendances between 2019/20 and 2020/21.

[82] A 'Mental Health Attendance' is found by analysing the free-text presenting complaint field for entries such as 'Overdose' or 'anxiety' and generating a flag. Entries such as 'anaphylactic' have been excluded. Local patient group codes have also been utilised that we know determine deliberate Self-Harm. All data presented is for service users ≥18 years old. All 'blank' results have been omitted when applicable, i.e. if no gender or deprivation level has been recorded, then these attendances have not been included in the segments that allude to these specific areas. 'Blank' results have been included in the overall attendances however as this does not affect the record of a Mental Health Attendance.

Graph 42: Count of all Attendances to Gloucestershire ED & MIIU across the period 01/04/2017 – 31/03/2021



Graph 43: Count of 'Mental Health Attendances' to Gloucestershire ED & MIIU across the period 01/04/2017 – 31/03/2021



By month

When considering cumulative attendances by month[83], July has the highest number of total Mental Health Attendances at 1,954, followed closely by August with 1,945 attendances. April has the lowest total attendances with 1452. July had the greatest number of MIIU attendances with 231 and December the lowest with 118 (April second lowest with 119). Age-band 18-24 had its highest 3 months for attendance activity being May, June & July whilst 25-34 & 35-44 had August as its highest. As these two banding make up the greatest number of attendances, this has contributed to these months having higher attendances.

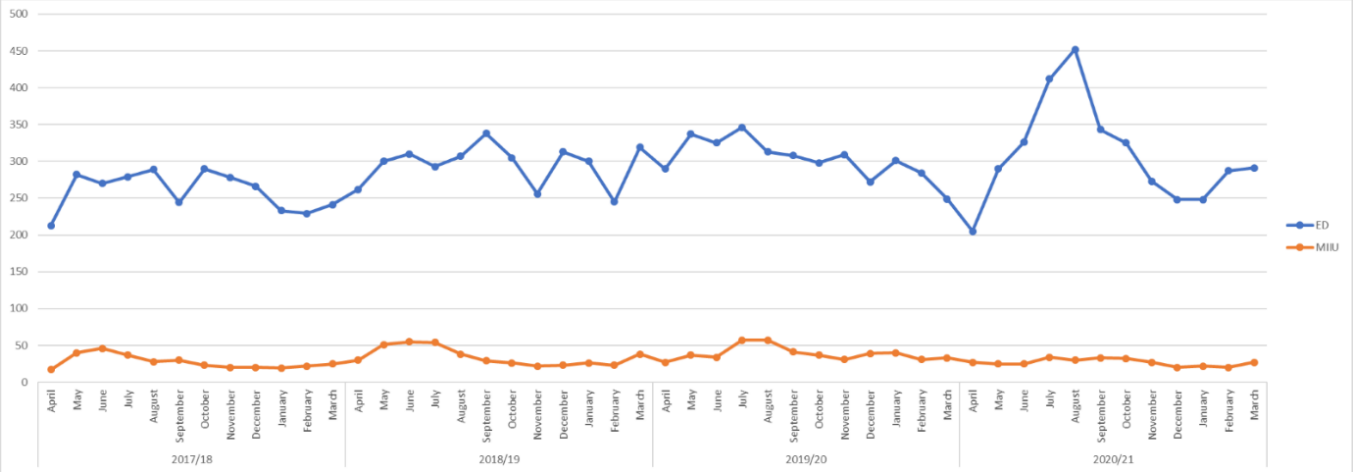
Although it is commonly reported that self-harm and suicide rates peak in the winter, it is actually highest in the summer[84], so it is not surprising that there is a peak in MH attendances in the summer months.

[83] This is the total of all attendances between 2017-2021 in that month

[84] Media Continue to Perpetuate Myth of Winter Holiday – Suicide Link (4/12/2001)

As seen in Graph 44, there was an initial trend of an increasing number of attendances for MH in both ED & MIIU up until March 2020. The significant decline seen in both April 2020 & November 2020 onwards can be linked to the initial March lockdown due to the COVID-19 Pandemic and the increasing of lockdown restrictions and rising cases in Winter in 2020. During the initial lockdown Cheltenham General Hospitals ED was closed with ED solely moved to Gloucester Royal Hospital, possibly also accounting for the decline in attendances during that period. During the initial lockdown period some Mental Health Services were also closed which may attribute to the significant increase in attendances in the months after the initial lockdown due to lack of help/availability of services (steep increase from July – September).

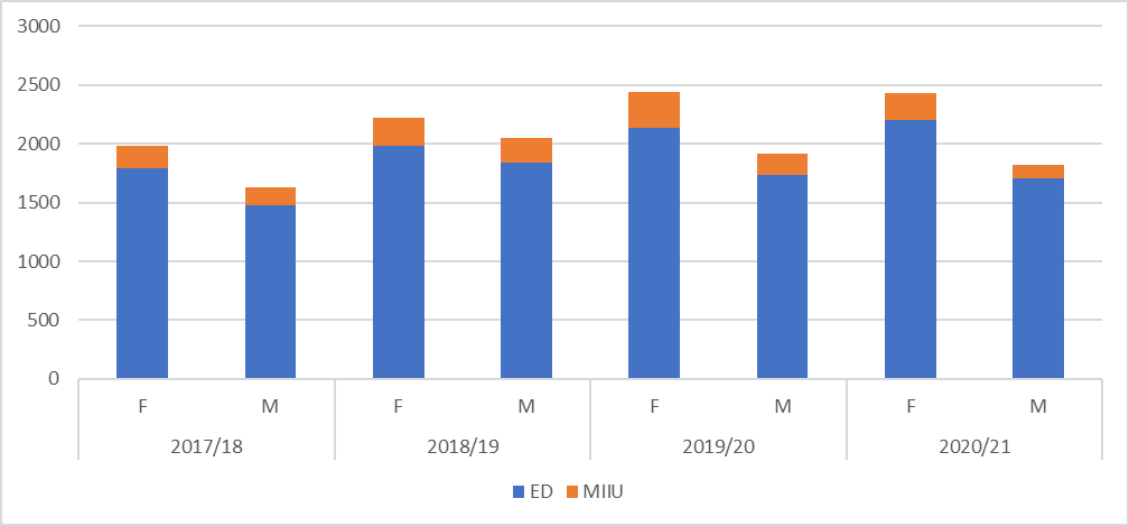
Graph 44: Count of 'Mental Health Attendances' to ED & MIIU across the period 01/04/2017 – 31/03/2021



Gender:

As can be seen in Graph 45, the difference in numbers of attendances by gender has increased over the 4-year period. MIIU presented the greatest variation with a 11.31% increase in female MH attendances in comparison to male MH attendances.

Graph 45: Gender Male/Female % of Mental Health Attendances across the period 01/04/2017 – 31/03/2021

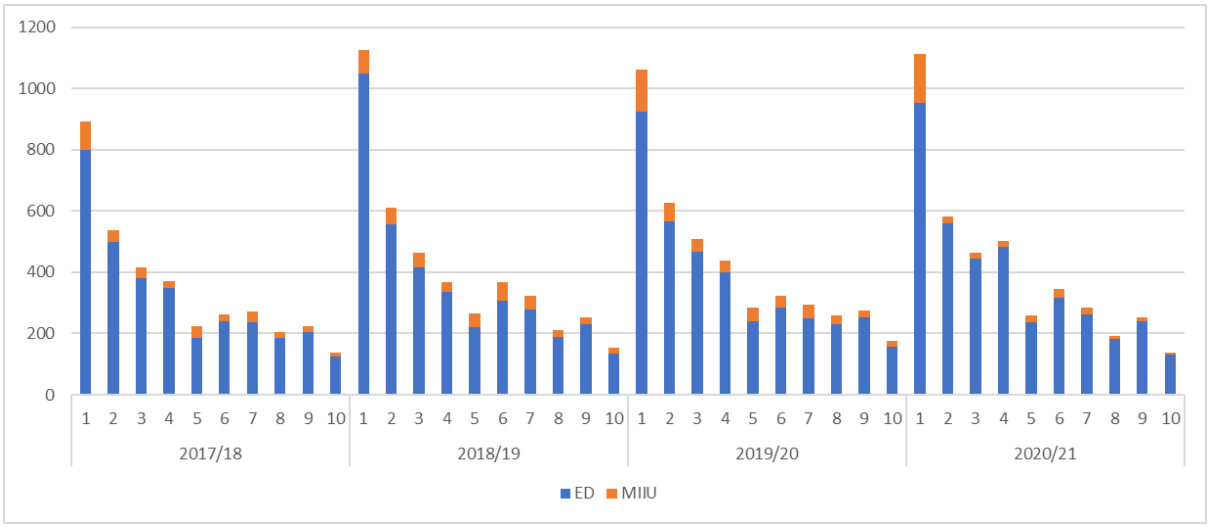


IMD deprivation level

Deprivation level is recorded via multiple factors within an area, such as income, employment, education and access to health services. A deprivation level of 1 is considered 'most deprived' and level of 10 is 'least deprived'. As can be seen in Graph 46 the most deprived cohort contributes to the greatest proportion of Mental Health Attendances with an average of 25.67% of ED attendances and 31.14% of MIIU attendances for MH reasons. Overall, IMD deprivation level 1 equated to an average of 26.08% of all MH attendances to ED & MIIU across the 4 years. In comparison, IMD deprivation level 10 gave an average of 3.78% of ED & 3.77% of MIIU MH attendances, for an average total of 3.78% of all MH attendances.

Commissioners and service providers need to ensure that mental health and wellbeing services are accessible to people who live in more deprived areas.

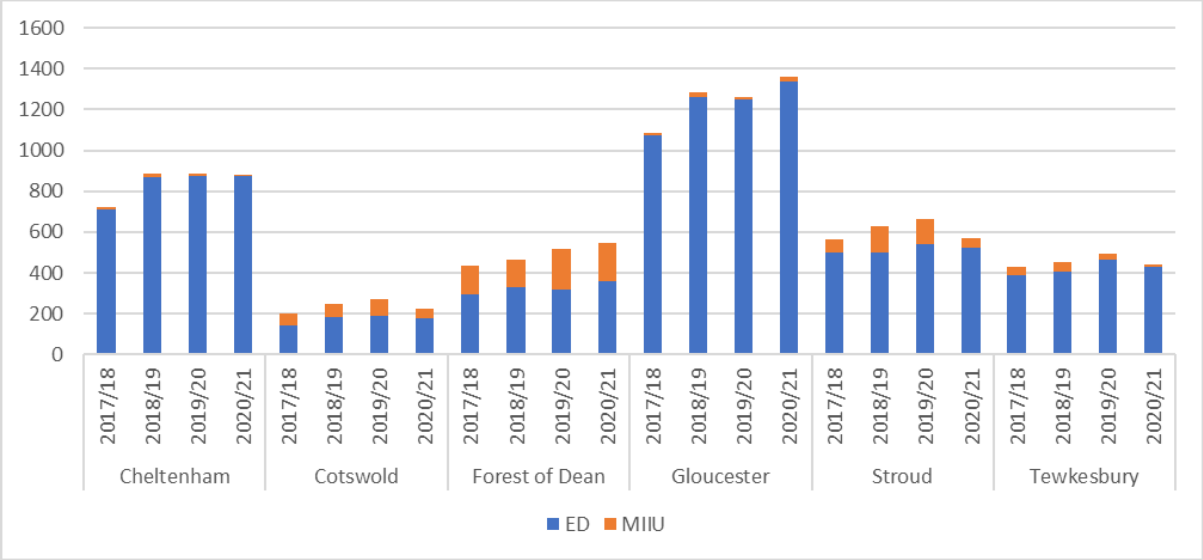
Graph 46: Count of 'Mental Health Attendances' to ED & MIIU by year, by deprivation level, across the period 01/04/2017 – 31/03/2021



Locality

Gloucester locality presented the greatest number of overall MH attendances with an average of 32.17% of all attendances across the 4 years. Cotswold presented the lowest with 6.09% of all attendances. Gloucester & Cheltenham have the highest population of the localities and as such the higher number of attendances is partly represented in this. Forest of Dean, Cotswold & Stroud all presented significantly higher MIIU MH attendances then compared to other localities with Forest presenting especially high. Forest of Dean on average accounted for 48.13% of MH attendances to MIIUs, Stroud 27.16% and Cotswold 18.12%. This may be due to access to an acute setting being more difficult in these areas. Each of these localities has a local MIIU available i.e. Lydney Hospital, Stroud District Hospital & Cirencester Hospital which may be used instead of attending ED in Gloucester & Cheltenham. Inversely this may partly explain the lower proportion of Gloucester & Cheltenham locality attending MIIU (5.27% and 3.39% respectively) as access to the ED is easier.

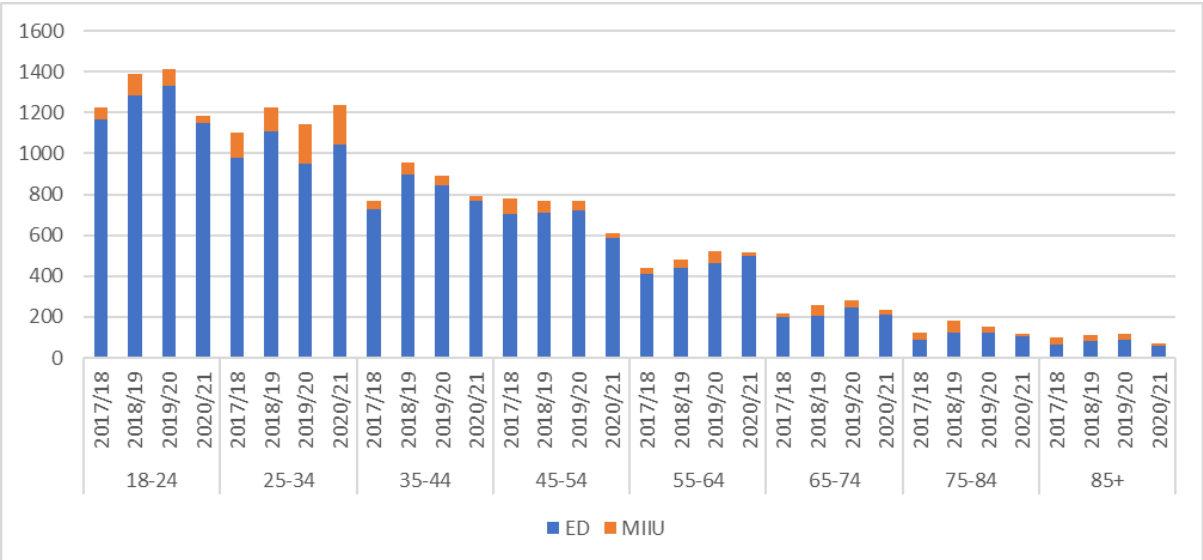
Graph 47: Count of 'Mental Health Attendances' by Locality, by year



Age

As shown in Graph 48, there is a descending trend of number of attendances as the age-bands go on. 18-24 and 25-34 equate to 49.14% of all Mental Health Attendance to ED & MIIU. 25-34 make up the greatest proportion of MIIU MH attendances, averaging 35.92% of MH attendances across the 4 years. 18-24 averaged 26.84% of MH attendances to ED. Most age-bands saw a consistency in numbers year-by-year 45-54 having the greatest decline, with a decrease in 2020/21 compared to previous years (706 in 2017/18, 709 in 2018/19, 719 in 2019/20 and then 587 in 2020/21). Age groups 18-24 & 45-54 saw the greatest decline in attendances during the period of 2020/21 when compared to previous years.

Graph 48: Count of 'Mental Health Attendances' by age-band, by year



Key findings of mental health attendances to Emergency Departments and Minor Injury and Illness Units (MIIU):

- The months with the greatest frequency of mental health attendances are in the summer.
- The gender gap in mental health attendances is increasing, with more women presenting due to mental health each year.
- Highest proportion of ED and MIIU Mental Health Attendances is in most deprived individuals
- The Forest of Dean accounted for 48.13% of MIIU mental health attendances between 2017-2021.
- The highest number of MIIU attendances due to mental health are in the 25-34 age group

Healthwatch: Experiences of urgent mental health care in accident and emergency (a Gloucestershire perspective) November 2020

In 2019, Healthwatch Gloucestershire explored the views of local people on mental health services in the county. A key message from that work was that people had difficulties in accessing support when in crisis: people were unsure of who did what, they did not know where to go to seek support, or were being left to fend for themselves. For someone suffering a mental health crisis, the emergency department (ED) is generally their last resort. A follow up report was published in November 2020. Healthwatch spoke to 10 individual service users, family members or carers, many of whom had multiple visits to the Emergency Departments for mental health. A key limitation of this data is the small sample size and it may not be representative of the population of interest.

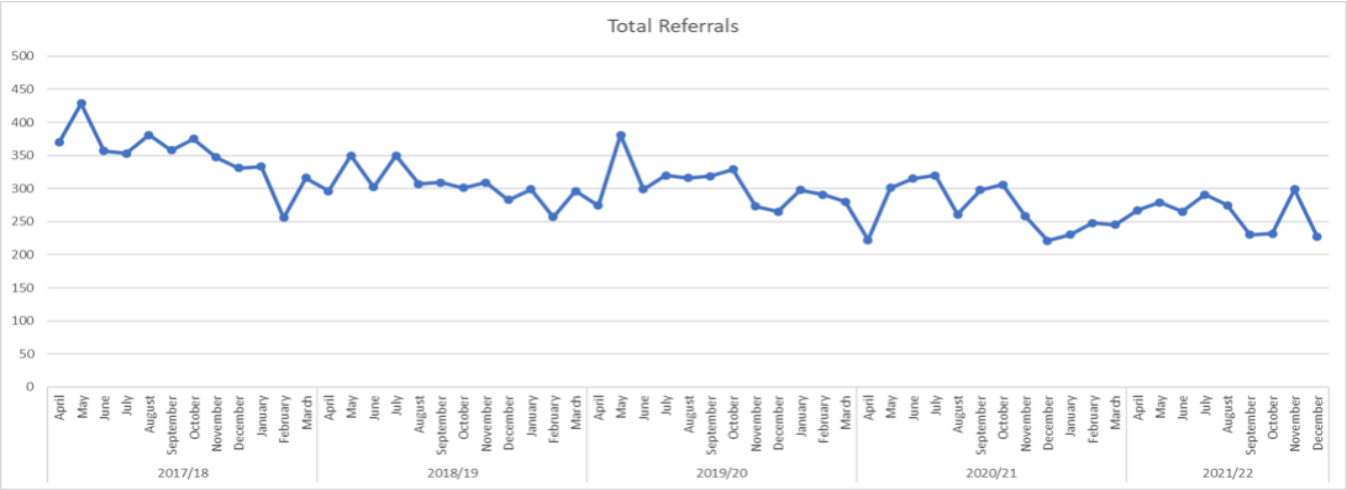
The main messages from the report are:

- "People told us that that they are often reluctant to access mental health support in the ED. For those who do access the ED, they are often at a 'desperation point'.
- Prior experience (or lack of it) not only further contributes to the level of anxiety people experience but also informs their expectations. Every contact counts and can inform the likelihood of people accessing further support.
- The people we spoke to expressed that feeling heard, understood and not being judged by ED staff was an important factor in feeling safe.
- People reported being left for long periods, left in busy environments, left in isolation without being checked on, and left without any indication of timescales. This was especially difficult for those in a fragile mental state and in some cases resulted in patients discharging themselves before treatment.
- Some people reported only receiving medical help for their presenting physical health needs. However, these were often only a symptom of a bigger mental health problem that also needed addressing.
- During assessments, positive feedback was associated with the framework of assessment being used to engage with and get to know the person. Negative experiences were associated with assessments being rigid and feeling like a tick box exercise.
- For those we spoke to, leaving the ED rarely equated to the mental health 'episode' being over. Clear follow-up and care plans that incorporated families, carers and signposting to ongoing support were seen as being the most beneficial for helping people on their mental health journey."

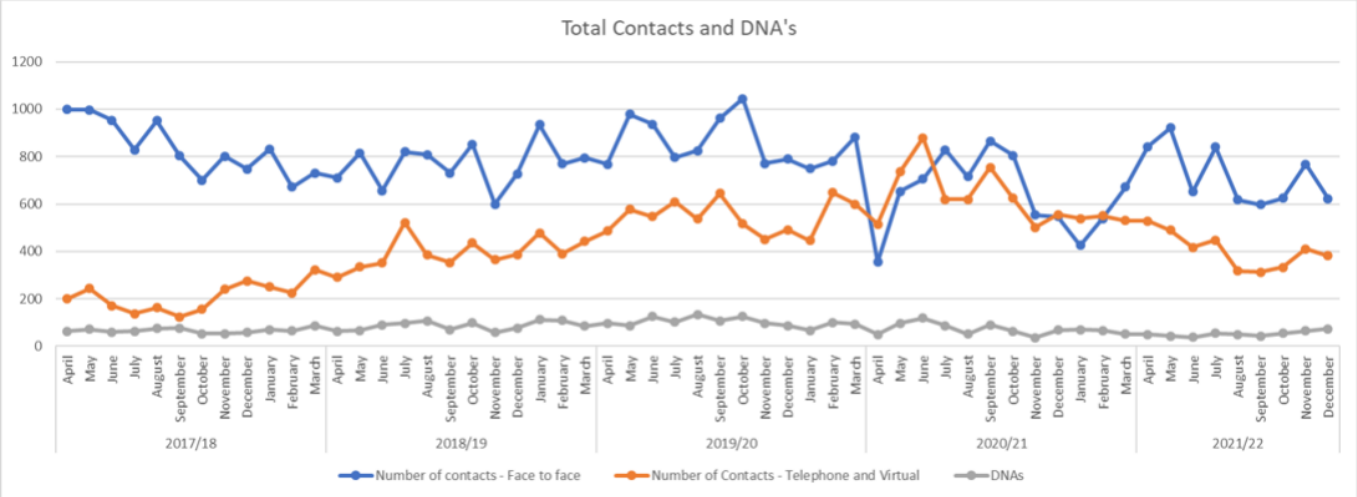
Crisis Resolution and Home Treatment Team

Referrals to the CRHT team have decreased each year, which may be due to service capacity challenges and staff shortages rather than true demand for the service. Total contacts increased during 2019/20, but interestingly referrals did not increase in 2019/20 compared to the previous year, showing that the current CRHT caseload may have had a higher need during this time due to the pandemic. There was also a 33% increase in DNAs in 2019/20 compared to the previous year.

Graph 49: Total referrals to CRHT 2017-2022



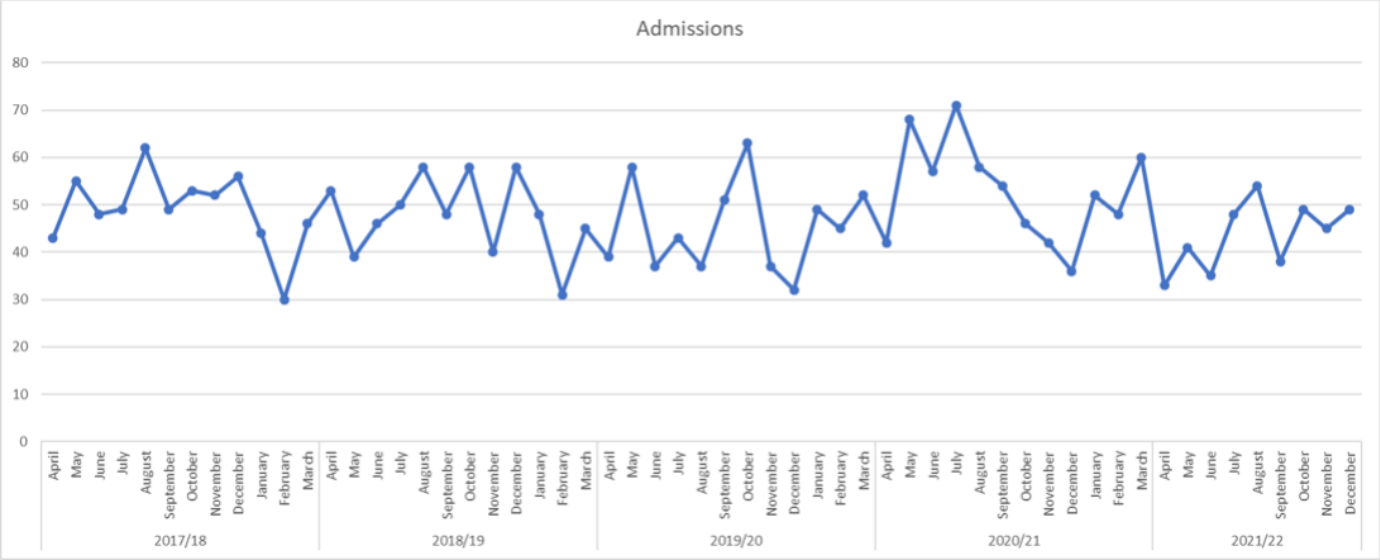
Graph 50: Total contacts to CRHT 2017-2022



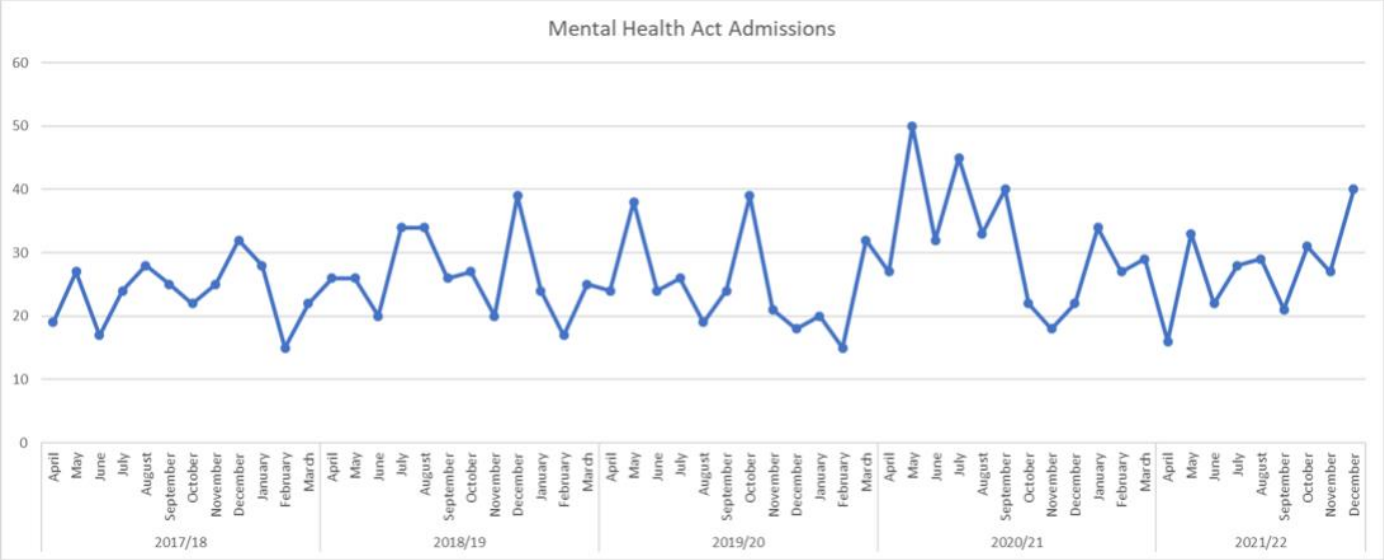
Mental Health Admissions

There was a higher number of admissions and MHA admissions to acute wards in 2020/21, more so in the first 6 months of the financial year. This could be due to the pandemic both having a negative impact on the mental health of the population, and also challenges with mental health services engaging with people face-to-face in the community. The proportion of MHA admissions is increasing in comparison to all acute admissions, in 2017/18 47% of all acute admissions were MHA admissions and this has been increasing year on year with 2019/20 having 59% off all acute admission being MHA admissions and 61% in 2020/21.

Graph 51: Acute admissions to mental health units 2017-2022



Graph 52: Acute admissions under the Mental Health Act 2017-2022



Transition to adult services:

Although this is an adult services mental health needs assessment, we are also exploring the service usage of 16-18 year olds within the Children and Young Peoples mental health services in Gloucestershire. It is known that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18[85]. We need to consider the needs of young people as an indication of adult service need5vgf, and we need to better understand the link between children's mental health services into adulthood and beyond.

Young Glos provides an alternative to statutory mental health services for 16-25yr olds who otherwise would not engage. There are currently 4 services:

- Linked up plus – a service for children in care or care Leavers aged 18-25 giving practical advice and counselling
- Link chat – commissioned as covid-19 response offering virtual and face to face support
- Flex service – a similar service to Linked up plus extended to those signposted from CAMHS
- Bounce service – 6 sessions of CBT alongside youth support (up to 6 months) for young people aged 14-25yrs who have been referred through a self harm route

The service data in the analysis includes new referrals between February 2021 - October 2021. By gender, female averaged 61.3% of referrals each month, male 31.5% and transgender 4.2%. Young Glos saw 419 new referrals across the 9 month period, averaging 47 a month with the highest month being June at 60. The gender split for referrals to Gloucester Health & Care (GHC) is 58.3% female and 41.7%, indicating Young Gloucestershire is seeing a higher proportion of females being referred to the service and lower proportion of males.

Commissioners need to consider how they can ensure that more young men are referred into the service.

[85] Mental Health problems in children and young people gov report

Conclusions

The main findings from this MHNA form the following recommendations:

Integrated approach to commissioning services for individuals needing support in multiple areas

- Mental health issues should be considered in the wider social context that a person is living in, including homelessness, substance misuse and domestic abuse.
- Joint working and co-location between mental health services and services that support those with substance misuse issues, those needing domestic abuse support services and those with wider complex needs.

Increase understanding and awareness of mental health services (including Voluntary and Community Sector) in the county

- Consider how we can improve healthcare professionals' awareness and understanding of the range and scope of mental health services in the county, both commissioned and Voluntary and Community Sector (VCS), to improve signposting to patients
- Standardise/normalise conversations about improving wellbeing (eg 5 ways of wellbeing) and social connectedness/community involvement as a way of improving mental health resilience in our population (similar to Make every contact count for physical health).
- Consider the need for a central portal containing information on local mental health services to assist adults in navigating the system. This could be a continuation of the Be Well Gloucestershire campaign (which encouraged people to access support for their mental health and wellbeing throughout 2021). It includes a comprehensive list of all the services and support available both locally and nationally. This could continue to be updated and used as a resource for signposting individuals to appropriate support.

Increased connectedness between Partnership boards with overlapping themes and priorities

- The numbers of people living alone are projected to increase by 2043. We need to consider how we can work together on a strategic level between partnerships to improve social connectedness and wellbeing in our communities as a form of primary prevention for social isolation, loneliness, and mental health conditions.

Consider wider determinants of health in developing mental health support

- Commissioners and providers should continue to consider wider determinants such as employment opportunities and housing when supporting individuals' mental health
- Increased understanding of how wider determinants, including housing/living environment, can have a big impact on an individual's mental health

Preparing for changes in population demographics and addressing unmet needs:

- Commissioners and those planning or providing services need to ensure that our services are accessible to older people, and encourage engagement with preventative services for those approaching older age. They need to ensure that methods of accessing support are suitable for older ages and also need to consider the impact of an aging population on those who will be caring for them and be proactive with signposting to mental health support for carers.

Further work required to greater understand our populations need. Any further information gathering should consider talking to people with lived experience as well as staff/professionals.

- Engage with GARAS as they have highlighted that we can better understand the needs of Gloucestershire's asylum seeker and refugee population, and the difficulties that they face in accessing mainstream services.

- Once the 2021 Census findings are released, we will have information on specific vulnerable groups for the first time (LGBTQ+ and Veterans). These groups are vulnerable to developing mental health conditions and further work to understand the needs of these groups should be considered once there is a better understanding of the population size in Gloucestershire.
- Engage with Eating disorder and Recovery services to understand how the findings from this analysis feed into their experiences from the service. Following this discussion further recommendations should be made about any adaptations to service provision/pathways.