# CHAPTER 7: MENTAL HEALTH NEEDS IN THE VULNERABLE GROUPS AND INEQUALITIES

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# 7 MENTAL HEALTH NEEDS IN THE VULNERABLE GROUPS AND INEQUALITIES

## 7.1 Introduction

Public Health England (PHE) defines health inequalities as avoidable and unfair differences in health status between groups of people or communities (Public Health England, 2018), while the NHS defines health inequalities as preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs (NHS England, n.d.).

Others make a distinction between health inequalities and inequities or disparities. Health inequality generically refers to differences in the health of individuals or groups. Any measurable aspect of health that varies across individuals or according to socially relevant groupings can be called a health inequality. In contrast, a health inequity, or health disparity, is a specific type of health inequality that denotes an unjust difference in health which are preventable and unnecessary, and allowing them to persist is unjust (Arcaya, Arcaya, & Subramanian, 2015).

The NHS and PHE definitions for health inequality form the basis of this chapter. Inequalities can be shown in access to services, service experiences, and outcomes (NHS England, 2020):

- Different groups access services differently, with underrepresentation in some services and overrepresentation in others. Examples include older people being underrepresented in talking therapies and Black-British men being overrepresented in mental health secure care.
- Different groups report having different levels of satisfaction with the healthcare they receive. This is an inequality in experience. An example is lesbian, gay, bisexual and transgender (LGBT+) and Black, Asian and other minority ethnic groups reporting poor levels of satisfaction with community mental health services compared to heterosexual and white-British counterparts.
- Different groups receiving the same treatment but having different recovery outcomes. This is an inequality in outcomes. As an example, minority ethnic groups generally have poorer recovery rates in talking therapy services than White-British groups.

Mental health is closely associated with many forms of inequalities. Across the UK, those in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on an average income (Office for Health Improvement and Disparities, 2022). Social risk factors include poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, trauma, and low social support, increase risk for poor mental health and specific disorders income (Office for Health Improvement and Disparities, 2022).

Certain population subgroups are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. These subgroups are at higher risk of mental health problems. The following groups have been identified at being of risk of mental health problems and are being considered in this report, but the list is not exhaustive (Public Health England, 2019):

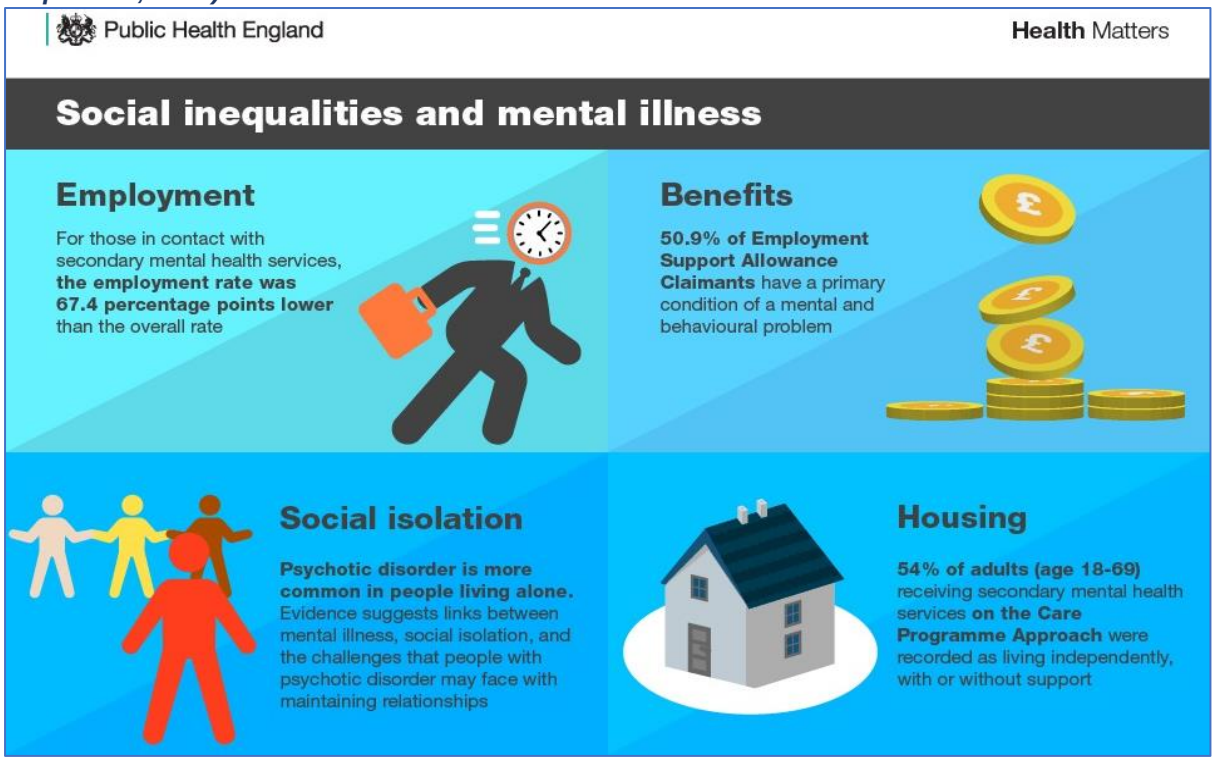
- People from ethnic minority backgrounds
- Gypsy, Roma, and Traveler groups
- LGBTIQ+ people
- Carers
- Individuals experiencing homelessness
- Service personnel
- People with learning disabilities
- Victims/survivors of abuse
- Young offenders
- Young people not in education, employment, or training (NEET)

This assessment looks at some of the groups listed above as being identified as having higher risk of mental illness and aims to present service access data for each of the protected groups listed above. Due to the emerging refugee problems at both national and local levels, a section on refugees and asylum seekers' mental health has been included.

## 7.2 Social Deprivation and Mental health

Figure 7.1 shows the relationship between social inequalities and mental health illness.

***Figure 7.1: Social inequalities and mental illness (Office for Health Improvement and Disparities, 2022)***

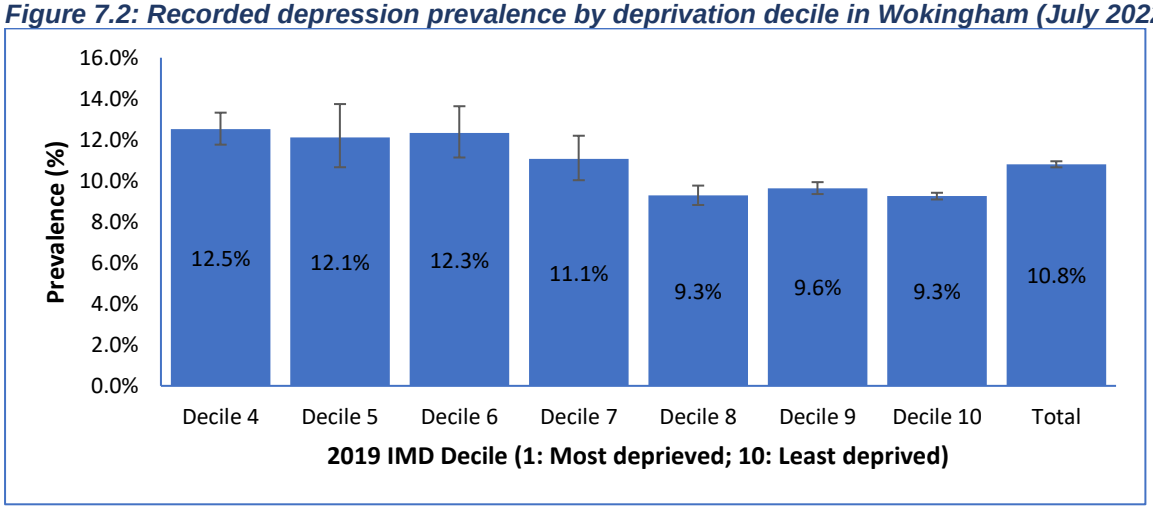


Living in an area of low socioeconomic status can expose people to a high number of stressors, such as, unsafe neighbourhoods and noise pollution, and this can have deleterious effects on mental health and self-rated overall health (Remes, et al., 2019). A systematic review (Richardson, Westley, G, Austin, & Nandi, 2015) however found inconsistent evidence in support of a longitudinal association between neighbourhood socioeconomic conditions and depression.

A UK study found that men living in the most deprived areas were 51% more likely to have major depressive disorder than those living in areas that were not deprived, but the association between deprivation and major depressive disorder was not statistically significant in women (Remes, et al., 2019).

Indices of multiple deprivation (IMD) deciles are used to classified areas based on levels of deprivation. Figure 7.2 provides a breakdown of patients on the local depression register by the 2019 IMD deciles. In 2022, people from more deprived areas in Wokingham (Deciles 4, 5, 6 and 7) were significantly more likely to be on the depression register compared with those from the least deprived Decile 8, 9 and 10 areas.

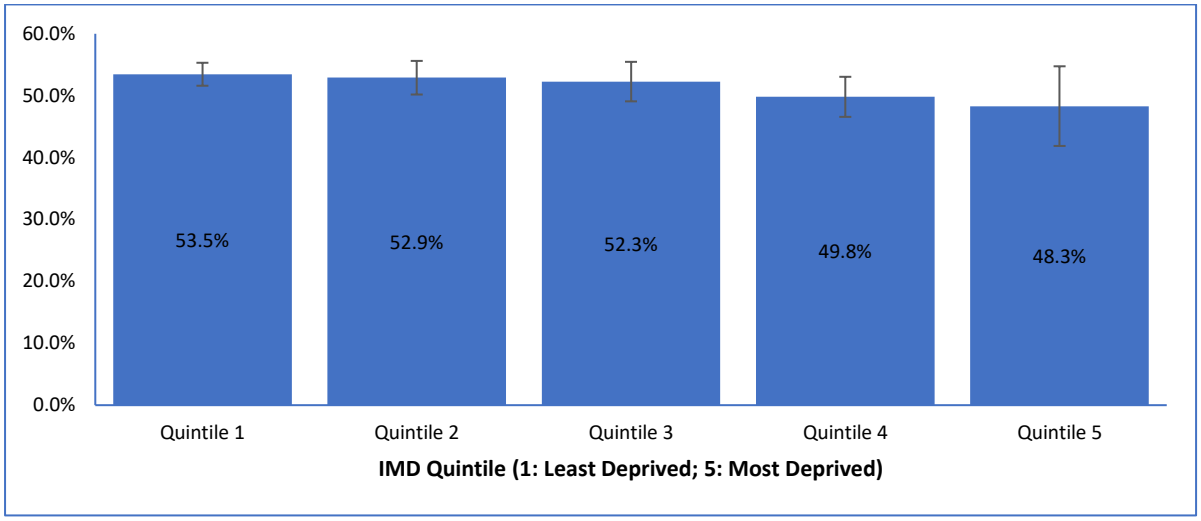
***Figure 7.2: Recorded depression prevalence by deprivation decile in Wokingham (July 2022)***




***Source: Connected Care accessed via Frimley ICS System Insights (30 June 2022)***

Generally, outcomes for Berkshire West (including Wokingham) residents referred to Improving Access to Psychological Therapies (IAPT) services in 2020/21 correlated with deprivation level with more deprived areas achieving lower reliable recovery rates. Those from the least deprived 1st IMD quintile areas of Berkshire West achieved highest reliable recovery rate of 53.5% while those from the most deprived 5th IMD quintile areas achieved the lowest rate of 48.3%. The observed differences were however not statistically significant (Figure 7.3).

*Figure 7.3: Reliable recovery rate by deprivation levels (all IAPT cases) – Berkshire West CCG, 2020/21*




***Source:*** ***Psychological Therapies, Annual report on the use of IAPT services, 2020-21***

## 7.3 Mental health and minority ethnic communities

It is well documented that people from ethnic minorities[1] living in the UK are more likely to (Fitzpatrick, 2014):

- Be diagnosed with a mental health problem
- Defer seeking help until in a crisis, and access that help via A&E
- Be admitted to hospital with a mental health problem
- Experience a poor outcome from treatment
- Disengage from mainstream mental health services

The following evidence summary has been taken mainly from the 2019 Race Equality Foundation review (Bignall, Samir, Helsby, & Butt, 2019). Other sources are appropriately cited where used.

- African Caribbean people are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia, more than any other ethnic group. Some illnesses, such as personality disorders are less likely to be diagnosed in Black African and Caribbean patients compared to White patients.
- Rates of depression are reportedly much higher in minority ethnic communities than in white communities. Some evidence suggests rates of depression are particularly high for South Asians, especially women.
    - There is a higher rate for Pakistani/Bangladeshi people primarily among women – 28.2% of whom at risk of poor mental health, compared with 17.4% of White women (Equality and Human Rights Commission, 2016)
- Black African and African Caribbean women are more likely to have a common mental health disorder than their White counterparts
- The White British group has the highest percentage of people reporting suicidal thoughts; 21.6% compared with 13.1% of the Asian/Asian British group. There are also disparities in those reporting self-harm, with 8.1 percent

[1] We use 'ethnic minorities' to refer to all ethnic groups except the white British group. Ethnic minorities include white minorities, such as Gypsy, Roma and Irish Traveller groups

of those in the White British group compared with 4.2% of those in the mixed, multiple and other ethnic group

### 7.3.1 Mental health risk factors among minority ethnic groups

#### *7.3.1.1 Racism and discrimination*

Discrimination is defined as the differential treatment of an individual based on a socially ascribed characteristic (Alvarax-Galvez, 2013). A growing body of research has investigated discrimination as a determinant of mental health (Goto JB., 2013), (Pascoe, 2009), (Schmitt, 2014) and these findings identified that discrimination was linked with poor mental health, including psychological distress and decreased life satisfaction (Pascoe, 2009), (Mantovani, 2017).

Racism is a recognised social determinant of health and a driver of ethnic inequalities in health (Williams DR., 2009). It can be understood as a complex, organised system embedded in socio-political and historical contexts, that involves classifying ethnic groups into social hierarchies. These groups are ideologically assigned differential value, which drives disparities in access to power, resources, and opportunities (Krieger, 2020), (Williams, 2013). It occurs at both structural and individual levels.

Racism has been associated with disturbances in neurobiological processes, with alterations observed in brain areas such as the anterior cingulate cortex, prefrontal cortex and amygdala which overlap with pathways associated with poor mental health (Berger, 2015).

#### *7.3.1.2 Stigma*

Stigma is associated with poor mental health. Stigma involves a combination of inaccurate knowledge and stigmatising attitudes, leading to individuals being excluded and discriminated against. Patterns of stigma and discrimination vary between and within communities and are related to conceptualisations of, and beliefs about mental health from historical experiences.

Family reputation is a consistent issue in studies of Asian ethnic groups; the implication being that mental health problems can compromise ability to fulfil family obligations and inhibits disclosure (Knifton, 2009).

Within the Chinese ethnic group, reports suggest that people often hide mental health problems and avoid treatment and have expressed lack of supportive relationships and blame from some family members (Knifton, 2009).

Within Black ethnic groups, studies have suggested that mental health illness is described negatively with terms such as ‘curse or insanity’ being used and is associated with violence and danger. There is also the expectation that one needs to ‘deal with it’ or ‘be strong’ which can affect how mental health is understood and how people coped (Knifton, 2009). Some have also found that a stereotype of Black African and African Caribbean women being ‘strong’ meant there was a lack of expectation that such women can experience mental health distress – this has inhibited them from seeking help and getting diagnosed (Mental health foundation, 2011).

#### *7.3.1.3 Social and economic inequalities*

People from ethnic minority communities often face disadvantages in society and are more likely to (Mental Health Foundation, 2022):

- Experience poverty and homelessness
- Do less well at school
- Be unemployed
- Be in contact with the criminal justice system
- Face challenges accessing services

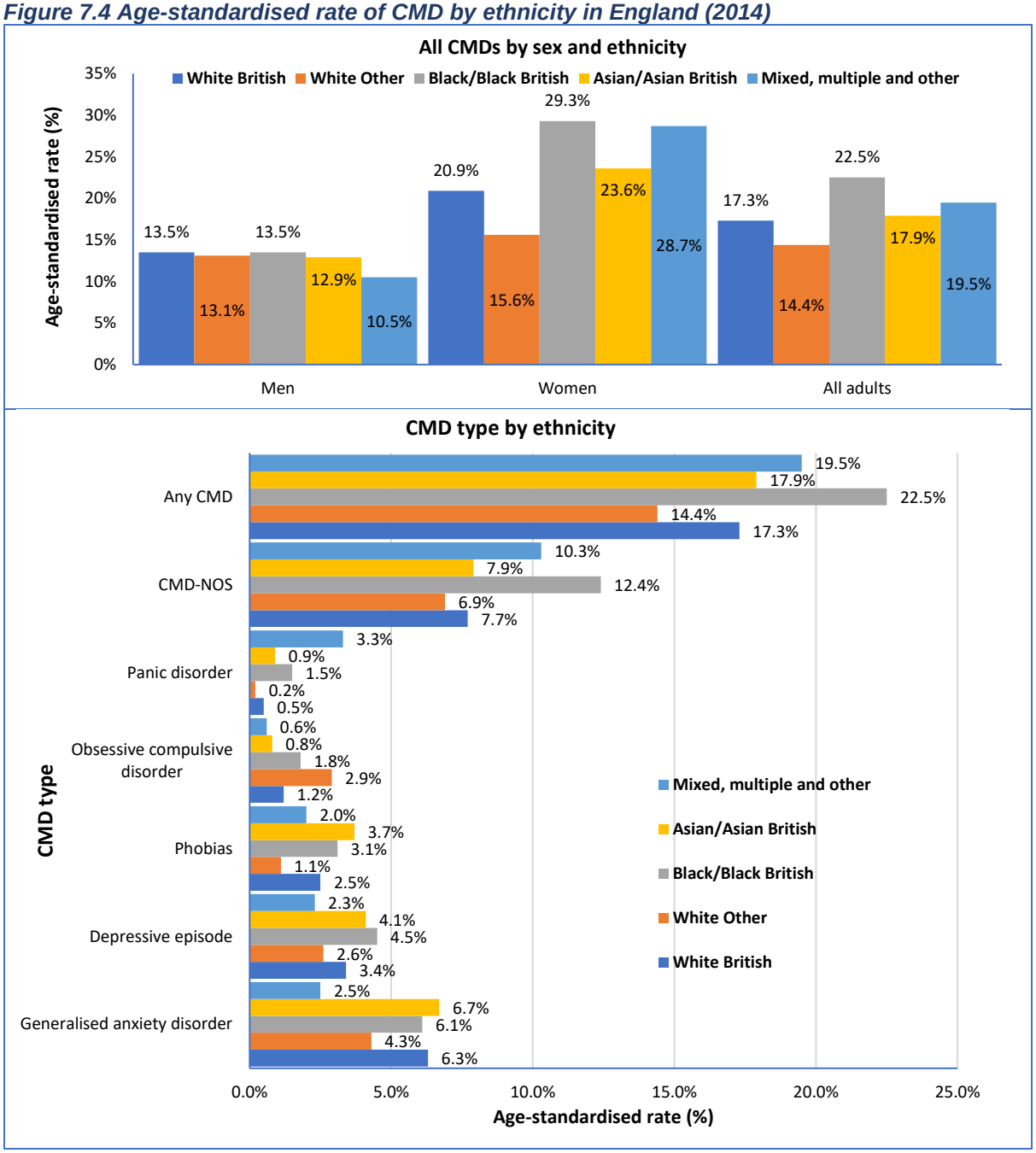
Each of these can increase the risk of developing mental health problems.

### 7.3.2 Ethnic minority communities – National mental health prevalence

#### *7.3.2.1 Common mental disorder (CMD) and depression*

The 2014 Adult Psychiatric Morbidity Survey (APMS) (NHS Digital, 2016) found that prevalence of common mental health disorders (CMDs) was highest among Blacks (22.5%) and lowest among those from Other White background. In men, prevalence of CMD did not vary significantly by ethnic group, whereas it did in women. Black women had the highest age-standardised prevalence of 29.3% while those from Other White background had the lowest of 15.6% (Figure 7.4). Generalised anxiety disorder (GAD) seemed to be least common among those from Other White background but similar across all other ethnicities.

*Figure 7.4 Age-standardised rate of CMD by ethnicity in England (2014)*

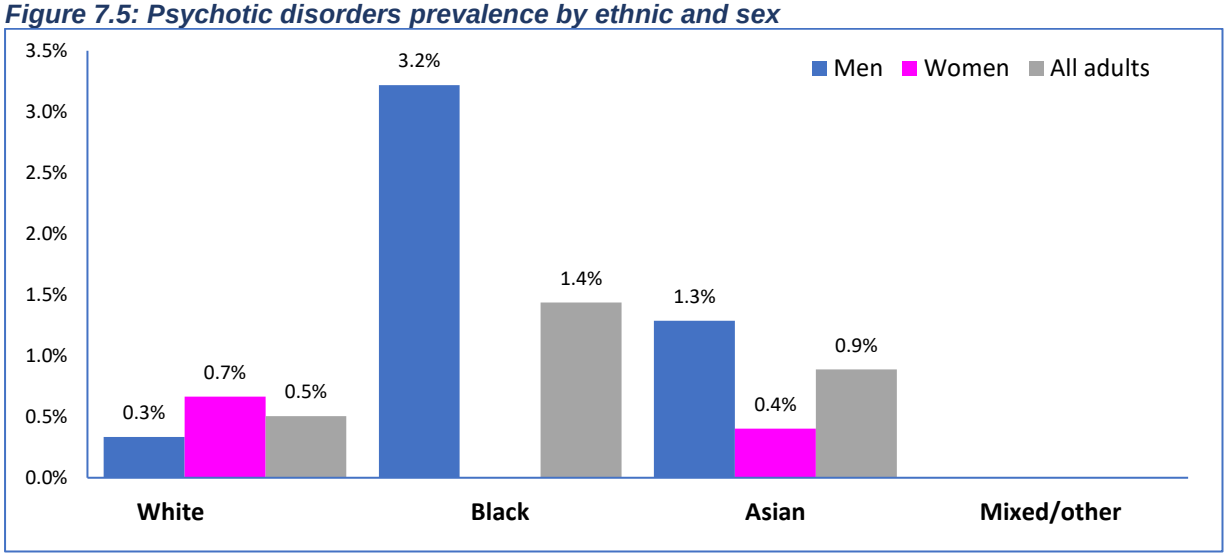



***Source: APMS 2014*** (NHS Digital, 2016)

### *7.3.2.2 Psychotic and bipolar disorders*

The 2014 APMS (NHS Digital, 2016) showed that the prevalence of psychotic disorders was higher in Black men than men from other ethnic groups. The prevalence of among Blacks was 1.4% compared with 0.5% among Whites and 0.9% among Asians (Figure 7.5). There were no data reported for Black women and all those from mixed ethnic backgrounds because the small numbers in these groups.

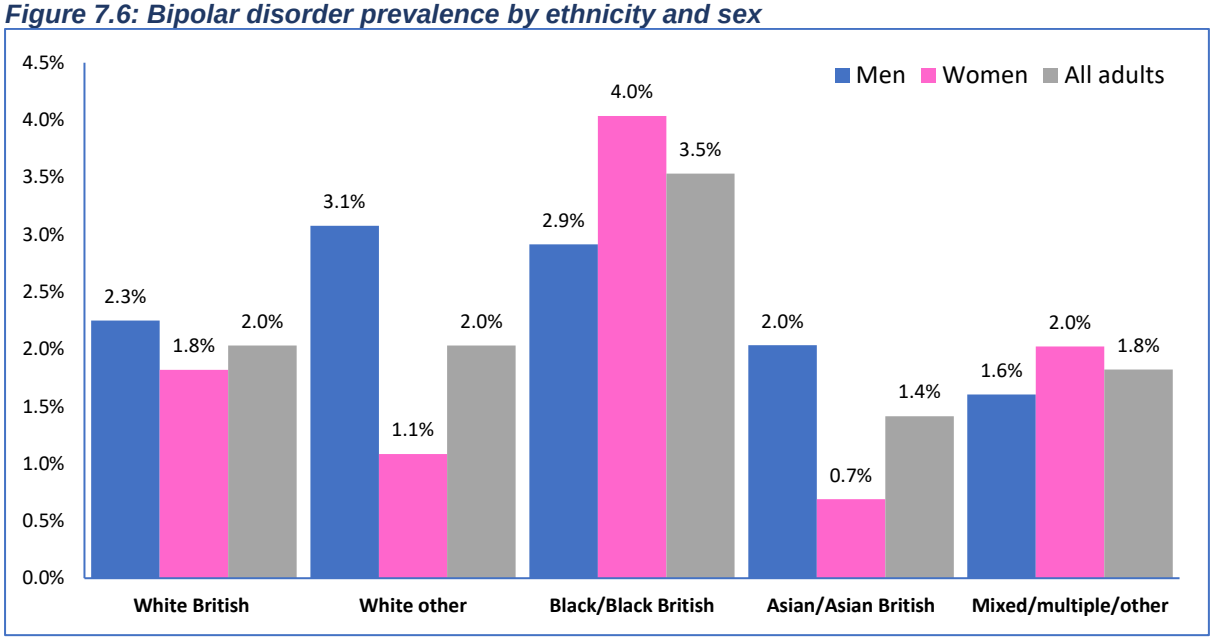
*Figure 7.5: Psychotic disorders prevalence by ethnic and sex*




***Source: APMS 2014*** (NHS Digital, 2016)

Blacks had the highest prevalence of bipolar disorders (3.5%) while Asians had the lowest prevalence of 1.8%. Black women were more than 4 times likely to report bipolar disorder compare with their Asian counterparts and more than twice compared with their White counterparts in the 2014 APMS (Figure 7.6).

*Figure 7.6: Bipolar disorder prevalence by ethnicity and sex*




***Source: APMS 2014*** (NHS Digital, 2016)

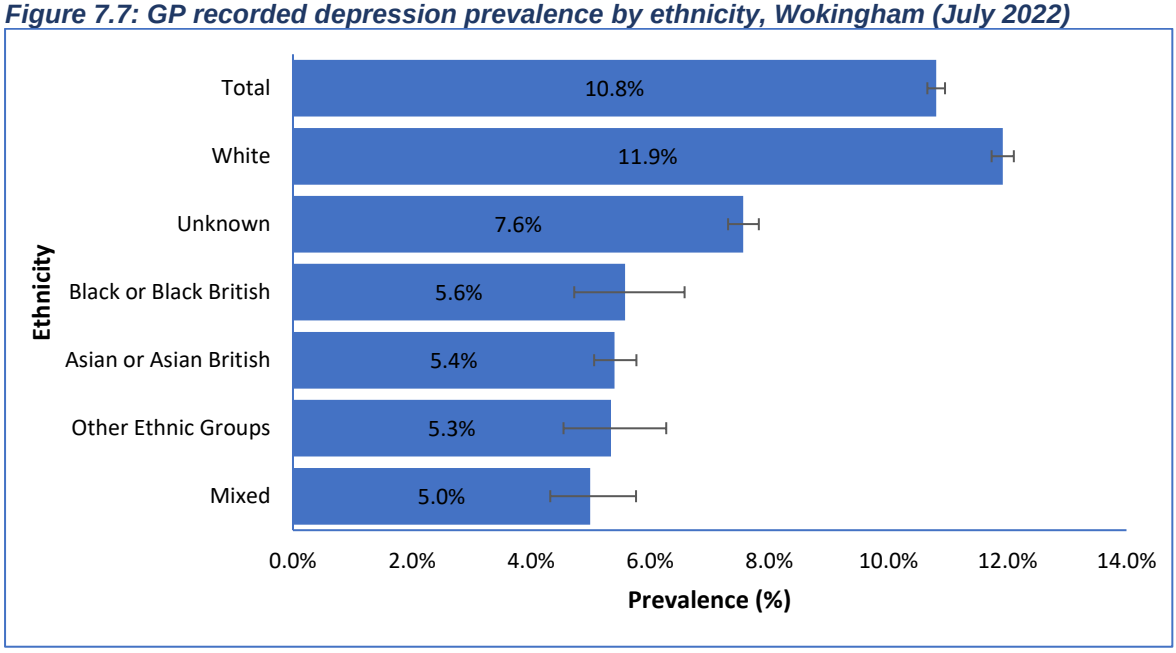
### 7.3.3 Minority ethnic communities – Local mental health prevalence

#### *7.3.3.1 Common mental disorder*

GP-recorded depression prevalence by ethnicity in July 2022 showed Whites had the highest prevalence of 11.9% while those from mixed ethnic backgrounds had the lowest prevalence of 5.0% (Figure 7.7). It is, however, possible that this is reflecting service access rather than differences in underlying prevalence.

Comparing Figure 7.4 and Figure 7.7 it could be inferred that those from minority ethnic backgrounds may not be seeking support for depression from primary care.

*Figure 7.7: GP recorded depression prevalence by ethnicity, Wokingham (July 2022)*




***Source: Source Connected Care accessed via Frimley ICS System Insights (20 June 2022)***

#### *7.3.3.2 Serious Mental Illness*

GPs also hold a register of all people with a recorded diagnosis of serious mental illness (SMI). Connected Care data showed similar pattern to the depression register with people registered with Wokingham GP Practices from White background being significantly more likely to appear on the register compared to those from minority ethnic backgrounds. Again, it is possible that this is reflecting service access rather than differences in underlying prevalence.

### 7.3.4 Minority ethnic communities – Service access

#### *7.3.4.1 Variation in receipt of mental health treatment, by ethnic group*

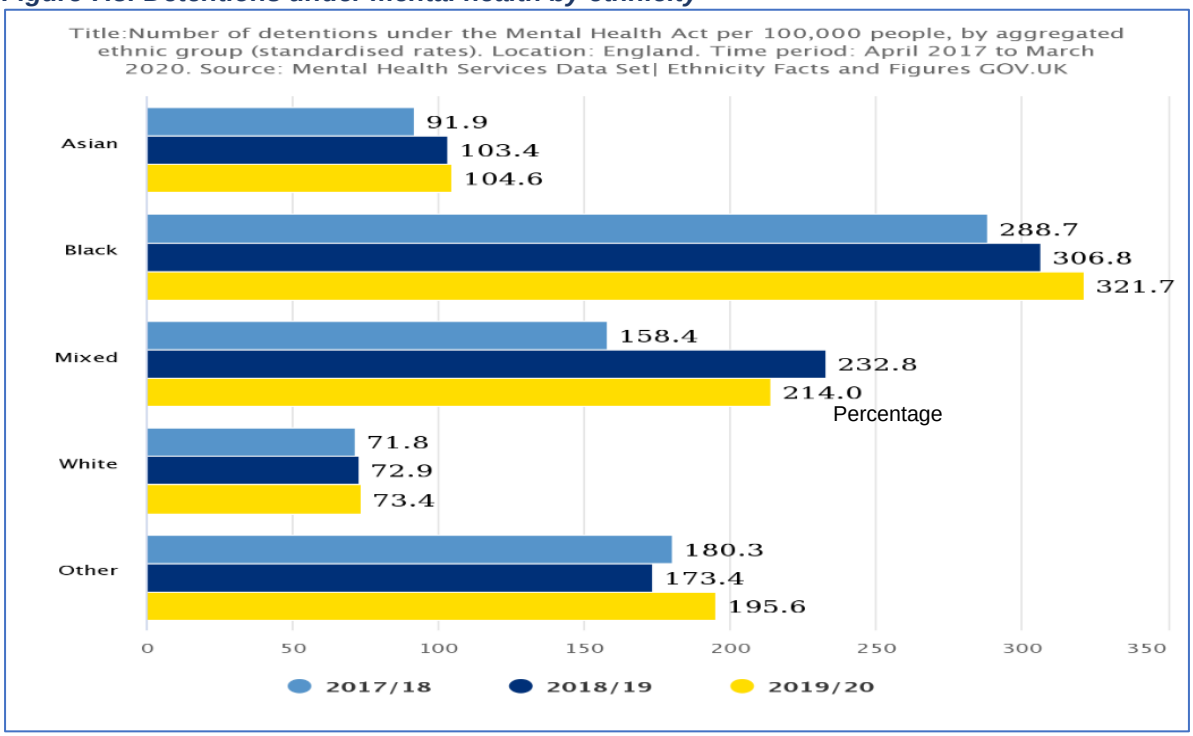
The 2014 APMS found treatment rates varied by ethnicity in England. White British people were most likely to report receiving treatment; 14.5% reported this compared with around 7% of people in minority ethnic groups (including non-British White) with Black adults having the lowest treatment rate of 6.5%. After controlling for other factors, people in the Black/Black British group were 73% less likely to be in receipt of treatment (odds ratio: 0.27) compared with the White British group. Analysis by ethnic group should be treated with some caution due to small sample sizes, although these findings were consistent with results from 2007 APMS.

Further evidence shows that rates of referral from GPs and community mental health teams to secondary mental health services are lower than average among people from Black and mixed Black backgrounds (Fitzpatrick, 2014).

#### *7.3.4.2 Detention under the mental health act*

Despite lower-than-average primary service access and referrals to secondary services, Figure 7.8 shows that in the year to March 2020, Blacks were more than 4 times as likely as Whites to be detained under the Mental Health Act. The figure also shows black adults being detained under the mental health act continues to increase each year to March 2020.

*Figure 7.8: Detentions under mental health by ethnicity*

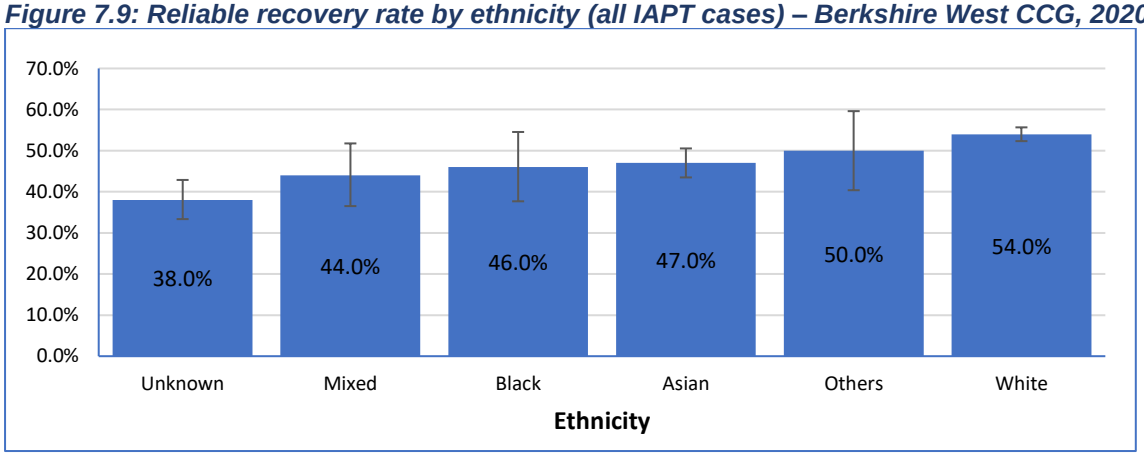



*Source: Detentions under the Mental Health Act, Gov.uk (Accessed November 2021)*

### *7.3.4.3 Local services and outcomes*

Analysis of the local Improving Access to Psychological Therapies (IAPT) data for 2020/21 showed that generally, there were lower reliable recovery rates among minority ethnic groups compared with those from White background. Those from mixed background were significantly less likely to achieve reliable recovery (44.0%) compared with 54.0% for those from White background. Though other ethnicities have lower reliable recovery rate compared to their White counterparts, the differences were not statistically significant. Those with no known ethnicity specified had the lowest reliable recovery rate of 38.0% which was significantly lower than the rate in Whites (Figure 7.9).

*Figure 7.9: Reliable recovery rate by ethnicity (all IAPT cases) – Berkshire West CCG, 2020/21*

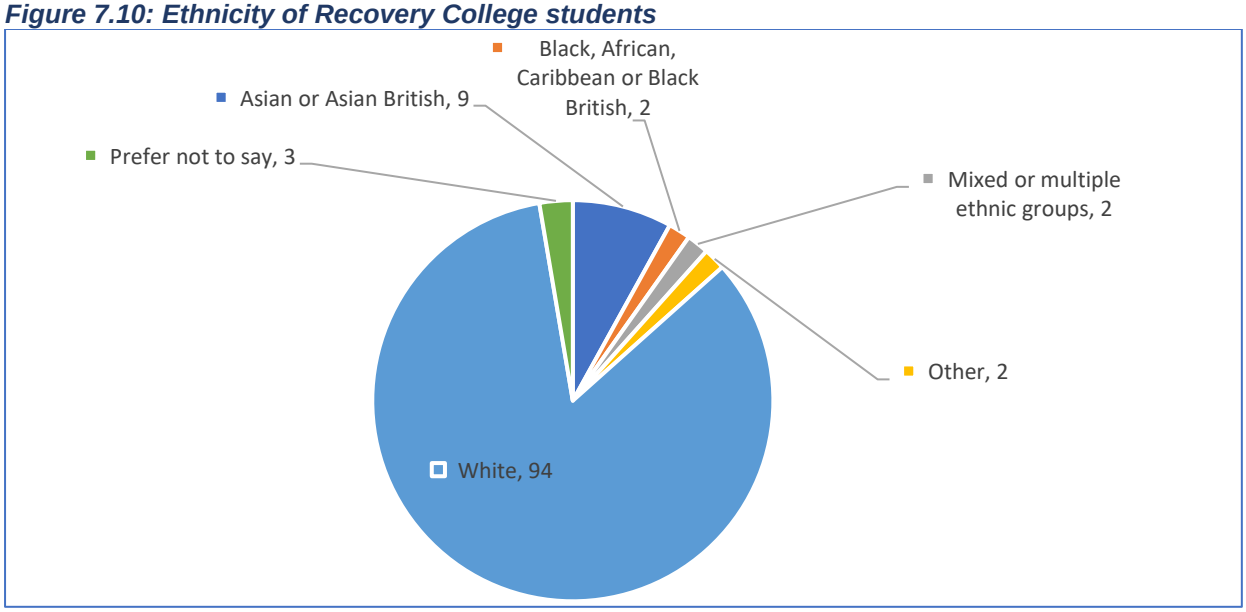



***Source:*** ***Psychological Therapies, Annual report on the use of IAPT services, 2020-21***

The Wokingham Recovery College (WRC) offers free mental health and wellbeing training courses to residents. The aim of WRC is to be inclusive and accessible for

everyone in Wokingham. Data from WRC report the attendees are predominantly White British. To increase attendance from ethnic minority groups the Recovery College have developed a Community Outreach scheme aimed to ensure that they are meeting the needs of minority groups within the community.

***Figure 7.10: Ethnicity of Recovery College students***




***Source: Wokingham Recovery College (Accessed December 2021)***

## 7.4 Gypsy, Roma and Traveller communities

The terms Gypsy, Roma and Traveller are used to describe a range of ethnic groups, or those with nomadic ways of life but not from a specific ethnicity. In the UK context, there is often differentiation made between Gypsies (including English Gypsies, Scottish Gypsy/Travellers, Welsh Gypsies, and other Romany people); Irish Travellers (who have specific Irish roots), and Roma (those who have more recently migrated from Central/Eastern Europe). The term Travellers also encompasses groups that travel, including New (Age) Travellers, Boaters (also known as Bargees) and Showpeople (Cabinet Office, 2022).

It is estimated that there are approximately 300,000 Gypsies and Travellers living in the UK (Friends, families & Travellers, n.d.). The 2011 census indicated there were 291 from Gypsy, Roma and Traveller background in Wokingham and this represented just under 0.2% of the total population (ONS, 2011). The latest count of traveller caravans conducted in Wokingham put the total caravan count on both authorised and unauthorised sites at 256. There are currently 2 traveller sites provided by the local authority in Wokingham (Department for Levelling Up, Housing and Communities, July 2021). If we assume that caravans are home to more than one individual, in addition with the fact that only 24% of Gypsy, Roma and Traveller people live in caravans (Cabinet Office, 2022), then this indicates that the figure reported in the 2011 census was a significant undercount of the Gypsy, Roma and Traveller population living in Wokingham.

### 7.4.1 Gypsy, Roma and Traveller communities – mental health risk factors

#### *7.4.1.1 Living circumstances and accommodation*

Mental health and insecurity of housing has been associated with suffering from anxiety and depression. People from Gypsy, Roma and Traveller groups experience insecure living conditions because of their planning status, threat of eviction and/or poor site conditions; or their reluctance acceptance of living in 'bricks and mortar' accommodation in the absence their preferred option of a pitch on a Traveller site (The Traveller Movement, 2016).

#### *7.4.1.2 Stigma*

Stigma is associated with mental health and is experienced by people within the Gypsy, Roma and Traveller communities. The term 'Mental Health' is an unacceptable term to be used in the community and 'suffering from nerves' is an acceptable term to describe mental health.

Women from Gypsy, Roma and Traveller groups express how 'you don't come out and say that you're stressed, you don't say you have a mental health problem, not as a Gypsy woman - people will think you're proper mental, that you're cracking up'. Additionally, women are especially concerned that a mental health diagnosis could lead to social services involvement and having children removed from their care (Race Equality Foundation, 2019).

Other research in this area has explored the meaning of mental illness with young travellers aged 15- 21 and found mental illness was referred to negatively. Words such as 'psycho' and 'mad' were used and there has been little understanding of mental illness. Most young Travellers implied they would 'suffer in silence' with a mental health condition, with males gaving reasons for the lack of interaction with mental health services as conforming to traditional hyper masculinity roles (YinHur, 2011).

### 7.4.2 Gypsy, Roma and Traveller communities – National mental health prevalence

Significant health inequalities exist between the Gypsy, Roma and Traveller population in England and the settled community, even when compared with other socially deprived or excluded groups, and with other ethnic minorities (Parry, 2007). Gypsy, Roma and Traveller groups experience wide ranging inequalities, and their lack of suitable accommodation underpins many of the inequalities they experience (Cemlyn, 2009).

Gypsies, Travellers and Roma have been found to suffer poorer mental health than the rest of the population in Britain and they were also more likely to suffer from anxiety and depression (Equality and Human Rights Commission, 2016). Research has shown that Gypsies and Travellers are nearly three times more likely to be anxious than average and just over twice as likely to be depressed (Greenfields & Brindley, 2016). The 2010 all-Ireland Traveller Health Study (Quirke, 2012) found suicide among Travellers was 6 times the rate of general population and accounted for approximately 11% of all Traveller deaths – male suicide rate was 6.6 times the rate in the general population while the female rate was 4.9 time higher.

### 7.4.3 Gypsy, Roma and Traveller communities – Local mental health prevalence

At the time of writing, there was no local data available on the prevalence of adult mental health needs in the Wokingham Gypsy, Roma and Traveller population.

### 7.4.4 Gypsy, Roma and Traveller communities – Service access

At the time of writing the needs assessment, there was no local service for Gypsy, Roma and Travellers communities in Wokingham but, according to Joint Commissioning Panel for Mental Health (JCPMH) and NICE guidelines, all mental health services should be culturally capable and able to address the diverse needs of a multi-cultural population (NICE, 2014).

In terms of wider support available, Friends Families and Travellers (FFT) is a leading national charity that seeks to end racism and discrimination against Gypsies, Roma and Traveller groups and to protect the right to pursue a nomadic way of life. They provide advice, services, work on research and policy, deliver training and promote the health and wellbeing of the Gypsy, Roma and Traveller groups (Friends, families & Travellers, n.d.).

## 7.5 LGBTIQ+ people

LGBTIQ+ stands for lesbian, gay, bisexual, trans, intersex, queer or questioning. LGBTIQ+ people are more susceptible to mental health problems than heterosexual people due to a range of factors, including discrimination, health inequalities, homophobia or transphobia, social isolation, rejection, and difficult experiences of coming out. It is important to note that embracing LGBTIQ+ can have a positive impact on someone's wellbeing too. It might mean they have more confidence, a sense of belonging to a community, feelings of relief and self-acceptance, and better relationships with friends and family (Mental Health Foundation, 2021).

### 7.5.1 LGBTIQ+ people – mental health risk factors

LGBTIQ+ people are at a higher risk of experiencing common mental health problems than the general population - the 2018 Stonewall report (Stonewall, 2018) highlighted experiences of discrimination and harassment in day-to-day life as some of the factors associated with this. Rejection from one's family and friends, being subjected to hate crimes and incident are major factors leading to poor mental health in people who are LGBTIQ+.

#### *7.5.1.1 Discrimination in healthcare*

Discrimination and lack of understanding of LGBTIQ+ specific health needs when accessing services are barriers to LGBTQ+ people. It's reported that their health needs are overlooked or not considered by healthcare professionals, which leaves them with a lack of trust in the provider. The Stonewall report found (Stonewall, 2018) the following:

- 13% of LGBTIQ+ people have experienced some form of unequal treatment from healthcare staff because they were LGBT while 32% of trans people have experienced unequal treatment.

- 14% of LGBTIQ+ people stated they had avoided treatment for fear of discrimination because they were LGBTIQ+. 37% of trans people and 33% of non-binary people had avoided treatment for fear of discrimination.

#### *7.5.1.2 Online/ Hate Crime*

Experiencing hate crime and hate instances can have a severe and long-lasting impact on people's health, wellbeing, and freedom to live their everyday lives. Levels of homophobic, biphobic and transphobic hate crime are high among the LGBTQI+ community - 1 in 5 LGBTIQ+ people reported that they had experienced a hate crime based on the fact they were LGBTIQ+ in the last 12 months, this rose to 2 in 5 of trans people (Stonewall, 2018). The Stonewall report also found that 10% of LGBTIQ+ people experienced online homophobic, biphobic and transphobic abuse or behaviour directed at them personally (Stonewall, 2018).

#### *7.5.1.3 Substance misuse*

Alcohol consumption is high in LGBTIQ+ people. It has been reported that 16% of LGBTIQ+ people said they drank alcohol almost every day over the last year. Frequency of alcohol consumption increases with age; the 2018 Stonewall report found that 33% of LGBTIQ+ people aged 65+ stated they drank almost every day, compared to just 7% of LGBTIQ+ people aged 18-24 (Stonewall, 2018).

#### *7.5.1.4 Employment*

Being comfortable to be yourself at work is a prerequisite for a happy and successful career and life. Many LGBTIQ+ employees still face anti- LGBTIQ+ discrimination at work, and levels of sexual harassment and abuse faced by LGBTIQ+ staff are alarmingly high (LGBT Foundation, n.d.).

A 2018 report found that 18% of LGBTIQ+ employees had been the target of negative comments or conduct from work colleagues in the preceding year because of being LGBTIQ+. As with more generalised experiences of discrimination, harassment and abuse experiences can potentially mean poorer mental health and higher stress levels. 3 in 10 LGBTIQ+ people were reportedly missing work in the last 12 months due to stress. Another study found stress-related absence from work among LGBTIQ+ people to be 16 times higher than the rate for all sexual orientations (LGBT Foundation, n.d.).

#### *7.5.1.5 Housing and homelessness*

Homelessness is an issue that disproportionately affects LGBTIQ+ people. It has been reported that 18% of LGBTIQ+ people have been homeless at some point in their lives (Bachmann & Gooch, 2018).

Safety, security, and stability remains an issue once in housing. A London-based study of service users of LGBT organisations found that for a third of respondents stated that ensuring safety at home was a constant or significant challenge (LGBT Foundation, n.d.).

Issues of parental abuse or rejection play a significant role for young LGBTIQ+ people. 24% of homeless young people identify as LGBTIQ+. The top three reasons for LGBTIQ+ young people being homeless were reported as being parental

rejection (69%), abuse within the family (physical, emotional, sexual) (69%) and aggression / violence in the family (62%) (LGBT Foundation, n.d.).

#### *7.5.1.6 Social attitude*

Though over the last four decades, there has been a positive shift in attitudes towards LGBTIQ+ people, negative homophobic, biphobic and transphobic attitudes are still prevalent in society.

A 2019 Galop survey found that 1 in 5 people said being LGBTIQ+ was 'immoral or against their beliefs'. This rose to 1 in 4 among 18 - 24-year-olds, higher than other age groups (LGBT Foundation, n.d.).

### 7.5.2 LGBTIQ+ people – National mental health prevalence

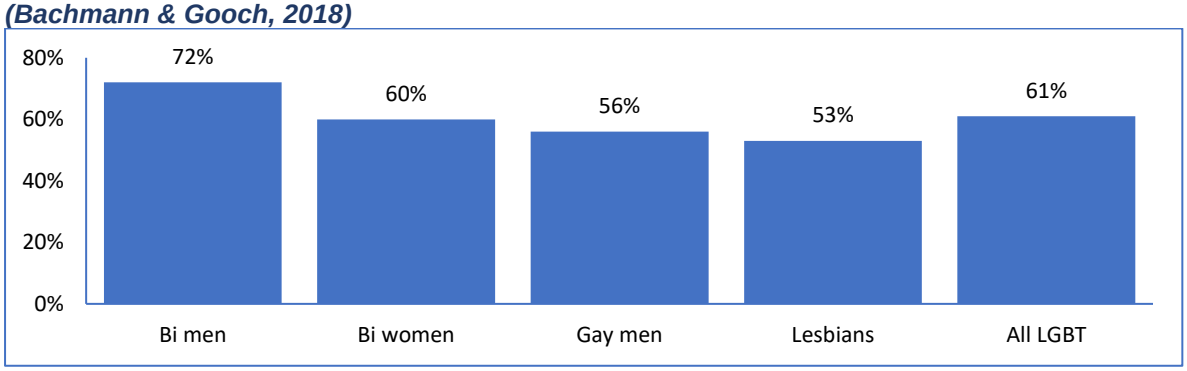
Statistics that highlight the mental issues among the LGBTQ+ communities include the following (UK Health Security Agency, 2017):

- 52% of young LGBT people reported self-harm either recently or in the past compared to 25% of heterosexual non-trans young people and 44% of young LGBT people have considered suicide compared to 26% of heterosexual non-trans young people.
- 3% of gay men have attempted to take their own life in 2013. This increases to 5% of Black and minority ethnic men, 5% of bisexual men and 7% of gay and bisexual men with a disability. In the same period, 0.4% of all men attempted to take their own life (Stonewall, 2015).
- 5% of lesbians and bisexual women say they had attempted to take their own life. This increases to 7% of bisexual women, 7% of black and minority ethnic women and 10% of lesbians and bisexual women with a disability (Stonewall, 2015).
- A 2012 study found that 11% of trans people had thought about ending their lives at some point in the last year and 33% had attempted to take their life more than once in their lifetime, with 3% attempting suicide more than 10 times (McNeil, Bailey, Ellis, Morton, & Regan, 2012).

A 2018 Stonewall survey (Bachmann & Gooch, 2018) found 52% of LGBT people said they had experienced depression in the year before the survey, with another 10% saying they think they might have experienced depression. 67% of trans people stated had experienced depression in the year preceding the survey while 70% of non-binary people, 55% of LGBT women and 46% of GBT men stated they have had the same experience.

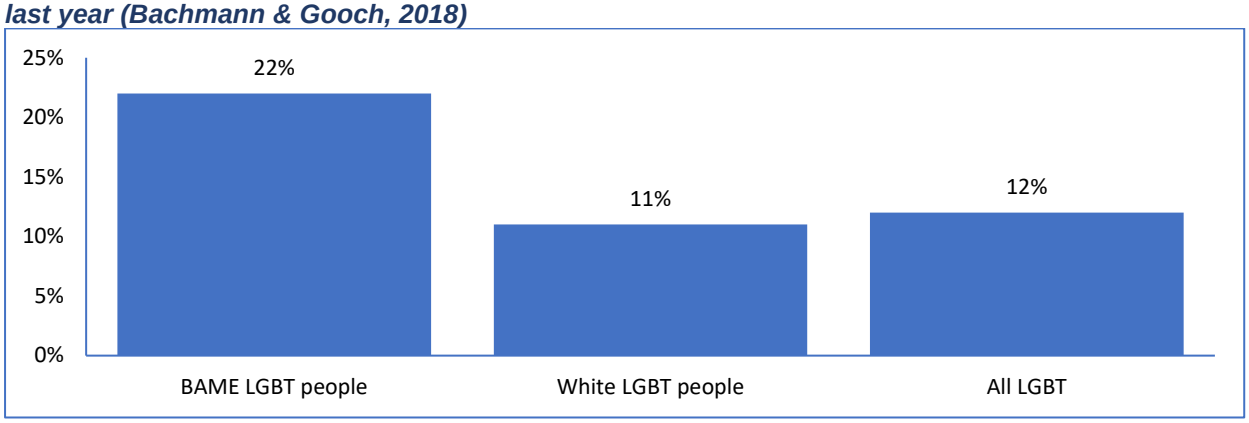
Figure 7.11 shows the proportion of LGBT people reporting they had experienced anxiety in the year preceding the 2018 Stonewall survey. Overall, 61% of LGBT people reported they had experienced anxiety in the year preceding the survey. Bi men had the highest rate of 72% while Lesbians had the lowest rate of 53%.

***Figure 7.11: Proportion of LGBT people reporting they experienced anxiety in the last year (Bachmann & Gooch, 2018)***



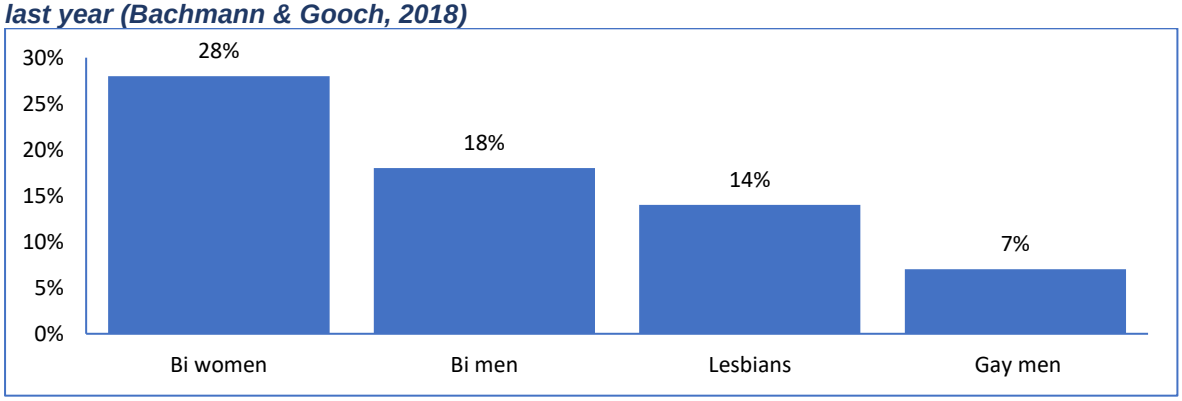

12% of LGBT people in the Stonewall survey reported they had experienced an eating disorder in the year preceding the survey – the rate was higher among minority ethnic LGBT people (22%) compared with White LGBT people (Figure 7.12).

***Figure 7.12: Proportion of LGBT people reporting they experienced an eating disorder in the last year (Bachmann & Gooch, 2018)***



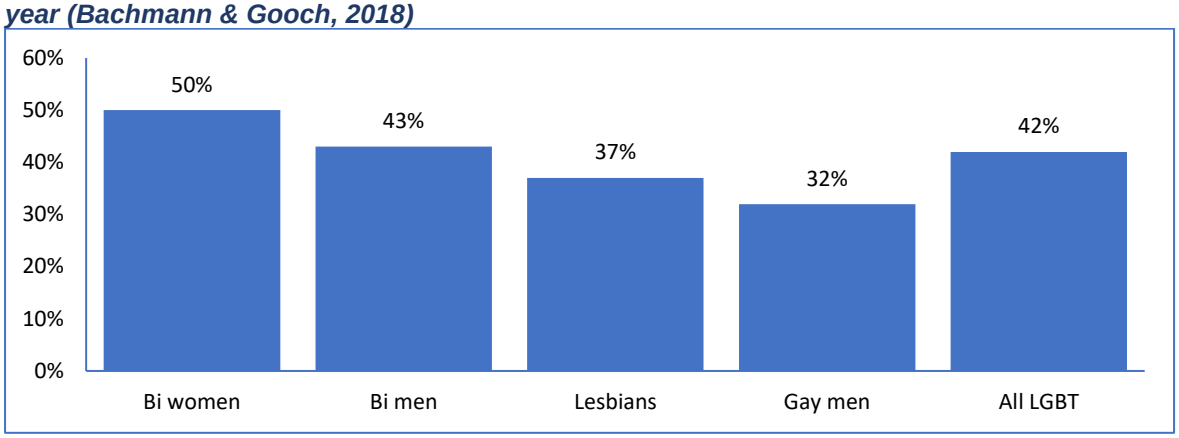

48% of LGBT people aged 18-24 said they had deliberately harmed themselves in the year preceding the survey. 41% of non-binary people said they harmed themselves compared to 20% of LGBT women and 12% of GBT men. 35% of trans people had self-harmed, compared to 14% of LGB people who are not trans. 28% of LGBT disabled people had self-harmed compared to 11% of LGBT people who are not disabled (Figure 7.13). These figures were generally higher than the NHS Digital findings available at the time of the survey, which showed around 6% of adults in general said they had self-harmed.

***Figure 7.13: Proportion of LGBT people reporting they deliberately harmed themselves in the last year (Bachmann & Gooch, 2018)***



42% of LGBT people in the 2018 Stonewall survey said they had felt at some point during the year preceding the survey life was not worth living. Bi women were more likely to report feeling life was not worth living (50%) while gay men were least likely (32%) (Figure 7.14).

***Figure 7.14: Proportion of LGBT people reporting they felt life was not worth living in the last year (Bachmann & Gooch, 2018)***




52% of LGBT people aged 18-24 had thought about taking their own life in the year preceding the survey. 50% of non-binary people and 46% of trans people had those thoughts, compared to 31% of LGB people who were trans. Bi people (41%) were more likely to report thoughts of taking their own lives than lesbian and gay people (28%).

According to the 2018 Stonewall survey, 13% of LGBT people aged 18-24 stated they had attempted taking their own life in the year preceding the survey. 12% of trans people had attempted to taking their own life, compared to 2% of LGB people who were not trans. Particular communities at higher risk include: 11% cent of non-binary people, 8% of Black, Asian and minority ethnic LGBT people, 8% of LGBT disabled people, and 7% of LGBT people in low-income households had attempted taking their own life.

NHS Digital research at the time of the survey found one in twenty adults in the general public reported thoughts of taking their own life in the past year and fewer than one per cent said they attempted to take their own life in the last year.

### 7.5.3 LGBTIQ+ communities– Local mental health prevalence

There is a lack of local data on the prevalence of mental health conditions in the population. Berkshire West Clinical Commissioning Group (CCG) referrals for IAPT services show that 6% of people referred described their sexual orientation as gay, lesbian, or bi-sexual. Based on regional estimate of 2.9% of the population identify as lesbian, gay or bisexual which is (ONS, 2019) suggesting an overrepresentation of LGBTIQ+ people being referred to IAPT services. This may be an indication of a higher prevalence of common mental health disorders requiring treatment amongst the local LGBTIQ+ population.

### 7.5.4 LGBTIQ+ communities– Service access

Berkshire Healthcare NHS Foundation Trust (BHFT) is a key local provider of both primary and secondary mental health services. BHFT have an Equality, Diversity and

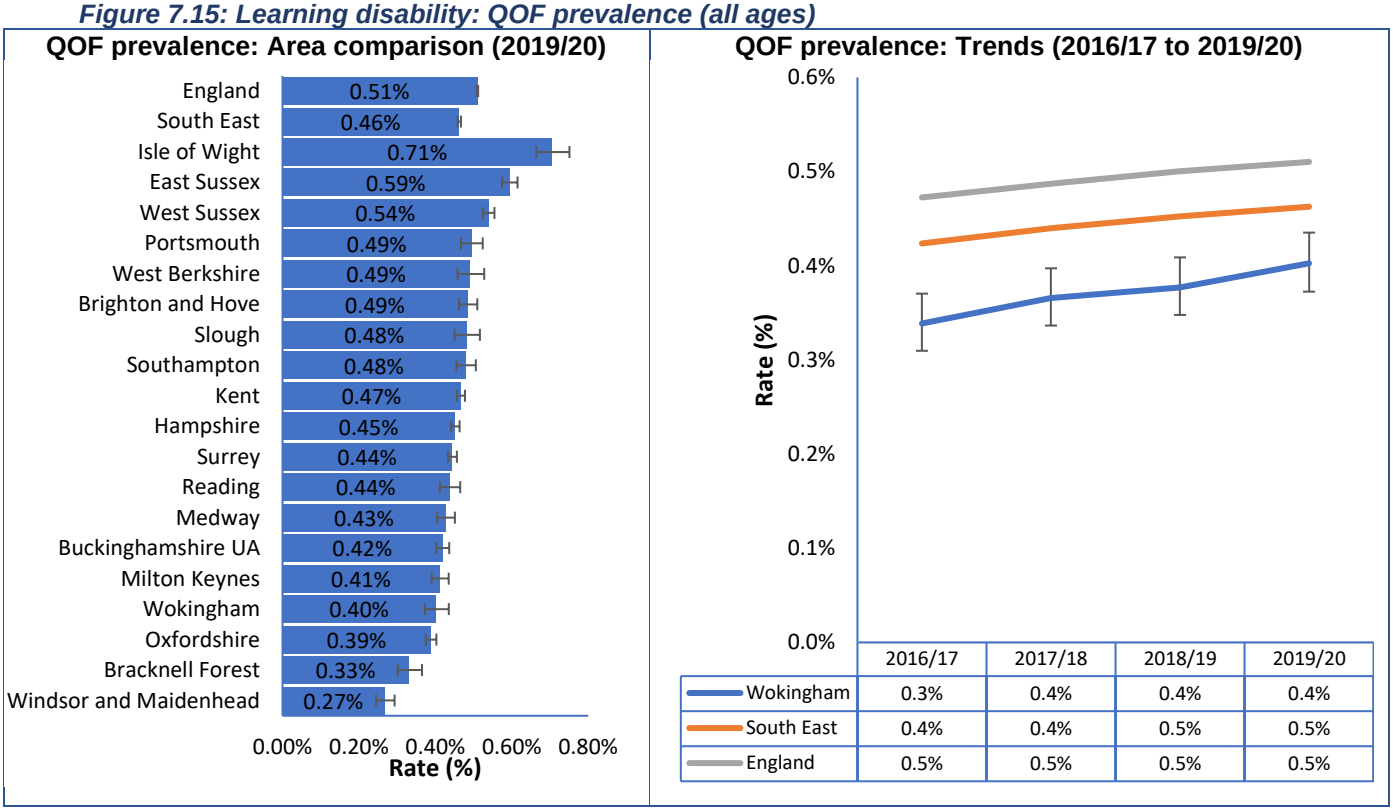
Inclusion strategy 2021-2024, that sets out their aim of creating an organisational culture that supports inclusion and belonging. Tackling inequality and discrimination is a top priority of this strategy and priority 4 of the strategy focuses on supporting LGBTIQ+ staff and communities through Stonewall and Reading Pride. To build on the engagement with the LGBTIQ+ community, BHFT has signed up to the Stonewall Diversity Champions' employer's index and has a long relationship with Reading Pride. These affiliations promote links between NHS and the public to reduce health inequalities in the LGBTIQ+ community. They are aiming to achieve gold status within the Stonewall framework and continuing to support and participate in Reading Pride (NHS, 2020), (Berkshire Healthcare NHS Foundation Trust, 2021-24).

In terms of wider support available, people can be supported by non-mental health services with their mental health and emotional wellbeing needs. At the time of writing this needs assessment, Cranstoun (a substance misuse service) in Wokingham reported that LGBTIQ+ people were an underrepresented group in the service and there were no specific local provisions for this group - LGBTIQ+ people in Wokingham were going to Reading for relevant services.

## 7.6 People with learning disabilities

A learning disability affects the way a person learns new things throughout their lifetime, it also affects the way a person understands information and how they communicate. This means that people with a learning disability can have difficulty understanding new or complex information, learning new skills, and coping independently (NHS, 2022). People with a learning disability have worse physical and mental health compared to people without a learning disability (Mencap, n.d.).

***Figure 7.15: Learning disability: QOF prevalence (all ages)***




***Source: Fingertips (OHID 2022)***

In 2019/20 Wokingham had the 3rd lowest proportion of its residents registered on GP learning disability register (0.40%) significantly lower than the South East and England averages of 0.46% and 0.51% respectively but there has been an upward trend between 2016/17 and 2019/20 (Figure 7.15 above).

### 7.6.1 People with learning disabilities – mental health risk factors

Mental health problems among people with learning disabilities are often overlooked and can be hard to diagnose. For this reason, there is a lack of clarity about how common mental health problems are among people with learning disabilities (Royal College of Nursing, 2022).

There are many reasons why people with learning disabilities are more likely to experience poor mental health. There are four types of such risk factors (Mencap, n.d.):

- Biological factors: Genetics may increase vulnerability to mental health problems. Pain, physical ill health and taking multiple types of medication can all contribute to poor mental health.
- Negative life events: People with a learning disability may be more likely to experience deprivation, poverty, abuse, and other negative life events earlier on in life. People with a learning disability may be particularly vulnerable to negative life events and might not have the mechanisms for adequately coping with these. The accumulation of negative life events over the life course can result in higher levels of stress, which can increase the risk of developing a mental health problem.
- Fewer resources: Lack of social support and reduced coping skills are associated with depression and anxiety in people with a learning disability.
- Other people's attitudes: Stigma and discrimination can become internalised, which can result in psychological distress.

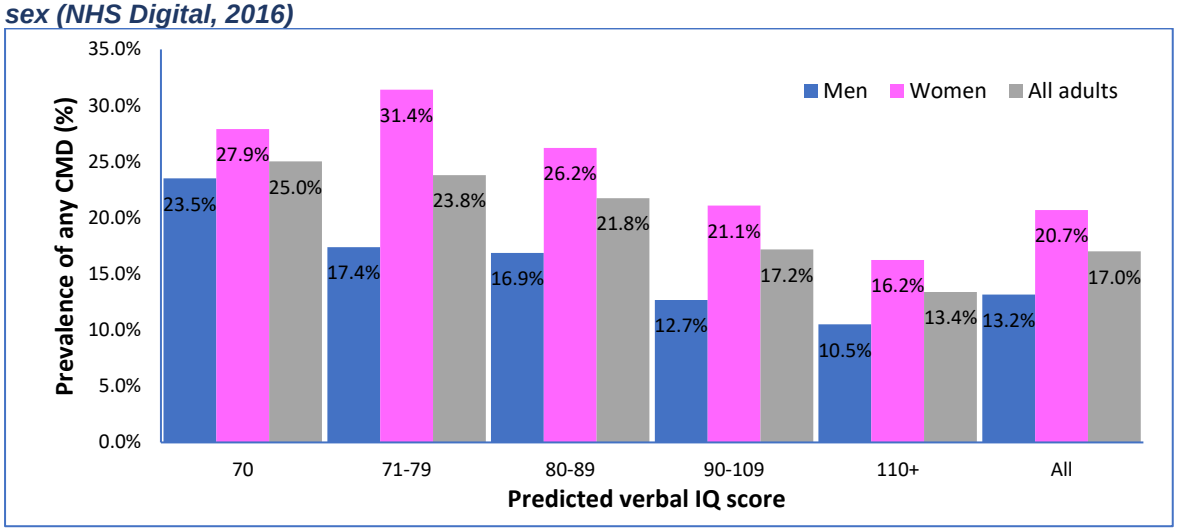
### 7.6.2 People with learning disabilities – National mental health prevalence

Existing evidence suggests the rate of mental health problems in people with a learning disability is double that of the general population with the estimated prevalence of mental health disorders ranging from 15% to 52%, depending on the diagnostic criteria used (Mencap, n.d.). A 2007 British study found the prevalence of mental ill-health was 40.9% based on clinical diagnoses in adults with intellectual disabilities (Cooper, Smiley, Morrison, Williamson, & Allan, 2007).

The 2014 APMS (NHS Digital, 2016) used the predicted verbal score (V-IQ) to classify participants by their learning disability status. A score below 80 was considered 'borderline intelligence' with a level of cognitive functioning associated with functional impairments and difficulties living independently without the assistance of support services.

The APMS showed that the lower the V-IQ the higher the prevalence of common and severe mental health disorders was. For example, those with a V-IQ of 70 had the highest prevalence of 25% while those V-IQ of 100 or higher had the lowest prevalence of 17.0% (Figure 7.16). Across all V-IQ ranges, women tended to report higher levels of common and severe mental health disorders compared to men.

*Figure 7.16: Prevalence of common and severe mental disorders, by predicted verbal IQ and sex (NHS Digital, 2016)*




### 7.6.3 People with learning disabilities – Local mental health prevalence

At the time of writing the needs assessment there were 689 adults aged 18 years or older, living in Wokingham, recorded on GP Practice registers as having a learning disability with 89 of them on the learning disability also on the depression register (Connected Care QOF Registers via System Insights, accessed April 2022). This equated to 12.9% which was close to the percentage for the total adult population (12%) and may an underestimation (Royal College of Nursing, 2022).

## 7.7 Carers

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health condition or an addiction and cannot cope without such support. The care they give is unpaid (NHS England, n.d.). any reference to carers in this report is inclusive of both adult and young carers.

Carers provide invaluable support and help to their family, friends and loved ones, whether this is for physical or mental health problems. The mental health needs of carers are often neglected, despite many carers having poor mental health (Mental Health Foundation, 2022):

- Looking after a family member with a mental health problem can have a significant impact on carers' own mental health. Mental health problems of carers include emotional stress, depressive symptoms and, in some cases, clinical depression (Shah, Wadoo, & Javed, 2010)
- The Department of Health indicated 71% of carers have poor physical or mental health (Department of Health, 2008), (Mental Health Foundation, 2022)
- The 2015 Carers UK's annual survey showed that 84% of carers felt more stressed, 78% felt more anxious and 55% reported that they suffered from depression because of their caring role, which was higher than findings in 2014 (Carers UK, 2015)
- The 2013 Young Adult Carers at School report found 38% of young carers reported having a mental health problem, with only half of them reporting they

were receiving additional support from a member of staff at school (Sempik & Becker, 2013)

***Table 7.1: The impact of caring for different mental disorders and associated risk factors (Shah, Wadoo, & Javed, 2010)***

| Mental Disorder | Risk factors | Impact on the carer |
|---|---|---|
| **Schizophrenia** | High disability, very severe symptoms, poor support from professionals, poor support from social networks, less practical social support, violence. | Guilt, loss, helplessness, fear, vulnerability, cumulative feelings of defeat, anxiety, resentment, and anger are commonly reported by caregivers. |
| **Dementia** | Decline in cognitive and functional status, behavioural disturbances, dependency on assistance | Anger, grief, loneliness and resentment |
| **Mood disorders** | Symptoms, changes in family roles, cyclic nature of bipolar disorder, moderate or severe distress | Significant distress, marked difficulties in maintaining social and leisure activities, decrease in total family income, considerable strains in marital relationships.<br>Psychological consequences during critical periods also persisting in the intervals between episodes<br>in bipolar disorder, poorer physical health, limited activity, and greater health service utilization than non-caregivers. |

Table 7.2 shows the number of people who reported providing unpaid care during the 2011 census by the number of hours of care provided. However, as the census data was over 10 years old at the time of writing the needs assessment, the picture had possibly changed in the intervening period.

***Table 7.2: Provision of unpaid care (LA is Wokingham local authority)***

| Provides care | LA Count | LA % | England % | South East % |
|---|---|---|---|---|
| Provides 1 to 19 hours unpaid care a week | 10190 | 6.60% | 6.51% | 6.68% |
| Provides 20 to 49 hours unpaid care a week | 1397 | 0.90% | 1.36% | 1.12% |
| Provides 50 or more hours unpaid care a week | 2315 | 1.50% | 2.37% | 2.01% |
| Provides no unpaid care | 140478 | 90.99% | 89.76% | 90.19% |

***Source: Census 2011 from NOMIS***

### 7.7.1 Carers – mental health risk factors

Risks for carers mental health relates to gender, age, health status and lack of social support. Women have higher rates of depression than men in care giving roles (Jan Shah, 2010).

There is a link between loneliness and poor mental and physical health. A British study (Victor, et al., 2021) found 43.7% of caregivers reported moderate loneliness and 17.7% reported severe loneliness. Greater social isolation and increased caregiving stress has also been linked with both moderate and severe loneliness. Interventions aimed at reducing caregiving stress and supporting meaningful relationships may help reduce loneliness (Victor, et al., 2021).

A German study found that caring for a relative with dementia was associated with poorer health, i.e., greater levels of subjective burden and depressiveness, and predicted lower care-related quality of life in caregivers, emphasizing the importance of specific interventions aiming to support informal caregivers of dementia patients (Karg, Graessel, Randzio, & Pendergrass, 2018).

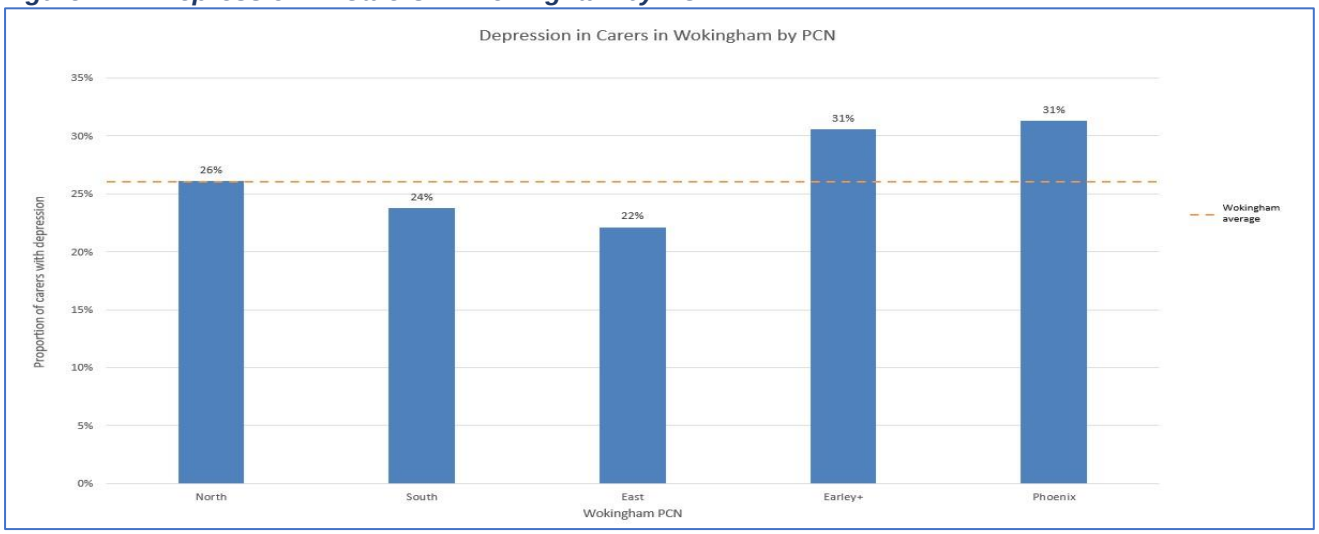
### 7.7.2 Carers – National mental health prevalence

Research shows that around 71% of carers have poor physical or mental health, 84% of carers feel more stressed, 78% feel more anxious and 55% reported that they suffered from depression because of their caring role (Mental Health Foundation, n.d.).

### 7.7.3 Carers – Local mental health prevalence

As of December 2021, depression was the second most prevalent long-term condition amongst carers registered with Wokingham GP Practices, with 26% of carers living with depression. Carers registered with Earley+ and Phoenix PCNs had a higher prevalence than the Wokingham PCNs average, with 31% of carers having depression in each (see Figure 7.17).

***Figure 7.17: Depression in Carers in Wokingham by PCN***




***Source - Integrated Population Analytics (IPA) tool (accessed December 2021)***

### 7.7.4 Carers – Service access

TuVida service was supporting carers and their families in Wokingham at the time the needs assessment was written. The services they offer includes (TuVida, n.d.):

- **Care at home**: Individualised, home-based support that helps people requiring care to remain as independent as possible.
- **Day centres and groups**: A change of scenery for people receiving care support, as well as the opportunity to meet new people in a fun and relaxing environment.
- **Carer respite**: Temporary home care provision that enables periods of respite for carers.
- **Carers Hub**: Our Carers Hubs (currently available in Reading & West Berkshire, and in Wokingham) exist to support carers and make their lives easier in a variety of ways – for example, by connecting them with other carers, or by providing free and confidential information and advice.
- **Wokingham Young Carers Service**: The Wokingham Young Carers Service provides support for young people who look after members of their family. It enables young carers to take regular breaks from caring, make new friends, take part in fun activities, and access information and advice.

The Wokingham Recovery College reported having carers registered at the service, with 5 out of 9 carers attending regularly at the time of writing this needs assessment.

## 7.8 Service personnel

As of October 2021, there were almost 150,000 people serving in the UK Armed Forces. 89% of these were male and 91% were from white British ethnic backgrounds. 40% were aged between 20-29 with a further 18% aged 30-34 (Ministry of Defence, 2021). The highest concentration of UK Armed Forces personnel is in the South East and South West of England. Although there were no personnel recorded as located in Wokingham, there were 1,040 personnel stationed in neighbouring Bracknell Forest, 1,080 in the Royal Borough of Windsor and Maidenhead, and 380 in West Berkshire (Ministry of Defence, 2021).

A military veteran is any person that has served at least one day in HM British Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations (Ministry of Defence). As of 31 March 2021, there were 884 Wokingham residents were in receipt of a pension or compensation under the Armed Forces Pension Scheme, War Pensions Scheme, or the Armed Forces Compensation Scheme, 768 of whom were veterans (Ministry of Defence, 2021).

### 7.8.1 Service personnel– mental health risk factors

#### *7.8.1.1 Loneliness and social isolation.*

Evidence shows the links between loneliness, isolation, and poor mental health of veterans. Loneliness and isolation are established risk factors for depression and anxiety (Royal British Legion, 2014).

Research suggest that some elements of armed forces lifestyle can increase vulnerability to loneliness and social isolation. These include:

- Increased volume of transitions in the Forces

- A culture of self-reliance and avoidance of 'weakness'
- Long periods of separation from partner and family
- Impact of injury and/or sudden discharge on career and family

Although there is not much evidence to support protective factors to loneliness and social isolation, research has indicated that there are some potential protective factors for loneliness and isolation. These may include having a social network of friends and family, having a personal confidant, spirituality or belief, higher levels of education, pet ownership particularly amongst older people (Royal British Legion, 2014).

#### *7.8.1.2 Substance misuse.*

Reports have associated higher rates of alcohol misuse in UK Armed Forces compared with the rate in the general population, especially within the Royal Navy and Army.

There is evidence of increased levels of alcohol misuse in active military service involving exposure to a range of risk factors including physical and psychological threats. Exposure to these threats has been linked to mental health conditions, such as common mental health disorders, posttraumatic stress disorder (PTSD) and alcohol misuse (Fear N. e., 2010). Substance misuse is discussed further in the substance misuse chapter of this needs assessment.

#### *7.8.1.3 Other factors*

Veterans' mental health problems may be worsened or caused by post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks. Younger veterans are at high risk of suicide in the first two years after leaving service. Ex-service personnel are also vulnerable to social exclusion and homelessness, both of which are risk factors for mental ill health.

Certain groups of veterans, regardless of deployment, are potentially more vulnerable to developing mental health conditions. These include Reservists, combat troops, those with pre-existing social or childhood adversities and early service leavers (leaving before completing four years of service) and female personnel (Mental Health Foundation, n.d.).

### 7.8.2 Service personnel – National mental health prevalence

A study of 403 military veterans about mental health found that 82% had PTSD, 74% had anger difficulties, 72% had anxiety and depression and 43% misused alcohol (Murphy, 2017).

There is an increased suicide rate in young men (under the age of 20) in the Army. Young veterans (aged 16-24) or those classified as early service leavers are at an increased risk of suicide. Evidence from several sources suggests that the increase in suicide risk in these two groups is mainly a result of pre-service vulnerabilities, such as childhood adversity.

### 7.8.3 Service personnel – Local mental health prevalence

At the time of writing, no data was available on the prevalence of mental health need amongst local military service personnel or veterans.

### 7.8.4 Service personnel – Service access

Wokingham Borough Council signed the Armed Forces Covenant in 2013 and was re-affirmed in 2021 (Wokingham Borough Council, 2021). The Armed Forces Covenant is a key mechanism for ensuring members of the armed forces community face no disadvantage compared to other citizens in the provision of public and commercial services; and that special consideration is appropriate in some cases, especially for those who have given the most such as the injured or the bereaved (Armed Forces Covenant, n.d.).

This support is provided in areas including:

- Education and family well-being
- Having a home
- Starting a new career
- Access to healthcare
- Financial assistance
- Discounted services

## 7.9 People experiencing homelessness

Homelessness can be viewed as a continuum, with rooflessness (so called rough sleepers) at one extreme and living in insecure accommodation at the other. Crisis UK uses the terms 'core homelessness' and 'wider homelessness' which relate to the severity of the housing situation to classify a wide range of homeless situations (Table 7.3).

***Table 7.3: Definitions of core and wider homelessness***

| |
|---|
| **Core homelessness** |
| • Rough Sleeping |
| • Sleeping in tents, cars, public transport |
| • Squatting (unlicensed, insecure) |
| • Unsuitable non-residential accommodation e.g., ‘beds in sheds’ |
| • Hostel residents |
| • Users of night/winter shelters |
| • Domestic violence victim in Refuge |
| • Unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotels etc |
| • Sofa Surfing’ – staying with others (not close family), on short term/insecure basis/wanting to move, in crowded conditions (this does not include students) |
| **Wider homelessness** |
| • Staying with friends/relatives because unable to find own accommodation (longer term) |
| • Eviction/under notice to quit (and unable to afford rent/deposit) |
| • Asked to leave by parents/relatives |
| • Intermediate accommodation and receiving support |
| • In other temporary accommodation (e.g., conventional social housing, private sector leasing) |
| • Discharge from prison, hospital, and other state institution without permanent housing |

***Source: Crisis UK***

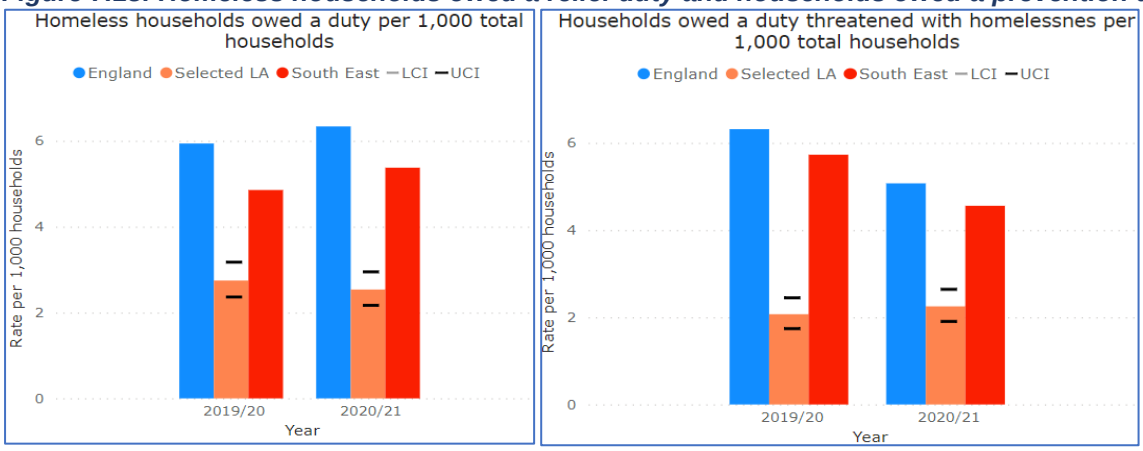
Core homelessness refers to households who are considered homeless at any point in time due to them experiencing the most acute forms of homelessness or living in short-term or unsuitable accommodation. Wider homelessness refers to those at risk of homelessness or who have already experienced it and are in temporary accommodation (Crisis, 2017).

Figure 7.18 shows the number of households in Wokingham who are owed a duty by the local authority as of October 2021.

The rate is shown for those who are homeless (relief duty owed) and those who are threatened with homelessness within 56 days (prevention duty owed), and Wokingham had statistically significantly lower rates of homelessness than England and the South East on both measures.

People experiencing homelessness face significant health inequalities and poorer health outcomes than the rest of the population. The individuals experiencing homelessness face barriers to accessing health and social care services including stigma, discrimination, a lack of trusted contacts and rigid eligibility criteria for accessing services (NICE, 2021).

***Figure 7.18: Homeless households owed a relief duty and households owed a prevention duty***




***Source: Ministry for Housing, Community and Local Governemt Live Homelessness Tables, October 2021***

### 7.9.1 People experiencing homelessness – mental health risk factors

Homelessness can have a significant impact on individuals' mental health resulting in long-term physical and mental health problems, which are very common among homeless people and vulnerably housed people compared to the general population (Ministry of Housing, Communities & Local Government, 2019). However, poor mental health is both a cause and consequence of being homelessness - homelessness can exacerbate mental health illness due to the stresses of being homeless and this can make it harder for those affected to achieve stability in their housing (Crisis, 2009).

Individual risk factors related to homelessness and mental health problems include personal crisis, traumatic events, pre-existing mental health problems, addiction, relationship problems including domestic abuse and violence, mental health conditions of other family members and a lack of financial resilience.

### 7.9.2 People experiencing homelessness – National mental health prevalence

A report for Crisis (Crisis, 2009) found that homeless people were nearly twice as likely to have experienced mental health issues as the general population. The rate of psychosis was 4-15 times as prevalent than in the general population. The same research shows that as a person's housing becomes more stable the rate of serious mental illness decreases. Nationally, a history of mental health problems was the second most common support need identified after physical ill health and disability (Department for Levelling Up, Housing and Communities, 2022).

### 7.9.3 People experiencing homelessness – Local mental health prevalence

Of the 319 households in Wokingham owed a prevention or relief duty in 2020/21, 49 had a history of mental health issues (15.4%) of all households owed a duty.

### 7.9.4 People experiencing homelessness – Service access

Two Saints are a service commissioned by Wokingham Borough Council for homeless people in the borough and is linked to Cranstoun, the substance misuse service in Wokingham.

## 7.10 People experiencing domestic abuse

The Government defines domestic violence by any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This definition also includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage (HM Government, 2012).

Domestic violence and abuse occur across all groups and sections of society, affecting people across all genders, social, economic, and geographical backgrounds regardless of age, gender, income, ethnicity, disability, religion, belief, or sexual orientation. This can include, but not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Research consistently found that violence or abuse had the most prevalent effect on mental health, leading to diagnoses of post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse (Coid, 2003).

### 7.10.1 People experiencing domestic abuse – mental health risk factors

There is a strong association between having mental health problems and experiencing domestic abuse. Mental health issues are also a risk factor for abuse perpetration. Research suggests there is a bidirectional relationship between domestic abuse and mental ill health; experiencing domestic abuse often leads to mental health conditions and having mental ill health can make a person more vulnerable to abuse (SafeLives, 2019).

### 7.10.2 People experiencing domestic abuse – National mental health prevalence

Research suggests that women experiencing domestic abuse are more likely to experience a mental health problem, while women with mental health problems are more likely to be domestically abused, with 30-60% of women with a mental health problem having experienced domestic violence (Howard, et al., 2010).

Domestic violence is associated with depression, anxiety, PTSD and substance abuse in the general population (Trevillion, Oram, Feder, & Howard, 2012).

Exposure to domestic violence has a significant impact on children's mental health. Many studies have found strong links with poorer educational outcomes and higher levels of mental health problems ( (Gilbert, et al., 2009). The National Association for People Abused in Childhood (NAPAC) found that callers to their support line between July 2016 and January 2017 reported the following (National Association for People Abused in Childhood, 2022):

- 74 % anxiety
- 68 % depression
- 30% suffer flashbacks
- 20 % suffer sleep disturbance
- 17% experience panic attacks
- 9% had felt suicidal
- 8% used drug or alcohol as a coping mechanism
- 3% suffered eating disorders

### 7.10.3 People experiencing domestic abuse – Local mental health prevalence

At the time of writing this needs assessment, no data was available on the prevalence of mental health need among people experiencing domestic abuse.

### 7.10.4 People experiencing domestic abuse – Service access

At the time of writing this needs assessment, Wokingham Brough council had commissioned Cranstoun DASS Wokingham Service to support victims of abuse/survivors. The service was an integrated domestic abuse service that supports victims and children and delivers programmes that tackle the root cause of perpetrator behaviour.

They provide a range of services:

- Assessment and support for victims and children
- Assessment and support for perpetrators
- Refuge accommodation
- Support related to domestic abuse for children and young people
- Targeting services to the most vulnerable and hard to reach groups.

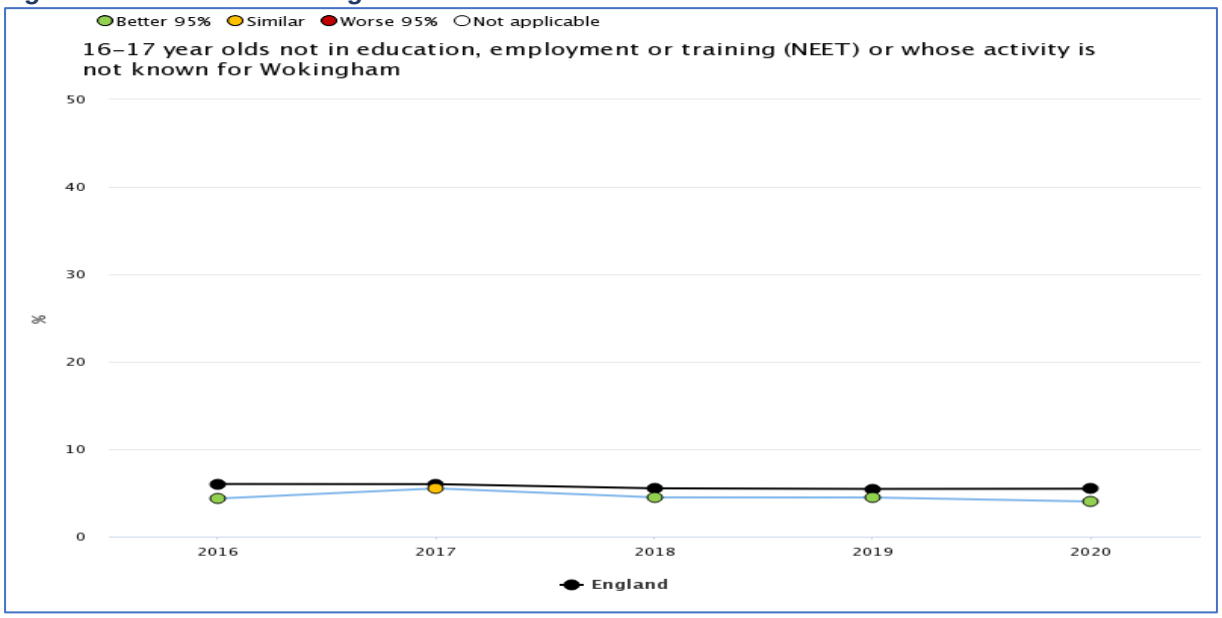
## 7.11 NEET

'NEET' refers to being not in employment, education, or training. To be considered a young person who is NEET, the person will be between the ages of 16 and 24 years. Young people who are NEET experience greater risk of a range of negative outcomes, including poor health, deterioration in mental health and an increased risk of suicide (Public Health England, 2014).

The Department for Education's official measure of young people who are NEET looks at those between the ages of 16 and 18 years. 16- and 17-year-olds are required to remain in Education and training in England and 18 years olds are in their first-year post-compulsory education. Separate data also shows all young people between the ages of 16 to 24 years who are NEET although this information is based on survey data and is not broken down by local authority.

The rate of children and young people aged 16 to 24 years who are NEET living in Wokingham is significantly lower than the rate for England. During 2020, 150 young people aged 16-17 were NEET in Wokingham. This was 4% of all 16–17-year-olds, which was significantly lower than the equivalent figure for England (5.5%) and the South East (6.4%). There has been no significant change in the percentage of 16–17-year-olds in Wokingham who are NEET over recent years.

***Figure 7.19: NEET in Wokingham***




***Source: Department for Education, Public Health England Prototype Public Mental Health Dashboard October 2021***

### 7.11.1 NEET – mental health risk factors

Not being in education, employment or training can affect physical and mental health as it can lead to reductions in income, increased social exclusion, isolation, lack of social support, and increases in unhealthy behaviours such as drinking and smoking (Public Health England, 2014).

Unemployment is linked to ill health, premature death, deterioration in mental health and an increased risk of suicide. The ways in which unemployment affects physical and mental health are through reductions in income, increased social exclusion, isolation, and lack of social support, and increases in unhealthy behaviours such as drinking and smoking (Public Health England, 2014).

There are additional risks associated with being unemployed at a young age. By the age of 21, people in this group are more likely to be low paid, have no training, have a criminal record, and suffer from poor health and depression. Also being unemployed under the age of 23 can lead to lower life satisfaction, poor health

status, low job satisfaction and low wages more than twenty years later (Public Health England, 2014).

### 7.11.2 NEET – National mental health prevalence

During 2021, figures taken from the Annual Population Survey show that an estimated 21% of NEET 16–24-year-olds had a mental health condition compared to 8% of all 16–24-year-olds. The percentage of NEET 16–24-year-olds who have a mental health condition had increased steadily since 2014 when the rate was 10% (Department for Education, 2021).

### 7.11.3 NEET – Local mental health prevalence

At the time of writing the needs assessment, no data was available on the prevalence of mental health need amongst young people who are NEET.

### 7.11.4 Refugees and asylum seekers' mental health

Asylum seekers and refugees are 5 times more likely to have mental health needs than the general population than the general population, including higher rates of depression, PTSD and other anxiety disorders (Mental Health Foundation, 2022). Generally, it is estimated 61% of refugees experience serious mental distress.

Refugees who resettle in western countries are estimated to be about ten times more likely to have post-traumatic stress disorder than age-matched general populations in those countries (Fazel, Wheeler, & Danesh, 2005). Estimates of prevalence of serious mental health disorders from systematic review are as follows (Fazel, Wheeler, & Danesh, 2005):

- 9% (95% CI: 8-10%) diagnosed with post-traumatic stress disorder
- 5% (95% CI: 4-6%) diagnosed with major depression
- Among refugee children a prevalence of 11% (95% CI: 7-17%) for post-traumatic stress disorder.

The World Health Organisation has identified problems and stressors facing migrants and refugees associated with the migration process which can contribute to poor mental health (World Health Organisation, 2021):

- Pre-migration: lack of livelihoods and opportunities for education and development, exposure to armed conflict, violence, poverty and/or persecution.
- Migration travel and transit: exposure to challenging and life-threatening conditions including violence and detention, and lack of access to services to cover their basic needs.
- Post-migration: barriers to accessing health care and other services to meet their basic needs as well as poor living conditions, separation from family members and support networks, possible uncertainty regarding work permits and legal status (e.g., relating to asylum application), and in some cases immigration detention.
- Integration and settlement: poor living or working conditions, unemployment, assimilation difficulties, challenges to cultural, religious, and gender identities, challenges with obtaining entitlements, changing policies in host countries,

racism and exclusion, tension between host population and migrants and refugees, social isolation and possible deportation.

#### *7.11.4.1 Risk and protective factors for mental health conditions*

All the above-mentioned stressors can increase the risk of developing mental health conditions. For example, unemployment, poor socioeconomic conditions, and lack of social integration among migrants and refugees are risk factors for mental health conditions such as depression. At the same time, these stressors can also exacerbate pre-existing social and mental health problems (World Health Organisation, 2021).

Other factors that negatively impact the mental health and well-being of migrant and refugee children include socioeconomic deprivation, discrimination, racism, low family cohesion, and frequent school changes. Children who have been separated from migrating parents are at heightened risk of developing depression, anxiety, suicidal ideation, conduct disorder, and substance use problems (World Health Organisation, 2021).

The impact of these stressors can be buffered by protective factors such as access to employment and services, social support, proficiency in the language of the host country, and family reunification. Among resettled refugee children, protective factors include better socioeconomic status, access to education, a perceived sense of safety, contacts with family, living and socialising alongside other people of the same ethnic origin, a stable and cohesive family structure and good parental mental health (World Health Organisation, 2021).

### 7.12 Conclusion

This needs assessment has highlighted mental health inequalities across a range of disadvantaged communities. Health inequalities are not new, nor are they caused by one single issue, but by a complex mix of factors impacting disproportionately on certain groups having differential access, experience, and outcomes of mental health services.

The needs assessment should inform local actions to address mental health inequalities experienced by these communities.

### 7.13 Considerations

The following should be considered by local partners:

- Raising awareness of mental health issues among vulnerable population with a view reducing stigma and improving access to support and services.
- Improve engagement with communities to improve trust and relationships, with the aim of improving access to mental health services among disadvantaged and marginalised communities.
- Identify the specific mental health needs of vulnerable service users to ensure that services are equipped to meet their needs.
- Working in partnership with trusted third/voluntary sectors to establish effective relationships with marginalised population groups to improve mental health.

- Raise cultural awareness amongst professionals to promote better working practices and reduce discrimination (actual or perceived) experienced by certain groups
- Ensure services are joined up to ensure seamless access to appropriate range of services to meet the often-complex needs of these population groups.

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