Equality Impact Assessment (EIA)

This document demonstrates how the council is meeting its duties under the Equality Act 2010, by giving due regard to the requirement to: eliminate discrimination; advance equality of opportunity; and promote good relations.

1. Background

Directorate	Adults
Service area	Prevention Wellbeing and Communities
Title of the activity being assessed i.e. the strategy, plan, policy or service	Procurement of a mental wellbeing helpline for adults, incorporating support for self-harm.
Brief outline of the proposal(s)	At present the County Council commissions two services which are in scope of this proposal: - Gloucestershire self-harm helpline (all age) (current contract ending March 2023) - Early intervention, open access mental health support for adults (Qwell) – remote/online open access mental wellbeing support (adults only) (short term contract ending Spring 2023) Both services provide open access, early intervention, remote, real time, anonymous support for individuals experiencing emotional distress linked to self-harm and general mental wellbeing support respectively. Commissioners are seeking Cabinet approval to commission a single early intervention, mental wellbeing support for adults aged 18 and over, including self-help resources and remote support (online, telephone and or text, to be agreed with successful bidder). The proposed service will include support available for individuals experiencing a range of emotional distress symptoms, including support for those experiencing self-harm or self-harm ideation as well as general emotional wellbeing. The proposed service is intended to improve the range and accessibility of early intervention support for people with low level & emergent mental health symptoms. The proposed services are expected to contribute to the following medium and long term outcomes: - reducing the incidence and prevalence of mental ill-health in Gloucestershire; - increasing emotional resilience and positive mental wellbeing; - reducing rates of suicide and self-harm;

	Commissioners have consulted on the changes, as described above. The consultation sought to gather views from current and potential service users. It had specific focus on gathering feedback from groups experiencing the highest inequalities regarding mental health, as well as protected characteristics, on their experiences of mental wellbeing/ emotional distress and seeking support, their views on the proposed service and any other factors that should be considered when developing the service specification. The findings related to the nine protected characteristics are covered in this EIA alongside further detail in the appendix and in the consultation report.
Who is affected by the proposals?	Service users [X] Workforce [ ] Other, please specify: [ ]
Decision to be taken and decision maker	Cabinet decision to be put forward by Cllr Nick Housden, Cabinet Member for Public Health and Communities; 'Procurement of a mental wellbeing helpline for adults, incorporating support for self-harm'. That Cabinet delegates authority to the Director of Public Health in consultation with the Cabinet Member for Public Health and Communities to: 1. conduct a competitive procurement process in respect of a contract for the supply of a mental wellbeing helpline for adults, incorporating support for self-harm. The proposed contract shall continue for an initial period of 3 years and include options to extend its term for two further periods of up to 2 years on each of its third and fifth anniversaries; 2. award such contract to the preferred tenderer; 3. determine whether to exercise the option to extend the term of such contract for a further period of not more than 2 years on the expiry of the initial 3-year term; 4. determine whether to exercise the option to extend the term of such contract again for a further period of not more than 2 years on its fifth anniversary.
Person(s) responsible for completing this assessment	Sam Howe, Commissioning Officer Suzie Lane, Senior Commissioning Manager
Date of this assessment	August 2022

2. Information Gathering

Briefly outline your approach to consultation and engagement, together with details of any other information and data sources you have utilised:

Research, Consultation and Engagement	
Service users	A consultation has been carried out to seek views on the proposals from current and potential service users. This was open to anyone to respond and actively promoted to groups representing/working with particular groups who experienced the highest inequality/poorest outcomes for mental health. This EIA document will help guide who we would seek to actively engage with as part of this process. This document includes the findings relating to protected characteristics from the public consultation. In addition, where available, data on the characteristics of service users has been drawn from existing activity data submitted by the current providers as part of routine contract monitoring. Data on population and need has been obtained from the following local and national sources, including: • Gloucestershire County Council Population Profile, 2021 • Gloucestershire Pupil Wellbeing Survey findings, 2020 • Office of National Statistics monthly surveys on social and mental health impacts of the pandemic on adults • Public Health England: Covid-19 mental health and wellbeing surveillance report • UCL: Covid-19 Social impacts study. Local survey and engagement data has also been considered, including: • Barnwood Trust (2020) Our Changing World: A report into disability and mental health in Gloucestershire during the Covid-19 pandemic • Kingfisher Treasure Seekers & Inclusion Glos (2020): accessing health services in Gloucestershire with a particular focus on BAME communities. • #BlackLivesMatter, Gloucestershire's Mental Health Services (2021) Other sources of insight into experiences of particular protected characteristics/ population groups (not specifically service users) have been drawn from and are cited within the respective sections below.
Workforce	Not applicable
Partners	We are continually engaging with system partners who lead key interdependent services: - Lead Commissioner for Adult Mental Health

	- Lead Commissioner for Children, Young People and Maternity - IAPT Service Managers - Crisis Service Managers - Complex Emotional Needs Service Managers - Community Mental Health Transformation Programme Managers - Mental Health and Wellbeing Partnership Board - Suicide Prevention Steering Group
Other	N/A

3. Equality Assessment

Briefly explain your assessment of the impact of the proposed activity on the protected characteristics below. This section evidences how the council is giving due regard to the three aims of the general equality duty, which are to: eliminate discrimination; advance equality of opportunity; and promote good relations.

Protected Characteristic	Service Users	Workforce
Age	<u>Children and Young People</u> The proposed service will be an adult only service. At present, the Gloucestershire Self-harm Helpline, which is in scope of this proposal, is all age. This proposal includes changing the access route to support for under 18s, but not removing support. The numbers of children and young people accessing the self-harm helpline is low (In 20/21 only 4.5% of contacts to the SHHL (where age was provided) were from under 18s) as other established support services in the county (such as TIC+ and CAMHS) are more clearly embedded within the CYP mental health pathway. Commissioners are proposing to make self-harm support for CYP easier to access by clarifying the pathway for CYP by re-directing children and young people to existing support available in the county. This will include the Council funded TIC+Chat helpline which already supports young people aged 9-25 years with self-harm and wider mental health issues. Data from Gloucestershire Pupil Wellbeing survey shows that in 2020, 76.1% of girls and 84% of boys had high or average levels of emotional and mental wellbeing. However, 21% of female secondary pupils and 17.5% of female Year 12/FE students had scores indicating ‘poor’ or ‘extremely poor’ mental health. These scores suggest that poor mental	NA

	wellbeing tends to increase as children get older. Notably, just under a third of pupils in the 2020 survey (29.5%) said that they found it 'pretty tough to be me' often or all the time. Some young people use self-harm as a coping mechanism for emotional distress; in the 2020 survey 77.1% of pupils had never self-harmed. However, of those who reported ever self-harming 17.1% had self-harmed in the previous week[1]. Adults 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[6] According to Fingertips data recorded prevalence of depression stands at 11.9% of the population aged 18+. This is below the median for rates in the South-West. However, we know that mental health need exceeds numbers of diagnosed cases which are captured in formal data monitoring. Mental wellbeing is impacted by all aspects of life (wider determinants) which can contribute to how emotionally well or unwell a person may feel at any given time in their life. It is widely understood that many life factors have been made more difficult in recent years (partly due to the pandemic) such as financial hardship, loneliness and isolation, physical health, home/family life and bereavement. This impacts on overall population mental wellbeing. There is a lack of available data to substantiate this as some of these areas are difficult to measure, however ONS data suggests that rates of anxiety, depression and loneliness have increased, and overall rates of happiness have reduced, during the pandemic, in line with this understanding[2]. Risks to mental health manifest themselves at all stages in life[3]. In particular[4]: common mental health disorders are most common in adults aged between 35-54 and the highest incidence of psychosis is in 20-34 year olds. The current adult's early intervention open access mental health support commissioned service, which is only available online, is open to all adults aged 18 years and above, and service data shows uptake across all age bands although there is less uptake amongst older adults. Gloucestershire Self-Harm Helpline (GSHHL) has experienced an increase in contacts during the last two years. Until September 2021, 18-24 year olds made up the highest proportion of contacts to GSHHL (except in November 2019).	

[1] pupil-wellbeing-survey-2020-headline-report.pdf (gloucestershire.gov.uk)
[2] UCL Covid-19 Social Study, available at: 3d9db5_8067187bec68433ba4d70850e219155f.pdf (filesusr.com)
[3] Investing in mental health (who.int)
[4] 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

	After September 2021, 25-34 year olds made up the highest proportion of callers. The Early Intervention Open Access service will be available for those that self-harm and those that do not. There will be age-appropriate resources available. <u>Older Adults</u> According to Fingertips data 9.1% of Gloucestershire residents are estimated to have a 'common mental disorder' such as anxiety or depression. This is below the average for rates in the South-West. A 2019 policy position paper by Age UK[5] 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. We need to ensure that our services are accessible to older people and encourage engagement with preventative services for those approaching older age. Under the current service, data suggests that uptake amongst older age groups (60+) is lower. There is scope to do further research to understand whether digital platforms are less acceptable and/or accessible to older adults; and it is important that we continue to promote all the mental health support available in the county to ensure people of all ages are aware of the different support options available to them. **<u>Public consultation – Mental Wellbeing Helpline Survey</u>** There were 22 (3.8% of all respondents) responses from young adults to the survey. The responses to the survey suggest that all (100%) young people would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is reflective of both those that have used the self-harm helpline in the past and those that have not. Comments in support of an integrated helpline for mental wellbeing and self-harm were dominated by a desire to be seen quicker by services and there was reflection that waiting lists were too long at present. No young people signalled they were against the integration of the service and so there were no further comments disagreeing with the proposal. The young adult respondents made a variety of comments when asked about the health inequalities a helpline may need to consider. This includes access for people who are Trans, for older adults and for people from deprived areas.	

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

	There was also acknowledgement that a helpline would need to be accessed via a variety of means (online/via phone) and that not everyone can get online. <u>Working aged adults (25-54)</u> There were 360 (63% of all respondents) responses from working age adults to the survey. The majority (92%) of working aged adults that responded to the survey would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is reflective of both those that have used the self-harm helpline in the past and those that have not. Comments in support of the integrated helpline included comments on the helpline providing extra capacity in the system and the view that self-harm does not exist without other mental health concerns. There were also comments on a service being accessible, non-judgmental and anonymous. There were also comments from the minority who disagreed with the proposal to integrate the helplines (8% of working age adult respondents). These included comments such as people being put off accessing mental wellbeing support as it is also for people who self-harm. There were also comments that the self-harm element of support would be minimised by the need to support other mental wellbeing issues. Comments were made about people not being able to link self-harming with wider mental health issues in the first instance so would not easily see the connection in an integrated helpline. Respondents were asked about any health inequalities that may need to be considered when developing the service offer. Comments from working aged adults included ensuring we consider the effects of digital exclusion including for people with sight impairments. There were a large number of comments about the professionalism of staff or people having a poor experience of health workers, especially when supporting people with self-harm and there were also comments about support in rural or deprived areas. <u>Older Adults (55+)</u> There were 165 (29% of all respondents) responses from people aged 55 and over. The responses to the survey suggest that the vast majority (89%) of older adults that responded to the survey would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is reflective of both those that have used the self-harm helpline in the past and those that have not.	

	Comments in support of the integrated service offer included comments about making sure the service is accessible to all, that singling self-harm out as a separate issue could be stigmatising and there were also a variety of comments suggesting waiting times for mental health services were currently too long. Comments made by those who did not agree (11% of older adult respondents) with integrating self-harm support with wider mental wellbeing support via a helpline were predominantly about the importance of face-to-face support. Older adults made a range of comments in relation to health inequalities. This included a concern around ageism, concerns around digital exclusion, access via interpreters and having a variety of access options for the helpline in general. <u>Considerations for a new service</u> Commissioners are working with the Lead Commissioner for Children and Young People's Mental Health at the Integrated Care Board to raise awareness of the services available in the system to support mental health need amongst children and young people. The service will be expected to have an awareness and understanding of issues that may be experienced by adults of different age ranges and operate in an unbiased way towards all age groups. With regards to ensuring equality of access for older adults without digital/internet access, it is envisaged that there will be the option for phone consultation. There will be a requirement to make telephone or text support available where digital/internet access is not possible or preferable.	
Disability	*The service will be open to individuals with a disability and overall it is not considered that the provision will have an adverse impact on people with a disability. However, it is important that we ensure accessibility and monitor access by people with a disability and any issues they may encounter using remote or digital offers.* The 'Our changing World' report by the Barnwood Trust[6] indicated that special consideration may need to be given to the accessibility of information for those with a sensory impairment or a learning disability. Some groups may also experience barriers to accessing digital services or may not have the privacy in their own home to access support online. There is scope to do further research to understand the experiences of people with disabilities in accessing	

[6] Our-Changing-World-Exec-Summary-v6.pdf (barnwoodtrust.org)

	digital mental health platforms, and commissioners will work alongside countywide initiatives aiming to increase digital inclusivity which may explore this issue. Self-Harm There is little local data on self-harm in people with disabilities, however a study looking at self-harm in British adolescents found that those with disabilities had considerably higher levels of emotional difficulties and instances of self-harm than their peers. Emotional difficulties and self-harm among adolescent girls with disabilities were 1.5–4.5 times higher than their peers[7] who did not have a disability. Adults Data cited by the Mental Health Foundation suggests that people with long-term physical conditions are more likely to have lower wellbeing scores than those without[8]. ONS research also suggests that nationally, adults living with disability were more likely than adults without a disability to be experiencing some form of depression. Further research by the Barnwood Trust also suggests that people living with disabilities are also more likely to experience social isolation. The new service will work alongside people experiencing isolation and support them to explore social opportunities and signpost where appropriate. Depending on the final commissioning model, there is an option for forums and remote group sessions to be provided by the new service, so that people can get peer support. Mental Health Conditions By the nature of the current and proposed service provided, most individuals contacting the service will be experiencing some form of mental ill health. A mental health condition is considered a disability if it has a long-term effect on someone's normal day to day activity. This is defined under the Equality Act 2010. While the service is intended to support individuals who are experiencing mild-moderate issues with their mental wellbeing, as the service is open access, individuals with more severe or longer-term mental health issues which impact on their daily life may also contact the helpline for support. Staff working in the service will be required to have the	

[7] Emotional difficulties and self-harm among British adolescents with and without disabilities: Cross sectional study - ScienceDirect
[8] Mental health statistics: physical health conditions | Mental Health Foundation

	necessary skills to support people experiencing mental ill-health and signpost accordingly to more specialist mental health services or other support services as required. The service will work within the existing Mental Health pathway in Gloucestershire and would ensure appropriate support and connection to other mental health services takes place where appropriate. **<u>Public consultation – Mental Wellbeing Helpline Survey</u>** There were 209 (36% of respondents) responses from people who disclosed they have a disability or long-term condition. The responses to the survey suggest that the majority (90%) of people with a disability or long-term condition, who answered the survey, would be happy receiving support for their mental health alongside a service which offered support for self-harm. This was reflective of those who had accessed the Self-Harm Helpline and those that had not. Comments in support of an integrated helpline included comments about the importance of signposting and getting this from one place. Comments against integration included those around the speciality of support needed for self-harm. Responses from people with a disability or long-term condition, to the following question: *'Are there any issues or experiences of cultural or health inequality relating to you, your community, or the community you are representing that you would like us to consider?'* can be summarised as below: - chronic illness and disability awareness is vital - importance of being aware of neurodiversity/ADHD - advocacy for people with LD - services need to be aware of poverty - considerations need to be made for people who have SEND, - a person needs to be supported holistically with mental health – you cannot separate physical and mental health as part of the whole, - some feel there is prejudice by some professionals - consider support services for deaf/nonverbal people <u>Considerations for a new service</u> The current services do not collect data on whether users have a disability or diagnosed mental health condition; and we will explore with the new provider whether this can be added as a service requirement (though service users will not be obliged to provide this information).	

	The proposed new service will be open access, i.e. open to all adults. This includes people with disabilities and diagnosed mental health conditions. It is not anticipated that the proposed change will negative impact adults with disabilities, but that it will increase options and access for early intervention mental health support. Consideration will be given to particular access issues that may be experienced by individuals who have a disability when using a digital/telephone. I.e. the service may need to ensure audio and visual accessibility assistance is available. A service would be expected to deliver non-judgemental support which takes into account why a person may find it difficult to access the offer. For those who are living with a longer term mental health condition, the successful provider would be expected to have a good understanding of how this can impact a person's life and how a person with a longer term mental health condition can best be supported. This could be through offering a listening service, or offering practical and signposting support e.g. if a person is struggling financially. Additionally, awareness of the above issues as identified as points of consideration in the consultation process, will also be a requirement of the new provider. Consideration will also be given to how the new service can be developed to ensure it feels accessible and appropriate to individuals with disabilities. The new service will be expected to address accessibility issues and ensure the service is accessible for everyone that needs it.	
Sex	*The service will be open to people of all genders and no negative impacts on the basis of gender have been identified.* Data from the current open access mental health service show that while the service is reaching both men and women; uptake is higher among women. National data shows that young women (aged 17-19) have higher levels of emotional mental health disorders, such as anxiety and depression; than other age groups and their male counterparts. These disorders, in which women predominate, affect approximately one in three people[9]. Gender-specific risk factors for common mental disorders include gender-based violence, socioeconomic disadvantage, low income, and responsibility for the care of others. This is also reflected in the Pupil Wellbeing Survey findings which show that female students tend to report poorer wellbeing overall[1]. National survey data also indicates that adult women may be more likely to report worsening mental health due to the pandemic than men. However, when looking at mental health data between men and women we should treat disparities with some level of caution as women may simply be more likely to report mental ill health than their male counterparts. <u>Self-Harm</u>	

[9] WHO/Europe | Gender and mental health

	Young women were more than twice as likely to report self-harm than young men. In the Pupil Wellbeing Survey 2020 1 in 3 females reported ever self-harming compared to 1 in 7 males. Furthermore, 77% of referrals to the Bounce Service (a self-harm support service offered by Young Gloucestershire) between December 2020 and November 2021 were female. Data from the GSHHL also suggests that use of the service is much higher amongst women who make up 92% of service users. **<u>Public consultation – Mental Wellbeing Helpline Survey</u>** There were 445 (78% of respondents) people who responded to the survey who identified as female and 92 (16%) respondents to the survey identified as male. 19 (3%) people preferred not to disclose their gender. <u>Female responses</u> The responses to the survey suggest that the majority (93%) of female respondents would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is true of both those that accessed the Self-Harm Helpline and those that did not. Comments in support of an integrated helpline included the importance of getting support at the right time and that self-harm doesn't exist as a behaviour without other causal factors. Feedback from those who did not agree with an integrated helpline (7% of female respondents) included comments about the importance of keeping a standalone service so it does not become generalised. Responses specific to women, to the following question: *'Are there any issues or experiences of cultural or health inequality relating to you, your community, or the community you are representing that you would like us to consider?'* can be summarised as follows: - there were fears that women's issues would not be taken seriously and receiving non-judgmental, non-sexist support - there was anxiety around support for women experiencing the menopause. <u>Male responses</u>	

	The responses to the survey suggest that the majority (88%) of male respondents would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is true of both those that accessed the Self-Harm Helpline and those that did not. Comments in support of an integrated mental health support line included the importance of wider factors causing mental ill health as well as self-harm and the importance for people to get initial support when in mental distress. There were no specific comments about the integration of a support line for those that disagreed with it. When respondents were asked about health inequalities in relation to men a lot of the comments were around the specific needs of men and that men can be reluctant to come forward for support. There were comments about the needs of men who have left the armed services as well as men who are rehabilitating after being in prison. The need of non-judgmental, professional support was also mentioned. <u>Considerations for a new service</u> We will work with the new provider to ensure equal access to both sexes. Staff working on the service will be expected to have an understanding of the key risk factors for mental health affecting women and men. Services would be expected to offer non-judgemental support to both sexes as well as have an understanding that the needs of men and women will differ. This may also be impacted by the intersectionality of age and the life course of a man or a woman. A service will need to recognise that young women in particular are at higher risk of self-harm whilst a number of factors may mean that young men are at greater risk of suicide.	
Race	*The service will be open to people of any ethnicity.* The Department of Health and Social Care *Modernising the Mental Health Act* report[10] 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 crisis services or 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[11]. We know that racism experienced in everyday life compounds already poor experiences of, and outcomes from, health services."	

[10] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk)

[11] #BLM Gloucestershire's Mental Health Services 4b4833cf58943d4c357fbb163d43ad25_BLM-Gloucestershire_MH_Services_Report.pdf (amazonaws.com)

Evidence does suggest that people from ethnic minority communities are at higher risk in general from mortality and morbidity related to Covid-19; which in turn may impact on mental wellbeing. Ethnicity may also overlap with other risk factors for poor mental health, including lower household income.

Service user data from the current open access service indicates that 10% of Gloucestershire users are from ethnic minority groups. This is slightly higher than the proportion of individuals within Gloucestershire's population from ethnic minority groups, which was recorded as 8.4% in The Gloucestershire County Council Population Profile 2022. This is also higher than other early intervention mental health services in Gloucestershire, where ethnic minority individuals are under-represented[11].

Self-Harm

The proportion of Black, Asian and minority ethnic young people who report self-harm or overdose is not significantly different to White British young people. However White Other young people are significantly more likely to report self-harm or overdose than White British young people, in both sexes. Indian female young people are significantly less likely to report self-harm or overdose than White British young people, in males there is no significant difference.

When looking at GP attendance before a self-harm admission – Black, Asian and minority ethnicity patients were slightly more likely to have seen their GP within 2 weeks of a self-harm admission than white patients, although not significantly so.

83% of A&E attendees for self-harm were White British, this is the highest proportion apart from when people were brought in deceased. 2% were classed as White Other, 1% Mixed, 0.4% Black and Black British, 0.5% Asian and Asian British and 0.5% Any Other Background. 10% of attendees did not have their ethnicity stated and 5% were classed as Unknown.

Data from the GSHHL suggests that over 90% of service users (who provide their racial identity) are White British. The next largest group of service users were Asian British Indian (4.04%) and this is followed by Asian British at 3.5%. This is largely in line with county demographic data on race.

The Council is working with NHS Gloucestershire ICB to understand the issues around why ethnic minority individuals are generally under-represented in early intervention services, and over-represented in crisis services, see report here: 4b4833cf58943d4c357fbb163d43ad25_BLM-Gloucestershire_MH_Services_Report.pdf (amazonaws.com)

Public consultation – Mental Wellbeing Helpline Survey

There were 60 (10% of respondents) responses from people who are from ethnic minority groups.

The responses to the survey suggest that the majority (91%) of people from an ethnic minority who responded would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is true of those that have accessed self-harm support previously and those that have not.

Those in support of an integrated service, made comments such as the following: ensure services are easy to access, take people seriously to avoid shaming people for self-harm, one number would be useful for accessing self-harm/mental wellbeing support, the integrated helplines would offer valuable signposting, having support whilst waiting for NHS face-to-face support is valuable.

There were no comments by people who disagreed (9% of ethnic minority respondents) with the integration of the service.

Responses from ethnic minority respondents to the following question: *'Are there any issues or experiences of cultural or health inequality relating to you, your community, or the community you are representing that you would like us to consider?'* can be summarised as below:

- having cultural competency and catering for all needs
- ensuring there is trauma informed practice
- there is a lack of culturally and linguistically appropriate preventative mental health services
- there are pressures in certain communities to be a certain way and 'successful'
- there is not enough support for BAME communities
- there is a need for culturally diverse counsellors
- ensure ethnically diverse communities are kept informed
- discretion is important
- consideration for some to pick a same-sex counsellor
- there are fears of discrimination
- having a workforce that reflects communities is key

<u>Considerations for a new service</u>
We understand that previous/existing mental health services may not feel accessible / appropriate by ethnic minority communities. Commissioners also understand that mental health and wellbeing is understood and experienced differently by different cultures. A service will be expected to provide a non-judgmental supportive service. In some cultures talking about mental wellbeing is not commonplace, and therefore services aiming to support individuals

	experiencing the first signs and symptoms of mental ill health/emotional distress, may not feel appropriate, and could be stigmatised. Commissioners have engaged with some ethnic minority communities to understand this further. It is anticipated that the new service will include a requirement for the provider to ensure cultural and racial competency in their provision to help address some of the areas we know are current barriers as identified in our engagement. Consideration will also be given to how the accessibility and promotion of these services can be considerate of existing reasons why some communities may not feel early intervention services are appropriate for them. It is our intention to ensure all individuals who are experiencing early signs and symptoms of mental ill health feel that the proposed new service is appropriate and accessible for them, to prevent symptoms worsening. This is specifically relevant with regards to race and ethnicity as we understand ethnic minority groups are under-represented in early intervention/prevention services, and over-represented in crisis services. We will ask the new provider to gather data on ethnicity – if people using the service are happy to share this (it will not be compulsory). This will help us monitor access to the service and put in an action plan if we find that representation of certain ethnic groups is below what we may expect.	
Gender reassignment	*The service will be open to those who have undergone gender reassignment as well as those who consider themselves as trans/non-binary; and no significant negative impacts on the basis of gender reassignment/gender identity have been identified as arising from the commissioning of the service.* Studies suggest that psychiatric disorders, such as anxiety and depression are higher in transgender people and that this can be related to societal responses to their gender identity. It is important therefore that mental health support is open to transgender people, that services have an understanding of experiences of transgender people, and that they feel comfortable accessing it. There is scope for research into transgender people's experiences of accessing services and any perceived or actual barriers. The current open access service also collects data on access by people identifying as agender or gender fluid, non-male and non-female. Proportions are lower than people identifying as male or female, but the service still remains accessible to all. It is difficult to benchmark uptake from these groups against the proportion of people identifying their gender as 'agender'; 'gender fluid' or 'other' in the Gloucestershire population as a whole as we don't have reliable data on this. <u>Self-Harm</u>	

	According to the PWS, transgender young people had a high reported level of self-harm, between 49% and 70% (there are 2 questions around gender identity). Although numbers in the cohort were small the proportion reporting self-harm was significantly higher than cis gendered young people. 6% of referrals to the Bounce Service between December 2020 and November 2021 were for Trans young people, there is limited data to estimate the population of Trans people but around 0.6% of young people in the Pupil Wellbeing Survey 2020 reported being Trans, suggesting this group may be over-represented. **<u>Public consultation – Mental Wellbeing Helpline Survey</u>** There were 3 responses from people who are trans or non-binary. Although this is a small number of people, 2 of those disagreed and 1 strongly agreed with the proposal to provide support for general mental wellbeing issues, alongside support for self-harm, as part of an expanded helpline for adults. Some reasons for this include feeling that it would be better to keep the existing services separate as their presence and branding is already known. 35 people (6%) preferred not to say whether the gender they identify as was the same as assigned at birth. Of these, 23 (65%) agreed or strongly agreed with the proposal to provide support for general mental wellbeing issues, alongside support for self-harm, as part of an expanded helpline for adults. <u>Considerations for a new service</u> The new service will be required to continue to collect data on people's gender identity, where individuals are happy to provide this, to help with understanding service accessibility and reach. Consideration will be given to how the promotion of this service can be targeted and appropriate to reach those people whose gender identification may put them at higher risk of poor mental health. Commissioners will endeavour to ensure that the new provider has a workforce which is aware and appropriately trained to talk to people about their gender identity to ensure that the new service is as inclusive as possible.	
Marriage & civil partnership	No significant negative impacts on the basis of marriage and civil partnership have been identified. The proposed new service will support individuals of any martial or relationship status.	

+ relationship status	Relationship breakdown is a common factor contributing to poor mental wellbeing. Nationally, relationship breakdown, either romantic or familial, is thought to be one of the most significant risk factors for suicide, particularly for men. The proposed new service will need to be aware of the impact relationship breakdown can have on mental wellbeing and will be able to provide emotional support for those experiencing it. **Public consultation – Mental Wellbeing Helpline Survey** Respondents to the survey were not asked about their relationship status. There were however comments from people who advised they were a single parent and that financial struggles and stresses were difficult as a result.	
Pregnancy & maternity	No significant negative impacts on the basis of pregnancy and maternity have been identified. The proposed new service will be open to individuals who are pregnant or who have recently given birth. According to the NHS, perinatal mental illness affects up to 20%[12] of new and expectant parents and covers a wide range of conditions. If left unsupported, mental health issues can have significant and long-lasting effects on parents, children, and the wider family. It is also known that partners of birthing people, in particular men, may also struggle with their own mental wellbeing. There is increasing evidence around how the postnatal period affects partners, as well as birthing people[13]. This service will be open to supporting and signposting partners as well as birthing people. Self-Harm Where women were admitted to a Gloucestershire hospital for a delivery episode in 2018/19 or 2019/20 1.6% also had an attendance at A&E for self-harm in the period between 2017/18 and 2020/21 (slightly below the proportion of attendances of women of childbearing age (15-45yrs) for self-harm – 2.1%) and 0.6% had a hospital admission for self-harm in the same period. **Public consultation – Mental Wellbeing Helpline Survey** The survey did not ask a direct question about pregnancy or maternity but there were some comments which deserve mention and reflection on, in relation to childcare.	

[12] 4. Perinatal mental health - GOV.UK (www.gov.uk)
[13] Dads Matter - why-dads-matter-the-need.pdf (dadsmatteruk.org)

	The comments received highlight the stresses of family life and the fact that services need to be available around supporting a family. Services needs to have flexible working hours so that parents are able to access it when they are not directly looking after children. <u>Considerations for a new service</u> The new service will be open to individuals who are pregnant or in the post-natal period, and partners of those individuals. The service will be cognisant of issues and difficulties commonly experienced by those in the post-natal period. It will also be aware of and work closely with other services that support birthing people and their partners.	
Religion and/or belief	*The service will be open to adults of any religion or belief.* Whilst no negative impact on the basis of religion or belief is expected as a result of this provision, the commissioners are aware that beliefs/attitudes about mental ill health differ between religions, and that this may have an impact on attitudes towards this type of service, a person's likelihood of seeking support from this type of service, and the type of support that would be appropriate to provide (i.e. attempting to align staff with service user's beliefs/religion where possible, where this pertinent to the individual's wellbeing/needs). <u>Self-Harm</u> In regards to self-harm we do not collect information about religion in the Pupil Wellbeing Survey, neither was this information available from Hospital Episode Statistics etc. However young people from South Asian communities are significantly underrepresented in CAMHS referrals when compared to probable need, this may be due to increased cohesion in certain religious communities providing informal support, or conversely an increase in stigma associated with mental ill health in some religious communities. **<u>Public consultation – Mental Wellbeing Helpline Survey</u>** There were 236 (41% of respondents) responses from people who have a religion. The main reported religion was Christianity. The responses to the survey suggest that the majority of people who have a religion would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is true of those that have access support for self-harm and those that have not.	

	Comments in support of integrating support for self-harm and general mental wellbeing included those about the need of receiving professional support, the need to build capacity in the system and the benefits of having one helpline for the purposes of signposting. Comments from those that disagreed (11% of respondents who declared having a religion) with the integration of self-harm and mental wellbeing support included, that the self-harm element of any helpline isn't 'lost' within wider mental wellbeing support, and that the help available for self-harm could be minimised. Responses from those that declared a religion to the following question: *'Are there any issues or experiences of cultural or health inequality relating to you, your community, or the community you are representing that you would like us to consider?'* can be summarised as below: - there was a fear of stigma in some religious communities - there is a need for culturally diverse counsellors - having a workforce that reflects community is key - concerns about digital poverty and exclusion - ensure language is inclusive - support in various languages <u>Considerations for a new service</u> The service will be required to ensure it is sensitive to these issues and can provide, or work towards providing, culturally appropriate services on the basis of religion. The service will also be expected to be non-judgemental and have a good understanding of cultural competency and the nuances involved in delivering a service for different communities. There will be opportunity for support through translation. Telephone support will also be available for those that cannot access support online.	
Sexual orientation	*The service will be open to people of all sexual orientations and no negative impacts on the basis of sexual orientation have been identified.* Studies that show that people who identify as non-heterosexual tend to have poorer emotional wellbeing. This may be linked to experiencing discrimination, homophobia or social isolation linked to their sexual orientation; as well as difficulties 'coming out' - otherwise known as 'toxic stress'[14].	

[14] About LGBTIQ+ mental health - Mind

	Self-Harm We know that non-heterosexual and transgender CYP were significantly more likely to report self-harm, 1 in 2 vs. 1 in 5 heterosexual young people. according to the Pupil Wellbeing Survey. **Public consultation – Mental Wellbeing Helpline Survey** There were 77 (13% of respondents) responses from people who identify as non-heterosexual (e.g. lesbian, gay, bisexual, asexual etc – LGB+). 43 (7%) people preferred not to disclose their sexual orientation. The responses to the survey suggest that the majority (89%) of LGB+ people surveyed would be happy receiving support for their mental health alongside a service which offered support for self-harm. This is true of those that have received for support for self-harm and those that have not. Some of the comments in support of an integrated helpline included the following: a wish for compassionate, non-judgmental anonymous support. Some believe such a helpline would offer useful signposting to further support for their mental wellbeing. Some of the comments from those who disagreed (11% of LGB+ respondents) with integrating self-harm and general mental wellbeing support include fears that support for self-harm would be lost in the general service offer for mental wellbeing. There are also fears that the support available on the integrated service would not allow those accessing the helpline to go into detail about their use of self-harm and the self-harm support element would be more utilised for safeguarding purposes. Responses from LGB+ respondents to the following question: *'Are there any issues or experiences of cultural or health inequality relating to you, your community, or the community you are representing that you would like us to consider?'* can be summarised as below: - There were fears of stigma - People had anxiety about speaking over the telephone - There were fears for LGB+ identifying people that they may not receive unbiased support - Some thought that access and understanding for LGBT+ people in particular was problematic at present Considerations for a new service Consideration will be given to how the promotion of this service can be targeted to reach those people whose sexual orientation may put them at higher risk of poor mental health and risk of self-harm. Counsellors working for the service will also be expected to have an awareness of the key stressors faced by LGBTQ+ people. LGBTQ+ people have	

	expressed the importance of being seen by a professional who is non-judgemental and this will be a core foundation of the support that is offered.	
Deprivation (NB We have added this section is as although it is not covered within the protected characteristics, we felt it is an important health inequality that should be considered)	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[15]. Although poverty is just one aspect of deprivation, the Mental Health Foundation report on Poverty and mental health[16] 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." Stresses across the life course including homelessness, redundancy and family breakdown all play a factor in how poverty and mental ill health interact. Furthermore, the corrosive impact of stigma and discrimination on people experiencing mental health problems and those living in poverty has to be recognised. <u>Self-Harm</u> Information from the PWS 2020 suggests in maintained mainstream secondary schools reported levels of self-harm were highest where the majority of pupils live in IMD quartile 2, although there was little significant difference between deprivation quartile groups. Pupils at independent schools had the lowest reported self-harm, this suggests rather than deprivation being a factor that contributes to self-harm behaviours in CYP, affluence and the associated privilege is more likely to be a protective factor. In 2018/19, 82% of patients attending A&E for self-harm injuries lived in Urban areas and 17% live in Rural areas. Patients from urban areas are over-represented in the admissions data (70% of Gloucestershire's residents lived in urban areas in 2019). Even proportion of attendees from most deprived areas vs. least deprived areas. Highest proportion for singular categories was the less deprived 10-20% areas accounting for 17% of attendees. Counsellors working for the new service will be expected to have an awareness of how factors contributing to deprivation and poverty can have an impact on a person's mental health.	

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652881/
[16] Poverty and Mental Health.pdf

	Digital Poverty When providing a service we have to be mindful that not everyone will have access to the means to access provision online. Research from the ONS suggests that the South West has 10.2% of non-internet users whilst 9% of the population have no digital skills[17]. This could be due to age - older adults not having the skills to access but it could also be due to poverty and not having the means to access the internet. The service that is provided will be expected to offer a telephone service for those that cannot access the internet or for those where speaking over the phone is preferable to online delivery. **Public consultation – Mental Wellbeing Helpline Survey** There were no direct questions to survey participants about their financial status, however there were a number of comments relating to this subject. There were comments about digital poverty and exclusion and making sure services were accessible. There were also comments on poverty being a root cause of poor mental health and the need of a service to be aware of this. Comments were made about rural poverty and the divides between rich and poor in these areas as well as the impacts this can have on people. There were a number of comments around financial hardship and the impact this has on mental health. Considerations for a new service It will be expected that the successful provider will have an understanding of how deprivation and the wider issues related to this have an impact on mental wellbeing. The service will be expected to have an understanding of current health inequalities within Gloucestershire and will be expected to ensure the service is targeted and promoted to those groups who are highest risk of poor health due to these inequalities.	

4. Completed Actions

Set out how the proposed activity has already been amended following the equality assessment, to maximise the positive impact or minimise the negative impact:

Completed Actions	Reason for Change

[17] Exploring the UK's digital divide - Office for National Statistics (ons.gov.uk)).

Commissioners have engaged with some marginalised groups / groups who experience highest risk factors for poor mental wellbeing, in preparation for commissioning this service. We will continue engaging with these groups to ensure their experiences are fully understood.	In order to understand perspectives in relation to early intervention mental health support.
Current services to increase the range of information on service users' protected characteristic collected as part of routine monitoring data (whilst also recognising that there is no requirement for service users to provide this data to access the service). This should include where possible and where supplied: - information on use by individuals with a disability; - information on the sexual orientation of service users; and - information on the gender identification of service users.	To ensure commissioners are able to better monitor uptake of the service across all the protected characteristics.
Current services to consider creative, appropriate targeted promotion of the service to groups at higher risk of poor mental health, as identified in this document.	Evidence shows that people with some protected characteristics may be more vulnerable to the mental health impacts of the pandemic. It is important that the service reaches these groups.

5. Planned Actions

Set out improvements that will be undertaken, following the equality assessment, to further maximise the positive impact or minimise the negative impact:

Potential impact (positive or negative)	Action	By when	Owner
Positive	Ensure the service specification developed for the proposed new service includes adequate requirements for the service to operate in an appropriate way to ensure no unintended harm or negative impact is caused for any particular population group, taking into consideration issues identified within this EIA and through the public consultation process. This might include cultural competency, addressing physical, societal or perceived barriers in access and ensuring awareness of unique experiences of individuals with any protected characteristic.	September 2022	Public Mental Health Team
Positive	Work with the CCG to analyse data on uptake of early intervention mental health services by ethnic minority individuals; and consider any improvements that need to be made to increase access; working with ethnic minority communities and people with lived experience.	Ongoing	Public Mental Health team
Positive	Work with the CCG, providers of mental health services and people with lived experience to better understand usage of mental health services by transgender individuals.	Ongoing	Public Mental Health Team
Positive	Work with Mental Health Partnership Board to better understand the impact of new models of service provision during the pandemic (including the use of digital platforms) on accessibility, particularly for people with a disability and also older adults.	Ongoing	Public Mental Health Team
Positive	Working alongside communities to understand how the promotion of and access to the service can be appropriate for those with protected characteristics and those in areas of deprivation	Ongoing	Public Mental Health Team

Positive	We are currently working with the Lead Commissioner for Children and Young People's Mental Health at the ICB to raise awareness of the support available for CYP requiring support around self-harm.	September 2022	Public Mental Health Team

6. Monitoring and review

The following processes/actions will be put in place to keep this 'activity' under review:
• Regular contract monitoring meeting with current providers which will include review of uptake data on service user characteristics. • Regular and ongoing engagement with communities to increase knowledge and understanding of experiences of people with protected characteristics and who may experience health inequalities.

7. Officer / Decision-maker Sign off

Officer: By signing this statement off as complete you are confirming that 'you' have examined sufficient information across all the protected characteristics and used that information to show due regard to the three aims of the general duty. This has informed the development of the activity

Signature of Senior Officer	
Name of Senior Officer	Siobhan Farmer, Director of Public Health
Date	15.08.22

Decision maker: I am in agreement that sufficient information and analysis has been used to inform the development of this 'activity' and that any proposed improvement actions are appropriate and I confirm that I, as the decision maker, have been able to show due regard to the needs set out in section 149 of the Equality Act 2010.

Signature of decision maker	
Name of decision maker	Cllr Nick Housden, Cabinet Member for Public Health and Communities
Date	8.9.22

8. Publication

If this document accompanies a Cabinet report or an Individual Cabinet Member (ICM) decision report it will be published, as part of the report publication process, on the GCC website. If this statement is not to be submitted with a Cabinet report or an Individual Cabinet Member (ICM) decision report, please maintain a copy for your own records that can be retrieved for internal review and also in case of future challenge.

Appendix 1 – Service User Data

Details of service users affected by the proposed activity

<table>
<tr><th>Protected Characteristic</th><th>Service User Data and Information</th></tr>
<tr><td>Age
percentage/profile of service user ages</td><td>
Gloucestershire Population Profile.

Service User data from Kooth to be inserted in the next iteration of the EIA.

Service User data from Gloucestershire Self-Harm Helpline:

The latest data for the GSSHL for year ending 31st March 2022 gives the following picture of service use (note: not all callers to the service want to give out their demographic data):

<table>
<tr><th>Age</th><th>Total for year</th><th>Percentage</th></tr>
<tr><td>Under 17</td><td>186</td><td>11.04%</td></tr>
<tr><td>18 - 24</td><td>409</td><td>24.27%</td></tr>
<tr><td>25 - 34</td><td>668</td><td>39.64%</td></tr>
<tr><td>35 - 44</td><td>356</td><td>21.13%</td></tr>
<tr><td>45 - 54</td><td>40</td><td>2.37%</td></tr>
<tr><td>55 - 64</td><td>25</td><td>1.48%</td></tr>
<tr><td>65-74</td><td>0</td><td>0%</td></tr>
<tr><td>75-84</td><td>0</td><td>0%</td></tr>
<tr><td>85+</td><td><5</td><td>0.06%</td></tr>
</table>
</td></tr>
<tr><td>Disability
percentage/profile of service users who have a disability</td><td>

The current Open Access Mental Health Service does not collect data on disability and neither does the GSHHL.
Some studies suggest the rate of mental health problems in people with a learning disability is double that of the general population (Cooper, 2007; Emerson & Hatton, 2007; NICE, 2016)

</td></tr>
</table>

<table>
<tr><td></td><td>

People with long-term physical conditions are more likely to have lower wellbeing scores than those without[18].
Of people with severe symptoms of mental health problems, 37.6% also have a long-term physical condition. This compares with 25.3% of people with no or few symptoms of a mental health problem.

</td></tr>
<tr><td>Sex
percentage/profile of service users who are male and who are female</td><td>The latest data for the GSSHL for year ending 31st March 2022 gives the following picture of service use (note: not all callers to the service want to give out their demographic data):

<table>
<tr><th>Gender</th><th>Total for year</th><th>Percentage</th></tr>
<tr><td>Female</td><td>1894</td><td>92.35%</td></tr>
<tr><td>Male</td><td>147</td><td>7.17%</td></tr>
<tr><td>Transgender</td><td>10</td><td>0.49%</td></tr>
</table>
</td></tr>
<tr><td>Race
percentage/profile of service users who are from black and minority ethnic backgrounds</td><td>The latest data for the GSSHL for year ending 31st March 2022 gives the following picture of service use (note: not all callers to the service want to give out their demographic data):

<table>
<tr><th>Ethnicity</th><th>Total for year</th><th>Percentage</th></tr>
<tr><td>Asian or Asian British - Any Other Asian background</td><td>58</td><td>3.50%</td></tr>
<tr><td>Asian or Asian British - Pakistani</td><td>67</td><td>4.04%</td></tr>
<tr><td>Black or Black British - African</td><td>0</td><td>0.06%</td></tr>
<tr><td>Black or Black British - Other Black background</td><td>0</td><td>0.00%</td></tr>
</table>
</td></tr>
</table>

[18] Raj, D., Stansfeld, S., Weich, S., Stewart, R., McBride, O., Brugha, T., … & Papp, M. (2016). Chapter 13: Comorbidity in mental and physical illness. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

	Mixed - Any Other Mixed background	0	0.00%
	Mixed - White and Asian	<5	0.06%
	Other ethnic group - Any other ethnic group	5	0.30%
	Other ethnic group - Arab	0	0.00%
	White - Any Other White background	6	0.36%
	White - British	1520	91.62%
	White - Gypsy or Irish Traveller	0	0.00%
	White - Irish	<5	0.12%

Gender reassignment *percentage/profile of service users who have indicated they are transgender*	• During the last year 0.49% of callers to the GSSHL identified themselves as transgender, however it is worth noting that this may not be a true picture as many callers may not wish to give out their personal data. • A recent study by Stonewall found that over the previous year almost half of trans people had thought about taking their life. • 60% of trans people have felt that life was not worth living in the last year (2018). • More than a third of trans people (35%) have self-harmed in the last year (2018), compared to 14% of LGB people who aren't trans. • Two thirds of trans people (67%) have experienced depression in the last year (2018). • Seven in ten trans people (71%) have experienced anxiety in the last year (2018)[19].
Marriage & civil partnership *percentage/profile of service users who are*	• This data is not collected by the current Open Access Mental Health Service or the GSHHL

[19] https://www.stonewall.org.uk/resources/lgbt-britain-health-2018

married or in a civil partnership	• Being in a supportive relationship could be a protective factor in having good mental health. Research has found that high marital quality is associated with lower stress and less depression. However, single people have better mental health outcomes than people who are unhappily married[20]
Pregnancy & maternity *percentage/profile of service users who are female and who are pregnant or on a maternity leave*	• This data is not collected by the current Open Access Mental Health Service or the GSHHL • According to the NHS, Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions
Religion and/or belief *percentage/profile of service users religious beliefs*	This data is not collected by the GSHHL This data is not collected by Kooth/Qwell.

Sexual orientation *percentage/profile of service users who are lesbian, gay, bisexual, heterosexual*	This data is not collected by the GSHHL or Qwell.
	
	• A recent study by Stonewall found that over the previous year:
	  • half of LGBTIQ+ people had experienced depression and three in five had experienced anxiety
	  • one in eight LGBTIQ+ people aged 18-24 had attempted to end their life

Appendix 2 – GCC Workforce Data

[20] Holt-Lunstad, J., Birmingham, W., & Jones, B.Q. (2008). Is There Something Unique about Marriage? The Relative Impact of Marital Status, Relationship Quality, and Network Social Support on Ambulatory Blood Pressure and Mental Health. *Annals of Behavioural Medicine*, 35, 239–244.

Details of Gloucestershire County Council staff affected by the proposed activity

Protected Characteristic	Total number of GCC staff affected:
N/A	