# West Sussex Mental Health Needs Assessment (Adults)

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**KEY FINDINGS AND RECOMMENDATIONS**

| Finding | Recommendation |
|---|---|
| **POPULATION CHANGE** | |
| The population across West Sussex is projected to increase by 10% (by 2021), although the projected increase is lower (at 5%) in the working age group (16-64 year olds). Of the CCG areas Crawley is projected to have the highest growth in the 16-64 age group (14%), Coastal West Sussex (5%), and a lower increase in Horsham and Mid Sussex (1.2%). | *In relation to functional mental health needs, Crawley is projected to have the highest population-driven growth in demand over the next 10 years, commissioning plans should reflect this.* |
| **WIDER DETERMINANTS AND VULNERABLE GROUPS** | |
| Socio-economic pressures, risk factors for poor mental health, have increased in recent years; including debt, housing pressures and reduced access to some services. While at any time these risk factors impact some people in the community, an economic recession will have impacted a greater number of people and resulted in an increased demand for support, notably for anxiety and depression. | *Commissioners should review the overall access, waiting time and outcomes of IAPT provision.* |
| These pressures have increased across the social gradient but there is some evidence that the impact has been greater in the most deprived areas of the county.<br><br>There is extensive research identifying groups within the population who are at higher risk of developing mental health problems; these include young people leaving care, people affected by violence, people from black and ethnic minorities, notably young black males, and people in insecure housing or homeless.<br><br>Although the relationship between mental health problems and risk factors is complex, ensuring that services are accessible to people / communities with a higher risk of mental health problem is clearly important. | *A Health Equity Audit should be conducted to examine the current use and provision of services (including IAPT ) by ethnicity, deprivation, gender and groups with a known higher risk of mental health problems.* |

| Finding | Recommendation |
|---|---|
| **DIVERSE GROUPS AND COMMUNITIES** | |
| Engagement with a range of diverse groups in West Sussex identified a range of barriers people experienced in accessing services and support. The key findings and recommendations: | |
| I. Increase the awareness and confidence of mental health staff in working with people from a range of backgrounds, and ensure staff have up-to-date knowledge of services and organisations that can specifically help them. | *Commissioners should explore how diverse organisations could provide training to mental health services and within primary care, to raise awareness and understanding of diverse groups.*<br><br>*Commissioners should consider facilitating partnerships between diverse organisations and mental health providers; with an aim to skill up people working in the main mental health trust, to become champions with specialist knowledge and skills.* |
| II. We need to make the best use of existing good practice and knowledge | *There are existing services and workers who have developed knowledge of specific groups and issues – their knowledge and practice should be shared, for example, where there are GPs with a special interest in homelessness.* |
| III. Tailoring the mental health pathway to ensure diverse needs are met. | *Consider funding specialist community based services from within diverse communities, to provide community support and engagement, to enable people to better access services, and to advise on all aspects of the mental health care pathway from recognition through to recovery.* |
| IV. Improve the availability of different languages. (It should be noted that information was not available on the diversity of the existing mental health workforce). | *Consider taking positive steps to employing people in the mental health provider organisations from West Sussex's diverse communities, including with language skills in the main languages (to include BSL)* |
| V. Diversity and cultural sensitivity should not be an add-on but embedded within the mental health service, so that it is part of everyday custom and practice and informs service development and improvement. | *Commissioner should explore the value of a diverse partnership forum and work to increase involvement of people from diverse communities who use services.* |

| Finding | Recommendation |
|---|---|
| **CO-MORBIDITIES** | |
| There are strong associations between mental health and other conditions, including physical health conditions:<br>• It is estimated that 30% of people with a long term condition also have a mental health problem.<br>• There is a high incidence of mental health and substance misuse problems, with 75% of people in treatment for drug and/or alcohol dependency estimated to have a mental health problem.<br>• There are also associations with learning disabilities and/or autism.<br>• This co-morbidity can act to increase the treatment and management costs of long term conditions and mental health. | *Mental health support should be embedded in programmes tackling other long term physical conditions; there should be a greater focus on how mental health provision can also facilitate the delivery of outcomes in other programmes.* |
| **DATA FROM EXISTING SERVICE PROVISION AND USE** | |
| Information was reviewed across a range of services, from identification and management within primary care to specialist services. | ***Post Natal depression*** *– data available indicates an inconsistency in the identification and/or recording of Post Natal Depression. This should be addressed.* |
| ***Management within primary care*** – a number of measures are included within the Quality Outcomes Framework relating to the management of mental health problems within primary care, reflecting national guidelines and best practice. | *The 2012/2013 QOF data show considerable variability between practices within CCG areas and therefore scope to ensure practices are supported to work to best practice guidelines.* |
| ***Urgent GP Referrals to Specialist Care***<br>The majority of urgent GP referrals do not meet SPT criteria; it is unclear (at a population level) what happens to these referrals. There is no information available to commissioners to determine which groups/conditions are being referred. | *Commissioners need to consider the range of information required from providers to identify unmet needs and support longer term service planning.* |

| GAPS IN KNOWLEDGE |
| --- |
| ***Transition from childhood*** – Many mental health problems are continued into adulthood from childhood and adolescence, continuity of support and longer term planning are clearly important but the commissioning and delivery of services remains disjointed. The effectiveness of transition planning and commissioning has been identified as a gap in this needs assessment, for example transitional support for adolescents with eating disorders. |
| ***Older People and Loneliness*** – There is considerable evidence, national and local relating to the association with loneliness in older age and health, again this relationship may be complex, people in poor health may be more likely to be lonely rather than loneliness causing ill health. Evidence |
| ***Prevention and Wider Mental Wellbeing.*** The emphasis of this needs assessment and the engagement with stakeholders is on mental health problems and poor health, more work is required to identify prevention and promotion of mental wellbeing. |
| ***Increasing / emerging issues / Unmet Needs.*** Engagement with stakeholders identified concerns where needs were currently being unmet or where issues / conditions were increasing, these include:<br>- Increased demand for support with eating disorders<br>- Support in hospital<br>- Support for adults with autism<br>- Mental health support for older adults<br>- Wider support for employment, housing, transport, managing finances and also social support and networks. |

**Introduction**

The West Sussex Joint Strategic Needs Assessment is an on-going process by which the health and wellbeing needs of the local population are examined. This needs assessment is part of that process and looks at the mental health of adults in West Sussex. This assessment focusses on adults (people aged 18 years or over), and includes "non-organic" mental health of older people; a separate needs assessment on dementia is being produced. The report examines not just mental illness or conditions, but also considers what promotes and supports mental and emotional wellbeing.

**The Aims of this Needs Assessment**

This needs assessment reviews the mental health and well-being needs of the county's population, and makes recommendations to support the commissioning of services to meet those needs.

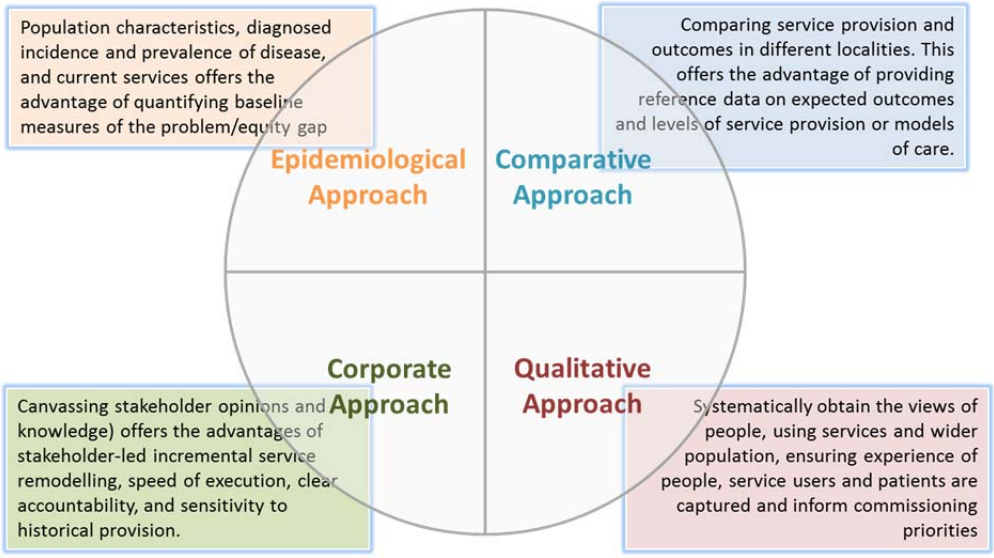
The information collated aims to answer some basic questions:

- What are the characteristics of the population of West Sussex?
- What are the risk factors and protective factors affecting the mental and emotional wellbeing of the population?
- What are the mental health conditions and needs requiring commissioned services? For who and how many?
- What services are currently provided to meet those needs?
- How well are current services meeting those needs? What gaps and/or barriers, if any, need to be addressed?

The needs assessment incorporates data from a wide variety of sources and includes evidence collated from an extensive consultation process with services users, local organisations and professionals.

**Methodology**

This needs asessment uses a mixture of methods, these are described in the diagram below.
The first two parts of the needs assessment collate the background data on the characteristics of the local population and the prevalence of disease (epidemiological approach); and information comparing local provision and outcomes (comparative approach). The following parts canvass the view of local stakeholders and those using services and the wider population.



**Previous Mental Health Needs Assessment**

A mental health needs assessment for people aged 16-64 years was conducted in 2008 and covered West Sussex, East Sussex and Brighton and Hove. This needs assessment provides an update for West Sussex.

**DEFINING MENTAL HEALTH AND WELLBEING**

**Mental Health -** The World Health Organisation (WHO) defines mental health as *"a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."*

Alongside the WHO's definition of overall health as *" a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity";* this means it is not just important to consider how to support people with mental health problems or disorders, but also how to promote and sustain good mental health in a population. This also highlights the intertwining of physical and mental wellbeing.

Aligned to WHO descriptions, the national mental health strategy *No Health without Mental Health*:- *"Good or positive mental health is more than the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities.".*

**Mental health problem -** This is an overarching term used to refer to a wide range of diagnosable mental illnesses and disorders, including common mental health problems of low severity and long lasting severe problems.

**Mental illness** - This is generally used to describe more serious mental health problems which may require specialist services, ranging from depression and anxiety (often referred to as common mental problems) to less common problems such as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness).

**Mental Disorder –** This is often used to cover a broad range of illnesses, learning disability, personality disorder and substance misuse problems. Under the 2003 Mental Health Act mental disorder was defined as *'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind*' and was divided into a number of classifications. The 2007 Mental Health Act amended to a more general statement and removed specific classifications.

**Wellbeing -** The concept of "*wellbeing*" has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. At a personal level wellbeing is *"a positive physical, social and mental state"* at a population, or national level, a range of indicators are being included, individual wellbeing but also the quality of the environment, equality, sustainability and the economy**.**

**POLICY CONTEXT**

In 2011 the Department of Health published the national mental health strategy *No Health without Mental Health*. This strategy sets out how the mental health and wellbeing of the whole population can be improved, and how outcomes for people with mental health problems could be improved. The report sets out six national objectives for mental health and wellbeing:-

1. **More people will have good mental health**
   *More people of all ages and backgrounds will have better wellbeing and good mental health, and fewer people will develop mental health problems- by starting well, developing well, working well, living well and ageing well.*
2. **More people with mental health problems will recover**
   *More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live;*
3. **More people with mental health problems will have good physical health**
   *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.*
4. **More people will have a positive experience of care and support**
   *Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure people's human rights are protected.*
5. **Fewer people will suffer avoidable harm**
   *People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service*
6. **Fewer people will experience stigma and discrimination**
   *Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.*

This is an all-age strategy, working across Government departments. The overall strategy was then followed by a plan to roll-out the comprehensive provision of talking therapies *Talking Therapies: a four year plan of action (2011).*

*Fair Society Health Lives (2010),* commonly referred to as The Marmot Review, examined the evidence relating to health inequalities. The report identified a clear social gradient in health, the lower a person's socio-economic status the poorer the health outcome, with people in the poorest neighbourhoods living, on average, seven years less than people in the wealthiest. A social gradient is evident in physical *and* mental health. While there are many interacting factors causing inequalities, the Marmot Review found that health inequalities are largely preventable and not only costly to the individual but also to society overall; estimating the annual cost of health inequalities to be in excess of £35 billion. In relation to mental health and wellbeing, the Marmot Review found:-

- Mental health, as well as physical health, is closely linked with inequalities; work which addresses inequalities will impact physical *and* mental wellbeing.
- Employment, good employment, is a protective factor. This is particularly true for people with mental health problems; who are at greater risk of being unemployed.
- Issues in childhood resonate throughout adulthood. The Marmot Review stressed the importance of early intervention, and identified this as a priority.

*Healthy Lives, Healthy People* (2010) the national public health strategy was published in 2010, responded to issues raised in the Marmot Review and outlined approaches to tackle inequalities and to support equity in service access and health outcomes. The strategy provides equal status to mental and physical health, noting similar drivers and risk groups, and states the benefits of tackling issues together not separately. In line with the Marmot Review findings the report concluded that there needed to be a greater focus on the root causes of ill health and that *"mental and physical health and wellbeing interact, and are affected by a wide range of influences throughout life."*

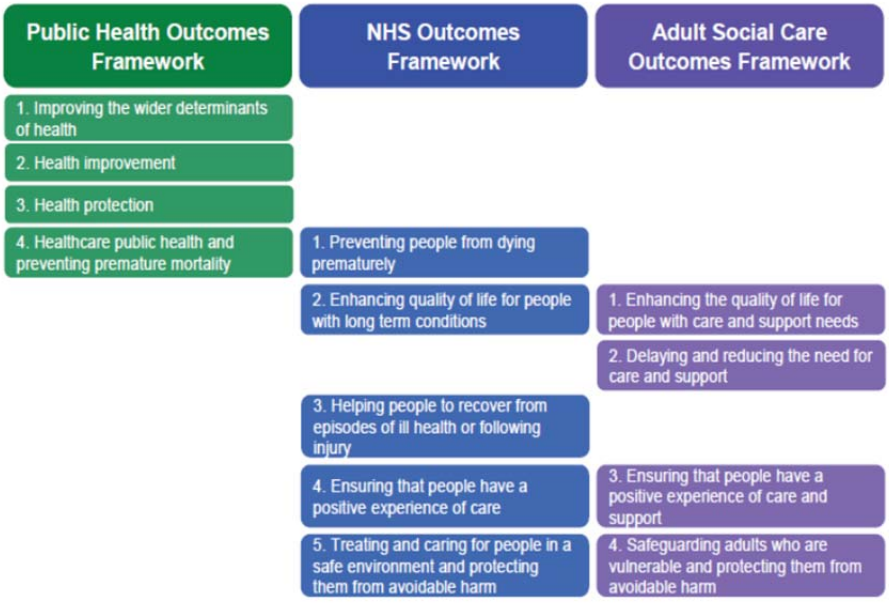
In 2012 a national cross government strategy *Preventing Suicide in England* was published, identifying action to reduce the number of suicides. This again emphasised the need to consider mental and physical health together, *"We have made it clear that mental and physical health have to be seen as equally important. For suicide prevention, this will mean effectively managing the mental health aspects, as well as any physical injuries, when people who have self-harmed come to A&E. It will also mean having an effective 24 hour response to mental health crises, as well as for physical health emergencies."*

**PUBLIC HEALTH, HEALTH AND SOCIAL CARE OUTCOME FRAMEWORKS**

Across all of the national health and social care strategies there is a strong focus on outcomes. In 2011 The Government reviewed all targets and indicators to "*re-focus the health and care system on people and the outcomes that matter most to them*" and move away from "*centralised top down targets and process measures*"; a shift away from measuring services to monitoring the outcomes for people and their carers/families.

There are three outcomes frameworks, the NHS Outcomes Framework (NHSOF), the Public Health Outcomes Framework (PHOF) and the Adult Social Care Outcomes Framework (ASCOF). These were reviewed and developed jointly to "form a three-way alliance, supporting the system to address challenges in an integrated way and providing a focus for quality improvement across the system. Each framework has a number of outcome indicators, which are reviewed annually, organised into themes or domains which set out the high level outcomes being aimed for, shown on Fig. 1 below

**Fig 1** Public Health, Health and Social Care Outcome Frameworks



## Outcome Indicators (2013/14)

Table 1 shows the outcomes relating to mental health from each of the frameworks, note not all domains include indicators which specifically reference mental health and some indicators are still in development.

*Current outcomes data relating to these indicators are shown in part 2 of the needs assessment*

Table 1 2013/14 Outcome Indicators - Specific to Mental Health

| Domain | Ref | Outcome |
|---|---|---|
| **Public Health Outcomes Framework** | | |
| 1. Improving the Wider Determinants of Health | 1.6 | People with mental illness and/or disability in Settled Accommodation |
| | 1.7 | People in Prison who have a mental health illness or significant mental illness. |
| | 1.8 | Employment for those with a long term condition including those with a learning disability or mental illness. |
| 2. Health Improvement | 2.1 | Hospital admissions as a result of self-harm |
| | 2.23 | Self-report well being |
| 4. Healthcare Public Health and Preventing Premature Mortality | 4.7 | Excess under 75 mortality in adults with a serious mental health illness |
| | 4.1 | Suicide |
| **NHS Outcomes Framework** | | |
| 1. Preventing People Dying Prematurely | 1.5 | Under 75 Mortality Rate for People with Serious Mental Illness |
| 2. Improving the Quality of Life for People with Long Term Conditions | 2.5 | Employment of people with mental illness |
| 3. Helping People to Recover from Episodes of Ill health or following injury | 3.1 | Improving outcomes for planned procedure – psychological therapies |
| 4. Ensuring that People have a Positive Experience of Care | 4.7 | Patient experience of community mental health services. |
| **Adult Social Care Outcomes Framework** | | |
| 1. Enhancing the quality of life for people with care and support needs | 1F | Proportion of adults in contact with secondary mental health services in paid employment |
| | 1H | Proportion of adults in contact with secondary mental health services living independently without the needs for support |

## RISKS AND RESILIENCE - FACTORS IMPACTING MENTAL HEALTH AND WELL BEING

Mental health is not just a function of an individual's characteristics or attributes, it is also affected by a wide range of social, economic and environmental factors. These have been summarised in Table 2 below.

- At an individual level people may be affected by biological or genetic factors or may have specific difficulties, for example communication difficulties, increasing vulnerability to mental health problems, by affecting their ability to engage, participate or understand aspects of daily living

- There are numerous socio-economic circumstances which impact mental health and wellbeing; the Marmot review highlighted the issue of employment and education; but specific events can also affect mental wellbeing including bereavement, family or relationship breakdown and exposure to violence or abuse. When considering a life course, people may be more exposed to risks at different ages; for example older people are more likely to experience bereavement of partners/friends and may become more socially isolated whereas younger adults may be more at risk of homelessness and unemployment.

Although this needs assessment is focussed on adults, it is recognised that experience in childhood is important and resilience in adulthood may relate to the experiences and skills developed in childhood.

- At a higher level wider factors such as basic access to services, economic recession or exposure to widespread violence or insecurity also impact mental health; these factors can be considered as the prevailing environment or conditions in which people live.

**Table 2** Risk Factors and Resilience
*(taken from Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors WHO 2012)*

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

**VULNERABLE GROUPS**

Understanding the range of factors outlined in Table 2 , it is possible to identify specific groups of people who have a greater risk or vulnerability to poor mental health , groups where we might expect to find greater levels of mental health need, including:-

- People with long term physical illness, conditions or disabilities;
- People with substance misuse problems;
- Deprived communities, people on low incomes;
- Unemployed and people on out of work illness and disability benefits;
- People with poor education outcomes, no qualifications and low skill;
- Military veterans and people affected by conflict and war;
- People affected by violence and/or abuse, including domestic violence;
- Homeless people and people at risk of homelessness;
- Offenders, young offenders, prisoners and detainees;
- People who have suffered bereavement, and/or family breakdown including “care leavers”;
- People who are socially excluded;
- People who experience barriers to accessing services and support.
- People from black and minority ethnic groups

Of course the relationship is complex, and risk factors may work both ways; so that people who are homeless may be at greater risk of poor mental health, and people who have mental health problems may be more at risk of being homeless.

*The epidemiology section of this report explores the nature (size, geography) of these vulnerable groups.*

Of course some people fall into numerous groups; for example many people rough sleeping on the streets have “tri-morbidity”, mental health problems and substance misuse problems and multiple long term health conditions or disabilities. And some vulnerabilities are complex, for example in relation to black and ethnic minority groups, rates of hospital admission and detention are far higher for people from Black African, Black Caribbean groups, and notably for young men; but there is low identification of some mental health problems amongst Asian women; and there is a high coincidence with ethnic background and many risk factors including deprivation, employment and social exclusion.

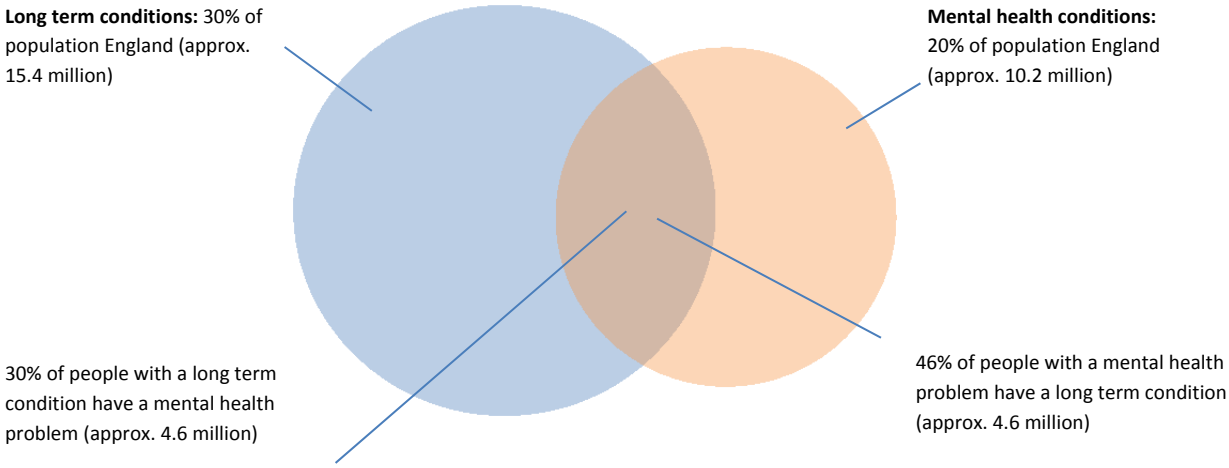
**RELATIONSHIP BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH**

There are strong links between physical and mental health outcomes. Research have identified that mental health problems are strongly associated with excess mortality, not just in relation to increased risk of suicide, but also excess mortality due to physical poor health, including cardiovascular disease and cancer.

The relationships and associations are complex, people with mental health problems are more likely to live in deprived, as are people who have long term physical health conditions; there is also reduced access to and take up of resources which act to protect or promote health in these areas. Also a physical health problem may lead to a mental health problem, and vice versa, for example depression and stress have been

identified as having a direct effect on the cardiovascular system and studies have identified that people with diabetes are two to three times more likely to have depression.

**Fig 2** Overlap Mental Health Problems / Long Term Conditions




*(Reproduced from: Long-term conditions and Mental Health The cost of co-morbidities Kings Fund ref)*

Not only is there an association between mental and physical health conditions, but this association is stronger where there are multiple long term conditions. A study of patients in Scotland found the probable prevalence of mental health problems amongst people with three or more long term physical health conditions was between 30-40%.

The co-existence of mental illness and long term conditions raises issues on how conditions are treated and managed in primary and secondary care. Research from Australia attributed 80% of excess mortality in people with mental illness to physical health problems, and that people with a mental illness were not benefitting to the same extent as the general population in advances in the management and treatment of long term conditions, so that the gaps in health outcomes were widening.

Co-morbidity also impacts the treatment and management costs of long term conditions. Analysis by the Kings Fund has estimated that between 12% to 18% of expenditure on long term conditions is related to poor mental health.

## INFORMATION AND RECOMMENDATIONS FROM RECENT HEALTH NEEDS ASSESSMENTS IN WEST SUSSEX

There have been a number of health needs assessments which have included mental health issues. These are summarised below:

### MILITARY VETERANS (2012)

*A full copy of this needs assessment is available on the West Sussex JSNA website.*

A comprehensive Health Needs Assessment of military veterans in Sussex was produced in 2012; this was undertaken jointly with East Sussex and Brighton and Hove Public Health departments.

In relation to mental health needs:-

- The commonest mental health conditions of military veterans are depression and anxiety, the same as the general population;
- Alcohol misuse much more frequent than general population
- PTSD was overall low amongst veterans but higher for specific groups- including reservists, especially those who have been in combat zones, and amputees
- Young male veterans were a notably vulnerable group – younger veterans were more likely to be from lower ranks and had an increased risk of mental health problems and suicide. Many younger veterans leave after only a few years and may have entered service with problems.

*RECOMMENDATION(S)*

The Needs Assessment recommended that provision in Sussex should be delivered in line with the recommendation of the Murrison report on mental health services for veterans and that, the balance of regular to reservist personnel changes, the access to support for veterans who served in reserve forces should be assessed.

### GYPSIES AND TRAVELLERS (2010)

### Health and social care needs of Gypsies and Travellers in West Sussex (2010)

*A full copy of this needs assessment is available on the West Sussex JSNA website.*

In 2010, as part of the West Sussex JSNA health and social care needs assessment of gypsies and travellers in West Sussex was commissioned from a research consultancy OPM. A review of national research and evidence was undertaken alongside local engagement with gypsies and travellers and traveller organisations.

Research identified that gypsies and travellers were over twice as likely to be depressed, and almost three times as likely to suffer from anxiety, as others; experienced poorer mental health, even compared with other socially deprived groups or other ethnic minorities. Women were more likely than men to have experienced mental health problems. An[1] EHRC report speculated that the stresses caused by accommodation problems, unemployment, racism and discrimination by services and from the public, and bereavement, may all be contributory factors.

The EHRC report says "for women, long-term mental health difficulties can result from feeling trapped on a site where no-one would want to live." However, moving into a house is also associated with depression

[1] Sarah Cemlyn, Margaret Greenfields, Sally Burnett, Zoe Matthews and Chris Whitwell, Inequalities experienced by Gypsy and Traveller communities: A review, EHRC Research Report 12, Equality and Human Rights Commission, 2009

and anxiety for many Gypsies and Travellers, and may be a result of isolation, loss of community and experiences of discrimination.

Mental health was a major theme in the local interviewing for the needs assessment. Several people reported severe and chronic mental health difficulties including depression, anxiety, paranoia, and possible bipolar disorder. Several also told us of family members with mental health problems. Many people made direct links between their current living and accommodation arrangements, and their mental health. Others – including those who were not experiencing poor mental health themselves - described the many stresses and uncertainties associated with travelling, and acknowledged the likelihood that this would impact on mental health.

In addition to accommodation and living arrangements, and the pressures associated with travelling, there appear to be a myriad of further issues that contribute to poor mental health amongst Gypsies and Travellers, including social isolation, the experience of racism and discrimination, domestic abuse, and frustration and a feeling of 'having no control' over one's life or living situation63. Interestingly, none of the people we interviewed cited poverty, debt or financial difficulties as factors affecting their mental health.

For most people, their GP had been the starting point for seeking treatment and support for mental health problems. Some were taking medication, and some had been referred to see mental health support workers or counsellors.

Despite a surprising degree of openness with the researchers, there remains a great deal of fear of mental illness, and of mental health services within the Gypsy and Traveller community. The adult family of a woman who suffered from depression and anxiety and had had "a breakdown" told us that she had been afraid that if she spoke to anyone about it, she would be "locked up". Before her own breakdown, this woman's children told us that their mother's attitude to mental health problems was that you should "pull yourself out of it", and her lack of understanding had contributed to her fear of engaging with mental health services once her own problems emerged.

*RECOMMENDATION(S)*

Of the recommendations in the report a specific issues of the mental health of travellers in settled accommodation was made:-

“NHS West Sussex should work in partnership with NHS trusts, primary care providers, housing authorities, and relevant voluntary sector organisations involved in health, welfare, advocacy and support for Gypsies and Travellers to address the needs of Gypsies and Travellers in settled housing, with particular focus on emotional and mental health needs.

This should include, for example, commissioning mental health outreach and support targeted at the Gypsy and Traveller community, and delivered by staff who have deep understanding and insight into Gypsy and Traveller culture and health needs, and appropriate training. NHS West Sussex and West Sussex County Council should work with the district and borough councils and housing associations to ensure that staff in local authority housing services and in housing associations receive cultural awareness training and understand the cultural, health, housing and other needs of Gypsies and Travellers.”

## PEOPLE HELD IN IMMIGRATION DETENTION CENTRES AND PRE-DEPARTURE ACCOMMODATION (2012)

*A full copy of this needs assessment is available via the West Sussex JSNA website.*

A health needs assessment of people held in Immigration Detention Centres and Pre-Departure Accommodation (based around Gatwick in West Sussex) was undertaken in July 2012. This needs assessment was undertaken by the Institute for Criminal Policy Research.

As part of this assessment national and local evidence was reviewed and detainees and staff interviewed. In relation to mental health evidence was examined in relation to prevalence of mental health problems amongst asylum seekers, the proportion of detainees with experience of torture who may be vulnerable to Post Traumatic Stress Disorder, the impact of detention on detainees' mental health and concerns about the mental health of children in detention.

*Mental health problems amongst asylum seekers*

- Mental health identified as a significant problem for migrant populations with particular vulnerabilities among asylum seekers and refugees.
- Higher incidence suicide and self-harm among asylum seekers in the UK – both those in detention and the community.

*Post Traumatic Stress Disorder (PTSD)*

- Research identified which raised the issue of detainees with evidence of torture and PTSD who are referred for help but who may not receive it.

*Impact of detention*

Only a small number of studies were identified which had examined the impact of detention on mental health. An Australian study identified that people detained for 24 months or more had particularly poor health, both mental and physical and that the proportion of people with at least one mental health diagnosis was related to time spent in detention. The estimated proportion of those with a new mental health diagnosis during the year varied from <1% in the group detained for less than three months to >27% of those in detention for longer than 24 months.

## ADULTS WITH AUTISM (2013)

*A full copy of this needs assessment is available on the West Sussex JSNA website.*

In relation to co-existing conditions (including mental health problems) the following recommendations were noted:

I. Care pathways in relation to co-existing conditions need to ensure autism is addressed and, where required, services are adapted.

II. Staff employed in mental health, learning disability and epilepsy services are trained in relation to autism.

In addition to needs assessments, there are a number of existing recommendations from service reviews.

### QUALITY CHECK OF MENTAL HEALTH SERVICES FOR ADULTS WITH ASPERGER'S SYNDROME AND HIGH FUNCTIONING AUTISM (NOVEMBER 2013)

*A quality check was commissioned by West Sussex County Council under their Autism Framework and Plan: 2012-2015, to monitor the appropriateness of the Mental Health Services being offered to people with Asperger's Syndrome and Higher Functioning Autism in West Sussex.*

The organisation *Impact Initiatives* worked in conjunction with members of Asperger's Voice Self-Advocacy Group and the West Sussex Asperger's Awareness Group, recommendations were made (below) based on the views of autistic users, carers, Sussex Partnership NHS Foundation Trust staff and Sussex Community NHS Trust / Time to Talk.

*RECOMMENDATIONS*

**Improved Autistic Spectrum Condition (ASC) Training for Mental Health Professionals**

ASC training could be improved in the following ways:

1. All staff in mental health services should have ASC awareness training as part of their induction, so that they are able to refer Users to the ASCs for diagnosis;
2. Users with an ASC whom have had experience of the mental health services should be involved in delivering the training;
3. Training should focus on adapting existing practices to meet the needs of people with an ASC; and
4. Training should include the role that Carers play in the treatment of someone with an ASC, more specifically their communication difficulties.

**Increased Awareness of the Services on Offer to People with an ASC**

5. Better communication links should be established between the Autism Spectrum Conditions Service (ASC) and Time To Talk;
6. Time to Talk should be represented at the Autism Planning Group;
7. More communication should be made between the ASCS, the SPT and Time to Talk, in order to share information on the services currently available to people with an ASC, as a means of providing on-going support; and
8. The SPT and Time to Talk should keep statistics about how many Users they encounter with an ASC.

**Specialised Mental Health Services for Users with an ASC**

9. Each mental health team should have an ASC Specialist who regularly corresponds with the ASCS in order to ascertain current best practice on working with Users on the spectrum. This person can then share their knowledge about ASCs with the rest of their team, facilitating the adaptation of therapy to suit Users with an ASC; and
10. When mental health symptoms arise from having an ASC, e.g., anxiety, the mental health services on offer should focus on the improvement of coping strategies, rather than recovery.

### REVIEW OF SELF-DIRECTED SUPPORT IN MENTAL HEALTH

*A review was undertaken by the mental health commissioning team in 2012/13.*

The recommendations are outlined below:

*RECOMMENDATIONS FROM THE 2012/13 SERVICE REVIEW*

1. Review of the current Resource Allocation System (RAS) for MH customers. A further issue is the disparity between the Older Persons RAS, which causes issues during the transition from under 65 to over 65.
2. For use of Direct Payments to be more flexible.

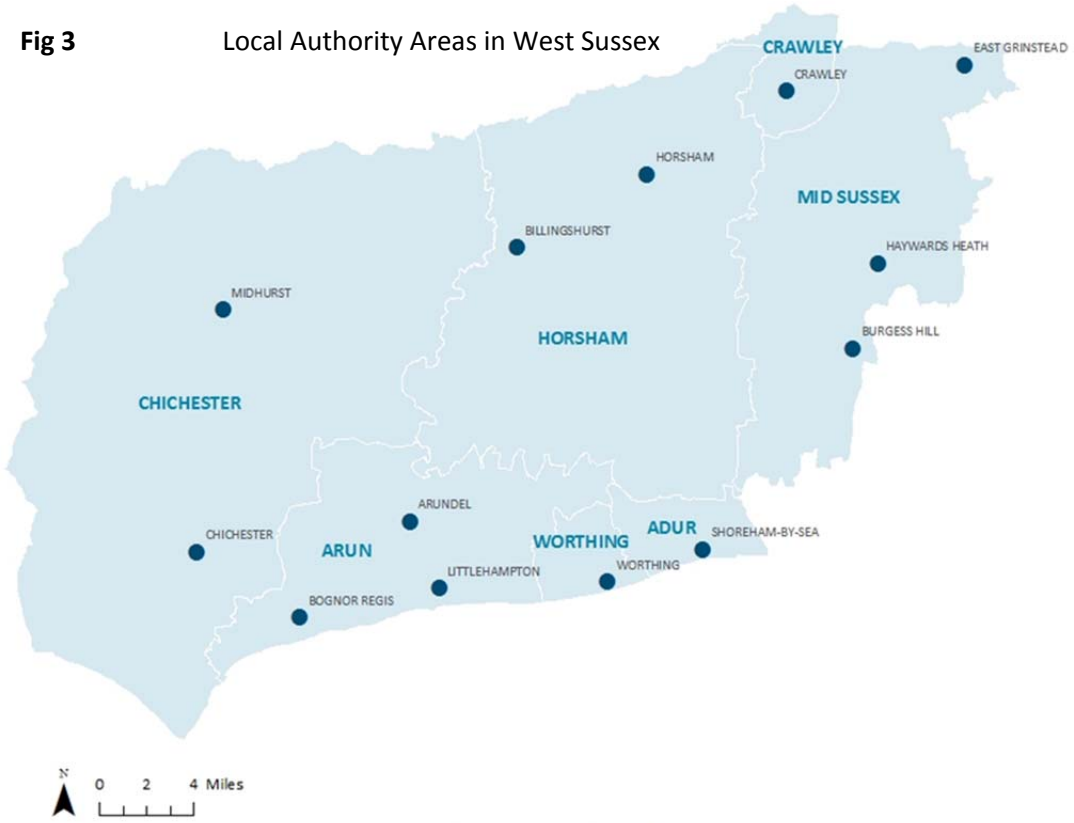
3. To look at different options/models around provision of care commissioning – Including looking at people with lived experience being involved. Could be a separate service would support individuals who meet social care eligibility by completing the necessary documentation, SoSA and support plan, exploring options and then negotiating with providers on the customers behalf in order to maximise the funding available to deliver the best possible outcomes. Alternatively could be a separate function sitting within existing teams (similar to current vocational support service provided by Southdown Housing).
4. Look at options around implementing individual service funds. This is where the customer's allocated RAS is held by a provider in order that they can deliver a service which is appropriate and personalised.
5. Introduce a more streamlined process so that paperwork is reduced, duplication is avoided and mental health practitioners can spend more time with service users rather than filling in forms.
6. Review the social care workforce in adult mental health services.
7. Strengthen the link between the supported employment and self-directed support pathways. This would enable service users who wanted to get into/back into paid employment more timely access to specialist support and ensure self-directed support is contributing to meeting needs around work.

## SECTION 2 EPIDEMIOLOGY

## POPULATION CHARACTERISTICS

West Sussex is a large county covering some 770 square miles, and is comprised as a coastal strip with a series of medium size coastal towns (Shoreham, Worthing, Littlehampton, Bognor), small to medium size tows in relatively rural areas (Petworth, Midhurst, Storrington, Burgess Hill, Arundel) and large town centres (Chichester, Crawley, Horsham, Haywards Heath). This needs assessment covers a geographical area containing seven Local Authorities and three Clinical Commissioning Groups.

**Fig 3** Local Authority Areas in West Sussex






Map produced by J Clay West Sussex Research Unit (Public Health)

There are approximately 808,900 people resident in West Sussex, 495,700 aged 16-64 and 168,100 aged 65 years or over.

**Table 3** Population by Local Authority Areas 2011

| Area | Total | Age Groups | | | |
|---|---|---|---|---|---|
| | | 0 - 15 | 16 - 64 | 65 & over | 18 - 24 |
| West Sussex | 808,900 | 145,200 | 495,700 | 168,100 | 58,700 |
| Adur | 61,300 | 10,600 | 37,200 | 13,600 | 4,300 |
| Arun | 149,800 | 23,400 | 86,800 | 39,600 | 10,600 |
| Chichester | 114,000 | 18,600 | 67,300 | 28,100 | 9,100 |
| Crawley | 107,100 | 22,200 | 71,300 | 13,600 | 9,100 |
| Horsham | 131,500 | 24,500 | 81,100 | 25,900 | 8,500 |
| Mid Sussex | 140,200 | 27,100 | 87,500 | 25,600 | 9,300 |
| Worthing | 105,000 | 18,700 | 64,500 | 21,800 | 7,800 |

**Source :** ONS Mid-Year Estimates 2011

**Fig 4** Clinical Commissioning Group Geographies in West Sussex

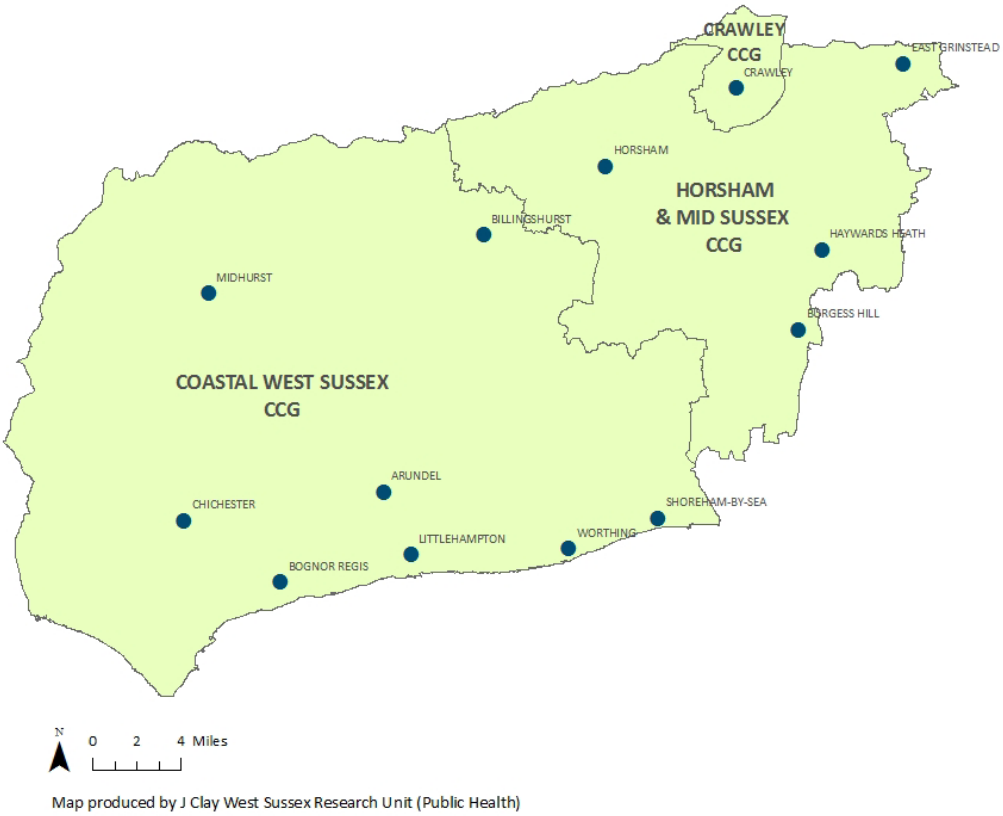



**Table 4** Population (Resident and Registered Patients) by CCG Area

| *Resident Population* | Total | Specific Age Groupings | | | |
|---|---|---|---|---|---|
| | | 0 - 15 | 16 - 64 | 65 & over | 18 - 24 |
| West Sussex | 808,900 | 145,200 | 495,700 | 168,100 | 58,700 |
| Coastal CCG | 480,030 | 79,910 | 284,950 | 115,180 | 34,720 |
| Crawley CCG | 107,050 | 22,190 | 71,300 | 13,560 | 9,250 |
| Horsham & Mid Sussex CCG | 221,830 | 42,840 | 139,680 | 39,310 | 15,630 |
| *Registered PATIENT Population* | Total | Specific Age Groupings | | | |
| | | 0 – 15 | 16 – 64 | 65 & over | 18 - 24 |
| Coastal CCG | 490,935 | 79,913 | 291,129 | 119,893 | 58,606 |
| Crawley CCG | 127,072 | 25,506 | 84,730 | 16,836 | 18,012 |
| Horsham & Mid Sussex CCG | 227,203 | 42,214 | 142,199 | 42,790 | 27,681 |

**Source:** *Resident* population – ONS MYE 2011, Registered *Patient* Population Exeter 2013

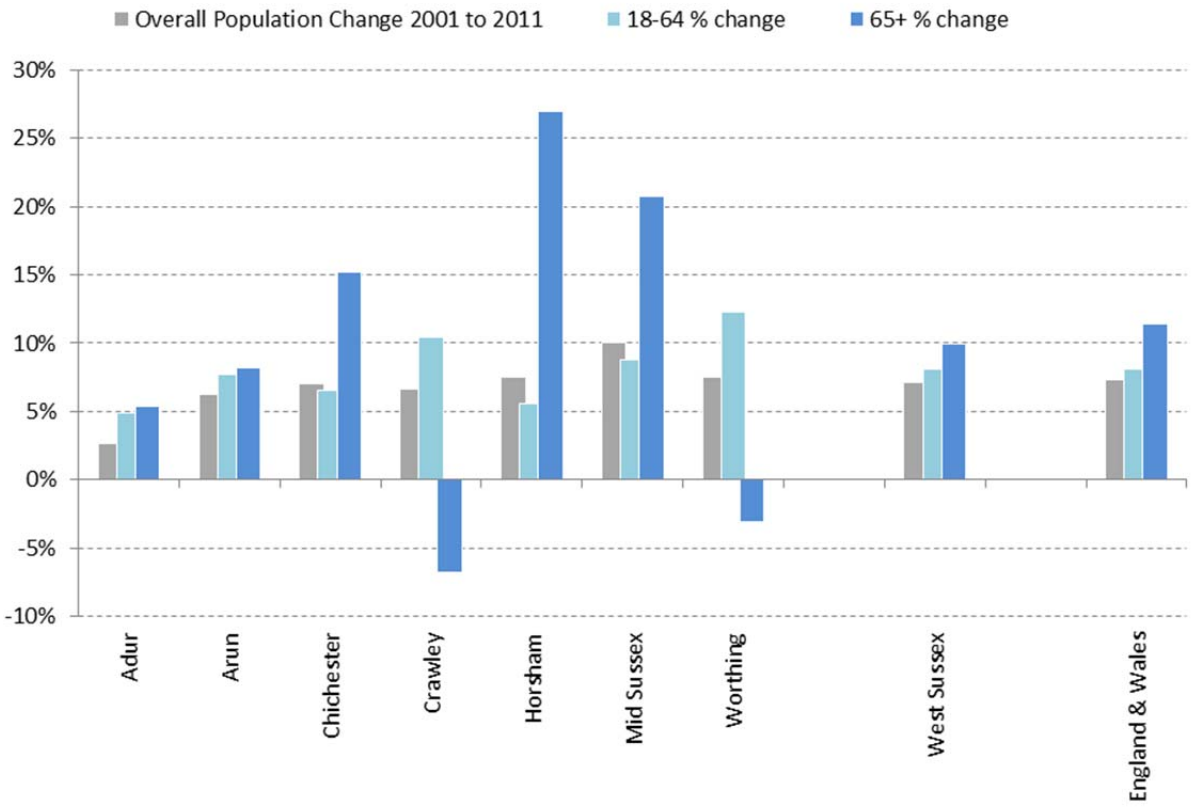
Overall there has been a 7% increase in population in West Sussex since 2001, with a 9% increase in 65+ year olds; there are considerable differences across the county, as shown in Table 5 and Figure 5 below. In Horsham and Mid Sussex there have been 27% and 21% increase in the number of people aged 65+, whereas in Crawley and Worthing there have been large increases in the number of 18-64 year olds (10.5% and 12.7% respectively). The differences in local population age structures need to be understood in the planning and delivery of services.

**Table 5** Population Change 1981 to 2011

| | People aged 18 - 64 years | | | |
|---|---|---|---|---|
| | 1981 | 1991 | 2001 | 2011 |
| Adur | 32,740 | 33,460 | 34,160 | 35,840 |
| Arun | 60,680 | 69,960 | 77,700 | 83,660 |
| Chichester | 55,460 | 58,340 | 60,700 | 64,700 |
| Crawley | 52,780 | 55,500 | 62,300 | 68,820 |
| Horsham | 58,400 | 66,460 | 73,900 | 78,000 |
| Mid Sussex | 68,920 | 76,020 | 77,620 | 84,400 |
| Worthing | 45,600 | 52,560 | 55,360 | 62,180 |
| West Sussex | 374,540 | 412,300 | 441,740 | 477,360 |
| | Total Population | | | |
| | 1981 | 1991 | 2001 | 2011 |
| Adur | 58,600 | 58,500 | 59,700 | 61,300 |
| Arun | 118,600 | 130,500 | 141,000 | 149,800 |
| Chichester | 98,800 | 101,800 | 106,500 | 114,000 |
| Crawley | 82,100 | 88,300 | 100,400 | 107,100 |
| Horsham | 100,400 | 109,700 | 122,300 | 131,500 |
| Mid Sussex | 117,300 | 124,000 | 127,400 | 140,200 |
| Worthing | 92,500 | 97,200 | 97,700 | 105,000 |
| West Sussex | 668,300 | 710,000 | 755,000 | 808,900 |

**Source:** ONS Mid-Year Estimates 2011

**Fig 5** Age Group Changes Change 2001 to 2011



## Projected Change in Population

**NOTE:** The projections included in this report show projected population change to 2021. These are Sub National Population Projections (SNPP) produced by ONS in 2013. These are not constrained in relation to housing provision and will be revised when detailed Census 2011 is released in the autumn of 2013.

Projections provided by ONS are currently available by local authority geographies. The figures below have been estimated at CCG level, using these ONS projections, by the West Sussex Public Health Research Unit.

**All projections should be treated with caution and the current ONS projections will be revised in 2014 incorporating data from the 2011 Census.**

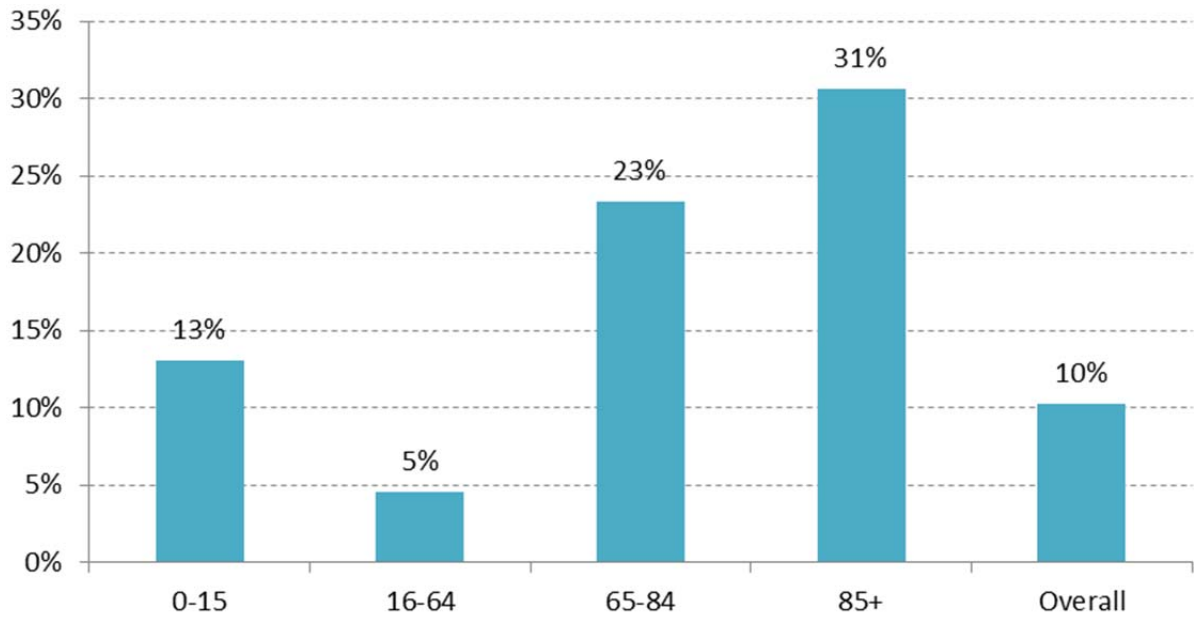
### West Sussex Level Projections

Current population projections for West Sussex, are estimating an overall population increase of 10% over the next ten years, but with higher percentage increases in 65-84 years olds and 85+ year olds.

**Table 6** Population 2011 (MYE) and 2021 Projected
*Figures rounded to the nearest 100.*

| Age Group | 2011 (MYE) | 2021 Projection | % Change |
|---|---|---|---|
| 0-15 | 144,900 | 163,800 | 13.0% |
| 16-64 | 495,900 | 518,700 | 4.6% |
| 65-84 | 141,100 | 174,100 | 23.4% |
| 85+ | 26,900 | 35,200 | 30.6% |
| Overall | 808,900 | 891,800 | 10.3% |

**Fig 6** Projected % Change 2011 to 2021



## Coastal CCG Projections

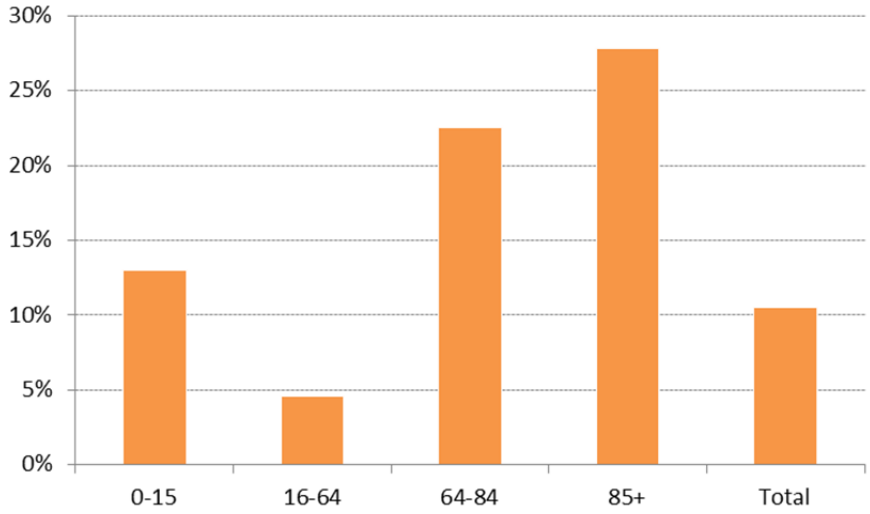
Current population projections for West Sussex, are estimating an overall population increase of 10% over the next ten years, but with higher percentage increases in 65-84 years olds and 85+ year olds.

**Table 7** Population 2011 (MYE) and 2021 Projected

*Figures rounded to the nearest 100.*

| Age Group | 2011 (MYE) | 2021 Projection | % Change |
|---|---|---|---|
| 0-15 | 79,900 | 90,300 | 13.0% |
| 16-64 | 284,960 | 297,930 | 4.6% |
| 65-84 | 96,270 | 117,980 | 22.6% |
| 85+ | 18,920 | 24,180 | 27.8% |
| Overall | 480,050 | 530,390 | 10.5% |

**Fig 7** Projected % Change 2011 to 2021 – COASTAL WEST SUSSEX CCG




## Crawley CCG Projections

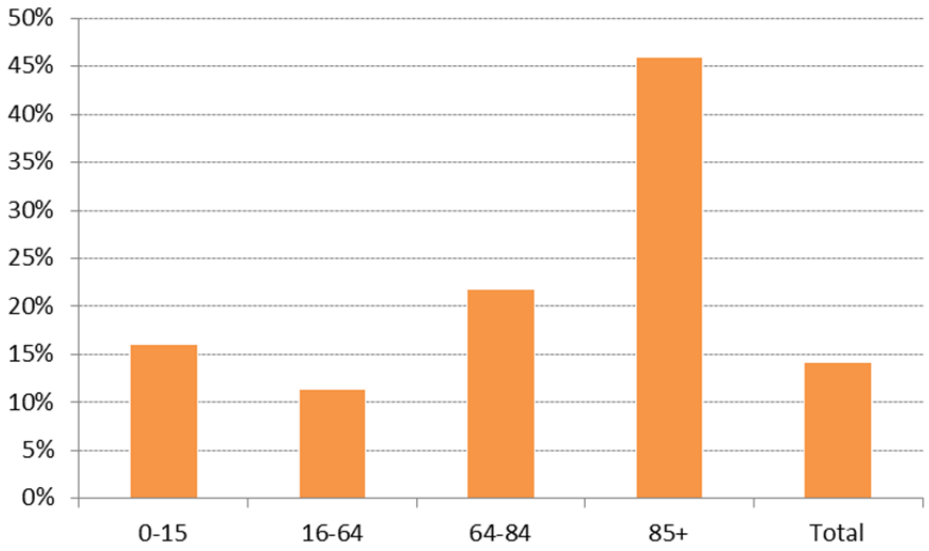
Current population projections for West Sussex, are estimating an overall population increase of 14% over the next ten years, but with higher percentage increases in 65-84 years olds and 85+ year olds.

**Table 8** Population 2011 (MYE) and 2021 Projected

*Figures rounded to the nearest 100.*

| Age Group | 2011 (MYE) | 2021 Projection | % Change |
|---|---|---|---|
| 0-15 | 22,200 | 25,750 | 16.0% |
| 16-64 | 71,300 | 79,450 | 11.4% |
| 65-84 | 11,500 | 14,010 | 21.8% |
| 85+ | 2,070 | 3,020 | 45.9% |
| Overall | 107,070 | 122,230 | 14.2% |

**Fig 8** Projected % Change 2011 to 2021 – CRAWLEY CCG




**Horsham and Mid Sussex CCG Projections**

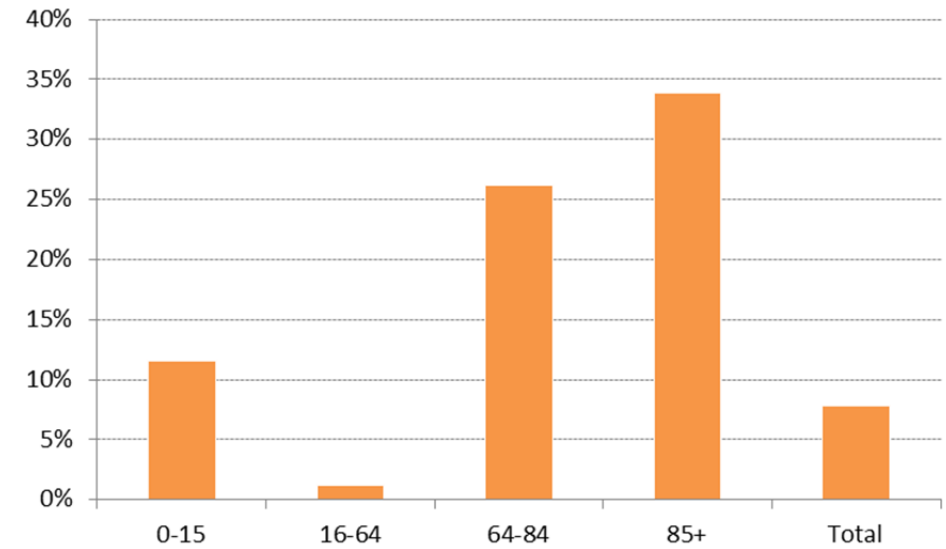
Current population projections for West Sussex, are estimating an overall population increase of 10% over the next ten years, but with higher percentage increases in 65-84 years olds and 85+ year olds.

**Table 9** Population 2011 (MYE) and 2021 Projected

*Figures rounded to the nearest 100.*

| Age Group | 2011 (MYE) | 2021 Projection | % Change |
|---|---|---|---|
| 0-15 | 42,850 | 47,810 | 11.6% |
| 16-64 | 139,690 | 141,370 | 1.2% |
| 65-84 | 33,390 | 42,140 | 26.2% |
| 85+ | 5,930 | 7,940 | 33.9% |
| Overall | 221,860 | 239,260 | 7.8% |

**Fig 9** Projected % Change 2011 to 2021 – HORSHAM AND MID SUSSEX CCG



**DEPRIVATION**

*Deprived areas have higher rates of poor mental health, higher admission rates to hospital and higher recorded prevalence of patients on the serious mental health register.*

There are two main sources of information relating to the level of deprivation experienced by people within specific areas or neighbourhoods, DCLG rankings (Indices of Deprivation 2010) and data collated from the decennial census.

**The Indices of Deprivation** is produced every 3-4 years and published by the DCLG; it ranks each small area of England and Wales in terms of deprivation and its findings are incorporated into many Government allocation formulae. The latest indices were published in 2010.

Using information from ID2010, West Sussex is a relatively affluent county however county level data masks considerable differences within areas and there are some very deprived neighbourhoods. In 2010 West Sussex ranked 130th out of 152 upper-tier authorities on the Indices of Deprivation; in 2007 West Sussex ranked 132nd. West Sussex may have become relatively more deprived although the change may not be significant. In relation to neighbouring authorities, West Sussex is relatively less deprived than East Sussex (ranked 90th) and Brighton and Hove (ranked 53rd); more deprived than Hampshire (ranked 141st) and Surrey (ranked 150th).

**Table 10** Ranking of West Sussex and neighbouring Upper Tier Authorities ID2010
*(Ranking out of 326 LAs. The most deprived LA is ranked 1)*

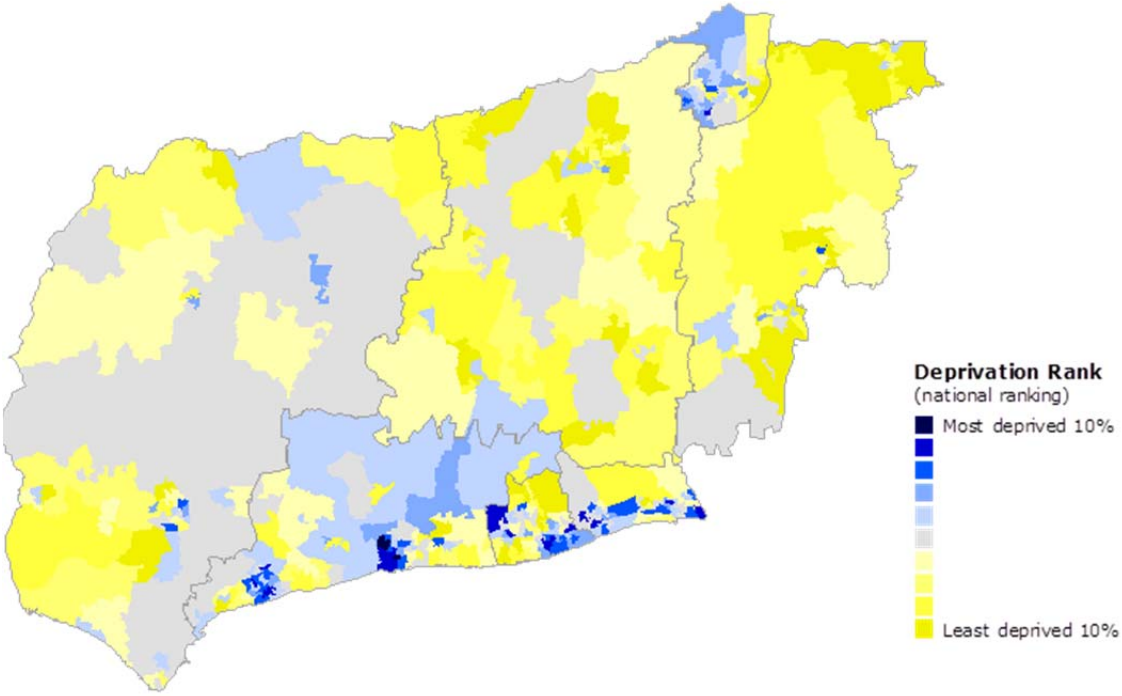
| | Rank 2004 | Rank 2007 | Rank 2010 |
|---|---|---|---|
| West Sussex | 135 | 132 | 130 |
| Brighton and Hove | 62 | 59 | 53 |
| East Sussex | 103 | 95 | 90 |
| Hampshire | 142 | 141 | 141 |
| Surrey | 150 | 150 | 150 |

Source: DCLG

The most deprived lower-tier authority in West Sussex is Adur (ranked 145th out of 326 local authorities), the least deprived Mid Sussex (ranked 315th). In relation to "neighbourhood level" deprivation, West Sussex has three small areas (within River and Ham wards in Littlehampton) falling in the 10% most deprived areas in England. At *ward* level River and Ham wards are within the most deprived 10% in England, a further seven wards are within the most deprived 20% in England . Decline in coastal areas, such as Littlehampton, is in line with the wider national picture of coastal decline, for example areas such as Eastbourne and Hastings and coastal resorts in Kent becoming more deprived.

**Fig 10** Overall Deprivation in West Sussex

- This maps shades small areas according to their relative deprivation ranking.
- The most deprived areas are shaded dark blue, and the least deprived shaded dark yellow.
- The darkest blue shading represents areas within the most deprived 10% in England.




In relation to Lower Super Output Areas the following were in the most 10% (dark blue shaded) and 20% deprived (light blue) of all LSOAs in England

**Table 11** Most Deprived Neighbourhoods In West Sussex

| LSOA | District | Ward | IMD National Overall Ranking (out of 324 |
|---|---|---|---|
| E01031427 | Arun | Ham | 1,764 |
| E01031456 | Arun | River | 2,616 |
| E01031429 | Arun | Ham | 2,783 |
| E01031454 | Arun | River | 3,270 |
| E01031819 | Worthing | Northbrook | 3,650 |
| E01031404 | Arun | Bersted | 3,704 |
| E01031779 | Worthing | Broadwater | 3,753 |
| E01031808 | Worthing | Heene | 3,812 |
| E01031790 | Worthing | Central | 4,023 |
| E01031436 | Arun | Marine | 4,120 |
| E01031432 | Arun | Hotham | 4,507 |
| E01031558 | Crawley | Broadfield South | 4,553 |
| E01031450 | Arun | Pevensey | 5,018 |
| E01031371 | Adur | Southlands | 5,399 |
| E01031348 | Adur | Eastbrook | 5,627 |
| E01031811 | Worthing | Heene | 5,952 |
| E01031341 | Adur | Churchill | 6,047 |
| E01031361 | Adur | Peverel | 6,274 |
| E01031783 | Worthing | Castle | 6,437 |

**DEPRIVATION INFORMATION FROM THE 2011 CENSUS**

The 2011 census collected a wide variety of information which can, in combination, be used to identify some of the characteristics common to deprived households. Census data are available at smaller geographies than the ID2010, down to output areas level (covering approximately 100 households); this is useful in West Sussex as in some areas deprivation is concentrated in small neighbourhoods, where affluence and deprivation are "cheek by jowl".

The census examines four dimension of deprivation:-

- Employment *(deprivation identified where any member of a household not a full-time student is either unemployed or long-term sick).*
- Education *(deprivation identified where no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student)*
- Health and disability *(deprivation identified where any person in the household has general health 'bad or very bad' or has a long term health problem).*
- Household overcrowding *(deprivation identified when the household accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.)*

Information is provided where households have none of the above, and where households "score" on one, two, three or score on all dimensions of deprivation.

The two maps below show areas which have households which have at least one measures of deprivation and the second map shows the percentage of households which have 3 or 4 measures of deprivation. Using the census 2011 groupings these represent the most deprived areas in the county.

**Fig 11a)**
**Households with At Least One Deprivation Measure**
*Source: Census 2011*

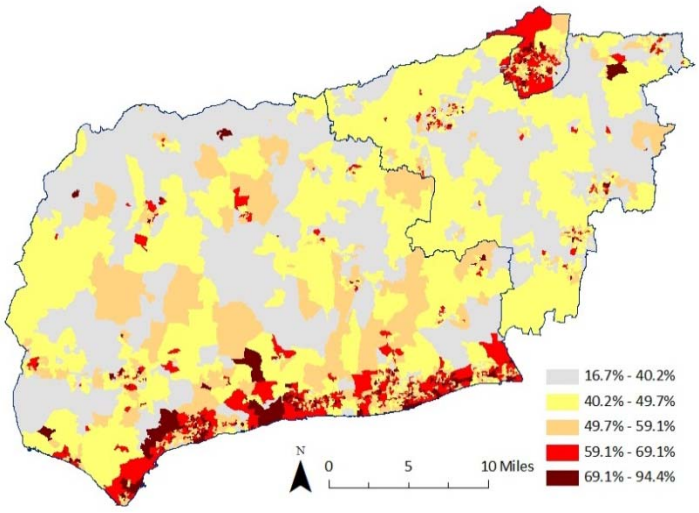
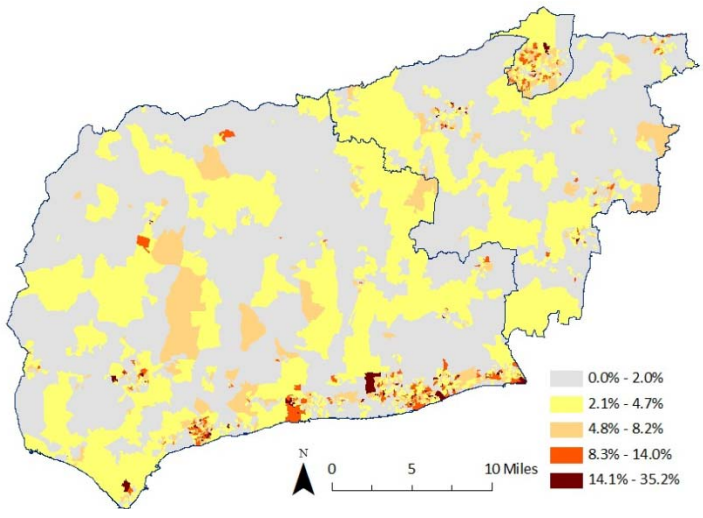


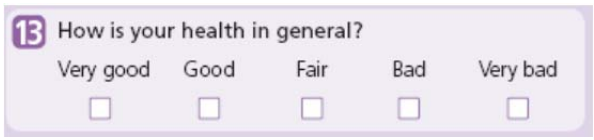

**Fig 11b)**
**Households with 3 or 4 Measures of Deprivation**
*Source: Census 2011*

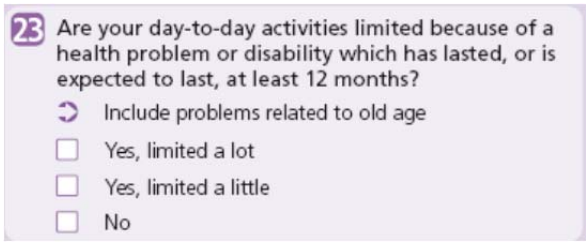


**POPULATION LEVEL HEALTH – DATA FROM THE 2011**

*There are strong links between physical and mental health. Population level data on health is provided by the census.*

The 2011 Census included two specific questions relating to health and long term limiting illness.




**General Health**

Across West Sussex as a whole, almost 34,000 people stated "bad or very bad" health, 4.3% of the population, compared with 5.4% of the England and Wales population. Clearly the health questions used in the census are aged related, 18.5% of the 85+ population stated poor health compared with 5.8% of the 50-64 year olds.

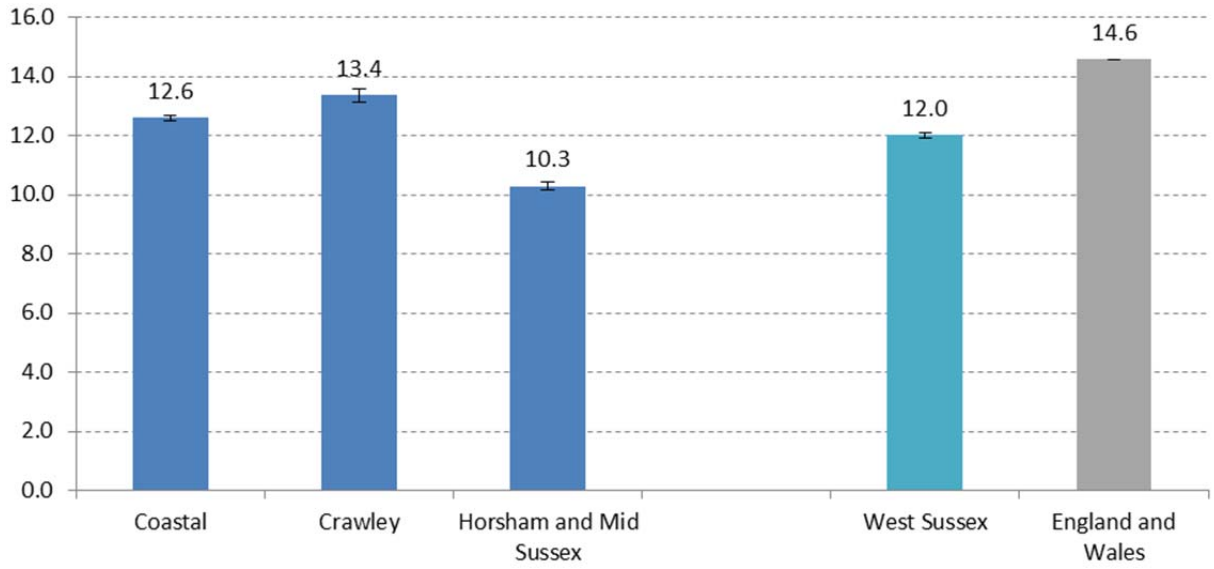
**Table 12** People Who Stated "Bad" or "Very Bad" General health
*(note this table excludes people who live in communal establishments)*

| | All ages | 0 to 15 | 16 to 24 | 25 to 34 | 35 to 49 | 50 to 64 | 65 to 74 | 75 to 84 | 85 and over |
|---|---|---|---|---|---|---|---|---|---|
| Coastal West Sussex | 22,300 | 450 | 450 | 850 | 3,400 | 5,850 | 4,150 | 4,400 | 2,800 |
| Crawley | 4,550 | 100 | 100 | 300 | 850 | 1,400 | 600 | 800 | 450 |
| Horsham & Mid Sussex | 6,850 | 200 | 150 | 300 | 1,100 | 1,850 | 1,100 | 1,350 | 800 |
| West Sussex | 33,750 | 750 | 700 | 1,450 | 5,300 | 9,100 | 5,900 | 6,500 | 4,050 |
| % in bad or very bad health | All ages | 0 to 15 | 16 to 24 | 25 to 34 | 35 to 49 | 50 to 64 | 65 to 74 | 75 to 84 | 85 and over |
| Coastal West Sussex | 4.8% | 0.6% | 1.0% | 1.8% | 3.5% | 6.2% | 7.5% | 11.5% | 18.2% |
| Crawley | 4.3% | 0.5% | 0.9% | 1.7% | 3.6% | 8.1% | 9.6% | 15.8% | 25.0% |
| Horsham & Mid Sussex | 3.2% | 0.5% | 0.8% | 1.2% | 2.2% | 4.2% | 5.6% | 10.5% | 16.8% |
| West Sussex | 4.3% | 0.5% | 0.9% | 1.6% | 3.1% | 5.8% | 7.3% | 11.6% | 18.5% |
| *England and Wales* | *5.4%* | *0.6%* | *1.1%* | *1.9%* | *4.3%* | *8.9%* | *11.5%* | *16.8%* | *23.6%* |

**Day-to-Day Activities Limited**

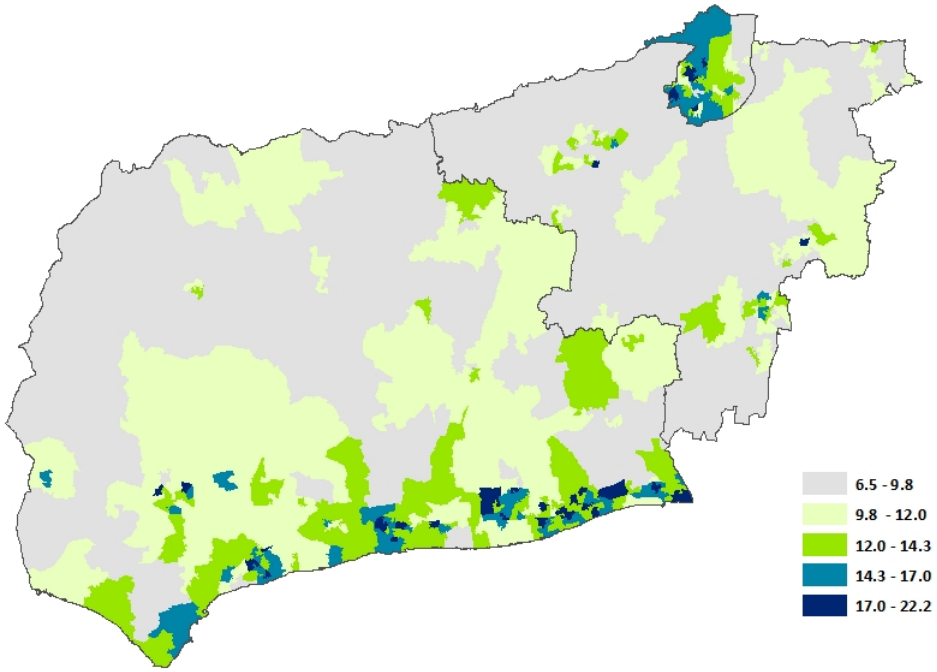
To take into account the differing age structure, data from the census have been age standardised, at CCG level Crawley has a significantly higher rate of people with a disability or long term health condition which impacts their daily living than Coastal or Horsham and Mid Sussex.

**Fig 12** Limiting Long Term Illness
*Source : Census 2011*
*(broad age ranges used and people living in communal establishments excluded)*




As with deprivation there are marked differences within the county, and a similar patterns is evident with the census question on health and disability. The map below shows the age standardised rate (per 100 population) at neighbourhood level (lower super output area). The areas shaded dark blue have up to 1 in 5 people with a limiting long term disability or health condition.

**Fig 13** Residents with a health condition or disability limiting day-to-day activities (a little or a lot)
*Standardised Rate (Per 100 Population)*
*Note: Excludes People Living in Communal Establishments, Broad Age Groups*



The claimant rate has increased in recent years, the impact of the 2008 recession clear on the graph below, claimant rates in the most deprived neighbourhoods increased at a greater rate and remain higher than the

**Fig 14** JSA Claimant Rate by West Sussex CCG area
Quarterly Data Feb 2004 to Aug 2013
*Source: Nome's*

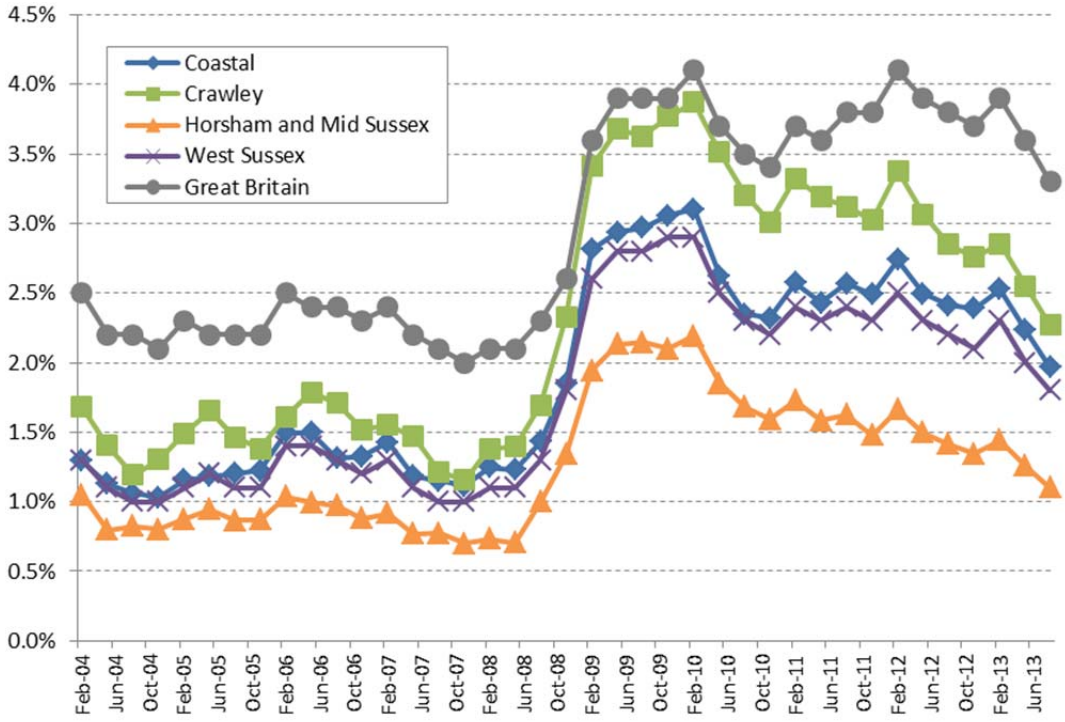



**Table 13** Disability Living Allowance by Disabling Condition (Mental Health Conditions Selected) February 2013 (All Ages)

| Condition | Total number of people in receipt of DLA | Psychosis | Psycho-neurosis | Personality Disorder | Dementia | Behavioural Disorder | Alcohol and Drug Abuse | Severely Mentally Impaired |
|---|---|---|---|---|---|---|---|---|
| Adur | 3,160 | 220 | 200 | 40 | 20 | 40 | 10 | 10 |
| Arun | 6,780 | 550 | 310 | 70 | 50 | 120 | 30 | 50 |
| Chichester | 3,810 | 340 | 200 | 40 | 30 | 60 | 10 | 20 |
| Crawley | 4,400 | 410 | 270 | 40 | 20 | 80 | 20 | 20 |
| Horsham | 3,890 | 320 | 240 | 30 | 20 | 50 | 20 | 40 |
| Mid Sussex | 3,970 | 370 | 200 | 40 | 30 | 80 | 20 | 30 |
| Worthing | 5,010 | 550 | 300 | 60 | 30 | 80 | 30 | 30 |
| West Sussex | 31,030 | 2,750 | 1,720 | 320 | 200 | 510 | 150 | 200 |

### Homelessness and People Living in Temporary Accommodation

The relationship between housing and wider health outcomes is complex. Young people most at risk of being in poor housing will be those with existing, and sometimes multiple problems; but for some young people problems can be *triggered* by housing problems, for example it is estimated that 20% of young people started drug use *after* they became homeless, in part due to greater exposure to drugs. For others having a long term condition or health problem makes them more vulnerable to becoming homeless.

At the extreme end, homelessness is associated with very poor *health outcomes*

- Mental health problems, increased risk of self-neglect/self-harming, and suicide
- Increased exposure to infections
- Limited ability to adopt healthy lifestyle in relation to diet or exercise
- Without a permanent address, limited access to primary care
- Young adults, and notably young men are also more likely to live in Houses in Multiple Occupation (HMOs), and more likely to suffer injury and twice as likely to die in fires than those living in "single dwelling".

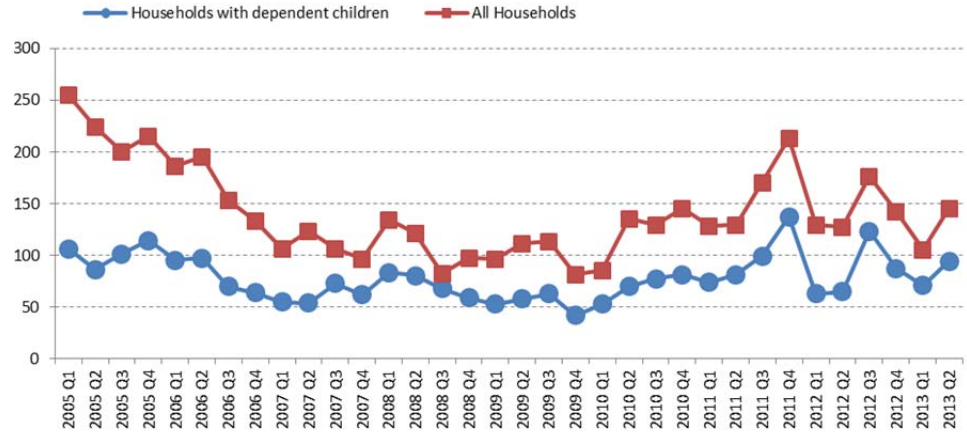
**Table 14** Numbers Accepted as being homeless and in priority need
(Rate per 1,000 Households)

| | 2004/5 | 2005/6 | 2006/7 | 2007/8 | 2008/9 | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|---|---|---|---|---|---|
| Adur | 5.4 | 5.9 | 3.8 | 2.7 | 2.6 | 2.7 | 3.3 | 2.2 | 2.9 |
| Arun | 2.3 | 1.7 | 1.6 | 0.9 | 1.3 | 0.8 | 1.2 | 1.5 | 0.8 |
| Chichester | 1.3 | 1.7 | 1.7 | 1.1 | 1.4 | 0.9 | 1.0 | 1.0 | 0.6 |
| Crawley | 6.0 | 3.9 | 2.1 | 2.6 | 1.6 | 2.0 | 3.0 | 3.5 | 6.6 |
| Horsham | 2.5 | 1.8 | 1.4 | 1.1 | 1.5 | 1.7 | 2.3 | 4.3 | 1.3 |
| Mid Sussex | 1.6 | 1.1 | 1.2 | 0.8 | 0.5 | 0.6 | 0.9 | 0.7 | 0.7 |
| Worthing | 2.4 | 2.8 | 2.2 | 1.6 | 0.7 | 0.4 | 0.4 | 0.3 | 0.4 |
| England | 5.7 | 4.5 | 3.5 | 3.0 | 2.5 | 1.9 | 2.0 | 2.3 | 2.4 |

*Source: DCLG P1E Data*

The majority of households accepted as homeless have dependent children, but young men should also be considered a risk group.

**Fig 15** Households Accepted as Homeless - with Dependent Children Accepted as Homeless* – *West Sussex *(Quarterly Data)*

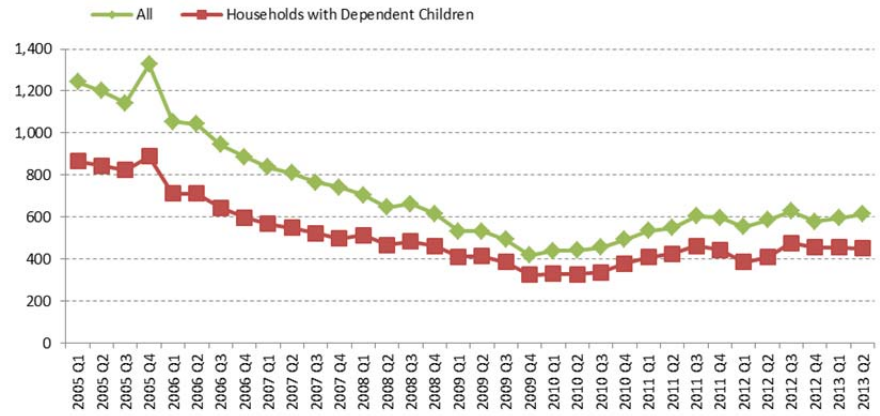



*Source: DCLG P1E Data*

**The number of households including dependent children who have had a duty to re-house accepted by their local authority in the period specified. This excludes households who are found to be homeless but not in priority needs, intentionally homeless or owed a duty but not currently homeless.*

*Source : DCLG (P1e returns from Local Authorities)*

**Fig 16** Households in Temporary Accommodation




*Source: DCLG P1E Data*

## Ethnicity

Although overall people from BME groups have been identified as having higher rates of mental health problems (for example in relation to diagnosis and admission to hospital); the picture in relation to specific BME groups is more complex.

So overall people from BME groups have greater rates of diagnosis, and are dis-proportionately represented in relation to admission to hospital, have poorer outcomes and may be more likely to dis-engage from services, but while this is well evidenced in relation to people from Irish and black Caribbean backgrounds but there is less evidence in relation from Asian minority groups. For example African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.

The relationship between ethnicity and mental health is also complex, as BME groups are more likely to live in poverty, have lower educational attainment and have higher rates of unemployment.

West Sussex is becoming more ethnically diverse. Data from the 2011 census show that 11% of the population is from an ethnic minority, compared with 6.5% in 2001. Of the black and ethnic minority (BME) groups, “white other” accounts for 4% of the West Sussex population.

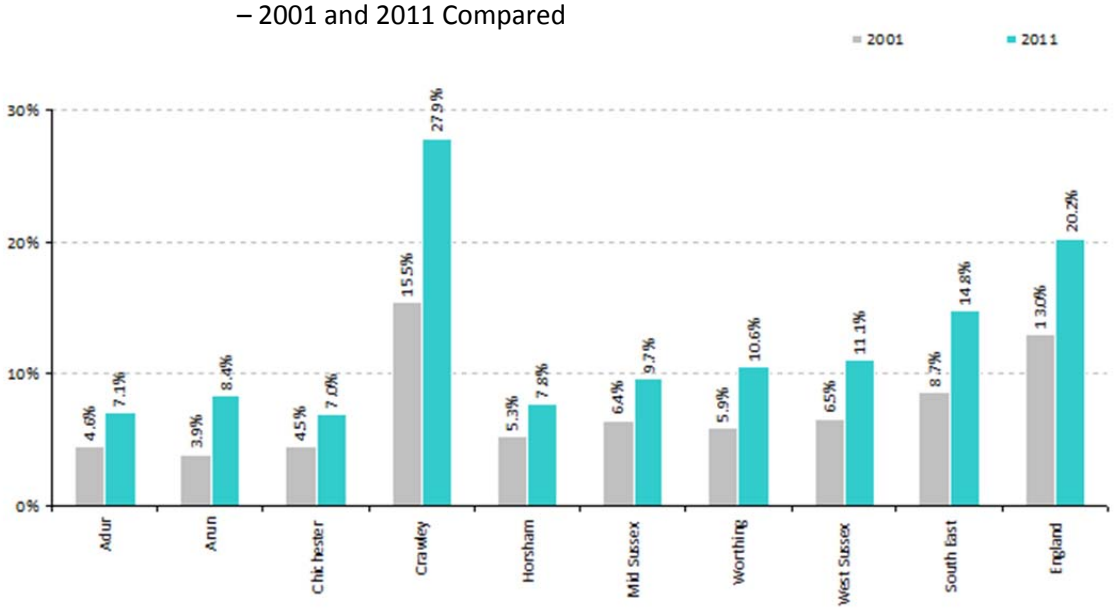
**Table 15** Ethnic Background of West Sussex Population

| 2011 Census Data | Numbers *(Figures rounded so may not sum)* | | | Percentage | | |
|---|---|---|---|---|---|---|
| | West Sussex | SOUTH EAST | ENG | West Sussex | SOUTH EAST | ENG |
| **ALL** | 806,890 | 8,634,800 | 53,012,500 | | | |
| **White:** English/Welsh/Scottish/Northern Irish/British | 717,550 | 7,359,000 | 42,279,200 | 88.9% | 85.2% | 79.8% |
| **White:** Irish | 5,980 | 73,600 | 517,000 | 0.7% | 0.9% | 1.0% |
| **White:** Gypsy or Irish Traveller | 1,070 | 14,500 | 54,900 | 0.1% | 0.2% | 0.1% |
| **White:** Other White | 31,900 | 380,700 | 2,430,000 | 4.0% | 4.4% | 4.6% |
| **Mixed/multiple ethnic group:** White and Black Caribbean | 2,890 | 46,000 | 415,600 | 0.4% | 0.5% | 0.8% |
| **Mixed/multiple ethnic group:** White and Black African | 2,060 | 22,800 | 161,600 | 0.3% | 0.3% | 0.3% |
| **Mixed/multiple ethnic group:** White and Asian | 4,270 | 58,800 | 332,700 | 0.5% | 0.7% | 0.6% |
| **Mixed/multiple ethnic group:** Other Mixed | 2,940 | 40,200 | 283,000 | 0.4% | 0.5% | 0.5% |
| **Asian/Asian British:** Indian | 9,660 | 152,100 | 1,395,700 | 1.2% | 1.8% | 2.6% |
| **Asian/Asian British:** Pakistani | 5,240 | 99,200 | 1,112,300 | 0.6% | 1.1% | 2.1% |
| **Asian/Asian British:** Bangladeshi | 2,350 | 28,000 | 436,500 | 0.3% | 0.3% | 0.8% |
| **Asian/Asian British:** Chinese | 2,960 | 53,100 | 379,500 | 0.4% | 0.6% | 0.7% |
| **Asian/Asian British:** Other Asian | 8,130 | 119,700 | 819,400 | 1.0% | 1.4% | 1.5% |
| **Black/African/Caribbean/Black British:** African | 4,570 | 87,300 | 977,700 | 0.6% | 1.0% | 1.8% |
| **Black/African/Caribbean/Black British:** Caribbean | 1,340 | 34,200 | 591,000 | 0.2% | 0.4% | 1.1% |
| **Black/African/Caribbean/Black British:** Other Black | 1,240 | 14,400 | 277,900 | 0.2% | 0.2% | 0.5% |
| **Other ethnic group:** Arab | 1,080 | 19,400 | 221,000 | 0.1% | 0.2% | 0.4% |
| **Other ethnic group:** Any other ethnic group | 1,680 | 31,700 | 327,400 | 0.2% | 0.4% | 0.6% |

Source: ONS Census 2011

The graph below shows that difference between local authority areas in West Sussex, and the change over time. In Crawley almost 28% of the population has an ethnic minority background, compared with 7% in Chichester. The growing ethnic diversity of the county should be considered by commissioners when planning services.

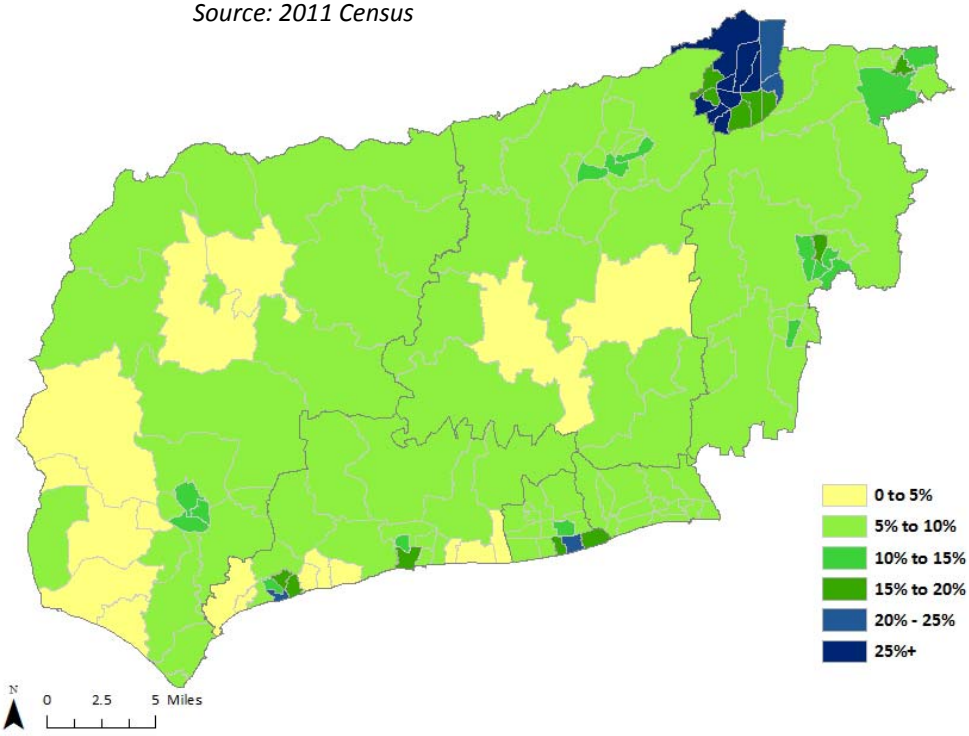
**Figure 17** Percentage of the Population from BME Groups – 2001 and 2011 Compared



**Ethnic Diversity – Ward Level**

Nationally approximately 20% of the resident population have ethnic minority backgrounds. In the map below West Sussex wards are shaded showing the percentage of the ward population from ethnic minorities. Wards shaded blue are areas where the percentage is at or above the national level. This shows the difference between Crawley and the rest of the county, with only areas in Worthing and Bognor with populations similar to the national level.

**Fig 18** Percentage of the Population from BME Backgrounds
*Source: 2011 Census*






Map produced by J Clay West Sussex Research Unit (Public Health)

**Table 16** Ethnic Diversity COASTAL CCG

| COASTAL WEST SUSSEX 2011 Census Data | Numbers (Figures rounded so may not sum) | | | Percentage | | |
|---|---|---|---|---|---|---|
| | Coastal CCG | SOUTH EAST | ENG | Coastal West Sussex CCG | SOUTH EAST | ENG |
| **ALL** | 478,950 | 8,634,800 | 53,012,500 | | | |
| **White:** English/Welsh/Scottish/Northern Irish/British | 440,440 | 7,359,000 | 42,279,200 | 92.0% | 85.2% | 79.8% |
| **White:** Irish | 3,200 | 73,600 | 517,000 | 0.7% | 0.9% | 1.0% |
| **White:** Gypsy or Irish Traveller | 720 | 14,500 | 54,900 | 0.2% | 0.2% | 0.1% |
| **White:** Other White | 16,490 | 380,700 | 2,430,000 | 3.4% | 4.4% | 4.6% |
| **Mixed/multiple ethnic group:** White and Black Caribbean | 1,420 | 46,000 | 415,600 | 0.3% | 0.5% | 0.8% |
| **Mixed/multiple ethnic group:** White and Black African | 990 | 22,800 | 161,600 | 0.2% | 0.3% | 0.3% |
| **Mixed/multiple ethnic group:** White and Asian | 2,090 | 58,800 | 332,700 | 0.4% | 0.7% | 0.6% |
| **Mixed/multiple ethnic group:** Other Mixed | 1,330 | 40,200 | 283,000 | 0.3% | 0.5% | 0.5% |
| **Asian/Asian British:** Indian | 2,100 | 152,100 | 1,395,700 | 0.4% | 1.8% | 2.6% |
| **Asian/Asian British:** Pakistani | 380 | 99,200 | 1,112,300 | 0.1% | 1.1% | 2.1% |
| **Asian/Asian British:** Bangladeshi | 1,380 | 28,000 | 436,500 | 0.3% | 0.3% | 0.8% |
| **Asian/Asian British:** Chinese | 1,610 | 53,100 | 379,500 | 0.3% | 0.6% | 0.7% |
| **Asian/Asian British:** Other Asian | 3,230 | 119,700 | 819,400 | 0.7% | 1.4% | 1.5% |
| **Black/African/Caribbean/Black British:** African | 1,560 | 87,300 | 977,700 | 0.3% | 1.0% | 1.8% |
| **Black/African/Caribbean/Black British:** Caribbean | 550 | 34,200 | 591,000 | 0.1% | 0.4% | 1.1% |
| **Black/African/Caribbean/Black British:** Other Black | 250 | 14,400 | 277,900 | 0.1% | 0.2% | 0.5% |
| **Other ethnic group:** Arab | 510 | 19,400 | 221,000 | 0.1% | 0.2% | 0.4% |
| **Other ethnic group:** Any other ethnic group | 710 | 31,700 | 327,400 | 0.1% | 0.4% | 0.6% |

**Table 17** Ethnic Diversity CRAWLEY CCG

| CRAWLEY CCG WEST SUSSEX 2011 Census Data | Numbers (Figures rounded so may not sum) | | | Percentage | | |
|---|---|---|---|---|---|---|
| | Crawley CCG | SOUTH EAST | ENG | Crawley CCG | SOUTH EAST | ENG |
| **ALL** | 106,600 | 8,634,800 | 53,012,500 | | | |
| **White:** English/Welsh/Scottish/Northern Irish/British | 76,890 | 7,359,000 | 42,279,200 | 72.1% | 85.2% | 79.8% |
| **White:** Irish | 970 | 73,600 | 517,000 | 0.9% | 0.9% | 1.0% |
| **White:** Gypsy or Irish Traveller | 80 | 14,500 | 54,900 | 0.1% | 0.2% | 0.1% |
| **White:** Other White | 7,250 | 380,700 | 2,430,000 | 6.8% | 4.4% | 4.6% |
| **Mixed/multiple ethnic group:** White and Black Caribbean | 810 | 46,000 | 415,600 | 0.8% | 0.5% | 0.8% |
| **Mixed/multiple ethnic group:** White and Black African | 620 | 22,800 | 161,600 | 0.6% | 0.3% | 0.3% |
| **Mixed/multiple ethnic group:** White and Asian | 880 | 58,800 | 332,700 | 0.8% | 0.7% | 0.6% |
| **Mixed/multiple ethnic group:** Other Mixed | 790 | 40,200 | 283,000 | 0.7% | 0.5% | 0.5% |
| **Asian/Asian British:** Indian | 5,530 | 152,100 | 1,395,700 | 5.2% | 1.8% | 2.6% |
| **Asian/Asian British:** Pakistani | 4,550 | 99,200 | 1,112,300 | 4.3% | 1.1% | 2.1% |
| **Asian/Asian British:** Bangladeshi | 430 | 28,000 | 436,500 | 0.4% | 0.3% | 0.8% |
| **Asian/Asian British:** Chinese | 500 | 53,100 | 379,500 | 0.5% | 0.6% | 0.7% |
| **Asian/Asian British:** Other Asian | 2,820 | 119,700 | 819,400 | 2.6% | 1.4% | 1.5% |
| **Black/African/Caribbean/Black British:** African | 2,160 | 87,300 | 977,700 | 2.0% | 1.0% | 1.8% |
| **Black/African/Caribbean/Black British:** Caribbean | 470 | 34,200 | 591,000 | 0.4% | 0.4% | 1.1% |
| **Black/African/Caribbean/Black British:** Other Black | 840 | 14,400 | 277,900 | 0.8% | 0.2% | 0.5% |
| **Other ethnic group:** Arab | 420 | 19,400 | 221,000 | 0.4% | 0.2% | 0.4% |
| **Other ethnic group:** Any other ethnic group | 600 | 31,700 | 327,400 | 0.6% | 0.4% | 0.6% |

Source: ONS Census 2011

**Table 18** Ethnic Diversity HORSHAM AND MID SUSSEX CCG

| HORSHAM AND MID SUSSEX WEST SUSSEX<br>2011 Census Data | Numbers<br>*(Figures rounded so may not sum)* | | | Percentage | | |
|---|---|---|---|---|---|---|
| | Horsham & Mid Sussex CCG | SOUTH EAST | ENG | Horsham & Mid Sussex CCG | SE | ENG |
| **ALL** | 221,350 | 8,634,800 | 53,012,500 | | | |
| **White:** English/Welsh/Scottish/Northern Irish/British | 200,230 | 7,359,000 | 42,279,200 | 90.5% | 85.2% | 79.8% |
| **White:** Irish | 1,810 | 73,600 | 517,000 | 0.8% | 0.9% | 1.0% |
| **White:** Gypsy or Irish Traveller | 270 | 14,500 | 54,900 | 0.1% | 0.2% | 0.1% |
| **White:** Other White | 8,160 | 380,700 | 2,430,000 | 3.7% | 4.4% | 4.6% |
| **Mixed/multiple ethnic group:** White and Black Caribbean | 660 | 46,000 | 415,600 | 0.3% | 0.5% | 0.8% |
| **Mixed/multiple ethnic group:** White and Black African | 460 | 22,800 | 161,600 | 0.2% | 0.3% | 0.3% |
| **Mixed/multiple ethnic group:** White and Asian | 1,300 | 58,800 | 332,700 | 0.6% | 0.7% | 0.6% |
| **Mixed/multiple ethnic group:** Other Mixed | 820 | 40,200 | 283,000 | 0.4% | 0.5% | 0.5% |
| **Asian/Asian British:** Indian | 2,030 | 152,100 | 1,395,700 | 0.9% | 1.8% | 2.6% |
| **Asian/Asian British:** Pakistani | 310 | 99,200 | 1,112,300 | 0.1% | 1.1% | 2.1% |
| **Asian/Asian British:** Bangladeshi | 540 | 28,000 | 436,500 | 0.2% | 0.3% | 0.8% |
| **Asian/Asian British:** Chinese | 860 | 53,100 | 379,500 | 0.4% | 0.6% | 0.7% |
| **Asian/Asian British:** Other Asian | 2,080 | 119,700 | 819,400 | 0.9% | 1.4% | 1.5% |
| **Black/African/Caribbean/Black British:** African | 850 | 87,300 | 977,700 | 0.4% | 1.0% | 1.8% |
| **Black/African/Caribbean/Black British:** Caribbean | 330 | 34,200 | 591,000 | 0.1% | 0.4% | 1.1% |
| **Black/African/Caribbean/Black British:** Other Black | 150 | 14,400 | 277,900 | 0.1% | 0.2% | 0.5% |
| **Other ethnic group:** Arab | 140 | 19,400 | 221,000 | 0.1% | 0.2% | 0.4% |
| **Other ethnic group:** Any other ethnic group | 360 | 31,700 | 327,400 | 0.2% | 0.4% | 0.6% |

Source: ONS Census 2011

### Adults with Autism

*(Information from the Health and Wellbeing Needs Adults with Autism June 2013 – West Sussex Public Health Research Unit)*

Autism (sometimes referred to Autistic Spectrum Condition [ASC] or Autistic Spectrum Disorder [ASD]) can be described as a neurodevelopmental disorder. It is a spectrum disorder meaning all people diagnosed with the condition will share certain behaviours and traits to different extents. There are no evidenced biological markers to identify and diagnose autism, so the following three behavioural descriptions are used:

- Social development/interaction is different or delayed
- Difficulties in communication - both verbal and non-verbal modes.
- Difficulties with thinking and behaviour (social imagination)

In relation to people aged 18 years and over there are an estimated 7,100 people living in West Sussex with Autism, the majority of these are men.

**Table 19** Prevalence Assumptions – Adults with Autism

| | Total adult population*(18+ years) | % prevalence of autism | Number of adults |
|---|---|---|---|
| Adult | 645,000 | 1.10% | 7,100 |
| Men | 306,800 | 2.00% | 6,100 |
| Women | 338,260 | 0.30% | 1,00 |

Estimation of Adults with Autism – West Sussex Figures may note round due to rounding
Source : applying assumption from Brugha et al.'s (2012) to ONS 2011 Mid-Year Estimate (accessed via www.nomisweb.co.uk)

**CCG Estimates – *of Patient Registered Populations***
- Coastal West Sussex 4,400
- Crawley 1,100
- Horsham and Mid Sussex* 2,000

*Co-morbidity with mental health problems*

A number of studies have found a higher prevalence of mental health conditions in adults with autism; including depression, anxiety, obsessive compulsive disorder. Some mental health problems may develop as a result of the lack of support or understanding of their specific needs. It should be noted that for many people only the mental health condition, and not autism, will be diagnosed. Skokauskas and Gallagher (2009) reviewed published studies relating to co-morbidity of autism and psychotic, anxiety and/or mood disorders, found conflicting evidence in relation to schizophrenia, depression to be common and anxiety disorders the most common psychiatric co-morbidity.

*Challenging and disruptive behaviour in adolescence*

Périsse D. et al (2010) studied the factors associated with acute states and regression in adolescents with autism; patients studied were in-patients.

The study found that "*Disruptive behaviours among adolescents with autism may stem from diverse risk factors, including environmental problems, comorbid acute psychiatric conditions, or somatic diseases such as epilepsy. The management of these behavioural changes requires a multidisciplinary functional approach'.*

**POPULATION LEVELSUBJECTIVE WELLBEING**

Office for National Statistics (ONS) collects data relating to subjective well-being to complement existing socio-economic indicators. These allow a fuller statistical picture of the nation's well-being. The aim is that these new measures will provide insights into the quality of life of people in the UK, environmental and sustainability issues, as well as the economic performance of the country.

Different aspects of wellbeing are measured, with data available to local authority level, with the four key questions asked:

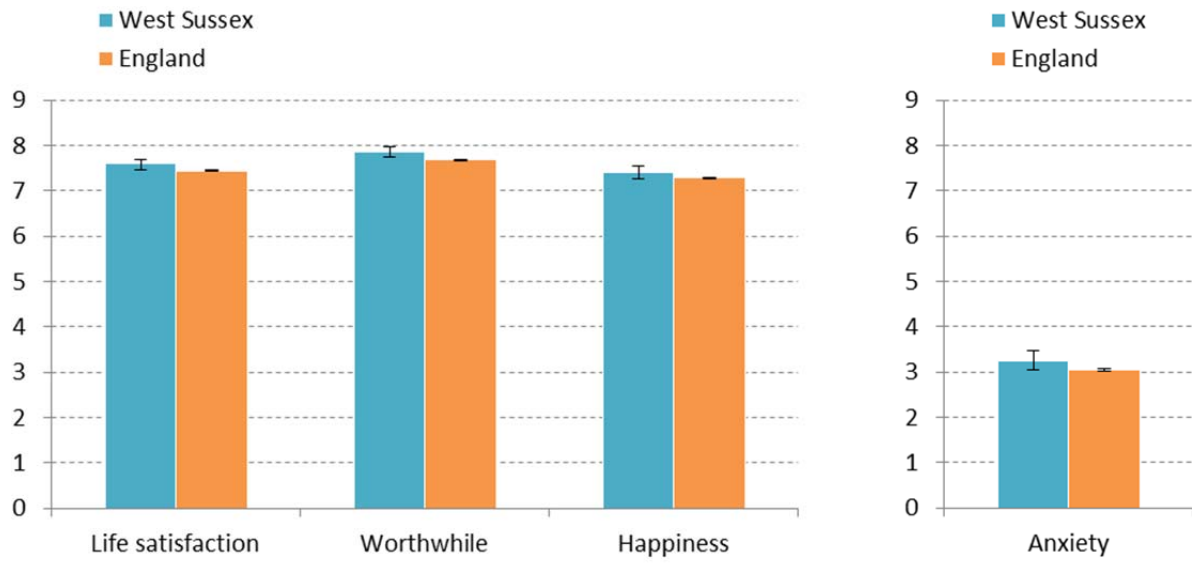
1. Overall, how satisfied are you with your life nowadays?
2. Overall, to what extent do you feel the things you do in your life are worthwhile?
3. Overall, how happy did you feel yesterday?
4. Overall, how anxious did you feel yesterday?

People were asked to respond to the questions using a 0 to 10 score, for satisfaction, worthwhile and happiness 0 is low 10 high (good) for anxiousness the more anxious the person feels the higher the score. The ONS provide information on average scores and also the distribution of scores in an area.

**Table 20** Average Scores ONS Subjective Wellbeing Measures
Information below relates to the average scores.

| | | Life satisfaction | Worthwhile | Happiness | Anxiety |
|---|---|---|---|---|---|
| West Sussex | 2011/12 | 7.7 | 7.9 | 7.5 | 3.0 |
| | 2012/13 | 7.6 | 7.9 | 7.4 | 3.3 |
| England | 2011/12 | 7.4 | 7.7 | 7.3 | 3.2 |
| | 2012/13 | 7.4 | 7.7 | 7.3 | 3.1 |

**Fig 19** Life Satisfaction, Worthwhile and Happiness Questions




Source: ONS Wellbeing Measures 2012

West Sussex rated significantly higher than England on measures of life satisfaction, life worthwhile and overall happiness but there was no significant difference in term of anxiety.

**LONELINESS**

***1.*** **IN OLDER AGE**

Social isolation and loneliness is increasingly becoming an issue of concern among older people. In the 2009/10 English Longitudinal Study of Ageing (ELSA) reported feelings of loneliness were analysed. This study found that 25% of the respondents reported feeling lonely sometimes while 9% reported feeling lonely often.

A higher percentage of respondents feeling lonely was noted among those aged 80 and above and among women compared to men. In addition, people who had been widowed/separated, in poor health and reported limitations in performing daily activities were more likely to be lonely.

***West Sussex Older People Survey – Loneliness***

In 2013 a survey was undertaken in West Sussex of people aged 65 or over. The surveys aims were to establish a baseline from which to measure community connectedness experienced by local older people and to investigate levels of social isolation and loneliness and their relationship with health and wellbeing.

Over 2,800 people aged 65+ completed telephone interviews with researchers in December 2012. The respondents were generally younger and from less deprived areas than the overall West Sussex population aged 65+ but there were over 400 respondents from each local authority area within the county.

Loneliness, social isolation, participation and health and wellbeing were measured using validated scales from the literature.

**Key Findings**

- 24% of respondents indicated that they were moderately or severely lonely. Those living in more deprived areas were 30% more likely to be lonely as those living in other parts of the county.

**Table 21** Loneliness by Local Authority Area

| Area | % Respondents aged 65+ Moderately or Severely Lonely |
|---|---|
| Adur | 29.0% |
| Arun | 23.8% |
| Chichester | 22.3% |
| Crawley | 28.3% |
| Horsham | 19.5% |
| Mid Sussex | 20.6% |
| Worthing | 27.1% |
| West Sussex | 24.4% |

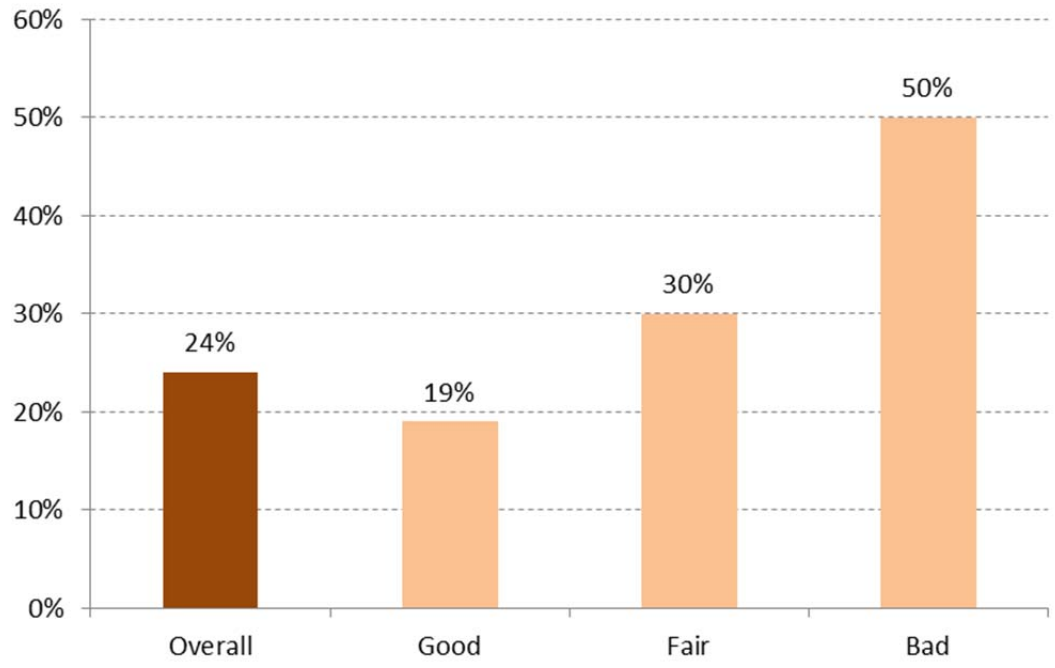
- Loneliness was found to be highly associated with health outcomes, even after controlling for a number of factors including age, sex, exercise and medication, lonely people were 60% more likely to be in poor health than non-lonely people and 78% more likely to have reported multiple emergency admissions to hospital. It is possible that people who have poor health find it difficult to maintain their social connections and it's also possible that loneliness itself leads to poorer health, especially poorer mental health. .

- Loneliness was more common in those with poor sight, poor hearing and problems with their memory

- It was also common in carers with high care burdens, but not if they lived independently

- Contact with neighbours and participation in groups were associated with a 20% reduction in the odds of a respondent being lonely.

**Fig 20** Percentage of Respondents – Loneliness by Health Status (Self Assessed)



## SECTION 2 PREVALENCE OF MENTAL HEALTH CONDITIONS AND DISORDERS

This section examines the prevalence of mental health problems and conditions in West Sussex. For this report the 'traditional' groupings (notably divided people according to neurotic or psychotic symptoms) have been adopted but it is acknowledged that has been considerable debate relating to the categorisation of mental health problems and there are caveats on how well people fit into any one specific group or definition and that some people will experience both neurotic and psychotic symptoms.

### Adult Psychiatric Morbidity Survey (APMS)

Many of the prevalence assumptions are derived from national surveys and research, of note the Adult Psychiatric Morbidity Survey (APMS) a national survey specifically designed to identify the prevalence of mental health disorders. Key points on the APMS:-

- APMS is a household survey and collects data on adults (and for these surveys this means aged 16 years and over); note being households surveys means that some very vulnerable adults, including rough sleepers or people in temporary accommodation are not surveyed.
- The 1993 and 2000 surveys were conducted by the Office of National Statistics (ONS). The 2007 survey was conducted by the National Centre for Social Research (in collaboration with the University of Leicester) for the NHS Information Centre.
- The 1993 survey related to adults aged 16-64 years, the 2000 16—74 years, and 2007 covered all people aged 16 years and over (no upper age limit).
- The 2007 survey included many of the same questions from 1993 and 2000 (for examine in identifying the prevalence of common mental disorders) but added a number of subjects, including questions relating to eating disorders, attention deficient hyperactivity disorder, posttraumatic stress disorder and problem gambling.

### Main Types of Mental Health Problems

- ***Common Mental Health problem / 'Neurotic'*** relates to symptoms which are regarded as extreme forms of 'normal' emotional experiences such as depression, anxiety or panic. These are more frequently referred to as 'common mental health problems'.

- ***Severe mental health problems / 'psychotic'*** symptoms act to alter the perception of reality, symptoms may include hallucinations, delusions or paranoia, with the person seeing, hearing, smelling, feeling or believing things that no one else does.

- ***Organic Mental health problems -*** Organic disorders relate to conditions which are caused by direct brain damage to or brain malfunction, the most common of these is dementia. These conditions are not covered by this needs assessment, a separate needs assessment is being undertaken for dementia.

## Prevalence of COMMON MENTAL HEALTH PROBLEMS

### Key Points

- Nationally approximately 1 in 6 people has a mental health problem at any given time and it is estimated that one third of all consultations with GPs relate to mental health problems

- A follow up of 750 people to the 2000 APMS found that in relation to people who sought treatment approximately half of the people identified as having a neurotic disorder had sought treatment.

### Prevalence assumptions

APMS 2007 found that the overall prevalence of adults having a common mental health was similar to the 2000 prevalence (approx. 16%) but there has been some change in specific age groups; for example an increase in CMD in women aged 16-64 years and the largest increase in a sub-age group was in women aged 45-54 years.

**Table 22** Prevalence of Common Mental health Problem in last week (by age group and sex) % of the population (APMS 2007)

| SEX | % of each age group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 8.2 | 7.4 | 7.4 | 8.1 | 6.8 | 3.9 | 3.8 | 6.9 |
| Generalised anxiety disorder | 1.9 | 4.1 | 4.7 | 4.1 | 2.7 | 2.9 | 2.2 | 3.4 |
| Depressive episode | 1.5 | 2.7 | 2.6 | 2.6 | 1.5 | 0.4 | 0.5 | 1.9 |
| All phobias | 0.3 | 1.5 | 1.5 | 0.7 | 0.6 | 0.3 | - | 0.8 |
| Obsessive compulsive disorder | 1.6 | 1.5 | 1.2 | 0.7 | 0.4 | 0.2 | 0.3 | 0.9 |
| Panic disorder | 1.4 | 0.9 | 1.3 | 0.8 | 0.6 | 0.1 | 0.3 | 1.0 |
| Any CMD | 13.0 | 14.6 | 15.0 | 14.5 | 10.6 | 7.5 | 6.3 | 12.5 |
| **WOMEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 12.3 | 14.1 | 9.7 | 14.3 | 9.0 | 8.6 | 7.2 | 11.0 |
| Generalised anxiety disorder | 5.3 | 4.3 | 5.9 | 8.0 | 5.5 | 3.6 | 2.9 | 5.3 |
| Depressive episode | 2.9 | 1.7 | 3.2 | 4.9 | 2.2 | 1.6 | 2.1 | 2.8 |
| All phobias | 2.7 | 2.4 | 2.7 | 2.2 | 2.2 | 0.4 | 0.2 | 2.0 |
| Obsessive compulsive disorder | 3.0 | 1.5 | 1.0 | 1.6 | 0.7 | 0.4 | 0.5 | 1.3 |
| Panic disorder | 0.8 | 2.3 | 1.4 | 1.1 | 1.4 | 0.1 | 0.6 | 1.2 |
| **Any CMD** | 22.2 | 23.0 | 19.5 | 25.2 | 17.6 | 13.4 | 12.2 | 19.7 |
| **ALL** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 10.2 | 10.8 | 8.5 | 11.2 | 8.0 | 6.4 | 5.9 | 9.0 |
| Generalised anxiety disorder | 3.6 | 4.2 | 5.3 | 6.1 | 4.1 | 3.3 | 2.6 | 4.4 |
| Depressive episode | 2.2 | 2.2 | 2.9 | 3.7 | 1.9 | 1.0 | 1.5 | 2.3 |
| All phobias | 1.5 | 1.9 | 2.1 | 1.5 | 1.4 | 0.3 | 0.1 | 1.4 |
| Obsessive compulsive disorder | 2.3 | 1.5 | 1.1 | 1.1 | 0.5 | 0.3 | 0.4 | 1.1 |
| Panic disorder | 1.1 | 1.6 | 1.3 | 0.9 | 1.0 | 0.5 | 0.5 | 1.1 |
| **Any CMD** | 17.5 | 18.8 | 17.3 | 19.9 | 14.1 | 10.6 | 9.9 | 16.2 |

The APMS age and sex specific prevalence assumptions have been applied to the 2011 MYE population figures at county level and the numbers of people affected are shown in the table below.

The table provides an estimate the number of people "likely to be diagnosable" with each conditions at any one time. This reflects the total number of people estimated to have a condition, not all those people would seek or want treatment.

**Table 23** Number of People with Common Mental health Problem – West Sussex

| **WEST SUSSEX** | **Numbers in each age group** *(Figures rounded to nearest 10 so may not round)* ***Note:*** *As some people may have more than one problem the "Any CMD" does not equate to the total of all specific problems* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 3,260 | 3,270 | 3,960 | 4,560 | 3,370 | 1,530 | 1,280 | 21,830 |
| Generalised anxiety disorder | 760 | 1,810 | 2,510 | 2,310 | 1,340 | 1,140 | 740 | 10,760 |
| Depressive episode | 600 | 1,190 | 1,390 | 1,460 | 740 | 160 | 170 | 6,010 |
| All phobias | 120 | 660 | 800 | 390 | 300 | 120 | - | 2,530 |
| Obsessive compulsive disorder | 640 | 660 | 640 | 390 | 200 | 80 | 100 | 2,850 |
| Panic disorder | 560 | 400 | 700 | 450 | 300 | 40 | 100 | 3,160 |
| Any CMD | 5,170 | 6,450 | 8,030 | 8,160 | 5,260 | 2,940 | 2,130 | 39,550 |
| **WOMEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 4,710 | 6,500 | 5,460 | 8,410 | 4,750 | 3,740 | 3,700 | 38,190 |
| Generalised anxiety disorder | 2,030 | 1,980 | 3,320 | 4,700 | 2,900 | 1,570 | 1,490 | 18,400 |
| Depressive episode | 1,110 | 780 | 1,800 | 2,880 | 1,160 | 700 | 1,080 | 9,720 |
| All phobias | 1,030 | 1,110 | 1,520 | 1,290 | 1,160 | 170 | 100 | 6,940 |
| Obsessive compulsive disorder | 1,150 | 690 | 560 | 940 | 370 | 170 | 260 | 4,510 |
| Panic disorder | 310 | 1,060 | 790 | 650 | 740 | 40 | 310 | 4,170 |
| **Any CMD** | 8,500 | 10,600 | 10,980 | 14,820 | 9,290 | 5,830 | 6,270 | 68,400 |
| **ALL** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 7,950 | 9,740 | 9,340 | 12,900 | 8,200 | 5,300 | 5,030 | 59,740 |
| Generalised anxiety disorder | 2,800 | 3,790 | 5,820 | 7,030 | 4,200 | 2,730 | 2,220 | 29,210 |
| Depressive episode | 1,710 | 1,980 | 3,190 | 4,260 | 1,950 | 830 | 1,280 | 15,270 |
| All phobias | 1,170 | 1,710 | 2,310 | 1,730 | 1,440 | 250 | 90 | 9,290 |
| Obsessive compulsive disorder | 1,790 | 1,350 | 1,210 | 1,270 | 510 | 250 | 340 | 7,300 |
| Panic disorder | 860 | 1,440 | 1,430 | 1,040 | 1,030 | 410 | 430 | 7,300 |
| **Any CMD** | 13,630 | 16,960 | 19,010 | 22,920 | 14,450 | 8,780 | 8,440 | 107,540 |

**COASTAL**

**Table 24** Number of People with Common Mental Health Problems

| COASTAL WEST SUSSEX CCG | Numbers in each age group *(Figures rounded to nearest 10 so may not sum)* ***Note:*** *As some people may have more than one problem the "Any CMD" does not equate to the total of all specific problems* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 1,890 | 1,720 | 2,190 | 2,620 | 2,080 | 1,040 | 890 | 12,430 |
| Generalised anxiety disorder | 440 | 950 | 1,390 | 1,330 | 830 | 770 | 510 | 6,220 |
| Depressive episode | 350 | 630 | 770 | 840 | 460 | 110 | 120 | 3,280 |
| All phobias | 70 | 350 | 440 | 230 | 180 | 80 | <5 | 1,350 |
| Obsessive compulsive disorder | 370 | 350 | 360 | 230 | 120 | 50 | 70 | 1,550 |
| Panic disorder | 320 | 210 | 380 | 260 | 180 | 30 | 70 | 1,450 |
| **Any CMD** | 2,990 | 3,390 | 4,440 | 4,700 | 3,240 | 2,000 | 1,470 | 22,230 |
| **WOMEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 2,740 | 3,450 | 3,070 | 4,950 | 3,000 | 2,570 | 2,540 | 22,320 |
| Generalised anxiety disorder | 1,180 | 1,050 | 1,860 | 2,770 | 1,830 | 1,080 | 1,020 | 10,790 |
| Depressive episode | 650 | 420 | 1,010 | 1,700 | 730 | 480 | 740 | 5,730 |
| All phobias | 600 | 590 | 850 | 760 | 730 | 120 | 70 | 3,720 |
| Obsessive compulsive disorder | 670 | 370 | 320 | 550 | 230 | 120 | 180 | 2,440 |
| Panic disorder | 180 | 560 | 440 | 380 | 470 | 30 | 210 | 2,270 |
| **Any CMD** | 4,950 | 5,640 | 6,160 | 8,720 | 5,860 | 4,010 | 4,310 | 39,650 |
| **ALL** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 4,620 | 5,140 | 5,200 | 7,500 | 5,100 | 3,620 | 3,460 | 34,640 |
| Generalised anxiety disorder | 1,630 | 2,000 | 3,240 | 4,090 | 2,620 | 1,860 | 1,530 | 16,970 |
| Depressive episode | 1,000 | 1,050 | 1,770 | 2,480 | 1,210 | 570 | 880 | 8,960 |
| All phobias | 680 | 900 | 1,290 | 1,010 | 890 | 170 | 60 | 5,000 |
| Obsessive compulsive disorder | 1,040 | 710 | 670 | 740 | 320 | 170 | 230 | 3,880 |
| Panic disorder | 500 | 760 | 800 | 600 | 640 | 280 | 290 | 3,870 |
| **Any CMD** | 7,930 | 8,950 | 10,590 | 13,330 | 9,000 | 5,990 | 5,810 | 61,600 |

**CRAWLEY**

**Table 25** Number of People with a Common Mental Health Problems

| CRAWLEY CCG | Numbers in each age group<br>*(Figures rounded to nearest 10 so may not sum)*<br>***Note:** As some people may have more than one problem the "Any CMD" does not equate to the total of all specific problems* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 480 | 670 | 610 | 580 | 360 | 120 | 110 | 2,930 |
| Generalised anxiety disorder | 110 | 370 | 390 | 290 | 140 | 90 | 60 | 1,450 |
| Depressive episode | 90 | 250 | 220 | 180 | 80 | 10 | 10 | 840 |
| All phobias | 20 | 140 | 120 | 50 | 30 | 10 | <5 | 370 |
| Obsessive compulsive disorder | 90 | 140 | 100 | 50 | 20 | 10 | 10 | 420 |
| Panic disorder | 80 | 80 | 110 | 60 | 30 | <5 | 10 | 370 |
| **Any CMD** | 750 | 1,330 | 1,250 | 1,030 | 560 | 230 | 180 | 5,330 |
| **WOMEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 730 | 1,310 | 780 | 1,030 | 490 | 280 | 320 | 4,940 |
| Generalised anxiety disorder | 310 | 400 | 470 | 580 | 300 | 120 | 130 | 2,310 |
| Depressive episode | 170 | 160 | 260 | 350 | 120 | 50 | 90 | 1,200 |
| All phobias | 160 | 220 | 220 | 160 | 120 | 10 | 10 | 900 |
| Obsessive compulsive disorder | 180 | 140 | 80 | 120 | 40 | 10 | 20 | 590 |
| Panic disorder | 50 | 210 | 110 | 80 | 80 | <5 | 30 | 560 |
| **Any CMD** | 1,310 | 2,140 | 1,560 | 1,810 | 950 | 440 | 540 | 8,750 |
| **ALL** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 1,200 | 1,980 | 1,390 | 1,600 | 860 | 410 | 420 | 7,860 |
| Generalised anxiety disorder | 420 | 770 | 860 | 870 | 440 | 210 | 190 | 3,760 |
| Depressive episode | 260 | 400 | 470 | 530 | 200 | 60 | 110 | 2,030 |
| All phobias | 180 | 350 | 340 | 210 | 150 | 20 | 10 | 1,260 |
| Obsessive compulsive disorder | 270 | 270 | 180 | 160 | 50 | 20 | 30 | 980 |
| Panic disorder | 130 | 290 | 210 | 130 | 110 | 30 | 40 | 940 |
| **Any CMD** | 2,070 | 3,440 | 2,820 | 2,850 | 1,510 | 680 | 710 | 14,080 |

**HORSHAM AND MID SUSSEX**

**Table 26** Number of People with a Common Mental Health Problems

| HORSHAM AND MID SUSSEX CCG | Numbers in each age group<br>*(Figures rounded to nearest 10 so may not sum)*<br>***Note:** As some people may have more than one problem the "Any CMD" does not equate to the total of all specific problems* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 900 | 890 | 1,160 | 1,360 | 940 | 370 | 290 | 5,910 |
| Generalised anxiety disorder | 210 | 490 | 740 | 690 | 370 | 280 | 170 | 2,950 |
| Depressive episode | 170 | 320 | 410 | 440 | 210 | 40 | 40 | 1,630 |
| All phobias | 30 | 180 | 240 | 120 | 80 | 30 | <5 | 680 |
| Obsessive compulsive disorder | 180 | 180 | 190 | 120 | 60 | 20 | 20 | 770 |
| Panic disorder | 150 | 110 | 200 | 130 | 80 | 10 | 20 | 700 |
| **Any CMD** | 1,430 | 1,750 | 2,360 | 2,440 | 1,460 | 710 | 490 | 10,640 |
| **WOMEN** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 1,240 | 1,730 | 1,620 | 2,460 | 1,280 | 890 | 840 | 10,060 |
| Generalised anxiety disorder | 540 | 530 | 990 | 1,380 | 780 | 370 | 340 | 4,930 |
| Depressive episode | 290 | 210 | 530 | 840 | 310 | 170 | 250 | 2,600 |
| All phobias | 270 | 300 | 450 | 380 | 310 | 40 | 20 | 1,770 |
| Obsessive compulsive disorder | 300 | 180 | 170 | 280 | 100 | 40 | 60 | 1,130 |
| Panic disorder | 80 | 280 | 230 | 190 | 200 | 10 | 70 | 1,060 |
| **Any CMD** | 2,240 | 2,830 | 3,260 | 4,330 | 2,500 | 1,390 | 1,430 | 17,980 |
| **ALL** | **16-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65-74** | **75+** | **All** |
| Mixed anxiety and depressive disorder | 2,150 | 2,620 | 2,750 | 3,800 | 2,240 | 1,270 | 1,140 | 15,970 |
| Generalised anxiety disorder | 760 | 1,020 | 1,720 | 2,070 | 1,150 | 660 | 500 | 7,880 |
| Depressive episode | 460 | 530 | 940 | 1,250 | 530 | 200 | 290 | 4,200 |
| All phobias | 320 | 460 | 680 | 510 | 390 | 60 | 20 | 2,440 |
| Obsessive compulsive disorder | 490 | 360 | 360 | 370 | 140 | 60 | 80 | 1,860 |
| Panic disorder | 230 | 390 | 420 | 310 | 280 | 100 | 100 | 1,830 |
| **Any CMD** | 3,690 | 4,570 | 5,610 | 6,750 | 3,950 | 2,110 | 1,920 | 28,600 |

**Impact of the Recession, Unemployment and Debt**

The prevalence assumptions used in this report are based upon findings of the **Adult Psychiatric Morbidity Survey (APMS),** the latest survey was undertaken in 2007 prior to the 2008 economic recession. While the APMS provides the most comprehensive breakdown of mental health problems (including prevalence assumptions based on age and sex) it should be noted that a number of underlying conditions known to impact mental health and wellbeing have worsened since APMS 2007. There is good evidence linking (association) unemployment and debt to mental health[2].

This report has not provided an estimate of the *increase* in prevalence as a result of the economic downturn but it should be noted that while at any one time a number of people can be affected by debt and/or unemployment, a recession acts across a population and *many* people may be affected. It is likely that there has been an increase in the prevalence of mental health problems, notably relating to anxiety and depression, and a subsequent increase demand for services, particularly for GPs and Time to Talk.

**SEVERE AND ENDURING MENTAL DISORDERS - PSYCHOTIC DISORDERS**

*"Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder."* [APMS 2007] The National Survey of Psychiatric Morbidity in the UK found a population prevalence of probable psychotic disorder of 5 per 1,000 in the age group 16 to 74 years.

The overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively).

**Table 27** Prevalence of psychotic disorder in past year
Prevalence assumption used from APMS 2007

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | - | 0.6% | 0.7% | 0.1% | - | - | - | 0.3% |
| Women | 0.4% | 0.2% | 1.1% | 0.8% | 0.6% | - | - | 0.5% |
| ALL | 0.2% | 0.4% | 0.9% | 0.5% | 0.3% | - | 0- | 0.4% |

- Applying these assumptions to the West Sussex population means **2,660 adults in West Sussex are estimated to have a psychotic disorder.**

- Breaking these figures down to CCG areas within the county:-
  - **1,600** people in the Coastal CCG area
  - **340** people in Crawley CCG area
  - **720** people in the Horsham and Mid Sussex CCG area

[2] Fitch, C., Hamilton, S., Bassett, P., *et al* (2009) *Debt and Mental Health*. *What do We Know? What Should we Do?* Royal College of Psychiatrists & Rethink.
Dorling D. (2009) Unemployment and health. *BMJ*, **338**, b829.

Prevalence is estimated as being significantly higher for black *men* (3.1%); no significant differences are estimated in women. Prevalence estimates also varies according to household income, 0.1% of adults in the highest income quintile to 0.9% of adults in the lowest income quintile; a difference noted as being more prominent among men than women.

**PERSONALITY DISORDERS**

Personality disorders are conditions where the individual personality characteristics can cause regular and long term problems in the way they cope with everyday life and interact with other people; anti-social personality disorder (ASPD) and borderline personality disorder (BPD) are two types.

APMS 2007 describes these disorders:-

*"ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women)."*

*"BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women)."*

**Table 28** Applying sex specific prevalence rates to the West Sussex population aged 16-64 years

| ***West Sussex*** **16-64 Year Olds** | *% males* | *% female* | *% All* | Total people aged 16-64 with personality disorder |
|---|---|---|---|---|
| Borderline personality disorder | *0.3* | *0.6* | *0.4* | 1,980 |
| Antisocial personality disorder | *0.6* | *0.1* | *0.3* | 1,490 |
| ***COASTAL*** **16-64 Year Olds** | *% males* | *% female* | *% All* | Total people aged 16-64 with personality disorder |
| Borderline personality disorder | *0.3* | *0.6* | *0.4* | 1,140 |
| Antisocial personality disorder | *0.6* | *0.1* | *0.3* | 850 |
| ***CRAWLEY*** **16-64 Year Olds** | *% males* | *% female* | *% All* | Total people aged 16-64 with personality disorder |
| Borderline personality disorder | *0.3* | *0.6* | *0.4* | 290 |
| Antisocial personality disorder | *0.6* | *0.1* | *0.3* | 210 |
| ***HORSHAM & MID SUSSEX*** **16-64 Year Olds** | *% males* | *% female* | *% All* | Total people aged 16-64 with personality disorder |
| Borderline personality disorder | *0.3* | *0.6* | *0.4* | 560 |
| Antisocial personality disorder | *0.6* | *0.1* | *0.3* | 420 |

The presence of a personality disorder, notably antisocial personality disorder may have considerable implications in the treatment and management of co-existing psychiatric and physical conditions.

Co-existence of a personality disorder and another mental health problem is high.

**PSYCHIATRIC COMORBIDITY**

Many people with a mental health problem are not just affected by one condition. From information collected from the APMS *of the people diagnosed with at least one condition*:-

- 68.7% met the criteria for only one condition,
- 19.1% met the criteria for two conditions
- and 12.2% met the criteria for three or more conditions.

**EATING DISORDERS**

APMS 2007 introduced for the first time screening questions relating to eating disorders. The screening tool (called SCOFF tool) was supplemented with an additional question, for those scoring 2 or more on the impact of behaviour on social participation. The SCOFF screening questions, amended for use on APMS 2007

In the last year

1. Have you lost more than one stone in a three month period? Yes/No
2. Have you made yourself be sick because you felt uncomfortably full? Yes/No
3. Did you worry you had lost control over how much you eat? Yes/No
4. Did you believe yourself to be fat when others said you were too thin? Yes/No
5. Would you say that food dominated your life? Yes/No

Supplementary question – (asked of respondents scoring two or more on the SCOFF): 'Did your feelings about food interfere with your ability to work, meet personal responsibilities and/or enjoy a social life?'

Saying yes to two or more questions represented a positive screen for eating disorder and indicated that that clinical assessment for eating disorder is warranted.

APMS 2007 found that:-

- 6.4%of adults screened positive for a *possible* eating disorder in the past year and the proportion who screened positive and also responded yes to the supplementary question was 1.6%.

- Eating disorders more likely in women than men (9.2%in women compared with 3.5% in men, with young women 20 times more likely than older women.

- Ethnicity and household income were *not* significantly associated with a positive screening.

**CO-MORDBITIES**

**DUAL DIAGNOSIS**

In broad terms the term refers to someone who has both mental health and alcohol and/or drug problems ('substance misuse'). Department of Health defines dual diagnosis as:

*'A primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of a psychiatric illness, intoxication and/or substance dependence leading to psychological symptoms or, substance misuse and/or withdrawal leading to psychiatric symptoms or illness.'*
(DH Dual Diagnosis Good Practice Guide 2002).

There is considerable overlap between mental health and substance misuse problems, although simple prevalence estimate is problematic as the links are complex. Analysis often examines links between specific conditions or examining people in receipt of mental health treatment and/or substance misuse treatment, for example:-

- *Specific conditions have strong associations* - APMS 2007 found a very strong association between the harmful use of alcohol and anti-social personality disorders, unsurprisingly as harmful use of alcohol contributes to ASPD diagnosis.
- *Evidence obtained from existing services users* – nationally it is estimated that a third of patients in mental health services have a substance misuse problem

A study conducted in four inner city areas in England in 2002 (Brent, Hammersmith and Fulham, Nottingham and Sheffield) examined the prevalence of mental health and substance misuse problems amongst people in receipt of mental health or substance misuse services This study found that 75% in drug services and 85% of people in alcohol misuse services had a diagnosis of the mental health problem in the previous year.

**Table 29** Estimated Prevalence of MH Problems - Substance Misuse Patients

| | % of **drug** treatment population *(CIs in brackets)* | % of **alcohol** treatment population *(CIs in brackets)* |
|---|---|---|
| All disorders | 75% (68.2 – 80.2) | 85% (74.2 – 93.1) |
| Non – substance induced psychotic disorders | 8% (4.7 – 12.3) | 19% (10.4 – 31.4) |
| Personality disorder | 37% (30.6 – 43.9) | 53% (40.1 – 66.0) |
| Depression and/or anxiety disorder | 68% (60.9 – 73.8) | 81% (68.6 – 89.6) |
| Severe depression | 27% (21.1 – 33.3) | 34% (22.3 – 47.0) |
| Mild depression | 40% (33.7 – 47.1) | 47% (34.0 – 59.9) |
| Severe anxiety | 19% (14.0 – 24.9) | 32% (20.9 – 45.4) |

(Reproduced from B&H Dual Diagnosis)

## RECORDED PREVALENCE

**Caveats**

- This is *recorded* prevalence and higher numbers may be related to improved identification.
- Not everyone with a condition is identified and placed on register, or present themselves to a GP.
- Some people with conditions will not be registered with a GP.

As part of the Quality and Outcomes Framework, GPs hold three registers relating to mental health; one for depression and one for severe mental illness (schizophrenia, bipolar disorder and other psychoses) and a register for dementia.

**Table 30** Overall West Sussex Figures (2011/12)

| **Register** | **Numbers** | **% of patients** | ***England %*** |
|---|---|---|---|
| Severe Mental Illness – West Sussex total | 6,125 | 0.7% | *0.8%* |
| - Coastal West Sussex | 3,918 | 0.8% | |
| - Crawley | 789 | 0.6% | |
| - Horsham and Mid Sussex | 1,418 | 0.6% | |
| Depression– West Sussex total | 83,363 | 12.4% | *11.7%* |
| - Coastal West Sussex | 52,560 | 13.3% | |
| - Crawley | 10,754 | 11.0% | |
| - Horsham and Mid Sussex | 20,049 | 11.3% | |
| Dementia – West Sussex total | 5,471 | 0.7% | *0.5%* |
| - Coastal West Sussex | 3,532 | 0.7% | |
| - Crawley | 568 | 0.5% | |
| - Horsham and Mid Sussex | 1,371 | 0.6% | |

QOF includes two registers associated with depression

***Depression 2*** **-** relates to all patients on practice lists aged 18+ who have a current diagnosis of depression. Note it is important to note that the Depression 2 indicator denominator is based only on a subset of this register, i.e. those who are recently diagnosed.

| | |
|---|---|
| Depression (2) – West Sussex total | 62,242 |
| Coastal West Sussex | 40,119 |
| Crawley | 8,360 |
| Horsham and Mid Sussex | 13,763 |

**Fig 21** % of Registered Patients (aged 18+) with Depression
Source : QOF 2011/12

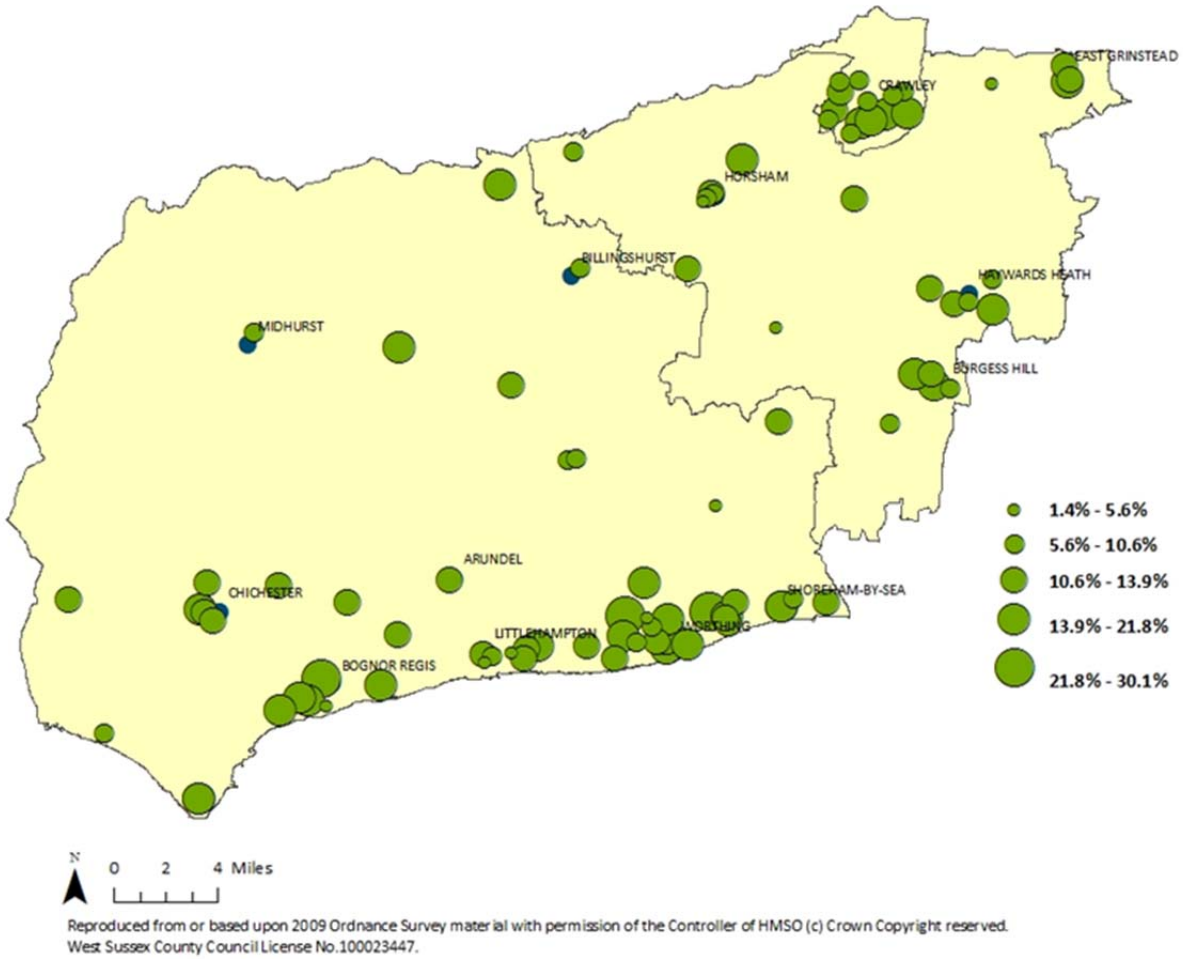
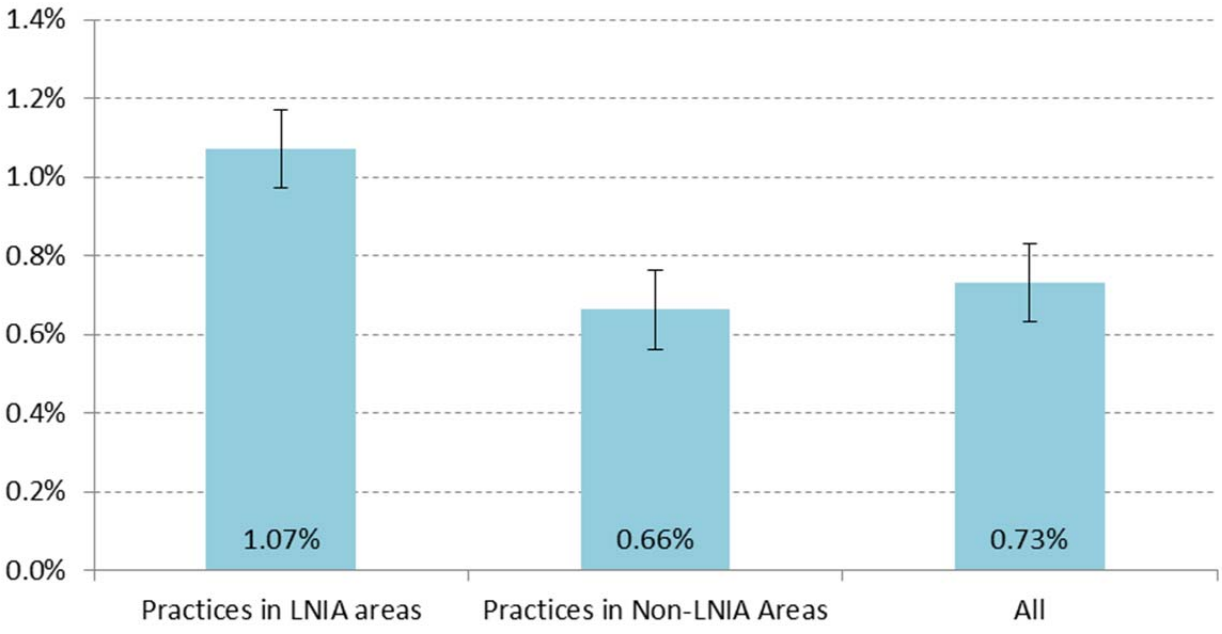





**Fig 22** **Severe Mental Illness**
*(QOF 2011/12 Registers – Local Neighbourhood Improvement Areas contain the most deprived areas of the county)*



**Identification of Post Natal Depression (PND)**

Post Natal Depression is a distressing condition that can affect a mother's ability to care for her baby and herself. It is common, affecting about 1 in 10 mothers. A small number develop psychotic symptoms and need to seek help urgently. Most women will get better within 3-6 months without treatment but 1 in 4 will still be affected when the baby is a year old. PND can spoil a mother's enjoyment of the new baby, put a strain on the relationship with her partner, and can affect the child's long term development and behaviour even after the depression has ended.

Postnatal Identification

*The following data relate only to those women who have agreed to a 12-16 week visit and therefore not all mothers are included in the figures*

Following NICE guidance a series of screening questions are used (the "Whooley" questions) notably:-

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

And a third question added:-

- Is this something you feel you need or want help with?

Women are then offered a screening using the Edinburgh Postnatal Depression Scale (EPDS).

The diagram overleaf shows how women are currently being screened and identified for support via the 3 month check. The figures in blue represent the number of women at each stage of the process.

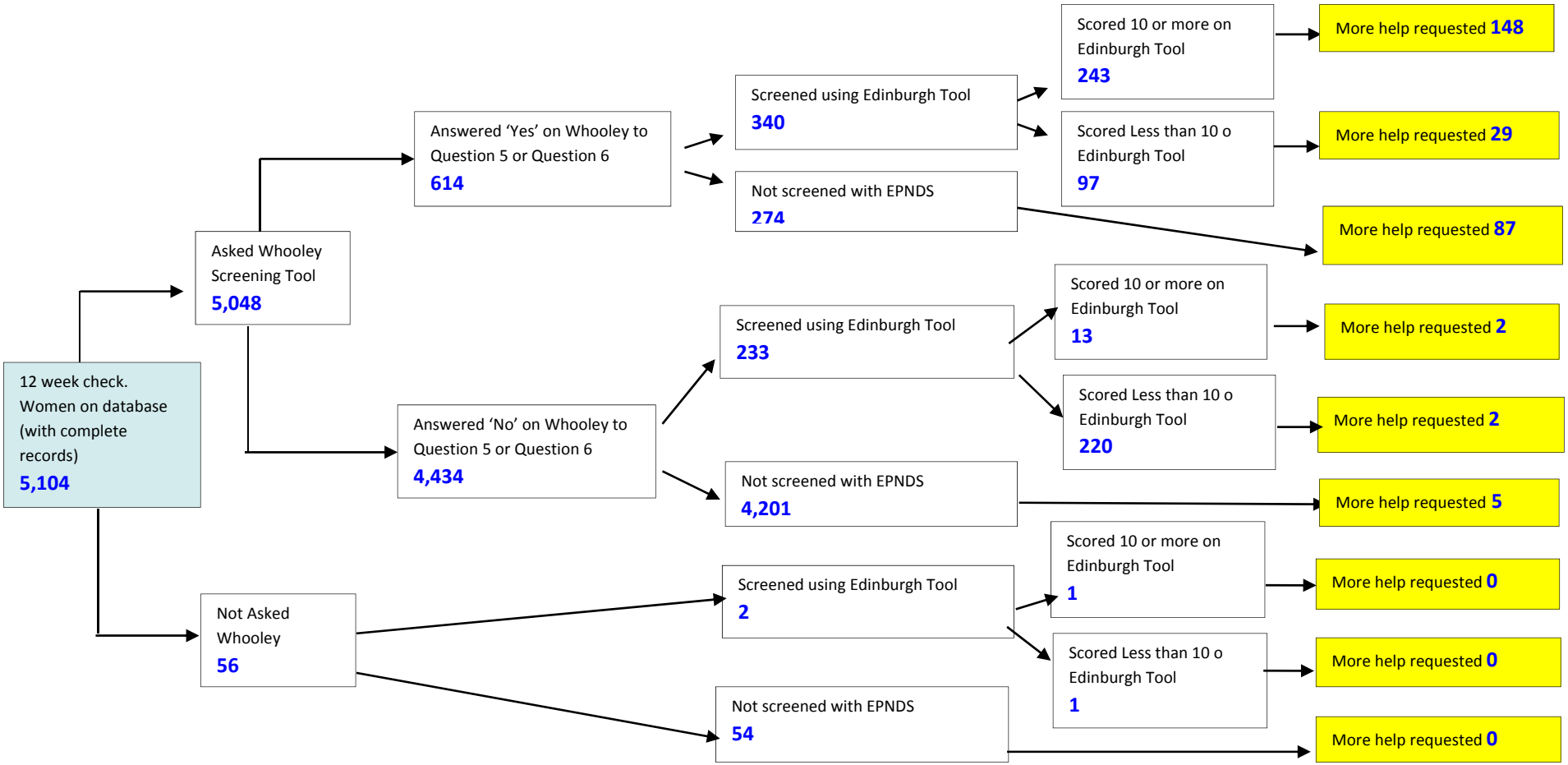
Of the 5,104 women with recorded information, 5,048 had been screened using the Whooley questionnaire. The data showed that various paths had been followed with the screening tools, some women had no initial screening data but then had been assessed using the Edinburgh scale, some had identified using the Whooley but then not assessed using the Edinburgh tool.
This indicates an inconsistency of practice with the tools, although it should be noted agreement to screening is voluntary.

**Identification of Post Natal Depression (PND)** (*Data relate to 2012)*

**STEP 1**
Women initially screened used the Whooley Tool.

**STEP 2**
Following Whooley, women who answered yes to either Q5 or Q6 offered to be screened using the Edinburgh Post Natal Depression Scale (EPNDS)

**STEP 3**
Women identified as being at risk of Post Natal Depression (scoring 10 or more on the EPNDS). Help then requested / offered.



**Annual report from MHMDS returns - England 2011/12, initial national figures**

**Fig 23** Prevalence Against Specific PbR Clusters *(National Estimates)*

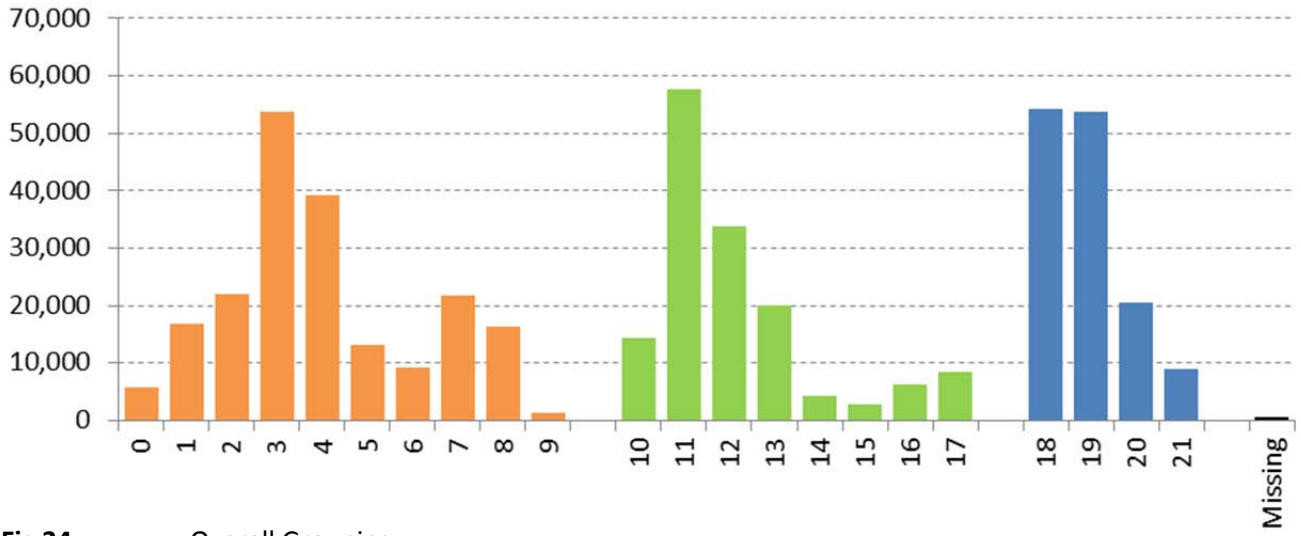



**Fig 24** Overall Grouping

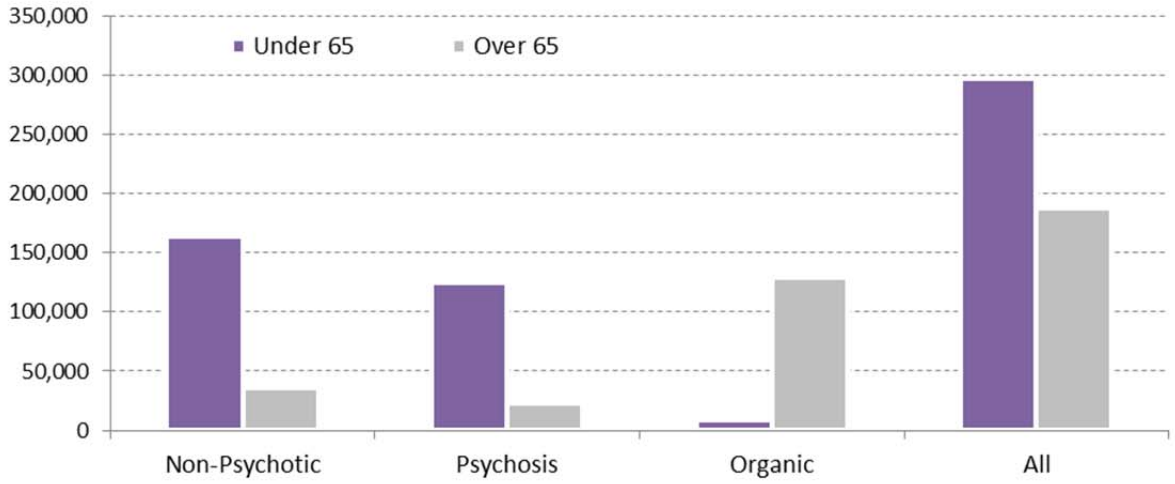
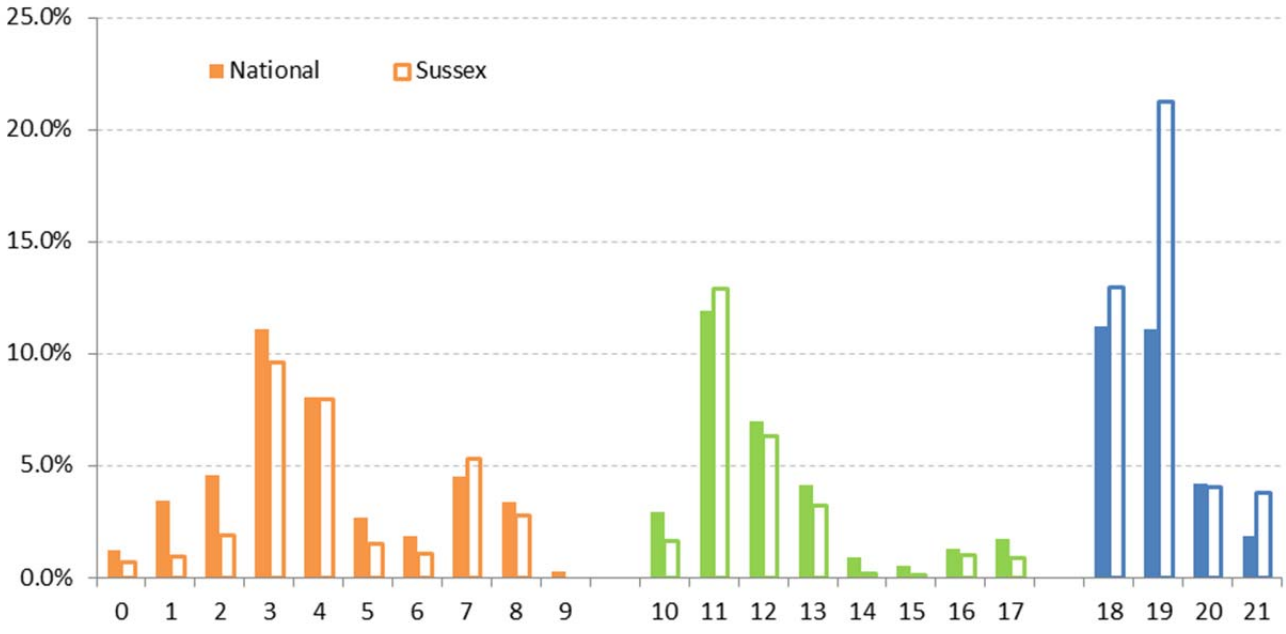


**Fig 25** National profile compared with valid clusters mapped by Sussex Partnership NHS Foundation Trust (April 2013 data – Sussex-wide data)



**Suicide**

*Suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent (ICD codesE950-E959 & E980-E989 excluding E988.8).*

Suicide is a significant cause of death in early (under 75) death. In 2011 there were 6,045 suicides in the UK in people aged 15 years or over. This was an increase of 437 compared with 2010.

Nationally:-

- The majority of suicides are male suicides (of the 6045 suicides in 2011 4,552 were male, 1,493 female.
- Highest rate observed in males aged 30-44.
- Nationally the suicide rate for males aged 45 to 59 increased significantly between 2007 and 2011.
- For women, the highest rates are observed in the 45-49 years age group.

**Table 31** Suicides West Sussex Local Authorities

| Local Authority | 2009 | 2010 | 2011 |
|---|---|---|---|
| Adur | 5 | 5 | 5 |
| Arun | 11 | 10 | 15 |
| Chichester | 6 | 2 | 8 |
| Crawley | 2 | 17 | 8 |
| Horsham | 4 | 7 | 19 |
| Mid Sussex | 5 | 5 | 6 |
| Worthing | 12 | 11 | 1 |
| West Sussex | 45 | 57 | 62 |

*Figures relate to people aged 15 and over, they exclude non-residents and relate to the date death registered*

**Fig 26** Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34 exc Y33.9)
MALES 2008-2010 (Pooled Years)
Rate per 100,000 Standard Population

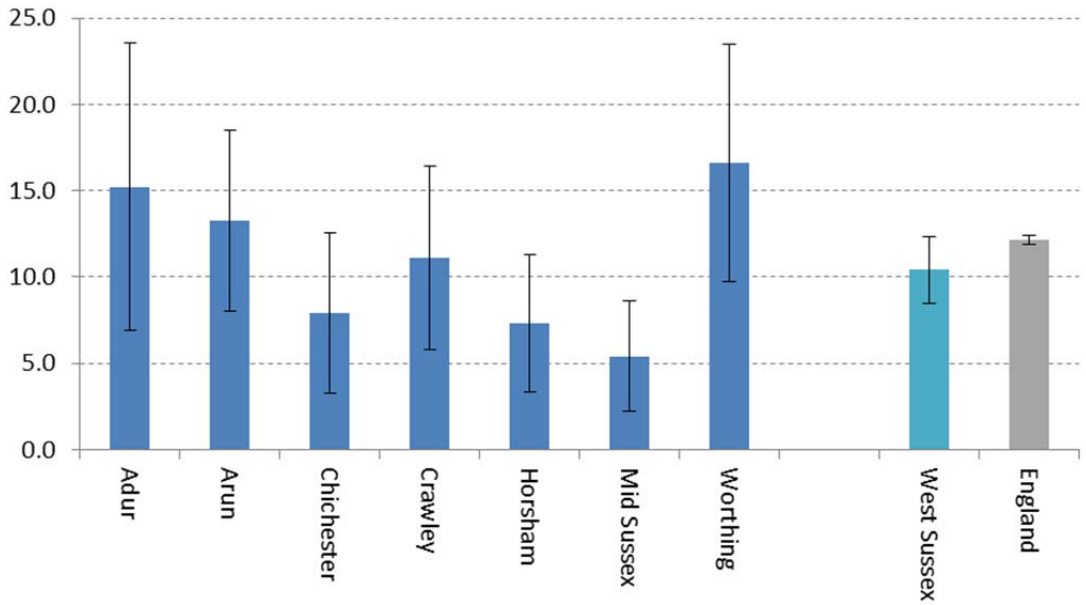
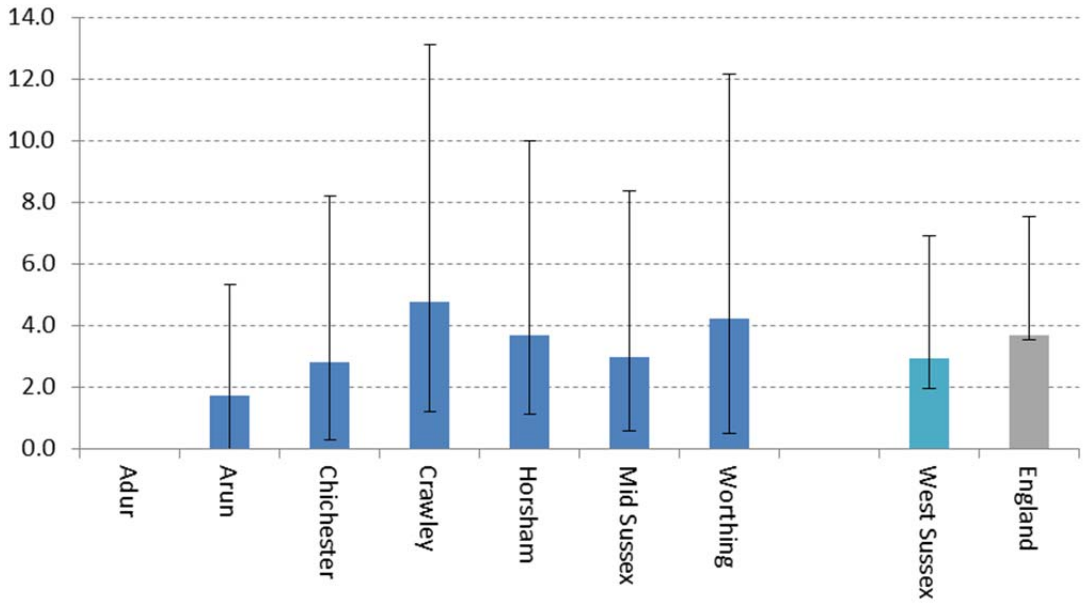


**Fig 27** Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34 exc Y33.9)
FEMALES 2008-2010 (Pooled Years)
Rate per 100,000 Standard Population




**Suicide Trend**

**Fig 28** Annual Trend – All People

Mortality from suicide and injury undetermined (ICD9 E950-E959, E980-E989 exc E988.8; ICD10 X60-X84, Y10-Y34 exc Y33.9): 1993-2010 (Annual trends) per 100,000 European Standard population

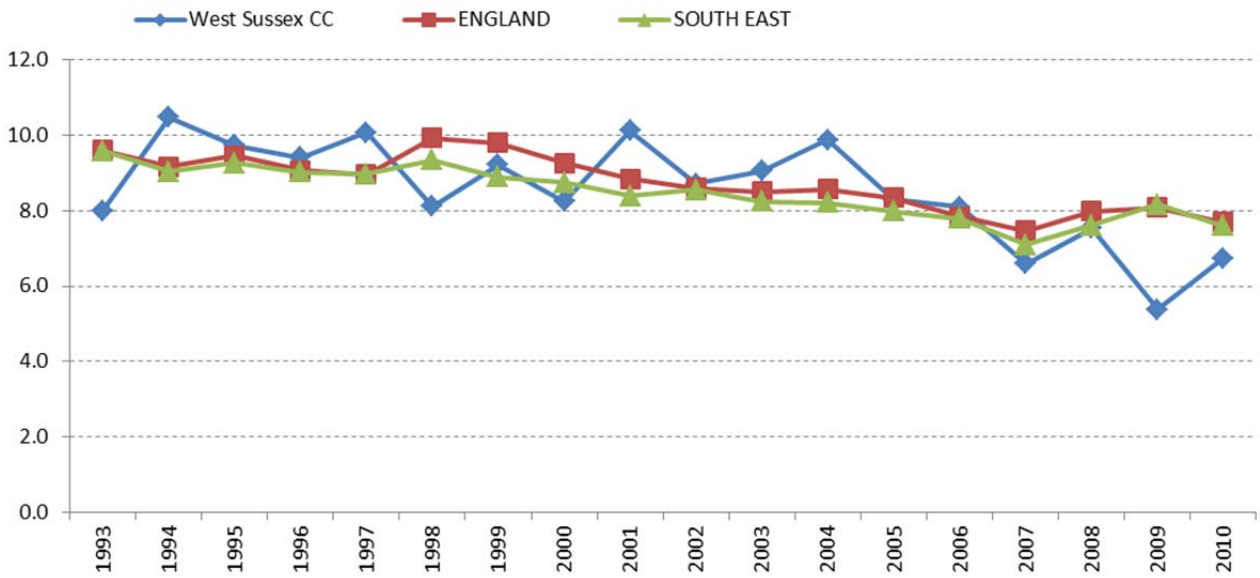


**Table 32 Outcomes of People with Mental Health Problems** – Public Health, NHS and Social Care Outcomes

| Domain | Ref | Outcome | |
|---|---|---|---|
| **Public Health Outcomes Framework** | | | **West Sussex – Latest Comparable Data** |
| 1. Improving the Wider Determinants of Health | 1.6 | **People with mental illness and/or disability in Settled Accommodation** | • 2010/11 WEST SUSSEX 72.6% ENGLAND 66.8% |
| | 1.7 | **People in Prison who have a mental health illness or significant mental illness.** | *Not available* |
| | 1.8 | **Employment for those with a long term condition including those with a learning disability or mental illness.** | *Not available* |
| 2. Health Improvement | 2.1 | **Hospital admissions as a result of self-harm** | |
| | 2.23 | **SELF REPORTED WELLBEING**<br><br>ONS measuring individual/subjective well-being based on four questions included on the Integrated Household Survey:<br><br>1. Overall, how satisfied are you with your life nowadays?<br>2. Overall, how happy did you feel yesterday?<br>3. Overall, how anxious did you feel yesterday?<br>4. Overall, to what extent do you feel the things you do in your life are worthwhile?<br><br>Responses are given on a scale of 0-10 (where 0 is "not at all satisfied/happy/anxious/worthwhile" and 10 is "completely satisfied/happy/anxious/worthwhile") | *Figures relate to 2011/12*<br>2.23i - % of respondents scoring 0-6 to the question "Overall, how satisfied are you with your life nowadays?" % with a low score<br><br>• WEST SUSSEX 20.3% (CI 17.5 – 23.0) significantly better than Eng.<br>• ENGLAND 24.3% (CI 24.0 – 24.6)<br><br>2.23ii - % of respondents scoring 0-6 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?" % with a low score<br><br>• WEST SUSSEX 15.3% (CI 12.7 – 17.8) significantly better than Eng.<br>• ENGLAND 20.1% (CI 19.8 – 20.4)<br><br>2.23iii - % of respondents scoring 0-6 to the question "Overall, how happy did you feel yesterday?" % with a low score<br><br>• WEST SUSSEX 26.1% (CI 23.0 – 29.3) no diff compared with Eng.<br>• ENGLAND 29.0% (CI 28.7 – 29.4)<br><br>2.23iv - % of respondents scoring 4-10 to the question "Overall, how anxious did you feel yesterday?" % with a low score<br><br>• WEST SUSSEX 38.0% (CI 34.4 – 41.6) no diff compared with Eng.<br>• ENGLAND 40.1% (CI 39.8 – 40.5) |

| Domain | Ref | Outcome | |
|---|---|---|---|
| 4. Healthcare Public Health and Preventing Premature Mortality | 4.7 | Excess under 75 mortality in adults with a serious mental health illness. | • 2009-2011 WEST SUSSEX 1,170 (CI 939/1401) rate per 100,000 population<br>• 2009-2011 ENGLAND 921.2 (CI 896.5/945.9) rate per 100,000 population<br><br>No sig diff. |
| | 4.1 | Suicide | • 2009-2011 WEST SUSSEX 6.4 (CI 5.4/7.5) per 100,000 population<br>• 2009-2011 ENGLAND 7.9 (CI 7.8/8.0) per 100,000 population<br><br>West Sussex has a significantly lower suicide rate compared with England. |
| **NHS Outcomes Framework** | | | |
| 1. Preventing People Dying Prematurely | 1.5 | Under 75 Mortality Rate for People with Serious Mental Illness | *As PHOF 4.7* |
| 2. Improving the Quality of Life for People with Long Term Conditions | 2.5 | **Employment of people with mental illness**<br><br>The difference in employment rate of England population and of people with a mental illness | • Q1 2011/12 GAP IN WEST SUSSEX 46.5%, GAP IN ENGLAND 43.1% |
| 3. Helping People to Recover from Episodes of Ill health or following injury | 3.1 | Improving outcomes for planned procedure – psychological therapies | *Not available* |
| 4. Ensuring that People have a Positive Experience of Care | 4.7 | Patient experience of community mental health services. | *Not available* |
| **Adult Social Care Outcomes Framework** | | | |
| 1. Enhancing the quality of life for people with care and support needs | 1F | Proportion of adults in contact with secondary mental health services in paid employment | • 2012/13 WEST SUSSEX 9.3% ENGLAND 7.7% |
| | 1H | Proportion of adults in contact with secondary mental health services living independently without the needs for support | • 2012/13 WEST SUSSEX 65.7% ENGLAND 59.3% |

**Management within Primary Care Data from Quality Outcomes Framework (QOF)**

GPs hold registers on patients identified with depression and with serious mental illness. Recorded prevalence is detailed on page 52.

- In relation to depression, information relating to the screening to assess the severity of depression and also the screening of people on other long term registers (diabetes and CHD) is collected.
- In relation to serious mental illness, changes have been made to specific QOF measures year on year, but the main objective remains to ensure that there is a comprehensive care plan in place.

Data for 2012/13 are shown for the following indicators at practice, CCG, county and England information.

**QOF 2012/2013 DEPRESSION AND MENTAL HEALTH INDICATORS**

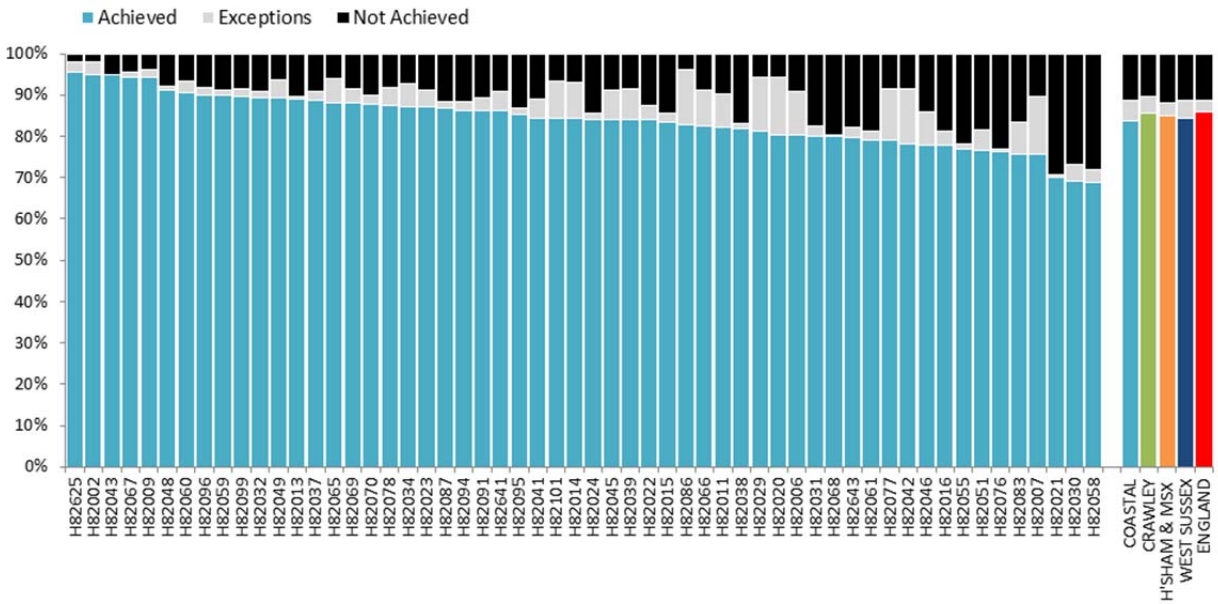
| QOF REFERENCE | DESCRIPTION |
|---|---|
| DEP01 | The percentage of patients on the diabetes register and/or the CHD register for who case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions. |
| DEP06 | In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care. |
| DEP07 | In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. |
| MH10 | The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. |
| MH11 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months |
| MH12 | The percentage of patients with schizophrenia, bipolar affective disorder and other pychoses who have a record of BMI in the preceding 15 months. |
| MH13 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months. |
| MH16 | The percentage of women (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. |
| MH17 | The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. |
| MH18 | The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. |
| MH19 | The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months. |
| MH20 | The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months. |

| | |
|---|---|
| **DEP01** | The percentage of patients on the diabetes register and/or the CHD register for who case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions. |

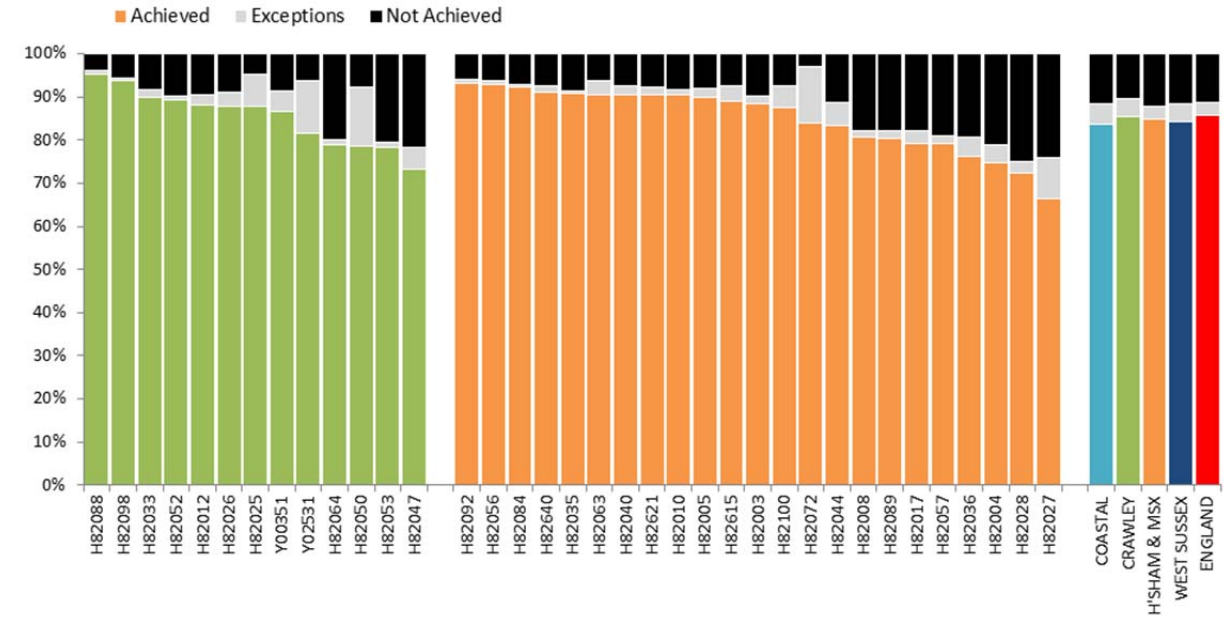
*Rationale (BMA QOF 2012/13 Guidance):*

*Depression is more common in patients with CHD and for patients with CHD; depression is associated with poorer outcomes.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

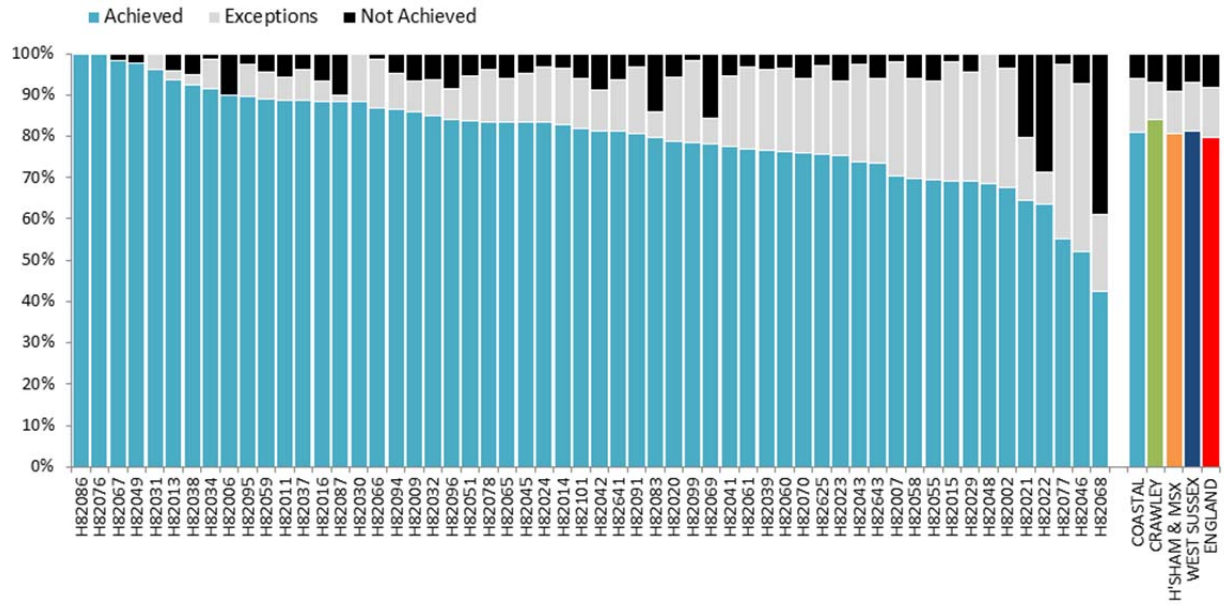


| | |
|---|---|
| **DEP06** | In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care. |

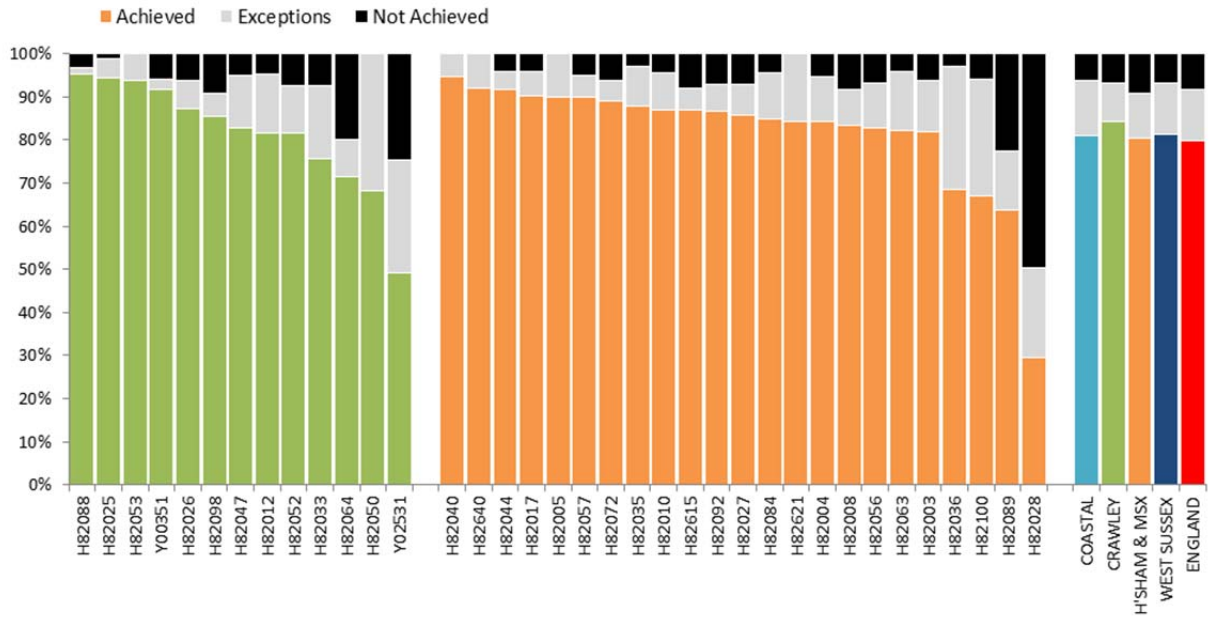
*Rationale (BMA QOF 2012/13 Guidance):*

*Assessment of severity in patients with depression is essential to decide on appropriate interventions and improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression. NICE guideline states, for example, that antidepressants are not recommended for the initial treatment of mild depression but should be routinely considered for all patients with moderate or severe depression.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

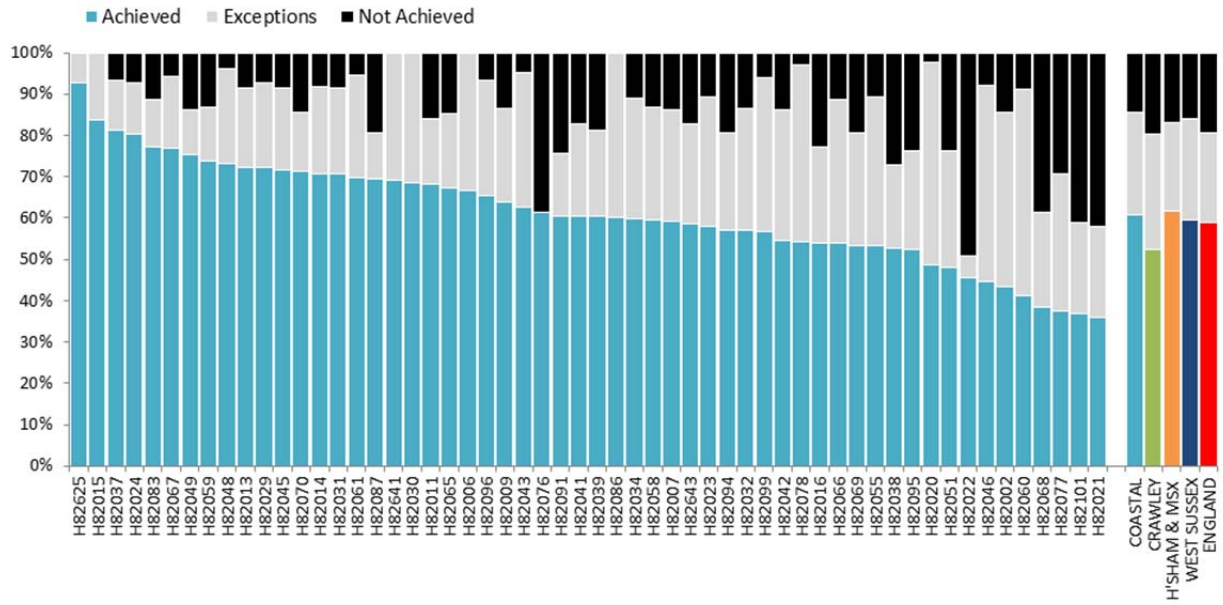


| | |
|---|---|
| **DEP07** | In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. |

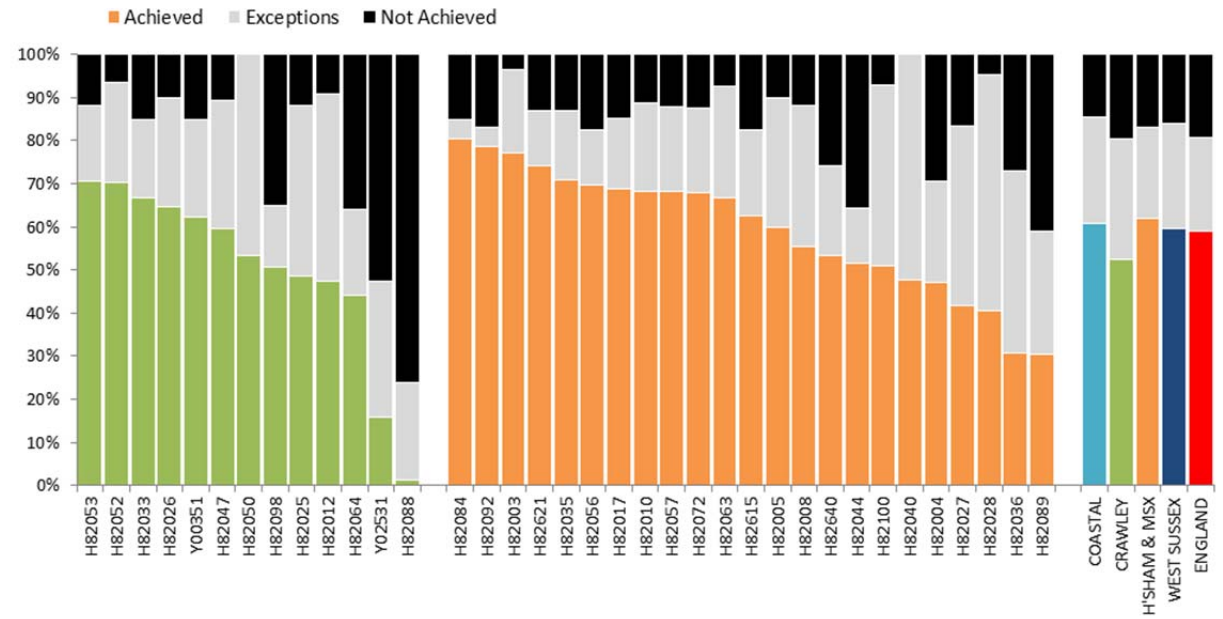
*Rationale (BMA QOF 2012/13 Guidance):*

*The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

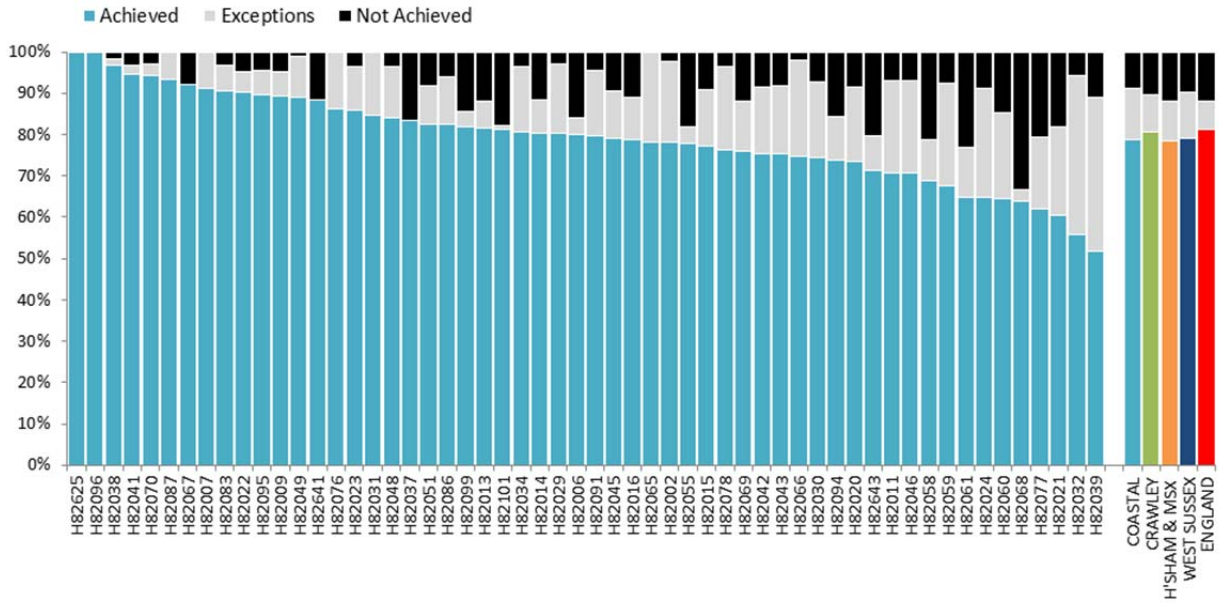


| | |
|---|---|
| **MH10** | The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. |

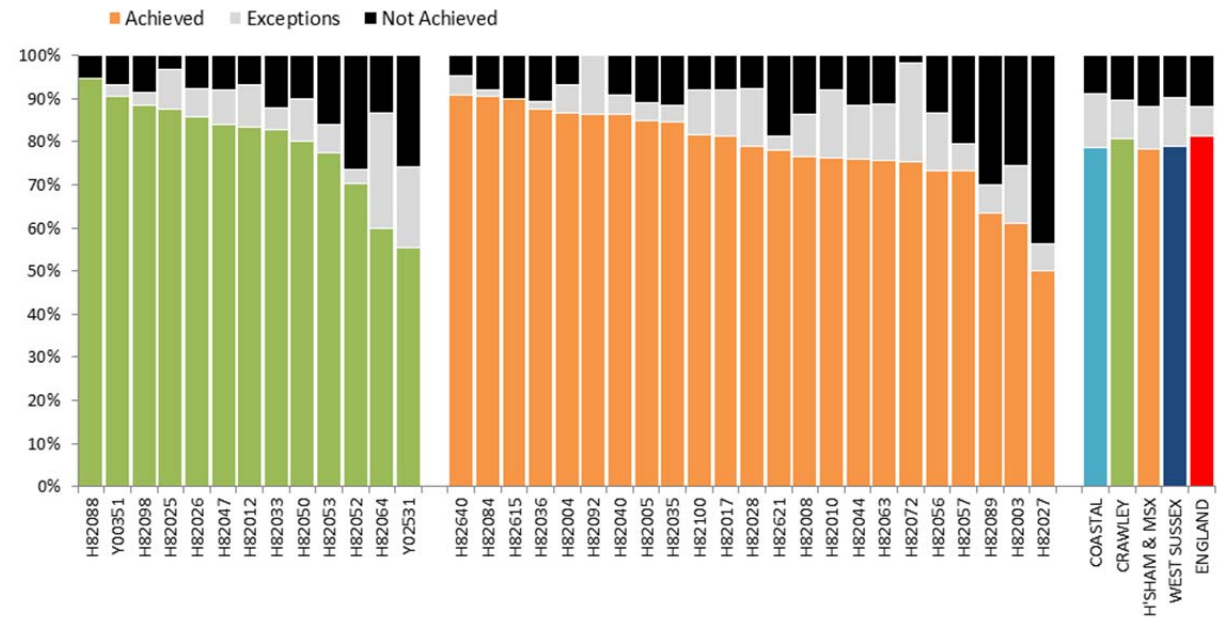
*Rationale (BMA QOF 2012/13 Guidance):*

*Indicator reflects good professional practice and supported by NICE clinical guidelines. Patients on the mental health register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. This consultation may include the views of their relatives or carers where appropriate. Up to half of patients who have a serious mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

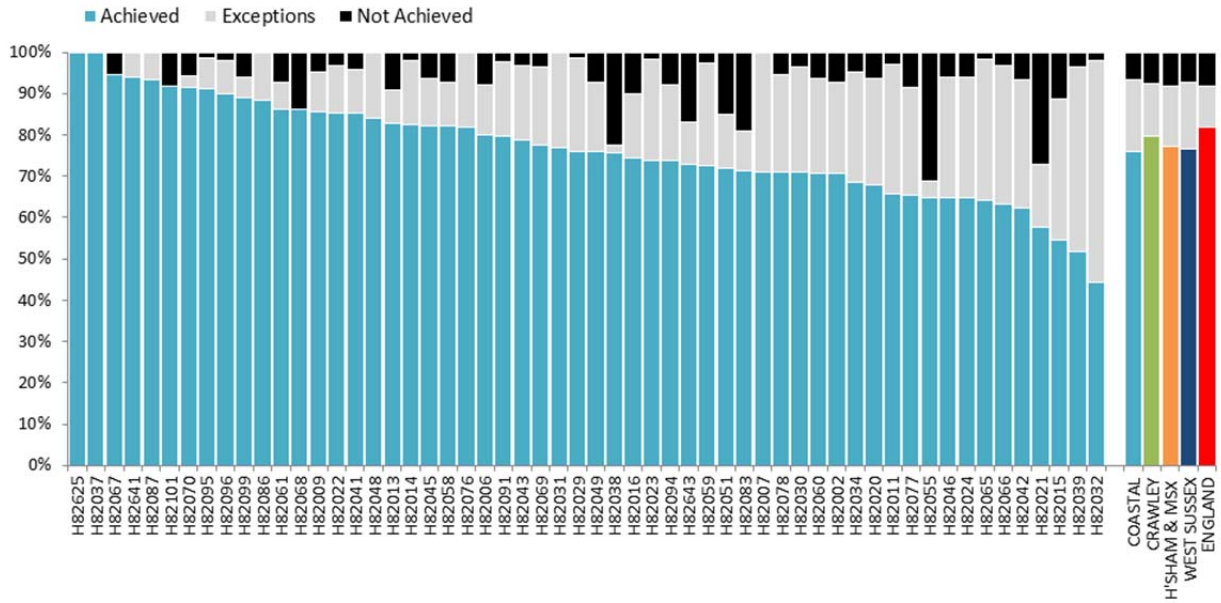


| | |
|---|---|
| **MH11** | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months |

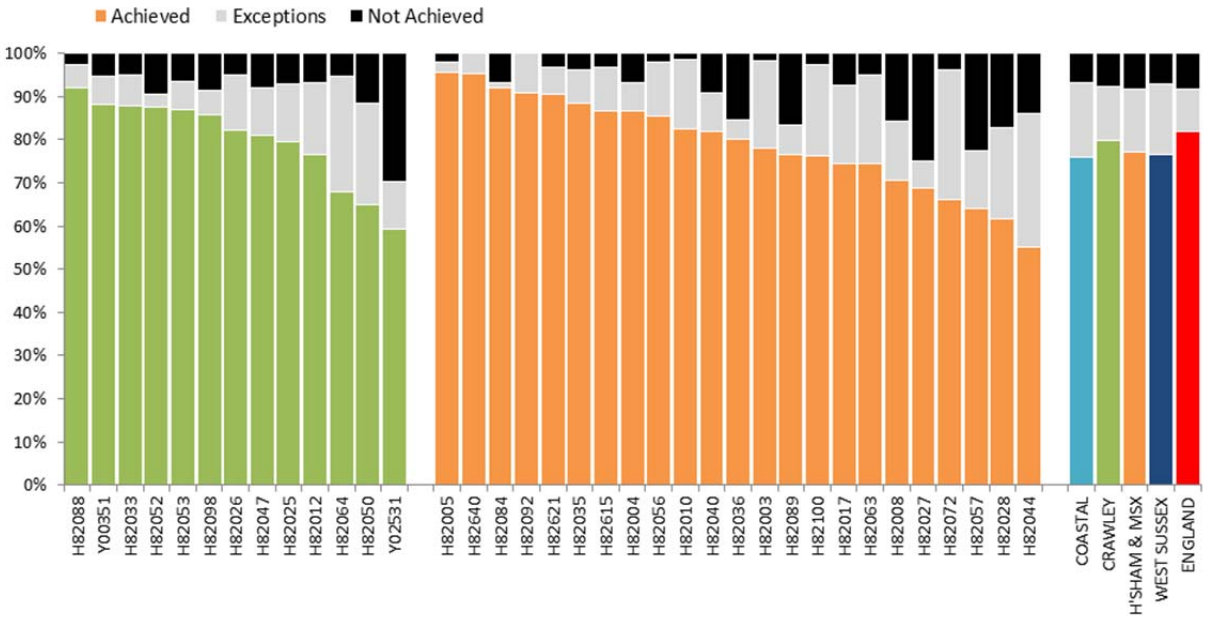
*Rationale (BMA QOF 2012/13 Guidance):*

*Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects. APMS found that 16% of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol for men and 14 units or alcohol for women a week. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

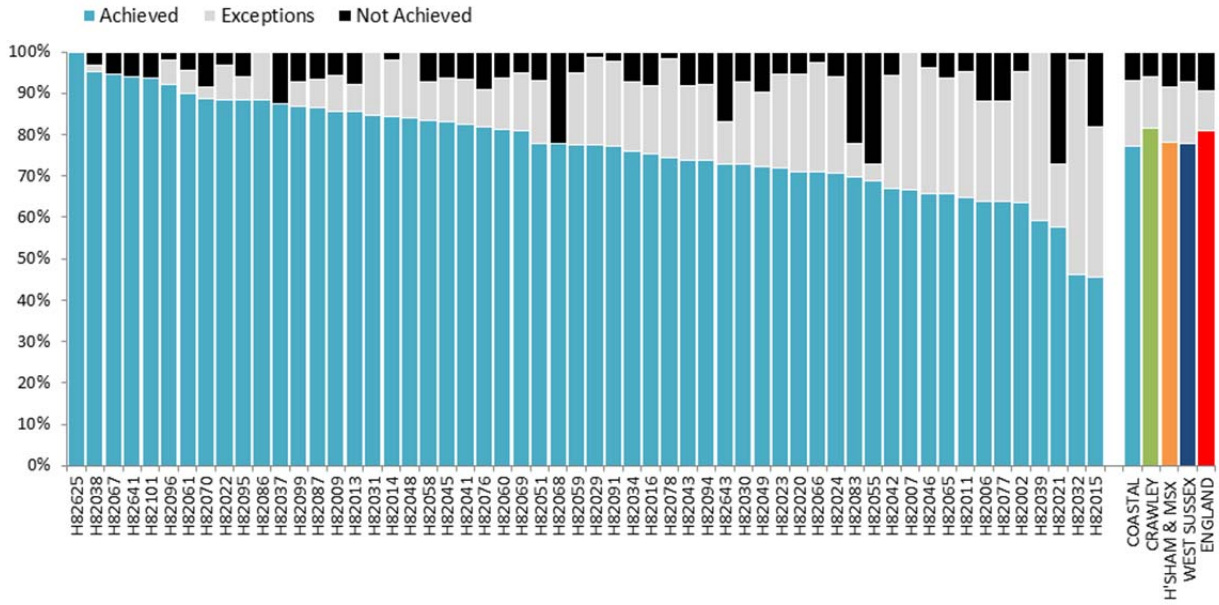


| | |
|---|---|
| **MH12** | The percentage of patients with schizophrenia, bipolar affective disorder and other pychoses who have a record of BMI in the preceding 15 months. |

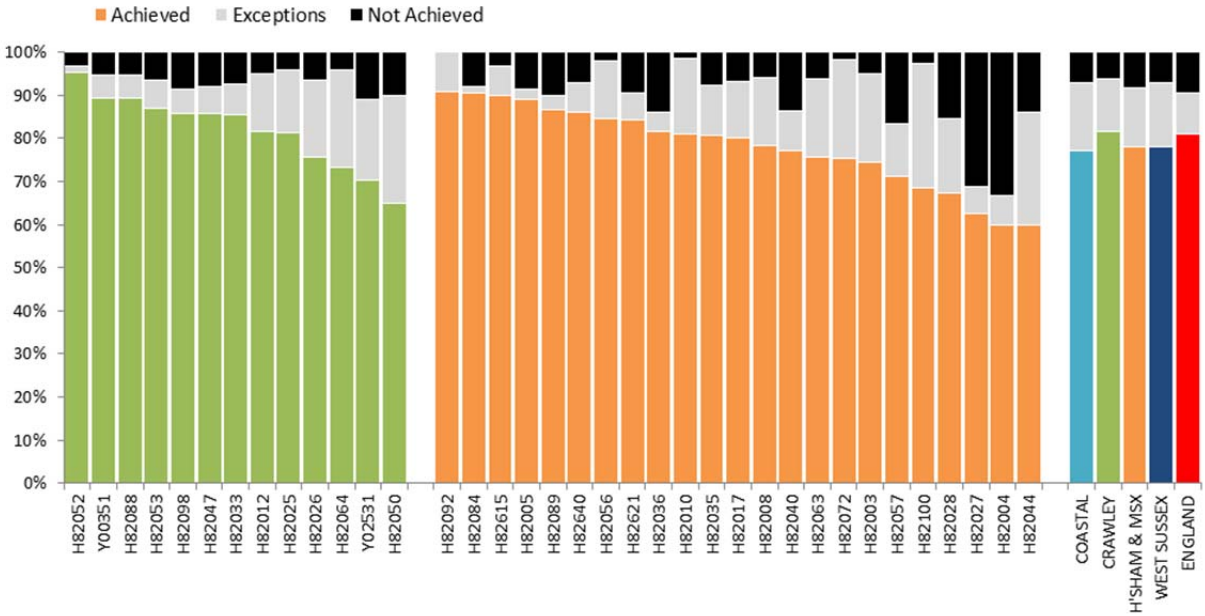
*Rationale (BMA QOF 2012/13 Guidance):*

*The general population in developed countries is experiencing an escalation in cardiovascular risk factors, such as obesity and lack of exercise, and increased rates of type 2 diabetes mellitus. Superimposed on this are lifestyle issues (not all actively chosen) for people with psychosis, generating an escalation of cardiovascular risks.*

Coastal West Sussex CCG



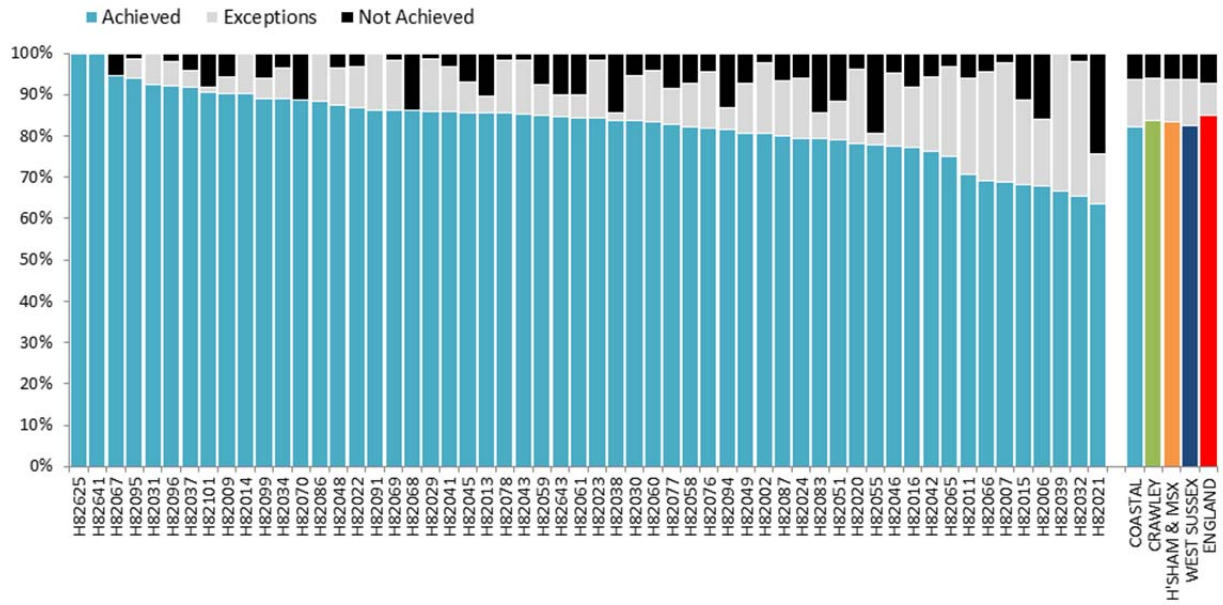

Crawley CCG and Horsham & Mid Sussex CCG



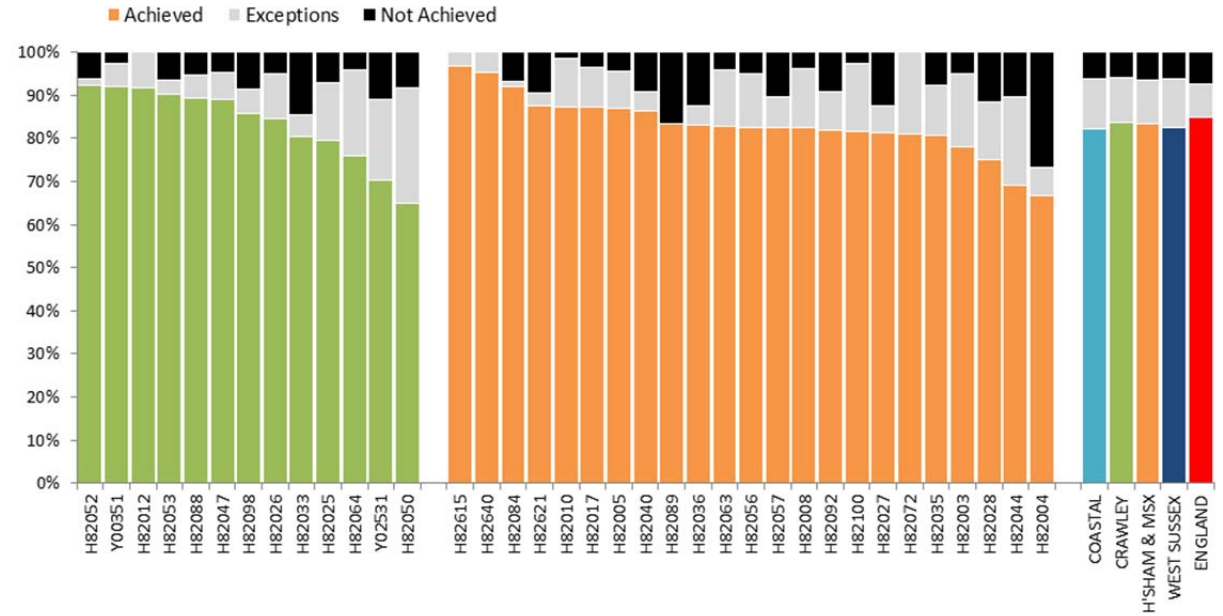
| | |
|---|---|
| **MH13** | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months. |

*Rationale (BMA QOF 2012/13 Guidance):*
*Patients with schizophrenia have a mortality of between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

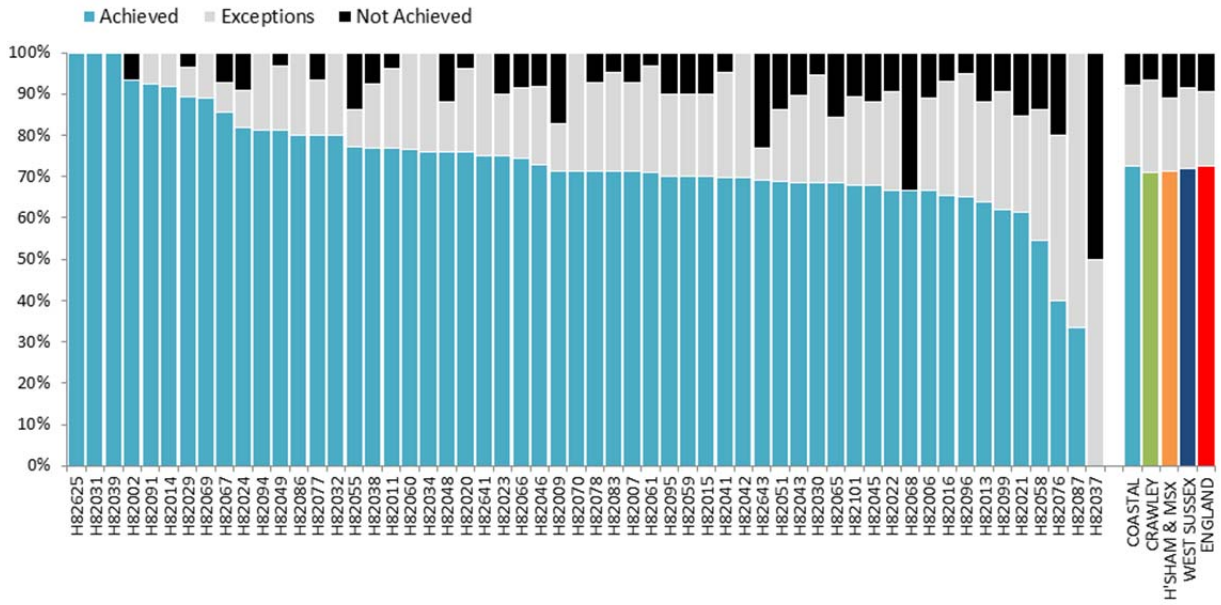


| | |
|---|---|
| **MH16** | The percentage of women (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. |

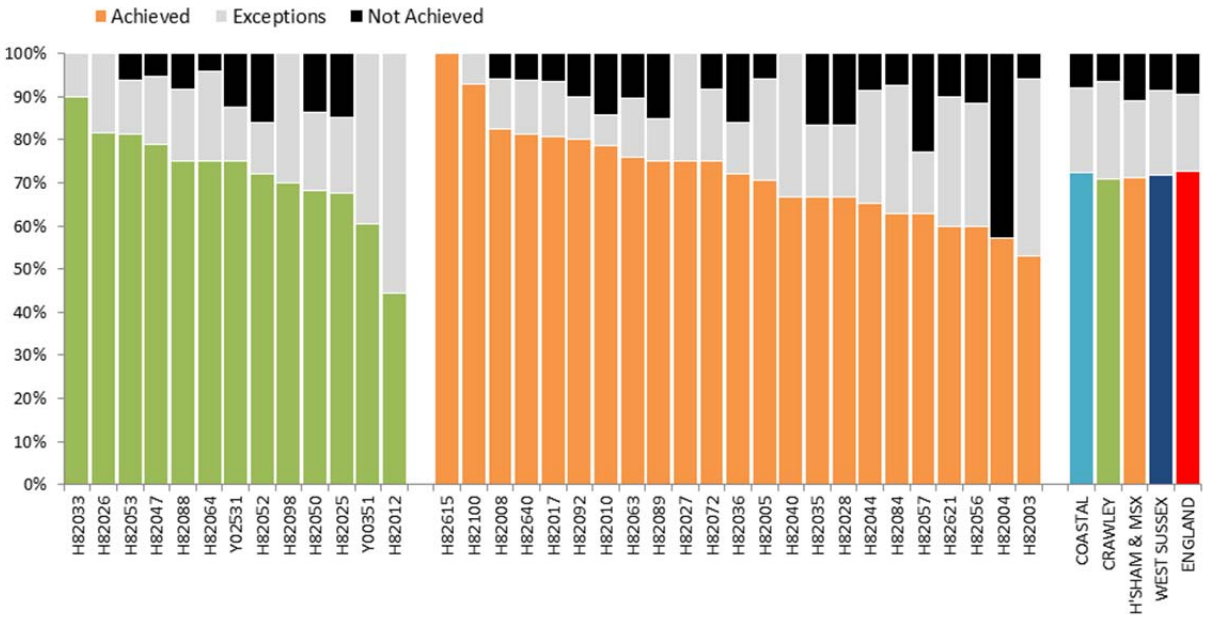
*Rationale (BMA QOF 2012/13 Guidance):*

*A report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less likely to have had a cervical sample taken in the previous five years (63%) compared with the general population (73%). This did not apply to patients with bipolar affective disorder.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

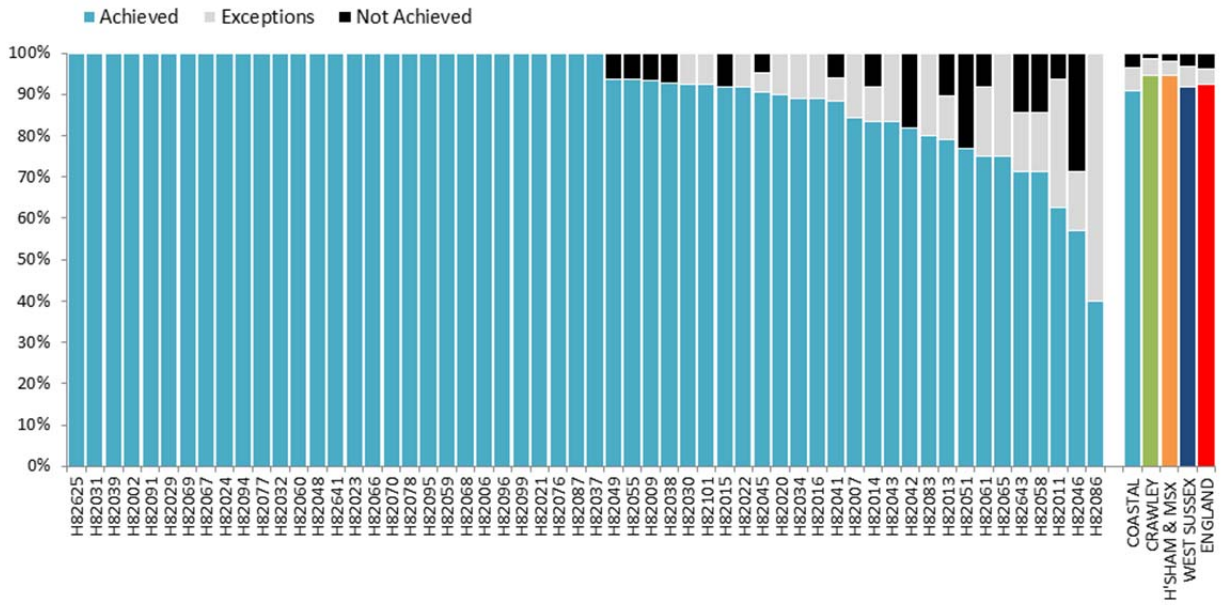


| | |
|---|---|
| **MH17** | The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. |

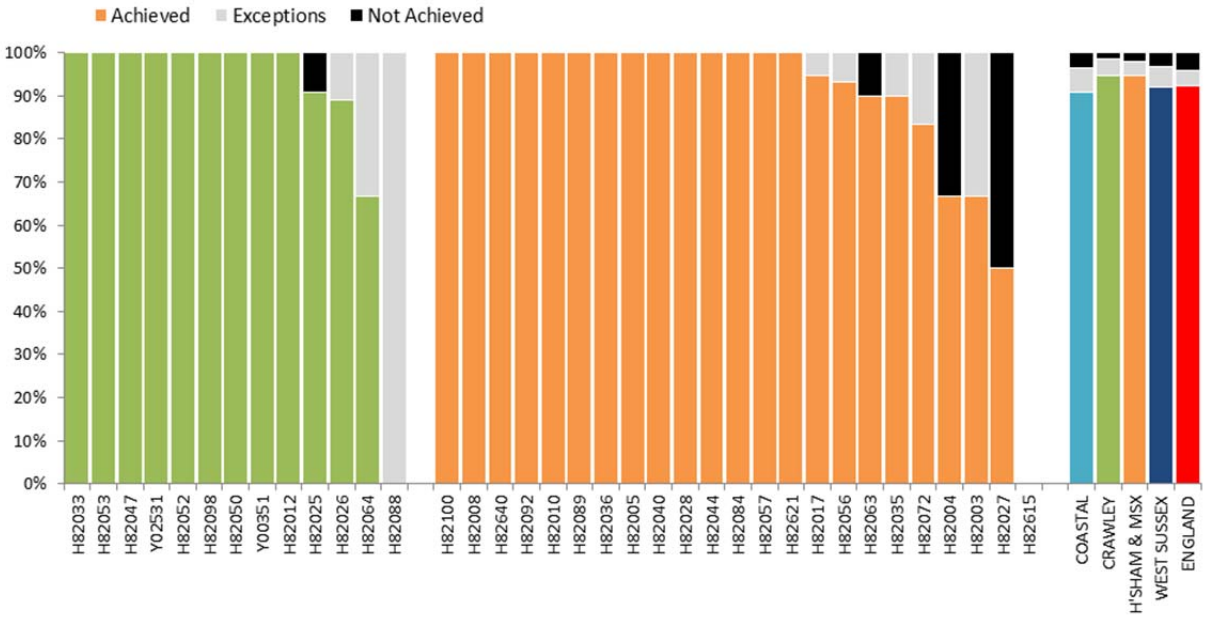
*Rationale (BMA QOF 2012/13 Guidance):*

*There is a much higher than normal incidence of hypothyroidism and hypercalcaemia, and of abnormal renal function tests in patients on lithium. Overt hypothyroidism has been found in between 8% to 15% of patients on lithium.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

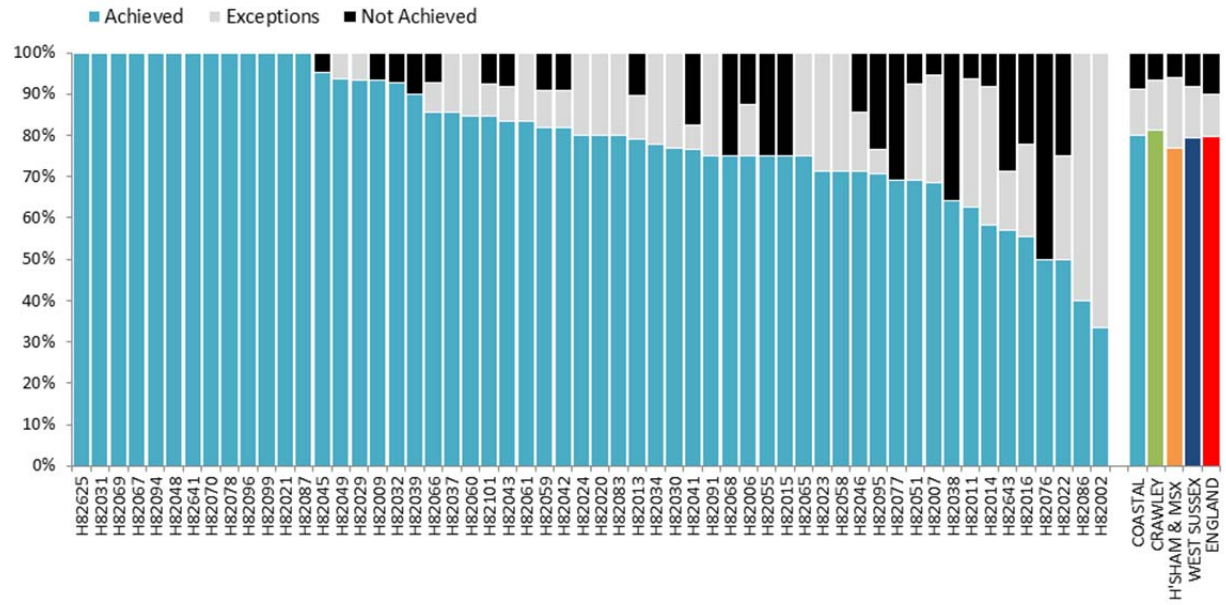


| | |
|---|---|
| **MH18** | The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. |

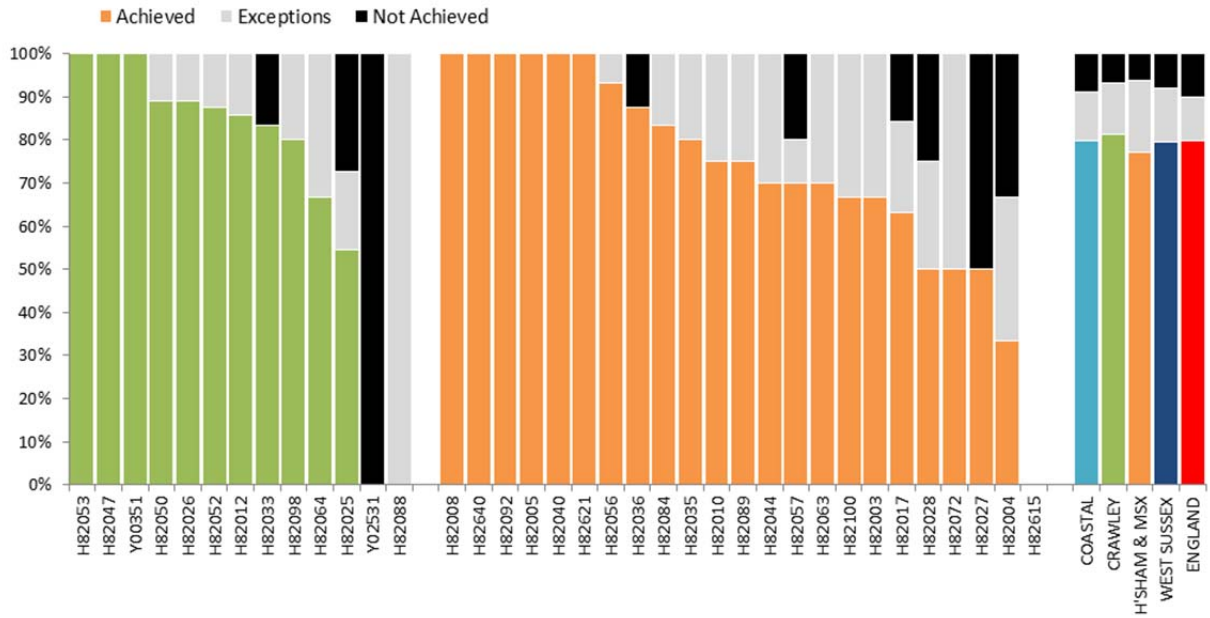
*Rationale (BMA QOF 2012/13 Guidance):*

*Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDS), which may reduce lithium excretion. The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium treatment for bipolar disorder, which demonstrated that wrong or unclear dose or strength, and monitoring were key issues for lithium therapy.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

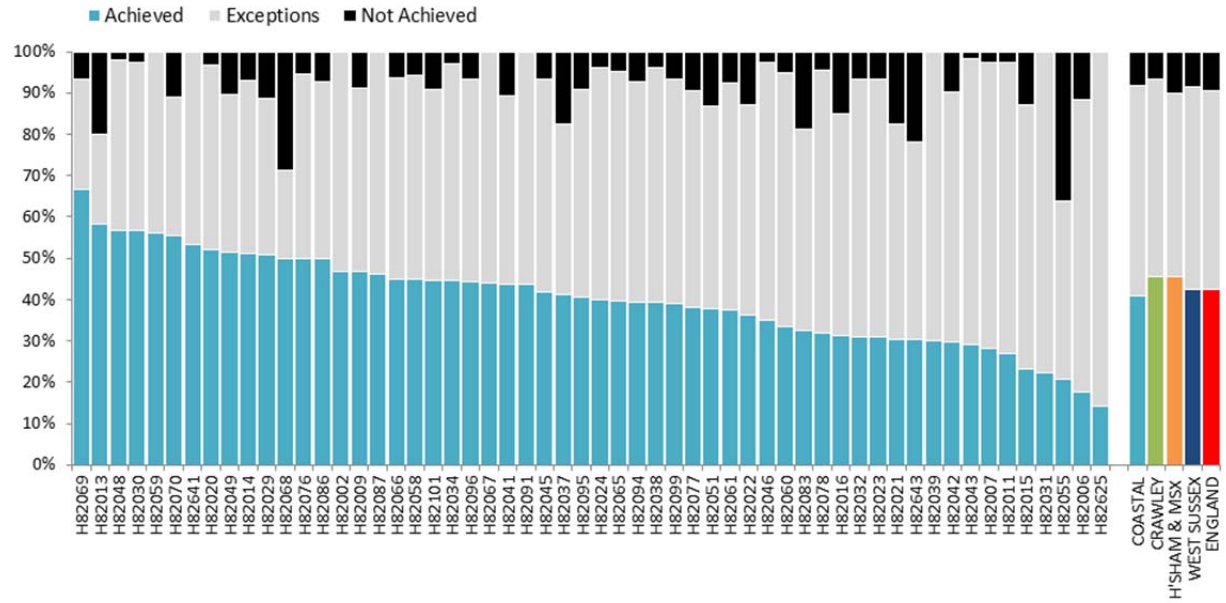


| | |
|---|---|
| **MH19** | The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months. |

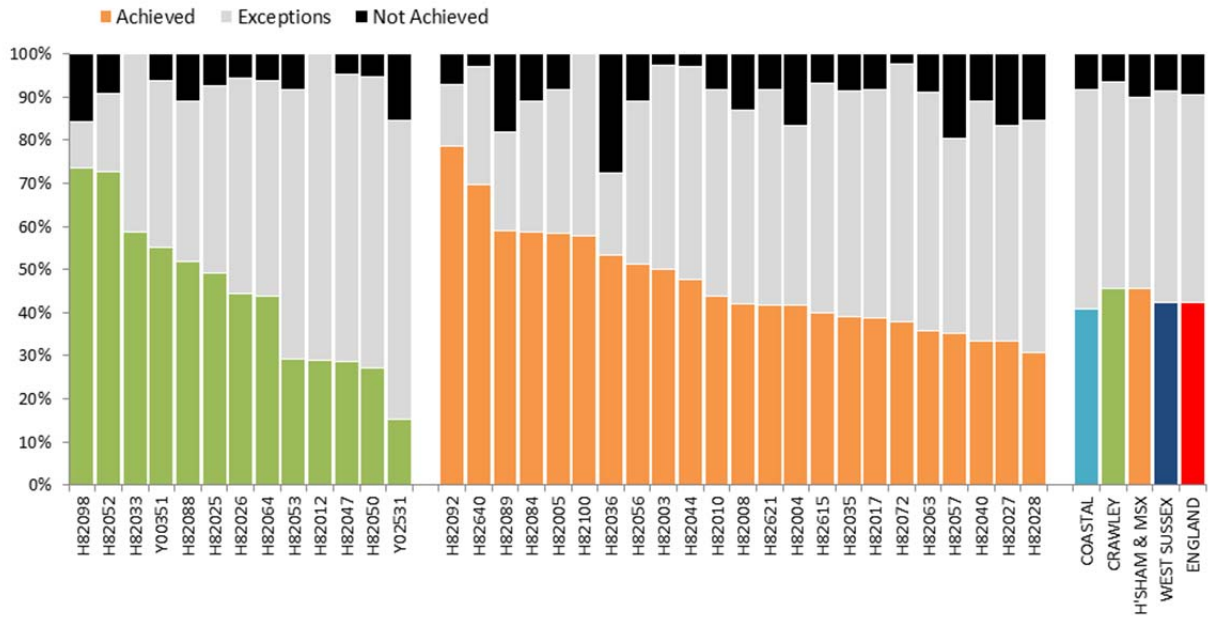
*Rationale (BMA QOF 2012/13 Guidance):*

*A cross-sectional study of 4,310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hyperlipidaemia of 23%. Patients with schizophrenia also have a much higher risk of raised total cholesterol:hdl ratio than the general population.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG

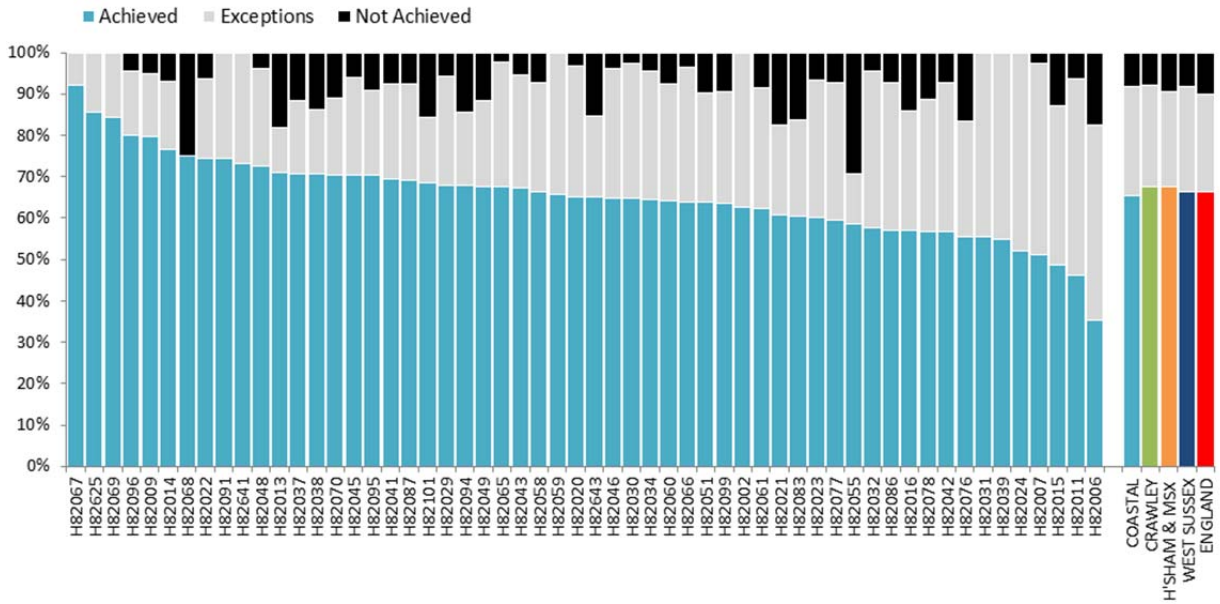


| | |
|---|---|
| **MH20** | The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months. |

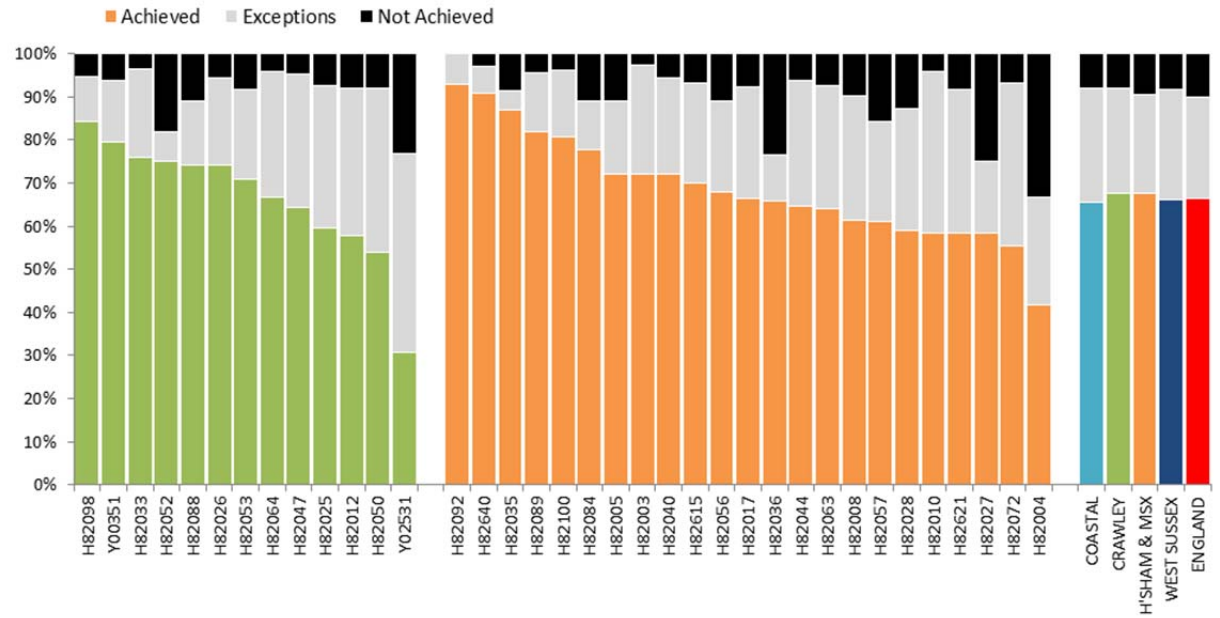
*Rationale (BMA QOF 2012/13 Guidance):*

*Studies have suggested that people with mental health disorders have a higher prevalence of chronic diseases, including diabetes, compared with the general population. The relative risk of developing diabetes mellitus is reported to be two to three times higher in people with schizophrenia than in the general population. There is insufficient evidence to support the use of blood glucose testing in patients of all ages with schizophrenia, bipolar affective disorder or other psychoses and therefore an age limit of 40 years or above has been applied to this indicator.*

Coastal West Sussex CCG




Crawley CCG and Horsham & Mid Sussex CCG



**Improving Access to Psychological Therapies (IAPT)**

*National Programme – Talking Therapies: A four-year plan of action* details the implementation of NICE recommendations relating to psychological therapies for anxiety and depression.

The IAPT programme aims to achieve (by 2015) "secure sustainable and equitable access for at least 15% of the local adult population in need of effective evidence-based psychological therapies and a 50% recovery rate among those completing treatment". Population in need of service estimated from the prevalence figures provided in the Adult Psychiatric Morbidity Survey.

In West Sussex IAPT provision is provided via the *Time to Talk* service provided by Sussex Community NHS Trust. The service is accessed via a referral from a health professional (in the main GPs) and in West Sussex is organised into three localities,

- *North East Locality* – covering Crawley, Mid Sussex and Horsham.
- *South Locality* – covering Littlehampton to Shoreham along the coastal strip.
- *West Locality* – covering Bognor and Chichester district area.

A range of information is collected as part of the programme, shown on the following pages. At present data are available at local authority area geographies

| Table | Description |
|---|---|
| KPI 1 | The number of people who have depression and/or anxiety disorders (taken from the Psychiatric Morbidity Survey) |
| KPI 3a | The number of people who have been referred for psychological therapies during the reporting period |
| KPI 3b | The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session (at the end of the reporting period) |
| PHQ13_05 | People who have entered (i.e. received) treatment as a proportion of people with anxiety or depression (%) |
| KPI 4 | The number of people who have entered (i.e. received) psychological therapies during the reporting period |
| KPI 5 | The number of people who have completed treatment (minimum 2 treatment contacts) during the reporting period broken down by gender |
| KPI 6a | The number of people who are "moving to recovery" (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) during the reporting period |
| KPI 6b | The number of people who have completed treatment not at clinical caseness at initial assessment. |
| PHQ13_06 | Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session (%) |
| KPI 7 | The number of people moving off sick pay or benefits during the reporting period |

***Caseness** – A patient is deemed to be at "caseness" when suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ9) for depression and/or the Generalised Anxiety Disorder (GAD7) for anxiety disorders, or other anxiety disorder specific measure as appropriate for the patient's diagnosis.*

***Recovery** is defined as movement to a score below caseness from a score of caseness or above.*

**Table 33** IAPT quarterly activity Data
2011/12 & 2012/13

| | | 2011/12 | | | | 2012/13 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **KP1 -** The number of people who have depression and/or anxiety disorders (taken from the Psychiatric Morbidity Survey) | West Sussex | 74,398 | 74,398 | 74,398 | 74,398 | 74,398 | 74,398 | 74,398 | 74,398 |
| **KPI 3A** - The number of people who have been referred for psychological therapies during the quarter | West Sussex | 4,307 | 4,276 | 4,023 | 4,670 | 4,254 | 4,434 | 4,533 | 4,611 |
| **KPI 3B** - The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session (at the end of the quarter) | West Sussex | 600 | 295 | 201 | 294 | 2,520 | 2,411 | 1,936 | 1,693 |
| **PHQ13_05 -** People who have entered (i.e. received) treatment as a proportion of people with anxiety or depression (%) | West Sussex | 3.4% | 3.6% | 3.4% | 3.8% | 3.6% | 3.7% | 3.9% | 3.7% |
| | *England* | *2.0%* | *2.1%* | *2.1%* | *2.4%* | *2.4%* | *2.5%* | *2.4%* | *2.5%* |
| **KPI 4 -** The number of people who have entered (i.e. received) psychological therapies during the quarter | West Sussex | 2,599 | 2,678 | 2,497 | 2,797 | 2,651 | 2,728 | 2,867 | 2,744 |
| **KPI 6A** - The number of people who are "moving to recovery" (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) during the quarter | West Sussex | 821 | 915 | 881 | 848 | 851 | 894 | 930 | 974 |
| **KPI 6B -** The number of people who have completed treatment not at clinical caseness at initial assessment | West Sussex | 246 | 235 | 252 | 204 | 199 | 207 | 214 | 188 |
| **PHQ13_06** - Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session (%) | West Sussex | | | | | 52.5% | 51.3% | 49.8% | 50.9% |
| | *England* | | | | | *46.1%* | *45.9%* | *45.0%* | *46.8%* |
| **KPI 7 -** The number of people moving off sick pay or benefits during the quarter. | West Sussex | 191 | 175 | 178 | 190 | 124 | 121 | 179 | 163 |

**REFERRALS TO SECONDARY MENTAL HEALTH SERVICES**

### Urgent Referrals - 4 hour response to urgent GP referrals

- Working Age Mental Health Services (WAMHS) / Adults Mental Health Services (<65 Years)

*Performance background description (SPT)*

*"All Urgent GP referrals are carefully screened by clinicians, to ensure they are responded to in the most appropriate way. Where, in the view of the clinician, the patient is presenting an immediate risk to themselves or others; an immediate response is required. The response that the Trust makes must be adequate to address the level of risk described above. This could be either assessment, or other actions, to ensure the safety of the patient and others appropriate to the particular circumstances. This may not necessarily mean meeting the patient face-to-face. This could be achieved through discussion with the GP or patient. The clinical responsibility is to ensure that the GP's request has been responded to and the patient is safe. 100% of all urgent GP referrals that meet the definition must be responded to within 4 hours."*

The target is 100% of all urgent referrals must be responded to within 4 hours.

The data available between the period August 2012 and December 2013 is shown on Fig 29 below. This shows a gap between GP urgent referrals and referrals which met the clinical definition. The data show a considerable fluctuation in the number of referrals, a fluctuation less apparent in relation to GPs in East Sussex (compared on fig overleaf)

**Fig 29** GP Urgent Referrals and GP Urgent Referrals the Met Definition
August 2012 to Dec 2013 (Working Age Adults ONLY)

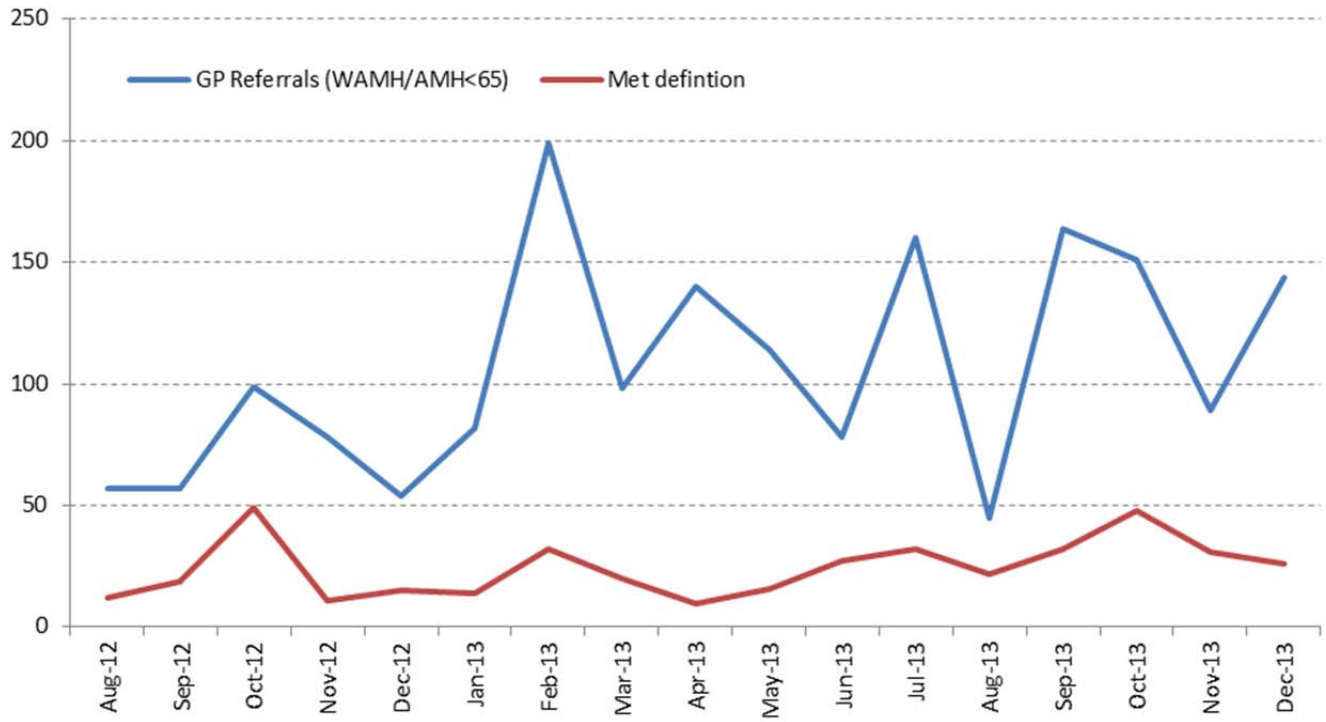
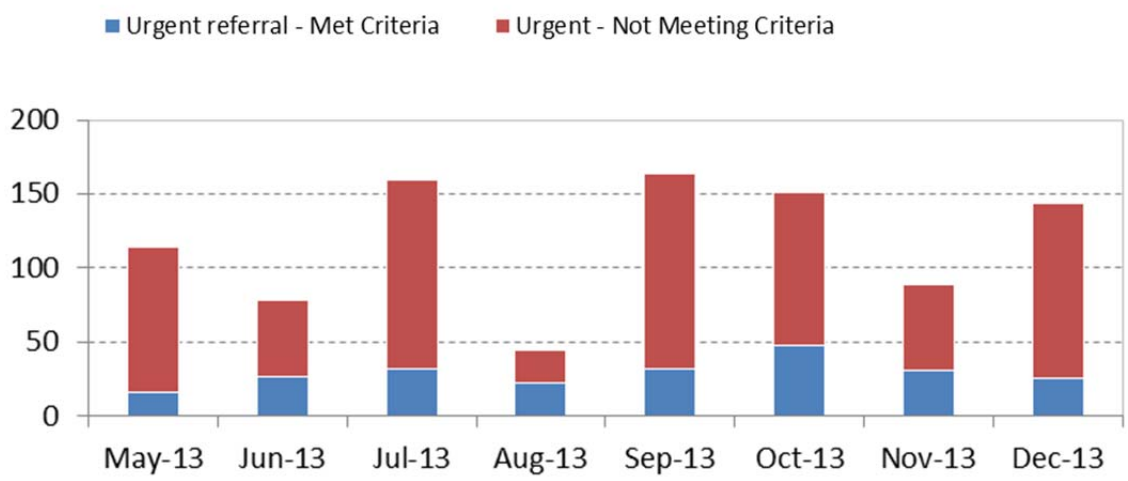
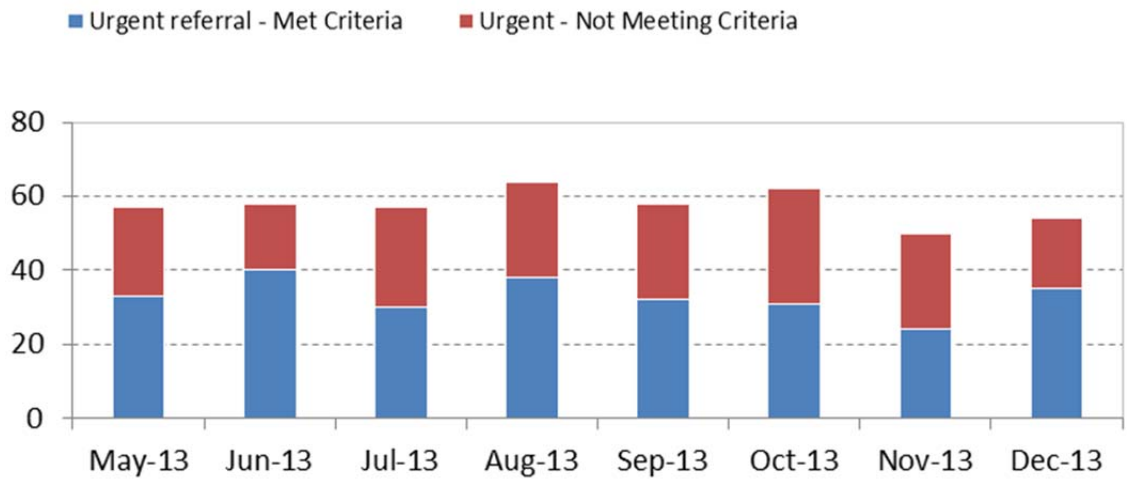


**Fig 30 GP Urgent Referrals and GP Urgent Referrals the Met Definition May 2013 to Dec 2013 (Working Age Adults ONLY)**

**a) West Sussex**




**b) East Sussex**



**2013/14 CCG Level Data**

Data were broken down by CCGs in April 2013 to December 2013.

**Table 34 CCG Level Data Urgent GP Referrals**

| | | Coastal | Crawley | Horsham & Mid Sussex | WEST SUSSEX TOTAL |
|---|---|---|---|---|---|
| **April 2013** | Urgent GP Referrals (Working Age) | 51 | 15 | 74 | 140 |
| | Meeting criteria | 6 | 1 | 3 | 10 |
| | % seen within 4 hrs* | 100% | 100% | 100% | 100% |
| **May 2013** | Urgent GP Referrals (ALL AGES) | 63 | 0 | 51 | 114 |
| | Meeting criteria | 9 | 0 | 7 | 16 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **June 2013** | Urgent GP Referrals (Working Age) | 68 | 0 | 10 | 78 |
| | Meeting criteria | 26 | 0 | 1 | 27 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **July 2013** | Urgent GP Referrals (Working Age) | 87 | 11 | 62 | 160 |
| | Meeting criteria | 22 | 2 | 8 | 32 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **August 2013** | Urgent GP Referrals (Working Age) | 12 | 9 | 24 | 45 |
| | Meeting criteria | 12 | 6 | 4 | 22 |
| | % seen within 4 hrs | 100% | 50% | 100% | 86.4% |
| **Sept 2013** | Urgent GP Referrals (Working Age) | 93 | 12 | 59 | 164 |
| | Meeting criteria | 22 | 8 | 2 | 32 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **Oct 2013** | Urgent GP Referrals (Working Age) | 85 | 7 | 59 | 151 |
| | Meeting criteria | 33 | 3 | 12 | 48 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **Nov 2013** | Urgent GP Referrals (Working Age) | 21 | 14 | 54 | 89 |
| | Meeting criteria | 7 | 11 | 13 | 31 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |
| **Dec 2013** | Urgent GP Referrals (Working Age) | 81 | 15 | 48 | 144 |
| | Meeting criteria | 12 | 2 | 12 | 26 |
| | % seen within 4 hrs | 100% | 100% | 100% | 100% |

*Of those meeting criteria

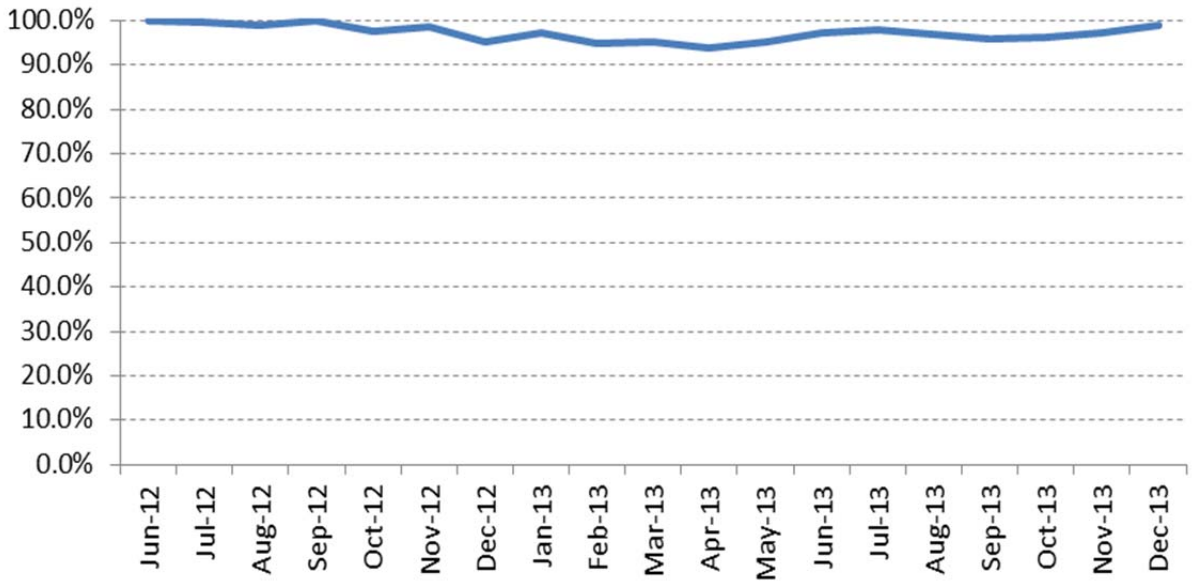
## Routine Assessment – Working Age Adults

The contractual target is that at least 95% of patients wait under 4 weeks for their assessment following referral

**Waiting time between referral and Assessment – WEST SUSSEX OVERALL**

Information from June 2012 to December 2013 shows a fall in the percentage of referrals assessed within the 4 week target period.

**Fig 31** % first assessments within 4 weeks




**CCG Level Data**

Data available at CCG level for the period April 2013 to December 2013, shows that Crawley has a lower percentage of first assessments made within 4 weeks of referral; referrals from Crawley are less likely to be assessed in the 4 week target period. Between April 2013 and December 2013 of the 619 waiting for assessment, 89.5%% were assessed within 4 weeks.

**Table 35** Referral to Assessment – CCG Level Data (April 2013 onwards)

| | | 0-4 weeks | 5 - 13 weeks | 14-18 weeks | 19-25 weeks | 26+ weeks | Number of first Assessments | 0-4 weeks |
|---|---|---|---|---|---|---|---|---|
| April 2013 | Coastal | 268 | 8 | 0 | 0 | 0 | 276 | 97.1% |
| | Crawley | 41 | 15 | 0 | 0 | 0 | 56 | 73.2% |
| | Horsham & Mid Sussex | 125 | 5 | 0 | 0 | 0 | 130 | 96.2% |
| May 2013 | Coastal | 280 | 5 | 0 | 0 | 0 | 285 | 98.2% |
| | Crawley | 73 | 11 | 4 | 0 | 0 | 88 | 83.0% |
| | Horsham & Mid Sussex | 110 | 4 | 0 | 0 | 0 | 114 | 96.5% |
| June 2013 | Coastal | 240 | 40 | 0 | 0 | 0 | 280 | 85.7% |
| | Crawley | 51 | 7 | 0 | 0 | 0 | 58 | 87.9% |
| | Horsham & Mid Sussex | 112 | 0 | 0 | 0 | 0 | 112 | 100.0% |
| July 2013 | Coastal | 298 | 5 | 0 | 0 | 0 | 303 | 98.3% |
| | Crawley | 61 | 3 | 0 | 0 | 0 | 64 | 95.3% |
| | Horsham & Mid Sussex | 114 | 1 | 0 | 0 | 0 | 115 | 99.1% |
| August 2013 | Coastal | 252 | 4 | 0 | 0 | 0 | 256 | 98.4% |
| | Crawley | 61 | 4 | 0 | 0 | 1 | 66 | 92.4% |
| | Horsham & Mid Sussex | 123 | 5 | 0 | 0 | 0 | 128 | 96.1% |
| Sept 2013 | Coastal | 270 | 9 | 0 | 0 | 0 | 279 | 96.8% |
| | Crawley | 63 | 9 | 0 | 0 | 0 | 72 | 87.5% |
| | Horsham & Mid Sussex | 109 | 1 | 0 | 0 | 0 | 110 | 99.1% |
| Oct 2013 | Coastal | 283 | 10 | 0 | 0 | 0 | 293 | 96.6% |
| | Crawley | 64 | 4 | 0 | 0 | 0 | 68 | 94.1% |
| | Horsham & Mid Sussex | 121 | 5 | 0 | 0 | 0 | 126 | 96.0% |
| Nov 2013 | Coastal | 254 | 4 | 1 | 1 | 0 | 260 | 97.7% |
| | Crawley | 84 | 4 | 1 | 1 | 0 | 90 | 93.3% |
| | Horsham & Mid Sussex | 124 | 2 | 0 | 0 | 0 | 126 | 98.4% |
| Dec 2013 | Coastal | 275 | 2 | 0 | 0 | 0 | 277 | 99.3% |
| | Crawley | 56 | 1 | 0 | 0 | 0 | 57 | 98.3% |
| | Horsham & Mid Sussex | 103 | 2 | 0 | 0 | 0 | 105 | 98.1% |

### Rapid Re-assessment – Working Age Adults

For people who have been in receipt of secondary mental health services, and then are discharged back to primary care, a rapid re-assessment (within 1 week of referral) is provided.

This indicator represents the number of patients, meeting the long term service user criteria:-

- Patients have been in receipt of services from the provider for six months or more in their last episode.
- Patients were discharged back to primary care no more than two years before the referral.

The target is 95% of patients meeting the criteria should be offered an assessment within 1 week.

**Fig 32** Rapid Re-assessment – WEST SUSSEX OVERALL

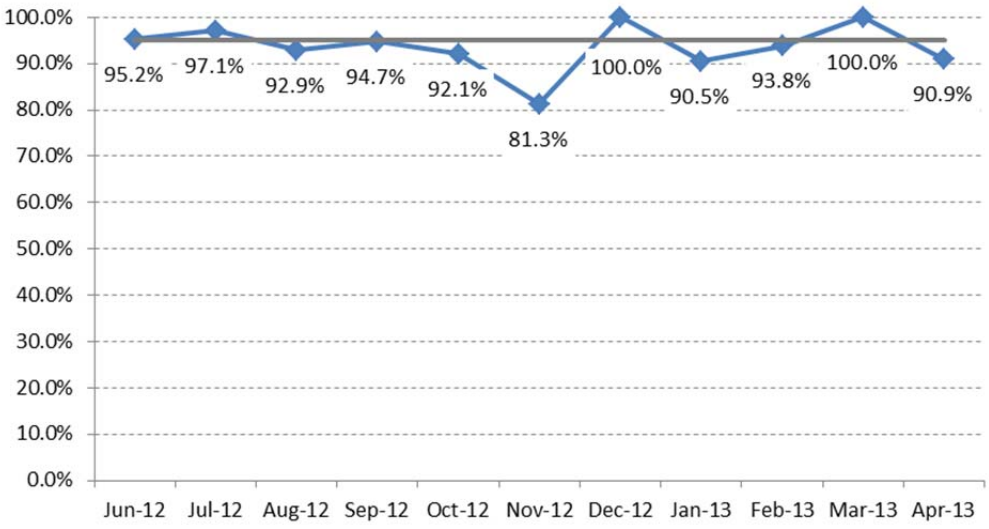


**Table 36 Rapid Re-assessment CCG Level Data**

*Data relate to period April 2013 to December 2013 (Source: SPT Commissioners Reports)*

| | | Coastal | Crawley | Horsham & Mid Sussex | WEST SUSSEX TOTAL |
|---|---|---|---|---|---|
| **April 2013** | No of referrals | 27 | 7 | 9 | 43 |
| | Seen within 7 days | 27 | 5 | 8 | 40 |
| | % seen within 7 days | 100.0% | 71.4% | 88.9% | 93.0% |
| **May 2013** | No of referrals | 20 | 9 | 8 | 37 |
| | Seen within 7 days | 20 | 8 | 7 | 35 |
| | % seen within 7 days | 100.0% | 88.9% | 87.5% | 94.6% |
| **June 2013** | No of referrals | 15 | 6 | 12 | 33 |
| | Seen within 7 days | 15 | 6 | 12 | 33 |
| | % seen within 7 days | 100.0% | 100.0% | 100.0% | 100.0% |
| **July 2013** | No of referrals | 26 | 4 | 8 | 38 |
| | Seen within 7 days | 23 | 4 | 8 | 35 |
| | % seen within 7 days | 88.5% | 100.0% | 100.0% | 92.1% |
| **August 2013** | No of referrals | 19 | 6 | 9 | 34 |
| | Seen within 7 days | 15 | 5 | 9 | 29 |
| | % seen within 7 days | 78.9% | 83.3% | 100.0% | 85.3% |
| **Sept 2013** | No of referrals | 19 | 2 | 5 | 26 |
| | Seen within 7 days | 19 | 1 | 3 | 23 |
| | % seen within 7 days | 100.0% | 50.0% | 60.0% | 88.5% |
| **Oct 2013** | No of referrals | 24 | 5 | 6 | 35 |
| | Seen within 7 days | 24 | 5 | 6 | 35 |
| | % seen within 7 days | 100.0% | 100.0% | 100.0% | 100.0% |
| **Nov 2013** | No of referrals | 53 | 19 | 31 | 103 |
| | Seen within 7 days | 53 | 10 | 30 | 93 |
| | % seen within 7 days | 100.0% | 52.6% | 96.8% | 90.3% |
| **Dec 2013** | No of referrals | 55 | 10 | 12 | 77 |
| | Seen within 7 days | 53 | 9 | 12 | 74 |
| | % seen within 7 days | 96.4% | 90.0% | 100.0% | 96.1% |

### Time to Treatment following Assessment

This indicator looks at the pathway from referral to assessment to the start of treatment. The second contact following referral representing treatment.

The target is that 95% of first referrals are treated within 18 weeks.

**Table 37** Time to Treatment following Assessment – *WEST SUSSEX OVERALL (Working Age)*

| | 0-4 weeks | 5 - 13 weeks | 14-18 weeks | 19-25 weeks | 26+ weeks | Number of first assessments | % treated within 18 weeks |
|---|---|---|---|---|---|---|---|
| Jun-12 | 224 | 29 | 1 | 0 | 0 | 254 | 100.0% |
| Jul-12 | 250 | 48 | 1 | 0 | 0 | 299 | 100.0% |
| Aug-12 | 275 | 45 | 10 | 0 | 1 | 331 | 99.7% |
| Sep-12 | 205 | 39 | 11 | 0 | 0 | 255 | 100.0% |
| Oct-12 | 280 | 58 | 12 | 0 | 0 | 350 | 100.0% |
| Nov-12 | 256 | 54 | 5 | 1 | 0 | 316 | 99.7% |
| Dec-12 | 201 | 47 | 12 | 0 | 0 | 260 | 100.0% |
| Jan-13 | 210 | 50 | 9 | 0 | 0 | 269 | 100.0% |
| Feb-13 | 210 | 51 | 11 | 0 | 1 | 273 | 99.6% |
| Mar-13 | 281 | 54 | 10 | 0 | 0 | 345 | 100.0% |
| Apr-13 | 294 | 64 | 6 | 0 | 0 | 364 | 100.0% |
| May-13 | 288 | 59 | 11 | 2 | 0 | 360 | 99.4% |
| Jun-13 | 264 | 51 | 13 | 0 | 0 | 328 | 100.0% |
| Jul-13 | 325 | 69 | 15 | 1 | 3 | 413 | 99.0% |
| Aug-13 | 297 | 62 | 11 | 0 | 5 | 375 | 98.7% |
| Sep-13 | 285 | 78 | 14 | 0 | 5 | 382 | 98.7% |
| Oct-13 | 304 | 73 | 7 | 0 | 2 | 386 | 99.5% |
| Nov-13 | 299 | 77 | 12 | 0 | 1 | 389 | 99.7% |
| Dec-13 | 321 | 61 | 5 | 0 | 0 | 387 | 100.0% |

**Fig 33** Time to Treatment following Assessment – *WEST SUSSEX OVERALL (18-64 only)*

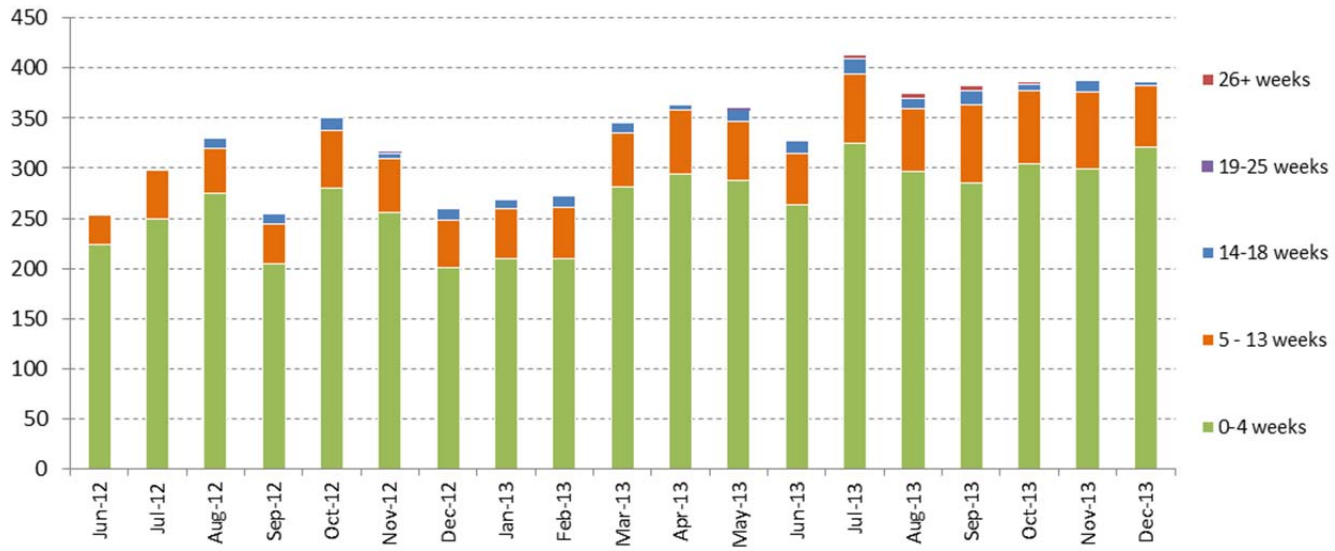


**Table 38** Time to Treatment following Assessment – *CCG (Working Age)*

| | Area | 0-4 weeks | 5 - 13 weeks | 14-18 weeks | 19-25 weeks | 26+ weeks | Number of first assessments | % treated within 18 weeks |
|---|---|---|---|---|---|---|---|---|
| April 2013 | Coastal | 213 | 36 | 2 | 0 | 0 | 251 | 100.0% |
| | Crawley | 8 | 16 | 2 | 0 | 0 | 26 | 100.0% |
| | Horsham & MSx | 73 | 12 | 2 | 0 | 0 | 87 | 100.0% |
| May 2013 | Coastal | 203 | 38 | 4 | 1 | 0 | 246 | 99.6% |
| | Crawley | 33 | 13 | 6 | 0 | 0 | 52 | 100.0% |
| | Horsham & MSx | 52 | 8 | 1 | 1 | 0 | 62 | 98.4% |
| June 2013 | Coastal | 181 | 26 | 6 | 0 | 0 | 213 | 100.0% |
| | Crawley | 26 | 12 | 3 | 0 | 0 | 41 | 100.0% |
| | Horsham & MSx | 57 | 13 | 4 | 0 | 0 | 74 | 100.0% |
| July 2013 | Coastal | 223 | 42 | 10 | 1 | 0 | 276 | 99.6% |
| | Crawley | 33 | 13 | 1 | 0 | 1 | 48 | 97.9% |
| | Horsham & MSx | 69 | 14 | 4 | 0 | 2 | 89 | 97.8% |
| Aug 2013 | Coastal | 190 | 36 | 6 | 0 | 1 | 233 | 99.6% |
| | Crawley | 34 | 11 | 3 | 0 | 3 | 51 | 94.1% |
| | Horsham & MSx | 73 | 15 | 2 | 0 | 1 | 91 | 98.9% |
| Sept 2013 | Coastal | 210 | 35 | 9 | 0 | 0 | 254 | 100.0% |
| | Crawley | 35 | 15 | 2 | 0 | 4 | 56 | 92.9% |
| | Horsham & MSx | 40 | 28 | 3 | 0 | 1 | 72 | 98.6% |
| Oct 2013 | Coastal | 209 | 39 | 3 | 0 | 1 | 252 | 99.6% |
| | Crawley | 28 | 14 | 3 | 0 | 0 | 45 | 100.0% |
| | Horsham & MSx | 67 | 20 | 1 | 0 | 1 | 89 | 98.9% |
| Nov 2013 | Coastal | 203 | 42 | 6 | 0 | 0 | 251 | 100.0% |
| | Crawley | 39 | 22 | 5 | 0 | 0 | 66 | 100.0% |
| | Horsham & MSx | 57 | 13 | 1 | 0 | 1 | 72 | 98.6% |
| Dec 2013 | Coastal | 227 | 29 | 3 | 0 | 0 | 259 | 100.0% |
| | Crawley | 29 | 13 | 1 | 0 | 0 | 43 | 100.0% |
| | Horsham & MSx | 65 | 19 | 1 | 0 | 0 | 85 | 100.0% |

### Delayed Transfers of Care

A delayed discharge occurs when a patient is assessed as medically ready to be discharged from an inpatient bed but remains due to non-medical delays. These may include, awaiting public funding, awaiting a housing placement or a package of care in their own home.

The indicator is expressed as the number non-acute patients (aged 18 and over on admission) per day whose transfer of care was delayed as a proportion of the total number of occupied bed days for the reporting period. For example, one patient delayed for five days counts as five.

Target is no more than 7.5%.

The graph below shows the overall delayed transfer of care percentage of working age adults. The data split down to CCG shows that there is a higher and growing rate of delayed discharge in Crawley.

**Fig 34** **% of Delayed Discharges (WORKING AGE ADULTS ONLY)**
– West Sussex Overall June 2012 – December 2013, CCGs April 2013 to December 2013

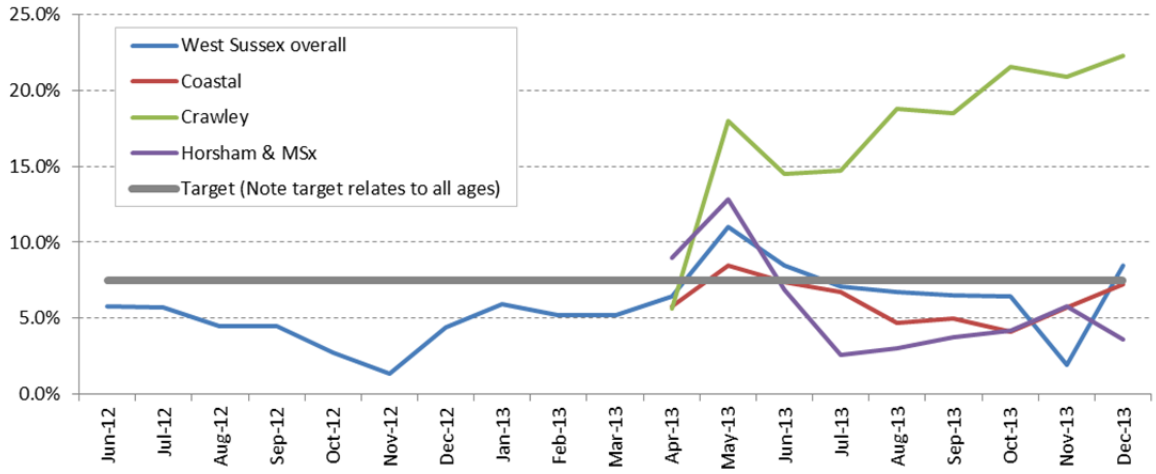



**Table 39 % of Delayed Discharges (WORKING AGE ADULTS ONLY)**

| | | Coastal | Crawley | Horsham & | WEST SUSSEX TOTAL |
|---|---|---|---|---|---|
| Apr-13 | Occupied Bed Days | 2,350 | 571 | 737 | 3,658 |
| | Bed Days Delayed | 136 | 32 | 66 | 234 |
| | % of Bed Days delayed | 5.8% | 5.6% | 9.0% | 6.4% |
| May-13 | Occupied Bed Days | 2,726 | 774 | 834 | 4,334 |
| | Bed Days Delayed | 232 | 139 | 107 | 478 |
| | % of Bed Days delayed | 8.5% | 18.0% | 12.8% | 11.0% |
| Jun-13 | Occupied Bed Days | 2,055 | 629 | 816 | 3,500 |
| | Bed Days Delayed | 152 | 91 | 56 | 299 |
| | % of Bed Days delayed | 7.4% | 14.5% | 6.9% | 8.5% |
| Jul-13 | Occupied Bed Days | 2,257 | 621 | 815 | 3,693 |
| | Bed Days Delayed | 151 | 91 | 21 | 263 |
| | % of Bed Days delayed | 6.7% | 14.7% | 2.6% | 7.1% |
| Aug-13 | Occupied Bed Days | 2,387 | 676 | 946 | 4,009 |
| | Bed Days Delayed | 112 | 127 | 28 | 267 |
| | % of Bed Days delayed | 4.7% | 18.8% | 3.0% | 6.7% |
| Sep-13 | Occupied Bed Days | 2,211 | 453 | 794 | 3,458 |
| | Bed Days Delayed | 111 | 84 | 29 | 224 |
| | % of Bed Days delayed | 5.0% | 18.5% | 3.7% | 6.5% |
| Oct-13 | Occupied Bed Days | 2,757 | 582 | 1,159 | 4,498 |
| | Bed Days Delayed | 112 | 126 | 49 | 287 |
| | % of Bed Days delayed | 4.1% | 21.6% | 4.2% | 6.4% |
| Nov-13 | Occupied Bed Days | 2,085 | 503 | 960 | 3,548 |
| | Bed Days Delayed | 119 | 105 | 56 | 280 |
| | % of Bed Days delayed | 5.7% | 20.9% | 5.8% | 7.9% |
| Dec-13 | Occupied Bed Days | 2,125 | 502 | 885 | 3,512 |
| | Bed Days Delayed | 154 | 112 | 32 | 298 |
| | % of Bed Days delayed | 7.2% | 22.3% | 3.6% | 8.5% |

## Comparative Data - Minimum Mental Health Data Set (MHMDS)

The **Minimum Mental Health Data Set** is a collection of patient level data which enables comparative analysis of the *use* of services.

Information is collected in relation to people aged 18 or over (this includes people aged 65 years or over) in receipt of NHS funded specialist secondary mental health or learning disability care services and are, or are thought to be, suffering from a mental illness or learning disability. The dataset excludes primary care or social care services. People under 18 can be included if in receipt of care from a specialist adult secondary mental health service or an early intervention service.
The MHMDS is a mandated data return for all NHS providers of specialist adult mental health services.

The data is published on the Information Centre website.
Data for 2011/12 are published by old PCT boundary areas.

### Contact with Secondary Mental Health Services

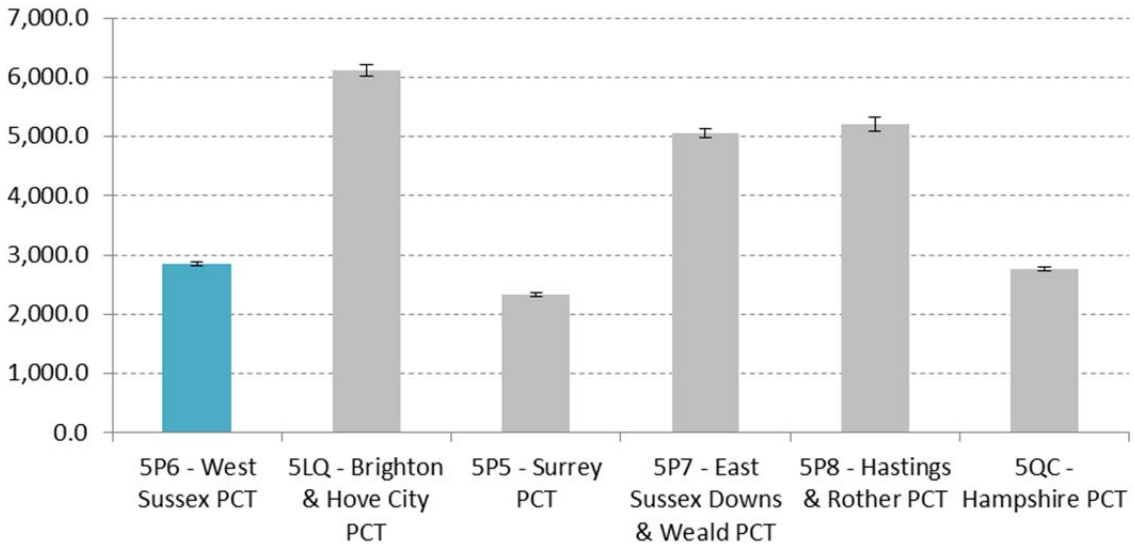
- The number of people using NHS mental health services
- The rate of access to NHS mental health services by 100,000 population

In 2011/12 Nationally over 1.5 million people were in contact with specialist mental health services, rate of access of 3,032 per 100,000 population (approximately one person in 32 in England).

In West Sussex approximately 21,000 people were in contact, the rate (crude rate) is lower than the national rate, at 3,008 per 100,000 population.

Compared with the general population a higher proportion of people using secondary mental health services are aged 65 years of over; so an age standardised rate, which takes into account the different age structures of the population, enables comparison with other local authority areas. Fig 35 below shows the age standardised rate of West Sussex compared with neighbouring areas, the West Sussex rate similar to Hampshire, higher than Surrey but significantly lower than Brighton and Hove and East Sussex.

**Fig 35** Rates of access to NHS funded adult specialist mental health services (2011/12)



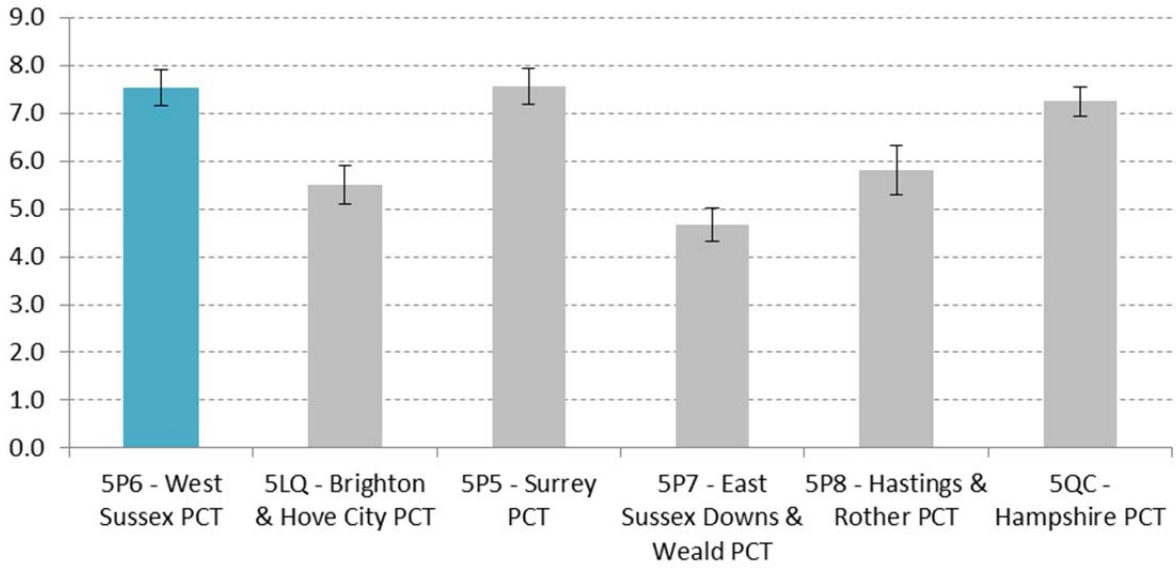

Source: MHMDS 2011/12

**In Patient Activity**
*(Note: this means specialist mental health inpatient services)*

In 2011/12 1,460 West Sussex residents spent some time in hospital (representing 7% of the people in contact with services).

The age standardised rate is 7.5 per 100 service users (shown on Fig 36 below). The West Sussex rate is similar to Surrey and Hampshire, higher than Brighton and Hove and East Sussex.

**Fig 36** Rates of Access to NHS funded Hospital Inpatient Care per 100 Mental Health Service *Users* 2011/12




**Total Bed Days, Admissions, Discharges and Mean Daily Occupied Beds – West Sussex**

**Note:**

- Data exclude records where the commissioner was unknown and Welsh organisations.
- Activity is not limited to one spell per person per provider, and therefore a person may be counted more than once in the year.
- Data for 2010/11 onwards include data from Independent Service Providers and therefore are not strictly comparable with previous reporting period England 2011/12, further analysis and organisation
- In 2011/12 there was a low return from private sector hospitals.

Using MHMDS data there were approximately 98,670 bed days in 2011/12, there has been a year on year fall in the total number of bed days, from almost 136,000 in 2008/9.

**Mean Daily Occupied Beds**

*Average number of beds occupied each day.*

In 2011/12 the mean daily number of beds occupied by West Sussex residents was **270.3.**

**Fig 37** Inpatient activity WEST SUSSEX – Admissions
2006/7 – 2011/12
*Admissions - The number of inpatient stays that started during the year.*

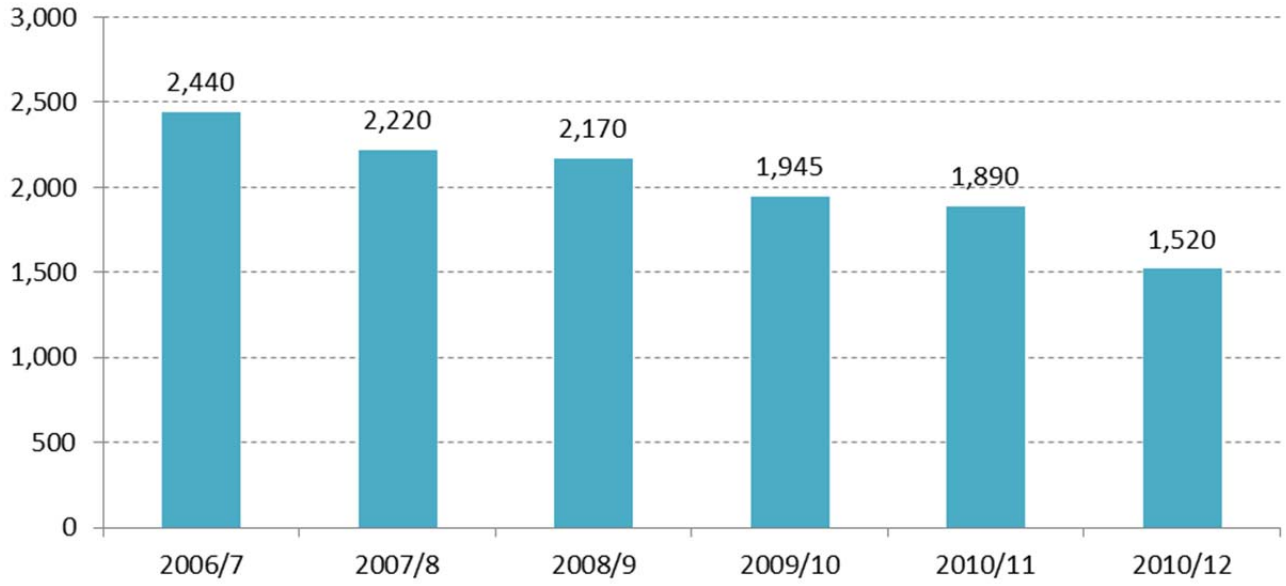
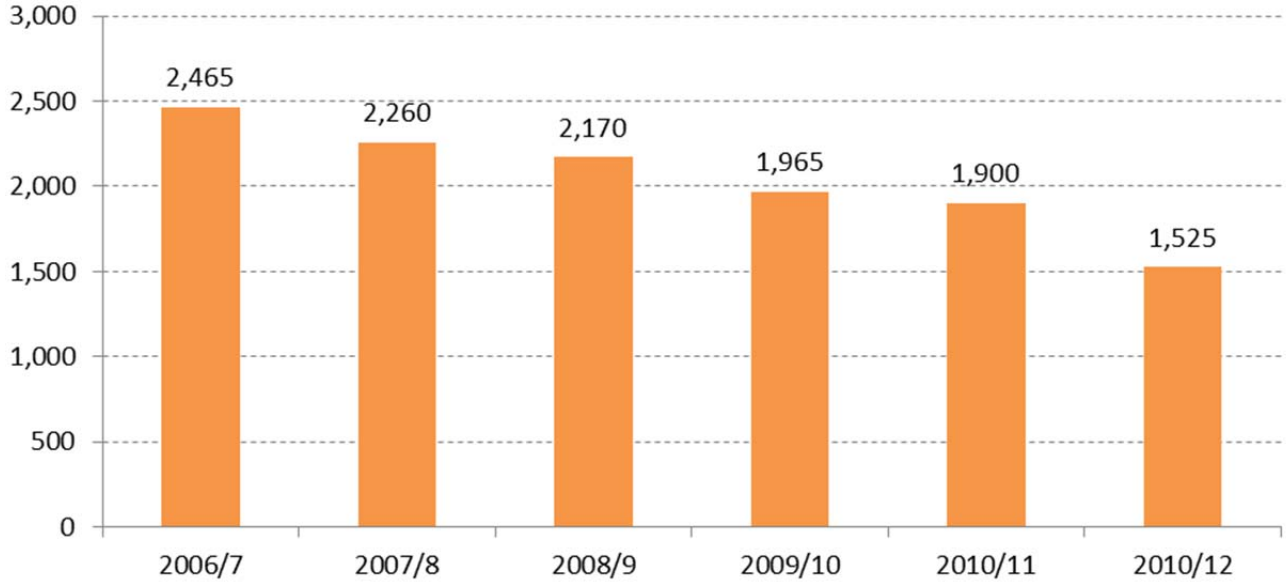



**Fig 38** Inpatient activity WEST SUSSEX – Discharges
2006/7 – 2011/12
*Discharges - The number of inpatient stays that ended during the year.*



The graph bellows show hospital admission rate for mental health overall and for unipolar depressive disorders. All England authority areas are shown in order on the graphs, the areas with the highest admission rates on the left, the areas with the lowest on the right. Areas which have rates significantly higher than the England admission rate are shaded red, areas with rates significantly lower green. The graphs show that overall West Sussex has a rate lower than England but for unipolar depressive disorders it was significantly higher for this time period.

**Fig 39** **Directly standardised rate for hospital admissions for mental health**
*(Pooled Years Data 2009/10 to 2011/12)*

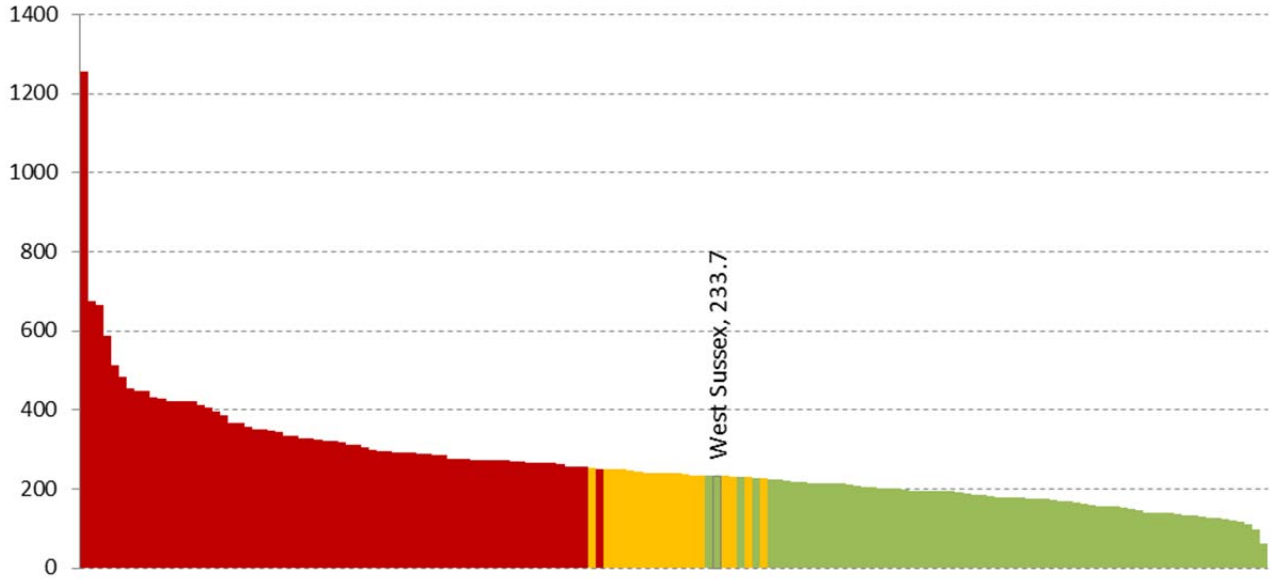
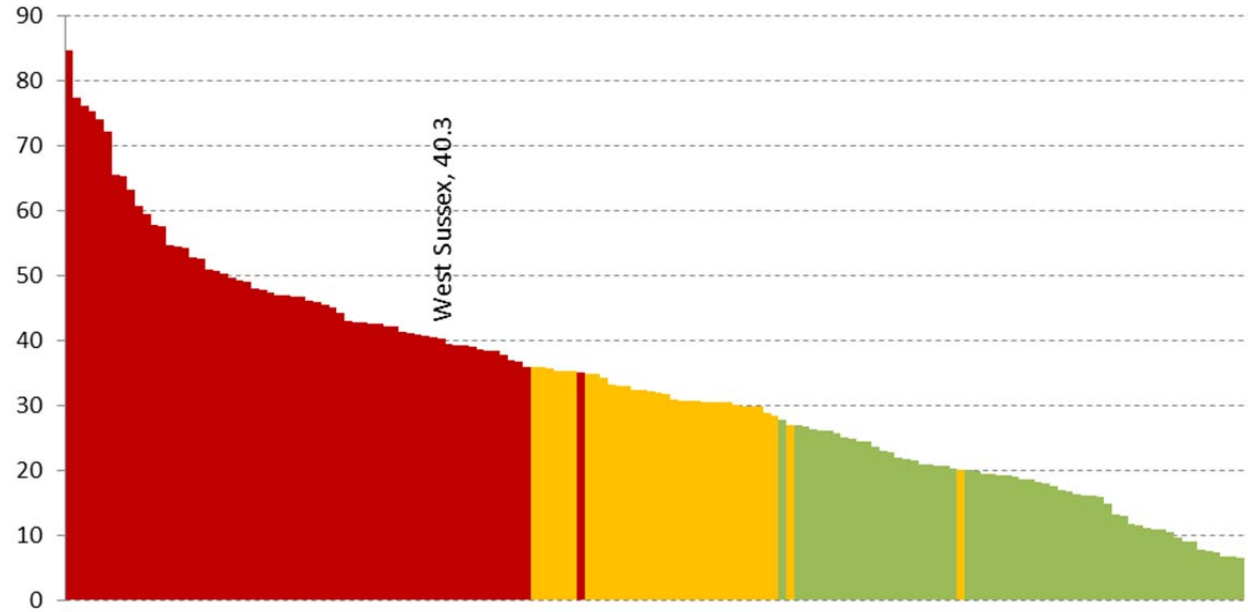



**Fig 40** **Directly standardised rate for hospital admissions for unipolar depressive disorders**
*(Pooled Year Data 2009/10 to 2011/12)*



**Admissions data from the Secondary Users Services**
**Hospital Admissions (Pooled Data 2010-2012)**
Data was collated for all mental health primary diagnosis code (ICD-10 Codes F00 – F99)

Mental and behavioural disorders

| | |
|---|---|
| F00-F09 | Organic, including symptomatic, mental disorders |
| F10-F19 | Mental and behavioural disorders due to psychoactive substance use |
| F20-F29 | Schizophrenia, schizotypal and delusional disorders |
| F30-F39 | Mood [affective] disorders |
| F40-F48 | Neurotic, stress-related and somatoform disorders |
| F50-F59 | Behavioural syndromes associated with physiological disturbances and physical factors |
| F60-F69 | Disorders of adult personality and behaviour |
| F70-F79 | Mental retardation |
| F80-F89 | Disorders of psychological development |
| F90-F98 | Behavioural & emotional disorders with onset usually occurring in childhood & adolescence |
| F99-F99 | Unspecified mental disorder |

Admissions were also included where the primary diagnosis code was not mental health but the treatment code was:-

| | | |
|---|---|---|
| 700 | LEARNING DISABILITY | Learning Disability |
| 710 | ADULT MENTAL ILLNESS | Adult Mental Illness |
| 711 | CHILD and ADOLESCENT PSYCHIATRY | Child and Adolescent Psychiatry |
| 712 | FORENSIC PSYCHIATRY | Forensic Psychiatry |
| 715 | OLD AGE PSYCHIATRY | Old Age Psychiatry |
| 721 | ADDICTION SERVICES | Addiction Services |

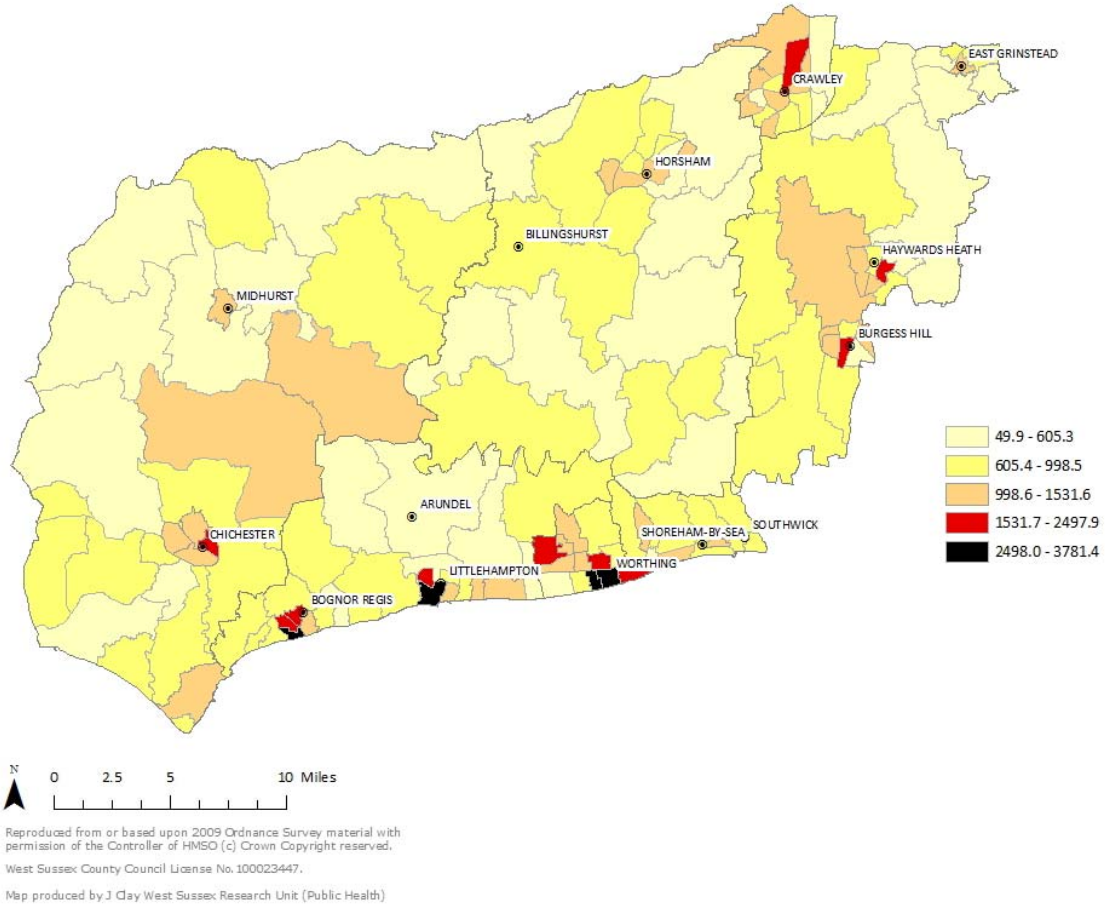
These are shown at the bottom of the table.

Over the 3 year period there were over 9,400 admissions across West Sussex using the above definitions.

**Table 40 Admissions 2010-2012**

| Admissions 2010-2012 Pooled (includes emergency) | CWS | Crawley | HMS |
|---|---|---|---|
| Adult personality & behavioural disorders | 353 | 98 | 169 |
| Alcohol | 897 | 205 | 296 |
| Behavioural syndromes | 74 | 11 | 44 |
| Childhood & Adolescence behavioural & emotional disorders | 24 | 7 | 20 |
| Drugs | 91 | 22 | 23 |
| Mental retardation | 9 | >3 | >3 |
| Mood disorders | 1,255 | 177 | 427 |
| Neurotic disorders | 450 | 81 | 194 |
| Organic mental disorders | 928 | 96 | 194 |
| Psychological development disorders | 179 | 6 | 18 |
| Schizophrenia & delusional disorders | 690 | 136 | 262 |
| Unspecified mental disorder | 22 | 6 | 10 |
| *Non- MH Primary diagnosis (but MH related treatment code)* | *1,116* | *182* | *224* |
| **Total** | **6,088** | **1,028** | **1,882** |

**Fig 41** Mental Health Admission Rate (per 100,000 population aged 17 years+)
Pooled Year Data 2010-2012
*Mental Health Diagnosis – excluding organic mental health*





Map produced by J Clay West Sussex Research Unit (Public Health)

The information mapped shows the rate of admissions with a primary diagnosis of mental health (ICD10 codes excluding) according to the patient's home postcode.

*Note :* This map also excludes a small number of outliers with a very high number of repeat admissions and people aged under 17 years.

**Number of people on the Care Programme Approach (CPA)**

**A Care Programme Approach (CPA)** is adopted for someone who has severe or complex mental health needs, to ensure co-ordination of the assessment, care and review of their needs. People who may have a CPA include people have a severe mental health disorder, with drug or alcohol problems, are at risk of self- harm or suicide, or harm to others or vulnerable to abuse from others, rely significantly or are themselves a carer. There are a small number of people with severe or complex problems who may receive specialist support outside of the CPA approach, for example people receiving treatment for an eating disorder. A CPA care co-ordinator should be appointed to co-ordinate the assessment and planning process and is usually a nurse, social worker or occupational therapist.

Overall a minority of people in receipt of secondary care services get CPA support.

In 2011/12 approximately 6,450 people in West Sussex were on a CPA, 31% of those in NHS services, this is higher than the national figure of 25% and much higher than 2010/2011, although this increase may reflect a change in administration than need. Previously there were two levels of CPA “standards” and “enhanced” this has now been changed to simply on a CPA or not and in the past there had been problems in providers submitting the information in the required format.

**Table 41** Prescribing Data – Anti-Depressant Prescribing

| Year | Financial Quarter | Items | Actual Cost | NIC |
|---|---|---|---|---|
| 2008/9 | Qtr1 | 128,936 | £831,250.60 | £901,943.58 |
| | Qtr2 | 132,011 | £842,675.89 | £913,930.68 |
| | Qtr3 | 137,345 | £815,196.70 | £883,408.73 |
| | Qtr4 | 134,588 | £771,134.84 | £835,254.49 |
| 2009/10 | Qtr1 | 138,886 | £779,759.70 | £843,852.68 |
| | Qtr2 | 143,943 | £811,896.68 | £878,417.43 |
| | Qtr3 | 150,938 | £772,964.13 | £835,658.08 |
| | Qtr4 | 147,128 | £744,649.32 | £804,049.35 |
| 2010/11 | Qtr1 | 151,980 | £784,740.20 | £847,673.17 |
| | Qtr2 | 159,133 | £831,095.42 | £897,958.23 |
| | Qtr3 | 157,039 | £789,695.57 | £852,841.53 |
| | Qtr4 | 158,598 | £1,083,211.66 | £1,170,686.35 |
| 2011/12 | Qtr1 | 161,409 | £1,086,559.89 | £1,174,175.41 |
| | Qtr2 | 167,690 | £1,007,713.77 | £1,088,349.52 |
| | Qtr3 | 170,717 | £925,281.67 | £998,158.78 |
| | Qtr4 | 171,162 | £796,371.95 | £857,312.45 |
| 2012/13 | Qtr1 | 170,959 | £757,196.60 | £815,725.95 |
| | Qtr2 | 175,670 | £764,894.60 | £821,203.66 |
| | Qtr3 | 182,665 | £723,133.02 | £778,129.43 |
| | Qtr4 | 178,111 | £865,054.38 | £930,210.22 |
| 2013/14 | Qtr1 | 185,676 | £1,149,989.70 | £1,239,894.50 |

**NIC =** Net Ingredient Cost. The cost calculated using the prices in Part VIII of the Drug Tariff or, if the medicine does not appear in the Drug Tariff, the manufacturer's price list.
**Actual Cost** = Net Ingredient Cost + Container Allowance – Assumed Average Discount

**Fig 42** Items Prescribed (Anti-Depressants)
2008/9 to 2013/14 Quarterly Data

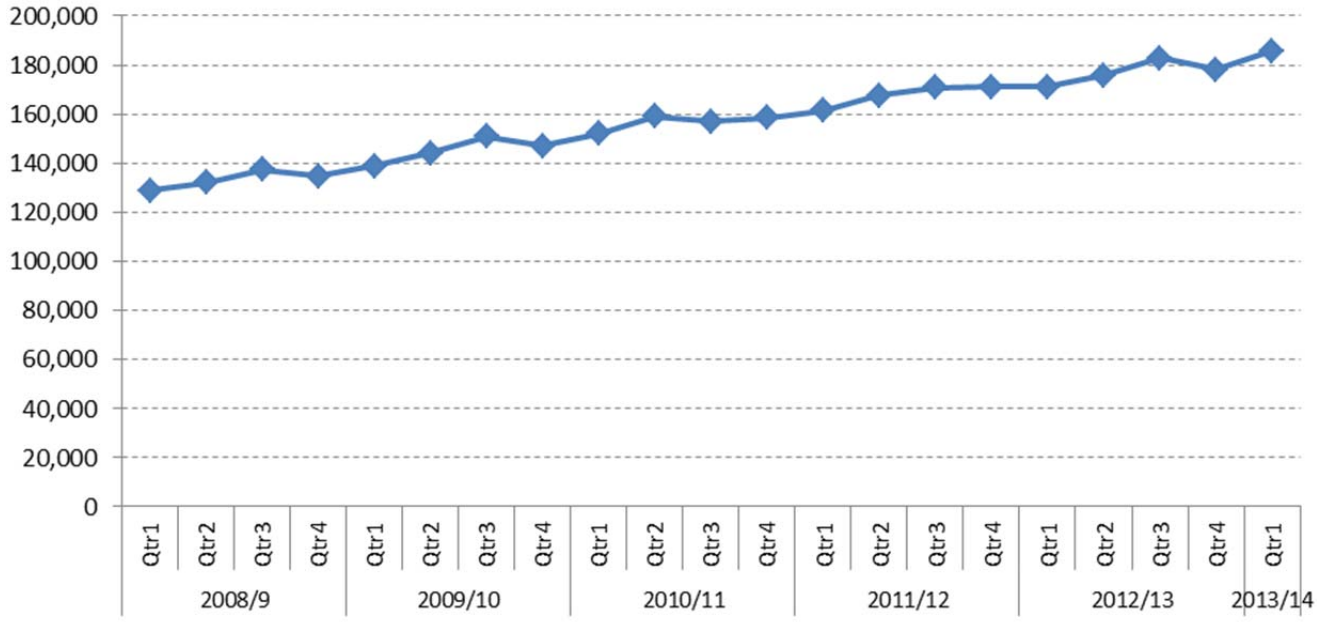


**Table 42** **CCG Totals**

CCG Level Data are available for 2013/14 Quarter 1

| | | Items | Actual Cost | NIC |
|---|---|---|---|---|
| 2013/14 Qrt1 | Coastal CCG | 122,610 | £722,617.50 | £778,740.00 |
| | Crawley CCG | 24,705 | £145,711.70 | £156,975.70 |
| | Horsham and Mid Sussex CCG | 38,361 | £281,660.50 | £304,178.80 |
| | TOTAL | 185,676 | £1,149,989.70 | £1,239,894.50 |

**Location of Key Services (Specialist Provision)**

**Assessment and Treatment Centres (ATCs) (Sussex Partnership NHS Foundation Trust)**

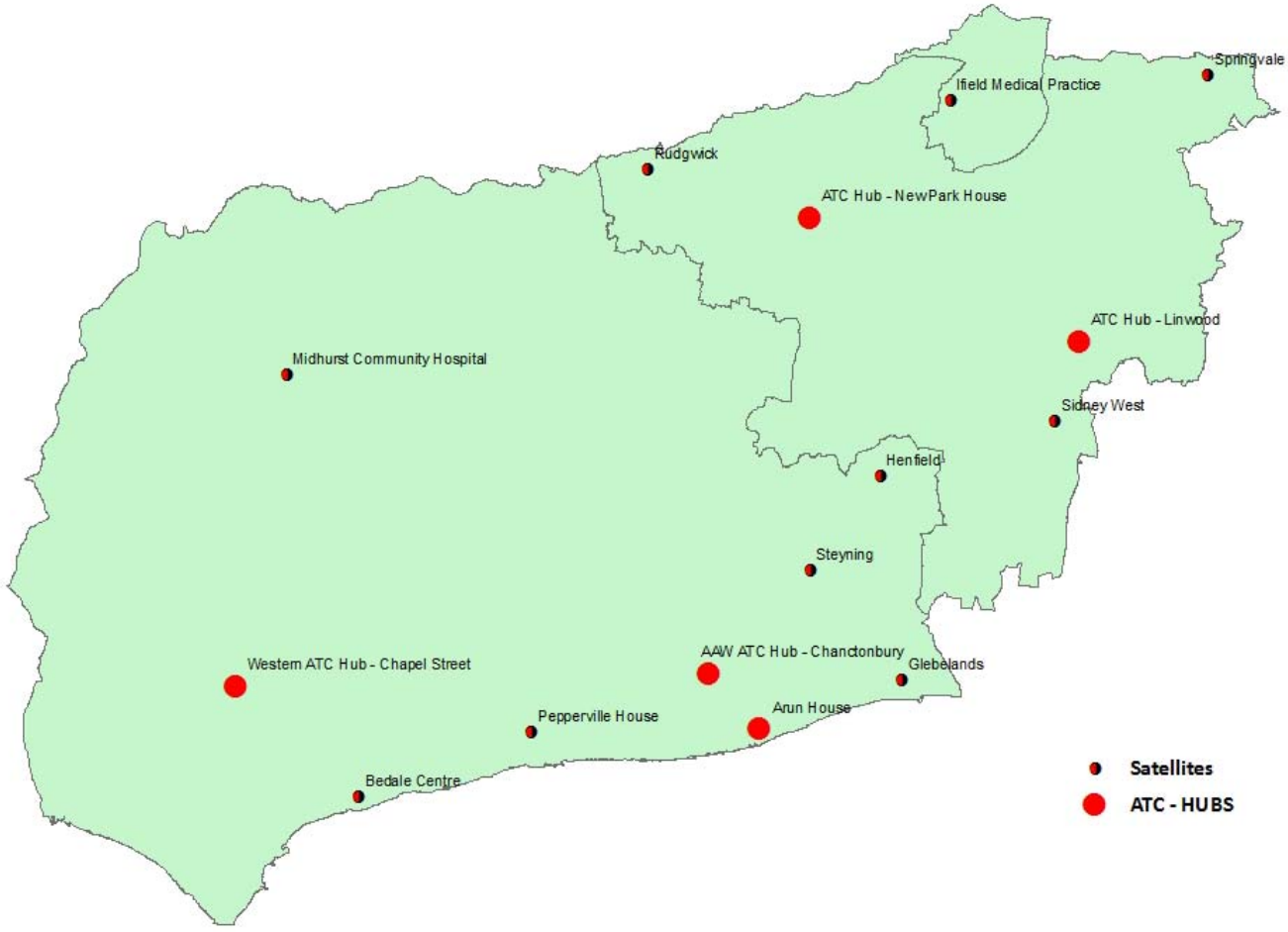
Referrals from GPs (and other health professionals) are made to assessment and treatment centres.

The basic function of these centres is a function is:-

- Assessment
- Systems Management
- Recovery and Wellbeing
- Treatment linked to Care Pathways

The ATCs in West Sussex shown on the map below and local satellites.

**Fig 43** Assessment and Treatment Centres (ATCs) and Satellites in West Sussex



**Third Sector Providers**

*Information provided by Mental Health Commissioning Team, Joint Commissioning Unit and data correct as of May 2013*

All services provide help and support to anyone with a mental health issue from low level drop-in / sign-posting support to 1-to-1 support as part of a care package for those with substantial needs. Referrals can be made direct to the providers from a GP Practice or other agencies or patients can contact services direct themselves. Basic details of each provider covering West Sussex are:

**Brighton & Hove MIND**

- *Advocacy services* across West Sussex for young people and adults
- *Independent Mental Health Services* (IMHA) provided to patients subject to treatment and care under the Mental Health Act. Services based in Langley Green and Meadowfield
- *Peer Mentoring* services to those in Crawley and Horsham areas.
- *Head Forward* website www.head-forward-west-sussex.info, provides free, accessible, comprehensive, up-to-date and reliable information about mental health topics, national resources and local services for anyone living in West Sussex. The service also produces a quarterly Head Forward electronic newsletter providing news and updates on local services and activities

**Chichester Area MIND**

- Chichester Area MIND offers a variety of groups and activities which have a focus on wellbeing and recovery.
- Chichester Area MIND provide a range of services to help people to understand their mental health problems and identify what keeps them well, and to try out new tools; and support to help them along a pathway to recovery.
- Covers the Chichester and Midhurst area

**Corner House Resource Centre,** Southwick www.corner-house.org.uk

- One Stop Shop/Resource Hub style service offering a place to drop in for all members of the community and will accept self, GP and other community services style referrals for information, advice, guidance, signposting, peer mentoring/peer support, whilst working with other invited agencies of key importance (CMHT staff, time to talk, primary care mental health liaison workers, credit union etc).
- Work in a range of settings in the community with individuals such as family centres, churches, community centres etc. Moving to keeping people out/decrease the use of segregated facilities for existing members with the use of peer mentoring/peer support. People supported to identify networks in the community and encouraged to move in to voluntary work and work placements.

**Worthing & Arun MIND** – The Gateway, Worthing www.worthingmind.co.uk

- Community Services –community services in Worthing and Littlehampton which aim to support recovery through personalised planning and a wide range of activities
- Peer Support – a service provided by people with mental health problems trained to offer individual and group support to others
- Housing Support – provides resettlement and floating support services to people living in the community

- Gardening Projects – training and voluntary and paid employment for people who want to develop their horticultural skills and contribute to the wellbeing of the community

**Capital Project Trust** –www.capitalproject.org

Capital Project Trust offers the following services:

- Mutual Support through:
  - Acceptance and understanding
  - Monthly local meetings
  - Peer run social events
  - Contact by phone, face to face and mail

- Opportunities for members to be involved in:
  - Training Mental Health staff, people who use services and community groups
  - Informing the development and planning of services
  - Supporting in-patients to have a voice by helping to facilitate patient viewpoint groups
  - Evaluating, monitoring and researching aspects of Mental Health care
  - Feeding back experience of current mental health services to demonstrate what works well and what does not

Capital Project also provide inpatient peer support services.

**UNITED RESPONSE** –www.unitedresponse.org.uk

United Response is a national charity that has been running for 41 years providing support to people with mental health needs, physical and/or learning disabilities or sensory impairment.
In West Sussex we offer a range of services-

- ***SUPPORTED HOUSING***
  A scheme for people aged 18+ who have mental health support needs. This service provides accommodation in the Littlehampton, Worthing and Shoreham areas. It enables tenants to live independently, offering advice and support to maintain a tenancy, claim appropriate benefits. Supporting people to take control of their lives and fulfil their individual needs, preferences and aspirations. We liaise with other mental health services, education, training and employment agencies.
- ***EXTRA CARE SERVICE***
  Providing emotional support and assistance to people with mental health needs in their own home in line with CPA. Helps maintain links with services, sustain social networks, accompany to OPA's, social or leisure outings, support with household tasks and help with finances such as budgeting and debt.
- ***RESOURCE CENTRE***
  A mental health support hub situated in the centre of Bognor Regis town centre offering signposting, information, advice and practical help. It provides a peer support service to support people in their recovery and focused engagement in mainstream activities, social inclusion and community participation, with such activities as swimming, allotment work, art workshops, walks, outings and our 'Café in the Community'. At the centre we also provide health and nutrition advice with 'Cook and Eat' sessions, creative writing skills, IT skills and weekly peer support meeting. Referrals are through CMHT's ,GP's and MHLP's.

- ***OUTREACH SERVICE***
  This service covers the Bognor, Chichester and Midhurst CMHT's, providing practical, social and emotional support to people with mental health needs living in their own homes. It supports people using a recovery model approach to enable people to take more control over their lives and increase their level of independence. Support given is in regards to finances/debts/benefits, household tasks, community engagement, creating and sustaining social networks, work & education, and improving people's mental and physical well-being.
- ***COMMUNITY SUPPORT WORKER SERVICE***
  CSW's are affiliated to CMHT's in the Chichester, Littlehampton, Worthing, Shoreham, Haywards Heath, Crawley and Horsham area and work as part of a multi-disciplinary team. They offer a 'listening ear' whilst providing help to resolve practical issues, helping people in their recovery and independent living processes. They work on issue of social inclusion and help clients have a positive sense of belonging in their own community. This involves helping them access resources such as suitable employment, education, appropriate housing and community engagement. Working closely with their teams they encourage clients to take an active part in their own healthcare, and by working with them, their carers and families take effective measures in identifying early signs of relapse.

**Richmond Fellowship** –www.richmondfellowship.org.uk
• Peer Support
• Contact Point
• Outreach Recovery Support Service
• Supported Living (Horsham)

Peer Support is provided by individuals who themselves have had mental health problems and have used secondary care mental health services.Peer support will enable the service user to:

- Identify their strengths and aspirations
- Establish what they want to achieve
- Plan the necessary steps to achieve them

Contact Point is a service that offers people short-term support by way of a maximum of four sessions of up to 45 minutes each. These sessions are provided by the Outreach Support Team at different locations in West Sussex as well as in SPFT services.
Access to the Contact Point does not require a referral. Appointments will be made over the phone and offered on the same day where possible.

The Outreach Recovery Support service provides support to:

- gain & maintain independent living
- to develop daily living skills
- to maintain physical & mental well being
- to gain & retain social contact
- to access activities in the local community that improve quality of life, confidence and self esteem.

Supported Living is provided in Supported Accommodation (Blatchford House) in Horsham.
Accommodation is provided for a maximum of 8 people with serious and enduring mental health problems who have complex needs, requiring intensive support and who are not yet able to sustain independent living in the community. Support can be provided for up to 18months.

Areas covered by these services Crawley Borough, Horsham District and Chichester District including rural surrounds.

**Sussex Oakleaf** –www.sussexoakleaf.org.uk
The services will provide a range of social community activities accessible for all service users. The service will also provide opportunities for focused 1:1 work with service users. This work will incorporate specific and tailored support as identified through the support planning process.

In both areas the services include:

- Access to either Sussex Oakleaf provided or other community services 7days-a-week.
- Community Cafes (Crawley only)
- Access to a variety of groups, some of which will regularly be provided in a "safe space"
- Peer Specialist Training
- Resource Library
- Volunteering Opportunities
- On Site Access to CMHT staff (Crawley only)
- Access to Gardening/ Conservation
- Creative Activities
- Access to physical and leisure activities
- Woodwork Activities (Crawley only)
- 1:1 with Recovery Stars
- Access to Brokerage
- Access to Food Hygiene and Food Safety Certificates
- Service User Involvement opportunities within Sussex Oakleaf
- Revolving leisure and interest groups (photography, relaxation, gender specific groups, practical skills building, 'how to' swap shops, etc)

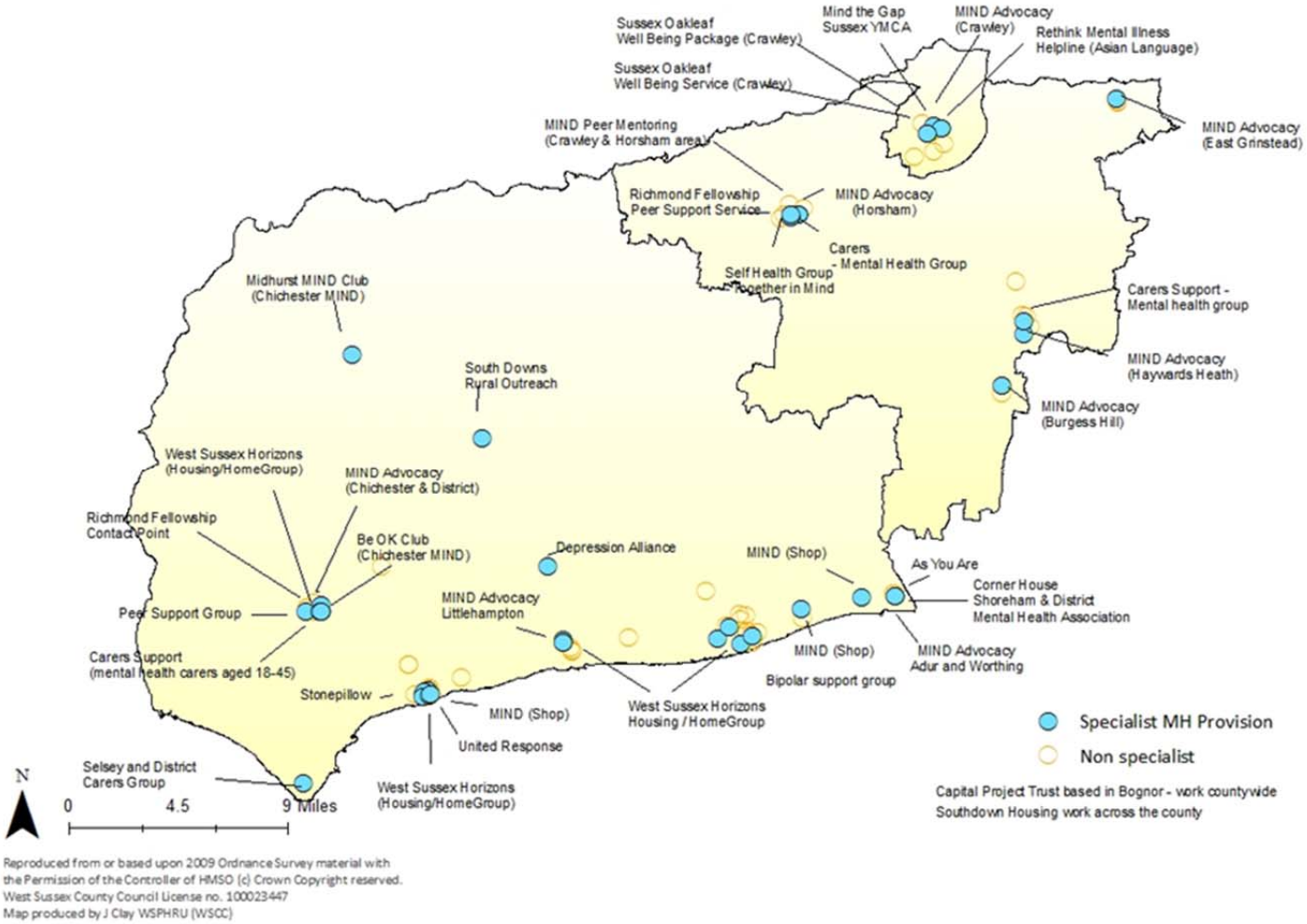
*Services provided in the Crawley and Mid-Sussex areas*

*Rethink – Asian Mental Health Helpline*
A culturally sensitive listening and information service for the Asian community in Kent, West Sussex, and Bexley. The service is for anyone affected by mental health issues - whether they are service users, carers or friends. Callers may speak to us in Asian languages (Gujarati, Punjabi, Hindu, and Urdu) or English. Helpline number: 0808 800 2073.

*Stone Pillow*
Stonepillow provides a care pathway for all clients, taking people from the streets into accommodation & support with a longer term view for them to re-integrate and sustain independent living in the community. Referrals into our services originate from many different agencies, including self referrals. Our frontline services such as St Josephs & The Hub accept clients who are rough sleeping. The main referrals into these are from the local CMHT, GP Surgeries, Job Centre Plus, and Local Authority. The longer term accommodation based services are through a simple application process and interview, which any client can be supported with through any frontline member of staff.

**Southdown Housing –** Employment Support Services
Deliver specialist support to enable vulnerable people to take an active part in the communities where they live and work. The employment specialists are directly placed within clinical teams.

**Fig 44** Map of Voluntary Sector Support



## SECTION 5 "STAKEHOLDER" VIEWS
## INCLUDING VIEWS OF SERVICE USERS, CARERS, VOLUNTARY ORGANISATIONS, STAFF, GPS ETC.

This section details information gained via wider stakeholder public engagement; there were two separate exercises undertaken.

1) During the summer of 2013 West Sussex mental health commissioners held a series of workshops across the county, a wide range of people attended these workshops including service users, carers, staff, GPs. A report from the workshops was drafted by mental health commissioners (Appendix 1).

2) Following these workshops West Sussex Public Health Research Unit commissioned additional engagement to identify issues relating to people from diverse groups, including people from BME groups; issues which may not have been captured as part of the initial workshop engagement. An external researcher was commissioned and their report, in full (Appendix 2), and recommendations are included as part of this needs assessment.

**APPENDIX 1**

**Report of Engagement Workshops (2013)** ***"Coming Through Load and Clear"***

Report drafted by WSCC Mental Health Commissioners 2013

**COMING THROUGH LOUD AND CLEAR**

***Engagement exercise summer 2013***

In June, July, August and September 2013 mental health commissioners held around 30 workshops with a wide range of stakeholders including customers/patients, carers, staff, GPs and service providers.

Stakeholders were asked to respond to 7 questions about their current experience of services and what they thought could be improved. Attendance at workshops was generally good and around 500 stakeholders have contributed. A GP survey was also undertaken.

These workshops have provided commissioners with a **temperature check** around these services, taken at a given point in time, reflecting how a range of stakeholders who were motivated to give feedback felt. Responses are of course subjective and therefore whilst this work is useful it should not be over-used or seen in isolation from a whole range of other evidence which can be drawn on to understand how mental health services are working and performing.

Some information was also given about areas which are outside of the remit of mental health commissioning – For example feedback around mental health services for children and also around substance misuse services. These messages have been passed to the relevant commissioners of these services.

There is a wealth of more detailed feedback which sits under this summary which can be used and referred to as service transformation and improvement plans develop in the coming period.

The feedback provided was remarkably consistent across the board – there seemed to be little local/regional variation in messages given.

This document, therefore, draws out from this detailed work the 10 key messages which were consistently expressed across the piece in these workshops. We have described these as the big messages.

***MESSAGE 1 – WHAT IS GOOD?***

**WHAT STAKEHOLDERS SAID:**

Many staff and services are making a huge difference and are highly valued particularly:

- Third sector
- Peer support
- Time to Talk
- Carers Support
- Employment support

**LEARNING:**

- **Learning point 1** – Some services and many staff are good – We need to make sure we can learn about what makes these services/staff better than others and also we need to value and praise good services and practice and make sure there is a system where good practice is recognised.

### *MESSAGE 2 – QUALITY – BIG INCONSISTENCIES*

**WHAT STAKEHOLDERS SAID:**

**This was the biggest message** - Service quality is very inconsistent – What you get from services depends on the individual staff you see, the individual service you use and the area you live in in terms of what is available. Some staff and or services are very good but some are not good. Inconsistency relates to:

- The knowledge and experience of first point of contact mainly GPs but also housing, etc.
- The quality of all professional staff at all stages and in all services – Their responses in terms of attitude and expertise – Some is great but some is very poor
- Service provision – What is available but also the way that services are run and provided – Huge variation between units and teams – Postcode lottery in terms of what is available

**LEARNING:**

- **Learning point 2** - Need to ensure services improve quality across the board – Patient/carer and stakeholder experience must improve. Need to ensure there are programmes to drive up performance of staff across the board.
- **Learning point 3** - Need to agree a West Sussex/CCG service framework/ blue-print/model – What services should be provided as a minimum – Ensure that we commission to make this minimum service offer available everywhere.

### *MESSAGE 3 – COMMUNICATION AND PARTNERSHIPS BETWEEN SERVICES – NOT GOOD*

**WHAT STAKEHOLDERS SAID:**

Communication and partnerships between different service providers is not always effective. Particularly relationships between TTT and CMHT/ATC, relationships between GPs and CMHTS/ATCs also in some circumstances relationships between CMHTS/ATCS and third sector providers. But also internally within services provided by one organisation for example ATC and MHLPs. Service users and carers still feel like they have to repeat the same information to different services and staff information. Their experience is that their care is and support is not joined up and well co-ordinated.

**LEARNING:**

- **Learning point 4** - Need to review the pattern of service provision and contracting to make sure it does not undermine co-ordinated care and effective partnership working and communication.
- **Learning point 5** - Need to ensure that there are mechanisms in local areas for effective joint working and that services work together to ensure that patient experience is as seamless as possible, that information is shared effectively, that hand-offs are minimised etc. Also that partners and services understand each other's remits and responsibilities and how they should be working effectively together.

### *MESSAGE 4 – WHEN DISCHARGED FROM SERVICES PEOPLE OFTEN GET LITTLE OR NO SUPPORT*

**WHAT STAKEHOLDERS SAID:** Strong message that when individuals are discharged from CMHTs or finish help from TTT they are often discharged to no service because there is nothing available which could continue to give them some level of support if they require it. Peer support was cited as an ideal option but it is not available everywhere. In some circumstances it was felt that support is available but is not known about by the services who are discharging. Not having any support network can mean that people's recovery is not maintained and they then need to be re-referred to CMHTs or TTT.

**LEARNING:**

- **Learning point 6** – Service model needs to ensure that some preventative services with some kind of peer support are available in all areas.
- **Learning point 7** - Need to make sure that information is widely available about these services.

### *MESSAGE 5 – SERVICES REACTIVE AND NOT PROACTIVE*

**WHAT STAKEHOLDERS SAID:**

Not enough work is taking place to prevent individuals from developing mental health problems which require specialist help. Also when people have recovered there is little support available to help people stay well. People also told us that there is still a lot of stigma and discrimination happening around mental health and they would like to see this tackled more. Generally a feeling that there is not enough information available about mental health. A concern that mental health does not have the same parity of esteem as physical health within community.

**LEARNING:**

- **See learning point 6**
- **Learning point 8** – Need clear strategic approaches to preventing mental health problems and to helping individuals and communities understand and have good mental well-being.

### *MESSAGE 6 – ACCESS TO SERVICES*

**WHAT STAKEHOLDERS SAID:**

- There are not always clear access criteria for services
- GPs and referrers often are inadequately trained/don‘t have the right knowledge, may inappropriately refer.
- People still wait too long for services, get bounced back and or between services.
- Poor communication from services can also hinder access
- Getting help in a crisis (Urgent care) is particularly an issue
- Most services are 9-5 – getting help out of hours continues to be an issue

**LEARNING:**

- **Learning point 9** - Services need to be developed to be more responsive including ensuring that waiting time targets are met, having clear access criteria, being available for longer hours and also ensuring that staff understand what services are available and how to appropriately refer.

### *MESSAGE 7 – UNDER-RESOURCED??*

**WHAT STAKEHOLDERS SAID:** Many stakeholders reported an overall view that mental health services are under-resourced particularly in comparison to services which meet physical health needs. Some people told us they felt there were not enough in-patient beds.

**LEARNING:**

- **Learning point 10 –** Commissioning strategies and plans should be transparent about the levels of resourcing for mental health services in local areas and how these benchmark against local and regional patterns of resourcing. Where under-resourcing is identified a plan should be developed to address this.

### *MESSAGE 8 – GAPS/UNMET NEED*

**WHAT STAKEHOLDERS SAID:**

There are a number of gaps in services/areas where there is little or inadequate provision. Areas that were particularly highlighted were:

- Mental health support for adults with autism and Asperger‘s syndrome
- Physical healthcare for individuals in hospital
- Safe places to go
- Respite
- Benefits/housing advice support for all people with mental health needs
- Mental health for young adults particularly those leaving children‘s services
- Mental health support for older adults
- Social support in evenings and weekends

- Transport
- Anger management
- Eating disorder services

**LEARNING:**

- **Learning point 11-** Commissioners need to consider how services can be improved and or developed to meet these specific needs

### *MESSAGE 9 – INVOLVEMENT*

**WHAT STAKEHOLDERS SAID:**

Carers and users of services have told us that they would like to be involved and consulted more. They would also like to be more involved in training of professionals particularly GPs.

**LEARNING:**

- **Learning point 12 –** Commissioners and providers need to consider how people with mental health problems and their carers can be involved and consulted more.

### *MESSAGE 10 - BIG IDEAS/SUGGESTIONS*

**STAKEHOLDERS SUGGESTED WE SHOULD**

Reduce bureaucracy and enable staff to spend more time with patients
Use IT more effectively across all MH service to improve MH support
Use 3rd Sector more to provide support

- Have more peer support
- Develop recovery model including recovery college approach
- Support innovation and creativity in services, practice and commissioning

**LEARNING:**

- **Learning point 12** - Commissioners need to work together with providers to look at **how IT can be more effectively used to enhance mental health support:** Web-based advice, information and support including; email referral and communication systems, integrated records etc.
- **Learning point 13** - Commissioners need to look at how **third sector and peer support** can be developed and more integrated into local models of service provision
- **Learning point 14** - Commissioners need to work together with providers to develop recovery model and look at how **recovery college** approach can be developed in West Sussex
- **Recommendation 15** - Commissioners need to work with providers to consider how **innovation and creativity** can be encouraged within the sector

## Appendix 2

**Mental Health Needs Assessment for diverse groups in West Sussex:**
*Report to West Sussex Public Health Department*

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