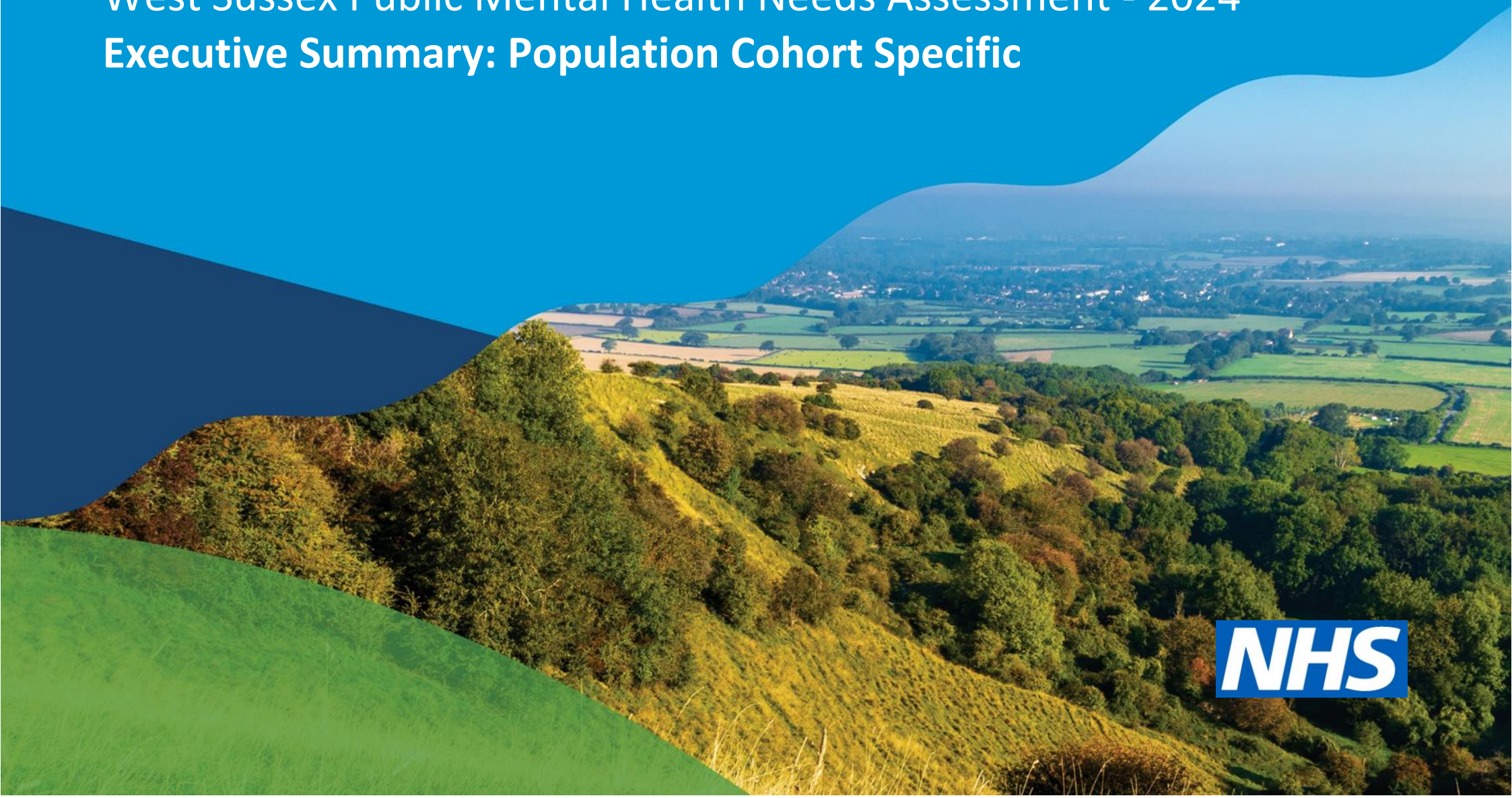
West Sussex Public Mental Health Needs Assessment - 2024

Executive Summary: Population Cohort Specific



West Sussex Public Mental Health Needs Assessment – **Executive Summary: Population cohort specific**

This document details the areas for focus across each the following population cohorts: perinatal, 0-5 years, 5-16 years, 16-25 years, 25-65 years, 65+ years and multiple compound needs. It provides both the overall areas for focus for each cohort as well as specific detailed areas for focus across the following six areas.

Many of the areas identified in the areas for focus have programmes of work in place to address these. These are not included in this needs assessment report, they will be part of strategies, action plans or frameworks for delivery.

1. **System under pressure**
2. **Preventing mental ill-health, supporting people earlier**
3. **Whole pathways and all people**
4. **Accessible, flexible and personalised support**
5. **Housing and accommodation**
6. **Complexity: Multiple physical and mental health, social care and or education needs and multiple services**

Note: Complexity refers to people who experience three or more areas in their life which require input or support from health, social care, or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

AREAS FOR FOCUS

Below are the high-level areas for focus, developed using the data and evidence from the needs assessment, co-produced and validated by professionals working within the system and people with lived experience. There is also an overall executive summary that includes key findings and high level areas of focus. You can find both summaries and full Public Mental Health Needs Assessment on the JSNA website.

Life Stage: PERINATAL

KEY POINTS

- In 2021 there were 8,515 live births in West Sussex.
- Prevalence: In terms of perinatal mental health, each year, it is estimated that between 990 and 1,970 women have adjustment disorder and distress (unhealthy or excessive emotional reaction or behavioural reaction to a stressful event of change). An estimated 650 and 990 have mild-moderate depressive illness and anxiety. Rarer conditions such as severe depressive illness and post-traumatic stress disorder impact approximately 195 a year, chronic serious mental illness 15 women a year.
- Expressed demand: There has been an increase in referrals to the specialist service. In December 2023 there were 87 referrals; the average number of monthly referrals has increased from below 80 in 2022.
- Access target: In West Sussex (in 2023/24) the national access standard is being met (reaching approximately 10% of 2016 births) and is higher than Brighton and Hove and East Sussex.
- Outcomes: The published data state a paired outcomes value of 46% - but this is across Sussex overall. Waiting times (across Sussex) 22 days for non-urgent referrals.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).

3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

Perinatal:

- Increase access to what's working - antenatal and postnatal classes, and birth afterthoughts.
- Workforce training to increase access to mental health and wellbeing support, prevention and early intervention including digital. Provide training across different organisations and services to increase understanding across the system and join up pathways.
- Joined up longer term commissioning for community peer support for perinatal mental health.
- Review access to support for pregnancy loss for all.
- Collect data and review impact of child removal and support available.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

Perinatal:

- Review perinatal mental health pathway for those who are considered too complex for talking therapies, but do not meet the criteria for the specialist perinatal mental health service to address gaps (support for those who have had their baby removed from their care within the perinatal mental health pathway) and join up services (antenatal and postnatal classes with care pathways).

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.

7. **Maintain access to immediate support during mental health crises**, linking with local communities.

Perinatal:

- Review improving access to perinatal mental health regarding flexibility of criteria based on need for access and drop-in services to address practical barriers for attendance.
- Review access to bereavement and loss support based on need and history not just weeks of pregnancy.
- Workforce training on diversity, neurodivergence, reducing stigma and increasing access to all
- Review of support for those on waiting lists to enable better 'waiting well' and 'waiting safely' and increase signposting to resources on Sussex LMNS | Local Maternity & Neonatal System website.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

Perinatal:

- Increase awareness of libraries as a setting for delivering services and community support for improving perinatal and children and young people mental health.
- Review of community spaces and where support can be provided in community non-judgemental easy access settings.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

Perinatal:

- Review specialist maternity pathways and access to full range of mental health and wellbeing support including talking therapies and GP postnatal maternal assessment.

Life Stage: 0 to 5 YEARS

KEY POINTS

- In terms of prevalence, the 2017 national survey was extended to include very young children (2-to-4 year olds). Applying the national survey estimate to the local population would equate to approximately 1,530 children.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

0-5 years:

- Reduce stigma to increase parents accessing support earlier for their children and themselves.
- Increase access to early years support and for increased capacity in early years services to manage demand and provide more support to those in needs including SEND families, preventing crises.
- Review of existing information structures and access such as the Library Service's CLiO service and social prescribing and further develop and promote sources of information and support through campaigns and engagement.
- Joined up commissioning for community-based support and linked with other support.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

0-5 years:

- Training early years workforce on early years development including mental health and wellbeing and mental health first aid and signposting.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.

4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

0-5 years:

- Review access to bereavement and loss support based on need and history not just weeks of pregnancy.
- Workforce training on diversity, neurodivergence, reducing stigma and increasing access to all.
- Review of support for those on waiting lists to enable better 'waiting well' and 'waiting safely'.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

0-5 years:

- Increase awareness of libraries as a setting for delivering services and community support for improving children's mental health.
- Review of community spaces and where support can be provided in community non-judgemental easy access settings.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

Life Stage: 5 to 16 YEARS

KEY POINTS

- Approximately 14,500 children and young people 5-16 years old are estimated to have a mental health disorder in West Sussex.
- Expressed demand: Where time series data are available, service data reviewed (including some VCSE services, MHST and CAMHS (SPFT)) show a long-term increase in the level of referrals.
- When the West Sussex Single Point of Access (SPOA) was established, the business case estimated approximately 7,000 referrals per annum. Between June 2022 and June 2023 there were approximately 8,500 referrals (21% higher than the business case). The SPOA activity level has not reduced.
- For CAMHS (SPFT) the increase predated the pandemic, and continued and escalated during the pandemic, notably in 2021. Further work is needed to establish whether demand to CAMHS (SPFT) is plateauing or continuing to rise.
- The large increase in referrals (to CAMHS (SPFT)) relating to neurodevelopmental disorders, are acting to obscure change. Monthly data identified in the December 2023 stocktake estimate accepted referrals up to 485 per month (excluding NDD) to over 1,000 per month (including NDD).
- Waiting lists: Data published by the Children's Commissioner stated waiting times for referral to 2nd contact in Sussex are longer than the England average.
- In relation to specific interventions within CAMHS (SPFT), the scale and length of waiting list is greatest for cognitive behavioural therapy.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

5-16 years:

- Increase resource and support for prevention in schools and communities to address complex needs including neurodivergence and those in touch with criminal justice system, emotionally based school avoidance (EBSA), self-harm, emotional distress, and dysregulation.
- Adopt I-Thrive model and incorporate within support.
- Review and join up youth support and promote mental health support including digital support at all levels, across communities, education, council, CVS and NHS.
- Kite mark for youth provision on mental health and wellbeing training. To support local provision.
- Develop county wide work programme to reduce harms of social media.
- LGBTQ+ visibility including comms and Pride events in supporting wellbeing to be recognised and supported.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.

5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

5-16 years:

- Leadership and strategic planning and connection at different levels across the system – join up vision, strategy, planning, address gaps, referral mechanisms, adoption of models to increase access.
- SPOA: Simplify information sharing, referrals and access to services; review function and info sharing between organisations inside and outside the SPOA
- Increase access for vulnerable CYP and prioritise evidence-based interventions for CYP with mental health difficulties and SEND (especially autism), ethnic minorities, LGBTQ+ and those in touch with youth justice system.
- Review pathways for gaps in support those identified include less common neurodevelopmental conditions: Tourette Syndrome and other tic disorders, foetal alcohol syndrome, etc.
- Data collection and use to ensure equity of access for all and from deprived areas. Recognise wide range of categories for self-definition of identity.
- Research required amongst specific groups including intersectionality and on protective factors for LGBTQ+.
- Research and evaluation on the effectiveness of interventions at improving all including LGBTQ+ CYP mental health.
- Support for parents / carers to support CYP with mental health including support for parent / carer mental health.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

5-16 years:

- Services to review equity of access for children and young people.
- Development of tailored offers, workforce training and communications to increase access to support for high risk (NDD, LGBTQ+, SEND, criminal justice) with co-production and peer support.
- Use of inclusive imagery, diverse representation and signage for physical environments.
- Support for victims of hate crimes to recognise the specific mental health impact of experiencing LGBTQ+ hate crime.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

5-16 years:

- Increase awareness of libraries as a setting for delivering services and community support for improving children and young people's mental health.
- Review of community spaces and where support can be provided in community, non-judgemental, easy access settings.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.

3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

5-16 years:

- Workforce training and support on compassionate practice, building trust, personalised support for mental health and complexity.

Life Stage: 16 to 25 year olds

KEY POINTS

- In West Sussex an estimated 6,150 young people aged 17-19 years, and 10,880 young people aged 20-25 years have a probable mental health condition.
- While rates for 8-16 year olds were similar between girls and boys, for young people aged 17-25 years rates were considerably higher (twice as high) for young women compared with young men. Over 30% of young women aged 17-19 years and 20-25 years were found to have probable mental health conditions.
- Transition is referred to in different ways in the data reviewed. Transition is seen from a service perspective to monitor transition of those known to services, often retrospective and this remains a challenge. There are known higher risk groups, of note looked after children and children with a neurodiversity.
- Services working with transition age young people (not all known to mental health or social care) report complex and multiple problems including housing support needs.
- The highest rates of secondary mental health hospital admission in West Sussex are ages 20-34.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

16-25 years:

- Keep what's working well, including carers support, pathfinder service / function, suicide prevention multiagency working.
- Review of access to early intervention support regarding trauma, including peer support.
- Waiting well and waiting safely measures and ongoing communication with those on waiting lists.
- Workforce training on lower level support, trauma informed support, mental health first aid.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

16-25 years

- Development of system-wide offer for 16-25 year olds building on existing support where it works well and developing more prevention, early intervention and intermediate care.
- Review pathway and support particularly for LGBTQ+, ethnic minorities, care experienced, those in touch with criminal justice system, bereaved through suicide and carers.
- Further simplify referrals and access to services: review function of the SPOA and information sharing between organisations inside and outside the SPOA.
- Structured support and pathway for those transitioning from children's mental health support to adults, increase support for care leavers and continuity of support during transition.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

16-25 years:

- Workforce training on mental health first aid.
- Review inpatient admissions across age cohorts, referral routes and pathways.
- Day services to bring services together in one place, drop in facility with extended hours so people can access a service when they need it.
- Step down support from urgent care, linking with social prescribing and high-risk adolescent services.
- Ongoing / continuous co-production with those that reflect communities within development of all services.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

16-25 years:

- Increase access to mental health support for people experiencing homelessness.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

16-25 years:

9. Review adult social care's young adults support function and continuity of care, particularly when moving children and young people to adult social care services.
10. Review role and access to advocates and peer support.
11. Development of gender informed approaches in mental health and multiple compound need services: Women-only spaces in male dominated services; working with men due to higher risk of suicide in males; use the Hastings approach to gender inequalities through co-production.
12. Expand offer for men who have been through criminal justice system and access to a personality disorder pathway forensic service for those who are registered sex offenders.

Life Stage: 25-to-65 year olds

KEY POINTS

- Prevalence: National surveys relating to the mental health of adults are relatively old (2014); data from the 2023 APMS are due to be published in 2025. Applying national assumptions to the West Sussex population 17.0% of adults (approximately 119,890 people) are estimated to have a common mental health disorder.
- Information from the ONS Wellbeing Survey has shown that levels of anxiety amongst the general population have been increasing (approximately 1 in 4 adults having a higher anxiety score on the ONS Wellbeing Survey).
- In terms of prevalence of specific conditions, in West Sussex it is estimated that:
    - 71,070 adults with attention-deficit/hyperactivity disorder (ADHD)
    - 4,780 adults with autism
    - 184, 050 adults have experienced trauma during their lifetime
    - 13,130 people with bipolar disorder
    - 3,710 with a psychotic disorder
- Expressed Demand:
    - In 2023 there were an average of 1,625 referrals a month to NHS Talking Therapies - approximately 100 a month lower than 2022. NHS Talking Therapies in West Sussex perform well on all remaining KPIs (including referral to 1st appointment, treatment wait and recovery rates).
    - Pathfinder Hubs maintain a caseload of over 1,400.
    - There are approximately 1,600 referrals of people aged U65 (18-65) to adult mental health services each month, with a further 800+ a month of 65+ year olds. Referrals of have increased by approximately 15%+ compared with pre pandemic. Under 65 referrals were already increasing pre pandemic, 65+ had been more stable.
- Inpatient - Under 65: Looking at the longer term, overall occupied bed days have declined, but delayed bed days have increased. The increase in delayed bed days precedes the pandemic, reduced during the pandemic, but has risen since.
- Urgent and Emergency Care: The Sussex Urgent and Emergency Care Plan sets out five objectives with associated metrics (Sussex wide). Of note the data shows that the discharge from mental health beds and the wait for a mental health bed of those requiring admission remain considerably challenging within the system.
- The highest rates of secondary mental health hospital admission in West Sussex are ages 20-34.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

25-65 years:

- Keep what's working well including carers support, pathfinder service / function, suicide prevention multiagency working.
- Review of access to early intervention support regarding trauma including peer support.
- Waiting well and waiting safely measures and ongoing communication with those on waiting lists.
- Workforce training on lower-level support, trauma informed support, and mental health first aid.

Area 3: Whole pathways and all people

High level areas for focus:

1. **R Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

25-65 years:

- Development and delivery of a strategic plan for commissioning and provision building on what's working well, addressing challenges including gaps for targeted support:
  - Access to mental health support for those with substance misuse, people in the criminal justice system, people on sex offences register, mothers who have a mental health need with a young child but don't meet thresholds, transgender friendly models of care, adults who are self-harming, those who are care experienced, wheelchair accessible properties.
  - Tailored support for LGBTQ+ including peer support, eating disorders, earlier access to support for those not in crisis and neurodevelopmental disorder and gaps in essential support such as care tasks for those not registered to do so such as collect meds.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.

6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

25-65 years:

- Workforce training on mental health first aid.
- Review inpatient admissions across age cohorts, referral routes and pathways.
- Day services to bring services together in one place, drop in facility with extended hours so people can access a service when they need it.
- Step down support from urgent care, linking with social prescribing.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

25–65 years:

- Increase access to mental health support for people experiencing homelessness.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.

4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

26-65 years:

- Keep what's working well - innovative service delivery models, dual diagnosis protocol, women's therapeutic house model and proactive care.
- Trauma informed care system, wide and compassionate approaches including communication methods by staff for example, giving diagnoses, domestic abuse support, and victim support.
- Development of gender informed approaches in mental health and multiple compound need services: Women-only space in male dominated services; working with men due to higher risk of suicide in males; use the Hastings approach to gender inequalities through co-production.
- Development and adoption of a common assessment tool that will lead to better referrals.

Life Stage: 65 years or over

KEY POINTS

- 20,000 people aged 65 years or over are estimated to have a common mental health problem.
- There are an estimated 14,800 people living with dementia in West Sussex. The majority were women, over the age of 80 years. In terms of recorded prevalence, as of January 2024 there were:
  - 9,365 West Sussex residents with a dementia diagnosis on GP registers.
  - 4,845 recorded as Alzheimer's.
  - 320 with a mixed type of dementia.
  - 3,415 other dementia type.
  - 815 vascular dementia.
- The diagnosis rate (diagnosis verses estimated prevalence) has not returned to pre-pandemic levels and there is considerable variation between the West Sussex primary care networks.
- In December 2023 there were a total of 1,880 bed days of adults aged 65 years or over. Of these 535 were delayed - 28.5% of the total occupied bed days. The percentage of bed days delayed has been increasing.

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

65+ years including dementia:

- Increase engagement across services and communities to promote earlier diagnosis of dementia.
- Increase early identification of those with dementia equitably – prioritising those unrepresented with risk factors.
- Increase access to talking therapies for older people in different settings including care homes.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

65+ years including dementia:

- Development and delivery of a strategic plan for commissioning and provision building on what's working well, addressing challenges including:
    - Gaps to join up in specialist services for complex dementia, alcohol related dementia, alcohol misuse issues, substance misuse issues, self-neglect and hoarding.
    - A lack of focus on older people's mental health (lower levels of referrals to talking therapies, in some cases maybe because dementia is more commonly considered).
    - Respite provision of 72 hours being too short.
    - Restrictions of Care Act thresholds to enabling earlier intervention for example, self-neglect, capacity and Deprivation of Liberty Safeguards (DoLS).
    - Difficulties identifying people with dementia living alone and available services.
    - Communication in advance when services have to change or cease to exist, or there is criteria change to support with signposting.
    - The issue of dual diagnosis with dementia leading to confusion in identifying services that fit needs, and difficulties connecting with private co-carers.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

65+ years including dementia:

- Workforce training on mental health first aid.
- Review inpatient admissions across age cohorts, referral routes and pathways.
- Day services to bring services together in one place, drop in facility with extended hours so people can access a service when they need it.
- Step down support from urgent care, linking with social prescribing and high-risk adolescent services.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

65+ years including dementia:

- Increase access to mental health support for people experiencing homelessness.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

65+ years including dementia:

- Keep what's working well - innovative service delivery models, dual diagnosis protocol, women's therapeutic house model and proactive care.
- Review neurodivergent pathway and support for adults and older people, workforce training and awareness - having perspective of neurodiversity.
- Trauma informed care system wide and compassionate approaches including communication methods by staff for example, giving diagnoses, domestic abuse and victim support.
- Development of gender informed approaches in mental health and multiple compound need services: women-only spaces in male dominated services; working with men due to higher risk of suicide in males; use the Hastings approach to gender inequalities through co-production.
- Development and adoption of a common assessment tool that will lead to better referrals.

Life Stage: Multiple and Compound Needs

KEY POINTS

- There is no routine data which provides a breakdown of people with multiple compound needs. Data collected as part of an audit for Changing Futures found that 88% of clients who had multiple disadvantage had a mental health need (and 29% of those who did not have multiple disadvantage had a mental health need).

Area 1: System under pressure

High level areas for focus:

1. **Joined up strategic system leadership** – in a system under pressure it is more important than ever to strengthen collaboration for best strategy and use of resources; system wide joined-up commissioning and provision, plans, processes and KPIs across organisations and between services and support; enable longer term investment in services working well and workforce; strengthening a culture of joint working at all levels; building relationships and improving information sharing and communication between and about services.
2. **Build on and further develop existing structures that foster the development of effective and collaborative practice across all partners** (for example, Multiple Compound Needs Boards).
3. **Keep what is working well across all six areas for focus.**
4. **Review consistency and equity** of offer and maintain, learn from and expand effective evidence-based practice to ensure consistent and equitable service delivery across the county.

Area 2: Preventing mental ill-health, supporting people earlier

High level areas for focus:

1. **Increase focus on preventative and early intervention** initiatives using evidence-based approaches and strategies and consider how this informs resource allocation across the system, to look at what to stop doing and where to shift resource to evidence-based prevention, early intervention and better use of existing resource including buildings, spaces and community-based support.
2. **Ensure co-production continues** to develop across all support to guide provision.
3. **Increase awareness and understanding of support offers and services**, improving understanding by professionals, people, and communities to improve access.
4. **Consider existing information structures** and access to them, and further develop and promote sources of information and support through campaigns and engagement to different settings to raise awareness within communities including workplaces.

Multiple compound needs:

- Keep what's working well including carers support, pathfinder service / function, suicide prevention multiagency working.
- Review of access to early intervention support regarding trauma including peer support.
- Waiting well and waiting safely measures and ongoing communication with those on waiting lists.
- Workforce training on lower-level support, trauma informed support, mental health first aid.

Area 3: Whole pathways and all people

High level areas for focus:

1. **Ensure collective understanding of referral mechanisms and pathways across all cohorts,** consider gaps within pathways initially prioritising those highlighted in the needs assessment and strengthen referral mechanisms.
2. **Prioritise access and evidence-based support for vulnerable groups,** ensuring equitable mental health care, including those who are neurodivergent, from ethnic minorities, LGBTQ+, care-experienced, involved in youth justice system, bereaved by suicide, and carers.
3. Improve **access** and **support for parents and carers** looking after people (all-ages) with mental health issues.
4. **Strengthen prevention and early intervention for 16–25-year-olds** through a clear and accessible mental health support offer.
5. **Continue to strengthen and utilise data and intelligence** to inform decision-making and help improve service delivery and outcomes. The use of system wide metrics in line with existing evidence and guidance will support data sharing between organisations, systems of scrutiny. Strengthening the use of outcomes and experience data will support service improvement (e.g. looking at what care plans are saying and if they are co-produced will help to improve quality.)

Multiple compound needs:

- Development and delivery of a strategic plan for commissioning and provision building on what's working well, addressing challenges including gaps highlighted in 25-65 years section for targeted support:
    - Access to mental health support for those with substance misuse, people in the criminal justice system, people on sex offences register, mothers who have a mental health need with a young child but doesn't meet thresholds, transgender friendly models of care, adults who are self-harming, wheelchair accessible properties; care experienced.
    - Tailored support for LGBTQ+ including peer support, eating disorder, earlier access to support for those not in crisis and neurodevelopmental disorder, and gaps in essential support such as care tasks for those not registered to do so such as collect medication.

Area 4: Accessible, flexible and personalised support

High level areas for focus:

1. **Simplify access to mental health support for everyone,** regardless of their needs ('no wrong front door') involving links between different access points and services.
2. **Strengthen support and communication for individuals waiting for assessments, support and or care,** promoting safety and wellbeing.
3. **Incorporate co-production and peer support in offering personalised and tailored support** for individuals from high-risk groups.
4. **Foster diversity and inclusion**, welcoming and representative spaces and communication to reduce mental health stigma. Strengthening workforce training on diversity including neurodivergence will support this.
5. **Use of inclusive imagery, diverse representation** and signage for communications and physical environments.
6. **Outreach to support people where they are** - working in neighbourhoods and together across agencies aligned with district and borough levels.
7. **Maintain access to immediate support during mental health crises**, linking with local communities.

Multiple compound needs:

- Workforce training on mental health first aid.
- Review inpatient admissions across age cohorts, referral routes and pathways.
- Day services to bring services together in one place, drop in facility with extended hours so people can access a service when they need it.
- Step down support from A&E, linking with social prescribing and high-risk adolescent services.

Area 5: Housing and accommodation

High level areas for focus:

1. **Partnership, multi-agency working and system wide planning at county and district and borough levels** across social care, mental health, NHS and housing to prioritise solutions to improve access to mental health and appropriate housing support.
2. **Workforce training and awareness raising** with housing staff regarding mental health and support offers available.
3. **Strengthen collection and use of data** between housing and mental health services and support to join up and inform the development of service models and support.

Multiple compound needs:

- Increase access to mental health support for people experiencing homelessness.

Area 6: Complexity: Multiple physical and mental health, social care and or education needs and multiple services

Complexity refers to people who experience three or more areas in their life which require input or support from health, social care or other services. This can be because of their physical and mental health, disability, or wider life circumstances such as homelessness, poverty or domestic abuse that have a significant impact their daily life.

High level areas for focus:

1. **Further development of trauma informed approaches** and training across the system will better support those with more complex needs.
2. **Foster the development of services that are welcoming, supportive and evidence-based for individuals with multiple complex needs,** utilising targeted interventions through Trauma Informed Care, Social Prescribing, Family & Carer Support, and Advocacy and Peer Support.
3. **Ensuring access to support for parents and carers of children and young people** with complexity and mental illness.
4. **Consider access and support for those waiting for assessments, care and or support** for those with complex needs and understand the needs of those people who have complex needs to achieve equity of access and ensure they are supported whilst waiting for services.
5. **Enable integration of mental and physical health support** within neighbourhoods, emphasising increased uptake of physical health checks for most vulnerable groups.
6. **Ensure all services are accessible and acceptable for people who are neurodivergent,** so that they are considered neurodivergent-friendly.
7. **Foster close collaboration between services to help ensure seamless transitions and continuity of** care for individuals with complex needs including self-neglect across all age groups and service boundaries.
8. **Strengthen joint working between substance misuse and mental** health services to increase access to both.

Multiple compound needs:

- Keep what's working well: Navigator roles for multiple compound needs, dual diagnosis protocol, women's therapeutic house model and proactive care.
- Trauma informed care system wide and compassionate approaches including communication methods by staff for example, giving diagnoses, domestic abuse, and victim support.
- Review and provide outreach care support for those with multiple compound needs.
- Development of gender informed approaches in mental health and multiple compound need services: women only space in male dominated services; working with men due to higher risk of suicide in males; use the Hastings approach to gender inequalities through co-production.