Mental health and wellbeing in Brighton & Hove

2022

Part of the Joint Strategic Needs Assessment programme

Final draft

NHS Sussex

Brighton & Hove City Council

1 Summary

The Executive Summary is available at (ADD LINK WHEN PUBLISHED)

2 Background

"**A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community**".[1] The World Health Organization (WHO) definition of mental health

Nearly 2 in 3 of us will experience a mental health problem during our lives, and 1 in 6 of us is managing fluctuating levels of distress each week. This means that mental health problems commonly affect our lives, our families, workplaces, and communities, impacting everyone.[2]

None of us will lead a long life without having felt limited by our mental health at some point, for a shorter or longer period. We need to nurture and protect everyone's mental health.

Mental Health is a wide-ranging concept

The Mental Health Foundation and the Faculty of Public Health define mental health as a spectrum "from mental health problems, conditions, illnesses and disorders, through to mental wellbeing or positive mental health."[3]

Mental health and wellbeing are often seen as distinct from mental illness (**Figure 1**).[4] A person with a diagnosable mental health condition may have high levels of wellbeing and conversely a person without a diagnosable condition may have low wellbeing.

Figure 1: Mental wellbeing and mental illness

Source: State of Queensland Department of Child Safety, Youth and Women[5]

Mental ill health accounts for a significant disease burden

Together with substance misuse, mental illness accounts for 21% of the total burden of disease in England.[6] This is likely to be an underestimate for several reasons, including the overlap with neurological disorders and the grouping of self-harm as a separate category. It is likely to have increased because of the COVID-19 pandemic.

The cost to the UK economy is large

The cost to the UK economy of mental health problems excluding dementia and alcohol and substance misuse is conservatively estimated to be £117.9 billion annually by the Mental Health Foundation and London School of Economics and Political Science. Most of this (72%) is due to the lost productivity of people living with mental health conditions as well as costs incurred by unpaid informal carers.[7]

Problems are often hidden, stigma is still widespread

And many people are not receiving support to access services.

Most lifelong mental health problems start early in life

Half of all mental health problems begin by the age of 14, rising to 75% by age 24.[8] Our mental health is shaped by our genes, our personal experiences and the social circumstances we find ourselves in such as income, poverty, employment, discrimination, education, and community. The foundations of mental health are laid down in infancy in the context of family relationships.[9]

Mental health is mutually and intrinsically linked with physical health

People with a physical disability or physical health problem are more likely to experience a mental health problem, while people with a mental health problem are more likely to experience a physical health problem.[10] Through neuroscience and other disciplines, our understanding is growing of the mechanisms and pathways through which mind and body are connected.

Those with mental health problems have shorter lives

People with severe mental illness such as bipolar disorder or schizophrenia, die on average 15 to 20 years earlier than those without.[11]

Population factors

Mental health problems are associated with higher rates of alcohol and drug abuse, smoking, lower educational outcomes, poorer employment prospects and social disadvantage. These in turn increase risks of mental and physical health problems.[12]

Poor mental health is both a cause and a consequence of inequalities

Those at greater risk of having poor mental health are often more likely to have difficulties in accessing support.

There is an ever-growing evidence base of what works and what is cost effective

Cost-effective public health and intersectoral strategies and interventions exist to promote, protect and restore mental health, many evaluated in a UK context.[13]

3 About this needs assessment

This Joint Strategic Needs Assessment (JSNA) pulls together the big picture as a snapshot in time. Some of the issues will be known already to some or all parts of the system, others will be new. The needs assessment provides the opportunity to develop an understanding, developed and shared by partners, of the city's challenges and assets. Based on that shared picture, it seeks to identify strategic actions and recommendations. The data within the needs assessment was data available up to end July 2022. A key source of national evidence is the Office for Health Improvement and Disparities Mental Health JSNA toolkit. Appendix 1 has a list of local reports and documents included in the review. There was no primary data collection of quantitative or qualitative data for this review.

3.1 Aim of the JSNA (Joint Strategic Needs Assessment)

This Brighton & Hove all-ages mental health and wellbeing needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by the Brighton & Hove Health & Wellbeing Board.

The aim is to provide evidence to:

- Increase population resilience
- Improve outcomes through improving the quality and range of support for those with mental health problems
- Address inequalities through a whole systems approach

To do this by:

- Describing the current and future mental health needs of the Brighton & Hove population, both children and young people and adults and older people, with particular consideration of inequalities and the impacts of the COVID-19 pandemic on mental health needs
- Describing protective and risk factors that affect mental health and wellbeing, such as neighbourhoods, education, employment, community safety, housing and homelessness
- Considering future population projected needs to cover the period up until 2030 to bring it in line with the Joint Health and Wellbeing strategy
- Making recommendations based on evidence of what works and what is cost effective at both individual and place level
- Co-producing with stakeholders, including services users, carers, and services provided by voluntary and statutory organisations.

The findings will:

- Shape city wide approaches to mental health and wellbeing including commissioning, prevention, and improvement
- Inform future NHS and local authority commissioning plans and investment decisions from 22/23 onwards

- Be used to inform our readiness for signing up to the Prevention Concordat (See Section 5.2.3)
- Be shared with Sussex partners and will inform mental health and inequalities work at both Place and Sussex work
- Will feed into relevant strategies and action plans, including but not limited to:
  - Foundations for our Future - Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027
  - Implementation of the national Mental Health Long Term Plan 2019/20 – 2023/24, including the Adult & Older Adult Community Mental Health Transformation programme
  - Sussex and Brighton and Hove Suicide and Self-harm Prevention Strategy
  - Brighton and Hove Drug Strategy
  - Relevant Brighton & Hove city council corporate and directorate strategies
  - Place Based Plans developed by the Health & Care Partnership
  - Family Hubs Transformation Programme
  - Multiple disadvantage programme
  - Fairer Brighton and Hove Framework
  - Brighton and Hove Joint Health and Wellbeing strategy 2019-2030
  - The Mental Health Collaborative Programme for 2021/22 strategy
  - Sussex Mental Health and Housing Strategy
  - Best Start for Life Strategy
  - Perinatal Equity and Equality of Access Plan for Sussex 2022-2025
  - Sussex-wide All Age Eating Disorder Pathway review
  - Autistic Spectrum Conditions (ASC) / Attention Deficit Hyperactivity Disorder (ADHD) pathway review
  - Crisis pathway review
  - Complex Trauma pathway

3.2 Governance

The development of the JSNA was overseen by a steering group (See Appendix 2). See also the acknowledgements section.

The steering group was made up of commissioners, providers, community and voluntary sector organisations and academic experts. It reported to the Mental Health Oversight Board and the Children Health Oversight Board.

Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight board.

The voices of those with lived experience were sought through established engagement and co-production forums, reviews of recent consultation events and views expressed in recent reports and JSNAs.

3.3 Acknowledgements

We would like to thank the Steering Group for advising on and guiding this needs assessment. The needs assessment was produced by a working group including:

- Bernadette Alves, Public Health Consultant
- Kate Gilchrist, Head of Public Health Intelligence
- Elpida Sideri, Public Health Intelligence Specialist
- Sarah Colombo, Public Health Programme Manager for Starting Well
- Anne Foster, Head of Mental Health Commissioning, Brighton and Hove NHS Sussex
- Lizzie Izzard, Head of Children and Young Peoples Mental Health Commissioning, Brighton and Hove NHS Sussex

In addition, we would like to thank all of those who provided evidence for and gave feedback on the needs assessment.

3.4 Life course

The JSNA takes a life course approach. It considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing. The approach is in line with that taken by the city's Joint Health and Wellbeing Strategy. Where there are areas of overlap across the stages, we have taken a pragmatic approach to reduce repetition and signpost to other sections.

3.5 Evidence of what works for prevention

A report was commissioned to examine evidence, mainly sourced from reviews and meta-analyses, to identify public health interventions that can promote good mental health or wellbeing and prevent mental illness. The summaries appear in the boxes entitled "**what works for prevention**" in the life course sections. Appendix 3 lists the documents that were used in this review. The summaries cover six areas:

1. In the perinatal period / infant mental health
2. In the early years
3. Among parents and school-aged children
4. In workplaces
5. Among older people facing loneliness
6. Among older people facing long-term conditions

3.6 Interpreting national and local data

A key source of evidence for this JSNA is national and local data. Each have their strengths and limitations:

- **Nationally available data:** (eg proportion of people claiming Employment Support Allowance because of their mental health problems) where we can compare the city with other areas. This kind of data allows us to benchmark, ie to know whether Brighton & Hove is better or worse, higher or lower, than other areas. However, it tends to be older, and the content will be determined at a national level.

- **Local data:** eg the Safe and Well at School Survey. This data is usually more up to date, richer and provides more detail but usually cannot be compared to other areas.

3.7 Comparators

Where meaningful, we compare the city to other geographies: England; the South East and CIPFA comparators. CIPFA comparators are areas with similar population demographics to Brighton & Hove which allows for more meaningful comparisons of outcomes and performance. The comparator local authorities for Brighton & Hove are Bournemouth, Bristol, Coventry, Leeds, Medway, Newcastle upon Tyne, North Tyneside, Nottingham, Plymouth, Portsmouth, Sheffield, Southampton, Southend-on-Sea, Swindon, and York.

Throughout the needs assessment, the colours used for comparison to England are based upon whether Brighton & Hove is statistically significantly lower / higher or better / worse than England (where this judgement can be made). See the key in Appendix 4.

3.8 The structure of the JSNA

- Executive summary
- Background
- About the JSNA
- Wider national and international crises
- Prevention and the determinants of mental health
- Risk and protective factors: environmental and population
- Prevalence (from key national surveys for children and young people and adults)
- Life course stages (these sections do overlap):
- Perinatal – conception to 1 year of age
- Children and young people and families – aged 0 to 25 years
- Working age adults – aged 18 to 65 years
- Older adults – aged 65 years or over
- Recommendations

Each of the life course sections has the following subsections:

- Introduction
- Risk and protective factors
- Level of need
- Voice
- Quality and outcomes
- What we know about the offer of support
- Opportunities to learn more
- What works for prevention

4 Wider national and international crises

Here we briefly cover impacts of the following on mental health and wellbeing:

- The COVID-19 pandemic
- The cost of living crisis
- Climate change
- Workforce

The first three of these crises increase the numbers of people with mental health needs and deepen inequalities. More vulnerable groups have been and are being disproportionately affected. The data in this document does not fully reflect the impact of these crises and may therefore underestimate both current and future need and the extent of inequalities. Challenges around workforce recruitment and retention impact on quality and capacity of support.

4.1 Impact of the Coronavirus (COVID-19) pandemic

The COVID-19 pandemic deepened existing inequalities including mental health inequalities.[14] Some groups were disproportionately affected by the pandemic and this includes those with existing mental health and physical health problems, learning disabilities, younger people, women, BME communities, deprived communities, frontline health and care staff, and those facing financial hardship. The medium and long impact of both the infection and the measures taken to control it, such as lockdown, are ongoing. The negative mental health effects of the pandemic are expected to last longer than its physical health impacts.[15] As we move into recovery, there is an opportunity to create a healthier, more resilient society and redress these inequalities.[16]

Demand for mental health support is predicted to increase. The Centre for Mental Health has estimated an increase of 8.5 million adults and 1.5 million children and young people requiring mental health support as a direct impact of the pandemic during the next three to five years.[17]

Routine and local data in this document may not fully reflect the impact of COVID-19 and may underestimate both current and future need and the size of inequalities.

The population may have experienced and may continue to experience short- or medium to long-term effects from:

- Direct infection: Mental health impact of short- or medium-term morbidity associated with having the virus, receiving treatment or developing Long Covid.
- Control measures like lockdown: The direct effects such as increases in domestic violence, isolation, reduced support from family and friends, loneliness, on-line schooling etc. and indirect effects on the wider determinants of health such as financial insecurity, unemployment, educational achievement and food insecurity. The cumulative effect of repeated pandemic waves and lockdowns may have led to an increased and prolonged negative effect on the mental health and wellbeing of some groups within the population.

- Reduced access to healthcare and wider support: Impaired access to or quality from healthcare for non-COVID-19 related conditions, fewer opportunities to identify safeguarding issues or to pick up developing problems at an early stage. This disruption continues as workforces are stretched, ambulance waiting times increase and there is a backlog of people waiting for treatment.
- Bereavement: Experience of losing loved ones at a time when people could not always visit at the end of their life and grieving processes were disrupted eg funeral arrangements.

Short or medium-term effects include mortality, morbidity, physical and mental health and wellbeing (WHO,2020). Appendix 5 summarises some key impacts by life course.

4.2 Cost of living crisis

The 'cost of living crisis' refers to the fall in real disposable income that the UK has experienced since late 2021.[18] The cost of living has risen steadily for at least 12 months and at the time of writing (autumn 2022) is predicted to increase further. It is driven by various factors including increases in the cost of consumer goods and increasing energy prices.[19] According to the Office for National Statistics, 89% of adults in Great Britain reported an increase in their cost of living in August 2022. The crisis will disproportionately affect low-income households, many of these are the same communities who have been disproportionately affected by COVID-19.

The crisis will have a profound negative impact on population mental health and increase demand for services. This has been highlighted by several organisations and agencies including The Royal College of Psychiatry.[20] It should be noted that because the crisis is evolving so rapidly, the estimates in this needs assessment do not take account of the impact of the cost of living crisis because data was not available. It means that need is likely higher and inequality gaps greater than presented in this report.

4.3 Climate change

Climate change has been recognised as a health emergency, but predominantly as a physical health emergency. Both the drivers and consequences of climate change can lead to mental health disorders and threaten emotional wellbeing.

Climate change is expected to have adverse impacts on well-being and to further threaten mental health. Climate change increases existing inequalities: children and adolescents, particularly girls, elderly people, and people with existing mental, physical and medical challenges are particularly at risk in addition to those with lower socioeconomic status. Mental health impacts are expected to arise from exposure to high temperatures, extreme weather events, displacement, malnutrition, conflict, climate-related economic and social losses, and anxiety and distress associated with worry about climate change.[21]

There are new terms to describe climatic events and the impact on individuals' mental health; ecoanxiety, eco-guilt, ecopsychology, ecological grief, solastalgia, biosphere concern.[22]

4.4 Workforce

Workforce shortages were the single biggest challenge facing the NHS well before COVID-19. But the pandemic has driven increased demand for health care, growing waiting lists and a substantial elective care backlog, while impacting negatively on staff wellbeing and absence.[23]

High level analysis points to an overall workforce supply-demand gap across the NHS Hospital and Community Health Service (HCHS) and general practice in 2021/22 of around 7% of estimated workforce demand and increasing to a peak gap in 2024/25 of around 9% of projected demand. There are particular issues in the GP workforce.[24]

The Covid-19 pandemic exacerbated long-term issues such as chronic excessive workload, burnout and inequalities experienced by staff from ethnic minority backgrounds.[25,26] People across all professions, and carers and volunteers, worked tirelessly to help those who needed care during the pandemic. The negative impact of working under this sustained pressure, including anxiety, stress and burnout, cannot be underestimated.[27]

Workforce shortages are having a direct impact on the quality of people's care.[28]

5 Prevention and the building blocks of mental health

This section provides an overview of what works to improve population wellbeing, prevent mental ill health and the need to intervene as early as possible to reduce impact and deterioration. It begins by describing factors that influence mental health and wellbeing.

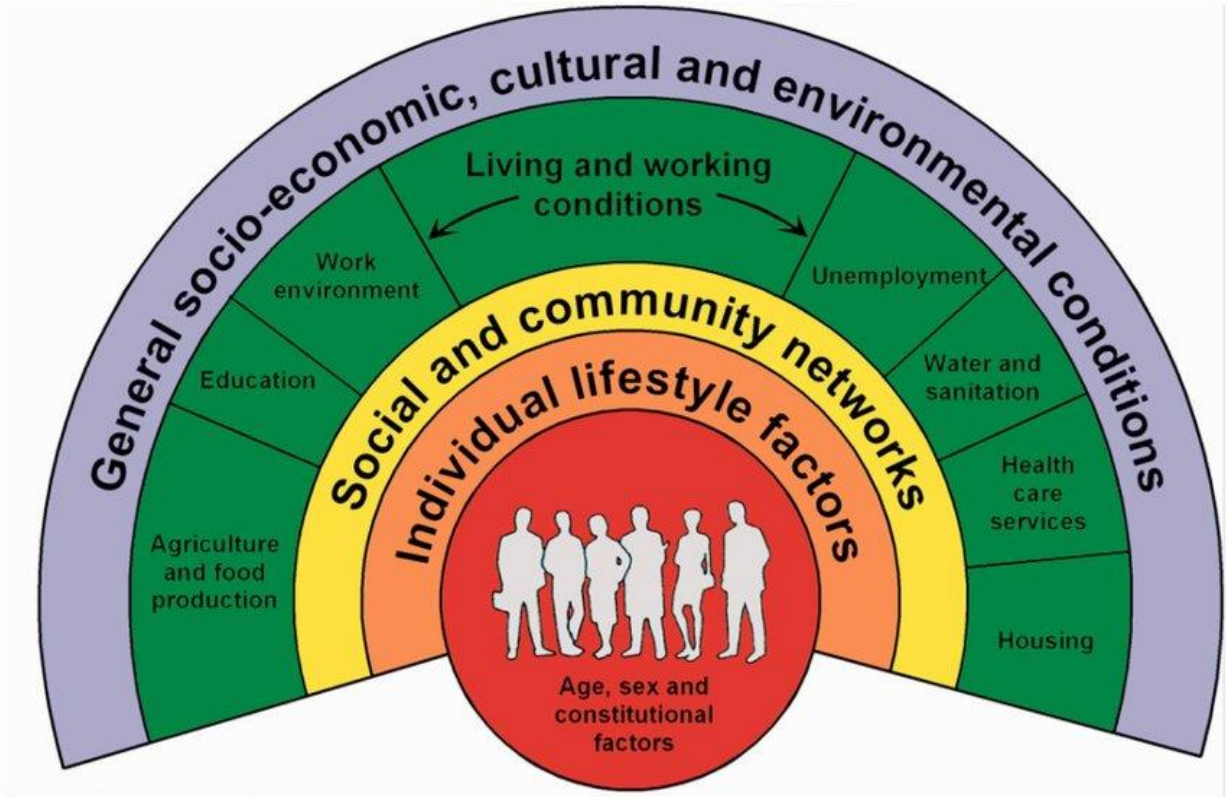
5.1 The building blocks of mental health

The risk of developing a mental health problem, such as a diagnosable mental illness, and the risk of having low levels of mental wellbeing, varies across people and communities and over time. It is strongly influenced by multiple factors past and present - by the environment in which we are born, grow, live, work and age, by our family relationships especially when we are a child, life experiences, trauma, and our biology.

Some factors increase the likelihood of having mental health problems (risk factors) and other reduce it (protective factors). Protective factors contribute to the ability to have control over one's life. Risk factors can undermine the development of individual level attributes and reduce the capability to flourish. Some risk and protective factors operate at an individual level, others at family and some within a community or setting.

Biological, psychological, and environmental factors combine to both protect from and increase the risk of developing mental health problems.

Figure 2: The determinants of health and wellbeing in neighbourhoods



Source: Dahlgren & Whitehead (1991)[29]

Although some mental health problems are partly influenced by genetics, it is important to look at the wide range of environmental, social, economic, community, family, and emotional factors, and health behaviours, that interact with biology (**Figure 2**).

Figure 3 summarises common risk and protective factors for mental wellbeing.

Figure 3: Common risk and protective factors for mental wellbeing at individual and family/community level

	Individual level	Family and community level
Risk factors	Adversity in early life Weak or difficult relationships with impact on attachment Adverse life events (ACEs) Healthy lifestyles Financial worries or debt Traumatic events Violence / abuse Natural disasters Serious illness or disability Bereavement	Poverty / deprivation Poor housing Homelessness Lack of employment Insecure or low paid employment Working conditions that create stress Crime and safety Poor quality neighbourhood environment Low social capital Social isolation
Protective factors	Includes factors that support or increase the development of individual level attributes such as: • Coping abilities, • Self-efficacy and resilience, and • The ability to learn and to develop social skills all of which may encourage healthy behaviours and mental health and wellbeing.	Protective family and community level factors include social support and protective influences organised in schools, neighbourhoods and workplaces. • Feeling part of a community • Access to green and open spaces • Shared public spaces • Sustainable local economy • Arts and creativity

Source: Office for Health Improvement and Disparities Mental health JSNA toolkit, prototype Mental Health tool and The Mental Health Wellbeing Impact Assessment Toolkit

Evidence shows that the largest determinant of our health is not health services or personal behaviour but the wider socio-economic circumstances of our life such as income, educational attainment, transport, employment, community cohesion.[30] These are the building blocks of health.

The factors are complex and often cluster eg a person who has financial insecurity is more likely to live in poorer quality housing, have difficulties in keeping their room warm and have worse access to green spaces. Factors can be inter-generational eg poor parental mental health is a key risk factor for their child's mental health. A parent with poor mental health means the family is more likely to be experiencing one or of more

disadvantage eg poor housing, job insecurity etc. Furthermore, they may have episodes where they have a lower ability and desire to connect with other family members and their baby/child in a warm, responsive way.

Risks accumulate over time, for example if a person experiences parental conflict as a child, and/or discrimination as a young adult, risks will grow and impact on mental health not only at the time, but also in later life.

5.2 Prevention

> ***Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible.***
>
> Department of Health and Social Care: Prevention is better than cure [31]

The government vision for "putting prevention at the heart of our nation's heath" highlights that:[32]

- Many causes of ill health are preventable: Over half of the attributed burden of poor health and early death can be linked to factors that can be modified
- Prevention works and is cost effective: A review of international studies suggests past investments in prevention have had a significant long-term social return on investment and this is estimated to be around £14 of social benefit for every £1 spent.

Prevention is a strand of national mental health policy:

- NHS Long Term Plan
- NHS Five Year Forward View
- Prevention Green Paper: Advancing our health: prevention in the 2020s.

However, it is widely acknowledged that there are challenges to implementing a prevention approach. Some of the wider system challenges are:

- Actions to prevent mental health problems sit for the most part in the wider system – the largest determinants of mental health are the building blocks of health such as income, education, occupation, employment, housing, community cohesion, early childhood development[33]
- Decision makers can be daunted by the challenge of "fixing" the wider system and actions often focus on the role of individual choices and behaviours[34]
- Most NHS targets are about services, few are focused on prevention
- Impact on outcomes can be difficult to measure and it may take years for the full impact to be realised

- Investment in one part of the system leads to savings in another part which can be a barrier to joint working
- The evidence base has gaps which creates uncertainty about future actions
- Cuts to public sector spend, eg NHS and local government funding, mean resources are directed at acute need rather than prevention approaches.

Commitment to, and championing of, a population prevention approach, with tools for system leaders, commissioners and planners to understand and implement prevention measures, could lead to large improvements in mental health and reduce health inequalities. There are toolkits that can help in developing a different, more evidence-based narrative that takes a social model approach and can help promote a sense of efficacy, the sense that the system has the ability to produce the desired change.[35]

This section covers:

- A definition of prevention
- Prevention frameworks
- Outline of the Prevention Concordat
- Individual behaviours

5.2.1 Prevention – definition

Widely accepted models define prevention at three stages:[36]

Primary (before problems emerge)

- Initiatives and strategies to prevent the onset or development of mental ill-health. These interventions may target: The whole community (universal); Particular groups known to be at higher risk (selected); or Individuals at very high risk who may be showing early signs of mental ill-health (indicated).

Secondary (as problems emerge)

- Initiatives and strategies to lower the severity and duration of an illness through early intervention, including early detection and early treatment. These interventions can occur at any stage of life, from childhood to old age and are targeted at risk individuals and those showing early signs and symptoms of mental ill-health.

Tertiary (when problems already exist)

- Interventions and strategies to reduce the impact of mental ill-health on a person's life through approaches such as rehabilitation and relapse prevention. It also includes actions to ensure people have access to supports within the community, such as housing, employment, physical health care and social engagement.

Actions to address each stage aim to mitigate the associated risks and safeguard the known protective factors (**Figure 4**).

Early intervention is a form of prevention activity and overlaps with both primary and secondary prevention. Early intervention can be: 1. Prevention focused - targeting individuals beginning to show the early signs and symptoms of a problem (indicated primary prevention); and 2. Treatment focused - targeting individuals experiencing a first episode of mental illness (secondary prevention).

Figure 4: Summary of types of prevention, target groups and aims

Prevention is often considered in terms of three types at difference stages:

	Type of prevention	Stage	Target group	Aim
○	Promotion and prevention (primary)	No mental health problems	Whole population (universal) and at-risk groups (targeted and specialist)	Prevent mental health problems happening
○	Early detection (secondary)	Early stage of mental health problems	At risk groups (targeted and specialist) and those displaying early signs and symptoms	Detect signs of mental health problems early and timely help
○	Recovery (tertiary)	Later stage of mental health problems	Those with mental health problems (targeted and specialist)	Reduce complications of mental health problems and support recovery and wellbeing

Source: Adapted from Beaglehole, R., Bonita, R., and Kjellstrom, T., (1993). Basic Epidemiology. Geneva: World Health Organisation)[37]

Universal, targeted and specialist prevention activity

Prevention activity may be undertaken on different levels:

- **Universal** – actions focused to everyone regardless of risk. Often primary prevention work is 'universal' in that it targets and benefits everyone in a community.

- **Targeted** (or selective)– focused on those regarded at increased risk either by category eg young parents, middle-aged men or by geography eg living in an area of high deprivation.
- **Specialist** (or indicated)– focused on an even more select group who are at particularly high risk or already exhibiting concerning symptoms.

5.2.2 Mental health prevention frameworks

There are several national evidence-based documents that set out frameworks for preventing mental ill-health and promoting mental wellbeing – some are focused on cost effectiveness, others on effectiveness of specific interventions, others focus on factors that influence health without specifying interventions. Appendix 3 provides a list of some of the key ones.

There is no one framework which reflects well the needs and areas of focus for mental health prevention relevant for Brighton & Hove.

5.2.3 The Prevention Concordat

The Prevention Concordat for Better Mental Health is a national evidence-based prevention-focused framework for improving the public's mental health and reducing health inequalities. It includes tried and tested approaches that impact on the wider upstream determinants of mental health.[38] It was refreshed in 2020 to take account of COVID-19 and has over 250 signatories across the country. Prevention Concordat for Better Mental Health - GOV.UK (www.gov.uk)

The government encourages local authorities, Health and Wellbeing Boards, ICSs, and other health and care partnerships to sign up to the Concordat. It:

1. Focuses on prevention and the wider determinants of mental health to impact positively on the NHS and social care system by enabling early help through the use of upstream interventions
2. Supports joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at the local level drawing on the expertise of people with lived experience of mental health problems, and the wider community
3. Encourages collaborative work across organisational boundaries and disciplines to secure place-based improvements tailored to local needs and assets
4. Builds capacity and capability across our workforce to prevent mental health problems.

5.2.4 Individual behaviors

Whilst the building blocks of health such as income, education and housing, play the largest role in determining health, the actions and behaviour of individuals also make a difference.

Connect

Reach out to your local community, neighbourhood, colleagues, family and friends.

Learn

Learning new things can be fun and can improve your confidence. Set a challenge you will enjoy achieving. Share what you have done with others.

Be Active

Exercising makes us feel good. If you can get outside, try and go for a walk every day. Discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take Notice

Look out as well as in. Notice your senses and what's around you. Pay attention to the present moment. Some people call this awareness "mindfulness".

Give

Acts of giving and kindness can help improve your wellbeing by creating positive feelings and a sense of reward, purpose and self-worth. They also help you connect with other people.

Care for the Planet

Look after your community and the world. Make small changes to your life that will reduce your energy use, recycle more, leave the car at home, use low energy light bulbs, small steps to a greener life can make a difference.

6 Brighton & Hove population and place – risk and protective factors

This section summarises some of the characteristics of the city – the population, the place and the wider determinants - that are associated with increased risks of, or greater protection from, developing mental health problems.

Appendix 6 shows the full list of indicators relevant to mental health where a comparison can be made between Brighton & Hove and England and its CIPFA comparators. This section highlights areas where Brighton & Hove has a potentially greater or smaller need or has risk or protective factors that are higher or lower than England, the South East or its CIPFA comparators. It has the following sections:

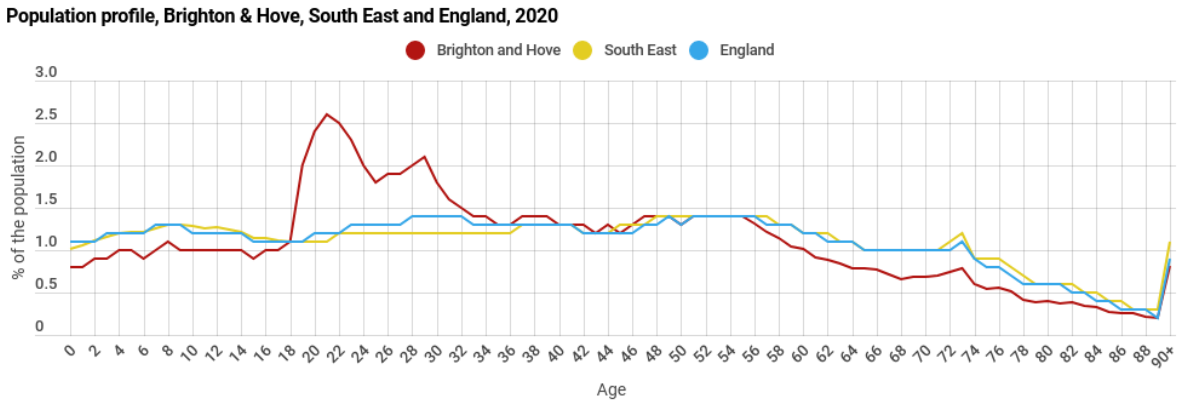
- Current population structure (age and gender) and population projections for 2030
- Environmental risk and protective factors
- Groups and communities at higher risk who are more exposed to, and more vulnerable to, unfavourable social, economic, and environmental circumstances.

6.1 The population of Brighton & Hove

The age and gender structure of the local population is an important driver of need and demand for mental health services.

In 2020, Brighton & Hove had an estimated 291,700 residents. It is estimated that 44,800 people (15%) are aged 0 to 15 years, more than two thirds (71%, 208,000 people) are aged 16 to 64 years, and just over one in ten (11%, 33,100 people) are aged 65 to 84 years and 5,900 people (2%) are aged 85 years or older (**Figure 5**).[39]

Figure 5: Population profile, Brighton & Hove, South East and England, 2020



Source: Brighton & Hove Population JSNA 2021 - Infogram

The population of Brighton & Hove differs from the South East and England (as shown in **Figure 5**):

- The city has a much higher proportion of people aged 19–38 years (37%, 106,800 people) compared to only 24% in the South East and 26% in England

- The difference is most pronounced between the ages 19 to 28. A fifth of Brighton & Hove's total population (21%, 62,300 people) is aged 19 to 28 compared to only 11% in the South East and 13% in England
- Brighton & Hove has a lower proportion of children aged 0 to 17 years (17%, 50,300 people) compared to 22% in the South East and 21% in England
- There are fewer people across all ages from the age of 56. In Brighton & Hove less than a quarter of the total population (23%, 65,700 people) is aged 56 or older compared to 31% in the South East and 29% in England.

Based on population estimates in 2020, Brighton & Hove has a relatively even gender distribution of males and females across all ages up until the age of 75 years. Beyond the age of 75 years, the proportion of female residents increases. There were an estimated 18,300 residents aged 75 or older, of whom 57% (10,400 people) were female and 43% (7,800 people) were male. By the age of 90 years or older the difference is almost two to one with 1,600 female (66%) and 800 male (34%) residents.

Population growth between 2019 and 2020 is mainly the result of inward international migration. There were 150 more births than deaths. Net international migration (from outside the UK) over this period was 2,200 more people, while net internal migration (between Brighton & Hove and the rest of the UK) was 1,500 fewer people (1,500 more people left than moved to the city). Most people moving from within the UK to Brighton & Hove do so from other parts Sussex or London. More people left for Sussex than arrive, but more people arrived from London than leave.[40]

6.1.1 Births

There are around 67,850 women of childbearing age resident in the city, that is defined as aged 15 to 44 years. This is 24% of the female population, higher than our CIPFA comparators (22%) and England (19%).[41]

Brighton & Hove had a general fertility rate of 34.8 live births for every 1,000 women aged 15-44 years in 2019, with 2,395 live births. This was the lowest general fertility rate of any upper tier local authority in England in this year. The rate has been falling; in 2010 it was 50 live births for every 1,000 women aged 15 to 44 years.

In 2020, 29% of all live births in England and Wales were to women born outside the UK; this is the highest since records began in 1969, continuing the general long-term increase. In Brighton & Hove in 2020, 28% of births were to non-UK born parents, an increase from 23% in 2007.[42]

The percentage of births in the city to mothers aged under 20 years was 1.5% in 2020 (2.5% England). The percentage of births to mothers aged 40+ was 9.9% which is more than double our CIPFA comparator areas (4.6%) and England (4.9%).

6.1.2 Future population change

There are projected to be 11,300 more people living in the city by 2030 (compared with 2020, a 4% increase to 303,000 people).

The city's population is predicted to get older, with the greatest projected increases by 2030 by broad age band in the 60-69 years (34%, 7,700 extra people) and 80-84 years (34%, 1,800 extra people). There are projected to be 400 (11%) more 85–89-year-olds and 300 (12%) more 90+ year olds.

6.2 Environmental risk and protective factors

See Appendix 6: Indicators of common risk and protective factors for mental wellbeing, Brighton & Hove, CIPFA comparators and England.

6.2.1 Introduction

This section describes some of the wider determinants of health in Brighton & Hove and considers social and contextual factors that affect mental health, such as employment, crime, safety and housing. The mental health of each individual is influenced by their social setting, such as having the ability to earn enough money and feeling part of a community. This section considers these determinants which lead to unfair and avoidable differences in health within and between populations and to shorter lives.

For each key factor, we have a short overview of national evidence and then present evidence for how Brighton & Hove compared with England.

We cover:

- Deprivation
- Poverty and financial insecurity
- Housing (the homeless population is covered in the next section)
- Education
- Employment
- Crime, safety and violence
- Community wellbeing and social capital
- Healthy lifestyles

Unless otherwise stated, the national evidence sections are taken from the Office for Health Improvement and Disparities Mental Health JSNA Toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)

6.2.2 Deprivation

National evidence

It is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health, including mental health. The prevalence of psychotic disorders among the lowest fifth of household income is 9 times

higher than in the highest and double the level of common mental health problems between the same groups.

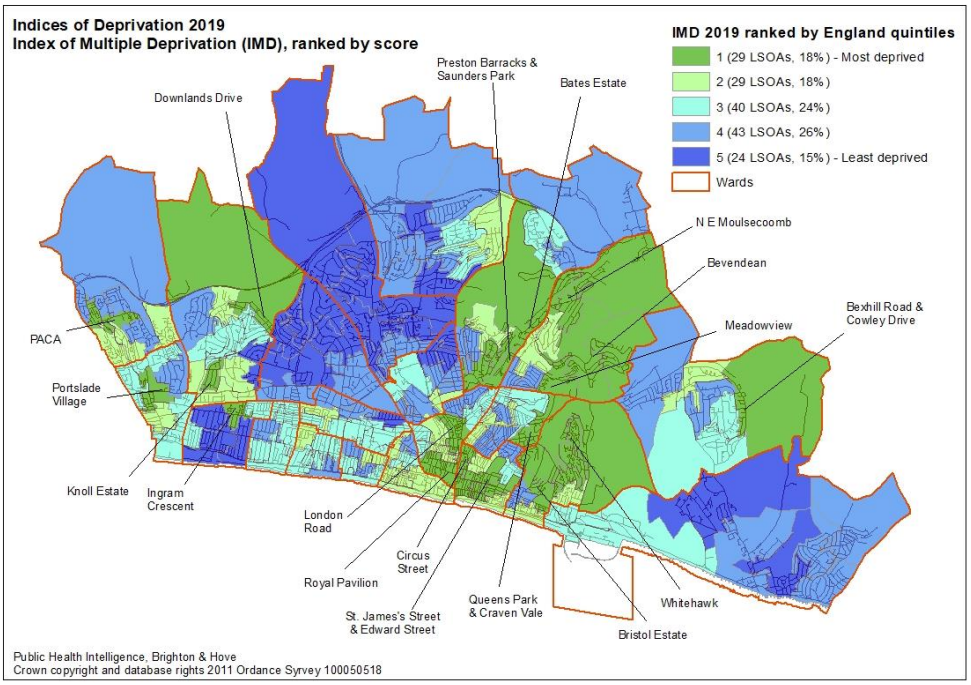
Explaining the relationship between deprivation and mental health is complex and it is hard to unpick cause and effect. Experiencing disadvantage can increase the risk of mental health problems. People with mental health problems can be affected by a 'spiral of adversity' where factors such as employment, income and relationships are affected by their condition. People who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment. This compounds and worsens mental health problems.

Brighton & Hove

According to the 2019 Index of Multiple Deprivation, Brighton & Hove is the 131st most deprived local authority in England (of 317), with 17% of the population of the city living in the 20% most deprived areas in England and 13% in the 20% least deprived areas. This means there are fewer people in both the most deprived and least deprived quintiles than in England – which may indicate lower levels of deprivation inequality. There are however some areas of very high deprivation.

The highest concentration of deprivation is in the Whitehawk, Moulsecoomb, and Hollingbury areas. Along the coast, to the west of the city and in Woodingdean there are also pockets of deprivation. All these areas are in the 20% most deprived areas in England (Figure 6).

Figure 6: Index of Multiple Deprivation (IMD), ranked by score, Lower Super Output Area (LSOA) in Brighton & Hove 2019



Source: Ministry of Housing, Communities and Local Government. IMD 2019 English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Deprivation within the city is summarised in Table 1. Brighton & Hove has a greater proportion of older people affected by income deprivation than in England.

Brighton & Hove has a similar proportion of children in low-income families compared to England. There are almost 7,900 children in low-income families before housing costs, but if housing costs are taken into account, then in 2019/20 there are almost 13,000 children in the city living in poverty.[43]

Table 1: Summary of Index of Multiple Deprivation (IMD), Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI), Brighton & Hove, 2019

Measure	Rank*	Quintile	Of 165 LSOAs, % in most deprived quintile	Of 165 LSOAs, % in least deprived	Size of affected pop
Index of Multiple Deprivation (IMD)	131	Third	18%	15%	17% (50,400 people) live in the 20% most deprived areas in England
Income Deprivation Affecting Children Index (IDACI)	145	Third	17%	15%	More than one in ten children aged under 16 (15%, 6,900 children) live in income deprivation
Income Deprivation Affecting Older People Index (IDAOPI)	53	First	25%	5%	One in five residents aged 60 or over (19%, 9,500 people) live in income deprivation

Source: Brighton & Hove City Council. English Indices of Deprivation 2019: Brighton & Hove Briefing. Available at REPORTS | BH Connected and Office for National Statistics Mid Year Population Estimates 2020 Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)
*(of 317 LAs in England)

6.2.3 Poverty and financial insecurity

National evidence

Poverty can be both a causal factor and a consequence of mental ill health. Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on an average income. The cumulative effects of poverty are present throughout the life course, starting before birth and continuing into older age.

Unmanageable financial debt is associated with poorer mental health. A quarter of people experiencing common mental health conditions also have financial problems, three times more than the general population. Half of adults with a debt problem also have a common mental health condition.

Brighton & Hove

In Brighton & Hove median house prices are 12 times annual residence-based earnings, significantly higher than England (9 times) - 28th highest of 151 local authorities in England, and the third highest in the South East.

In Brighton & Hove 12% of all households (15,800 households) are estimated to be living in fuel poverty compared to 13% in England.

Tourism continues to be an important driver of the Brighton & Hove economy: the sector supports around 1 in 5 jobs in the city. Seasonal jobs and casual employment can create financial insecurity.[44]

6.2.4 Housing (see also population section for people experiencing homelessness)

National evidence

Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions. One in five (19%) adults living in poor quality housing in England have poor mental health outcomes.

Brighton & Hove

In 2020, 16.2% of homes across England did not meet the decent homes standard. Using the English rate and the latest ONS household projections this would mean there are in the region of 20,000 homes in the city that do not meet the decent homes standard.

At the time of the 2011 Census, 7% of homes in Brighton & Hove were classed as overcrowded, significantly higher than England (5%) and 35th highest of 151 local authorities in England.

6.2.5 Education

National evidence

Education is an important determinant of later health and wellbeing. It improves peoples' life chances, increases their ability to access health services and enables people to live healthier lives. A high level of educational attainment at school can lead to higher qualifications and in later life, more secure jobs and housing that can in turn lead to better health.

Brighton & Hove

The city has similar school readiness at the end of reception to England and has seen an improving trend in recent years and a higher average attainment 8 score than

England. There is also a lower rate of 16–17-year-olds not in education, employment or training in Brighton & Hove than England.

6.2.6 Employment and work

National evidence

Stable and rewarding employment is a protective factor for mental health and can be a vital element of recovery from mental health problems. Unemployment and unstable employment are risk factors for mental health problems.

People who are unemployed are between 4 and 10 times more likely to report anxiety and depression and to complete suicide.

Being in work is beneficial to health and well-being. However, it is important to distinguish between 'good work' (characterised by fair treatment, autonomy, security and reward), and 'bad work' in which individuals feel unsupported, undervalued and demotivated.

Brighton & Hove

The city has significantly lower rates of long-term claimants of Jobseeker's Allowance, with 260 people in 2021 (1.3 per 1,000 working age adults compared to 2.1 in England). In 2021, the unemployment rate in Brighton & Hove was 4.8% compared to 4.4% across Great Britain and higher than the South East (3.8%).

6.2.7 Crime, safety, and violence

National evidence

The relationship between crime and mental health problems is complex. It can also be controversial, as public perception about the relationship can contribute to stigma, discrimination and social exclusion. While there is public perception that people with mental health problems are offenders, the vast majority of these individuals are not violent, and most crimes are committed by people who do not have mental health problems. People with mental health problems are three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault (rising to 10 times more likely for women).

People in contact with the criminal justice system have substantially more risk factors for suicide (increased prevalence of mental health conditions, substance misuse and socioeconomic deprivation).

Being a victim of crime, or exposure to violent or unsafe environments can increase the risk of developing a mental health problem.

Being a victim of intimate partner violence or domestic abuse increases the risk of mental health problems. The relationship between domestic violence and mental health is bidirectional, with research suggesting that women experiencing abuse are at a

greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse.

Brighton & Hove

In 2020/21 there was a similar rate of violent crime offences per 1,000 population in Brighton & Hove compared to England (29.5 and 27.8 respectively) with 8,593 offences within that year.

The rate of domestic abuse-related incidents across Sussex (not available below this level) is lower than England (22.1 compared to 25.9 per 1,000 people), however this may be due to differences in reporting to the Police.

There were 315 first time offenders in 2020 in Brighton & Hove, a lower rate than England (120 and 160 per 100,000 respectively). There is no prison in Brighton & Hove, but one located in nearby Lewes.

6.2.8 Community wellbeing and social capital

National evidence

The mental wellbeing of individuals is influenced by factors at a community level such as social networks, sense of local identify, levels of trust and reciprocity and civic engagement. The benefit of this "social capital" can be felt at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering).

Whilst disadvantaged communities have higher health need, they may also have assets within the community that can improve health and build resilience.

Community assets improve the health and the quality of the community. They include physical assets such as public green space, play areas and community buildings and social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strengthen resilience.

Brighton & Hove

Brighton & Hove is fortunate to have access to the sea, the South Downs National Park and have many parks and open spaces in the city. More people use outdoor spaces for exercise/health reasons in Brighton & Hove than England (18.3% compared with 17.9%) and more people are physically active. Brighton & Hove also has a strong arts and culture sector, with lots of opportunities for residents to participate in arts and culture activities.

The city has significant community assets with higher rates compared to England of:

- Belonging (76% of Brighton & Hove respondents agree compared to 62% for England)

- Pulling together (76% of Brighton & Hove respondents agree compared to 59% for England)
- Formal volunteering (44% of Brighton & Hove respondents compared to 38% for England)
- Feeling that people from different backgrounds get on (94% of Brighton & Hove respondents compared to 82% for England)
- Satisfied with their local area as a place to live (89% of Brighton & Hove respondents compared to 78% for England).

However, according to the 2012 Brighton & Hove Health Counts survey, 68% of respondents see or speak to their neighbours at least once or twice a week. This is a large decrease from 2003, when 80% of respondents said they saw or spoke to their neighbours at least once or twice a week.

Brighton & Hove has a large community and voluntary sector who support individuals, groups and communities. The voluntary, community and social enterprise (VCSE) sector is broad encompassing independent organisations working with a social purpose. They range from small community based groups or schemes through to larger charities and organisations that may operate locally, regionally or nationally. The city has a strong and vibrant VCSE sector. The VCSE sectors plays a key role in improving health, wellbeing and care outcomes and tackling health inequalities. They do this not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

In the last Taking Account report in 2019 there were 2,330 third sector organisations in the city with an estimated 4.5 million volunteer hours per year with an estimated £37million in volunteer time (based upon the minimum wage).[45] The most frequently reported activities relate to health and wellbeing (15%), environment, sustainability and conservation (10%) and community development (9%) - all crucial for improving mental wellbeing. Improving mental health and wellbeing was an additional aim for one in five organisations.

6.2.9 Healthy lifestyles

National evidence

Positive health behaviours, such as not smoking, eating healthy food, healthy sleep routines and engaging in physical activity, can encourage psychological wellbeing, improve physical health, prevent mental health problems, and support recovery among people who are unwell. In addition to supporting individuals to make healthy choices, interventions should focus on providing environments which support adopting healthy behaviours.

Brighton & Hove

Smoking rates are significantly higher amongst both children and young people and amongst adults (17.5% compared to 13.9% for England), including those with a long-term mental health condition.

Physical activity and inactivity, and obesity: 69% of adults in Brighton & Hove are physically active (England 66%), but we have seen a worsening rate which used to be significantly better than England. One in 5 (22%) are physically inactive (England 23%) – conversely, we have seen an increasing (worsening) rate which used to be significantly better than England. In 2019/20, 28% of 10-11 years were overweight or obese in the city, significantly better than England (35%). Local data suggests that this has increased during the pandemic both within the city and nationally. In 2020/21, 33% of 10-11 years were overweight or obese in the city, a 5% increase on the previous year. However, rates are still significantly better than England (41%). For adults, it is estimated that 59% are overweight or obese compared to 64% for England (2020/21).

6.3 Population risk and protective factors

See Appendix 6: Indicators of common risk and protective factors for mental wellbeing.

6.3.1 Introduction

This section describes some of the communities and subgroups who are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. It includes information on people with characteristics protected under the Equality Act 2010 where it is against the law to discriminate.

For each group, we have a short overview of national evidence and then present evidence for how Brighton & Hove compares with England.

We cover the following groups – many are identified as being of high risk of mental health problems:[46],[47]

- People with alcohol and/or drug dependence
- People experiencing homelessness
- Prison population, offenders and victims of crime (covered in environmental factors)
- People with complex needs and multiple disadvantage
- Ethnic minority groups
- Migrants, refugees, asylum seekers and stateless person
- Gypsy, Roma and Travellers
- Children in care and care leavers
- Students
- Lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+) people
- Transgender people
- Carers
- People with long-term physical health conditions

- People living with physical disabilities
- People living with learning disabilities
- Neurodiverse people
- People with sensory impairment
- Relationship status
- Armed forces personnel

Unless otherwise stated, the national evidence sections are taken from the Office for Health Improvement and Disparities Mental Health JSNA Toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)

Local evidence on the mental health needs of these groups is covered within the appropriate life stage of the report where possible.

6.3.2 People with alcohol and/or drug dependence

National evidence

Drinking more than the low-risk guidelines can harm mental and physical health. Regular consumption of alcohol has been shown to cause mental ill health including depression, anxiety, and a connection to higher levels of self-harm and suicide in people with alcohol problems. Regular heavy drinking can also lead to alcohol dependence. The relationship between mental health problems and alcohol is a vicious cycle. Mental health problems can cause people to drink more, particularly as people often drink alcohol as a form of 'self-medication'.

Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment, 41% of people entering community alcohol and drug treatment in 2017-2018 reported a co-occurring mental health treatment need. There are many factors associated with harmful alcohol and drug use. Drug misuse can cause social disadvantage, and social disadvantage may lead to drug use and dependence. Many are social factors, such as deprivation.

Brighton & Hove

Drinking and substance misuse are significantly higher amongst both children and young people and amongst adults, including those with a long-term mental health condition.

Brighton & Hove has the 9th highest rate of deaths related to drug misuse at upper tier local authority level in England (2018-2020).

6.3.3 People experiencing homelessness

National evidence

Everybody who experiences homelessness will feel stress and anxiety, and many report depression. Mental health problems among people experiencing homelessness are

more prevalent than in the general population, particularly among people caught in the 'revolving door', between hostels, prison, hospitals and the streets. Compared with the general population, homeless people are twice as likely to have a common mental health condition, and psychosis is up to 15 times more prevalent. They are also over 9 times more likely to complete suicide. People experiencing homelessness find it difficult to access health services, including mental health care.[48]

Brighton & Hove

Brighton & Hove has a higher rate of homelessness, with 37 rough sleepers in the last Street Count (autumn 2021), and the second highest rate of statutory homelessness (households in temporary accommodation) of all local authorities in England outside of London (18th highest in England including London).

According to research carried out by Shelter, 1 in every 78 people in Brighton & Hove are homeless, compared to an average of one in every 206 people across England. London is the worst hit city for homelessness, outside the capital, Luton is the area with the highest rate of homelessness, followed by Brighton & Hove.

6.3.4 People with complex needs and multiple disadvantage

National evidence

There is a huge overlap between the offender, substance misusing and homeless populations. For example, in any given year, two thirds of people using homeless services are either in the criminal justice system or in drug treatment services. It is estimated that, in England, there are 58,000 people who experience the multiple disadvantages of offending, substance misuse and homelessness; and 55% of these individuals have a diagnosed mental health problem.[49]

Brighton & Hove

In Brighton & Hove, 20 per 1,000 working age adults were estimated to receive services across homelessness, substance misuse or offending. The 2020 Brighton & Hove JSNA of Adults with Multiple Complex Needs showed that in 2010/11, there were a total figure of 1,500 adults with two or more needs (420 with all three). Brighton & Hove ranked 61st highest (worst) of 151 local authorities in England. With population growth, this gave an estimated 1,670 people in 2018 with two or more needs.

The JSNA also estimated the number of adults receiving support for at least one of these issues, who also have mental health problems, estimated at 52% of those with severe and multiple disadvantage. The authors note however, that the incidence of mental health problems may be significantly greater than is recorded in the data used. Thus, these figures may underestimate the overlap between mental health problems and severe and multiple disadvantage.

6.3.5 Ethnicity

National evidence

Racial discrimination is recognised as a determinant of racial and ethnic health inequalities and evidence shows strong associations between racial discrimination and adult health outcomes. A systematic review considered the effects of racial discrimination on child and youth health and found that experiencing racial discrimination can impact:

- Positive mental health (eg self-esteem, resilience)
- Behaviour problems
- Wellbeing
- Pregnancy/birth outcomes.[50]

People from Black and Minority Ethnic groups living in the UK are more likely to:[51]

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

People from Black African and Caribbean backgrounds are disproportionately seen in the 'hard end' of services and are more likely to receive harsher more coercive treatments. Some research has found the concept of 'eurocentricity' of service design resulting in people from some Black and Minority Ethnic group communities struggle to access services in ways meaningful to them.[52]

Following the referendum vote to leave the European Union, some experts have suggested that a culture of extremism and intolerance has become more visible in political debate. Stigma, prejudice and discrimination appear to be on the rise, with examples of racism and assault against migrants and religious and ethnic minorities.[53] A study based in south east London found that discrimination was associated with higher rates of common mental health conditions, and this effect was strongest for individuals who had recently migrated to the UK.[54]

Brighton & Hove

The 2011 census (**Table 2**) showed that one in five Brighton & Hove residents (53,351, 19.5%) is from a BME background, higher than the South East (14.8%) but similar to England (20.2%).

The largest BME community is White Other, making up one third (37%) of the BME population. It is 7.1% of the total population, very much higher than in the South East (4.4%) and England (4.6%).

Brighton & Hove has a higher proportion of people of Mixed ethnicity (3.8%) than England (2.3%), with the proportion of people of Mixed White and Asian (1.2%) and

other Mixed ethnicity (1.0%) double the value found in England. Other ethnicities that are more prevalent in Brighton & Hove than across England include White Irish (1.4%), Chinese (1.1%) and Arab (0.8%).

By contrast, the proportion of Asian people (4.1%) is below that for the South East (5.2%) and England (7.8%), with particularly low numbers of people of Pakistani ethnicity (0.2%) compared with England as a whole (2.1%). The proportion of Black people in Brighton & Hove (1.5%) is also less than half that for England (3.5%) but similar to the South East (1.6%).

Table 2: Ethnicity in Brighton & Hove, South East, England, 2011 Census

	Brighton & Hove		South East	England
	Number	%	%	%
All usual residents	**273,369**			
White	**243,512**	**89.1%**	**90.7%**	**85.4%**
English/Welsh/Scottish/Northern Irish/British	220,018	80.5%	85.2%	79.8%
Irish	3,772	1.4%	0.9%	1.0%
Gypsy or Irish Traveller	198	0.1%	0.2%	0.1%
White Other	19,524	7.1%	4.4%	4.6%
Mixed / multiple ethnic group	**10,408**	**3.8%**	**1.9%**	**2.3%**
White and Black Caribbean	2,182	0.8%	0.5%	0.8%
White and Black African	2,019	0.7%	0.3%	0.3%
White and Asian	3,351	1.2%	0.7%	0.6%
Other Mixed	2,856	1.0%	0.5%	0.5%
Asian / Asian British	**11,278**	**4.1%**	**5.2%**	**7.8%**
Indian	2,996	1.1%	1.8%	2.6%
Pakistani	649	0.2%	1.1%	2.1%
Bangladeshi	1,367	0.5%	0.3%	0.8%
Chinese	2,999	1.1%	0.6%	0.7%
Other Asian	3,267	1.2%	1.4%	1.5%
Black/African/Caribbean/Black British	**4,188**	**1.5%**	**1.6%**	**3.5%**
African	2,893	1.1%	1.0%	1.8%
Caribbean	879	0.3%	0.4%	1.1%
Other Black	416	0.2%	0.2%	0.5%
Arab	**2,184**	**0.8%**	**0.2%**	**0.4%**
Any other ethnic group	**1,799**	**0.7%**	**0.4%**	**0.6%**
Black & Minority Ethnic (BME)	**53,351**	**19.5%**	**14.8%**	**20.2%**

Note: Black & Minority Ethnic (BME) is defined as all ethnic groups other than White English / Welsh / Scottish / Northern Irish / British.

Source: ONS, 2011 Census, table KS201EW

The overall age structure of the Black and Minority Ethnic (BME) population is younger than the city's White British population (see Table 3). The 2011 Census data shows that 22% of the city's population are aged 19 or younger, but this proportion is higher for many ethnic groups: mixed ethnic background (50%), Asian (26%), Black (24%) and Arab (30%). The Census data also shows that while people aged 65 or older make up 13% of the city's population, the proportion is very much lower in all other high level ethnic groups (6% or less), aside from White UK/British and White Irish.

Table 3. Age profile by high level ethnic group, Brighton & Hove, 2011 Census

Ethnic group	Age group (%)			
	0 to 19 years	20 to 44 years	45 to 64 years	65 years and older
All persons (n=273,369)	22%	43%	22%	13%
White UK/British (n=220,018)	21%	40%	24%	15%
White Irish (n=3,772)	7%	45%	28%	21%
White Other (n=19,524)	13%	66%	15%	5%
Mixed / multiple ethnic group (n=10,408)	50%	38%	9%	2%
Asian/Asian British (n=11,278)	26%	55%	15%	5%
Black/Black British (n=4,188)	24%	57%	17%	3%
Arab (n=2,184)	30%	49%	16%	5%
Other ethnic group (n=1,799)	20%	53%	22%	6%
All BME (n=53,351)	24%	55%	15%	5%

Source: ONS 2011 census, table DC210EW

6.3.6 Migrants, refugees, and asylum seekers

National evidence

High rates of people moving home within and between areas can disrupt social ties and community networks and is related to higher levels of stress and mental health problems.[55]

People who have recently arrived from abroad to live in an area may face barriers to accessing mental health services. Refugees are more likely to have experienced trauma and have a higher prevalence of mental health conditions such as post-traumatic stress disorder (PTSD), depression and anxiety and these experiences and conditions require skilful engagement in order to minimise the risk of being re-traumatised. Additionally, people who do not speak English well might need specific help to enable them to access the mental health services. [56]

Brighton & Hove

The city is a destination for migrants (people living or intending to live in the city for 12 months or more) from outside the UK. The latest ONS figures (2020) estimates that 55,000 residents (19%) were born outside of the UK. This is similar to 2019 (53,000 people, 18%) and similar to what is seen in the South East (14%) and England (16%). ONS migration statistics at the local authority level are subject to large confidence intervals. For Brighton & Hove the figure is +/- 13,000 people, therefore the true number of migrants in the city will be between 42,000 and 68,000 people (14% - 23%).

As of December 2021, in Brighton & Hove, there were thought to be:

- 100 adult asylum seekers and a further 70 in contingency hotels
- Circa 45 unaccompanied asylum-seeking children (under 18) and 78 care leavers aged 18 to 25
- Circa 69 people on the vulnerable person's resettlement scheme
- Using national estimates at the local level would mean there were circa 300 undocumented people. These are likely to be overstayers and refused asylum seekers.

As of 13 June 2022, Brighton & Hove is expecting 570 individuals from Ukraine, with 295 already arrived, of whom 113 are children.

6.3.7 Gypsies, Roma and Travellers

National evidence

Gypsies, Roma and Travellers (GRT) are amongst the most deprived communities in England; they continue to suffer from poorer health and lower life expectancy, which is ten years lower than the general population.[57] Gypsies, Roma and Travellers are approximately three times more likely to be anxious than the general population and twice as likely to be depressed.[58]

GRT are more likely to lack access to opportunities such as income, education, employment and housing which leads to them being at higher risk of mental illness.[59]

Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child.[60]

GRT youth, due to exclusion and discrimination within the educational system, have poorer outcomes in terms of school achievement, unemployment and housing problems, which are all factors associated with psychological distress and depression.[61]

Brighton & Hove

There is no definitive data on the number of Gypsies, Roma and Travellers in Brighton & Hove. Within the city there are a range of locations where families reside. Some locations are short term (12 weeks), others permanent, some are authorised by the council, others are not. According to the 2011 Census, 198 people in the city identified themselves as Gypsies and Travellers.[62]

6.3.8 Religion or belief

More than two out of five residents (117,276 people, 42.9%) are Christian, significantly lower than can be found in England (59.4%) and the South East (59.8%). The Muslim community is the largest non-Christian faith group in the city with 6,095 people (2.2%) (Table 4).

More than two out of five city residents (115,954 people, 42.4%) stated that they had no religion, significantly higher than in the South East (27.7%) and England (24.7%). Older people are most likely to say they have a religion with only 13% not having one. Nearly a half of 0 to 15 year-olds (47%) and 16 to 64 year-olds (47%) don't have a religion.

Table 4: Religion or belief, Brighton & Hove, 2011 Census

	Brighton & Hove		South East	England
	number	%	%	%
All Persons	273,369			
Christian	117,276	42.9%	59.8%	59.4%
Muslim	6,095	2.2%	2.3%	5.0%
Buddhist	2,742	1.0%	0.5%	0.5%
Jewish	2,670	1.0%	0.2%	0.5%
Hindu	1,792	0.7%	1.1%	1.5%
Sikh	342	0.1%	0.6%	0.8%
Other religion	2,409	0.9%	0.5%	0.4%
No religion	115,954	42.4%	27.7%	24.7%
Religion not stated	24,089	8.8%	7.4%	7.2%

Source: ONS 2011 census, table KS209EW

6.3.9 Children in care and care leavers

National evidence

Care experienced children and young people have consistently been found to have much higher rates of mental health difficulties than the general population, including a significant proportion who have more than one condition.[63] They are approximately four times more likely to have a mental disorder than children living in their birth families. Almost half (rising to three quarters in residential homes) meet the criteria for a psychiatric disorder[64,65] compared to 10% of the general population.[66]

The latest measure of the emotional and behavioural health of looked after children using the Strengths and Difficulties Questionnaire (SDQ) found that 37% had scores considered a cause for concern, compared to 12% of children in the general population.[67]

Care leavers are an especially vulnerable group of young people, who have an increased risk of experiencing mental health difficulties and substance abuse issues.[68] Barnardo's surveyed care leavers and found that 46% were identified as

having mental health needs, with 65% of them not receiving any form of statutory support and are between four and five times more likely than their peers to attempt suicide https://www.nyas.net/wp-content/uploads/NYAS-looked-after-mind-report.pdf.[69]

Brighton & Hove

There were 373 Brighton & Hove children in care in 2021, a rate of 74 per 10,000 people which is higher than the rates in England (67 per 10,000) and the South East (53 per 100,000). There were 153 children leaving care in 2021 in Brighton & Hove. With a rate of 30 per 100,000 under 18-year-olds, this is significantly higher than England and the South East (23 and 22 per 100,000 respectively).

6.3.10 Students

National evidence

Research suggests that prevalence and severity of mental illness in university students is increasing and that students have poorer health than the non-student population.[70]

Students' life transitions, including moving home within and between areas can disrupt social ties and community networks and is related to higher levels of stress and mental health problems.[71]

Brighton & Hove

For the academic year 2019/20 there were 38,380 students at the University of Sussex and University of Brighton. 58% of students were female (22,315 people) compared to 42% male (16,005 people). There were also in the region of 1,700 students at other Higher Education Institutes in the city. It should be noted that not all students at universities in Brighton & Hove live in Brighton & Hove. There are also 9,100 Brighton & Hove residents who are students enrolled at a UK higher education institute.

According to the 2011 Census, there were 32,294 full time students aged 16 or over in the city, 14.1% of residents aged 16 or over. This is significantly higher than the South East (7.5%) and England (8.2%).

6.3.11 Lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+)

National evidence

Evidence suggests that people who identify as lesbian, gay, bisexual and/or trans (LGB&/T) or ace (asexual) are at a higher risk of experiencing poor mental health. This includes a higher risk of a range of mental health problems, including depression, suicidal thoughts and self-harm, and alcohol and substance misuse. This higher prevalence can be related to a wide range of factors, including discrimination, isolation and homophobia or transphobia.[72]

Where possible within the needs assessment, we look at sexual orientation and gender identity separately, as risks/assets, needs and experiences do differ, however some

literature and evidence presents LGBTQ+ populations combined and where this is the case we have referred to the groups referenced in the evidence.

Brighton & Hove

Brighton & Hove has large LGBTQ+ populations. Our best estimate from large scale surveys (including Count Me In Too) is 11% to 15% of the population aged 16 years or more are LGBQ+.

According to the 2011 UK Census, 6,425 people aged 16 and over (and living in a household) were living as part of a same sex couple (in a civil partnership or cohabiting). This represents 2.9% of all residents aged 16 and over, three times higher than the rate for both the South East (0.9%) and England (0.9%).

Trans: It is estimated that between 1,500 (0.6%) and 2,500 (1%) adults living in Brighton & Hove are trans. The true figure is probably greater than this because a significant proportion of trans people do not disclose their gender identity in surveys. In addition, as Brighton & Hove is seen as inclusive, many people who are trans and live elsewhere, visit Brighton & Hove to socialise study and/or work.[73]

Data suggest that people who are trans and live in Brighton & Hove:[74]

- have a younger population distribution than the overall population, although they are represented in all age groups
- have diverse gender identities, including non-binary identities
- are more likely to have a limiting long-term illness or disability than the overall population
- come from a diverse range of ethnic backgrounds
- have diverse sexual orientations
- live across the city, with no concentration in any geographical area
- are more likely to live in private sector rented housing than the overall population.

6.3.12 People with long-term physical conditions

National evidence

Mental and physical health are intertwined. Poor mental and physical health are both determinants and consequences of each other. Long-term physical conditions are those which cannot currently be cured but can be managed with medication or other treatments. They are also known as chronic conditions. Examples include diabetes, asthma, arthritis, epilepsy, chronic fatigue, and high blood pressure. Long-term physical conditions affect the mental health and wellbeing among all age groups, including children and young people. [75]

People with SMI (Severe Mental Illness), such as schizophrenia or bi-polar disorder, on average, have 15 to 20 years shorter life expectancy than the general population. Most of this reduced life expectancy is due to a higher rate of physical conditions such as

cardiovascular disease. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk.

Some of the burden of poor physical health among those with mental health problems can be explained by health behaviours such as smoking and alcohol.[76] Other factors also play a part such as barriers to receiving adequate physical healthcare; less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.[77]

It is important to also consider the mental health needs of people with long-term physical health problems. Integrated care for physical health should include provision of psychological support, as failure to do so is associated with poorer outcomes and faster disease progression.[78] People with long term chronic conditions should receive psychological therapy support to improve their recovery.[79]

Brighton & Hove

According to the 2011 Census the day-to-day activity of more than one in twenty Brighton & Hove residents (20,445 people, 7.5%) is 'limited a lot' due to a long-term health problem or disability. For a further 24,124 residents (8.8%) their day-to-day activity is 'limited a little'. This is similar to the proportions found in the South East and England.

In Brighton & Hove and seen in the South East and England, limiting illness increases with age. 4% in those under 20, 13% among 20- to 64-year-olds, rising to nearly a half (47%) of 65- to 84-year-olds and four out of five (81%) of those aged 85 or older.

6.3.13 People with physical disabilities or impairments

National evidence

People living with physical disabilities are at least three times more likely to experience depression compared to the general population. The reasons for this are complex and often related to societal constraints rather than the physical disability itself. People with physical disability experience multiple risk factors for depressive symptoms, including facing negative stereotypic social and personal attitudes; abuse; loss of roles; and stressors related to poverty, environmental barriers, and/ or lack of access to appropriate health care.[80]

Brighton & Hove

See section on physical health problems above as population estimates include both long-term health problems and disability.

6.3.14 People with a learning disability

National evidence

There is strong evidence that individuals with a learning disability are more likely to experience mental ill-health and poor emotional wellbeing. Adults[81] and children and

adolescents with a learning disability have higher prevalence of psychiatric disorder symptoms[82] and mental health problems.[83]

Risk factors are physical ill health, psychological stress, poor social relationships, lack of employment and poverty. Although children with a learning disability had a 6.5 fold increased risk of mental health conditions, 20-50% of this increased risk was accounted for by low socio-economic status.[84]

Mental health problems among people with a learning disability are often overlooked, underdiagnosed, and left untreated as a result of poor understanding, awareness, evidence in this area and symptoms mistakenly being attributed as the person's learning disability.

According to the Adult Psychiatric Morbidity Survey (APMS, 2014), people with lower intellectual ability had higher rates of symptoms of common mental health problems (25%) compared to those with average (17.2%) or above average (13.4%) intellectual functioning.[85]

Brighton & Hove

Using national prevalence rates of learning disability and the ONS 2020 Population Estimates, it is estimated that there are 5,861 adults (2.4%) aged 18 or older in the city who have a learning disability. This includes 5,052 adults aged 18 to 64 (2.4%) and 819 adults (2.1%) aged 65 or older. This includes 1,260 adults (0.5%) aged 18 or over with a moderate or severe learning disability (1,150 adults aged 18 to 64 (0.6%) and 110 adults (0.3%) aged 65 or older).

6.3.15 Neurodiverse people (including those with Autistic Spectrum Conditions (ASC) and attention deficit hyperactivity disorder (ADHD))

National evidence

There is strong evidence that individuals with a neurodevelopmental condition are more likely to experience mental ill-health and poor emotional wellbeing.

Just like everyone, neurodiverse people (including those with ASC and ADHD) can have good mental health.

However, according to the autism research charity Autistica, eight out of ten autistic people have mental health issues during their lives.[86] There is little research into why this is, but the Mental Health Foundation suggests it may be because autistic people:

- can struggle to try to fit into or make sense of the world, which can lead to feelings of depression and anxiety
- may face delays in getting their mental health problems diagnosed
- are more likely to face stigma and discrimination

- are less likely to have appropriate support available. For example, group therapy might not be suitable for some autistic people, or therapists might not know how to adapt their approach to helping an autistic person.[87]

People with attention deficit hyperactivity disorder (ADHD) are more likely to experience a mental health problem. These include anxiety, depression, sleep problems, conduct disorder (showing aggressive or antisocial behaviour) and substance abuse.[88] Half of adults aged 20-39 years with ADHD have had a substance use disorder (SUD) in their lifetime according to new research. young adults with ADHD were still 69% more likely to have had a substance use disorder when compared to their peers without ADHD.[89]

Brighton & Hove

It is estimated that there are just over 1,700 adults aged 16 or over in the city with Autistic Spectrum Conditions (ASC) and 23,958 with attention deficit hyperactivity disorder (ADHD) (Table 5).

Estimates for children and young people are given in that section.

Table 5: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

	Sub-conditions	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Neurodevelopmental conditions	ASC	0.7%	1,729	1,815
	ADHD	9.7%	23,958	25,155

Source: Adult Psychiatric Morbidity Survey 2014 South East regional estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

6.3.16 Sensory impairment

National evidence

Individuals experiencing sensory impairments have been found to be at a higher risk of having mental health problems across the life course; however, this can be overlooked when considering the needs of this group.[90]

A 2011 survey, carried out by the University of Cambridge and Deafblind UK, found that, among 439 deaf and blind people in the UK, 61% reported psychological distress. A 2015 study including 298 people from England, Scotland and Wales found that individuals who are deaf have high levels of depression, with 31% of women and 14% of men self-reporting levels of depression.[91] It should also be recognised that deaf and blind children and young people are also at a higher risk of having mental health problems.

Brighton & Hove

There are an estimated 1,200 adults aged 18 years or over with visual impairments and 7,500 with some hearing loss (1,000 with severe hearing loss).

6.3.17Carers

National evidence

The mental health of carers is often neglected despite many carers having poor mental health. This is also true for young carers, whose long-term outcomes in education, employment and training can be significantly impacted by the caring role that they take on. Looking after a family member with a mental health problem can have a significant impact on carers' own mental health. The review found that the mental health problems of carers included emotional stress, depressive symptoms and, in some cases, clinical depression.[92]

Brighton & Hove

Nearly one in ten of the city's residents (23,967 people, 8.8%) provide unpaid care to a family member, friend or neighbour who has either a long-term illness or disability or problems related to old age. Two thirds of those providing unpaid care (16,401 people, 68%) do so for 1 to 19 hours a week. However, 4,716 people, nearly 20%, provide more than 50 hours a week of unpaid care. The proportion of residents providing unpaid care (8.8%) is slightly lower than the South East (9.8%) and England (10.2%).

As seen in the South East and England, people in Brighton & Hove aged 50 to 64 provide the most unpaid care with one in five (20%) providing at least one hour a week of unpaid care. More than one in ten of those aged 65 or older (13%) and 35 to 49 year-olds (11%) also provide at least 1 hour a week of unpaid care a week. Among younger people 1% of 0 to 15 year-olds provide unpaid care and nearly one in 20 (4.5%) of 16 to 34 year-olds also providing at least one hour of unpaid care.

Parent carers of children and young people with special educational needs and disabilities are not always recognised as carers; it is important to remember parent carers are also similarly at a higher risk of mental health problems.

6.3.18 Relationship status

National evidence

Being happily married or in a stable relationship is linked to both physical and mental health benefits, including lower morbidity and mortality. People in a stable relationship have greater life satisfaction, lower stress levels, lower blood pressure and better heart health than individuals who are single.[93]

Brighton & Hove

According to the 2011 Census, less than a half of Brighton & Hove's 16+ population (48%) live in a couple. Significantly lower than seen in the South East (61%) and

England (58%). In Brighton & Hove, two thirds of residents (67%) living in a couple are married or in a registered civil partnership with a third (33%) cohabiting.

6.3.19 Armed forces personnel

National evidence[94]:

Most British military personnel do not experience mental health problems while they are in service, or afterwards in civilian life. However, they face unique risks in service and, if they do experience mental health problems, they may require particular treatments and particular mental health services.

Experiences during service and the transition to civilian life mean that their mental ill health may be triggered by different factors. Post Traumatic Stress Disorder (PTSD), depression, anxiety, homelessness and substance abuse affect a significant minority of service personnel and veterans.

A study of 10,000 serving personnel (83% regulars; 27% reservists) found lower than expected levels of PTSD. Common mental disorders and alcohol misuse were the most frequently reported mental health problems among UK armed forces personnel. In particular, levels of alcohol misuse overall were substantially higher than in the general population.[95]

Brighton & Hove

Brighton & Hove is not home to any military installations and therefore does not house a substantial community of armed forces personnel. At the time of the 2011 Census there were 147 residents employed by the armed forces in the city, less than 0.1% of the total population. As of March 2020, 532 veterans in Brighton & Hove were in receipt of a pension or compensation under the Armed Forces Pension Scheme. This is a rate of 2.2 per 1,000 people aged 18+, much lower than the South East (8.7 per 1,000) or England (6.9 per 1,000).

7 Prevalence of mental health conditions

This section describes the scale and pattern of mental health need in children and young people and in adults based on national surveys. It describes the prevalence of conditions, how they vary by age, sex, ethnicity and other factors. It also provides estimates of population need in Brighton & Hove based on these national surveys. It is important to note, however, that these estimates will underestimate need in Brighton & Hove because the city has higher overall need than England.

The "need" in a population is defined as the capacity to benefit from health care. Need is often different to the number of people known to services and depends on many factors including the type of condition. For example, for a severe and life-long mental illness such as schizophrenia, the "need" in the population is likely to be similar to the number of people known by their GP to have a diagnosis.

However, for a condition such as depression, a person with symptoms may not seek help, and even if they do, they may not be diagnosed. For depression, therefore the "need" in the population is likely to be very much higher than the number of people known to services.

Two national surveys: Adult psychiatric morbidity survey (2014) and the Mental Health of Children and Young People survey (2017) are seen as the gold standard in terms of estimation of population need. Using these surveys, this section estimates population need in the city and how it varies by age, sex, ethnicity and other characteristics.

- Mental Health of Children and Young People in England 2017 – a large survey of 9,117 children and young people aged 2 to 19
- Mental Health of Children and Young People in England (Wave 2) - a smaller follow up survey of 3,667 children and young people who took part in the 2017 survey aged 6 to 23. It explored the mental health of children and young people in February/March 2021, during the Coronavirus (COVID-19) pandemic and changes since 2017
- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 of 7,546 adults aged 16 or over.

7.1 Children and young people

7.1.1 Children and young people 2017 survey[96]

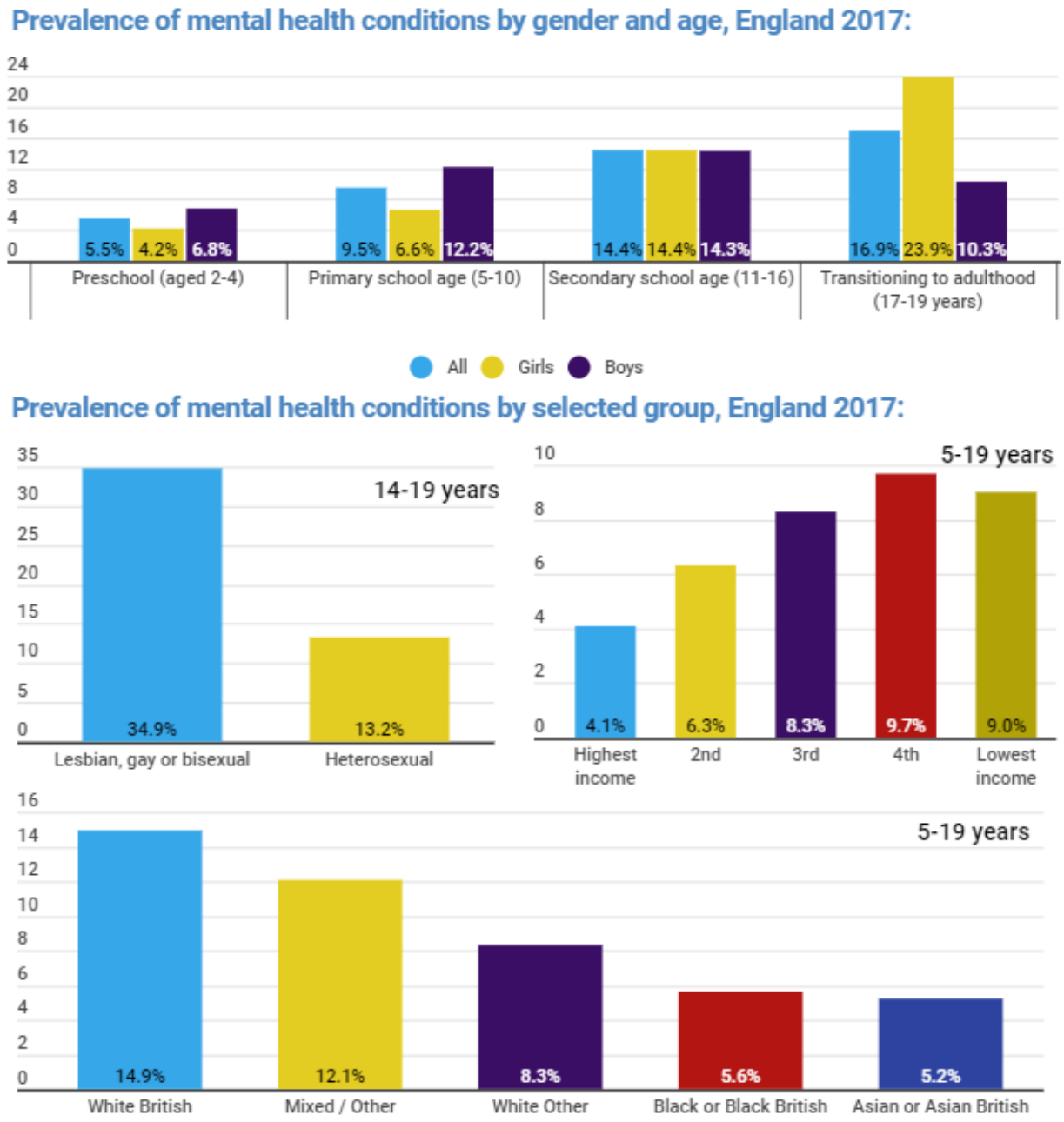
Major surveys of the mental health of children and young people in England were carried out in 1999, 2004, and 2017. Trend data is available for those aged 5 to 15 year-olds – because this age group was covered in all three surveys. The 2017 survey for the first time provides findings on the prevalence of mental disorder in 2- to 4-year-olds and in 17- to 19-year-olds.

The 2017 survey found (Figure 7):

- One in eight (12.8%) 5 to 19 year-olds had at least one mental disorder

- Specific mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders
- Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year-olds in 2017 (8.1%)
- Rates of mental disorders increased with age: 5.5% of 2 to 4 year-old children experienced a mental disorder, compared to 16.9% of 17 to 19 year-olds
- Data from this survey series reveal a slight increase over time in the prevalence of mental disorder in 5 to 15 year-olds. Rising from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017
- Young women aged 17 to 19 have the highest prevalence, with 23.9% having a mental health condition
- Emotional disorders have become more common in 5 to 15 year-olds – going from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017. All other types of disorder, such as behavioural, hyperactivity and other less common disorders, have remained similar in prevalence for this age group since 1999
- The pattern of association between age and disorder was different for boys and girls. In girls the association was pronounced. Among 5 to 10 year-olds, boys were almost twice as likely as girls to have a disorder (boys 12.2%, girls 6.6%). While in 17 to 19 year-olds, girls were more than twice as likely as boys to have a disorder (boys, 10.3%, girls 23.9%)
- The differences in likelihood of having a disorder by gender and age is due in part to differences in the types of disorder boys and girls had (eg more behavioural disorders in young children which are more prevalent in boys and more emotional and anxiety disorders in 17 to19 year-olds which are more prevalent in girls)
- Those who identified as LGBTQ individuals were more than 2.5 times more likely to have a mental health disorder
- Mental disorders tended to be more common in children living in lower income households.

Figure 7: Prevalence of mental health conditions by various demographic factors, England, 2017



Source: Mental Health of Children and Young People in England 2017

Table 6 gives a breakdown of the estimates of the numbers of people with mental disorders in children and young people in Brighton & Hove based on the percentages reported in the national 2017 survey.

There are an estimated 6,650 children and young people aged 2 to 19 years with a mental health condition. With population projections, this would increase to around 6,900 by 2030.

These are likely to be underestimates given the overall estimate of common mental health disorders for Brighton & Hove, adjusted for population factors, is significantly higher than that for England.

Table 6: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 2-19 years, 2020 and 2030 (based on England prevalence rates from the 2017 Mental Health of Children and Young People in England Survey)

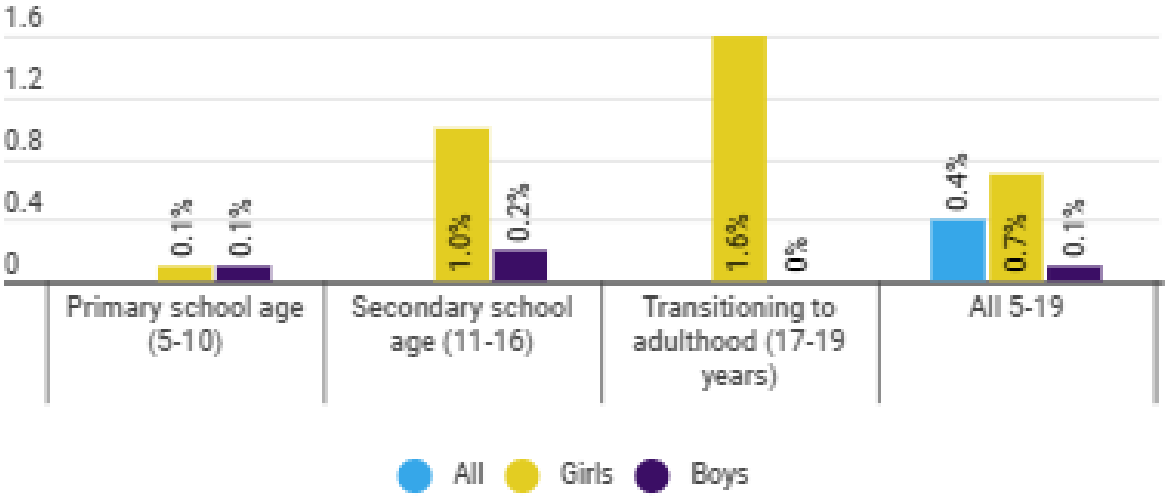
Age and gender		England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Any disorder (boys and girls)	2–4 yrs	5.5%	457	436
	5–10 yrs	9.5%	1,645	1,451
	11–16 yrs	14.4%	2,463	2,370
	17–19 yrs	16.9%	2,081	2,619
Any disorder (girls)	2–4 yrs	4.2%	169	163
	5–10 yrs	6.6%	562	495
	11–16 yrs	14.4%	1,200	1,159
	17–19 yrs	23.9%	1,484	1,906
Any disorder (boys)	2–4 yrs	6.8%	288	273
	5–10 yrs	12.2%	1,083	956
	11–16 yrs	14.3%	1,263	1,211
	17–19 yrs	10.3%	597	713

Source: NHS Digital Mental Health of Children and Young People in England 2017 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020.

Body dysmorphia and eating disorders

- 1 in 18 (5.6%) young women were identified with body dysmorphic disorder (an anxiety disorder characterised by the obsessive idea that some aspect of one's body part or appearance is severely flawed and warrants exceptional measures to fix it)
- Eating disorders were identified in 0.4% of all 5- to 19-year-olds (Figure 8)
- They were more common in girls (0.7%) than boys (0.1%); and in older age groups than younger ones (0.1% of 5 to 10 year-olds; 0.6% of 11 to 16 year-olds; 0.8% of 17 to 19 year-olds). Rates of eating disorder were higher in girls aged 17 to 19 (1.6%) than in other demographic groups
- Numbers were too small for a breakdown by ethnic group.

Figure 8: Prevalence of eating disorders by gender and age, England, 2017



Source: NHS Digital Mental Health of Children and Young People in England 2017 [Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital]

Self-harm or suicide attempt

Self-harm or suicide attempt in one in four 11 to 16 year olds with a disorder

Ever self-harmed or attempted suicide
11 to 16 year olds with a mental disorder were more likely to have self-harmed or attempted suicide at some point (25.5%) than those without a disorder (3.0%). The association with mental disorder was clear in both boys and girls. In 17 to 19 year olds with a disorder, nearly half (46.8%) had self-harmed or made a suicide attempt.

Recent self-harm or suicide attempt
11 to 16 year olds with a disorder were more likely to have self-harmed or attempted suicide in the past four weeks (13.0%) than those without a disorder (0.3%). They were also more likely to have spoken about self-harm or suicide (16.5% compared with 1.4%).

Variation by type of disorder
Rates of having ever self-harmed or attempted suicide varied by the type of disorder present, and at one in three (34.0%) this was highest in children with an emotional disorder.

25.5%
of 11 to 16 year olds with a disorder reported self-harm or suicide attempt

3.0%
of 11 to 16 year olds without a disorder reported self-harm or suicide attempt

7.1.2 Children and young people 2021 survey[97]

A follow up survey of over 3,500 children and young people who took part in the 2017 survey was undertaken in Feb/March 2021. It looked at several areas including:

- How mental health had changed between 2017 (before the pandemic) and 2021
- Covid19 related experiences in Feb/March21 and the preceding months

It found:

- Rates of probable mental disorders increased from the 2017 to 2021 survey: in 6 to 16 year-olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year-olds from one in ten (10.1%) to one in six (17.4%).

- Many more people experienced a deterioration than an improvement in mental health. Four in ten (39.2%) 6 to 16 year-olds had experienced deterioration in mental health since 2017, and two in ten (21.8%) experienced improvement. Among 17 to 23 year-olds, 52.5% experienced deterioration, and 15.2% experienced improvement
- The proportion of children and young people with possible eating problems increased since 2017; almost doubling from 6.7% to 13.0% in 11 to 16 year-olds and increasing from 44.6% to 58.2% in 17 to 19 year-olds
- Sleep problems were common and were more common in older age groups: In 2021, problems with sleep on three or more nights of the previous seven affected over a quarter (28.7%) of 6 to 10 year-olds, over a third (38.4%) of 11 to 16 year-olds, and over half (57.1%) of 17 to 23 year-olds. Across all age groups figures were much higher in those with a probable mental disorder (59.5%, 74.2%, 86.7% respectively)
- Children with a probable mental disorder were twice as likely to have missed 15 or more days at school in the 2020 autumn term (18.2%) than those unlikely to have a mental disorder (8.8%).

Estimates for Brighton & Hove for children and young people with a mental disorder with Figures based on the 2021 update to the survey are given in Table 7.

This estimates that there would be around 5,550 children and young people aged 6 to 16 years in the city with mental disorders, if we experienced the same prevalence as England. Applying the prevalence to population projections, which for this age group show a reduction in the number of children, suggests that there could be 5,100 children

and young people aged 6 to 16 years with mental disorders in 2030. For 17 to 23 year-olds, the estimates for 2021 suggest there are around 7,050 young people with mental health disorders, rising to 8,300 by 2030 based on population projections.

Table 7: Estimated number of children and young people with a mental disorder, Brighton & Hove, 2021

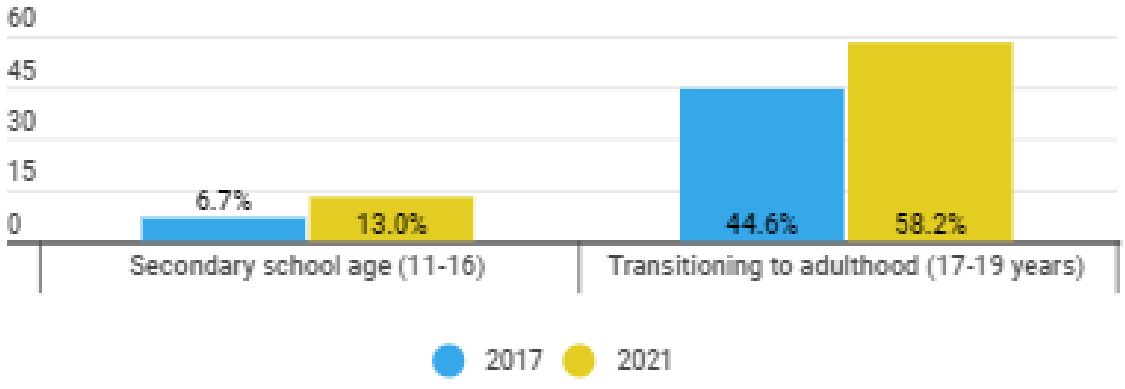
Age and gender		England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Any disorder (boys and girls)	6–10 yrs	17.1	2,500	2,200
	11–16 yrs	17.7	3,050	2,900
	17–23 yrs	16.9	7,050	8,300
Any disorder (girls)	6–10 yrs	12.0	850	750
	11–16 yrs	19.8	1,650	1,600
	17–23 yrs	23.5	4,950	5,850
Any disorder (boys)	6–10 yrs	21.9	1,650	1,450
	11–16 yrs	15.6	1,400	1,300
	17–23 yrs	10.7	2,100	2,450

Source: Based on Mental Health of Children and Young People in England, 2021 Wave 2 follow up to the 2017 survey Published 30 September 2021, and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020 and population projections 2030.[98]

Possible eating problems

The proportion of children and young people with possible eating problems almost doubled between 2017 and 2021 from 6.7% to 13.0% in 11 to 16 year-olds and increased from 44.6% to 58.2% in 17 to 19 year-olds (Figure 9). Applying these to Brighton & Hove, we would expect almost a further 1,600 people with a potential eating problem (from around 9,200 to 10,800 young people) (Table 8).

Figure 9: Percentage of children and young people with a possible eating problem, England 2017 and 2021



Source: Mental Health of Children and Young People in England, 2017 and 2021 Wave 2

Table 8: Estimated number of children and young people with a possible eating problem in Brighton & Hove, 2020 and 2030

Disorder	Age	England % (2021)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Possible eating problems	11-16	13.0%	2,232	2,147
Possible eating problems	17-19	58.2%	6,986	8,667

Source: Based on Mental Health of Children and Young People in England, 2021 Wave 2 follow up to the 2017 survey Published 30 September 2021, and ONS Population Estimates MYE2: Persons by single year of age and sex for local authorities in the UK, mid-2020 and population projections 2030.[99]

7.2 Adults

Major surveys of the mental health of adults in England were carried out in 1993, 2000, 2007 and 2014 (Adult Psychiatric Morbidity Survey). The 2014 survey looked at adults aged 16 years or over. It had no upper age limit for participation. The report has chapters on:

1. common mental disorders (CMD)
2. post-traumatic stress disorder
3. psychotic disorder
4. autism
5. personality disorder
6. attention-deficit/hyperactivity disorder
7. bipolar disorder
8. alcohol
9. drugs
10. suicidal thoughts, suicide attempts and self-harm
11. comorbidity

The full report and executive summary of the Adult Psychiatric Morbidity Survey 2014 are available on-line.

It found that:

- One adult in six (17%) had a common mental disorder (CMD): one in five women and one in eight men
- Young women have become a key high-risk group. The gender gap in mental illness had become most pronounced in young people, and there is evidence that this gap has widened in recent years. Young women have high rates of CMD, self-harm, and positive screens for post-traumatic stress disorder (PTSD) and bipolar disorder
- Reported rates of self-harming increased in men and women and across age groups since 2007

- Rates of mental illness increased in men and women aged 55 to 64. Men in this age-group have some of the highest rates of registered suicide, and have been identified as a priority group in England's National Suicide Prevention Strategy
- Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed
- There was comorbidity with chronic physical conditions, low mental wellbeing and intellectual impairment. For five chronic physical conditions: asthma, cancer, diabetes, epilepsy, and high blood pressure, all had some association with at least one mental disorder.

Figure 10 and Table 9 give estimates for Brighton & Hove for common conditions and presenting needs based upon prevalence estimates for England from the 2014 Adult Psychiatric Morbidity Survey for adults aged 16 years or over, applied to Brighton & Hove population estimates and projections for 2020 and 2030. In 2020 there are an estimated 42,000 adults with a common mental health disorder and by 2030 just over 44,000 adults. The classifications in this section reflect the wording used in the 2014 survey and may not reflect currently used terms. The 2014 survey included ASC, ADHD and comorbidities, these are included within the life course sections.

These are likely to be underestimates given the overall estimate of common mental health disorders for Brighton & Hove, adjusted for population factors, is significantly higher than that for England – at 1 in 5 adults rather than 1 in 6. This would equate to approximately over 46,000 adults in Brighton & Hove and could increase to over 48,400 by 2030.[100]

Figure 10: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

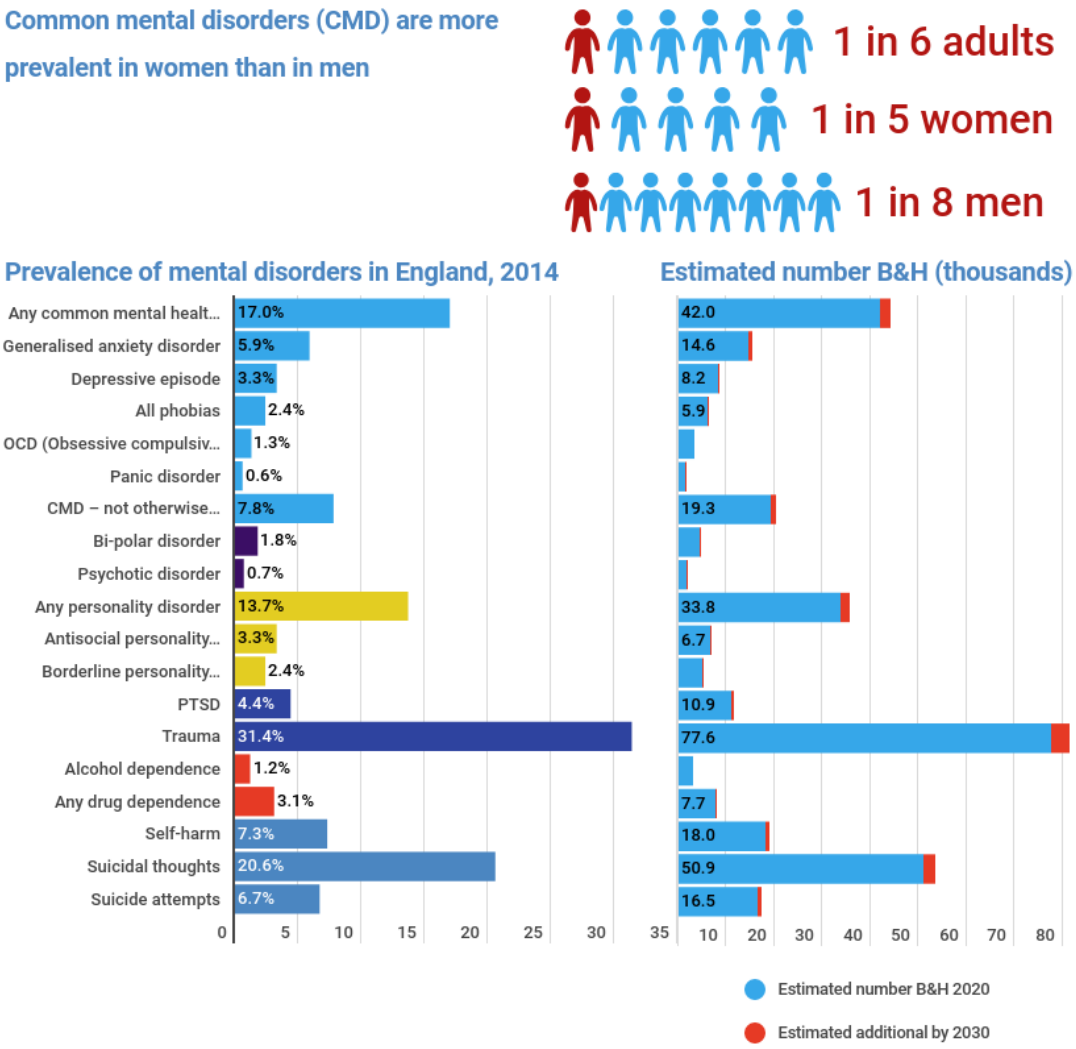


Table 9: Summary of common conditions, prevalence and estimated number of people in Brighton & Hove aged 16+, 2020 and 2030 (based on England prevalence rates from the 2014 Adult Psychiatric Morbidity Survey)

	Sub-conditions	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Common MH disorders (CMD)	Any CMD	17.0%	41,988	44,085
	Generalised anxiety disorder	5.9%	14,572	15,300
	Depressive episode	3.3%	8,151	8,558
	All phobias	2.4%	5,928	6,224
	Obsessive compulsive disorder	1.3%	3,211	3,371
	Panic disorder	0.6%	1,482	1,556
	CMD – not otherwise specified	7.8%	19,265	20,227
Severe Mental Illness	Bi-polar disorder	1.8%	4,446	4,668
	Psychotic disorder	0.7%	1,729	1,815
Personality disorders	Any personality disorder	13.7%	33,837	35,695
	Antisocial personality disorder*	3.3%	6,679	6,752
	Borderline personality disorder**	2.4%	4,991	5,109
Trauma	Post traumatic stress disorder (PTSD)	4.4%	10,867	11,410
	Trauma	31.4%	77,554	81,428
Dependence	Alcohol dependence	1.2%	2,964	3,112
	Any drug dependence	3.1%	7,657	8,039
Self-harm and suicide	Self-harm	7.3%	18,030	18,931
	Suicidal thoughts	20.6%	50,880	53,421
	Suicide attempts	6.7%	16,548	17,375

Source: Adult Psychiatric Morbidity Survey 2014 South East regional estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

Note: many people may have more than one condition

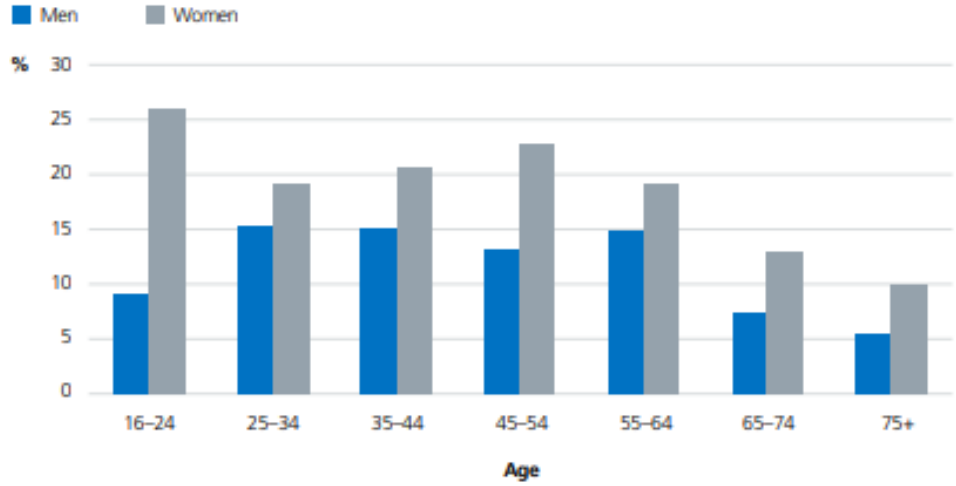
* 18-64 years, ** 16-64 years

7.2.1 Common mental health disorders (CMD)

One in six adults (17%) had a CMD: one in five women and one in eight men. CMDs were about three times more common in women of aged 16 to 24 (26%) than men the same age (9%).

CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked cigarettes (Figure 11).

Figure 11: Common mental disorders (CIS-R score of 12 or more), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

7.2.2 Trauma

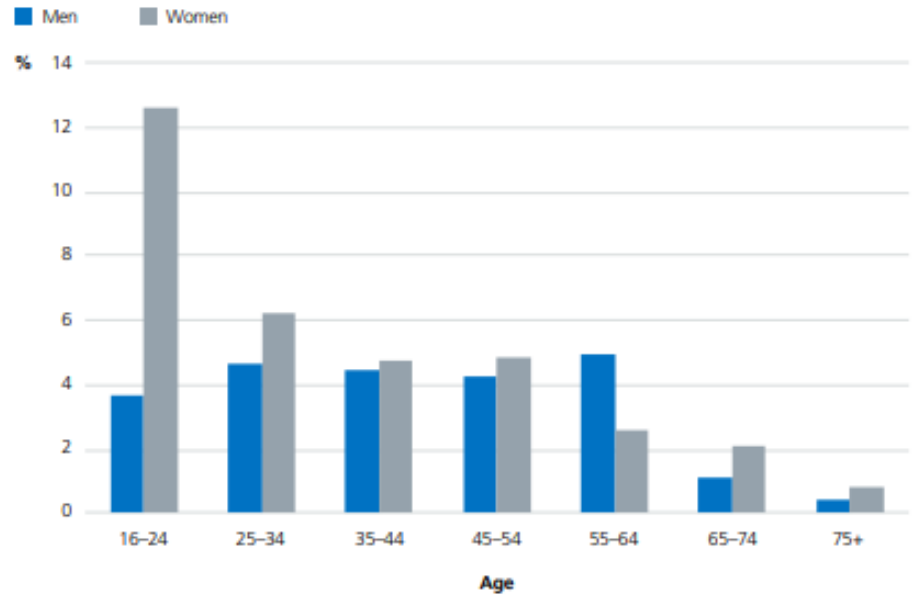
Overall, about one participant in twenty (4.4%) screened positive for Post Traumatic Stress Disorder (PTSD) in the past month, with similar rates for men and women.

Among women, the likelihood of screening positive for PTSD was particularly high among 16–24-year-olds (12.6%) and then declined sharply with age. In men, the rate remained quite stable between the ages of 16 and 64, only declining in much later life (Figure 12).

About a third of all adults (31.4%) reported having experienced at least one major trauma in their lifetime. Trauma in the study was defined as “a major natural disaster, a serious automobile accident, being raped, seeing someone killed or seriously injured, having a loved one die by murder or suicide, or any other experience that either put you or someone close to you at risk of serious harm or death.”

The national 2014 survey did not ask about complex trauma. Complex trauma is defined as traumatic experiences involving multiple events with interpersonal threats during childhood or adolescence. These events may include, for example, abuse, neglect, interpersonal violence, community violence, racism, discrimination, and war.[101]

Figure 12: Screen positive for Post Traumatic Stress Disorder (PTSD), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

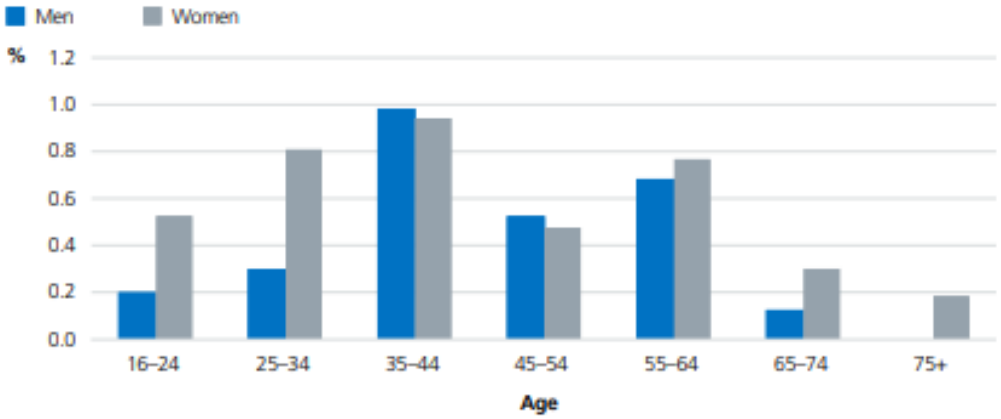
7.2.3 Psychotic disorder

Less than one adult in a hundred was identified with a psychotic disorder in the past year. The estimate for 2007 was 0.4% and for 2014 it was 0.7%. Prevalence is highest in those aged 35-44 years (Figure 13). It is higher for women than men in all age groups except those aged 35-54 years).

The prevalence of psychotic disorder in the past year (using combined 2007 and 2014 data) was 10 times higher among black men (3.2%) than white men (0.3%).

Psychotic disorder was more common in people who live alone, a finding consistent with wider evidence on links between mental illness, social isolation, and the challenges that people with psychotic disorder may face with maintenance of relationships.

Figure 13: Psychotic disorder in the past year (2007 and 2014 combined), by age and sex, England, 2014



Source: Adult Psychiatric Morbidity Survey 2014

7.2.4 Bi-polar disorder

Table 10: Screen positive for bipolar disorder (lifetime), by age and sex, England, 2014

	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men (%)	3.1	3.1	2.9	2.1	1.6	0.4	-	2.1
Women (%)	3.7	3.1	1.9	1.2	1.3	0.4	-	1.8
All adults (%)	3.4	3.1	2.4	1.6	1.5	0.4	-	2.0

Source: Adult Psychiatric Morbidity Survey 2014

There was no significant difference in the rates for men and women (2.1% for men and 1.8% for women) (Table 10). However, the proportion screening positive for bipolar disorder did vary by age, being more common in younger age-groups: 3.4% of 16- to 24-year-olds screened positive compared with 0.4% of those aged 65-74 years. None of the participants aged 75 years or over screened positive for bipolar disorder.

Table 11: Screen positive for bipolar disorder (age-standardised), by ethnic group and sex, England, 2014

	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men (%)	2.3	3.1	2.9	2.0	1.6
Women (%)	1.8	1.1	4.0	0.7	2.0
All adults (%)	2.0	2.0	3.5	1.4	1.8

Source: Adult Psychiatric Morbidity Survey 2014

Positive screening for bipolar disorder did not vary significantly by ethnic group, but was highest among Black/Black British women (Table 11). Rates of positive screening for bipolar disorder were higher in non-employed people, in those receiving particular benefits, and in people living alone.

7.2.5 Personality disorder

3.3% of people aged 18–64 screened positive for antisocial personality disorder (ASPD). It was more common in men (4.9%) than women (1.8%). Screening positive for ASPD decreased with age. Positive screens for ASPD were more common in men aged 18 to 24 (6.4%) and 25 to 34 (6.6%) than in men in older age groups (4.1% of men aged 55 to 64). A similar pattern was observed among women: 3.3% of women aged 18 to 24 screened positive for ASPD, compared with 0.4% of women aged 55 to 64 (Table 12).

2.4% of people aged 16 to 64 screened positive for borderline personality disorder (BPD), differences between men and women did not reach statistical significance. Younger people were more likely to screen positive for BPD than older people, this pattern was more evident in women than men (Table 12). There was no significant association between any measure of BPD and ethnicity (Table 13).

Table 12: Screen positive for antisocial and borderline personality disorder (SCID-II), percentage by age and sex, England, 2014

	16/18-24	25-34	35-54	55-64	All
Men					
Antisocial (%)	6.4	6.6	3.6	4.1	4.9
Borderline (%)	4.2	0.9	1.7	1.1	1.9
Women					
Antisocial (%)	3.3	2.7	1.3	0.4	1.8
Borderline (%)	7.3	3.7	1.4	0.8	2.9
All adults					
Antisocial (%)	4.9	4.6	2.4	2.2	3.3
Borderline (%)	5.7	2.3	1.5	1.0	2.4

Source: Adult Psychiatric Morbidity Survey 2014

Table 13: Screen positive for any personality disorder (age-standardised), percentage by ethnic group and sex, England, 2014

	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men (%)	13.0	16.8	16.1	22.7	10.2
Women (%)	14.9	11.7	17.7	10.8	21.9
All adults (%)	13.9	14.2	17.0	17.3	16.7

Source: Adult Psychiatric Morbidity Survey 2014

7.2.6 Self-harm and suicidal thoughts

Table 14 shows that a fifth of adults (20.6%) reported that they had thought of taking their own life at some point. This was more common in women (22.4%) than men (18.7%), and in people of working-age than those aged 65 or more. As for suicidal thoughts, lifetime suicide attempts were more likely in working-age adults than in those who were older. While the overall pattern by age was not significantly different in men and women, the rate of suicide attempts reported by young women (aged 16 to 24) was notably high.

The age gradient for self-harm was more pronounced, particularly in women. One in four women aged 16-24 report having self-harmed, compared with one in a hundred women aged 75 or over. Young women were much more likely than young men to self-harm: 26% of women aged 16-24, 10% of men.

Lifetime suicidal thoughts, attempts and self-harm were evident across all ethnic groups, but rates did not differ significantly after age-standardising (Table 15). People under 60 who lived on their own were more likely to have suicidal thoughts than those living with others, also the case for having made a suicide attempt and having self-harmed.

Table 14: Prevalence (%) of lifetime suicidal thoughts, suicide attempts and self-harm, by age and sex, England, 2014

%	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men								
Suicidal thoughts	19.3	21.1	21.1	20.7	22.5	11.9	7.1	18.7
Suicidal attempts	5.4	8.0	6.5	5.4	5.4	3.5	1.0	5.4
Self-harm	9.7	10.9	6.6	3.3	3.3	2.0	-	5.7
Women								
Suicidal thoughts	34.6	24.1	22.8	26.6	22.9	11.7	8.8	22.4
Suicidal attempts	12.7	9.1	9.5	8.2	8.6	3.7	2.1	8.0
Self-harm	25.7	13.2	9.2	5.0	5.0	1.8	0.6	8.9
All adults								
Suicidal thoughts	26.8	22.6	21.9	23.7	22.7	11.8	8.1	20.6
Suicidal attempts	9.0	8.5	8.0	6.8	7.0	3.6	1.7	6.7
Self-harm	17.5	12.1	7.9	4.1	4.1	1.9	0.3	7.3

Source: Adult Psychiatric Morbidity Survey 2014

Table 15: Lifetime suicidal thoughts, suicide attempts and self-harm (age-standardised), by ethnic group and sex, England, 2014

%	White British	White other	Black/ Black British	Asian/ Asian British	Mixed/ multiple/ other
Men					
Suicidal thoughts	19.6	23.3	21.4	12.0	9.5
Suicidal attempts	5.3	6.0	8.9	5.1	1.5
Self-harm	5.8	8.3	5.5	6.1	1.9
Women					
Suicidal thoughts	23.5	18.6	20.3	14.3	26.6
Suicidal attempts	8.5	6.2	3.9	5.6	10.0
Self-harm	10.3	4.3	4.2	4.7	6.6
All adults					
Suicidal thoughts	21.6	20.8	20.7	13.1	17.9
Suicidal attempts	6.9	6.1	6.1	5.3	5.7
Self-harm	8.1	6.1	4.8	5.5	4.2

Source: Adult Psychiatric Morbidity Survey 2014

8 Perinatal mental health

8.1 Introduction

Perinatal mental health is the term for mental health during pregnancy and the first year after birth. It includes both existing mental health issues and conditions that arise during pregnancy or related to pregnancy.

The perinatal period is a time of enormous change and transition. Having existing or past mental health problems can increase the risk of becoming unwell, particularly after birth. New problems may develop for the first time. Good support can prevent many problems from arising or from becoming worse.

The physical and mental health of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to the lifelong mental health of the baby and child. While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict a number of physical, social, emotional and cognitive outcomes for their child from babyhood through to adulthood.[102]

The impact of poor mental health during the perinatal period, particularly if left untreated, can lead to long lasting effects on women and their families.[103] Paternal and maternal depression is shown to have a negative impact on how parents interact with children[104] and can have long-term consequences if left untreated.[105]

Evidence suggests perinatal mental health issues are associated with an increased risk of pre-term birth, low birth weight[106] and a negative impact on breastfeeding duration.[107]

In addition to the direct impact on families, it is estimated that perinatal mental health problems cost the NHS and social services around £1.2 billion annually.[108] A significant proportion of this cost relates to impact on the child.

Mental health problems occurring during the perinatal period can range from symptoms that do not meet the threshold for clinical diagnosis to severe mental illness and include depression, anxiety, post-traumatic stress disorder, postpartum psychosis, adjustment disorders and distress, eating disorders and drug and alcohol-use disorders.[109]

The confidential Enquiry into Maternal Deaths shows that suicide remains one of the leading causes of maternal mortality in the UK.[110]

8.2 Risk and protective factors

Many of the risk and protective factors associated with mental health problems during pregnancy and after childbirth reflect those associated with mental illness in the general population,[111,112] however there are factors which can have a particular impact at this life stage.

Appendix 6 gives the available data on the prevalence of identified risk factors for maternal mental ill health issues locally, along with how we compare to England and similar local authorities. The table shows that, where we have data, Brighton & Hove is similar to England in the level of risk. However, there are many factors where data is not available and we do not know the scale of the challenge in the city nor how it compares with England and the South East. These include:

- Having a poor relationship with a partner.[113]
- Inadequate social support[114]
- Extreme stress
- History of mental health problems[115,116,117,118,119]
- Childhood abuse and neglect
- Unplanned or unwanted pregnancy
- Emergency situations and natural disasters (including public health emergency such as pandemics)
- Trauma.

The birth of a child with a disability has an impact on the family, leading to possible depression, anxiety, health problems, or other psychological distress.[120] In addition, research has found that parents of premature babies are more likely to experience mental health problems than parents whose babies arrived full term.[121]

The perinatal mental health of fathers, other co-parents and other partners is less well researched. A 2021 systematic review showed that 10% of the fathers experience perinatal depression and 5-15% perinatal anxiety. Non-birthing partners including fathers, co-mothers, and stepparents may themselves experience perinatal mental health difficulties.

Fathers may also experience post-traumatic stress symptoms following the birth of a child. Paternal deaths are not recorded; however, fathers face an increased risk of suicide in the perinatal period.[122] The review found that there was a lack of evidence of the prevalence of perinatal mental health disorders in stepparents, co-mothers, trans and gender-diverse parents. But suggested that there may be distinct challenges for LGBT+ parents, linked to heteronormative systems, stigma, marginalisation, assisted reproduction, and invisibility/social and legal recognition as parents.

8.3 Level of need in Brighton & Hove

See demographics of births and mothers

8.3.1 Prevalence of perinatal mental health issues

Perinatal mental illness is estimated to affect 10-20% of new and expectant mothers. Based on Office for National Statistics birth estimates for 2020 between 225 and 450 women in Brighton & Hove could be affected by perinatal mental illness. With births predicted to increase, by 2030 this could increase to between 280 and 560 mothers.

There are no registers for perinatal mental illness. However, the Office for Health Improvement and Disparities (previously Public Health England) Perinatal Mental Health Profiles[123] provide estimates of the prevalence of maternal mental illness by Local Authority based on national survey data (Table 16).

Adjustment disorders (an unhealthy or excessive emotional or behavioural reaction to a stressful event or change in a person's life) and distress are estimated to be the most common maternity related mental illness (between 1 in 6 and 1 in 3 deliveries), followed by mild-moderate depressive episodes (between 1 in 10 and 1 in 6 deliveries). It is important to note that the estimates **do not** take account of socio-economic or demographic differences which are likely to cause variation across areas.

Table 16: Estimated number of pregnant women with specific mental health issues in the perinatal period, Brighton & Hove, 2017/18 and estimates for 2030

	National estimated prevalence (pregnant women)	Brighton & Hove 2017/18	Brighton & Hove 2030
Mild-moderate depressive illness and anxiety in perinatal period (lower -upper estimate)	100 - 150 in 1,000	207-311	283-424
Severe depressive illness in perinatal period	30 in 1,000	62	86
Chronic serious mental illness in perinatal period	2 in 1,000	4	6
Adjustment disorders and distress in perinatal period (lower – upper estimate)	150 – 300 in 1,000	311-621	424-848
PTSD in perinatal period	30 in 1,000	62	85
Postpartum psychosis	2 in 1,000	4	6

Source: Office for Health Improvement and Disparities. Perinatal mental health profile. Available at: **Perinatal Mental Health - OHID (phe.org.uk)** and Office for National Statistics Subnational Population Projections 2030 for births https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2018based

Fetal Alcohol Spectrum Disorder (FASD) is a lifelong condition caused by alcohol exposure to the developing fetus. The first national effort to quantify FASD in the UK was published late 2018. The study found a screening prevalence range in the UK of 6% to 17%.[124]

The neuro-developmental problems associated with FASD can create great difficulties for individuals in childhood that persist throughout life. Impaired ability to learn, remember, make judgements, and forward plan make day-to-day life challenging.[125]

In 2021/22 there were 11 pregnant women in substance misuse services, 25 women with children under one year and 24 men with children under one year.[126] This appears low given the evidence on risk factors and Brighton & Hove's population. We need to know if this due to recording or access to the service.

8.4 Voices in the perinatal period

We did not identify any recent local engagement reports with pregnant women or new mothers for Brighton & Hove that provide insight into local needs and experiences.

According to the Care Quality Commission 2021 Maternity Survey, across England:[127]

- 69% of women said that during their antenatal check-ups, the midwife asked them about their mental health. Most women (83%) said that if needed, they were given enough support for their mental health during their pregnancy.
- 95% of women said that a midwife or health visitor asked them about their mental health postnatally when they were visited at home or seen in a clinic.
- Respondents felt that information about mental health postnatally could be improved. 56% were 'definitely' given information about changes they might experience in their mental health after having their baby, from 63% in 2019
- Most respondents (79%) were told who to contact if they needed advice about any changes to their mental health after the birth
- 10% of women who responded to the survey said they had a mental health condition. Women with a mental health condition reported more negative experiences, compared to the average experience, in most areas of care.

In Sussex wide engagement (2021), fathers were interviewed about their experience of becoming a father, their needs and what works to support them. They identified a need for non-stigmatised support provided by men and for services to think about more ways to increase confidence of fathers to engage with antenatal and postnatal services.[128]

8.5 Quality and outcomes

There are no local figures, but the UK and Ireland 2021 Confidential Enquiry into Maternal Deaths[129] found that mental health remains one of the leading causes of maternal death during pregnancy and the first postnatal year:

- Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy
- Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes
- Improvements in care might have made a difference in outcome for two thirds of women who died by suicide.

8.6 What we know about the local perinatal mental health offer

Support for mild to moderate perinatal mental health is provided through primary and secondary care mental health services.

8.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

8.6.2 Midwifery service

The Midwifery service offers support to all pregnant women from the moment they are booked into the NHS, usually early on in pregnancy, up until health visiting makes the New Birth Visit around 10 days after birth. For the antenatal period where there is an identified mental health and emotional wellbeing need, there is a focus on signposting to primary, secondary care and private sector organisations, with a specialist direct offer to those who are at higher risk of poor mental health. The pandemic and the subsequent increase in mental health referrals has limited the capacity to meet need.

8.6.3 Health visiting Service

The health visiting services supports women from 28 weeks into pregnancy until their baby is 5 years old. In Brighton & Hove (as is the case nationally) the key universal intervention for all mothers and new babies are the five checks provided by the health visiting service at 28 weeks into the pregnancy, the New Birth Visit, 6-8 week check, 12 month review and 2-2.5years review. Health visitors will ask about the mother's mental health at these checks and provide support and signpost as required.

The Healthy Futures Team within the Health visiting service provides additional support for families with additional vulnerabilities. This service includes a Specialist Health visitor for Perinatal Maternal and Infant Mental Health who provides peer support groups for mothers and a group for fathers alongside 1:1 support and referrals to the specialist perinatal mental health service.

8.6.4 Specialist Perinatal Mental Health Service

The specialist perinatal mental health service is a community-based service providing specialist support to mothers who are experiencing, or who have previously experienced, severe and complex mental health difficulties during the perinatal period.

8.6.5 Inpatient care

Mother and baby units (MBUs) provide inpatient care for mothers experiencing severe mental illness. There is no MBU in Brighton and Hove but there are a number in the greater London and South East area.

8.6.6 Community and Voluntary Sector organisations

Support to improve mental health and wellbeing is provided by many local Community and Voluntary Sector (CVS) organisations. In addition to support and services that are

open to all adults there are also a small number of CVS organisations that provide support for mental health and emotional wellbeing needs to birthing and non-birthing parents and their infants.

8.7 Opportunities to learn more

There is work already planned that will enable us to develop a more detailed view of parents' experiences of the mental health offer in the perinatal period:

- Perinatal Equity and Equality of Access Plan for Sussex 2022-2025 – Mental health peer support is a focus in this 3-year plan lead by the Local Maternity and Neonatal System team. The plan involved consulting with a wide range of stakeholders including the Maternity Voices Partnership
- Recommissioning of the Health Visiting and School Nursing service – the process of recommissioning will include undertaking a JSNA and service review to understand how the services meet need and identify potential gaps. There will be a consultation with families to inform the specification for the service
- Development of Family Hubs – Brighton & Hove has been awarded funding to develop Family Hubs from June 2022 to March 2024. It will involve transforming the current Children's Centres and Early Help Services in the city into Family Hubs which have a wider remit and cover an extended age range – from 0-19 yrs (and up to 25 for CYP with SEND). Consultation with families, communities and service partners will include some relevant services eg Community Midwifery and the Health visiting services which are provided from Children's Centres.

8.8 What works for prevention

Box 1: What works for prevention: perinatal period / infant mental health

Opportunities:

- The perinatal period provides a significant opportunity to improve mental health outcomes for families
- There is strong evidence for perinatal interventions targeting parent tobacco, alcohol and substance use during pregnancy; interventions during pregnancy and immediately after birth to prevent child mental health issues; and home visiting and parenting programmes to improve child-parent attachment and prevent child adversity.

Improving systems:

- There is a need to develop Integrated Care Pathway approaches across local areas that take in to account the physical needs of pregnancy and child development alongside the potential challenges to mental health
- Establish a Maternal Mental Health Pathway (eg by strengthening consistent and seamless support). This will set out guidance for healthcare professionals supporting mothers during pregnancy and after birth to prevent the development or worsening of mental health problems during this period and to manage existing conditions
- Mother and baby units and community perinatal mental health teams should aim to be accredited by the Royal College of Psychiatrists' Centre for Quality

Improvement (CCQI). This accreditation, through ongoing review, will assess staff training and support and positive feedback from parents and carers.

What works:

- Universal infant programmes, which include those offered in the context of antenatal care and programmes offered at birth to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant
- Universal infant programmes help parents identify temperamental differences, provide them with knowledge of child development, and help them manage infant behaviours like sleep and crying. More progressive, targeted interventions to address specific needs among more vulnerable and at risk groups can complement these universal programmes where necessary
- Ensure that perinatal and infant mental health pathways include opportunities, for those that need it, to access appropriate support prior to conception and that every woman (where clinically appropriate) has access to mother and baby units
- Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions
- Promotional interviewing, an approach which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme during pregnancy and the postnatal period
- Implement national improvement initiatives locally, including:
  - developing local Health Visitor Champions;
  - implementing the Family Nurse Partnership Programme for young first-time mothers;
  - ensuring that midwives have access to Perinatal Mental Health Training; and
  - implementing guidelines for GPs and primary care from NICE and the Royal College of General Practitioners.
- Effective programmes to address both antenatal and postnatal depression cover prevention in high-risk groups and intervention in mothers with established depression. They include cognitive behavioural and person-based counselling, both of which are equally effective if the practitioner can establish a trusting relationship with the mother
- Produce prevention plans that address suicide within the perinatal period following the Joint Commissioning Panel for Mental Health's three steps, including identifying those at increased risk and developing a personalised care plan for each woman at increased risk.

More evidence needed:

Compared to mothers, there are less interventions specifically for fathers, and other non-birthing fathers, during the perinatal period and the evidence of effectiveness is limited.

9 Children, young people and families

9.1 Introduction

This life stage runs from conception to age 25 years. Until the age of 18, services for children and young people with long-term health conditions are provided by child health and social care services. From 18, they are usually provided by adult services, with this transition process starting from age 16.

Early adulthood for young people (between 16 to 25) is a key life stage:

- Around half of lifetime mental health problems are established by age 14 and three quarters by age 24[130]
- Young people are making important transitions in their lives and becoming more independent
- Between the ages of 16 and 18, young people are more susceptible to mental illness[131]
- Adult and child service criteria differences mean that some people are no longer able to access services as they turn 18. For these people, support can reduce sharply at age 17 /18 even though need has not changed
- Capabilities such as planning, self-control, flexibility, awareness help adults to manage life and work effectively. Ages 15 to 23 years is a period of significant development of these executive function capabilities.[132] Early life adversity directs the brain away from planning and impulse control.

Services for children and young people do not all have the same upper age limit for those receiving a service. National policy is to extend current service models to create a comprehensive offer for 0 to 25 year-olds that reaches across mental health services for children, young people and adults.[133] The Special Education Needs (SEN) code of practice covers the 0 to 25 age range. Between the ages of 16-25 years, children who were looked after by the local authority become care leavers. Local authorities have a statutory duty to provide Personal Adviser (PA) support to all care leavers up to age 25, if they want this support.

Where relevant, we pull out information about young people aged up to 25 years in this life stage, but some will be covered in the next section on working age adults where this breakdown is not possible.

The foundations of life-long wellbeing are laid down in infancy and childhood. It is a time of rapid development, and the needs of infants differ from primary school aged children and differ again from young people of secondary school age and above.

Nurturing families are paramount in supporting the mental health and wellbeing of children and young people. Nurturing education settings from nurseries to universities support life chances and are important in identifying mental health needs.

The first 1,000 days refers to a child's life from the moment they are conceived until they reach 2 years of age (24 months). This is a crucial time when a child's brain, body and immune system grows and develops significantly.

9.2 Risk and protective factors

Many of the risk and protective factors associated with mental health problems for CYP are similar to those associated with mental illness in the general population, for example socio-economic status, housing, access to nature etc,[134,135] however, there are factors which can have a particular impact at this life stage.

During infanthood, secure attachment is paramount in shaping lifelong wellbeing. A growing body of evidence indicates that peer and family relationships, alongside their wider school and neighbourhood environment, have the strongest links to children and young people's wellbeing.[136]

Use of social media can be a risk factor for some children and young people. Social media has been linked to increased rates of anxiety, depression and poor sleep.[137] Cyber bullying and exposure to damaging normative messaging around ideal body shapes may have a profound negative effect on children and young people. Online groups associated with self-harm and suicide are extremely risky spaces for vulnerable children and young people. Children and young people also report a positive effect – finding likeminded communities on-line can be empowering. In the Brighton & Hove Safe and Well at School Survey conducted in late 2021, some groups including LGBTQ+, Young Carer and BME pupil cohorts were more likely to say that social media made them feel better about themselves, happier and more connected than all pupils.[138]

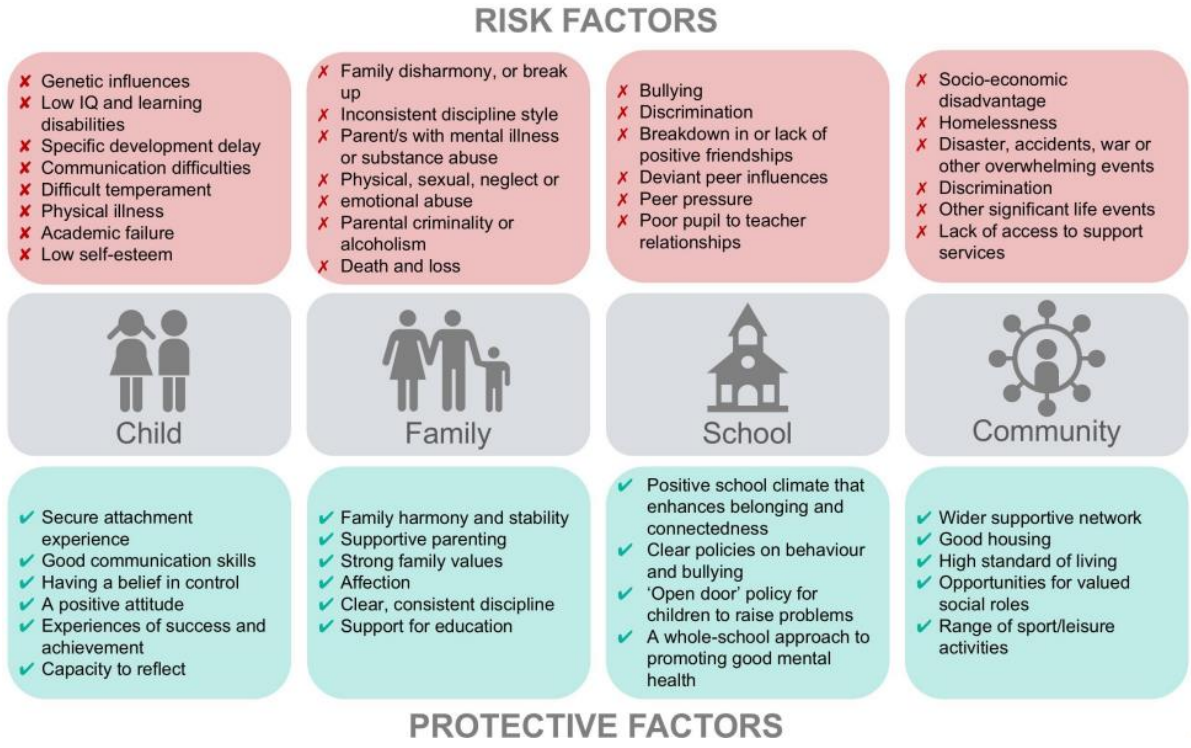
Risk and protective factors are shown in **Figure 13**.

Appendix 6 summarises risk factors associated with reduced mental health and wellbeing where comparisons can be made between Brighton & Hove and England and similar local authorities. The table shows that:

- Whilst Brighton & Hove compares relatively well to England for proportion of children in low-income families before housing costs, there are very high numbers with almost 7,900 children in low-income families. However, if housing costs are taken into account, this figure rises by over 60% with almost 13,000 children in the city living in poverty in 2019/20[139]
- Brighton & Hove has higher rates for both children in care and care leavers than both England and the South East. The proportions of care leavers are statistically significantly higher than both England and the South East)
- It has a significantly higher rate of children in need due to family stress due to dysfunction or absent parenting and children subject to child protection plans with initial categories of abuse or neglect

- Brighton & Hove has a statistically significantly higher percentage of school pupils with social, emotional and mental health needs than England and this proportion is increasing
- Although a few years out of date, in 2015, of all upper tier local authorities in the South East Brighton & Hove had the highest percentage of 15-year-olds with three or more risky behaviours, such as current smokers, alcohol use, cannabis use, use of other drugs, poor diet; or physical inactivity than any upper tier local authority in the South East and significantly higher than the South East and England. Although there is no more recent comparative data, we include local data from the Safe and Well at School Survey (2021) later in this section which gives a more recent picture
- Brighton & Hove has similar school readiness at the end of reception to England and has seen an improving trend in recent years. Brighton & Hove has a higher average attainment 8 score than England, however the attainment for children in care in comparison to the all-pupil average attainment is very poor
- Brighton & Hove had 457 children and young people registered as home educated in the academic year 2021/22 which is an increase on 380 for 2020/21 and 394 for 2019/20. There are a wide range of reasons why children and young people are home educated. We do not have evidence of the mental health needs of this group.

Figure 13: Overview of risk and protective factors for CYP's mental health



Source: The Mental Health of Children in England, 2016

9.2.1 Adverse Childhood Experiences (ACEs) and trauma

Trauma

Traumatic events are those that put you or someone close to you at risk of serious harm or death. Our usual ways of coping are overwhelmed, leaving us feeling frightened and unsafe. We can be traumatised through one-off events or ongoing stress, eg:[140]

- one-off events such as an accident, violent attack or natural disaster
- ongoing stress such as childhood or intimate partner abuse, bullying, long-term illness or a pandemic such as COVID-19
- living in an unstable or unsafe environment
- parental mental illness
- seeing someone else get hurt.

Multiple, long-lasting, repeated or continuous trauma is commonly referred to as complex trauma.[141] The impact of complex trauma is thought to be more severe if it happened in childhood.[142] ACEs can be a measure of childhood on-going stress or trauma.

Adverse Childhood experiences (ACEs)

ACEs are on-going stressful events and situations occurring in childhood including abuse, neglect and family dysfunction (**Figure 14**). They have been shown to increase the risk of developing mental ill health in childhood and adulthood, as well as increasing the likelihood of developing health harming behaviours such as sexual risk-taking, problematic alcohol use and substance misuse or violence, each of which in turn is linked to poor mental and physical wellbeing. Almost two thirds (an estimated 61%) of the adult population have had at least one ACE, however ACEs frequently co-occur and it is estimated that 1 in 6 adults (16%) have experienced 4 or more ACEs.[143] Compared to those with no ACEs, people with 4+ ACEs are:

2 times more likely (currently) to binge drink and have a poor diet

3 times more likely to be a current smoker

6 times more likely to have had, or caused, an unplanned teenage pregnancy

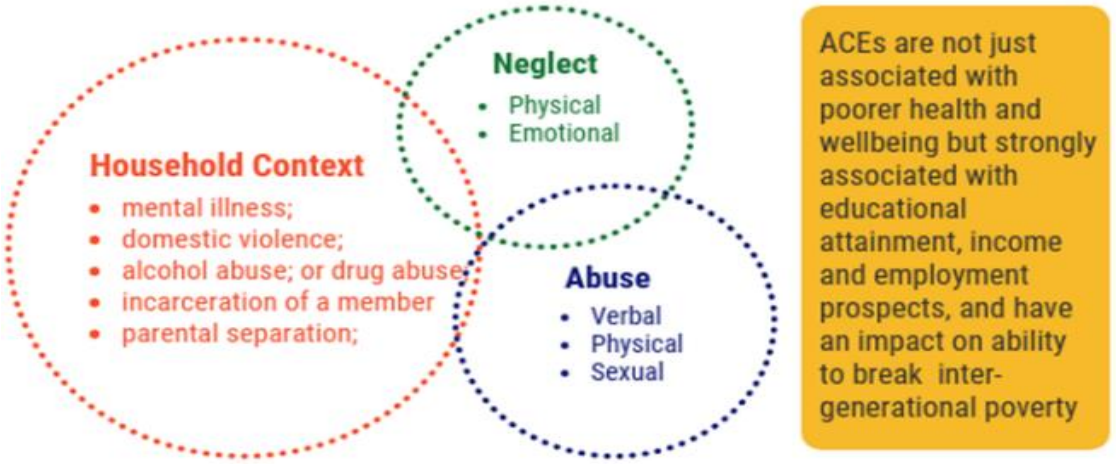
7 times more likely to have been involved in violence in the previous year

10 times more likely to have felt suicidal or self-harmed

11 times more likely to have used heroin/crack[144]

The outcomes most strongly associated with multiple ACEs represent ACEs risks for the next generation.[145]

Figure 14: Adverse childhood experiences[146]



Estimated prevalence (based on national research of adults retrospectively reporting their childhood).

- verbal (18%)
- physical (15%)
- sexual (6%)
- mental illness (12%)
- domestic violence (13%)
- alcohol abuse (10%) or drug abuse (4%)
- incarceration of a member (4%)
- Parental separation (24%)

9.2.2 Parental mental ill health

Poor maternal and paternal mental health has been associated with poor outcomes in children but not all children of parents who have mental health problems are at risk. A number of biological dispositions, sociocultural contexts and psychological processes are likely to interact and can serve as protective factors or risk factors for both parents' and children's mental health.[147] This is covered further in the perinatal mental health section.

9.2.3 Children in Care and Care leavers

Children in care and care leavers have much higher rates of mental health problems than the general population. They have been identified within Future in Mind and the NHS Long Term Plan as one of the most vulnerable groups in terms of emotional wellbeing and mental health. It is estimated that nearly 50 per cent of looked after children will meet the criteria for a diagnosable mental health disorder.[148]

Research has shown that children in care are more likely to have a mental health difficulty compared to their peers and this can be as a result of the abuse or neglect they experienced, an over-exposure to isolation and loneliness or living in socioeconomic hardship, all of which increases their likelihood to develop a mental health issue. The Commission on Young Lives warns that children's mental health services are buckling under pressure post-Covid.[149]

There are too many young people leaving care with diagnosed mental health conditions, but an even larger population of young people in care who have mental health needs but do not meet the threshold for CAMHS or adult mental health services. Whilst these

needs may not meet clinical thresholds, they often have a very significant impact on their quality of life, can lead to multiple moves whilst in care, and poor education and employment outcomes when leaving care.[150]

Most children and young people are taken into care following abuse and neglect, both of which are major ACEs, and all will have experienced trauma. They are more likely to self-harm and are at great risk of attempting suicide in adulthood. Referrals and subsequent wait times for mental health services further disadvantage young people that are brought into care in adolescence. Once in care children and young people who experience placement changes may find their wait time for a mental health service is lengthened as they re-enter a new wait list.

Brighton & Hove has higher rates for both children in care (not statistically significantly higher) and care leavers (statistically significantly higher) than England and the South East. See the population groups section for figures on children in care and care leavers.

9.2.4 Mothers of children taken into care

When children are taken into care, the safety and well-being of the child are the highest priority. This process often overlooks the health and wellbeing of the mother. We refer to mothers here, because most children are not living with their fathers when they go into care.[151]

Studies have found that mothers who had a child taken into care often have more health issues and social instability than mothers in the general population; these challenges worsen after their child is taken into care alongside higher rates of mental illness.[152,153,154] Mothers who had a child taken into care have higher rates of suicide attempts and death by suicide.[155]

See the population groups section for figures on children in care.

9.2.5 Children with Special Educational Needs and Disability (SEND)

Children with Special Educational Needs (SEN) do not necessarily have a disability or a mental health need, and some disabled children and young people do not have special educational needs. However, in comparison to children without special education needs and without Disability, children and young people with SEN and/or with disabilities are more likely to live in poverty and experience material deprivation; have higher rates of mental health issues; be excluded permanently or for a fixed period from school; not be in education, employment or training (NEET); experience social exclusion and discrimination, and live in unsuitable housing and have more difficulty accessing outdoor space for play[156]; all factors which are associated with reduced mental wellbeing.

Nationally, the percentage of children in schools with SEN has increased from 14.9% in 2019 to 16.3% in 2022. In January 2021, 3.7% of all pupils had an Education, Health and Care Plan (EHCP); and 12.21% of all pupils had SEN support.[157] The most common type of need for those with an EHCP is Autistic Spectrum Disorders and for those with SEN support, Speech, Language and Communication needs.[158]

In January 2022:

- 19.1% (6,061) of pupils attending Brighton and Hove schools, were recorded on school special educational needs registers. This is above the England SEN figure of 16.3%
- 4.3% (1,352) of Brighton & Hove pupils have an Education, Health & Care Plan. The national figure is 3.9%
- 14.9% (4,709) of Brighton & Hove pupils were receiving SEN Support (on their school's SEN register, but do not have an EHCP). The national figure is 12.4%
- The most common type of need for those with an EHCP in Brighton and Hove and nationally, is Autistic Spectrum Condition.

9.2.6 Neurodiverse people (including those with ASC, Autistic Spectrum Condition, and ADHD, Attention Deficit Hyperactivity disorder)

People with autistic spectrum conditions (ASC) are at increased risk of anxiety and Obsessive-Compulsive Disorder (OCD). Evidence from combined studies showed that in children and adolescents, 40% of young people with ASC had at least one comorbid anxiety disorder, the most frequently specific phobia (30%), OCD (17%) and social anxiety disorder (17%).[159]

There is no local data available of the number of children and young people with ASC in the city. It is estimated from studies that 1% of the population has ASC,[160] this would equate to almost 1,000 children and young people aged 0-25 in Brighton & Hove.

Attention-deficit hyperactivity disorder (ADHD) is a common childhood behavioural disorder. Systematic reviews indicate that the community prevalence globally is between 2% and 7%, with an average of around 5%. At least a further 5% of children have substantial difficulties with overactivity, inattention, and impulsivity that are just under the threshold to meet full diagnostic criteria for ADHD. Estimates of the administrative prevalence (clinically diagnosed or recorded) vary worldwide and have been increasing over time. However, ADHD is still relatively under-recognised and underdiagnosed in most countries, particularly in girls and older children.[161]

There is no local data available of the number of children and young people with ASC or ADHD in the city. Applying the above estimate of 2-7% to the Brighton & Hove population aged 0-25 years (99,411 children and young people) would give an estimate of between 2,000 and 7,000 children and young people.

9.3 Level of need in Brighton & Hove

This section looks at need from the following sources:

- Emotional wellbeing – local survey in schools and further education – Safe and Well at School Survey (SAWSS)
- Prevalence of mental health disorders – national estimates of local prevalence
- Pupils with identified social, emotional and mental health needs in schools
- Percentage of children in contact with secondary MH services and trends in that measure.

9.3.1 Emotional wellbeing

We have a very rich picture of need in Brighton & Hove from the Safe & Well at School Survey (SAWSS) which takes place every two years. The survey is an anonymous online survey conducted by Brighton & Hove City Council Public Health team, in partnership with the University of Sussex, across primary and secondary schools in the city. Results from the survey are presented in this section and on the section on outcomes. We thank Brighton & Hove schools for their active participation in this important survey.

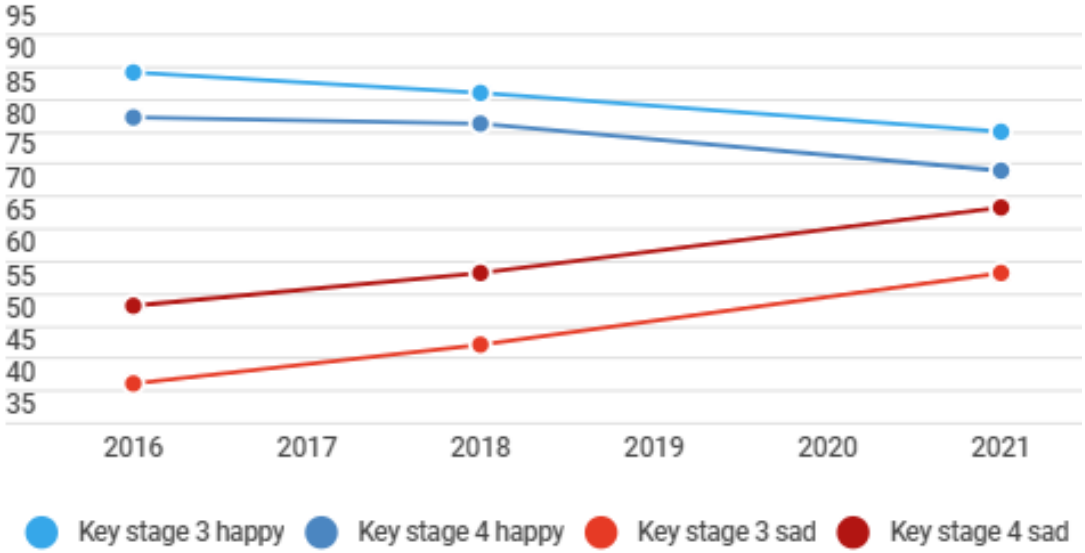
The most recent survey is based on data collected in November 2021, this was at a time when schools had returned to face to face teaching after the Covid lockdowns and restrictions. A total of 7,190 young people aged 11-16 took part from the 10 secondary schools across the city (59% of pupils). 5,322 primary school children aged 8-11 years took part (70%). The high participation in the survey from schools gives us valuable information which can be used to support communities. It helps us and the participating schools to understand and better meet the needs of children and young people in the city.

The survey shows that young people's emotional wellbeing has seen a significant deterioration in 2021 compared with previous surveys (**Figure 15**).

There was less change for primary school pupils, but for secondary school pupils:

- 78% often feel happy, down from 84% in 2018
- 61% often feel sad, up from 51% in 2018
- 63% worry about their future, up from 58% in 2018
- 56% often or sometimes struggle to sleep at night, up from 50% in 2018.

Figure 15: Percentage of pupils who strongly agree or agree that they have often felt happy or sad in the last few weeks, Brighton & Hove, 2016 to 2021



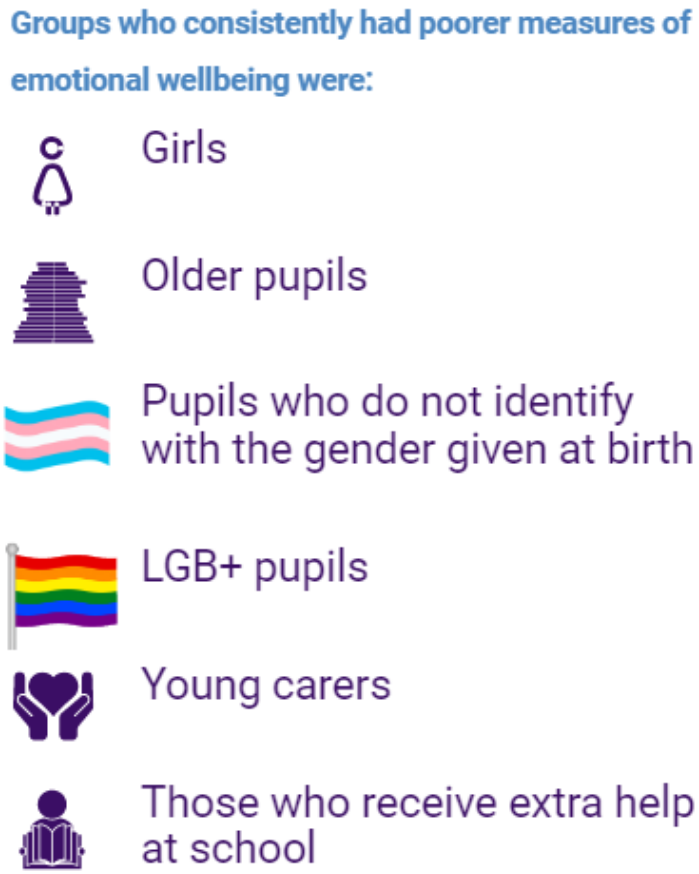
Source: Safe and Well at School Survey, Brighton & Hove City Council and University of Sussex

Some groups were disproportionately affected, **Figure 16** shows the groups who consistently had lower levels of wellbeing.

We do not have trend data, but the 2021 survey also shows:

- 32% often or sometimes have issues with food
- 51% often or sometime struggle with their body image and
- 62% often or sometimes feel angry.

When asked if they had asked for help with worries or feelings, around a third (34%) of pupils said that they had asked for help and 40% said that there was an adult at school that they could speak to about worries or feelings.



Whilst only 31 pupils who identified as children in care completed the survey, they were significantly less likely to be happy (59%) compared to 79% of those not in care; more likely to feel sad often (70% compared to 61%); significantly more likely to have self-harmed (46% compared to 18%) and; more likely to have had suicidal thoughts (36% compared to 23% of children not in care).

9.3.2 Pupils with social, emotional, and mental health needs

Table 18: Percentage of school pupils with social, emotional and mental health needs, Brighton & Hove, and England, 2021

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Primary school age	2021	518	↑	2.8%	2.4%	-
Secondary school age	2021	508	↑	4.0%	2.9%	-
All school age	2021	1,076	↑	3.4%	2.8%	-

Source: Public Health England Children and Young People's Mental Health and Wellbeing Profile Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)

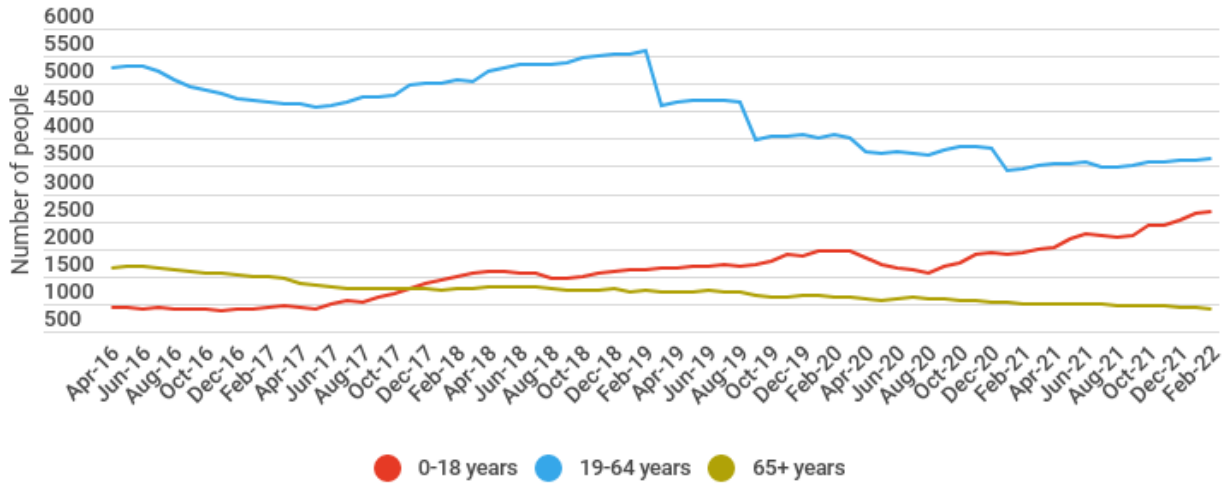
In Brighton & Hove, 1,076 school pupils are identified as having social, emotional and mental health needs, expressed as a primary need under Special Education Needs (518 primary school age and 508 secondary school age) in 2021 (**Table 18**). Rates have increased over the last five years in the city, as well as across England.[162]

9.3.3 Contact with secondary mental health services

As of February 2022, there were 5,560 people in Brighton & Hove using NHS funded secondary mental health services including learning disabilities and autism services (**Figure 17**). Comparison between age groups is shown here and referenced to from the other life stages in the report. The number of people in contact with contact with secondary mental health services:[163]

- aged under 19 years has been rising and is 2.8 times higher than it was in April 2016 (from 945 people to 2,685)
- aged 19-64 years has seen a large fall since 2019, but numbers have started to rise since mid-2021
- aged 65 years or over has fallen steadily over recent years with 910 people in contact in February 2022 compared with 1,645 in April 2016.

Figure 17: Number of people in contact with secondary mental health services by age, Brighton & Hove CCG, April 2016 to February 2022



Source: NHS Digital, Mental health services monthly statistics. Mental health services monthly statistics - NHS Digital

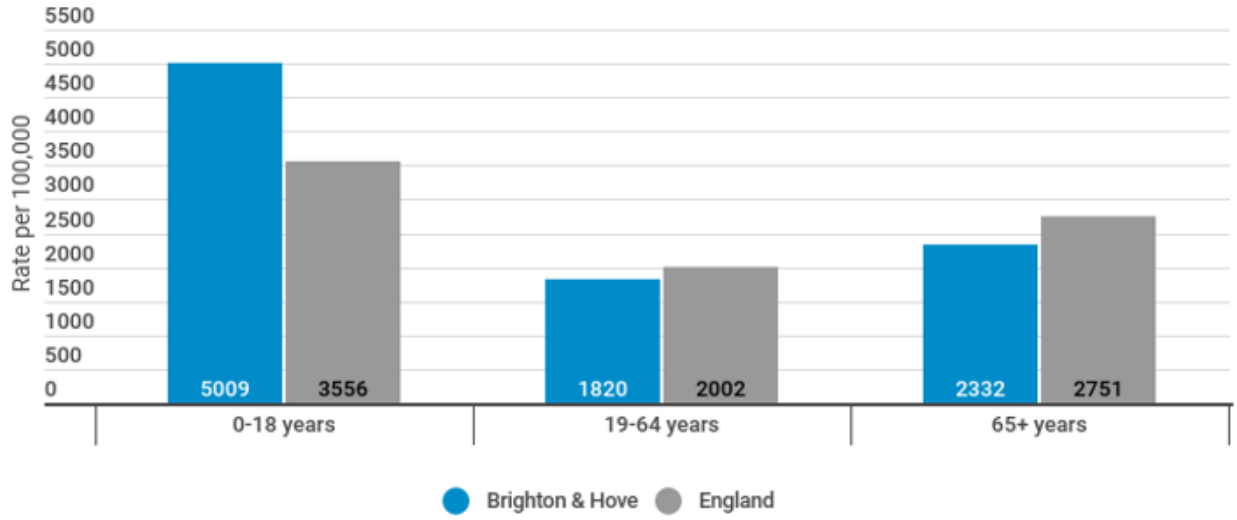
Figure 18 shows the rate per 100,000 population of people using NHS funded secondary mental health services including learning disabilities and autism in Brighton and Hove and England. It shows that:

- Brighton & Hove has a much higher rate of young people in contact with mental health services than England (5,009 people per 100,000 compared to 3,556).

This is in contrast to the rates for working age and older adults:

- Brighton and Hove has a slightly lower rate for those aged 19-64 years than England (1,820 people per 100,000 compared to 2,002) and a lower rate than those aged 65 years or over (2,332 people per 100,000 compared to 2,751)
- Older people have a higher rate of contact with secondary mental health services compared with working age adults in both Brighton & Hove and England.

Figure 18: People in contact with secondary mental health services by age, rate per 100,000, Brighton & Hove CCG, February 2022



Source: NHS Digital, Mental health services monthly statistics. Mental health services monthly statistics - NHS Digital and ONS Mid-Year Population Estimates 2020

9.3.4 Safeguarding concerns related to mental health

The YMCA have identified an increase in safeguarding concerns related to mental health across the services they provide in the city for young people.

9.4 Children and young people's voice

No primary qualitative evidence has been gathered for this rapid review. In practice there is limited routine collection of children and young people's or parents' voices by services. This assessment is informed by a review of the key findings from 11 recent engagement projects lead by children and young people to gain their experiences and voice around mental health and wellbeing.

The engagement projects span 2020-2022 and involved hundreds of young people in primary and secondary schools and older young people aged up to 25.

The list of these projects can be seen at Appendix 7 and the summary report is available alongside this report.

Across the range of engagement projects some key themes emerge:

Equity and equality of access

- Equality of inclusion matters. Engage all young people from all walks of life. Don't take the easy road. Don't work only with the same often heard voices
- A recognition and understanding of the impact of racism on children and young peoples' sense of identity and belonging in schools
- The need to take a gender sensitive approach to supporting the mental health needs of young men and to recruit more male mental health practitioners to support young men.

Getting help early enough

- Ensure children and young people gain timely support for their mental health and that this support is tailored and appropriate to their mental health needs as well as other access/financial barriers
- Make children and young people much more aware of services in their communities regardless of their mental health need and create services to fill the gaps where needed. Also make sure parents know about these services and how to make appropriate referrals to them
- Provide more relatable self-care strategies that reflect our experiences to support our mental health and avoid 'toxic positivity'
- Address the stigma around youth loneliness and social isolation
- More understanding following the death of a parent and going into care and the impact on emotional wellbeing
- We need 'friends with training' to be able to notice, advise and support those with eating difficulties but also know who to turn to for support if they get worried.

Co-design and co-production and meaningful engagement

- When asked for their views, children and young people said they wanted to see more involvement of peers and people with lived experience in designing and commissioning services and more support for the development of peer support
- For some services there was no routine engagement opportunities. Some populations had little or no opportunities to express their views.

The importance of the education setting

- Ensure a whole school approach to mental health
- School staff, Mental Health Support Teams and other support services must reflect the diversity of the communities they serve and support
- Train those with lived experience of mental health and ex-service users to become Wellbeing Ambassadors
- Primary schools need to recognise the importance of offering transition support throughout Year 6 to enable early identification of those who might struggle and plan appropriately, not leaving it until after the SATs.

Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.

Co-production with people with lived experience of services, their families and carers is a key principle of the national Five Year Forward View for Mental Health and improves outcomes. It was included in the Care Act 2014 that Local Authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. NHS organisations have a duty under Section 14Z2 of the Health and Social Care Act 2012 and the NHS Act 2006 to 'make arrangements' to inform, involve and consult with the public.

Brighton & Hove Citizens UK – Commission into Mental Health

Brighton & Hove Citizens brings together a range of institutions including schools, colleges, faith institutions, universities, unions and community groups across the city. Following a large and intensive listening exercise focused on people's experience of mental health, Brighton & Hove Citizen published a manifesto. The link is given below: https://drive.google.com/file/d/1IkR6QOS9A85Twk90mR2MVwoPKhK2zcuk/view?usp=sharing

The manifesto has asks grouped into six workstreams:

1) Mental Health Charter
2) Community Isolation
3) Mental Health as a Stigma
4) Access to Support
5) Waiting Lists
6) Transition between Children's Services and Adult Services

9.5 Quality and outcomes

This section shows outcomes across the following areas:

- Thoughts of self-harm
- Hospital admissions for self-harm
- Suicide and suicidal thoughts.

The comparative data on outcomes is presented in Appendix 8.

9.5.1 Self-harm

According to the 2021 Safe and Well at School Survey, 18% of 14–16-year-olds in Brighton & Hove said that they often or sometimes hurt or harm themselves, an increase from 10% in 2018.[164]

Groups who had higher rates of self-harm were:

- Girls (24% compared to 7% of boys)
- Pupils who do not identify with the gender given at birth (46% compared to 15% for those who do identify with the gender assigned at birth)
- Those born in the UK (19% compared with 12% of those born outside the UK)
- LGB+ pupils and those unsure of their sexual orientation (43% compared to 10% of heterosexual/straight pupils)
- Young carers (29% compared with 18% of those not a young carer)

- Those who receive extra help at school (30% compared to 17% of those who do not receive extra help.

There were no statistically significant differences by ethnicity.

Brighton & Hove has significantly higher rates of hospital admission as a result of self-harm for young people than England. In 2020/21, for Brighton & Hove residents there were 405 hospital admissions of children and young people aged 10-24 as a result of self-harm (**Table 19**). Whilst hospital admissions for self-harm provide a helpful indicator, they represent only a fraction of the actual self-harming behaviours in children and young people as the majority will not and may never present at hospital with self-harm. Furthermore, the type of self-harm that leads to an admission, may differ from the types that leads to attendance at A&E without admission.

Table 19: Hospital admissions as a result of self-harm, 10–24-year-olds, rate per 100,000, Brighton & Hove residents, 2020/21

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Hospital admissions for mental health conditions (<18 years)	2020/21	70	→	139.1	87.5	-
Hospital admissions as a result of self-harm (10-24 years)	2020/21	405	→	594.7	421.9	-
Hospital admissions as a result of self-harm (10-14 years)	2020/21	35	→	239.6	213.0	-
Hospital admissions as a result of self-harm (15-19 years)	2020/21	170	→	971.5	652.6	-
Hospital admissions as a result of self-harm (20-24 years)	2020/21	200	→	578.6	401.8	-

Source: Public Health England Children and Young People's Mental Health and Wellbeing Profile
Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)

Across Sussex, in 2019/20 and 2020/21 there were more repeat self-harm incidents requiring hospital admission compared to 2018/19. Some people experience multiple episodes of self-harm with 10% of individuals having had three admissions or more. The majority of admissions were of 18- to 24-year-olds, with four out of five admissions in 2020/21 were female.[165]

9.5.2 Hospital admissions for mental health conditions

In 2020/21 there were 70 admissions to hospital of Brighton & Hove residents aged under 18 years for mental or behavioural disorders as the primary diagnosis, up from 40 in 2019/20. This is a rate of 139 per 100,000, significantly higher than England (87.5 per 100,000) and the highest of our CIPFA comparators. There has not been a significant change in this rate over the last decade, although the local rate is the highest it has been since 2010/11 when data is first available.

9.5.3 Suicide and suicidal thoughts

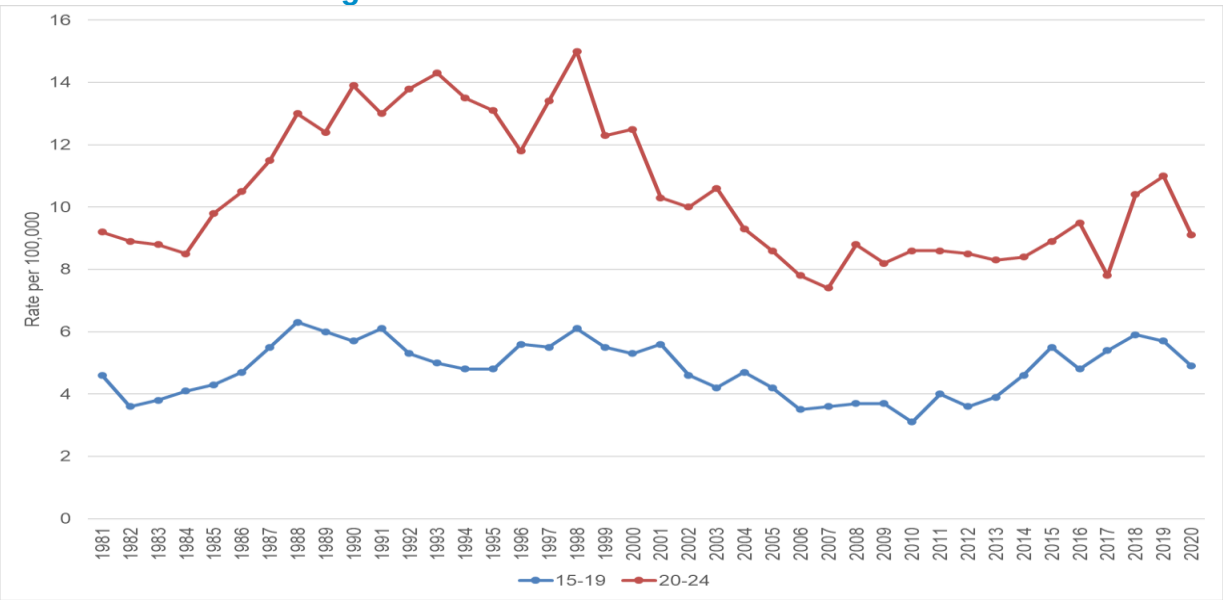
According to the 2021 Safe and Well at School Survey, 24% of 14–16-year-olds in the city said that they often or sometimes have suicidal thoughts, an increase from 17% in 2018.[166] Groups who had higher rates of suicidal thoughts were:

- Girls (28% compared to 14% of boys)
- Pupils who do not identify with the gender given at birth (59% compared to 20% for those who do identify with the gender assigned at birth)
- LGB+ pupils and those unsure of their sexual orientation (54% for LGB+, 39% of those unsure compared to 14% of heterosexual/straight pupils)
- Young carers (35% compared with 23% of those not a young carer)
- Those who receive extra help at school (39% compared to 22% of those who do not receive extra help
- Pupils from Black and Minority Ethnic groups (27% compared to 22% for White British Pupils). Rates were highest for White non-British and Chinese pupils.

For suicide and undetermined injury deaths between 2016 and 2019, almost one in ten (9%) deaths in Brighton & Hove were children and young people aged under 25 years, similar to England (10%). There were 44 deaths in this age group in the four years, 33 male deaths and 11 female deaths.

Across England and Wales the rates of suicide and undetermined injury deaths in those aged 15-19 and 20-24 have been increasing in recent years (Figure 19). Whilst numbers of suicides are too low for a yearly trend for Brighton & Hove, Table 20 shows that there has been an increase in suicide and undetermined injury deaths of Brighton & Hove residents aged under 25 years.

Figure 19: Age-specific suicide rates: by five-year age group, England and Wales, 1981 to 2020 annual registrations



Source: Office for National Statistics, Suicides in England and Wales: 2020 registrations. Available at Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

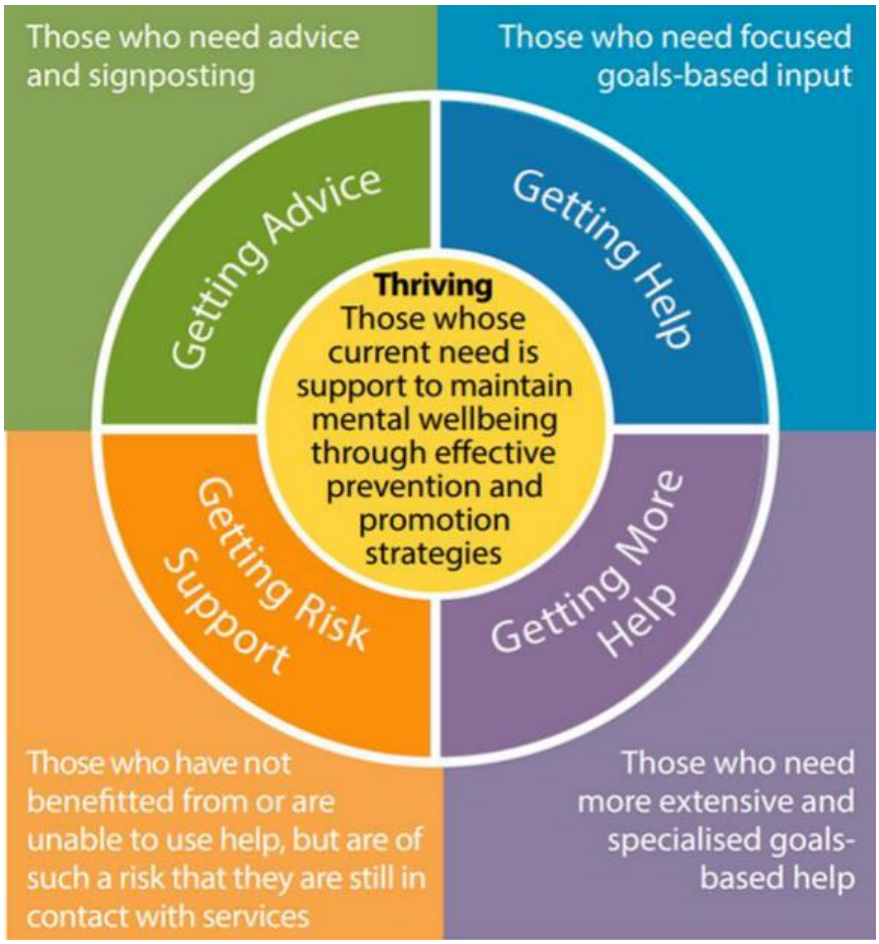
Table 20: Number of suicide and undetermined injury deaths for those aged under 25, Brighton & Hove, three-year periods from 2006-2008 to 2018-2020

Years of death (occurrence)	2006-2008	2009-2011	2012-2014	2015-2017	2018-2020
Number	<6	8	11	8	17

Source: Brighton & Hove City Council Public Health team from death registration data

9.6 What we know about the local mental health offer for children and young people

There are a wide range of services available across Brighton & Hove which are commissioned either by health, the local authority or by schools and colleges and University. In addition, there are local charity and national services which can be accessed. The core services commissioned by health and the local authority are summarised below and Appendix 9 gives a list of more services in the city mapped against the Thrive model shown below:



Source: THRIVE Framework (annafreud.org)

9.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

9.6.2 Schools Wellbeing Service

The BHISS (Brighton & Hove Inclusion Service) Schools Wellbeing service works to promote mental wellbeing in schools and reduce stigma around mental health. The service is embedded in all secondary schools and further education (FE) colleges, and it reaches in to Primary schools. The Department for Education (DFE) funded Mental health in schools programme is housed within the Schools Well-being Service. This is a targeted service for the areas of highest need and includes Cognitive Behavioural Therapy (CBT) informed interventions to support children.

The most common presenting issues for the Schools Wellbeing Service in the Autumn and spring terms of the 2021/22 academic year were generalised anxiety; family or peer relationship difficulties; social anxiety/phobia and attendance difficulties.

9.6.3 Children and Young Peoples Wellbeing Service - Primary care mental health service for children and young people.

The Brighton & Hove Wellbeing Service is delivered in partnership by Sussex Partnership Foundation Trust and YMCA Downslink Group. It offers a range of support and NICE compliant psychological therapies, information advice and guidance for those aged 4 to 25. It includes an online offer (E-Wellbeing).

9.6.4 Specialist Children and Adolescent Mental Health Service (CAMHS)

Specialist NICE compliant support commissioned from Sussex Partnership Foundation Trusts which offers assessment and treatment to children and young people who have moderate to severe emotional, behavioural or mental health problems. This includes intensive and crisis services, and A&E liaison services for young people who present at crisis.

There has been significant additional investment in CAMHS services over the last year to respond to the significant increases in demand. These have to date focused on urgent and crisis support and admission avoidance, duty and liaison services and additional investment in services targeted at supporting the neurodevelopmental pathway.

9.6.5 Sussex Family Eating Disorder Service (SFEDS)

The Sussex Family Eating Disorder Service provides specialist assessment and treatment for children and young people with an eating disorder. In line with national trends, demand for this service has significantly increased and the number of young people accessing the service has increased. However, numbers of young people being treated by the specialist service are low compared to the numbers of people estimated to have an eating disorder. In addition, a lower proportion of young people who are seen by the specialist eating disorder service as urgent cases, are seen within a week than for England.

The has been significant investment into the service to increase capacity to meet the rising demand but workforce availability has impacted on the expansion of the service. An All Age Eating Disorder Pathway is currently under development in Sussex to better meet the needs, and improve outcomes, for children, young people and adults with an eating disorder. It is expected that the pathway will be agreed in Autumn 2022.

Inpatient services are provided by Sussex Partnership Foundation Trust.

9.6.6 Parenting programs

Brighton & Hove has an established Reducing Parental Conflict programme of practitioner training, interventions and guidance and tools for parents with a lead Parental Relationships Coordinator role based in the Council's Parenting Team.

There are a number of interventions focused on improving parental relationships available to parents in the city alongside regular opportunities for practitioner training to increase frontline expertise and understanding of the impact on children and young people of persistent and poorly resolved parental conflict.

Parental relationships interventions comprise the following evidence based groupwork interventions: Triple P Transitions for separated parents; Parents as Partners for couples and Family Foundations for expectant parents. The Council's Parenting Team also provides a range of online tools for parents including the Getting on Better Pack; Arguing Better guide; Getting it Right for Children guidance and Baby, You and Me Too.

9.6.7 Suicide prevention

Any death in a child or young person aged up to 18 will trigger statutory Child Death Review processes. For deaths by suspected suicide, there is also a wider system response aimed at identifying those who may have been bereaved or affected by the death and offering support to these individuals. A toolkit has been developed locally to support schools and colleges in Brighton and Hove to respond to an unexpected death.

9.7 Opportunities to learn more

Planned work that will enable a more detailed view of population need and children, young people and their parents and carers experience of the mental health offer:

- Development of a Single Point of Access (SPOA) will provide a gateway to all mental health services for children and young people and an opportunity to monitor the needs of children and young people and their characteristics. Data collected from this initiative will create a significant opportunity to understand more about demand, referral methods and patient journey
- Foundations for our Future – youth participation. As part of the delivery of Foundations for our Future, there is a plan to strengthen the youth voice through deliberate engagement, agreed by children and young people. This includes the mapping of Sussex youth voice groups with a lead for mental health and emotional wellbeing

- The views of the young people will be heard through participation work that is being developed within SPFT and already well embedded within YMCA.
- Development of an All Age Eating Disorder Pathway for Sussex is underway in which young people and their families will share their experience and co-design the pathway.
- Development and improvement of service performance reporting.

9.8 What works for prevention

See Section X for more on how these were identified.

9.8.1 Early Years

Box 2: What works for prevention: Early years

Parenting programmes and mental health:

- There is a strong evidence base for the effectiveness of how parenting and home visiting programmes can prevent child mental health issues, antisocial behaviours and unintentional injury and improve child behavioural outcomes, parenting and parental mental health
- The evidence-base for (strengths-based) parenting programmes is substantial and demonstrates an impact on a wide range of outcomes including child conduct disorder and parental mental health
- Home visiting programmes can also improve attachment-related outcomes in preschool children including among children with existing severe attachment problems
- Universal parenting programmes for all the relevant population, as well as targeted programmes for parents and their children at risk of mental health problems, or for those already experiencing behavioural difficulties, have been shown to be effective
- Examples of programmes to help parents, children and parenting in families where a parent has a mental health problem include: The William Beardslee programme (a family-based approach for prevention in children at risk); Let's Talk About Children (a manual for a two-session discussion with parents who are living with a mental health problem); and Parenting under Pressure (a programme for supporting parenting in families where parents abuse drugs or alcohol).

Specific parenting and family-based programmes and mental health

- Ensure families at greater risk of poor mental health can access evidence-based support, including:
  - Triple P; the Solihull Approach; Mellow Parenting; Strengthening Families Strengthening Communities; and Incredible Years
  - A family-systems approach to consider the care giving relationship between the parent and the child as well as the relationship between parents.
- Video Interaction Guidance (VIG), as this is currently considered to be the best evidenced therapy for developing mother-child interactions

Delivery of parenting programmes:

- Parenting programmes are often delivered within or around school settings, with teachers and teaching assistants trained to deliver the programmes.

More evidence needed:

- Access to and the provision of parenting programmes are not universal and is considered a 'postcode lottery'.

9.8.2 School age children, young people, and their parents

Box 3: What works for prevention: School age children, young people and their parents

Whole-school approach:

- A whole-school approach to mental health is widely acknowledged to have the biggest impact. Supporting your local schools to adopt this approach will boost children's mental health and school achievement
- Key elements of a 'whole-school approach' are:
  - Promoting leadership and commitment to the 'whole-school approach' by ensuring that head teachers and teachers can access mental health literacy support and training
  - Creating a mentally healthy school environment through, for example, providing teacher-led mental health education and providing school nursing services
  - Implementing evidence-based bullying prevention programmes
  - Providing parent training at the secondary school level in the implementation of interventions to promote pro-social behaviours
  - Creating self-management opportunities and access to resources for students and teachers
  - Taking a progressive approach to 'whole-school' work to reduce stigma and promote help-seeking behaviours for children and young people
  - Creating clear and supportive pathways through stepped care (the most appropriate treatment based on assessment).
- Implement whole settings-based programmes within local colleges and universities informed by the work of the English Healthy Universities Network, Student Minds and the World Health Organisation's Health Promoting Universities Programme.

Guidance and local initiatives:

- Promote and implement the Healthy Child Programme through a multi-agency approach including, as examples, primary mental health workers, safeguarding, youth workers, counsellors, and public health specialists
- Collaborate with NHS England to support the local implementation of the Early Intervention in Psychosis (EIP) model - to reduce treatment delays at the onset of psychosis and promote recovery by reducing the probability of relapse following a first episode of psychosis
- Implement NICE guidance on preventing psychosis, such as access to pre-emptive CBT for people considered to be at increased risk
- There are significant effects in favour of Wraparound care in improving young people's mental health (wraparound invests in a care coordinator with low caseloads who convenes a team that includes the family's friends and natural supports, as well as professionals)

- Early Support Hubs offer a speedy, easy-to-access and non-stigmatising way of getting mental health support for young people. See #FundTheHubs campaign
- There is a strong evidence-base for the effectiveness of 'school-based' interventions:
    - To help reduce the incidence of bullying and have positive benefits for mental health. These interventions can also lead to better outcomes for the perpetrators of bullying
    - To prevent mental health issues and alcohol/tobacco/drug use, reduce child adversity, promote mental wellbeing and resilience, and improve social-emotional skills.
- Adopt a range of prevention strategies for eating disorders:
    - Universal media literacy and using the media to critically look at body ideals
    - Prevention interventions aimed at children at risk using body image focused cognitive behavioural activities in schools
    - Cognitive dissonance activities that engage young people in conversation on body image.
- Tackle racism and discrimination. Racial injustice is toxic to young people's mental health
- To implement brief psychological interventions to prevent mental health issues in young people (eg group-based CBT resilience and protective factors; coping skills; mindfulness; emotion recognition and management; empathic relationships; self-awareness and efficacy; and help-seeking behaviour)
- There is an evidence-base for the effectiveness of school based Social and Emotional Learning (SEL) programmes that help children and young people to recognise and manage emotions; set and achieve positive goals; appreciate the perspectives of others; establish and maintain positive relationships; make responsible decisions and handle interpersonal situations constructively
- Promote and implement preschool programmes to support school readiness, communication and the development of social and emotional skills
- Target support to children who are out / or at risk of being out of school and who have greater exposure to factors that negatively impact mental health, for example, children who are homeless or those in the criminal justice system
- Consider using digital interventions which have been shown to be effective to reduce depression in young people (eg MoodGym)
- Reducing Parental Conflict (RPC) has become a government priority through the Department for Work and Pensions, given the detrimental impact this can have on children's mental health. The evidence shows some positive changes in children's mental health from the RPC programme.

More evidence needed:

- There is guidance on Mental Health First Aid (MHFA) training to help individuals recognise risks for poor mental health – however, the evidence of effectiveness is limited
- Further evidence is needed about which interventions are most effective for bullying, and whether their impact is sustained over the long-term.

10Working age adults

10.1 Introduction

The working age population is defined as those aged 18 to 64. Some information cannot be broken down into working age (18 to 64) and older people (65+) so is relevant for all adults.

Working age is often a time where people experience maximum independence and control over their life. Some of the common markers of adulthood include:[167]

- Starting full time work
- Moving out of the parental home
- Having a baby
- Moving in with a partner
- Buying a house
- Getting married
- Becoming a carer.

Each of these changes has potential mental health and wellbeing risk and protective elements. As highlighted in the section on children and young people, young adulthood from aged 16 to 24 is seen as a time of very great risk and transition.

In this life stage adults can have strong influence on the mental wellbeing of others through their various roles as partner, co-worker, parent and carer.

10.2Risk and protective factors

Many of the risk and protective factors for working age adults are similar as for other life stages. However, for working age adults, low educational attainment, material disadvantage and unemployment are particularly strong factors affecting mental health and wellbeing. Work, or lack of it, matters greatly as well as the quality of the working environment. People in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression. Cost-effective interventions exist to promote and protect employee mental health.

Many people become parents and the quality of relationships in the home with partners, if present, and children has a very strong influence on parents' mental health. Family relationships matter to adults as well as children. Being in a stable relationship is more strongly associated with both physical and mental health benefits.

Many adults take on the role of caring for a partner, spouse or family member who is ill or has a disability. This can have a negative impact on their mental wellbeing, due to feeling increasingly isolated and unsupported.

Access to community resources, such as friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and

discrimination, all impact on adult mental health. The neighbourhood environment is an important factor in the health and functioning of adults.

The Section on Common risk and protective factors summarises key risk and protective factors for Brighton & Hove

10.3 Level of need in Brighton & Hove

The earlier section on prevalence sets out the estimates for mental health conditions for adults based on the England Adult Psychiatric Morbidity Survey.

The Office for Health Improvement and Disparities (previously Public Health England) produces estimates for local authorities which take account of the different demographics of the population. It is estimated that there are over 46,000 adults (19%) in Brighton & Hove with a common mental health disorder, this is almost 10% higher than the estimates based on the England survey prevalence (42,000, 17%). The numbers of people with mental health conditions in the city could increase by over 2,400 people to over 48,400 by 2030, based upon expected population growth.

Brighton & Hove has higher prevalence across most of the indicators for mental health issues (See Table 21) available at local authority level, including:

- High anxiety score (8th highest upper tier local authority in England)
- A lower proportion of the population who feel that the things they do in life are worthwhile
- Depression and anxiety according to the GP patient survey
- Depression and anxiety among social care users
- Estimated new incidents of psychosis
- Severe mental illness diagnosis in Primary Care (12th highest upper tier local authority in England)
- Employment Support Allowance (ESA) claimants for mental and behavioural disorders
- Self-reported mental health problem in the GP Patient Survey (highest in England).

Need may be greater, where these indicators represent diagnosed mental health conditions, as individuals may not seek support or have a specific diagnosis.

Table 21: Estimated prevalence of mental health conditions, Brighton & Hove, CIPFA comparators and England, various dates

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Self-reported wellbeing						
People with a high anxiety score	2020/21	-		30.8%	24.2%	-

People with a low satisfaction score	2019/20	-		4.7%	4.7%	-
People with a low worthwhile score	2018/19	-		6.3%	3.6%	
People with a low happiness score	2020/21	-		10.2%	9.2%	
People reporting a mental health problem (GP Patient survey)	2021			17.1%	11.0%	
Common mental health disorders						
Estimated prevalence of common mental disorders: % of population aged 16+	2017	46,244		19.0%	16.9%	-
Depression: Recorded prevalence (18+ yrs)	2020/21	34,150	↑	12.5%	12.3%	12.4%
Depression: QOF incidence (18+) - new diagnosis	2020/21	4,609	→	1.7%	1.4%	1.5%
Depression and anxiety prevalence (GP patient survey): % 18+	2016/17	-		18.5%	13.7%	-
Depression and anxiety among social care users: % of social care users	2018/19	-		63.6%	50.5%	-
Severe mental illness						
New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64 yrs	2011	48		24.9	24.2	25.8
Mental health: QOF prevalence (all ages). Adults on Severe Mental Illness register	2020/21	4,201	→	1.29%	0.95%	0.98%
Mental health						
Employment Support Allowance (ESA) claimants for mental and behavioural disorders: rate per 1,000 working age population	2018	6,440		32.1%	27.3%	31.8%

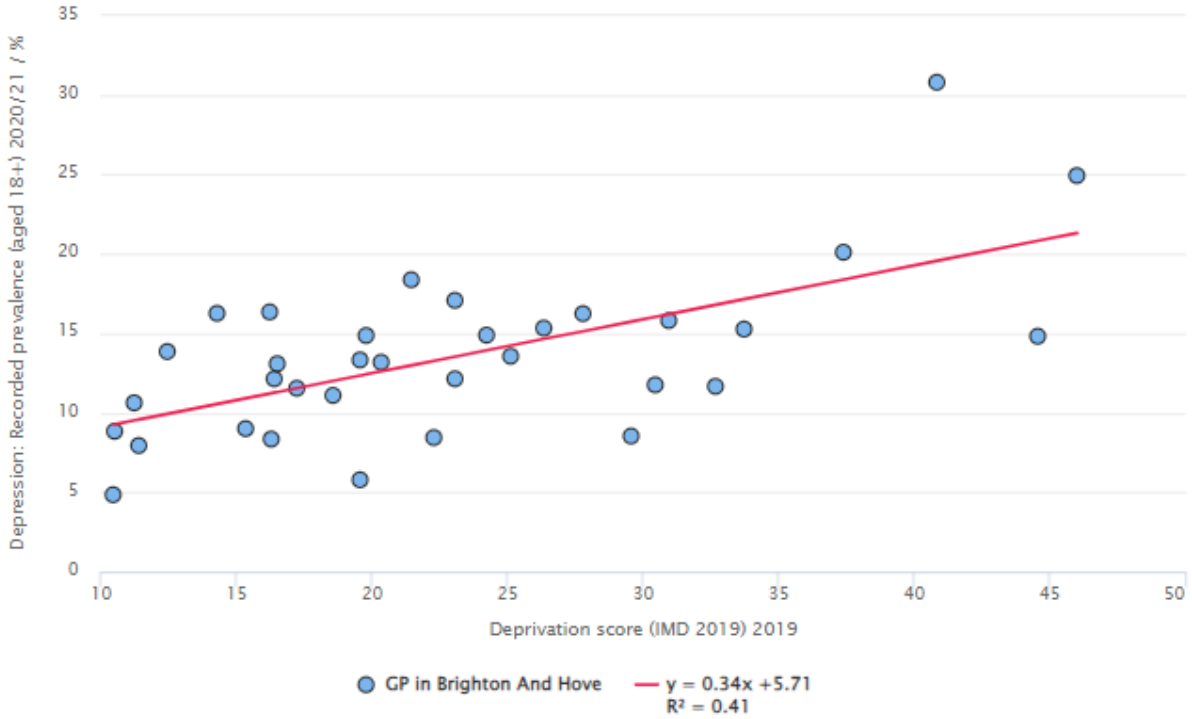
Source: Office for Health Improvement & Disparities. Mental health and Wellbeing JSNA. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

10.3.1Depression

There were 34,150 adults on GP practice registers for depression as of March 2021 (12.5% of adults compared with 12.3% for England), with 4,609 new diagnoses within the last year.

This varies considerably by GP practice, from 5% to 25% (aside from the specialist homeless GP practice Arch (31%) which has a different population profile). There is an association with deprivation, with practices having a higher level of deprivation tending to have more patients on depression registers (Figure 20).

Figure 20: Association between Index of Multiple Deprivation (IMD) 2019 and recorded depression prevalence (aged 18+) 2020/21, GP practices in Brighton & Hove



Source: Office for Health Improvement and Disparities. National GP Practice Profiles available at National General Practice Profiles - Data - OHID (phe.org.uk)

10.3.2 Severe mental illness

There were 4,201 adults on GP registers for severe mental illness, 1.3% of adult patients compared with 0.95% for England.

10.3.3 Mental health and physical health conditions

The relationship between physical and mental health is complex. There are high rates of mental health problems among people with long-term physical conditions. Almost half (46%) of people with a mental health problem have a long-term physical condition and almost one third (30%) of people with long-term physical conditions have a mental health problem.[168]

There is a two-way causal relationship; people with long-term physical condition are two to three times more likely to experience mental health problems than the general population.[169] The likelihood of having a mental health condition increases as the number of physical conditions increase. Co-existing physical and mental health problems can lead to:

- increased hospitalisation rates
- increased outpatient service use
- less effective self-management.

Physical and mental health problems should be supported in an integrated way across all aspects of the health system, from public health and prevention initiatives to the care provided by GPs, hospitals and the social care sector.[170] Cost-effective interventions which protect the mental health of people with long term conditions are available.[171]

The Brighton & Hove Adults with Multiple Long Term Conditions JSNA is available at B&H MLTCs JSNA 2018 full report FINAL.pdf (bhconnected.org.uk) (Summary available at B&H MLTC JSNA 2018 Exec Summary FINAL.pdf (bhconnected.org.uk)).

The needs assessment showed that in Brighton & Hove, in 2018:

- Just over 19,000 adults have both mental and physical health long-term conditions (8%)
- This increases to 35,000 (15%) if mild depression is included
- The likelihood of having a mental health condition increases with age and as the number of physical health conditions increases and is much greater in people living in more deprived areas
- The majority (63%) of adults with multiple long-term conditions under 65 have a recorded mental health condition and / or recorded substance misuse (alcohol or drugs misuse). However, in adults aged 65 or over, the majority (77%) do not.

10.3.4 Contact with secondary mental health services

See earlier section

10.3.5 Inequalities

This section presents local needs based on the Health Counts survey (of 2000 adults aged 18+ living in the city), the Count me in Too survey (of LGBT people in Brighton and Hove) some service data and recent local needs assessments. Local routine data was limited, and this is a potential gap in our understanding of population need. It would require further local work to gather and analyse local data where it is being collected.

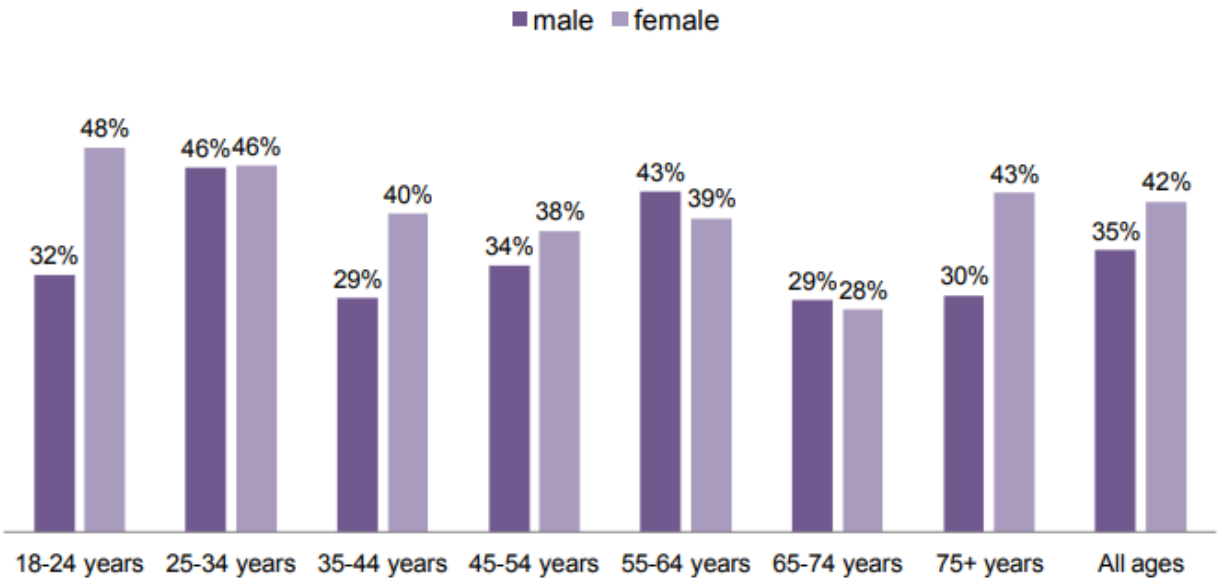
Risk of major depression

Every ten years, since 1992, there has been a Brighton & Hove health and wellbeing survey of adults aged 18+ called Health Counts. The most recent survey was undertaken in 2012[172] and found that 38% of respondents were at risk of major depression (screen for depression from the SF-36 validated tool). This proportion has

changed little over the last twenty years (surveys in 1992 and 2003). Using the latest ONS estimates and projections this would mean that in 2020, 91,700 adults in Brighton & Hove could be at risk of major depression rising to 96,700 by 2030.

Being at risk of major depression was significantly higher for females (42%) than males (36%), but there is no consistent pattern with age (Figure 21).

Figure 21: Risk of major depression (%) by age group and gender, Brighton & Hove, 2012



Source: Brighton & Hove Health Counts Survey 2012

There was a significant association between being at risk of major depression and deprivation. In 2012, in the most deprived quintile of deprivation, 51% of respondents are at risk of major depression, compared to 32% of the least deprived.

In line with national evidence, risk of major depression was higher for the following population groups (38% for all respondents):[173]

- LGB and unsure respondents (46%) are more likely to be at risk of major depression than heterosexuals (37%), though neither group is statistically significantly different to all respondents
- BME respondents (43%) are more likely to be at risk of major depression than White British respondents (37%), but again the difference to all respondents is not statistically significant
- Those who are married, in a civil partnership or living as a couple are significantly less likely to be at risk (31%) than all respondents, with those who were separated or divorced (51%) or single (48%) significantly more likely
- Those with a limiting long-term illness or disability are significantly more likely to be at risk of depression (57%) than all respondents
- Carers (42%) are more likely to be at risk of major depression than all respondents, but not significantly so

- Respondents with a religion other than Christian are statistically significantly more likely to be at risk of major depression (49%) than all respondents
- Those who rent from a private landlord (48%) and those who rent from a housing association or local authority (59%) are significantly more likely to be at risk of major depression. There is a significantly lower risk of major depression for those who own their own homes (29%)
- Respondents who are unemployed and looking for work, unable to work or are caring for home and family (67%) are significantly more likely to be at risk of major depression
- Respondents with a degree level qualification or higher are significantly less likely to be at major risk of depression (33%) than all respondents
- Students did not have a significantly different level of risk to all adults. However, students had a significantly lower feeling of belonging to their immediate neighbourhood (41%) than all survey respondents (58%).

Sexual orientation

Sexual orientation (Count me in Too (CMIT) 2006 and Health Counts 2012): Almost one in five CMIT respondents described their mental and emotional health as poor or very poor over the last year, and only one fifth of respondents had not experienced difficulties in the past five years. Almost a quarter of respondents say that they have had serious suicidal thoughts, with 7% attempting suicide in the past five years. In the Health Counts survey 2012, LGB respondents and respondents unsure of their sexual identity (20%) were more likely to say that they had ever self-harmed than heterosexuals (9%), this was highest for lesbian/gay women (39%) and bisexuals (41%).

Trans

As part of the Trans needs assessment 2015, a trans community survey found high levels of mental health need (including stress, depression, self-harm, suicidal ideation), which participants related to gender dysphoria but more commonly to factors such as discrimination and NHS treatment delays.

10.4Voice of working age adults

The views of adults presented in this section come primarily from a review of recent Brighton & Hove JSNAs (See Appendix 1). Many of the city's JSNAs undertook consultation and engagement with communities and some of the views were about mental health and wellbeing support.

One of the recommendations of the Five Year Forward View for Mental Health is 'to develop evidence-based approaches to co-production in commissioning.' Co-production is defined by the National Collaborating Centre for Mental Health as "an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them".

There was some routine involvement of people with lived experience and commissioners report that co-production is growing, for some services there are no routine engagement opportunities. Service users and their parents and carers said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services.

Common issues highlighted through the review of recent JSNAs, about services include the need for:

- More accessible support and services, and support promoted more widely - using different promotion routes and increasing awareness of support services available amongst primary care and other general access services
- Simplify referral processes, including for self-referral
- Consider all needs, not just mental health (thresholds often on single issues) for example dual diagnosis
- More joined up services, working better together. Better information sharing between services, especially between primary care and specialist services
- When asked for their views, adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more support for the development of peer support (see Children and young people voice section for more on co-production)
- Taking a more trauma informed approach. More mental health awareness and suicide prevention training across NHS frontline services
- Waiting times reduced. More support for those on waiting lists or who do not meet service thresholds
- Higher levels of support/ more accessible support for those who have come out of in-patient facilities
- More support to families and carers and within schools.

Below is a summary of views expressed in specific JSNAs or studies:

The International migrants needs assessment 2018

Mental health is widely described as the most important health problem for migrant populations, particularly asylum seekers and refugees. The need to manage issues linked to immigration status may further impact on mental health. Migrants may not necessarily understand the concept of mental ill health as being something they were experiencing, or it may be difficult to talk about. Language and cultural barriers and stigma mean that it may be difficult to communicate feelings and ‘open up’ in counselling sessions. The needs assessment found that there is insufficient specialist mental health support to meet the needs of migrants, especially asylum seekers and refugees. Limits to the number of sessions for mental health treatment were felt to be insufficient to meet the level of need of some patients.

A qualitative study of BME mental health and wellbeing in Brighton & Hove (2012)

with the University of Brighton found the following identified obstacles to maintaining good mental health in Brighton & Hove: experience of racism; poverty; poor education;

and acculturation difficulties. 81% of respondents in this study reported experiencing barriers to getting help, most commonly stigma, which was particularly prevalent amongst less acculturated members of BME communities.[174]

Trans needs assessment 2015

As part of the needs assessment, some community research participants described negative experiences of NHS mental health services. Many found community and voluntary sector services more supportive but were aware of their limitations. The most frequently suggested action for improving healthcare for people who are trans was an increase in training.

Adults with multiple long-term conditions (MLTCs) needs assessment 2018

Within the needs assessment those with MLTCs and professionals working with them identified the following key issues: Links between mental and physical health services and more joined up care and care coordination is needed for those with mental illness for their physical conditions; Focus on the person rather than single conditions; More focus on mental health for those with physical health conditions and training / education.

JSNA for adults with multiple complex needs 2020

The needs assessment looked at people with two or more of: mental health needs; homelessness; substance misuse; domestic violence or; offending. Key issues identified by individuals with MCNs and professionals working with them included: Can't access services due to other complex needs i.e. drugs and alcohol use; Long waits for referrals; Lack of staff with skills in dual diagnosis; Mental health eligibility thresholds make it hard for clients with multiple complex needs to access services; More outreach support needed; Information sharing; Siloed working and service coordination; Insufficient housing options (mental health and housing needs are not aligned). It was felt many crises could be de-escalated with a more trauma informed approach.

Switchboard, NHS, impact of COVID-19 on LGBTQ communities of Brighton & Hove, Brighton & Hove City Council

Findings showed that 74% of the respondents felt depressed with 68% of 18–24-year-olds and 41% of people of colour considering suicide. 68% of LGBTQ people felt lonely or isolated as a result of the impacts of pandemic. LGBTQ people said they could not access support when they needed it. Some trans and non-binary respondents had enjoyed not having to navigate spaces where they felt uncomfortable or unsafe because of their identities.

10.5 Quality and outcomes

Here we consider key outcome measures for mental health in Brighton & Hove compared to England.

Brighton & Hove has greater Disability Adjusted Life Years (Burden of disease) due to mental health than England.

Brighton & Hove has significantly worse rates than England of:

- Premature mortality of adults with severe mental illness (in contact with mental health services in the last five years)
- Detentions under the Mental Health Act 1983
- Emergency hospital admissions for self-harm

Suicide and undetermined injury deaths:

- Brighton & Hove has had one of the highest rates of suicide in England, with rates significantly higher than England for several years. Our rates remain higher than for England in both men and women.

Brighton & Hove has significantly better rates than England of:

- Adults in contact with secondary mental health services who live in stable and appropriate accommodation
- Employment of people with mental illness or learning disability.

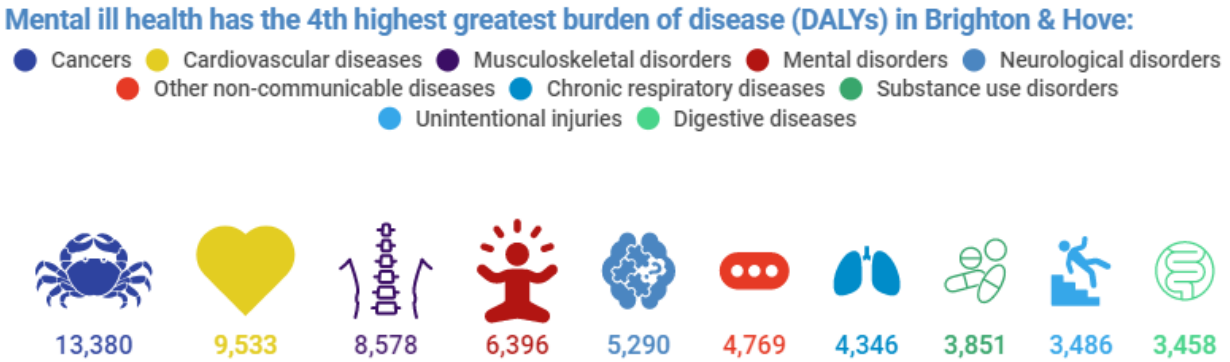
Appendix 8 provides a summary of these outcome measures, and they are considered further below.

10.5.1Disability Adjusted Life Years (Burden of disease)

Brighton & Hove has the greatest disability adjusted life years due to mental health ill health of any local authority in the South East, for both males and females.

Disability-adjusted life years (DALYs) are a measure of disease burden (see Box 4). In Brighton & Hove, mental ill health contributes 8.3% of disability-adjusted life years, greater than both the South East and England (7.4% and 7.3% respectively) (Figure 22). Mental Ill health has the 4th highest burden of disease. The contribution of mental disorders to the overall burden has grown across both the South East and England but has grown at a greater rate in Brighton & Hove.[175]

Figure 22: Global burden of disease: Leading causes of DALYs, Brighton & Hove, 2019



Source: Institute for Health Metrics and Evaluation. Global Burden of Disease 2019 Available at Global Burden of Disease Visualisations: Compare (thelancet.com)

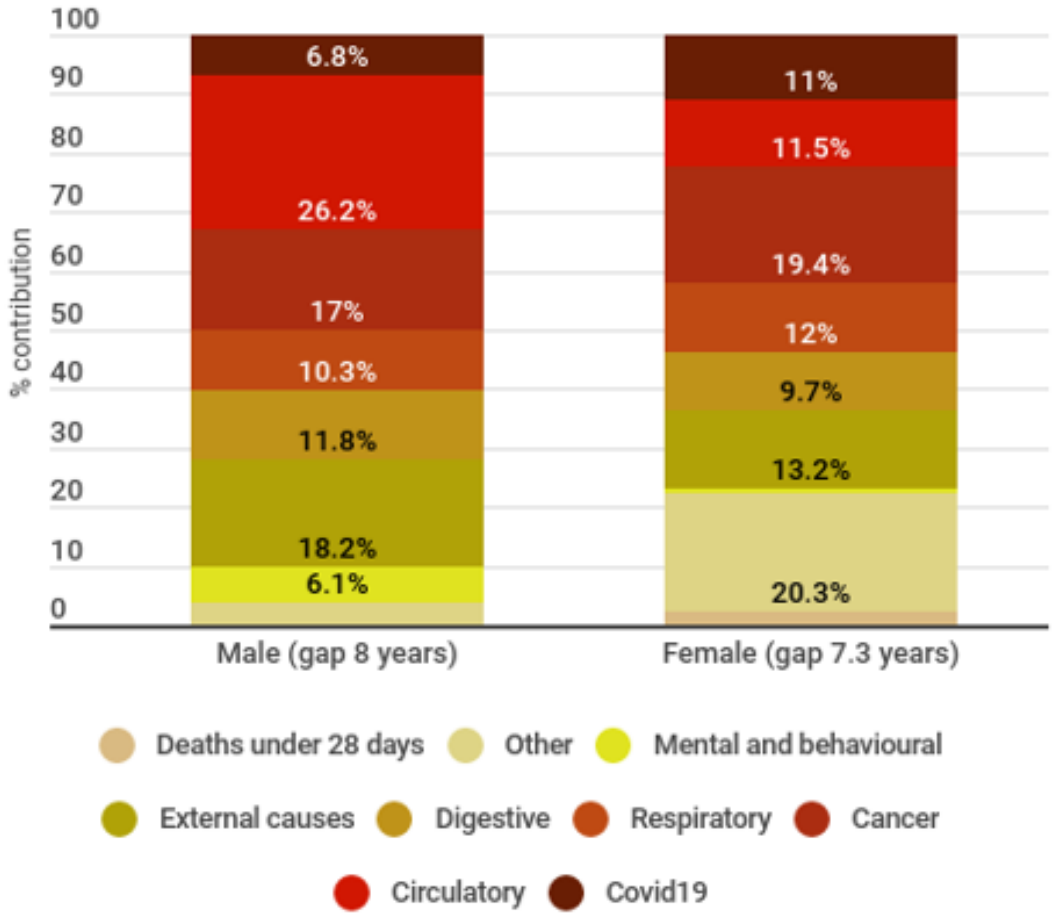
Box 4: Disability adjusted life years

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not cause death but do cause disability (such as cataract causing blindness).

10.5.2 Life expectancy inequality gap

Mental and behavioural conditions contribute 6.1% to the life expectancy gap in the city for males and 0.8% for females, compared with 3.8% and 6.1% respectively for England (Figure 23). However, external causes which includes suicide and undetermined injury deaths but also include deaths from poisoning and injury, contribute another 18.2% to the life expectancy gap for males and 13.2% for females in Brighton & Hove, compared to 10.3% and 5.4% respectively for England.[176]

Figure 23: Breakdown of causes contributing to the life expectancy gap between the most and least deprived quintiles of Brighton & Hove by cause of death, 2020 to 2021 (Provisional)



Source: Office for Health Improvement and Disparities based on ONS death registration data (provisional for 2021) and 2020 mid year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019
Footnote: Data are provisional. Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease. Percentages may not sum to 100 due to rounding.

10.5.3 Premature mortality in those with severe mental illness (SMI)

People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Compared with the general patient population, patients with SMI are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with SMI make more use of secondary urgent and emergency care, and experience higher premature mortality rates.[177]

Between 2018 and 2020, 610 people in Brighton & Hove died aged 18-74 years who had had a referral to mental health services in the preceding five years. To compare to other area, a directly age standardised rate of deaths of adults, aged 18 - 74, with SMI, per 100,000 population is calculated.[178]

Brighton & Hove has a significantly higher rate of premature death of those referred to mental health services in the preceding five years (120 per 100,000 people aged 18-74 years) than England (104 per 100,000). In the city adults with SMI can be considered to have 434% higher risk of premature mortality than adults without SMI, compared to a 390% higher risk across England.

The rate in the city is significantly higher for males (150 per 100,000) than for females (91 per 100,000), for England the figures are 124 and 84 per 100,000, respectively. Whilst we do not have a comparison within Brighton & Hove, for England rates are highest for those living in the most deprived areas.

10.5.4 Detentions under the Mental Health Act 1983

In 2020/21, 375 people in Brighton & Hove were detained under the Mental Health Act 1983. This is a crude rate of 128.9 per 100,000 population, higher than the rate for England (94.6 per 100,000) and 16th highest of 135 CCGs in England. This was similar to the rate in 2019/20.[179]

The breakdown of these detentions is not available by CCG, but across England:

- Known detention rates were higher for males (94.8 per 100,000 population) than females (87.9 per 100,000 population)
- Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (142.5 detentions per 100,000 population) were around 56% higher than for those aged 65+ (91.6 per 100,000 population)

- Amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group (343.5 detentions per 100,000 population) were over four times those of the White group (74.7 per 100,000 population).

10.5.5 Self-harm

Self-harm rates for working age adults in Brighton & Hove is higher than for England. Evidence for this comes from estimates of DALYs, the Health Counts survey and hospital admissions.

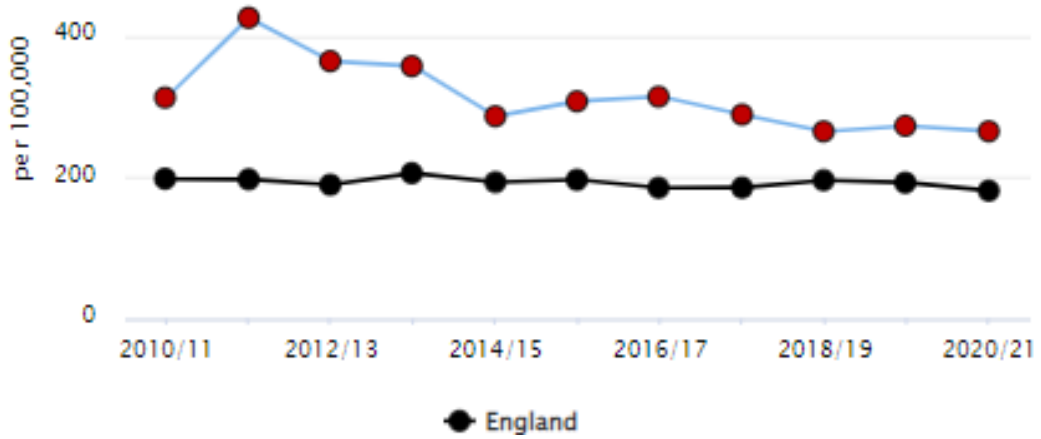
DALYs: Self-harm contributes 1.9% to Brighton & Hove's total disability adjusted life years, higher than South East (1.1%) and England (1.2%) (Figure Y). Whilst across the South East, the contribution of self-harm to the overall burden of disease has reduced, in Brighton & Hove it has increased. For self-harm, Brighton & Hove is the highest for all people, and for females but is ranked 2nd behind Southampton for males.

The 2012 Health Counts survey found that:

- One in ten respondents said that they had ever deliberately self-harmed, but not with the intention of killing themselves
- Self-harm was significantly higher in females (13%) than males (8%)
- There was a significant association with age – from 19% of 18–24-year-olds to 2% of 75+ year olds
- Self-harm has a significant association with deprivation, increasing in each quintile of deprivation: 14% of those living in the most deprived 20% of areas in the City said that they have ever self-harmed compared to 6% of those living in the least deprived 20% of areas
- LGB respondents and those unsure of their sexual orientation (20%) were more likely to say that they had ever self-harmed than heterosexuals (9%), and statistically significantly more likely than all respondents to have self-harmed. The highest percentages were for lesbian/gay women (39%) and bisexuals (41%). The figure for gay men is 9%
- Those who are single were significantly more likely to have self-harmed (17%) than all respondents
- There was little difference between BAME (10%) and White British respondents.

Whilst there has been a reduction in emergency hospital admissions for intentional self-harm for Brighton & Hove, in 2020/21 there were 900 admissions of residents of Brighton & Hove. This is a rate of 265 per 100,000 population (directly age standardised to allow comparison) and remains significantly higher than England (181 per 100,000) (Figure 24).

Figure 24: Emergency hospital admissions for intentional self-harm, directly age standardised rate per 100,000, Brighton & Hove and England, 2010/11-2020/21



Source: Office for Health Improvement and Disparities Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

In most wards in the city, admissions to hospital for self-harm are significantly higher than England (Figure 25). They are highest in two of the most deprived wards, East Brighton & Queens Park and there is a relationship with deprivation (Figures 25 & 26).

Figure 25: Hospital admissions for self-harm, indirectly age-standardised rate (England = 100), Brighton & Hove wards, 2015/16 to 2019/20

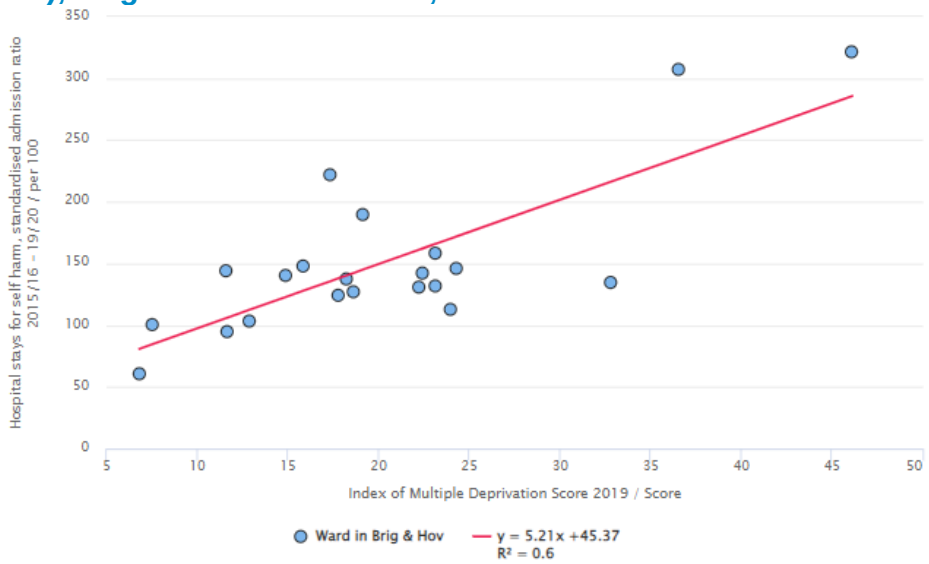
Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Areas: All in Brighton and Hove | Display: Table | Table and chart

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	100.0	99.7	100.3
Brighton and Hove	-	149.5	145.3	153.9
East Brighton	-	321.4	292.7	352.1
Queen's Park	-	307.4	282.3	334.1
Westbourne	-	222.2	193.7	253.7
Central Hove	-	189.6	163.3	219.0
South Portslade	-	158.2	133.8	185.8
Goldsmid	-	147.6	129.6	167.3
Hangleton and Knoll	-	145.6	126.5	166.9
Rottingdean Coastal	-	144.6	124.7	166.9
North Portslade	-	142.4	119.5	168.3
Wish	-	140.2	117.1	166.6
Woodingdean	-	137.5	114.3	164.0
Moulsecoomb and Bevendean	-	134.9	121.3	149.7
Regency	-	131.7	113.5	151.9
St. Peter's and North Laine	-	131.3	117.9	145.7
Hanover and Elm Grove	-	126.9	112.8	142.4
Brunswick and Adelaide	-	124.0	105.5	144.7
Hollingdean and Stanmer	-	112.7	100.2	126.5
Patcham	-	103.5	87.1	122.1
Withdean	-	100.8	85.3	118.2
Preston Park	-	94.9	80.6	111.1
Hove Park	-	60.7	46.4	78.0

Source: Office for Health Improvement and Disparities. Local Health https://fingertips.phe.org.uk/profile/local-health

Figure 26: Association between hospital admissions for self-harm, indirectly age-standardised rate (England = 100), and Index of Multiple Deprivation Score (IMD 2019), Brighton & Hove wards, 2015/16 to 2019/20

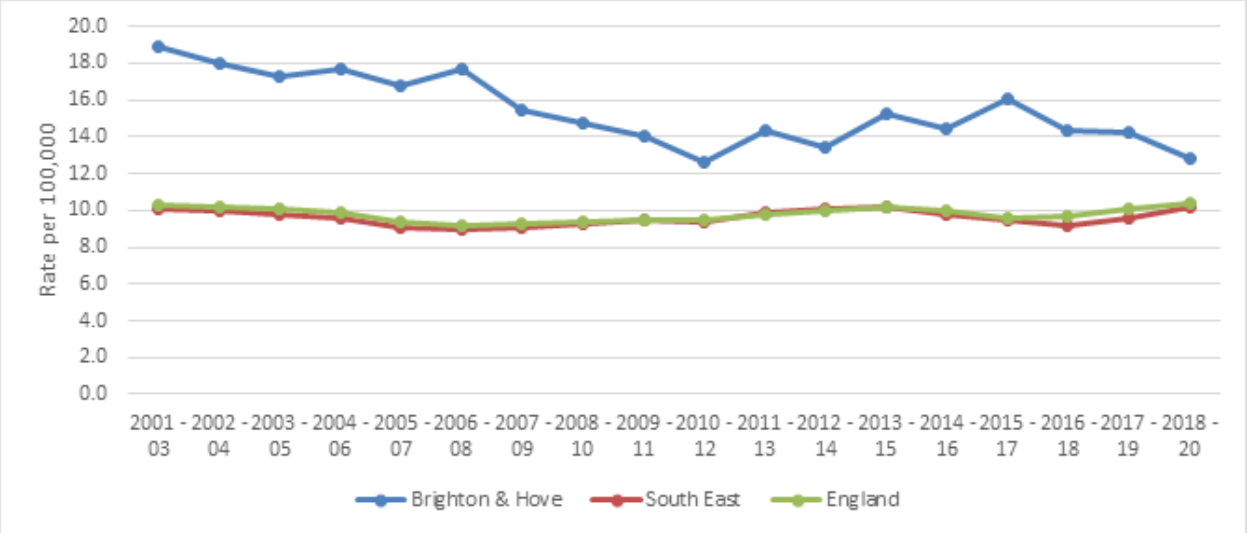


Source: Office for Health Improvement and Disparities. Local Health https://fingertips.phe.org.uk/profile/local-health

10.5.6 Suicide and undetermined injury deaths

Historically, Brighton & Hove has had one of the highest rates of suicide in England, with rates significantly higher than England for several years. However, this is no longer the case: for the most recent period (2018-2020) there was no statistically significant difference between Brighton & Hove and England (Figure 27).

Figure 27: Suicide and undetermined injury deaths: rate per 100,000 population for Brighton & Hove, South East and England, 2001-03 to 2018-2020



Source: Office for Health Improvement and Disparities. Public Health Profiles **Public health profiles - OHID (phe.org.uk)**

Nationally, there is approximately a 10-fold increase in risk of suicide for people under secondary mental health care,[180] however the majority of deaths by suicide are in those

who are not using secondary mental health services. Nearly three quarters of suicides occur in the non-mental-health patient population.[181]

There were 34 deaths per year (on average) in the last three years, 2018 to 2020 and Brighton & Hove remains in the 25 upper tier or unitary local authorities with the highest suicide rates.

As is seen nationally, the majority of deaths continue to be amongst males (2018-20, 69%), although the male suicide rate is no longer significantly higher than England. We have however seen an increase in deaths amongst females from 2013 onwards. The rate in females locally (7.8 per 100,000) is significantly higher than England (5 per 100,000) and the highest rate in the South East.

The age distribution of suicide deaths in Brighton & Hove is similar to England. Whilst the most common age-group was 40 to 54 years (34%), similar to England, almost 1 in 10 (9%) were children and young people aged 10 to 24 years. The age distribution of male deaths is younger than that of females, both in Brighton & Hove and England.

Around three quarters of Brighton & Hove residents who died from suicide or undetermined injury had a mental health diagnosis although they were not necessarily in contact with mental health services. Around one in five of suicide deaths were also recorded as drug related deaths. Over a quarter had been in contact with a support service within a week of their death. Other factors included physical health conditions, drugs and alcohol, relationship breakdown, bereavement, financial difficulties, debt, unemployment or job insecurity, homelessness and housing difficulties.

10.5.7 Employment

It was estimated that in 2018 (Quarter 4) that 63% of those with mental illness or learning disability[a] are in employment in Brighton & Hove compared to 48% for England.

However, the estimated percentage point gap in the employment rate of those in contact with secondary mental health services, and the overall employment rate is 67 percentage points for Brighton & Hove (77 for England).

10.6 What we know about the local working age adults mental health community offer

There are a wide range of community services available for across Brighton & Hove which are commissioned either by health, or jointly with the Local Authority. In addition, there are local charity and national services which can be accessed. Core commissioned services include:

[a] This is based upon data from the Labour Force Survey who report that they have a mental illness and are in employment as a percentage of all respondents who report that they have a mental illness. The definition of "mental illness" used is survey respondents who report having depression, bad nerves or anxiety, severe or specific learning difficulties (mental handicap), mental illness, or suffer from phobia, panics or other nervous disorders.

10.6.1Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

10.6.2 UOK (formerly Community Roots)

UOK is a network of local community-based services working together to support good mental health and wellbeing in Brighton & Hove. The network brings together 16 separate organisations to strengthen, develop and integrate mental health support for different levels of need. The lead provider is Southdown. Service offers include:

- Central Access Point
- Preston Park Wellbeing Centre
- Recovery College
- Lighthouse Personality Disorder Service (non-clinical element of service)
- Employment Support services
- Staying Well (crisis café)
- Screen & Intervene
- Mental Health Promotion Specialist
- Mental Health Support Coordinators in primary care and secondary care
- Mental Health Awareness and Suicide Prevention training
- Bereavement support (including suicide bereavement)
- Debt and welfare benefit advice
- Specialist psychosocial support for communities; people with Asperger's Syndrome and high functioning Autism, men, women, LGBTQ community, ethnically & culturally diverse communities, offenders & ex-offenders, Gypsy, Traveller and Roma communities.

10.6.3 Brighton & Hove Wellbeing Service (Primary Care Mental Health Service)

The Brighton & Hove Wellbeing Service is delivered in partnership by Sussex Partnership Foundation Trust, YMCA Dialogue and Brighton & Hove Mind.

They offer a variety of support and NICE compliant psychological therapies for Adults with mild to moderate mental health needs. Service offers include:

- Improved Access to Psychological Therapy (IAPT)
- Adult Wellbeing - Primary Care Mental Health Practitioner support
- Employment Support
- Wellbeing College courses.

10.6.4 Primary Care Network Mental Health Teams (Emotional Wellbeing Service)

Mental Health Practitioners and Mental Health Support Coordinators (part of UOK) embedded into Primary Care Networks (PCNs)[b] delivering triage, assessment and support for mental health needs within general practice. New initiative as part of the developing Emotional Wellbeing Service, currently in place in three of the six PCNs within Brighton & Hove (North and Central Brighton, East and Central Brighton, West Hove). Provided by Sussex Partnership NHS Foundation Trust and Southdown Housing Association.

10.6.5 The Community Transformation Programme

The Community Transformation Programme aims to develop integrated care that connects clinical mental health services with support offers that address wider determinants of mental health. Services will be developed at a neighbourhood level of a Primary Care Network (PCN) population. The first step towards developing this vision has been to develop embryonic teams in three PCN Accelerator sites.

10.6.6 Specialist Mental Health Services

Specialist mental health services (secondary mental health care) in Brighton & Hove are provided by Sussex Partnership Foundation Trust. The independent sector also provides inpatient care when SPFT inpatient units have reached capacity and for more specialised inpatient care. Table 22 gives a brief overview of the community services provided.

Table 22: Specialist Mental Health Services provided by Sussex Partnership Foundation Trust

Service	Description of the service
Assertive Outreach	People who have used mental health services before and may have a higher risk of being admitted to mental health hospital more frequently. The services works with individuals to create a care plan that allows them to feel supported in their community.
Adult Community Mental Health – Assessment and Treatment Services (ATS)	Specialist mental health assessment, treatment and care that provides specialist assessment and support to people who have more complex mental health needs than cannot be supported by their GP or the Wellbeing Service alone.
Eating Disorders	Specialist assessment and treatment service for adults with an eating disorder.

[b] PCNs are made up from groups of neighbouring general practices. Funding for PCNs means that they can deliver services to patients across the member practices.

Mental Health Homeless Team (MHHT)	The MHHT provides support to people with coexisting severe mental illness and substance misuse. This includes multiple needs (including physical health problems, homelessness or unstable housing). The service supports clients directly through outreach and in-reach sessions on the streets, day centres and emergency/temporary accommodation as well as referrals.
Neurodevelopmental	Diagnostic assessments of neurodevelopmental conditions. This includes autism spectrum conditions, ADHD and Tourette's Syndrome.
The Lighthouse – provided in partnership with Southdown and Brighton & Hove Mind	The Lighthouse is a specialist service for people over the age of 18, living in Brighton & Hove who are experiencing Personality Disorder and Emotional Intensity.
Early Intervention in Psychosis	Early intervention community-based support to people who are experiencing their first episode of psychosis.
Rehabilitation	The Community Rehabilitation Team provides high quality, safe and effective rehabilitation for adults with psychosis and complex mental disorder within Brighton and Hove. The team works collaboratively with service users to deliver personalised rehabilitation in their local area to: • Support a personally meaningful recovery • Improve subjective quality of life • Enable social inclusion and participation in the wider community to achieve personal recovery goals.
SMILES	Clinical Nurse Liaison Service provided by Sussex Partnership NHS Foundation Trust. The team provides step down care from secondary care (ATS) to primary care (GP). The service includes supporting primary care in the delivery of annual physical health checks for those with Serious Mental Illness who are known to secondary care.
Urgent and Crisis Care	
Mental Health Rapid Response Service (MHRRS)	Urgent response service for people when they feel they are in a mental health crisis and are at immediate risk of harming themselves or others.
Crisis Resolution and Home Treatment Team (CRHT)	Designed to provide safe and effective care in your own home if you experience a mental health crisis and would otherwise need to be admitted to hospital.

Psychiatric Liaison	Psychiatric liaison services provide mental health assessment and treatment for people who are inpatients in general hospitals or for those who may go to an A&E department and are in need of a mental health assessment.
The Haven	The Haven at Mill View is a dedicated, mental health crisis assessment facility

10.6.7 Complex Trauma Pathway

The Brighton & Hove Complex Trauma pathway is an integrated pathway, providing support to those who have who have been a victim of a (recent or historical), sexual or domestic violence incident.

A range of therapeutic interventions are delivered to those who present with trauma reactions and trauma related symptoms and experiences, including PTSD and complex PTSD. The pathway is a partnership approach streamlining provision between SPFT and community and voluntary sector partners. SPFT has overall clinical leadership for the pathway. Services are provided by:

- Sussex Partnership NHS Foundation Trust (SPFT)
- Survivors' Network (sexual violence)
- Mankind (sexual violence) and
- RISE (domestic violence and abuse).

The pathway is currently being reviewed which will inform the re-procurement of the pathway in Autumn 2022.

There are very long wait lists in Brighton & Hove for the complex trauma pathway, these waiting lists are now growing to nearly three years. There is insufficient capacity to meet demand and the pathway does not provide a service to all sections of the Brighton & Hove population that have experienced complex trauma. The pathway is currently being reviewed to address this.

Inpatient services are provided by Sussex Partnership Foundation Trust.

10.6.8 Trauma Informed Care (TIC)

The evidence on the impacts of trauma, including adverse childhood experiences (ACEs), on mental health is set out in the Children and young people section of the report. The impact of trauma is increasingly being recognised, along with the benefits of taking a trauma informed approach to care and practice. It can help improve patient engagement, treatment adherence and health outcomes, as well as provider and staff wellness. Trauma informed care can help reduce burnout among health and social care providers, potentially reducing staff turnover.

The Brighton & Hove JSNA for adults with multiple complex needs recommended that services should practice a trauma informed approach. Training staff in a trauma

informed approach is an effective way of supporting adults with trauma as a result of ACEs. It builds knowledge and awareness about the consequences of ACEs amongst professionals; as well as collaborative approaches across sectors and organisations. Staff across a wide range of agencies should be supported to understand the impact people's Adverse Childhood Experiences and adverse adult experiences can have on behaviours, health and wellbeing and enable staff to respond appropriately. This will require training at all levels across all services to develop a shared learning and understanding of the local approach to trauma.

Sussex Health and Care Partnership are implementing a Trauma Informed Care (TIC) programme across Sussex. Trauma Informed care seeks to:

- **Realise** the widespread impact of trauma and understand paths for recovery
- **Recognise** the signs and symptoms of trauma in patients, families and staff
- **Respond** through integrate knowledge about trauma into policies, procedures and practices and
- Actively avoid **Re-traumatisation**.

Trauma informed services are also **Reflective** in their practice, which involves curiosity about ourselves in the work we do. With a fundamental focus on **Relationships** at the heart of our work. The five key principles of trauma informed care are trustworthiness, safety (psychological and physical), choice, collaboration and empowerment.

Training on trauma informed reflective practice has been provided to a number of organisations across the city. There is a small team in place to allow more effective sharing of learning and development of initiatives.

Whilst good progress is being made, there is potential to widen the training offer across the city.

10.6.9 Mental Health Supported Accommodation and short stay accommodation

NHS Sussex (Brighton and Hove) (previously Brighton & Hove CCG) and Brighton & Hove City Council jointly commission supported accommodation to adults (18+) for individuals with support needs around mental health. The pathway consists of high support, medium support and low support. Discharge to Assess provision is also commissioned providing a short-term package of tailored support and accommodation to people ready to leave mental health inpatient settings.

Mental Health Supported Accommodation, Discharge to Assess provision has recently been reprocured and the new contracts will begin in Autumn 2022. As part of the procurement a new seven bed Crisis House for people needing short stay accommodation was procured. The Crisis House will provide a short term (average length will be seven days), non-medical and caring space for people to prevent an escalation of mental health crisis.

10.6.10 Suicide prevention

There are multiple actions taken by the city to reduce deaths by suicide and to reduce rates of self-harm. The local strategic suicide and self-harm prevention group steers our local response and is working on priorities that include:

- Strengthening and improving our response to deaths and possible clusters and our Sussex and city wide surveillance.
- Increasing uptake of suicide prevention training, tailored to different workforces, to improve the skills of confidence of our wider workforce
- Expanding our whole schools approaches to suicide and self-harm prevention
- Wider promotion of information and national and local resources
- Collaboration with partners across Sussex on developing pan-Sussex approaches.

In 2023, there will be a Sussex suicide and self-harm strategy and a new city wide action plan. The Brighton and Hove plan will align strategic intentions and actions with those held at Sussex level and be based on the seven national priority areas.[182]

10.7 Opportunities to learn more

A number of programmes are already underway to transform the way people access and receive mental health support. Integral to this work is understanding the experience of people with mental health issues. There will be opportunities through:

- The Adult Community Mental Health Transformation Programme –NHS England » The community mental health framework for adults and older adults - this is a three year programme from March 2021 to March 2024 and is central to the plans to develop services for this age group. The programme vision is: A new community-based offer that will include access to psychological therapies; improved physical health care; employment support; personalised and trauma-informed care; medicines management and support for self-harm and coexisting substance use; and proactive work to address inequalities based around neighbourhood populations
- Mental Health Supported Accommodation and Hospital Discharge Pathway procurement
- Review and re procurement of the complex trauma pathway
- Sussex wide report to review and optimise the housing-based services that support patients to be safely discharged from hospital or provide an alternative to admission to mental health hospitals
- Supplementary Substance Misuse Grant for Treatment and Recovery – a three year programme of service development as part of the 10 year national drug strategy (Public Health)
- Drug Strategy for Brighton and Hove – under development.
- Changing Futures - a pan Sussex system change programme focusing on improving the system for people experiencing multiple disadvantage. It is funded by Department for Levelling Up, Housing and Communities (DLUHC) until March 2024

- Improving the percentage of annual health checks carried out for people living with Severe Mental Illness as part of the national Core20plus5 approach to reducing health inequalities
- The Brighton & Hove Common Ambition project will work with people with lived experience of homelessness, frontline providers and commissioners to develop a new approach to co-production within homeless health services, in order to improve health services and outcomes for people experiencing homelessness in Brighton & Hove
- Brighton & Hove Health Counts survey of adults planned for 2023. It will give valuable information on the emotional and mental health of the adult population and include questions on protected characteristics and other vulnerable groups.
- Review of the crisis pathway
- Neurodevelopmental pathway work, including tackling the challenges around undiagnosed neurodivergence.

10.8What works for prevention

See Prevention section for more on how these were identified.

Box 5: What works for prevention: workplace based interventions

Workplace-based interventions to reduce employee mental health issues, increase wellbeing and promote recovery from mental ill-health is an intervention area 'with the strongest evidence base'.

Guidance on the workplace and mental health:

- NICE (2022) guidance on mental wellbeing at work; the Public Health England (PHE) Healthy Workplace Charter; The Public Health England Local Healthy Workplace Accreditation Guidance; and the Workplace Wellbeing Charter all offer guidance to promote mental health in the workplace
- Support local organisations to help employ people with mental health challenges through the Individual Placement and Support (IPS) scheme, and support those currently facing mental health issues at work through programmes such as Access to Work
- Look for opportunities to work in partnership with local business leaders and employers to apply a whole workplace approach (to protect and improve mental health at the individual, collective and organisational levels).

Prevention of mental illness and promotion of good mental health or wellbeing among those of working age:

The government commissioned 'Thriving at Work' review created six 'mental health core standards' to be implemented in all organisations.

- Produce, implement and communicate a mental health at work plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available when employees are struggling
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development

- Promote effective people management through line managers and supervisors
- Routinely monitor employee mental health and wellbeing.

The ‘Thriving at Work’ reviews also identified four more ambitious ‘enhanced’ standards for employers, to:

- Increase transparency and accountability through internal and external reporting
- Demonstrate accountability
- Improve the disclosure process
- Ensure provision of tailored in-house mental health support and signposting to clinical help.

Reviews indicate that effective workplace-based policies to promote mental wellbeing and prevent mental health issues include:

- Workplace resources which can improve employee wellbeing and organisational performance
- Increasing employee control via flexible working
- Workplace-based physical activity promotion
- Mindfulness and yoga
- To cope with work pressures, preventative mental health measures include the resources of autonomy, strong work relationships, opportunities for advancement, coaching and mentoring, and learning and development
- Additional measures targeted at wellbeing at work can include access to gyms, exercise and sports opportunities and changes to food options
- Explicitly address stigma and discrimination, guided by approaches developed in national programmes such as Time to Change (to help open up discussions around mental health in the workplace)
- There is evidence showing the effectiveness of online interventions at work such as online mindfulness.

11 Older adults

11.1 Introduction

Older age is generally considered to be 65 years and above and this is the age considered within this section, unless otherwise specified.

Ageing presents both challenges and opportunities and intensifies the need for physical and social environments to be made more age friendly. Societies that adapt to this changing demographic and invest in healthy ageing can enable individuals to live both longer and healthier.[183]

The rate at which people age is influenced by the accumulation of lifelong experiences, and their past and present socio-economic circumstances. Ageing is often associated with life transitions such as retirement, relocation to more appropriate housing and the death of friends, family and partners. Changes in physical and mental capacity are neither linear nor consistent and they are only loosely associated with a person's age in years.

Older people are particularly vulnerable to factors that lead to depression such as bereavement, physical disability and illness and loneliness. They are disproportionately affected by loneliness and social isolation and the effects on health that accompany them. Some are caring for partners and spouses, and this can also increase the risk of poor mental health.[184]

Poor physical health is a risk factor for mental health problems and older people may have more physical health needs. At a national level, male life expectancy is 79.5 years, however, on average 16 years (20.3%) are spent in poor health. Female life expectancy is 83.1 years, however on average 19 years (22.9%) are spent in poor health.[185] This varies by socio-economic status.

Whilst mental health conditions are prevalent in later life, they are not an inevitable part of ageing. Most older people are not depressed and often are less dissatisfied than younger people.

However, when mental health problems arise in older people, they tend not to have the same level of priority compared to problems in their younger counterparts. Mental health problems in older people are as treatable as mental health problems in younger people.[186]

We do not focus on dementia within this needs assessment.

11.2 Risk and protective factors

Many risk factors for working age adults, set out in the common risk and protective factors section, are also risk factors for older people. Here we cover risk and protective factors which are particular to older people.

Older people experience complex social, psychological and physical factors that influence the pattern, cause, diagnosis, treatment and prognosis of mental health conditions.[187] Older people who have experienced any of the following are at a greater risk of a decline in their independence and wellbeing:[188,189,190]

- Their partner died in the past two years
- They are a carer
- They live alone and have little opportunity to socialise
- Recently separated or divorced
- Recently retired (particularly if involuntarily)
- Unemployed later in life
- On low income
- Have recently experienced or developed a health problem
- Have had to give up driving
- Have an age-related disability
- Frailty
- Falls
- Are aged 80 or older
- If they are subject to different levels of discrimination
- Have dementia
- Have delirium
- They have been subject to abuse
- They have experienced alcohol and substance misuse
- If they are taking multiple prescribed medications (polypharmacy).

See Appendix 6 for the full breakdown of risk and protective factor indicators for Brighton & Hove, Compared with CIPFA comparators and England.

For most of the risk/protective factors where we have data, Brighton & Hove compares similarly or better to England. However, in the following important areas Brighton & Hove does not compare well:[191]

- 18.7% of older people were estimated to be living in poverty in 2019 (9,271 people). This is a significantly higher proportion than England (14.2%) and the second highest of South East Upper Tier Local Authorities (4th highest of the CIPFA nearest neighbours comparator local authorities)
- A higher estimated rate of fuel poverty, with 11% of all households estimated to be living in fuel poverty
- According to the 2011 Census, 41% of people aged 65 year or over in Brighton & Hove were living alone. This is the highest proportion in the South East and significantly higher than England (32%). This equated to 14,468 people and is the highest proportion among the CIPFA comparator group for Brighton & Hove
- A significantly higher rate of emergency hospital admissions due to falls injuries in those aged 65+ with 1,010 emergency hospital admissions in 2019/20.

Whilst similar to England, less than half of adult social care users aged 65+ have as much social contact as they would like (41%) and adult carers aged 65+ (42%).

According to the 2011 Census 12.7% of people aged 65 or over in the city were an unpaid carer (at that time just over 4,500 older people).

There are some risk and protective factors where we do not have comparative data for Brighton & Hove.

The 2012 Health Counts Survey in Brighton & Hove showed that:[192]

- Sense of belonging increases with age for both males and females, with 78% of those aged over 75 years feeling very/fairly strongly that they belong compared to 46% of those aged 18-24 years
- Those aged 75 or over were least like to use parks and open spaces in the city at least once a week (36% for males and 23% for females compared with 54% of all adults)
- Likelihood of seeing or speaking to a neighbour at least once or twice a week is similar for males and females (69% males, 67% females) and increases with age for both males and females
- Males aged 65-74 year had the highest percentage in doing the recommended physical activity
- Males aged 65-74 years had the highest rate of higher risk drinking.

According to the 2018 Brighton & Hove City Tracker Survey,[193] those aged 55+ are significantly more likely, than those aged under 55, in the city to be:

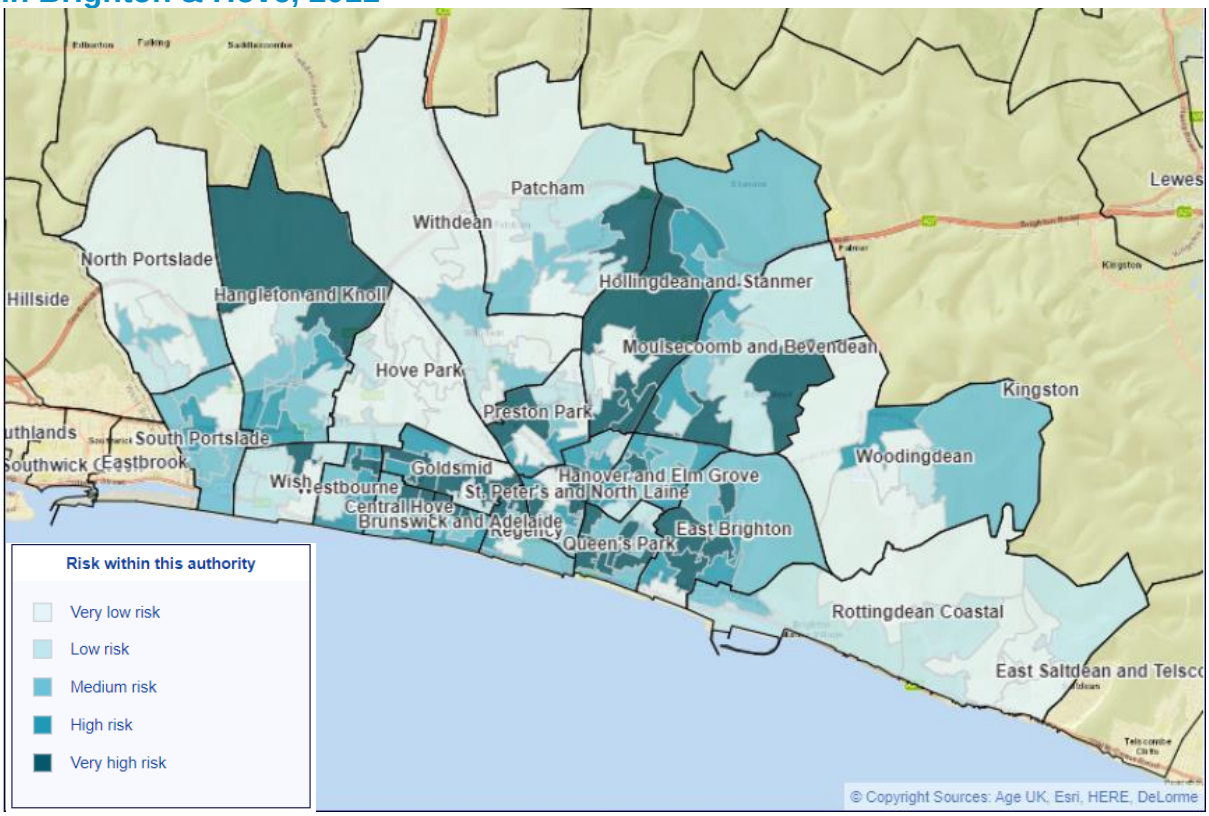
- Satisfied with their local area as a place to live
- Feel that they belong in their immediate neighbourhood
- Agree that people in their neighbourhood pull together to improve the neighbourhood
- Take part in formal volunteering.

Although linked, loneliness and social isolation are not the same. People can be isolated yet not feel lonely, equally they can be surrounded by others and feel lonely.[194,195] While loneliness and social isolation can affect all ages, older people are especially vulnerable. Being lonely or isolated can lead to deterioration in health and wellbeing and is a symptom of common mental disorders.[196]

Age UK has estimated that between 2008 and 2033 there will be a 44% increase in the number of 65–74 year-olds living alone, a 38% increase in those aged 75-85 and a 145% increase in those aged 85+. They produced small area level estimates based on the population characteristics of local areas which are related to loneliness.

There are areas of the city with high and very high levels of risk of loneliness for those aged 65+ within many city centre wards, Moulsecoomb and Bevendean, Hollingdean and Stanmer, and Hangleton and Knoll (Figure 28).

Figure 28: Risk of loneliness for those aged 65 or over, Lower Super Output Area in Brighton & Hove, 2011



Source: AgeUK (Age UK Loneliness maps)

We do not have local data, but national evidence shows that mental health problems in older people are common in settings such as hospitals and care homes. For example, in a 500-bed general hospital on an average day, estimates suggest that 330 beds will be occupied by older people, of whom 220 will have a mental disorder, 100 will have dementia and depression, and 66 will have delirium.[197] Depression affects four in ten people living in care homes[198] and in nursing homes around one in ten residents have psychotic symptoms such as delusions and hallucinations.[199]

In 2022, there were 2,150 registered care home beds in the city.

11.3 Level of need in Brighton & Hove

The earlier section on prevalence sets out the estimates for mental health conditions for all adults based on the England Adult Psychiatric Morbidity Survey.

The Office for Health Improvement and Disparities (previously Public Health England) produces estimates for local authorities which take account of the different demographics of the population and these are presented below.

11.3.1 Prevalence

The estimated prevalence of common mental disorders, defined as any type of depression or anxiety, in those aged 65 year or over in Brighton & Hove is 11.4% (4,450 people) (Table 23). This is based upon the Adult Psychiatric Morbidity Survey, with local authority estimates produced by the Office for Health Disparities (OHID), adjusting for the demographics of local areas.

This is higher, but not statistically significantly higher than the South East (9.2%) and England (10.2%). The estimate for Brighton & Hove is the third highest of Upper Tier Local Authorities in the South East.[200]

By 2030, it is estimated that 5,300 adults aged 65 or over in the city will have a common mental disorder due to the growing number of older adults.

Table 23: Estimated prevalence of common mental health conditions in those aged 65+, Brighton & Hove, 2020 and 2030

	England % (2014)	Estimate Brighton & Hove 2020	Estimate Brighton & Hove 2030
Common MH disorders (CMD) – population aged 65+	11.4%	4,450	5,300

Source: Office for Health Improvement & Disparities. Mental health and Wellbeing JSNA. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk) estimates applied to Brighton & Hove population from Office for National Statistics 2020 Mid Year Estimates and Office for National Statistics Subnational Population Projections

As shown in Table 24, taking national estimates for the prevalence of various conditions by age and gender, and applying to Office for National Statistics population projections for local areas we see that by 2030 we might expect:

- To have almost 600 more adults aged 65+ with depression, a 17% increase to almost 4,000 people (from 3,370 people in 2020)
- To have around 200 more older people with severe depression, a 19% increase to almost 1,300 people (from 1,073 people in 2020)
- The prevalence is higher in females than males in most 65+ age groups (with the exception of those aged 80-84 years).

Table 24: Estimated number of people aged 65+ with depression and severe depression, Brighton & Hove, 2020 and 2030

Condition and age group	England prevalence estimate			Brighton & Hove	
	Male	Female	All	2020	2030
Depression[i] – 65+				3,370	3,968

65-69	5.8%	10.9%		890	1,196
70-74	6.9%	9.5%		846	858
75-79	5.9%	10.7%		595	678
80-84	9.7%	9.2%		499	660
85+	5.1%	11.1%		539	576
Severe depression[ii] – 65+				1,073	1,276
65-69			2.5%	263	355
70-74			1.6%	165	166
75-79			3.5%	249	284
80-84			3.0%	159	210
85+			3.9%	238	261

Source: Oxford Brookes University and Institute of Public Care. Projecting Older People Population Information System (POPPI). Accessed 17/03/2022. Available at: https://poppi.org.uk/ (registration required)

The 2012 Health Counts Survey in Brighton & Hove showed that:[201]

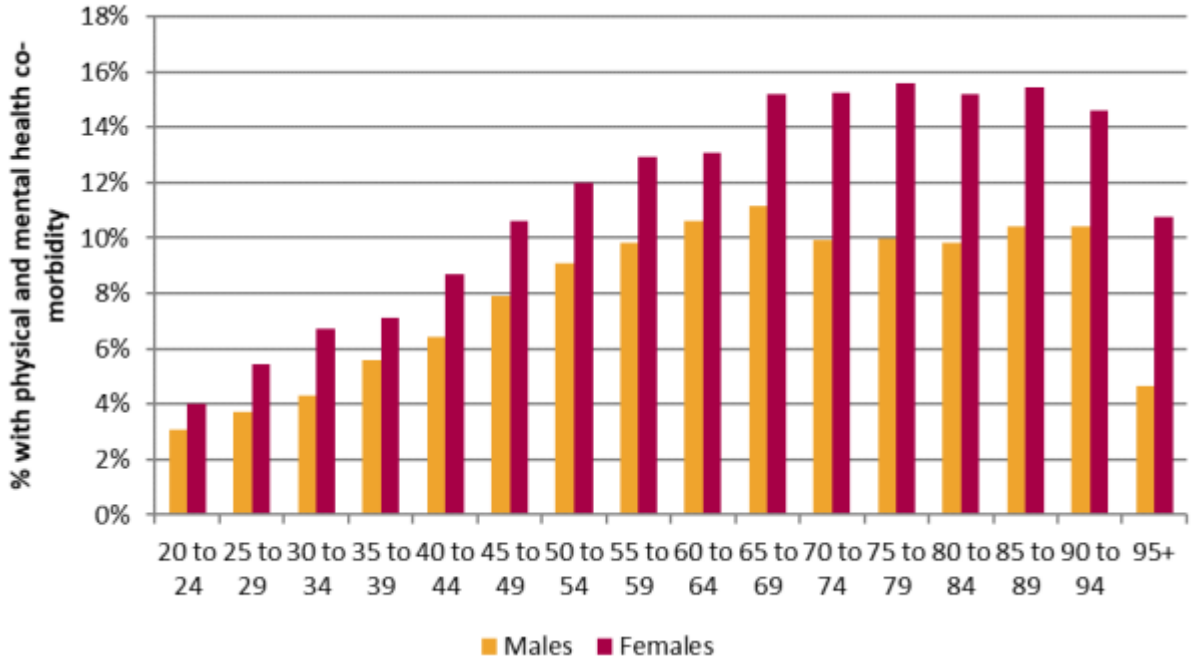
- Risk of major depression was low compared to other age groups for those aged 64-74 years (29% of males and 28% of females aged 65-74 compared to 35% and 42% of all adults aged 18 or over). However, for those aged 75 years or over, risk was higher for females, with 43% at risk of major depression, compared to 30% of males
- Respondents aged over 75 years were least likely to feel that things in their life are worthwhile (65% compared to 74% for all adults)
- Respondents aged 65-74 year were most happy, 78% for men and 77% for women compared to 71% and 72% respectively for all adults).

11.3.2 Mental health and physical long-term conditions in older people

See Section 8.3.3 in the working age adult section on multiple long-term physical and mental health conditions.

The prevalence of mental and physical long-term conditions increases with age up to around age 70 and then is fairly stable (Figure 29). From ages 65 to 95 approximately 15% of women and 10% of men have both physical and mental health problems. However, those who reach 95 years or over are less likely to have physical and mental health conditions than younger older age adults. Physical and mental health comorbidity tends to be higher in females than males.

Figure 29: Percentage of people with physical and mental health conditions by gender and age, Brighton & Hove, March 2017



Source: Brighton & Hove City Council. Adults with multiple long-term conditions needs assessment

11.4 Voice of older people

No information was readily available on the voice of all older adults aside from a consultation in 2018 by Mindout. It looked at the experiences of people who identify as LGBTQ and are over 50. The consultation included 80 survey respondents from LGBTQ people in Brighton & Hove, 131 members of Opening Doors London responding to their annual survey, two focus groups of 12 MindOut service users and volunteers, members of Brighton & Hove Switchboard Older People's Project and members of Older and Out, a Brighton based social group.

Key findings:[202]

- Respondents suggested that all older people's service providers should receive LGBTQ affirmative practice training, that LGBTQ 'kite marks' for older people's services should be developed and that LGBTQ groups should go into older people's services on a regular basis.
- Many LGBTQ people report high levels of loneliness and lack of social and community engagement. Approximately half of respondents to the MindOut surveys use social media to support their mental health. 70% were keen to increase their digital confidence to use existing online support as well as to explore developing online services.
- Older LGBTQ people report high levels of suicidal distress. Last year 80% of MindOut service users talked about suicidal distress, 90% of MindOut Trans clients were at risk of suicide.

Many respondents spoke of the need for, and positive experiences of, LGBTQ groups, services, events and opportunities for older people.

11.5 Quality and outcomes

Most outcomes indicators are published for all adults and are covered in the working age section of this report, with comparative data on outcomes in Appendix 8.

From the last published data for the period 2013-2017, males aged 65 years or over in Brighton & Hove had a significantly higher rate of suicide and undetermined injury deaths England (Table 25).

Table 25: Suicide and undetermined injury rate in those aged 65+, Males, Brighton & Hove, 2013-17

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2013-17	20		23.1	12.4	12.8

Source: Office for Health Improvement and Disparities. Productive Health Ageing Profile Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Note: rate for females not published as numbers too low at local authority level

However, there have been a reduction in suicide deaths of older people in the city, with 7 deaths of those aged 65+ in Brighton & Hove in the three-year period from 2018 and 2020 compared to 23 deaths in the preceding three year period (this is for males and females combined) (Table 26).

Table 26: Number of suicide and undetermined injury deaths for those aged 65 or over, Brighton & Hove, three-year periods from 2006-2008 to 2018-2020

Year of death (occurrence)	2006-2008	2009-2011	2012-2014	2015-2017	2018-2020
Number	17	16	11	23	7

Source: Brighton & Hove Public Health Intelligence team from death registration data

11.6 What we know about the local older adults mental health offer

11.6.1 Primary Care

GPs can provide information, advice and treatment and can refer individuals to a mental health or psychological therapies service if needed.

11.6.2 Social prescribing

Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing. It improves outcomes for people by giving more choice and control over their lives and an improved sense of belonging. It is also effective at targeting the causes of health inequalities and is an important facet of community and neighbourhood centred practice.

In Brighton & Hove Social Prescribing within Primary Care Networks (PCNs) is provided by link worker provided by Community and Voluntary Sector organisations or directly employed by the PCN. In addition to this, Together Co deliver a City Wide Social Prescribing service which aims to reduce health inequality and improve outcomes for people who may not traditionally access services via their GP practice.

The social prescribing service provides support to people who may have 'falling through the gaps' and 'not feeling heard' by existing services and feedback suggests this a valued form of support. People receive support on a range of problems they are facing which include money, housing, mental health and loneliness. The service is a key form of support and can help problems escalating from needing more formal support from mental health services.

11.6.3 Specialist Older Adults Mental Health (SOAMHS)

Specialist support and treatment with both health and social care needs by Sussex Partnership Foundation Trust (SPFT) for:

- older adults experiencing moderate to severe mental health problems
- people who have a diagnosis of Dementia who have complex and challenging needs relating to this.

11.6.4 Ageing Well B&H

A programme of services & activities for people aged 50+ delivered by a partnership of providers lead by Impact Initiatives. It provides activities, including peer support, befriending, cognitive stimulation therapy, cafes and centres, groups and activities, befriending, information and advice, multi-cultural activities, LGBTQ+ specific activities, and access to resources.

11.6.5 Carers Hub

Is a partnership of three local charities and local authority assessment staff, who have been commissioned to create a central point for unpaid carers, to get the information and support they need. Carers Hub aims to improve the quality of life of carers in Brighton & Hove by offering a wide range of services and comprehensive local resources for carers of all ages.

11.6.6 Contact with secondary mental health services

See earlier section

11.7 Opportunities to learn more

- Adult and Older Adult Community Mental Health Transformation Programme
- Development of the Brighton & Hove Dementia and Ageing Friendly City Action Plan being led by Brighton & Hove City Council Public Health team.

11.8 What works for prevention

See Prevention section for more on how these were identified.

Box 6: What works for prevention: older people facing loneliness

There is a need to understand that loneliness applies to some older people but also affects other age groups too such as those who are unemployed, living alone, carers and those who are LGBTQ+.

There is a growing evidence base suggesting that interventions tackling loneliness and isolation in older people can also be protective of both their physical and mental health.

A connected society: A Strategy for tackling loneliness – laying the foundations for change: This strategy is an important first step; government is also committed to long-lasting action to tackle the problem of loneliness.
To tackle loneliness and support people's social connections, we all need to act. This includes government, local authorities, businesses, and the voluntary sector, where there is an opportunity to embed loneliness as a consideration across their work. Alongside this, it is also the responsibility of communities, families, and the individual. By working together, we can help to create a more socially connected society.
Campaigns and awareness raising:

- The Campaign to End Loneliness provides Adult Social Care, Clinical Commissioning Groups, and public health teams with guidance on developing strategies to address loneliness amongst older people in their local populations
- NICE guidance (2015 - see below) outlines principles of good practice to promote older people's independence and wellbeing. Much of which relates to reducing loneliness.

Prevention of mental illness and promotion of good mental health or wellbeing among those facing loneliness:

- The Mental Health Foundation suggest the following to prevent loneliness:
  - Try to do some enjoyable things that will keep you busy
  - Think about doing a physical activity
  - Try to engage with the people you meet in your daily life
  - Find people that 'get you'
  - Spend time with pets
  - Try to use social media in a positive way
  - Talking therapies can help.

- NICE guidance (2015) outlines principles of good practice to promote older people's independence and wellbeing. Consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people and ensure these:
  - Include a clear description of what is on offer
  - Take place at regular times and in a regular location
  - Provide the opportunity to socialise
  - Complement other activities that may support different aspects of older people's independence and mental wellbeing, such as their physical health.

- Community approaches to reduce isolation in older people that have been found to be effective include befriending and mentoring and social group schemes which incorporate self-help support and peer involvement. One example is the 'Standing Together' peer support service delivered by the Mental Health Foundation. This includes self-help groups to improve the emotional health and reduce loneliness among older people living in supported housing
- Befriending initiatives are potentially of value both to the person being befriended and the befriender
- Additional recommendations to reduce loneliness include building a greener living environment that supports social contact and ensuring that everyone has access to digital communication technology. Also, staying in touch with friends and family, volunteering, visiting a senior centre, and joining a group are useful strategies
- There is evidence that psychological therapies delivered to at risk populations such as the bereaved can be cost-effective and protect mental health
- Involve new technologies such as assistive technology (eg Alexa), games consoles and internet-based communication.

More evidence needed:

- Volunteering is beneficial although there is less evidence of its effects on reducing isolation among older people.

Box 7: what works for prevention: older people with long term conditions

System recommendations:

- Promote better integration between mental health support and primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals
- Improve collaborative care arrangements between primary care and mental health specialists
- Clinical Commissioning Groups integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care
- Create Dementia Friendly Communities and then adopt the Dementia Friends initiative which aims to change people's perceptions of dementia and to change the way the nation thinks, talks, and acts about the condition.

Prevention of mental illness and promotion of good mental health or wellbeing among those with long-term conditions:

- Protecting the mental health of people living with long-term health conditions shows promising evidence from brief psychological support such as CBT or mindfulness-based therapy
- Provide access to evidence-based interventions to prevent depression developing in older people, by:

- Providing Mental Health First Aid training to enable services in contact with older people to respond to distress
- Providing brief intervention approaches for people with physical health problems who are experiencing depressive symptoms
- Creating local service pathways for older people who often encounter significant barriers in accessing help to ensure that they have timely access to stepped care approaches, including CBT and psychotherapy
- Developing initiatives that aim to improve mood and social connectedness including for those with dementia
- Promoting the development of dementia friendly communities.

- Adopt integrated approaches to health and mental health for older people who can experience higher rates of co-morbid mental and physical health problems, including by providing reminiscence therapy for older people in health care settings and developing physical activity programmes.

12 Recommendations

Delivery of the seven recommendation areas will be overseen by the Brighton and Hove Health and Care Partnership, with actions specific to Children and Young People or Adults directed through the relevant place based oversight board. The Brighton and Hove Health and Care Partnership is a place-based partnership bringing together NHS Sussex (Brighton and Hove), University Hospitals Sussex NHS Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, and Sussex Partnership Foundation NHS Trust, Community Works (Representing the Voluntary and Community Sector), Primary Care Networks (PCNs) - General Practice, patients and the public.

Reducing inequalities needs to be at the heart of tackling and improving the mental health of the population of Brighton & Hove and this is embedded in each of the recommendation areas. There are tools that can assist in assessing impact of proposals on health inequalities.

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 4 – Whole System Working)

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

Area 7: Inequalities, influence and implementation

We sought to take account of what is already happening to improve outcomes and reduce inequalities so that recommendations are focussed on areas that have the greatest additional impact.

Area 1: Population prevention. Develop and promote a population wellbeing approach encompassing the building blocks of health

No.	Recommendation
1.1	Strengthen our city-wide prevention-focused approach to improving population wellbeing and reducing inequalities. The Brighton & Hove Health and Care Partnership, linking with cross sector city organisations, should consider options for achieving this, for example utilising the national Prevention Concordat for Better Mental Health. The approach to include: • Increasing awareness that experiences in childhood, particularly the first 1,000 days from conception to 2 years, lay down the foundations of life-long wellbeing • Increasing awareness that mental health is everyone's responsibility and that the key building blocks of health are the social determinants such as employment, debt, income, education, housing, community cohesion, access to green spaces etc • Increasing awareness of what people can do to make a difference to population mental health and wellbeing • Strengthening whole system approaches to reducing stigma.

Context

- An individuals' mental health is determined by past and present experiences and the circumstances of their daily life such as housing, income, education, access to green spaces etc. These are the building blocks of health
- Adopting a prevention approach that focuses on the building blocks of health is cost effective.
- In the city, there is high need and inequalities, and these have been exacerbated by the impacts of Covid, the cost of living crisis and climate change. Workforce challenges make it difficult to meet current and future need
- Decision makers are not always fully aware of what works and how they can bring about desired change and there are challenges in taking a prevention approach
- Commissioning often focuses on treatment and acute care in part because many of the NHS targets are about treatments. A greater focus on prevention is needed
- The Prevention Concordat is a national evidence-based prevention-focused framework.
- Commitment to, and championing of, a population prevention approach, with tools for system leaders, commissioners, and planners to understand and implement prevention measures could lead to large improvements in mental health and reduce health inequalities.

Area 2: Communities. Co-production and co-design of mental health services with people with lived experience, community development and VCSE sector provision

No	Recommendation
2.1	Commissioners and providers to ensure co-production with experts by experience, including parents and carers, is a fundamental part of all redesigned/transformed mental health pathways working as equal partners from the beginning. Seek to engage with marginalised communities and seldom heard voices including care leavers and children in care
2.2	Ensure co-production best practice is embedded in all aspects of mental health commissioning (both NHS and Local Authority). Start by mapping co-production across the system
2.3	Ensure more peer support opportunities are built into commissioning and delivery.
2.4	Promote community development. Support communities to build on their assets and strengths so that they can improve their local mental health outcomes or the factors that affect their mental health. Consider geographical communities and communities whose voices are less often heard.
2.5	Strengthen VCSE sector provision, including support for smaller organisations. Commission and develop VCSE sector as essential providers in mental health and wellbeing pathways, as equal partners with statutory services and as trusted advocates for their communities.

Context

- Co-production with people with lived experience of services, their families and carers is a key principle of the national Five Year Forward View for Mental Health and improves outcomes
- Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
- When asked for their views, children and young people and adults with lived experience said they wanted to see more involvement of peers and people with lived experience in developing and commissioning services and more peer support
- Whilst the JSNA found some examples of co-production, it was patchy and far from universal. For some services there was no routine engagement. Some communities had little or no opportunities to express their views
- Children and young who are looked after or are care leavers are at greater risk of developing mental health problems and need strong advocacy - the CIC (children in Care) council and the care leavers forum are opportunities to engage with this group.
- When there was engagement, people with lived experience were not always included from the outset of new commissioning proposals.
- The voluntary, community and social enterprise (VCSE) sector is broad and encompasses independent organisations working with a social purpose. They range from small community based groups or schemes through to larger charities and

organisations that may operate locally, regionally or nationally. The city has a strong and vibrant VCSE sector.

- The VCSE sectors plays a key role in improving health, wellbeing and care outcomes and tackling health inequalities. They do this not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

Area 3: Whole System working. Develop pathways that encompass all levels of mental health need with a focus on early intervention. Develop trauma-informed pathways that support individuals in a holistic way

No.	Recommendation
3.1	New mental health service developments, transformation work and reviews of existing services and pathways should take a trauma-informed whole systems approach. To be modelled by senior leaders and at all levels of organisational delivery. • Co-production with people with lived experience and their families and carers • Consider differing levels of need: universal support, early help, and specialist services. • Consider other needs eg substance misuse, physical health, social care, homelessness, criminal justice, healthy lifestyles. • Consider role of different sectors in providing mental health support including community groups and the voluntary, community and social enterprise (VCSE) sector • Consider role of different settings eg schools, colleges, and workplaces
3.2	Commissioners and providers to ensure that there is good communication between mental health and other services eg substance misuse, physical health, social care, homelessness, criminal justice to ensure care is provided holistically, takes account of all needs, and considers mental health in the context of what has happened to an individual (possible trauma history or adverse childhood experiences) and their whole needs.
3.3	Organisations, commissioners and providers to ensure that staff wellbeing is a priority - there are evidence based whole workplace approaches in place to promote wellbeing
3.4	Commissioners and providers to ensure universal and specialist services such as substance misuse, physical health, healthy child programme, social care, homelessness, criminal justice etc. routinely identify mental health need and where appropriate, offer brief interventions, and/or refer onwards.
3.5	Through training, increase the mental health and trauma-informed knowledge, skills and confidence of workforces both in mental health services in other sectors for example physical health services, substance misuse services, social care, housing, education etc. consider, for example, Mental Health First Aid training, suicide prevention, trauma informed approaches etc
4.6	Support the continued embedding of Trauma Informed Care, Practice and Values across the Brighton and Hove Health and Care Partnership and extend the Sussex wide Trauma Informed Care (TIC) programme to wider workforces for example blue light services, housing, education

Context

- Commitment to whole systems working is required at all levels within organisations: at a strategic level, modelled by senior managers, by team managers and team members
- An individual's mental health and wellbeing changes over time and the level and intensity of support needed varies. Early intervention can prevent problems from getting worse. Good and sustained support after a period of intense need can help a person to stay well
- Promoting population wellbeing and preventing mental illness is complex and requires a dynamic way of working in partnership with a broad range of stakeholders
- Many people with mental health conditions have experienced trauma which can impact on their ability to access and engage with services. Taking a trauma informed approach to care and practice can help improve patient engagement, treatment adherence and health outcomes, as well as provider and staff wellness.
- Many people with mental health conditions have other needs. Their needs may impact on their family and friends. For example, a parent with severe mental illness who has a housing problem and whose child is having difficulties at school may need support not only from mental health but also potentially housing, social care, the school
- Outcomes are improved if a persons' multiple needs are considered holistically and where there is a diverse and varied offer of support
- Trauma informed care can help reduce burnout among health and social care providers, potentially reducing staff turnover. Trauma Informed care seeks to:
    - **Realise** the widespread impact of trauma and understand paths for recovery
    - **Recognise** the signs and symptoms of trauma in patients, families and staff
    - **Respond** through integrating knowledge about trauma into policies, procedures and practices and
    - Actively avoid **Re-traumatisation**.

  Trauma informed services are also **Reflective** in their practice, which involves curiosity about ourselves in the work we do. With a fundamental focus on **Relationships** at the heart of our work.
- Better join up is needed across eg: Mental health and physical health; Substance misuse and mental health; People with multiple disadvantage (homelessness / domestic violence / criminal justice / mental health).

Area 4: Transform mental health services to take account of current unmet need and predicted growing future need and to improve accessibility (in context of Area 3 – Whole System Working)

No.	Recommendation
4.1	Brighton & Hove City Council and NHS Sussex commissioners to strengthen their use of intelligence (data, stakeholder views, and evidence of what works) to inform the development of services in order to make best use of resources in responding to current and emerging needs and focusing on early intervention and prevention.
4.2	Commissioners and providers to raise awareness of existing services and pathways so that those referring to and those needing services know where to go and how to access them. Promote via channels that are relevant to different communities. Promote to groups with higher need or poorer access, including: • LGBTQ+ • Ethnic Minority groups • Young people and young adults • Children in care and care leavers • Those less digitally literate eg people with learning disability, older people.
4.3	Shift the balance of investment to increase support for children and young people with mental health and wellbeing problems to bring a lifetime of benefits to young people, their families, communities and the economy.
4.4	Agree priorities for health and care commissioners and providers to work together to address areas where there is significant potential to improve performance. For example: • Long waiting lists for some services • Excess deaths in people with SMI under 75 years old. • People newly diagnosed with depression have lower rates of review by their GP 10-56 days after diagnosis. • Gaps between services for example between primary and second mental health services for adults.

Context

- The needs assessment provides evidence of very high need in the city – both in terms of the numbers of people affected, but also relative to England – and this need is growing.
- It is estimated that in Brighton and Hove, 1 in 5 adults have common mental health disorders, higher than the national average of 1 in 6
- Several crises are unfolding that increase need and increase inequalities including Covid, the cost of living crisis and climate change. Workforce challenges continue to put pressure on service capacity and quality
- The needs assessment highlighted service challenges including long waiting lists, unclear referral pathways, need for comprehensive information and support for greater advocacy

- Some services were highlighted as having very long waiting lists: assessment for neurodivergence such as ASC (autistic spectrum conditions) and ADHD (attention deficit hyperactivity disorder), eating disorder and complex trauma
- There is a lot of work underway to transform services – much of it under the umbrella of the Adult Community Transformation Programme
    - Crisis care; Complex trauma
    - All ages Sussex Eating Disorder
    - Physical health checks for those with serious mental illness
    - Trauma Informed Care (TIC).

Area 5: Children and Young people. Improve the care and support offer for young people ensuring that they and their families are at the heart of an integrated service approach

No.	Recommendation
5.1	Adult and children mental health services should have a dedicated transition function to ensure there is continuity of care for young people.
5.2	Ensure that mental health services are tailored to needs of young people particularly those aged 16 to 25.
5.3	Commissioners and providers to ensure adult and children's mental health services take a whole family approach to mental health. For example, adults' services to take account of the potential impact of poor parental mental health on children and vice versa.
5.4	Expand capacity to meet unmet need in children and young people. In particular in areas where there are rapidly growing needs or large unmet need such as substance use, eating disorder, neurodivergence assessment, self-harm, body image.

Context

- The needs assessment provides evidence of very high risk factors and need in the city – both in terms of the numbers of people affected, but also relative to England. It also provides evidence of increases in need.
- The first 1,000 days (from conception through to age 2) are crucial in laying down foundations for lifelong wellbeing. Support to families in this period is paramount
- Around half of lifetime mental health problems are established by age 14 and three quarters by age 24
- Young adulthood (age 16 to 25) is a key age: Mental health problems often arise for the first time; the service offer changes as people turn 18 (25 for people with SEND); capabilities such as planning, self-control, flexibility, awareness, continue to develop significantly up to the mid-twenties; adult and child service criteria differences mean that some people are no longer able to access services.
- The Safe & Well at School Survey shows some groups are more likely to experience negative impacts on their mental health and wellbeing. This includes girls, older pupils and pupils and students who identify as LGB+, Trans and Non-Binary; those who need additional help in school, Young Carers and those who identify as Black or Black British.
- In childhood, living in a difficult situation (parental conflict, domestic violence, parents with mental health and/or substance misuse issues etc.) can be very harmful and sometimes leads to complex trauma which can have lifelong impacts
- There are high waiting times for specialist CAMHS services, in particular for neurodivergence assessment and diagnosis and eating disorder.

Area 6: Information sharing. Improve monitoring and information sharing across the system to improve quality of care, planning and decision making

No	Recommendation
6.1	All contract monitoring should routinely monitor activity by • protected characteristics • whether people are or were in council care • whether people are neurodivergent. • whether adults are parents / carers for children and young people This should include information on referrals, access and outcomes to be able to assess if services are effectively meeting the higher needs of groups more at risk of poor mental health.
6.2	Information held by organisations on their clients and patients with mental health needs should be comprehensive, up to date and shared appropriately and in a timely manner between care providers when it needs to be.
6.3	Locally commissioned Brighton & Hove health surveys should take account of the JSNA findings to better capture the needs of groups identified as more vulnerable to poorer mental health.
6.4	Collection, collation, reporting and analysis of population level data should be improved to maximise opportunities to improve prevention. • Analysis should be conducted of the anonymised Sussex Integrated Dataset to provide a better picture of the mental health needs of the local population and how people are currently accessing services. The inclusion of data from drug and alcohol treatment services in this dataset should be explored • Annual update of mental health profile to be published.

Context

- There is a lack of routine service data to be able to clearly identify trends or to be able to compare service access and quality
- For the most part, we were not able to use routine service data to look at access and outcomes by protected characteristics beyond age and gender
- We are very fortunate to have the Safe and Well at School Survey to give us clear evidence around trends and vulnerable groups of children and young people
- Voice evidence from children and young people, and from other recent JSNAs of adults with physical and mental health conditions and adults with multiple complex needs cited the lack of information sharing across services as a key barrier to good care.
- The Sussex Integrated Dataset provides linked anonymised data to be able to look at all the contacts those with mental health conditions have with services (eg in Primary Care, hospitals and with Specialist Mental Health Services) for the first time.

Area 7: Inequalities, influence and implementation

No	Recommendation
7.1	The Brighton and Hove Health and Care Partnership to oversee the system response to the recommendations by: • developing and monitoring an action plan that identifies which team/ board/organisation/ partnership leads on each action and with goals that are SMART - Specific, Measurable, Achievable, Realistic, and Timely. • Actions specific to Children and Young People or Adults to be directed through the relevant place based oversight boards.
7.2	The findings and recommendations from this JSNA are used by commissioners, providers and decision makers to • improve outcomes and reduce inequalities. • inform relevant strategies, programmes and action plans. At the time of writing these include but are not limited to: ○ Foundations for our Future - Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027 ○ Implementation of the national Mental Health Long Term Plan 2019/20 – 2023/24, including the Adult & Older Adult Community Mental Health Transformation programme ○ Sussex and Brighton and Hove Suicide and Self-harm Prevention Strategy ○ Brighton and Hove Drug Strategy ○ Relevant Brighton & Hove city council corporate and directorate strategies ○ Place Based Plans developed by the Health & Care Partnership ○ Family Hubs Transformation Programme ○ Multiple disadvantage programme
7.3	Commissioners, providers and decision makers across Brighton and Hove Health and Care partnership to ensure appropriate impact assessments are undertaken when commissioning, developing and reviewing programmes, plans, services and policies. Tools include: Equality and Health Inequalities Impact Assessments (EHIAs)/ Equality Impact assessments (EIA) and quality impact assessments (QIAs).

Context

- The Brighton and Hove Health and Care Partnership is a place-based partnership bringing together NHS Sussex (Brighton and Hove), University Hospitals Sussex NHS Trust, Brighton & Hove City Council, Sussex Community Foundation Trust, and Sussex Partnership Foundation NHS Trust, Community Works (Representing the Voluntary and Community Sector), Primary Care Networks (PCNs) - General Practice, patients and the public.
- Delivery of the recommendations will be overseen by the Brighton and Hove Health and Care Partnership with actions specific to Children and Young People or Adults directed through the relevant place based oversight boards

- Reducing inequalities needs to be at the heart of tackling and improving the mental health of the population of Brighton & Hove and this is embedded in each of the recommendation areas. There are tools that can assist in assessing impact of proposals on health inequalities.

13 Glossary

13.1 Common mental health disorders

Depression

Characterised by persistent low mood and a loss of interest and enjoyment in ordinary things Overview | Depression in adults: recognition and management | Guidance | NICE)

Generalised anxiety disorder

Characterised by excessive worry about many different things and difficulty controlling that worry Overview | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE

Social anxiety disorder

A persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life Overview | Social anxiety disorder: recognition, assessment and treatment | Guidance | NICE

Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety Overview | Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE

Obsessive compulsory disorder

An anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both Overview | Obsessive-compulsive disorder and body dysmorphic disorder: treatment | Guidance | NICE

Specific phobias

An overwhelming and debilitating fear of an object, place, situation, feeling or animal Overview - Phobias - NHS (www.nhs.uk)

Post-traumatic stress

A set of psychological and physical problems that can develop in response to threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action Overview | Post-traumatic stress disorder | Guidance | NICE

Health anxiety

A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem Health anxiety - NHS (www.nhs.uk)

13.2 Severe mental illness

Bipolar affective disorder

A potentially lifelong and disabling condition characterised by episodes of mania (abnormally elevated mood or irritability and related symptoms with severe functional impairment or psychotic symptoms for 7 days or more) or hypomania (abnormally elevated mood or irritability and related symptoms with decreased or increased function for 4 days or more) and episodes of depressed mood. Introduction | Bipolar disorder: assessment and management | Guidance | NICE

Schizophrenia

Represents a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. Introduction | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

Personality disorder

A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person Personality disorders - NHS (www.nhs.uk)

Severe depressive episodes with or without psychotic episodes

Describes the presentation and impact of severe depression and the range of social, psychological, medication and other interventions Symptoms - Clinical depression - NHS (www.nhs.uk)

Eating disorders

One of the conditions which often begin in childhood but can persist into or develop in adulthood. Eating disorders are also covered in Children and young people life course.

Self-harm

Self-harm is when individuals hurt themselves as a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences.

13.3 Perinatal mental health conditions:

Adjustment disorders

An unhealthy or excessive emotional or behavioural reaction to a stressful event or change in a person's life such as illness or relationship breakdown.

Depression

A mood disorder that can affect a woman during pregnancy (antenatal) or begins after childbirth (postnatal) and usually lasts beyond six weeks.

Postpartum psychosis

A severe episode of mental illness usually with rapid onset in the days or weeks after giving birth (see Severe Mental Illness for symptoms).

Post-traumatic stress disorder (PTSD)

Nightmares, flashbacks, anger and difficulty concentrating or sleeping; it may be pre-existing or triggered by traumatic labour.[203]

Severe mental illness (SMI)

refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Can include diagnoses which involve psychosis, most commonly schizophrenia, bipolar disorder and psychotic depression.

13.4 Other definitions:

Disability adjusted life years

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (Years of life lost - YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not cause death but do cause disability (such as cataract causing blindness).

LGBTQ+

The acronym for Lesbian, Gay, Bi, Trans, Queer, Questioning and Ace (asexual). In this document various acronyms are used according to the specific sexual orientation and gender identities recorded in each piece of research or data. For this reason, the acronyms may vary.

Transition:

Any change or adjustment that impacts individual's life in a significant way. There are several transition periods during the life course:

- from home to early learning and childcare
- starting school
- changing school
- leaving school – University
- Leaving University – Employment
- Leaving school – Employment
- From children's to adult's services
- Geographical transitions
- Care leavers' to adulthood.

14 Appendices

14.1 Appendix 1: Local reports reviewed for the needs assessment

This appendix lists the qualitative and quantitative sources used for this needs assessment, including other relevant reports reviewed.

14.1.1 Qualitative data sources

Year	Report title	Published by	Population
2021	Summary report Speak Your Mind report	WSCC, Brighton & Hove City Council (BHCC) ,NHS, Children First, Priority 1-54	Children and young people
2021	The impact of Covid-19 on LGBTQ people in Brighton & Hove	BHCC, NHS Brighton & Hove CCG, Switchboard	LGBTQ
2021	JSNA Adults with multiple complex needs	Awaiting publication	Adults
2020	Brighton & Hove Hospital Discharge Wellbeing Project (HOPs)	Healthwatch	Adults
2018	JSNA International Migrants	BHCC	Adults
2015	Trans Needs Assessment	BHCC	Trans - All ages
2016	Sexual orientation JSNA	BHCC	LGBTQ - All ages

14.1.2 Quantitative data sources

Data	Organisation	Summary
Fingertips	PHE	Fingertips is the central national data source of indicators across a range of health and wellbeing themes across all areas/regions in England.
Prototype Public Mental Health Dashboard	PHE	This mental health needs assessment tool that brings together and summarises existing evidence, compiled and commissioned by PHE and its partners.
NHS Digital	NHS	NHS Digital is the national body responsible for collecting processing and using data from lots of different organisations that make up the NHS. These include GP Surgeries, hospitals, clinics, care homes, local authorities. IAPT referrals, prescribing data, hospital admissions, A&E attendances, secondary (acute) admissions and inpatients, specialist services and specific activity (eg eating disorders, gender dysphoria, meeting needs of military veterans), people detained under MHA, provider performance reports.
Various datasets	Office for National Statistics	is the UK's largest independent producer of official statistics. Census, Annual Population Survey (APS) is a continuous household survey covering the UK: health, education, religion, employment, unemployment, housing, ethnicity.
Projecting Adult Needs and Service Information (PANSI)	PANSI	It gives easy access to projections of the numbers, characteristics and care needs of people aged 18-64 in England at national, regional, and council level
Projecting Older People Population Information (POPPI)	POPPI	It gives easy access to projections of the numbers, characteristics and care needs of people aged 65 and over
Adult Psychiatric Morbidity Survey	NHS Digital	
Children and Young People Mental Health Survey	NHS Digital	

14.1.3 Other reports reviewed

Year	Report	Published by	Population
2022	Services for Unaccompanied Asylum-seeking Children	NIHR Applied Research Collaboration Kent, Surrey and Sussex	Children and Young people
2022	Suicide Prevention Data	Brighton & Hove City Council	All ages
2022	The Brighton & Hove Mental Health and Housing Plan	Healthwatch	Adults
2022	The Safe and Well School Survey (SAWSS)	Brighton & Hove City Council, University of Sussex	Children and Young people
2021	CYP Digital Mental Health	Kent Surrey Sussex Academic Health Science Network, NIHR Applied Research Collaboration Kent, Surrey and Sussex, e-wellbeing YMCA downslink group	Children and Young people
2021	Covid Social study, Unequal pandemic, fairer recover		All ages
2021	Rapid CYP Mental Health needs assessment	West Sussex City council	Children and Young people
2021	Suicide Prevention Strategy	Brighton & Hove City Council	All ages
2021	Summary report Speak Your Mind report	WSCC, Brighton & Hove City Council (BHCC) ,NHS, Children First, Priority 1-54	Children and Young people
2021	The impact of Covid-19 on LGBTQ people in Brighton & Hove	BHCC, NHS Brighton & Hove CCG, Switchboard	Adults
2020	Brighton & Hove Hospital Discharge	Healthwatch	Adults

	Wellbeing Project (HOPs)		
2020	Brighton & Hove mapping report	Kent Surrey Sussex Academic Health Science Network, NIHR Applied Research Collaboration Kent, Surrey and Sussex	Children and Young people
2020	East Sussex Community Feedback COVID-19 Crisis	People in Partnership	Adults
2018	Brighton and wellbeing – Evaluation report		All ages
2018	Complex Patient Pilot: Evaluation Report	Brighton & Hove City Council	All ages
2018	JSNA International Migrants	Brighton & Hove City Council	Adults
2016	Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England		All ages
2016	Vulnerable migrants JSNA	Brighton & Hove City Council	All ages
2016	Sexual orientation JSNA	Brighton & Hove City Council	All ages
2015	JSNA Trans Needs Assessment	Brighton & Hove City Council	Adults
2013	NEET (Not in Education, Employment, or Training) JSNA	Brighton & Hove City Council	Children and Young people
	National Audit Office (NAO) suicide, Suicide by		Children and Young people

	occupation (ONS) and Suicide amongst young people in B&H		

14.2 Appendix 2: Steering Group Membership and Governance

The needs assessment steering group reported to the Mental Health Oversight Board and Children and Young Person's Health Oversight Board through the Consultant in Public Health and the Head of Mental Health Commissioning. See acknowledgements for report authors.

The voices of those with lived experience were sought through established engagement and co-production forums, review of recent consultation events, reports and JSNA**.**

Membership

Organisation	Role
Brighton & Hove City Council (BHCC) – Public Health	Consultant in Public Health
BHCC – Public Health	JSNA Specialist
BHCC – Public Health	Head of Public Health Intelligence
BHCC – Public Health	Starting Well Programme Manager
BHCC – Adult Social Care	Health and Adult Social Care Commissioning Manager – Mental Health
BHCC – Adult Social Care	General Manager Adult Social Care
BHCC – Families Children and Learning	Assistant Director - Health SEN & Disabilities - Health SEN & Disability Services
BHCC – Families Children and Learning	Assistant Director - Children's Safeguarding & Care
BHCC – Families Children and Learning	Service Manager - Directorate Policy & Business Support
BHCC – Families Children and Learning	Head of School Organisation
NHS Sussex (formerly Brighton and Hove Clinical Commissioning Group (BH CCG))	Head of Mental Health Commissioning
NHS Sussex (formerly BH CCG)	Assistant Head – Mental Health Commissioning
NHS Sussex (formerly BH CCG)	Brighton & Hove Clinical Director Mental Health and Suicide Prevention
NHS Sussex (formerly BH CCG)BH CCG (now ICB)	Brighton & Hove Clinical Director Children and Young People
NHS Sussex (formerly BH CCG)	Senior Quality Manager
NHS Sussex (formerly BH CCG)	Sussex Health and Care Partnership - Health Inequalities and Participation Lead for the Mental Health Collaborative
Sussex Partnership Foundation Trust (SPFT)	SPFT Adults- Deputy Service Director Brighton & Hove CDS
SPFT	SPFT Children - General Manager East Sussex and Brighton & Hove CYPD

SPFT	SPFT - Clinical Lead for the Brighton & Hove Wellbeing Service SPFT
UOK (formerly Community Roots)	Head of Service, Southdown
YMCA Downslink Group	Director for Children and Young People
Community works	CEO
University of Sussex	Head of School of Psychology
University of Sussex	Professor (Honorary Consultant) of Epidemiology & Public Health Medicine (Primary Care & Public Health) Brighton and Sussex Medical School

14.3 Appendix 3: National prevention frameworks

A report was commissioned to examine evidence, mainly sourced from reviews and meta-analyses, to identify public health interventions that can promote good mental health or wellbeing and prevent mental illness. The summaries appear in the boxes entitled “what works for prevention” in the life course sections. This appendix lists the documents that were used in this review.

Title	Author	Date
Public health implementation	Royal College of Psychiatrists	March 2022
The economic case for investing in the prevention of mental health conditions in the UK	LSE and Mental Health Foundations	February 2022
Prevention and mental health: Understanding the evidence so that we can address the greatest health challenge of our time	Mental Health Foundations	2019
Making Prevention Happen	Mental Health Foundations	2020
Mentally healthier council areas Manifesto ideas for the 2022 local authority elections	Centre for Mental Health	March 2022
Mental Health Promotion and prevention		
Prevention First: A Prevention and Promotion Framework for Mental Health	Hunter institute for mental health	2015
Better Mental Health For All: A public health approach to mental health improvement.	Mental Health Foundations	2016
Emotional and Wellbeing support for children and young people	Foundations for our Future	2020

Sources for the “what works for prevention” sections

Title	Author	Date
Mentally healthier council areas: Manifesto ideas for the 2022 local authority elections.’ Centre for Mental Health.	Centre for Mental Health	2022
Reducing Parental Conflict programme evaluation: Third Interim report: findings from the second and third years of delivery	Department for Work and Pensions	2022

What Works and What Doesn't Work? A Systematic Review of Digital Mental Health Interventions for Depression and Anxiety in Young People	Garrido, S., Millington, C., Cheers, D., Boydell, K., Schubert, E., Meade, T., and Nguyen, Q. V.	2019
Reducing loneliness amongst older people: a systematic search and narrative review	Hagan, R., Manktelow, R., Taylor, B.J., and Mallett, J.	2014
Prevention First: A Prevention and Promotion Framework for Mental Health	Hunter Institute	2015
Mental health promotion and mental illness prevention: The economic case London School of Economics and Political Science	The economic case London School of Economics and Political Science	2011
Prevention and mental health: Understanding the evidence so that we can address the greatest health challenge of our times	Mental Health Foundation	2019
The economic case for investing in the prevention of mental health conditions in the UK.	Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science	2022
Mental health and prevention: Taking local action for better mental health.	Mental Health Foundation	2016
Review paper on mental health risk and protective factors and interventions	Mental Health Foundation	2015
Better Mental Health For All: A public health approach to mental health improvement	Mental Health Foundation	2016
Mental Health Foundation Strategy 2020-2025 Making Prevention Happen	Mental Health Foundation	2020
All the lonely people	Mental Health Foundation	2022
Long-term conditions and mental health The cost of co-morbidities	The King’s Fund	2012
Older people: independence and mental wellbeing.	NICE	2015
Workplace resources to improve both employee wellbeing and performance: A systematic review and meta-analysis	Nielsen, K., Nielsen, M.B., Ogbonnaya, C., Känsälä, M., Saari, E., and Isaksson, K.	2017
Systematic Review and Meta-Analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents	Olsen, J. (2021)	2021
Recommendations for the provision of services for childbearing women	Perinatal mental health services	2021
Summary of evidence on public mental health interventions	Royal College of Psychiatrists	2022

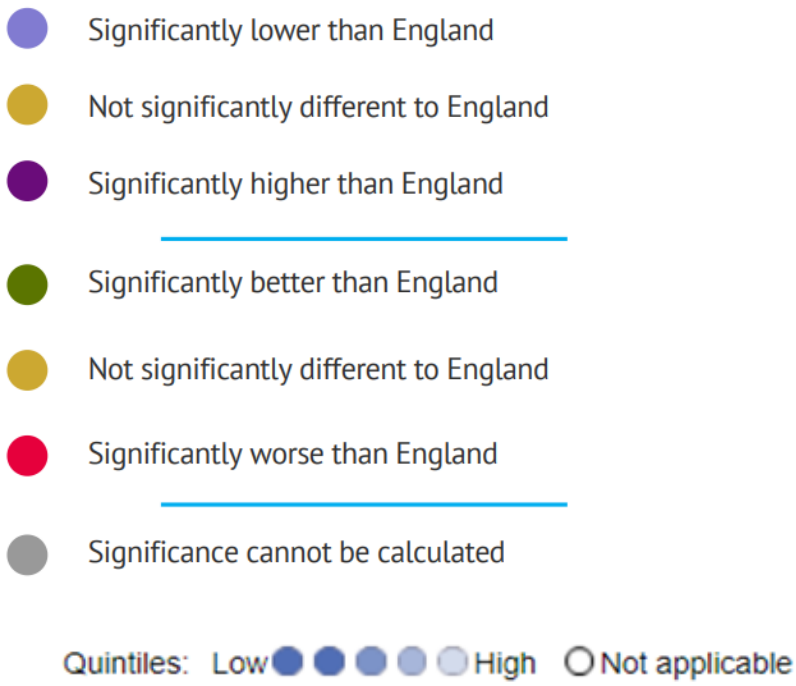
The Independent Review of Mental Health and Employers	Thriving at work	2017

14.4 Appendix 4: Comparator key

Where meaningful, throughout the JSNA we compare the city to other geographies: England; and CIPFA comparators (These are areas with similar population demographics to Brighton & Hove which allows better comparisons of outcomes and performance. The comparator local authorities for Brighton & Hove are: Bournemouth, Bristol, Coventry, Leeds, Medway, Newcastle upon Tyne, North Tyneside, Nottingham, Plymouth, Portsmouth, Sheffield, Southampton, Southend-on-Sea, Swindon, York).

Throughout the needs assessment, the colours used for comparison to England are based upon whether Brighton & Hove is statistically significantly lower / higher or better / worse than England (where this judgement can be made).

Key:



Recent trends:

14.6 Appendix 5: Summary of impacts of COVID-19 pandemic by life stage

This section provides evidence on impact from Covid19 on each life stage from a rapid review of the evidence in June-July 2022

Perinatal mental health	**Children and young people**
Women and their families faced extra pressures on their mental health, such as anxiety about giving birth during lockdown or about becoming unwell, fears about losing employment, and increasing levels of domestic violence. The impact was unequal with women from ethnic minorities and those more socioeconomically deprived disproportionately affected.[204] Changes to service provision meant that women were not able to access appropriate mental health care. Informal support from friends and family was also drastically reduced.[205] As a result of changes to mental health and other health and social care services during the pandemic, healthcare staff reported feeling less able to assess women, particularly their relationship with their baby. Reduced face-to-face contact made it harder to detect easy signs of mental health issues.[206]	Some children and young people's mental health and wellbeing has been substantially impacted due to and during the pandemic. Some children and young people coped well as life satisfaction only slightly reduced and happiness was relatively stable. It was females and those with pre-existing mental health issues who experienced more negative impacts, compared to pre-pandemic.[207] However, children and young people also appeared to have experienced a reduction in mental health symptoms as restrictions eased.[208] Children's social and emotional development, and language and physical development was negatively affected.[209] For many, school closures meant increased food insecurity, missed learning as well as the loss of important sources of emotional support. Levels of psychological distress among 18–24 year-olds had almost doubled in April 2020 compared with 2017/18. Loss of employment was significantly higher among young people. Young people from a Black background were more likely to have reduced employment than their white peers.[210] There was an increase in children with SEND experiencing worsening mental health, including anxiety, feeling unhappy and being more isolated.[211]
Working age adults	**Older people**
The COVID-19 pandemic has had a significant impact on the mental health of the population, through increased exposure to stressors. The prevalence of psychological distress in adults significantly rose from 21% in September	One pre-existing cohort study (with a convenience sample) that focuses on older adults (aged 50+) found slight increases in average self-reported depression and anxiety symptoms and that these were associated with

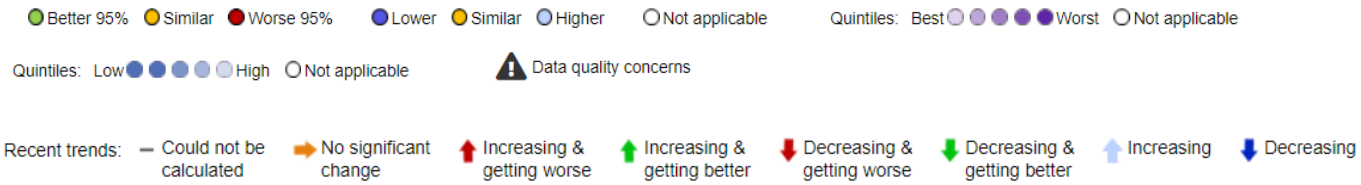
2020 to 27% in January 2021.[212] Particular issues include: • Social isolation disproportionately affected working age adults who live alone, the poor and people in rented accommodation • Jobs and financial losses have increased during the pandemic • Loss of regular coping mechanisms to relieve anxiety, like taking regular exercise, easy access to outdoor space and seeing friends and family [213] • Bereavement has affected many people. Additionally, there has been limited ability to spend time with loved ones and have the usual funeral arrangements, disrupting grieving processes[214] • Work-related stress and trauma, particularly for those working in frontline/ essential roles during the pandemic, is a risk for post-traumatic stress disorder[215] • Restrictions have increased challenges for carers[216] • Damaging or taking away their support structures of people with long-term mental health issues by.[217] Adults with a learning disability were at even greater risk of dying than those with a physical disability. Many disabled people also experienced a decline in health due to cancellations of treatment, reduced access to health care, or a worsening of conditions from a drop in physical activity and were six times more likely to report feeling depressed than the general public (in June 2020).[218]	loneliness and decreases in physical activity. However, overall levels are lower than those reported by younger adults, and these have been consistently low for the last five years.[219] The Understanding Society cohort, study however suggests that, among people aged 55 and over there was no evidence of a change in mental health and wellbeing due to Covid.[220]

14.7 Appendix 6: Risk and protective factors indicators

These tables give comparative data for Brighton & Hove, CIPFA comparators and England, as well as trend for identified risk and protective factors which can be measured and compared. They are drawn from the Office for Health Improvement and Disparities profiles (links provided in each section to relevant profiles).

14.7.1 Common risk factors

Indicators of common risk factors for mental wellbeing, Brighton & Hove, CIPFA comparators and England, various dates (see table)



Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Children and young people						
Children in low-income families (all dependent children aged < 20) (%)	2016	7,865	↓	16%	17%	-
Low birth weight of term babies (% of live births)	2020	55	→	2.6%	2.9%	-
Reception: % overweight (incl. obesity)	2019/20	275	→	22.6%	23.0%	
Year 6: % overweight (including obesity)	2019/20	660	→	28.3%	35.2%	36.2%
Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years	2018	1,007	–	197.5	181.4	235.0
Children in care: rate per 10,000	2021	373	→	74	67	-
School pupils with social, emotional and mental health needs: %	2020	1,047	↑	3.3%	2.7%	-
Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18 years	2017	718	–	140.0	93.8	79.2

15-year-olds with 3 or more risky behaviours: %	2014/15	-	–	23.7%	15.9%	-
First time entrants to youth justice system: rate per 100,000 10-17 yr olds	2020	32	→	143.7	169.2	-
16–17-year-olds not in education, employment or training (NEET) or whose activity is not known: %	2020	220	→	4.4%	5.5%	-
Physical health						
Percentage of adults (aged 18+) classified as overweight or obese	2019/20	-	–	49.3%	62.8%	-
Deprivation						
Fuel poverty (low income, high-cost methodology): % of households	2018	14,575	→	11.2%	10.3%	-
Employment deprivation: score	2015	-	–	0.112	0.119	-
Deprivation score	2019	-	–	20.8	21.7	
Employment and support allowance claimants	2018	11,690	↓	5.7%	5.4%	5.9%
Housing and employment						
Long term claimants of Jobseeker's allowance	2020	281	↓	1.4	2.6	3.2
Statutory homelessness (households in temporary accommodation)	2017/18	1,705	↑	13.2	3.4	2.0
Statutory homelessness (eligible homeless people not in priority need)	2017/18	110	↓	0.8	0.8	-
Housing affordability ratio	2016	-	–	11.2	7.2	-
Crime deprivation score	2015	-	–	0.13	0.01	-
First time offenders	2020	315	↓	120	160	-
Crime, safety and violence						

Domestic abuse-related incidents and crimes per 1,000 population	2020/21	-		22.1 Sussex	30.3	
Violent crime: violence offences per 1,000 population	2020/21	8,593	↑	29.5	29.5	-
Re-offending levels: percentage of offender who reoffend	2018/19	700		32.4%	27.9%	-
Alcohol, drugs and tobacco						
Admission episodes for alcohol related conditions: persons	2018/19	3,852	→	1,580	2,367	-
Admission episodes for alcohol related conditions: male	2018/19	2,451	→	2,149	3,246	-
Admission episodes for alcohol related conditions: female	2018/19	1,401	↓	1,069	1,608	
Estimated prevalence of opiate and/or crack cocaine use	2016/17	2,065		10.0	8.9	10.6
Smoking prevalence in adults (18+) - current smokers: %	2019	42,107		17.5%	13.9%	-
Smoking status at the time of delivery: %	2020/21	131	→	5.9%	9.6%	-
Smoking status in adults with anxiety or depression (18+) - current smokers: %	2016/17	-		26.9%	25.8%	-
Smoking status in adults with a long-term mental health condition (18+) - current smokers: %	2019/20	-		32.4%	25.8%	-
Drugs related deaths	2018-20	95		10.9%	5%	-
Other risk factors						
Statutory homelessness: rate per 1,000 households	2017/18	492	→	3.8	2.4	2.5
Children leaving care: rate per 10,000 children aged under 18	2017/18	176	→	34.5	25.2	30.1

Migrant GP registrations: rate per 1,000 population	2017	5,906	↓	20.5	12.6	17.8
Children subject to a child protection plan with initial category of abuse: rate per 10,000 children aged under 18	2018	186	–	36.5	21.2	28.1
Children subject to a child protection plan with initial category of neglect: rate per 10,000 children aged < 18	2018	169	–	33.1	21.8	23.5
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged < 18	2018	91	–	17.8	16.4	21.0
Looked after children aged under 5: rate per 10,000 population aged < 5	2017/18	58	–	41.0	34.9	42.0

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

Indicators of common protective factors for mental wellbeing, Brighton & Hove, and England (where available), various dates (see table)

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Best Worst Not applicable

Quintiles: Low High Not applicable Data quality concerns

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Community resilience / social capital						
% of adults satisfied with Brighton & Hove as a place to live[1]	2018	-	-	88%	-	
% of adults satisfied with their local area as a place to live [1]	2018	-	-	89%	78%	
% of adults who say they have enough money to meet basic living costs [1]	2018	-	-	66%	-	

% of adults who feel they belong in their neighbourhood [1]	2018	-	-	76%	62%	
% of adults who think that people from different backgrounds get on well together in their neighbourhood[1]	2018	-	-	94%	82%	
% of adults who think that people pull together to improve their neighbourhood [1]	2018	-	-	76%	59%	
% of residents who say they have given unpaid help to groups, clubs or organisations in the past year [1]	2018	-	-	44%	38%	
Education and employment						
School readiness: % of children achieving a good level of development at the end of reception	2018/19	1,888	↑	71.5%	71.8%	69.9%
Average attainment 8 score	2020/21	111,523	–	52.4	50.9	-
Average attainment 8 score of children in care	2020	790	–	23.9	21.4	-
Percentage of people in employment	2020/21	157,600	→	76.3%	75.1%	-
Outdoor space and physical activity						
Utilisation of outdoor space for exercise/health reasons	2015/16		–	18.3%	17.9%	-
Percentage of physically active adults	2019/20		–	71.9%	66.4%	-
Social contact						
Percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2019/20	1,455	–	42.8%	45.9%	44.1%
Percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	135	–	36.3%	32.5%	32.5%
Indicators for elsewhere:						

Satisfaction with local mental health services [1]	2018			63%	-	

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile: Protective factors. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
Unless otherwise stated

[1] Brighton & Hove City Council: City Tracker Survey 2018. Available at SURVEYS | BH Connected

14.7.2Perinatal mental health

Risk factors for maternal mental ill health issues, Brighton & Hove, England and CIPFA comparators, various dates

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Low High Not applicable

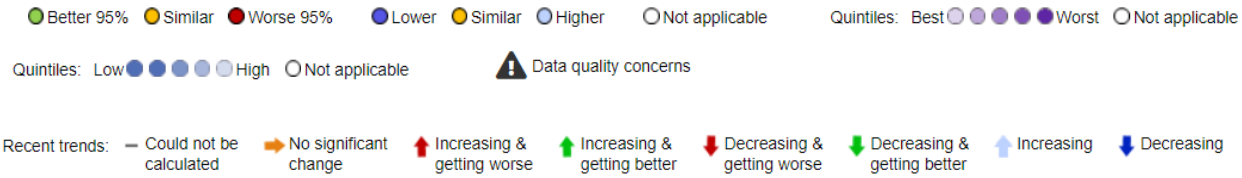
Risk factor	Indicator	Period	Count	Rate		
				B&H	Eng.	CIPFA
Poverty	Children in low-income families (all dependent children aged under 20)	2016	-	16%	17%	-
Migration status	Percentage of births to non-UK mothers	2020		28%	29% (E&W)	-
Ethnicity[221, 222,223]	Percentage of births to mothers from Black and Ethnic Minority Groups	2019/20	330	15%	20%	-
Lone parenthood [224]	Percentage of births registered to a sole parent	2017	138	5%	5%	6%
	Lone parent families (% of households)	2011	8,637	7.1%	7.1%	7.6%
Alcohol or drug abuse	Estimated number of alcohol dependent adults living with children per 1,000 population[c]	2018-19	788	3	3	3
	Estimated number of opiate dependent adults living with children per 1,000 population	2014-15	470	2	2	3
Exposure to violence[225]	Domestic abuse-related incidents and crimes per 1,000 population	2020/21	-	22.1 (Sussex)	30.3	-
Bereavement by miscarriage, stillbirth or neonatal death[226,227]	Still births per 1,000 live births	2017-2019	27	3.5	4	4
	Infant deaths per 1,000 live births	2018-2020	24	3.3	3.3	-

[c] Public Health England. Parents with problem alcohol and drug use: Data for England and Brighton & Hove, 2019 to 2020. Accessed 24/03/2022. Available at Parents with problem alcohol and drug use: Data for England and Brighton & Hove, 2019 to 2020 (ndtms.net)

Source: Office for Health Improvement and Disparities. Perinatal mental health profile. Available at: Perinatal Mental Health - OHID (phe.org.uk) unless otherwise stated

14.7.3Children and young people

Indicators of common risk factors for children and young people's mental wellbeing, Brighton & Hove, CIPFA comparators and England, various dates (see table)



Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
Children in low-income families (all dependent children aged < 20) (%)	2016	7,865	↓	16%	17%	-
Low birth weight of term babies (% of live births)	2020	55	→	2.6%	2.9%	-
Reception: % overweight (incl. obesity)	2019/20	275	→	22.6%	23.0%	
Year 6: % overweight (including obesity)	2019/20	660	→	28.3%	35.2%	36.2%
Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years	2018	1,007	–	197.5	181.4	235.0
Children in care: rate per 10,000	2021	373	→	74	67	-
School pupils with social, emotional and mental health needs: %	2020	1,047	↑	3.3%	2.7%	-
Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18 years	2017	718	–	140.0	93.8	79.2
15-year-olds with 3 or more risky behaviours: %	2014/15	-	–	23.7%	15.9%	-
First time entrants to youth justice system: rate per 100,000 10-17 yr olds	2020	32	→	143.7	169.2	-
16–17-year-olds not in education, employment or training (NEET) or whose activity is not known: %	2020	220	→	4.4%	5.5%	-

Children leaving care: rate per 10,000 children aged under 18	2017/18	176	→	34.5	25.2	30.1
Children subject to a child protection plan with initial category of abuse: rate per 10,000 children aged under 18	2018	186	–	36.5	21.2	28.1
Children subject to a child protection plan with initial category of neglect: rate per 10,000 children aged < 18	2018	169	–	33.1	21.8	23.5
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged < 18	2018	91	–	17.8	16.4	21.0
Looked after children aged under 5: rate per 10,000 population aged < 5	2017/18	58	–	41.0	34.9	42.0

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

Indicators of common protective factors for children and young people's mental wellbeing, Brighton & Hove, and England (where available), various dates (see table)

Better 95% Similar Worse 95% Lower Similar Higher Not applicable Quintiles: Best Worst Not applicable

Quintiles: Low High Not applicable Data quality concerns

Indicator	Period	Count	Trend	Rate		
				B&H	Eng.	CIPFA
School readiness: % of children achieving a good level of development at the end of reception	2018/19	1,888	↑	71.5%	71.8%	69.9%
Average attainment 8 score	2020/21	111,523	–	52.4	50.9	-
Average attainment 8 score of children in care	2020	790	–	23.9	21.4	-
Mean score of the 14 Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) statements at age 15	2014/15	-	–	47.1	74.6	-

Source: Office for Health Improvement and Disparities. Mental health and wellbeing JSNA profile: Protective factors. Available at: Mental Health and Wellbeing JSNA - OHID (phe.org.uk)

14.7.4Working age adults

Covered in common risk and protective factors

14.7.5Older people

Risk and protective factors for older people's mental health, Brighton & Hove, Various dates

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Older people in poverty: Income deprivation affecting older people index (IDAOPI)	2019	9,271		18.7%	14.2%	-
Fuel poverty (low income, high-cost methodology)	2018	14,575	→	11.2%	10.3%	-
Older people living alone: % of households occupied by a single person aged 65 or over	2011	14,468		11.9%	12.4%	12.0%
Percentage of the total population aged 80 or over	2020	11,200		3.8%	5.0%	-
Percentage of population aged 65+ who are carers	2011	4,527		12.7%	13.8%	
Percentage of adult social care users who have as much social contact as they would like (65+ yrs)	2019/20	750	→	41.1%	43.4%	42.6%
Percentage of adult carers who have as much social contact as they would like (65+ yrs)	2018/19	75		41.5%	34.5%	33.5%
Healthy life expectancy at 65 (male)	2017-2019	-		11.5	10.6	-
Healthy life expectancy at 65 (female)	2017-2019	-		12.3	11.1	
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2020/21	256	→	656	498	-
Hospital admission episodes for alcohol related conditions (narrow definition) 65+ years: age standardised rate per 100,000 population (Persons)	2019/20	274		713	839	-
Males	2019/20	211		1,171	1,334	-
Females	2019/20	62		306	420	-
Emergency hospital admissions due to falls in people aged 65+: Directly age standardised rate per 100,000	2019/20	1,010	→	2,415	2,222	-
Dementia: Recorded prevalence rate aged 65+	2020	1,781		4.2%	4.0%	-

Source: Office for Health Improvement and Disparities. Productive Health Ageing Profile Productive Healthy Ageing Profile - OHID (phe.org.uk) unless otherwise stated

14.8 Appendix 7: Priority 154 engagement events

This Appendix provides a list of the various engagement events with young people between 2018 and 2022 which were synthesized for this needs assessment to provide the voice of young people.

Title	Date	Link
Takeover Day: mental health and emotional wellbeing	2018	https://1drv.ms/b/s!AvUpw5WUlW4khbFrhFshStZuSSIdQ?e=edJFIc
Building Connections: Youth Loneliness	2019	https://1drv.ms/b/s!AvUpw5WUlW4kha9MdF_tMYpEeErF-A?e=LPGQXl
Foundations for Our Futures Away Day	2022	https://1drv.ms/w/s!AvUpw5WUlW4khbFqn5q-CKKG2-zPLA?e=DzHJ7Y
Speak Your Mind: MHST project	2021	https://1drv.ms/b/s!AvUpw5WUlW4khaMnyyjReVZvGtr5vw?e=KaQNvp
Connecting Mind: MHST project	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaMjNLo7gNmSc80N3w?e=VkAVqY
Supporting Early Eating Disorders	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaUnywM-1Px3k482g?e=Tb6goY
Smooth Moves to Secondary School	2022	https://1drv.ms/b/s!AvUpw5WUlW4khaMp905b8Uz9B8yhHA?e=TnNRlO

14.9 Appendix 8: Summary of key outcome measures for mental health

These tables give comparative data for Brighton & Hove, CIPFA comparators and England, as well as trend for identified outcome measures which can be measured and compared. They are drawn from the Office for Health Improvement and Disparities profiles (links provided in each section to relevant profiles).

Summary of key outcome measures for mental health, Brighton & Hove, CIPFA comparators and England, various dates (see table)

Indicator	Period	Count	Trend	Rate		
		B&H	B&H	B&H	Eng.	CIPFA
Self-harm						
Emergency hospital admissions for intentional self-harm	2020/21	900	↓	265.1	181.2	-
Mental health related care						
Successful completion of drug treatment: opiate users	2020	57	↓	5.0%	4.7%	4.5%
Successful completion of drug treatment: non-opiate users	2020	162	↓	22.8%	33.0%	31.9%
Successful completion of alcohol treatment	2020	166	↓	24.9%	35.3%	34.3%
Satisfaction with social care protection: % of users	2017/18	-	–	87.3%	86.3%	-
Concurrent contact with mental health services and substance misuse services for drug misuse	2016/17	142	–	22.1%	24.3%	19.5%
Concurrent contact with mental health services and substance misuse services for alcohol misuse	2016/17	83	–	20.4%	22.7%	17.4%
Contact with mental health or learning disability services: rate per 1,000 patients on GP practice list aged 18+	2014/15	7,985	–	31.6	38.7	38.0
Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow)	2018/19	209	↓	75.0	75.6	-
Severe mental illness						
Employment of people with mental illness or learning disability: %	2018 Q4	20,400	→	63.1%	48.0%	49.3%

Adults in contact with secondary mental health services who live in stable and appropriate accommodation (persons)	2020/21	-		74.0%	58.0%	-
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (female)	2020/21	-		77.0%	59.0%	-
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (male)	2020/21	-		71.0%	56.0%	-
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2019/20	-		66.7	67.2	
Premature mortality in adults with severe mental illness	2018-20	610		120.1	103.6	-
Excess under 75 mortality rate in adults with severe mental illness suicide (SMI)	2018-20	-		433.7%	389.9%	-
Suicide						
Suicide rate	2018-20	102		12.8	10.4	-

Source: Office for Health Improvement and Disparities, Mental Health and Wellbeing JSNA profile

14.10 Appendix 9: Children and young people's mental health services Brighton & Hove

This Appendix gives further detail on the services in Brighton & Hove who support children and young people's mental health.

Service	Offer	Thrive area	Age range
Allsorts	LGBTQ + support and advocacy charity	Thriving, Getting help	No age limit
Audio Active	Social initiative to support young people to reach their potential	Thriving, Getting help	
BHISS	Support for children who need extra help to learn	Getting help, getting more help	0-18
Chathealth	Text based support service	Getting help	
Mental Health Support Team Schools	Target offer aimed at reducing health inequalities: offers Low intensity Cognitive Behavioural Therapy (LI-CBT) informed interventions to young people, support and training to parents/carers and support around whole school approaches to mental health and wellbeing.	Getting help, getting more help	5 to 18
MIND/Young minds	Promotes positive mental health, information advice and guidance	Thriving, Getting help	
Mindout	LGBTQ+ support	Getting help, getting more help	18 +
Safety Net	Advice and guidance around bullying, friendships, feeling safe etc.	Getting help, getting more help	
Samaritans	Listening, signposting advice and guidance	Getting help, getting more help	No age limit
School nurses	Overall child health support and wellbeing	Getting help	0 to 18
Schools Wellbeing Service	Range of work includes 1-1 work, group work, parent/carer consultations, training for parents/carers and school staff. Focussed activities around aspects such as transition stages. Also offer specific interventions around EBSA such as	Getting help, getting more help	5 to 18

	online art therapy, mountain biking, bouldering, and Forest Schools.		
SPFT Specialist CAMHS	Urgent help Service, Home Treatment Team, Duty and Referral, FISS, LD team, Eating disorders service	Getting more help, risk support	0-18
Togetherall	Online community for mental health and wellbeing support	Thriving, Getting help	16+
Winstons Wish	National charity - support to CYP after close bereavement	Getting help, getting more help	0-18
WISE – Child Sexual Exploitation Service (YMCA)	121 long-term support, brief interventions programme, youth volunteering programme, Bespoke and multi-agency training.	Getting help, getting more help	16+
YAC	Youth advice service offers support and guidance including housing, emotional health and wellbeing needs, family mediation etc.	Getting help, getting more help	13 to 25
YAP (Youth Advocacy Project) MIND	Advocacy - care leavers, UASC, under 18's with a disability and social worker, etc		
YMCA Dialogue		Getting help, getting more help	<26
YMCA E-Wellbeing	Digital wellbeing service	Thriving, Getting help	<26
Young Carers	Support and advice for young people with regular caring responsibilities	Thriving, Getting help	8 to 24
Young Minds	Information, advice and guidance - champions mental health	Thriving, Getting help, getting more help	<26
Young Oasis	for young people affected by substance misuse - included therapeutic support, young women's services	Getting help, getting more help	5-25 (service offers vary)
Young Peoples Centre (Impact Initiatives)	Safe social space where young people can access advice, support and Counselling	Getting help, getting more help	13-25

15 References

[1] World Health Organization. Mental health: strengthening our response. 2022 https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

[2] Mental Health Foundation. No Health without Mental Health No health without mental health | Mental Health Foundation

[3] Faculty of Public Health and Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement. 2016 better-mental-health-for-all-final-low-res.pdf (fph.org.uk)

[4] Queensland Mental Health Commission, Adapted from Tudor (1996) The dual continuum of mental health and mental illness | Child Safety Practice Manual (csyw.qld.gov.au)

[5] Queensland Mental Health Commission, Adapted from Tudor (1996) The dual continuum of mental health and mental illness | Child Safety Practice Manual (csyw.qld.gov.au)

[6]https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-3-trends-in-morbidity-and-risk-factors#mental-health

[7] The Mental Health Foundation, The economic case for investing in the prevention of mental health conditions in the UK. 2022 MHF-Investing-in-Prevention-Report-Summary.pdf (mentalhealth.org.uk)

[8] Local Government Association. Children and young people's emotional wellbeing and mental health – facts and figures. 2022. Children and young people's emotional wellbeing and mental health – facts and figures | Local Government Association.

[9] Mental Health Foundation. Prevention and mental health report. 2019. MHF_Prevention_Report_ONLINE-VERSION.pdf (mentalhealth.org.uk)

[10] Mental Health Foundation. Physical health conditions: statistics. Mental health statistics: physical health conditions | Mental Health Foundation

[11] Thornicroft G. Premature death among people with mental illness. BMJ, 2013; 346: f2969

[12] Public Health England. Mental Health and wellbeing JSNA Toolkit. Population Factors 3. Mental health: population factors - GOV.UK (www.gov.uk)

[13] Mental Health Foundation. The economic case for investing in the prevention of mental health conditions in the UK. 2022. MHF_Investing_In_Prevention_FULLReport_FINAL.pdf (mentalhealth.org.uk)

[14] The Health Foundation. Unequal pandemic, fairer recovery. 2021 Unequal pandemic, fairer recovery - The Health Foundation

[15] Mental Health Foundation. Mental Health in the Covid-19 pandemic. MHF Mental Health in the COVID-19 Pandemic.pdf

[16] The Health Foundation. Unequal pandemic, fairer recovery. 2021. Unequal pandemic, fairer recovery - The Health Foundation

[17] Centre for Mental Health. Covid-19 and the nation's mental health: Forecasting needs and risks in the UK: May 2021. CentreforMentalHealth_COVID_MH_Forecasting4_May21.pdf

[18] Institute for Government. Cost of living crisis. 2022. Cost of living crisis | The Institute for Government

[19] House of Commons Library. Rising cost of living in the UK. 2022. Rising cost of living in the UK - House of Commons Library (parliament.uk)

[20] Royal College of Psychiatrists. Cost-of-living crisis threat of 'pandemic proportions' to mental health. 2022 Cost-of-living crisis threat of 'pandemic proportions' to mental health, warns UK's leading psychiatrist (rcpsych.ac.uk)
[21] Intergovernmental Panel on Climate Change. Climate Change 2022: Impacts, Adaptation and Vulnerability. Health, Wellbeing and the Changing Structure of Communities. Climate Change 2022: Impacts, Adaptation and Vulnerability | Climate Change 2022: Impacts, Adaptation and Vulnerability (ipcc.ch)
[22] Cianconi P, Betrò S, Janiri L. The Impact of Climate Change on Mental Health: A Systematic Descriptive Review. Front Psychiatry. 2020 Mar 6;11:74. doi: 10.3389/fpsyt.2020.00074. PMID: 32210846; PMCID: PMC7068211. The Impact of Climate Change on Mental Health: A Systematic Descriptive Review - PMC (nih.gov)
[23] The Health Foundation. NHS workforce projections 2022. NHS workforce projections 2022 - The Health Foundation
[24] The Health Foundation. NHS workforce projections 2022. NHS workforce projections 2022 - The Health Foundation
[25] The King's Fund. NHS workforce: our position. 2022 NHS workforce: our position | The King's Fund (kingsfund.org.uk)
[26] The King's Fund. Workforce race inequalities and inclusion in NHS providers. 2020. Workforce race inequalities and inclusion in NHS providers | The King's Fund (kingsfund.org.uk)
[27] Care Quality Commission. State of Care. 2022 State of Care - Care Quality Commission (cqc.org.uk)
[28] Care Quality Commission. State of Care. 2022 State of Care - Care Quality Commission (cqc.org.uk)
[29] Barton, H. and Grant, M. (2006) A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253. ISSN 1466-4240 developed from the model by Dahlgren and Whitehead, 1991. Dahlgren G, Whitehead M (1991). "The main determinants of health" model, version accessible in: Dahlgren G, and Whitehead M. (2007) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional Office for Europe http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf
[30] Social determinants of health and the role of local government
[31] Department of Health and Social Care. Prevention is better than cure. 2018 Prevention is better than cure (publishing.service.gov.uk)
[32] Department of Health and Social Care. Prevention is better than cure. 2018 Prevention is better than cure (publishing.service.gov.uk)
[33] Local Government Association. Social determinants of health and the role of local Government. 2020. Social determinants of health and the role of local government
[34] The Health Foundation. How to talk about the building blocks of health
A communications toolkit for people working in public health. 2022 How to talk about the building blocks of health - The Health Foundation

[36] Hunter institute of mental health. Prevention First: A prevention and promotion framework for mental health. 2015 Prevention-First-A-Prevention-Promotion-Framework-for-Mental-Health-Hunter-Institute.pdf (ssatuk.co.uk)
[37] Savic R. Beaglehole R, Bonita R, Kjellstrom T. Basic Epidemiology [Internet]. Academia.edu. 2022.

https://www.academia.edu/34738560/Beaglehole_R_Bonita_R_Kjellstrom_T_Basic_Epidemiology

[38] Office for Health Improvement and Disparities. Policy paper Prevention Concordat for Better Mental Health. 2022 Prevention Concordat for Better Mental Health - GOV.UK (www.gov.uk)

[39] Brighton & Hove City Council. Joint Strategic Needs Assessment (JSNA) Executive Summary March 2022. NEEDS ASSESSMENTS | BH Connected

[40] Brighton & Hove City Council. JSNA Population summary Brighton & Hove Population JSNA 2021 - Infogram

[41] Office for Health Improvement and Disparities. Perinatal mental health profile. Perinatal Mental Health - OHID (phe.org.uk) unless otherwise stated

[42] Office for National Statistics. Births by parents' country of birth, England and Wales: 2020. Births by parents' country of birth, England and Wales - Office for National Statistics (ons.gov.uk)

[43] Centre for Research in Social Policy at Loughborough University. *Local indicators of child poverty after housing costs, 2019/20*

[44] Brighton & Hove Economic Strategy, 2018 Brighton & Hove Economic Strategy (brighton-hove.gov.uk)

[45] Community Works Brighton & Hove with support from University of Brighton. Taking Account 4: The economic and social audit of the third sector in Brighton & Hove. Taking Account - Community Works (bhcommunityworks.org.uk)

[46] Department of Health. Annual report of the Chief Medical Officer 2013 - Public health priorities 2014 Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors 3. Mental health: population factors - GOV.UK (www.gov.uk)

[47] Joseph Rowntree Foundation. Population turnover and area deprivation 2007 Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors 3. Mental health: population factors - GOV.UK (www.gov.uk)

[48] Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: environmental factors 2. Mental health: environmental factors - GOV.UK (www.gov.uk)

[49] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)

[50] Priest N, Paradies Y, Trenerry B, Truong M, Karlsen S, Kelly Y. A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. Social Science & Medicine. 2013;95:115-127.

[51] Fitzpatrick R, Kumar S, Nkansa-Dwamena O, Thorne L. Ethnic inequalities in mental health: promoting lasting positive change 2014. Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors

[52] Bhui K. Brexit, social division and discrimination: impacts on mortality and mental illness? The British Journal of Psychiatry (2016); 209(2):181-2. Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors

[53] Bhui K. Brexit, social division and discrimination: impacts on mortality and mental illness? The British Journal of Psychiatry (2016); 209(2):181-2. Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors

[54] Hatch SL, Gazard B, Williams DR, Frissa S, Goodwin L, Team SES, Hotopf M. Discrimination and common mental disorder among migrant and ethnic groups: findings

from a South East London community sample. Social Psychiatry and Psychiatric Epidemiology (2016); 51:689-701. Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors

[55] Vostanis P. Meeting the mental health needs of refugees and asylum seekers. The British Journal of Psychiatry (2014); 204(3):176-7 Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors

[56] Blackmore R, Gray K, Boyle J, Fazel M, Ranasinha S, Fitzgerald G et al. Systematic Review and Meta-analysis: The Prevalence of Mental Illness in Child and Adolescent Refugees and Asylum Seekers. Journal of the American Academy of Child & Adolescent Psychiatry. 2020;59(6):705-714.

[57] Equality and Human Rights Commission. Gypsies and Travellers: simple solutions for living together. Gypsies and Travellers: simple solutions for living together | Equality and Human Rights Commission (equalityhumanrights.com)

[58] Data.kingston.gov.uk. 2022 http://data.kingston.gov.uk/wpcontent/uploads/2017/11/JSNA_GypsiesandTravellersChapter2016.pdf

[59] Sándor J, Kósa Z, Boruzs K, Boros J, Tokaji I, McKee M et al. The decade of Roma Inclusion: did it make a difference to health and use of health care services?. International Journal of Public Health. 2017;62(7):803-815.

[60] Equality and Human Rights Commission. Gypsies and Travellers: simple solutions for living together. Gypsies and Travellers: simple solutions for living together | Equality and Human Rights Commission (equalityhumanrights.com)

[61] Equalityhumanrights.com. 2022 https://www.equalityhumanrights.com/sites/default/files/research_report_12inequalities_experienced_by_gypsy_and_traveller_communities_a_review.pdf

[62] Brighton & Hove City Council Safe and Well at School Survey 2021 SURVEYS | BH Connected

[63] Mental Health Foundation. Children in care and care leavers. National Care Leavers' Awareness Week 2020 | Mental Health Foundation

[64] NSPCC. What works in preventing and treating poor mental health in looked after children? 2014 What works in preventing and treating poor mental health in looked after children? (ox.ac.uk)

[65] Social Market Foundation. Looked-after children. The silent crisis. 2018 Looked-after Children: The Silent Crisis (smf.co.uk)

[66] Who Cares? Scotland. THE IMPACT OF COVID-19 ON SCOTLAND'S CARE EXPERIENCED COMMUNITY Microsoft Word - Impact of Covid-19 on Scotland's Care Experienced Community May 2020 (whocaresscotland.org)

[67] Alliance for children in care and care leavers. Promoting looked after children's emotional wellbeing and recovery from trauma through a child-centred outcomes framework. 2022. 08-16-Alliance-Promoting-Emotional-Wellbeing-Recovery-from-Trauma.pdf (tactcare.org.uk)

[68] Mental Health Foundation. Children in care and care leavers. National Care Leavers' Awareness Week 2020 | Mental Health Foundation

[69] Iriss. Care experienced children and young people's mental health. 2020. Care experienced children and young people's mental health | Iriss

[70] Mental Health Foundation. Students. Students | Mental Health Foundation

[71] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)

[72] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[73] Brighton & Hove City Council. JSNA Executive Summary November 2021. http://www.bhconnected.org.uk/sites/bhconnected/files/bandh-jsna-exec-summary-november-2021.pdf
[74] Brighton & Hove City Council. Trans needs assessment 2015. NEEDS ASSESSMENTS | BH Connected
[75] Long-term physical conditions and mental health [Internet]. Mental Health Foundation. 2022. https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/long-term-physical-conditions-and-mental-health
[76] Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors 3. Mental health: population factors - GOV.UK (www.gov.uk)
[77] NHS England. Five year forward view for mental health (2016) Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors
[78] Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors 3. Mental health: population factors - GOV.UK (www.gov.uk)
[79] NHS England. Five year forward view for mental health (2016) Taken from Public Health England. Mental health and wellbeing JSNA toolkit: Mental health: population factors
[80] Noh JW, Kwon YD, Park J, Oh IH, Kim J. Relationship between Physical Disability and Depression by Gender: A Panel Regression Model. PLoS One. 2016 Nov 30;11(11):e0166238. doi: 10.1371/journal.pone.0166238. PMID: 27902709; PMCID: PMC5130183.
[81] Jason Buckles, Ruth Luckasson & Elizabeth Keefe (2013) A Systematic Review of the Prevalence of Psychiatric Disorders in Adults With Intellectual Disability, 2003–2010, Journal of Mental Health Research in Intellectual Disabilities, 6:3, 181-207, DOI: 10.1080/19315864.2011.651682
[82] Glasson EJ, Buckley N, Chen W, Leonard H, Epstein A, Skoss R, Jacoby P, Blackmore AM, Bourke J, Downs J. Systematic Review and Meta-analysis: Mental Health in Children With Neurogenetic Disorders Associated With Intellectual Disability. J Am Acad Child Adolesc Psychiatry. 2020 Sep;59(9):1036-1048. doi: 10.1016/j.jaac.2020.01.006. Epub 2020 Jan 13. PMID: 31945412.
[83] Cooper, S.-A., Smiley, E., Finlayson, J., Jackson, A., Allan, L., Williamson, A., Mantry, D. and Morrison, J. (2007), The Prevalence, Incidence, and Factors Predictive of Mental Ill-Health in Adults with Profound Intellectual Disabilities. Journal of Applied Research in Intellectual Disabilities, 20: 493-501. https://doi.org/10.1111/j.1468-3148.2007.00401.x
[84] Campion J (2019) Public mental health: Evidence, practice and commissioning. Royal Society for Public Health
[85] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[86] Autistica. Autism and mental health: a guide to looking after your mind. Mental-health-autism-E-LEAFLET.pdf (autistica.org.uk)
[87] Mental Health Foundation. Autism and mental health. 2022 Autism and mental health
[88] Mental Health Foundation. Attention deficit hyperactivity disorder (ADHD). 2021. Attention deficit hyperactivity disorder (ADHD) (mentalhealth.org.uk)

[89] Fuller-Thomson E, Lewis D, Agbeyaka S. Attention-Deficit/Hyperactivity Disorder and Alcohol and Other Substance Use Disorders in Young Adulthood: Findings from a Canadian Nationally Representative Survey. Alcohol and Alcoholism. 2021;57(3):385-395.
[90] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[91] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[92] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[93] Mental Health Foundation. Fundamental facts about mental health 2016. fundamental-facts-about-mental-health-2016.pdf (mentalhealth.org.uk)
[94] Mental Health Foundation. Armed forces and mental health. Armed forces and mental health | Mental Health Foundation
[95] Fear NT, Jones M, Murphy D et al (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. The Lancet (2010) 375 (9728): 1783–1797.
[96] NHS Digital Mental Health of Children and Young People in England 2017 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital
[97] NHS Digital Mental Health of Children and Young People in England 2021 Wave 2 Digital Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey - NHS Digital
[98]https://www.ons.gov.uk/file?uri=%2Fpeoplepopulationandcommunity%2Fpopulationandmigration%2Fpopulationestimates%2Fdatasets%2Fpopulationestimatesforukenglandandwalesscotlandandnorthernireland%2Fmid2020/ukpopestimatesmid2020on2021geography.xls
[99]https://www.ons.gov.uk/file?uri=%2Fpeoplepopulationandcommunity%2Fpopulationandmigration%2Fpopulationestimates%2Fdatasets%2Fpopulationestimatesforukenglandandwalesscotlandandnorthernireland%2Fmid2020/ukpopestimatesmid2020on2021geography.xls
[100] Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[101] Complex trauma - UKTC (uktraumacouncil.org)
[102] Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) Taken from Public Health England 2019 Mental health and wellbeing JSNA toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)
[103] Royal College of GPs. Position Statement on Perinatal Mental Health. 2016. Perinatal Mental Health (rcgp.org.uk)
[104] Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement. 2016. better-mental-health-for-all-final-low-res.pdf (fph.org.uk)
[105] Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems – report summary (2015) Taken from Public Health England 2019 Mental health and wellbeing JSNA toolkit Mental health and wellbeing: JSNA toolkit - GOV.UK (www.gov.uk)
[106] Archives of General Psychiatry A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction (2010)

[107] Henderson JJ, Evans SF, Straton JA, Priest SR, Hagan R. Impact of postnatal depression on breastfeeding duration. Birth. 2003 Sep;30(3):175-80. doi: 10.1046/j.1523-536x.2003.00242.x. Erratum in: Birth. 2004 Mar;31(1):76. PMID: 12911800.
[108] Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems – report summary. 2015
[109] NHS England. Perinatal mental health. NHS England » Perinatal mental health
[110] MBRRACE-UK. Confidential Enquiry into Maternal Deaths. Confidential Enquiry into Maternal Deaths | NPEU > MBRRACE-UK (ox.ac.uk)
[111] National Collaborating Centre for Mental Health. Antenatal and postnatal mental health: clinical management and service guidance. Updated edition. NICE guideline (CG192). Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2014 www.nice.org.uk/guidance/cg192/evidence
[112] National Collaborating Centre For Primary Care. Clinical guidelines and evidence review for post natal care: routine post natal care of recently delivered women and their babies. NICE guideline (CG37). London: National Collaborating Centre For Primary Care and Royal College Of General Practitioners, 2006 http://www.nice.org.uk/guidance/cg37/evidence
[113] NICE (Internet). NICE clinical knowledge summaries. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013 Depression - antenatal and postnatal | Health topics A to Z | CKS | NICE
[114] NICE (Internet). NICE clinical knowledge summaries. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013 Depression - antenatal and postnatal | Health topics A to Z | CKS | NICE
[115] National Collaborating Centre For Primary Care. Clinical guidelines and evidence review for post natal care: routine post natal care of recently delivered women and their babies. NICE guideline (CG37). London: National Collaborating Centre For Primary Care and Royal College Of General Practitioners, 2006. http://www.nice.org.uk/guidance/cg37/evidence
[116] NICE (Internet). NICE clinical knowledge summaries. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013. Depression - antenatal and postnatal | Health topics A to Z | CKS | NICE
[117] Scottish Intercollegiate Guidelines Network (SIGN). Management of perinatal mood disorders SIGN guideline 127. Edinburgh: SIGN, 2012 www.sign.ac.uk/guidelines/fulltext/127/index.html
[118] Pearlstein T, Howard, M., Salisbury, A., & Zlotnick, C. Postpartum depression. American Journal of Obstetrics and Gynecology (2009) 200(4):357-6 ↩
[119] Jones I, Craddock N. Familiarity of the Puerperal Trigger in Bipolar Disorder: Results of a Family Study. American Journal of Psychiatry (2001)158(6):913-7
[120] Graungaard, A. H., & Skov, L. (2007). Why do we need a diagnosis? A qualitative study of parents' experiences, coping and needs, when the newborn child is severely disabled. Child Care, Health and Development, 33(3), 296–307. https://doi.org/10.1111/j.1365-2214.2006.00666.x
[121] Tommy's. Mental health problems after a premature birth. 2021 Mental health problems after a premature birth | Tommy's (tommys.org)
[122] Darwin Z, Domoney J, Iles J, Bristow F, Siew J and Sethna V (2021) Assessing the Mental Health of Fathers, Other Co-parents, and Partners in the Perinatal Period: Mixed

Methods Evidence Synthesis. *Front. Psychiatry* 11:585479. doi: 10.3389/fpsyt.2020.585479

[123] Public Health England. Perinatal Mental Health Profile. Perinatal Mental Health - OHID (phe.org.uk)

[124] Fetal alcohol spectrum disorder: health needs assessment - GOV.UK (www.gov.uk)

[125] Fetal alcohol spectrum disorder: health needs assessment - GOV.UK (www.gov.uk)

[126] Brighton & Hove City Council Public Health Team from data from the substance misuse service.

[127] Care Quality Commission. Maternity Survey 2021. 2022. Maternity survey 2021 - Care Quality Commission (cqc.org.uk)

[128] Coleman, L (2022) 'Exploring the views and experiences of Fathers and Non-Birthing Partners (FNBPs), Health Professionals and Pregnant Women/Mothers (PWMs) to inform how the local system can better support FNBPs during the perinatal period.' Report for East Sussex County Council.

[129] MBRRACE-UK. Saving Lives, Improving Mothers' Care. 2021. Suicide remains the leading cause of direct maternal death in first postnatal year | Maternal Mental Health Alliance

[130] Kessler R et al (2005), the National Comorbidity Survey Replication. Archives of General Psychiatry. 62 (6), 593–602

[131] NHS Long Term Plan. 2019 https://www.longtermplan.nhs.uk/

[132] Center on the Developing Child. Executive Functioning in Adults: The Science Behind Adult Capabilities (harvard.edu)

[133] NHS Long Term Plan. 2019 https://www.longtermplan.nhs.uk/

[134] National Collaborating Centre for Mental Health. Antenatal and postnatal mental health: clinical management and service guidance. Updated edition. NICE guideline (CG192). Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2014 www.nice.org.uk/guidance/cg192/evidence

[135] National Collaborating Centre For Primary Care. Clinical guidelines and evidence review for post natal care: routine post natal care of recently delivered women and their babies. NICE guideline (CG37). London: National Collaborating Centre For Primary Care and Royal College Of General Practitioners, 2006 http://www.nice.org.uk/guidance/cg37/evidence

[136] Department for Education. State of the Nation 2019: Children and Young People's Wellbeing: Research report. 2019 State of the Nation 2019: Children and Young People's Wellbeing (publishing.service.gov.uk)

[137] Royal Society for Public health. #StatusofMind: Social media and young people's mental health and wellbeing. 2022. https://www.rsph.org.uk/static/uploaded/d125b27c-0b62-41c5-a2c0155a8887cd01.pdf

[138]Brighton & Hove City Council. Safe and Well at School Survey 2021 Briefing http://www.bhconnected.org.uk/sites/bhconnected/files/2021%20SAWSS%20city%20briefing.pdf

[139] Centre for Research in Social Policy at Loughborough University. Local indicators of child poverty after housing costs, 2019/20

[140] Mental Health Foundation. Trauma. 2021. Trauma | Mental Health Foundation

[141] PTSDUK PTSD UK

[142] NHS. Complex PTSD - Post-traumatic stress disorder. 2022. Complex PTSD - Post-traumatic stress disorder - NHS (www.nhs.uk)

[143] Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACEs): preventing early trauma to improve adult health. 2021. Adverse Childhood Experiences (ACEs) | VitalSigns | CDC
[144] Walsh I. Age 2 to 18: Systems to protect children from severe disadvantage. Wave Trust. 2018
[145] Hughes, K., Bellis, M., Hardcastle, K., & Dunne, M. (2017, August). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Retrieved October 2021, from https://www.thelancet.com/action/showPdf?pii=S2468-2667%2817%2930118-4.
[146] West Sussex Local Transformation Plan (2015-2021) Refresh 2019/20 Children and Young People's Mental Health and Emotional Wellbeing October 2019
[147] Mental Health Foundation. Family and parenting: statistics. Family and parenting: statistics | Mental Health Foundation
[148] National Institute for Health and Care Excellence (NICE). Looked-after children and young people. NICE guideline [NG205] Published: 20 October 2021 Context | Looked-after children and young people | Guidance | NICE
[149] Commission Young Lives (July 2022) Thematic Report 4 Heads Up Rethinking Mental Health Services for Vulnerable Young People
[150] MacAlister, J. Independent Review of Children's Social Care Final Report. 2022. Home - The Independent Review of Children's Social Care (childrenssocialcare.independent-review.uk)
[151] Berger LM, Paxson C, Waldfogel J. Mothers, men, and child protective services involvement. *Child Maltreat*. 2009; 14(3):263–276.
[152] Wall-Wieler E, Roos LL, Bolton J, et al. . Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data. J Epidemiol Community Health. 2017;71(12):1145–1151.
[153] Kenny KS, Barrington C, Green SL. "I felt for a long time like everything beautiful in me had been taken out": women's suffering, remembering, and survival following the loss of child custody. Int J Drug Policy. 2015;26(11):1158–1166.
[154] Wall-Wieler E, Roos LL, Bolton J, et al. . Maternal mental health after custody loss and death of child: a retrospective cohort study using linkable administrative data [published online ahead of print October 29, 2017]. Can J Psychiatry. (doi:10.1177/0706743717738494).
[155] Wall-Wieler E, Roos LL, Brownell M, et al. . Suicide attempts and completions among mothers whose children were taken into care by child protection services: a cohort study using linkable administrative data. Can J Psychiatry. 2018;63(3):170–177.
[156] Scambler, M. East Sussex Children and Young People with Special Educational Needs and Disabilities (SEND) Comprehensive Needs Assessment 2021. http://www.eastsussexjsna.org.uk/JsnaSiteAspx/media/jsna-media/documents/comprehensiveneedsassessment/SEND-Needs-Assessment-August-2021.pdf.
[157] Department for Education. Special educational needs in England: Academic Year 2019/20. https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england/2019-20.
[158] Department for Education. Special educational needs in England:: Academic Year 2020/21. https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england/2020-21.

[159] Van Steensel F, Bögels S, Perrin S. Anxiety Disorders in Children and Adolescents with Autistic Spectrum Disorders: A Meta-Analysis. Clinical Child and Family Psychology Review. 2011;14(3):302-317.
[160] Department for Education and Department for Health and Social Care. The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)
[161] Sayal K, Prasad V, Daley D, Ford T, Coghill D. ADHD in children and young people: prevalence, care pathways, and service provision. The Lancet Psychiatry. VOLUME 5, ISSUE 2, P175-186, FEBRUARY 01, 2018. DOI: https://doi.org/10.1016/S2215-0366(17)30167-0
[162] Public Health England Children and Young People's Mental Health and Wellbeing Profile Children and Young People's Mental Health and Wellbeing - OHID (phe.org.uk)
[163] NHS Digital, Mental health services monthly statistics. Mental health services monthly statistics - NHS Digital
[164] Brighton & Hove City Council. Safe and Well at School Survey SURVEYS | BH Connected
[165] East Sussex County Council, &; Sussex Health and Care Partnership Suicide Prevention Working Group. (n.d.). Initial Cluster Response Plan Sussex Children and Young People Suicide.
[166] Brighton & Hove City Council. Safe and Well at School Survey SURVEYS | BH Connected
[167] Milestones: journeying into adulthood - Office for National Statistics (ons.gov.uk)
[168] Kings Fund. Bringing together physical and mental health. 2016 Bringing together physical and mental health | The King's Fund (kingsfund.org.uk)
[169] Kings Fund. Long-term conditions and mental health: The cost of co-morbidities (2012).
[170] Kings Fund. Bringing together physical and mental health. 2016 Bringing together physical and mental health | The King's Fund (kingsfund.org.uk)
[171] Public Health England. Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health September 2017.
[172] NHS Brighton & Hove. Health Counts Survey 2012. SURVEYS | BH Connected
[173] NHS Brighton & Hove. Health Counts Survey 2012. SURVEYS | BH Connected
[174] Memon A, Taylor K, Mohebati LM, Sundin J, Cooper M, Scanlon T, de Visser R. Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. BMJ Open. 2016 Nov 16;6(11):e012337. doi: 10.1136/bmjopen-2016-012337. PMID: 27852712; PMCID: PMC5128839.
[175] Institute for Health Metrics and Evaluation. Global Burden of Disease 2019. Global Burden of Disease Visualisations: Compare (thelancet.com)
[176] Office for Health Improvement and Disparities. Health Inequalities Segment Tool. Segment Tool (phe.gov.uk)
[177] Public Health England. Severe mental illness (SMI) and physical health inequalities. 2018. https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities
[178] Office for Health Improvement and Disparities. Mental Health and Wellbeing JSNA profile. Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[179] NHS Digital. Mental Health Data Hub. Mental Health Data Hub - NHS Digital

[180] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

[181] college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)

[182] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

[183] World Health Organizaion. Ageing. 2022. https://www.who.int/health-topics/ageing
[184] Mental health in later life | Mental Health Foundation
[185] Chapter 1: life expectancy and healthy life expectancy - GOV.UK (www.gov.uk)
[186] Taken from 7. Living well in older years - GOV.UK (www.gov.uk)
[187] Mental Health Foundation. Mental health in later life (2019)
[188] Age UK: Promising approaches to reducing loneliness and isolation in later life. 2015
[189] IoTUK. Social Isolation and Loneliness in the UK. 2017.
[190] Public Health England. Mental health and wellbeing JSNA toolkit: Living well in older years. 7. Living well in older years - GOV.UK (www.gov.uk)
[191] Office for Health Improvement and Disparities. Productive Healthy Ageing Profile. Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)
[192]NHS Brighton & Hove. Health Counts Survey 2012. SURVEYS | BH Connected
[193] Brighton & Hove City Council. City Tracker Survey 2018. SURVEYS | BH Connected
[194] Age UK. Evidence Review: Loneliness in Later Life. (2015)
[195] Department of Health. Social action for health and well-being: building co-operative communities (2011)
[196] British Geriatrics Society. Introduction to frailty (2014)
[197] Burns A. Better access to mental health services for older people (2015)
[198] Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016)
[199] Department of Health. Annual Report of the Chief Medical Officer 2013 - Public Health Priorities (2014)
[200] Office for Health Improvement and Disparities. Productive Healthy Ageing Profile. Productive Healthy Ageing Profile - OHID (phe.org.uk)

[201] NHS Brighton & Hove. Health Counts Survey 2012. SURVEYS | BH Connected
[202] MindOut Report: Ageing well in LGBTQ communities | Healthwatch Brightonandhove [Internet]. Healthwatchbrightonandhove.co.uk. 2022. https://www.healthwatchbrightonandhove.co.uk/news/2018-05-29/mindout-report-ageing-well-lgbtq-communities
[203] World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders.; 1993. https://apps.who.int/iris/bitstream/handle/10665/37108/9241544554.pdf?sequence=1&isAllowed=y
[204] Centre for Mental Health Maternal Mental health during a pandemic. A rapid evidence review of COVID-19's impact. 2021.
[205] Centre for Mental Health Maternal Mental health during a pandemic. A rapid evidence review of COVID-19's impact. 2021.
[206] Archives of Women's Mental Health Challenges and opportunities of the COVID-19 pandemic for perinatal mental health care: a mixed-methods study of mental health care staff. 2021.

[207] NHS Digital. Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey. Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey - NHS Digital
[208] University of Oxford Co-Space Study. Changes in children's mental health symptoms from March 2020 to Jan 2021 - Co-Space (cospaceoxford.org)
[209] The Health Foundation. Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report. July 2021. . Unequal pandemic, fairer recovery - The Health Foundation
[210] The Health Foundation. Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report. July 2021. . Unequal pandemic, fairer recovery - The Health Foundation
[211] Office for Health Improvement and Disparities. COVID-19 mental health and wellbeing surveillance report. 4. Children and young people - GOV.UK (www.gov.uk)
[212] Daly, M., & Robinson, E. (2021, September 29). Psychological distress associated with the second COVID-19 wave: Prospective evidence from the UK Household Longitudinal Study. https://doi.org/10.31234/osf.io/8mpxr
[213] The Health Foundation. Emerging evidence on COVID-19's impact on mental health and health inequalities | The Health Foundation. https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-mental-health-and-health?gclid=CjwKCAiAl4WABhAJEiwATUnEFwbJiggmxTjSI92whMMVHidjBOrZZeC_yg4P6GiOwxZWpmytUryXkBoCHp8QAvD_BwE
[214] September: Impact of grief during the pandemic | News and features | University of Bristol
[215] Mahase E. Covid-19: Many ICU staff in England report symptoms of PTSD, severe depression, or anxiety, study reports. BMJ. 2021;372:n108. doi:10.1136/bmj.n108
[216] National Autistic Society. Left Stranded: The Impact of Coronavirus on Autistic People and Their Families in the UK.; 2020. https://www.autism.org.uk/what-we-do/news/coronavirus-report AND Oxford Health NHS Foundation Trust. COVID-19: Caring for our families, friends and carers. https://www.oxfordhealth.nhs.uk/news/covid-19-caring-for-our-families-friends-and-carers/
[217] Leeming, D., Lucock, M., Shibazaki, K. et al. The Impact of the COVID-19 Pandemic on Those Supported in the Community with Long-Term Mental Health Problems: A Qualitative Analysis of Power, Threat, Meaning and Survival. Community Ment Health J 58, 1297–1309 (2022). https://doi.org/10.1007/s10597-021-00932-4
[218] The Health Foundation. Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report. July 2021. Unequal pandemic, fairer recovery - The Health Foundation
[219] Creese, B., Khan, Z., Henley, W., O'Dwyer, S., Corbett, A., Vasconcelos Da Silva, M., . . . Ballard, C. (2021). Loneliness, physical activity, and mental health during COVID-19: A longitudinal analysis of depression and anxiety in adults over the age of 50 between 2015 and 2020. International Psychogeriatrics, 33(5), 505-514. doi:10.1017/S1041610220004135. Loneliness, physical activity and mental health during Covid-19: a longitudinal analysis of depression and anxiety between 2015 and 2020 | medRxiv Taken from UK Health Security Agency (UKHSA) Prototype Public Mental Health Dashboard.
[220] Pierce M et al. 2020. Mental Health Before and During the COVID-19 Pandemic: A Longitudinal Probability Sample Survey of the UK Population. The Lancet Psychiarty. Vol 7: Issue 10 Pg 883-892. Taken from UK Health Security Agency (UKHSA) Prototype Public Mental Health Dashboard.
[221] Royal College of Physicians Tackling inequality in maternal health: Beyond the postpartum (2021)

[222] BMC Medicine Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study (2020)
[223] Maternal Mental Health Alliance. Black, Asian and minority ethnic women and access to perinatal mental health services (2021)
[224] Podolska M, Majikowicz M, Sipak-Szmigiel O, Ronin-Walknowska E. [Cohabitation as a strong predicting factor of perinatal depression] - PubMed. *Ginekol Pol*. 2009;80(4):280-284.
[225] Howard LM, Oram S, Galley H, Trevillion K, Feder G. Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. PLOS Medicine. 2013;10(5):e1001452. doi: 10.1371/journal.pmed.1001452.
[226] NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines (CG192). London: National Institute for Health and Care Excellence, 2014. www.nice.org.uk/guidance/cg192
[227] National Collaborating Centre for Mental Health. Antenatal and postnatal mental health: clinical management and service guidance. Updated edition. NICE guideline (CG192). Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2014. www.nice.org.uk/guidance/cg192/evidence