

**Acute and emergency mental health
– an epidemiological needs assessment for East Sussex**

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by 5LoopLtd
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1. Introduction

Mental health problems constitute the largest single burden of disease nationally at almost a quarter of the total (23%). Mental health problems also have a considerable economic impact. They represent the largest single cost to the NHS with nearly 11% of England's annual secondary care budget spent on mental health, and an estimated total cost to the country of over £100 billion per year.^{1,2} The cost of treating mental health problems is predicated to double over the next 20 years.³

"No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact"

Royal College of Psychiatrists 2010

Mental health problems often begin earlier than other causes of disability such as heart disease and cancers, affecting the most productive years of people's lives. There is also continuity between mental health problems in childhood and adulthood; we know that over half of people with a lifetime mental health disorder at the age of 26 will have met the diagnostic criteria first by the age of 14.⁴ Parental mental health problems and issues such as domestic abuse can have a significant impact on the mental wellbeing of the child.⁵ At the other end of the scale, depression in older people affects up to 25%, and up to 40% of those in care homes.⁶ Mental health is a lifetime issue, requiring a joined up approach across the lifespan.⁵

Mental health problems are associated with multiple negative personal and social impacts, including poor physical health and reduced life expectancy, high levels of smoking and obesity, unemployment and deprivation, social exclusion, stigma and discrimination.

The severity, duration and impact of mental illness varies hugely, some conditions are long lasting and can significantly affect the quality of people's lives, especially if they are not treated. Some people only experience a single episode of mental ill health. Others, who may have longer-standing problems, can enjoy a high quality of life. However, the personal, social and economic costs of mental ill health can be considerable.

1.1 Policy background

There has been a significant shift in policy on mental health in the last few years. This has been strengthened by a developing evidence-base around how to promote and protect mental health and wellbeing.^{5,7,8,9}

The National Institute for Health and Clinical Excellence (NICE) has published a range of evidence-based guidance on promoting and protecting mental health and wellbeing underpinning national policy. The Marmot Review *Fair Society, Healthy Lives* - makes a compelling social and economic case for addressing the significance of inequalities in health, including mental health. It also supports the public mental health and wellbeing agenda.¹⁰

Outcomes - *No health without mental health:*

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

¹ The Royal College of Psychiatrists. No Health without Public Mental Health: the case for action. 2010.

² Department of Health. 2011/12 National survey of investment in adult mental health services. 2012. Ref 1596-11

³ McCrone P, Dhanasiri S, Patel A et al. (2008) *Paying the Price: The cost of mental health care in England*. King's Fund.

⁴ Kim-Cohen J et al Prior juvenile diagnoses in adults with mental disorder. Archives of General Psychiatry 60 2003

⁵ DH No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. 2011

⁶ Age Concern. Improving services and support for older people with mental health problems. London: Age Concern; 2007

⁷ Foresight Report: Mental Capital and Well-being 2008

⁸ HM Government. New Horizons: a shared vision for mental health. London: HM Government 2009

⁹ Confident Communities, Brighter Futures: A framework for developing well-being 2010

¹⁰ Marmot et al. The Marmot Review: Fair Society, Healthy Lives - strategic review of health inequalities in England 2010

Mental health problems – the statistics

At least 1 in 4 people will experience a mental health problem at some point in their life and 1 in 6 adults has a mental health problem at any one time.

1 in 10 children (5 - 16 years) has a mental health problem, and many continue to have mental health problems into adulthood.

Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.

Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).

Almost half of all adults will experience at least one episode of depression during their lifetime.

1 in 10 new mothers experiences postnatal depression.

Approximately 1 in 100 people has a severe mental health problem.

60% of adults living in hostels have a personality disorder.

90% of all prisoners are estimated to have a diagnosable mental health problem

Taken from *No health without mental health 2011*

Alongside this wider agenda, the most recent strategy *No health without mental health* and the associated implementation framework also has an increased focus on improving mental health care, treatment and support for those with mental illness.¹¹

1.2 Purpose of the needs assessment

Health needs assessment is used to understand the needs of a population in order to better inform the commissioning of resources and services.¹²

This needs assessment is intended to examine the acute and emergency mental health needs of East Sussex residents aged 18 to 64 years, in order to better shape strategies to improve acute mental health care within the county. The specific aims are:

- . To attempt to quantify the burden of mental illness in East Sussex in terms of numbers of people with common mental disorders and severe mental illness, and to consider how this may change in the future.
- . To assess current levels of specialist service activity related to severe mental illness (as a proxy for need).

The report does not cover dementia or alcohol/substance misuse, both of which are important issues in their own right. However, some of the figures and statistics presented does include these conditions, in particular activity data presented in section six. The recent Child and Adolescent Mental Health needs assessment for East Sussex provides an up-to-date assessment of the mental health needs of children and young people in the county.¹³

¹¹ DH No health without mental health: implementation framework

¹² NICE. Health needs assessment: a practical guide. 2005.

¹³ Scambler M. East Sussex Child and Adolescent Mental Health Services – needs assessment 2014 [CAMHS 2014.pdf](#)

2. Definitions

Terminology in mental health is contentious and not used consistently. This section provides the definitions used in this report.

2.1 Mental health

Mental health, mental illness and mental disorders are terms that are often used interchangeably. However, mental health is wider than simply the absence of a mental illness. It is a fundamental

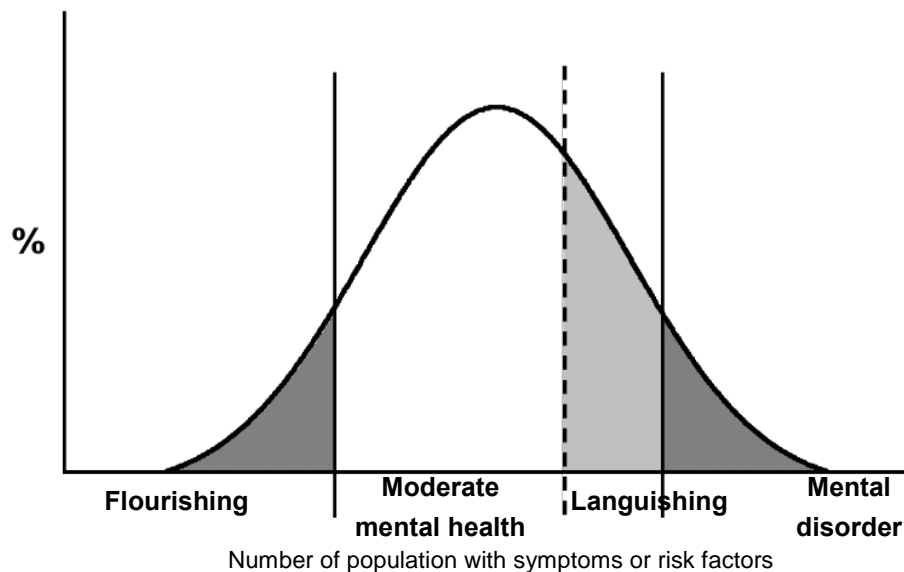
“... a state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community.”

element of the resilience, capabilities and positive adaptation that enables people to cope with adversity and to reach their full potential.¹⁴

Mental health is distributed in society from ‘flourishing’ at one end to having a mental disorder at the other (Figure 1.1). In a population such as that of East Sussex, approximately 17% of people are said to be ‘flourishing’, with a comparable proportion with a mental disorder.

Between these two extremes, most of population have ‘moderate’ mental health, and many (about another 11%) are not reaching their full potential i.e. ‘languishing’.

Figure 1.1: Distribution of mental health within the population.



Taken from Huppert et al¹⁵

This diagram illustrates how the absence of mental disorder does not necessarily imply a presence of good mental health. Any state of mental health less than flourishing is associated with increased impairment and burden to self and society.

The aim of this needs assessment is to examine the need those in East Sussex at the extreme right of Figure 1, those with diagnosed, serious mental disorder who are likely to require support and input from acute and emergency mental health services. However, as mental disorders are dynamic with individuals moving up and down the spectrum of severity and acuity, this section takes a wider view including examining the prevalence of common mental disorders and other mental health disorders

¹⁴ Friedli L. Mental health, resilience & inequalities. World Health Organisation 2009

¹⁵ Huppert Ch.12 in Huppert et al. (Eds) The Science of Well-being

which may or may not require care from specialist services.

2.2 Mental disorder

Mental disorder comprises a broad range of problems with different symptoms. "Disorder" is not an exact term, but it is used imply the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. That is, mental disorders are generally characterised by some combination of disturbed thoughts, emotions, behaviour and relationships with others.¹⁶

¹⁶ Centre for Communicable Diseases <http://www.cdc.gov/mentalhealth/basics/mental-illness.htm> 2013

3. Types of mental disorder

Mental disorders comprise a broad range of problems, with different symptoms. They are generally characterised by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia.

Severe and enduring mental illness

There is no universal definition of severe mental disorders. However, the term usually refers to illnesses where psychosis occurs.

Psychosis describes the loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to.

It has been estimated that people with severe mental disorders die 10 years younger than other people because of poor physical health.

Rethink Mental Illness – Lethal Discrimination

These can be broadly categorised into non- affective (for example schizophrenia), affective (for example major depressive disorder with psychotic symptoms; bipolar disorder with psychotic symptoms) and substance- induced disorders. All are associated with significant personal distress, social disability, and need for care. Overall, the average age of onset is in the mid- to late- twenties, with evidence that onset tends to occur earlier for non- affective disorders and later for women. Although relatively uncommon, more severe mental health conditions such as psychotic disorders result in high costs to the NHS and society.¹⁷

The exact causes of severe mental illness are not known. There may be a genetic vulnerability in some people that can be triggered by environmental and emotional factors such as bereavement, moving home, loss of a job or a breakdown in relationships.

Many people who experience severe mental illness can, and do, recover a meaningful and fulfilling quality of life. Treatments and support addressing all an individual's needs are required for the best chance of recovery. This includes medicines, talking therapies, appropriate housing, employment, social networks and financial independence.

3.1 Characteristics

Table 3.1 summarised the characteristics of some key mental disorders.

¹⁷ McManus, S. *et al* Adult Psychiatric Morbidity in England 2007: Results of a household survey. Information Centre. 2009

Table 3.1: Characteristics of mental health disorders

Common mental disorders (CMD) cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition.	
Common mental disorders	<p>Depression is characterised by a depressed mood, or loss of pleasure in everyday activities. The International Classification of Disease (ICD-10) describes ten key symptoms: (1) depressed mood; (2) loss of interest and enjoyment; (3) reduced energy leading to increased fatigability and diminished activity; (4) reduced concentration and attention; (5) reduced self-esteem and self-confidence; (6) ideas of guilt and unworthiness; (7) bleak and pessimistic views of the future; (8) ideas or acts of self-harm or suicide; (9) disturbed sleep; and (10) diminished appetite.¹⁸</p> <p>There are a number of subtypes of depression.¹⁹</p> <ul style="list-style-type: none"> . <i>Mild depressive episode:</i> characterised by the presence of four of the above symptoms for at least 2 weeks. . <i>Moderate depressive episode:</i> characterised by the presence of six of the above symptoms. The minimum duration of the episode is 2 weeks, with a considerable impact on functional ability of the individual. . <i>Severe depressive episode:</i> characterised by the presence of seven or more of the above symptoms, some of which will be of severe intensity. The episode will normally have been present for at least 2 weeks, although in some circumstances if the symptoms are particularly severe, the diagnosis can be made sooner than this. The functional impact on the sufferer is likely to be severe. . <i>Recurrent depressive episode:</i> repeated episodes of depression, without any intercurrent episodes of mood elevation or overactivity. . <i>Chronic depression:</i> chronic depression is diagnosed when a person meets the diagnostic criteria for depression for at least 2 years. . <i>Treatment-resistant depression:</i> defined by NICE as that which fails to respond to two or more antidepressants given sequentially at an adequate dose for an adequate time.
	<p>Anxiety disorders are characterised by excessive and unrealistic worry about everyday tasks or events, or may be specific to certain objects or rituals.²⁰</p> <ul style="list-style-type: none"> . <i>Simple phobias</i> involve excessive anxiety evoked by specific objects (e.g., marked fear of snakes). . <i>Social phobias</i> are fears of interacting with others, particularly in large groups. . <i>Obsessive-compulsive disorder (OCD)</i> intrusive and recurrent thought, idea, sensation or feeling – coupled with a compulsion – a behaviour that is recurrent and ritualized, such as checking, avoiding, or counting. <p>In addition to being helped by pharmacotherapies, anxiety disorders are often addressed by exposure (to the object or event obsessed over) and response prevention –not permitting the compulsive behaviour, to help the individual learn that it is not needed.</p>

¹⁸ ICD10 http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf

¹⁹ NICE *Depression in adults – the treatment and management of depression* Clinical guideline 90 <http://www.nice.org.uk/guidance/cg90>

²⁰ Sadock BJ, Sadock VA. *Kaplan & Sadock’s Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry (10th ed.)*. Philadelphia, PA, Lippincott, Williams & Wilkins; 2007.

Personality disorders	Personality disorders are longstanding problematic personality features which cause the person to have difficulty functioning and in making and sustaining relationships. There are various types but these two are particularly important in terms of need for health and other services.	
	Borderline PD	Borderline personality disorder is significant because this condition involves high levels of emotional instability, self-harm and suicide. ¹⁷
	Antisocial PD	Antisocial personality disorder, characterised by an aggressive and irresponsible pattern of behaviour, also has a wider impact on society as it is linked with crime and violence. ²¹
Psychotic disorders	Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality.	
	Despite being relatively uncommon, psychotic illness results in high service and societal costs.²² The World Health Organisation calculates that the burden and human suffering associated with psychosis at the family level is exceeded only by dementia and quadriplegia.²³ People with such conditions are known to have low rates of employment and when employed, are often in poorly paid and less secure jobs.¹⁷	
	Typically, psychotic disorders are treated with antipsychotic medications and some forms of psychosocial interventions.²⁴	
	Schizophrenia	Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. It is a condition that affects thinking, feeling and behaviour and causes people to have abnormal experiences. It is thought that schizophrenia and related psychoses result not from one single cause but from a range of interacting biological, psychological and social factors. Heavy use of amphetamines and cannabis has also been shown to increase risk. Schizophrenia is associated with a higher risk of other mental health problems, poorer physical health, less healthy lifestyles and lower life expectancy. People with schizophrenia die 15-20 years earlier than other people. ²⁵
	Affective psychosis	Bipolar affective disorder (formerly known as “manic-depressive disorder”) is the most common type of affective psychosis. It is characterised by episodes of depression and episodes of mania. ²⁶ Mania is characterised by clearly elevated, unrestrained, or irritable mood, which may manifest in an exaggerated assessment of self-importance or grandiosity, sleeplessness, racing thoughts, pressured speech, and the tendency to engage in activities which appear pleasurable, but have a high potential for adverse consequences. ²⁴
Self harm and suicide	Suicidal thoughts, suicide attempts and self-harm are of particular interest because of their power in predicting who is most likely to go on to commit suicide. These thoughts and behaviours are also associated with high levels of distress, both for the people engaging in them and for those around them.¹⁷	
	Self harm	Deliberate self-harm ranges from destructive behaviours with no suicidal intent, but which relieve tension or communicate distress, through to attempted suicide. ²⁷ It is recognised that most of those who attend A&E after self-harming would meet the criteria for one or more psychiatric diagnoses. More than two-thirds would be classed as depressed. People who have self-harmed are at significant risk of suicide (Mental Health Foundation, 2007).

²¹ East Sussex JSNA – Borderline personality disorder [BPD-Needs-Assessment-December-2013.pdf](#)

²² Knapp M (2003). ‘Costs of schizophrenia’. *British Journal of Psychiatry*; 171:509-518.

²³ World Health Organisation (2001) *The World Health Report: 2001: Mental health: new understanding, new hope*. Geneva: World Health Organisation.

²⁴ Andreasen NC, Black DW. *Introductory Textbook of Psychiatry*. (4th ed.). Arlington, VA: American Psychiatric Publishing, Inc., 2006

²⁵ Pickin M and Alves B Croydon JSNA key topic – schizophrenia 2013

²⁶ Campbell RJ, *Campbell’s psychiatric dictionary*. (9th ed.). New York, Oxford, 2009.

²⁷ Mental Health Foundation, 2007

	<p>Suicide and suicide ideation</p> <p>Nearly all people who commit suicide have a diagnosable psychiatric condition, such as major depressive episodes, schizophrenia, post traumatic stress disorder and/or anxiety.¹⁷</p> <p>Previous national surveys have also shown that most people who have suicidal thoughts and have made suicide attempts also experience psychiatric illness. However, most people with a psychiatric disorder do not attempt suicide, and other factors as well as mental disorder can play a role in suicidal behaviour, including social factors and physical illness.^{28,29}</p>
<p>Eating disorders</p>	<p>Eating disorders, including anorexia nervosa, bulimia nervosa and related conditions, generally have an onset in childhood or adolescence.³⁰ They include a variety of types of disordered eating, and range greatly in severity.</p> <p>People with eating disorders often experience acute psychological distress, as well as severe physical complications such as gastrointestinal problems and osteoporosis.³¹ The disorders often become chronic, with poor rates of recovery. Eating disorders and their resulting complications may be fatal and some studies have identified them as having the highest mortality rate of all mental disorders.¹⁷ Even in those who recover, the negative impacts on employment, relationships, fertility and parenting can persist for a long time.³²</p>
<p>Post traumatic stress disorder</p>	<p>Post traumatic stress disorder (PTSD) is a disabling condition characterised by flashbacks and nightmares, avoidance and numbing, and hyper-vigilance. It is different from other psychiatric disorders in that symptoms are caused by an external, traumatic event. While most of these people will feel symptoms such as distress, insomnia, anxiety or unhappiness, only a minority will develop a mental health problem such as posttraumatic stress disorder (PTSD) as a result. Where PTSD does occur, it usually onsets within three months of the event and may persist for months or even years.³³</p> <p>A traumatic event is when an individual experiences, witnesses, or is confronted with life endangerment, death or serious injury or threat to self or close others. Traumatic events are distinct from and more severe than generally stressful life events.</p>
<p>Perinatal mental health</p>	<p>Pregnancy, and the first year after giving birth, represents a period of increased risk for developing mental health disorders. Perinatal mental health disorders include depression, anxiety and postnatal psychotic disorders.</p> <ul style="list-style-type: none"> • Women who already have a mental health problem are more likely to become ill again during the perinatal period than at other times in her life. • Severe mental illness may develop more rapidly and be more serious. • Women with a diagnosed mental disorder may stop taking medication without consultation potentially causing relapse or increased symptoms.³⁴ <p>Maternal mental illness has important consequences for the child and family and is the leading cause of maternal deaths in the UK.^{34,35}</p>

²⁸ Meltzer H, *et al* *Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain*. The Stationary Office, London. 2002

²⁹ Jenkins R, *et al* *Psychiatric and social aspects of suicidal behaviour in prisons*. *Psychological Medicine*. 35:257- 269. 2005

³⁰ Hoek HW and van Hoeken D. Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders*, 34, 383-396. 2003

³¹ Hudson JI, Hiripi E, Pope HG, Jr, and Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61, 348-358. 2007

³² NICE *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*. www.nice.org.uk/ 2004

³³ Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/>

³⁴ NICE Antenatal and postnatal mental health: Clinical management and service guidance <http://www.nice.org.uk/Guidance/CG45>

³⁵ Hogg,S. Prevention in Mind All Babies Count: Spotlight on Perinatal Mental Health. NSPCC2013

3.2 Risk factors

There are a variety of determinants that influence whether people are more or less likely to be susceptible to mental health problems.

Many of the modifiable risk and protective factors for mental health and wellbeing are linked to socioeconomic status and area deprivation (Table 3.2). However, there are some exceptions to this rule, indicating that people are either doing better or worse than expected given their life circumstances. Why certain people or places adapt to adversity and achieve better outcomes is the subject of much current interest in *resilience* and *assets* for health.

Individual resilience and the capacity to respond positively to adverse life events are supported by factors ranging from good parenting, positive early life experiences, and family and peer relationships to opportunities for life-skill development, educational achievement and meaningful activity and employment, and access to responsive, high quality, coordinated services within safe secure and prosperous environments.

Table 3.2: Main determinants for different types of mental disorders

Determinant	Common mental disorders	Psychosis	Personality disorders	Suicidal thoughts
Age	Highest rates in 35-54 age group	Highest rates 20-34 age group, median age at onset approx. 3 years later in women than men	Highest rates in younger people	Highest rates in young adults
Gender	Female rates > male	Male rates > female Secondary peak in women 40-45 years	Male rates > female	Female rates > male However, for suicide: Male rates > female
Ethnicity	Higher rates in Irish and Black Caribbean	Higher rates in several BME groups, notably Black Caribbean and Black African populations		
Marital status	Increased in separated and divorced	Increased in separated and divorced	Increase in single	Increased in single, separated and divorced
Family composition	Increased in lone parents			Increased in those living alone
Employment	Increased in social class V and unemployed	Increased in social class IV and V, and in economically inactive Little evidence that parental social class is influential	Increased in those with lower socioeconomic status and low educational achievement	Higher rates in those with lower educational qualifications and lower social class
Social supports	Increased in those with few social supports	Increased in those with few social supports		Increased in those with few social supports
Immigration status		Higher rates in immigrants, probably due to increased stressful life events, urban living, discrimination, social isolation		
Housing tenure	Increased rates in people who rent	Increased rates in people who rent		Increased rates in those living alone
Urbanisation	Urban rates > rural	Urban rates > rural	Urban rates > rural	Urban rates > rural
Deprivation index		Increased rates with neighbourhood deprivation and lack of social cohesion, both in childhood neighbourhood and current neighbourhood		

Adapted from: *Cumbria mental health joint strategic needs assessment: adults, 2010* www.cumbria.nhs.uk

Poor mental health underlies risk behaviours, including smoking, alcohol and drug misuse, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity. Risk factors and behaviours cluster in particular groups. Clustering of health-risk behaviours in childhood is a particular problem that leads to greater lifetime risks of mental illness, as well as social, behavioural, financial, and general health problems.

There are some key additional risk factors for severe mental disorders.

- Family history (schizophrenia):** family history of schizophrenia is a significant risk factor (Box). However, other factors influence whether such genetic risk translates into psychosis. A range of early socio-psychological adversities such as separation from a parent, being a migrant, growing up in a city, or being persistently bullied or abused, all increase risk of psychosis. Similarly, adverse life events and trauma can precipitate the illness.³⁶ In particular, a child-rearing environment with infrequent criticism and clear, straightforward communication appears to be protective against the symptomatic expression of this genetic risk.³⁷

• No family history	1%
• Third degree relative (e.g. cousin)	2%
• Second degree relative (e.g. niece)	2-6%
• First degree relative (e.g. parent, child)	6-17%
• Non identical twin	17%
• Identical twin	50%

- Pre-term birth:** in England and Wales, about one in 13 babies is born prematurely with 8000 babies born before 33 weeks each year.³⁸

 - Those born prematurely at 32 to 36 weeks are 1.6 times more likely to have non-affective psychosis, 1.3 times more likely to have depressive disorder, and 2.7 times more likely to have bipolar affective disorder compared to 'term births' (37-41 weeks).³⁹
 - Those born before 32 weeks more likely to have non-affective psychosis, were 2.5 times 2.9 times more likely to have depressive disorder, and 7.4 times more likely to have bipolar affective disorder compared to term births.³⁹

- Abuse:** child abuse includes physical abuse, emotional abuse, sexual abuse, neglect, bullying and domestic violence. It is associated with a threefold increase in risk of psychosis although the impact is greater if abuse is repeated.⁴⁰ Adults subjected to childhood physical and sexual abuse are more likely to be admitted to a psychiatric hospital, have longer and more frequent admissions, take more psychiatric medication, have more severe symptoms, self harm and commit suicide (Read et al, 2009).⁴¹

• 25% of 18 to 24-year-olds, 19% of 11 to 17-year-olds and 5.9% of under 11's experienced severe maltreatment during childhood (NSPCC, 2011).
• 7% of 11 to 17-year-olds, and 12% of 18 to 24-year-olds, experienced physical violence by an adult.
• 3% of women and 1% of men experienced sexual intercourse during childhood.
• 11% of women and 5% of men experienced sexual touching (Bebbington et al, 2011).

Repeated sexual abuse during childhood

³⁶ Schizophrenia Commission. The abandoned illness. A report by the Schizophrenia Commission 2012

³⁷ Tienari P *et al.* Genotype-environment interaction in schizophrenia-spectrum disorder. Long-term follow-up 2004

³⁸ ONS (2012) Gestation –specific infant mortality in England and Wales. 2010. Table 2. <http://www.ons.gov.uk>

³⁹ Nosarti C *et al* Preterm birth and psychiatric disorders in young adult life. Arch Gen Psychiatry 69(6): 610-617 2012

⁴⁰ Jonas S *et al* Sexual abuse and psychiatric disorder in England: results from the 2007 APMS. 2011

⁴¹ Read J, Bentall RP, Fosse R (2009). Time to abandon the bio-bio-bio model of psychosis: exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. Epidemiol Psichiatr Soc 18: 299–310.

and adolescence is associated with even higher risk of probable psychosis (15 times higher).⁴⁰ A prospective study in The Netherlands found that people who had been abused as children were nine times more likely than non-abused people to experience 'pathology-level psychosis'.⁴²

- Neighbourhood factors: although the incidence of schizophrenia is relatively stable over time it varies significantly from place to place according to socio-demographic characteristics of its residents. It is also greatly affected by neighbourhood-level factors such as population density and socioeconomic deprivation.⁴³ For instance, schizophrenia incidence rates per 100,000 are 49 for South East London, 24 for Nottingham and 32 for England.⁴⁴ However, there is no evidence of geographical or neighbourhood variation for affective psychosis.⁴³
- Drug abuse: heavy abuse of drugs such as amphetamines and cannabis is increasingly considered to be important.^{45,46}

3.3 Higher risk groups

Risk factors disproportionately affect the mental health of people from higher-risk and marginalised groups. Those at higher risk include looked- after children, children who experienced abuse, black and minority ethnic individuals, those with intellectual disability and homeless people. Such groups are also at a higher risk of stigma and discrimination.

- Adults with learning disabilities have a three times higher risk of schizophrenia and twice the risk of depression compared with adults in the general population.⁴⁷
- Lesbian, gay, bisexual and transsexual people in England have rates of probable psychosis almost four times higher than the general population.⁴⁸
- Black and minority ethnic groups:
 - Non-affective psychosis: Incidence rates are 4 times higher in the black Caribbean group. 3.5 times higher in black African group and 1.6 times higher in the South Asian population group.⁴³
 - Schizophrenia: Incidence rates are 5.6 times higher in the black Caribbean group, 4.7 times higher in black African group and 2.4 times higher in Asian groups compared to the white British population.⁴³
 - Affective psychosis: Black Caribbean, black African and non-British white groups have 2-3 fold higher rates of affective psychosis than the white British population.⁴⁹
- Prisoners: individuals with mental disorders are significantly over-represented in the prison population.⁵⁰ Functional psychoses such as schizophrenia, other delusional disorders, mania and severe depression have been found to be up to ten times more common in prisoners than in the general population.^{51,52}
 - 10% of prisoners in England & Wales have psychotic disorder⁵³
 - 63% of male remand prisoners having antisocial personality disorder compared with 0.3% of the general population.⁵¹

⁴² Janssen I *et al* Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatr Scand* 109: 38–45 2004

⁴³ Kirkbride J *et al* Incidence of schizophrenia and other psychoses in England, 1950–2009, 2012

⁴⁴ Kirkbride J *et al* Heterogeneity in incidence rates of schizophrenia and other psychotic syndromes. *Arch Gen Psych*. 2006

⁴⁵ Di Forti M *et al* High-potency cannabis and the risk of psychosis. *British Journal of Psychiatry*, 195:488- 491 2009

⁴⁶ Casadio P *et al* Cannabis use in young people. The risk for schizophrenia. *Neurosci and Biobehav Rev* 35 2011

⁴⁷ Smiley E. Epidemiology of mental health problems in adults with learning disability: an update. *Ad Psy Treat* 2005

⁴⁸ Chakraborty A, McKenzie K Does racial discrimination cause mental illness? *BJPsych* 180: 475-477 2002

⁴⁹ Kirkbride J *et al* Psychoses, ethnicity and socioeconomic status. *British Journal of Psychiatry* 193(1):18 24. 2008

⁵⁰ Brooker C *et al* Mental health services and prisoners: a review. SCHARR University of Sheffield. 2002

⁵¹ Brook D *et al* Point prevalence of mental disorder in un-convicted male prisoners in England and Wales. *BMJ* 313 1996

⁵² Singleton N *et al* Psychiatric morbidity among prisoners in England and Wales. ONS. London 1998

⁵³ Stewart D. The problems and needs of newly sentenced prisoners: results from a national survey, *MoJ* 2008.

- Homeless people: A review found that homeless people in the UK are 4-15 times more likely to have psychotic disorder while street homeless people are 50–100 times more likely to have a psychotic disorder.⁵⁴

The recent government strategies, 'No Health Without Mental Health' and the Suicide Prevention Strategy, both recognise special population groups as being at higher risk of mental illness than the general population. Targeted intervention for groups at higher risk of mental illness can prevent a widening of inequalities in comparison with the general population.^{36,55}

3.3 Mental and physical health and wellbeing

People with mental health problems are less likely to have effective physical health treatment. This is despite a strong link between mental illness and increased early mortality and morbidity.⁵⁶ Life expectancy for people with schizophrenia is on average 25 years shorter than the general population.⁵⁷ More premature deaths in people with mental illness are due to treatable cardiovascular, pulmonary and infectious diseases than from suicide and undetermined injury.⁵⁸

This increased cardiovascular mortality reflects in part increased health-risk behaviours. People with mental health disorders are more likely to engage in behaviours that are detrimental to health. They are more likely to have a poor diet, exercise less, smoke and misuse drugs and alcohol. Conversely good mental health and wellbeing are associated with reduced mortality rates, both in healthy people and in those with illness.

People with SMI are more likely to smoke than the general population, though precise estimates vary. The Information Centre for Health and Social Care indicate that 61% of people with schizophrenia and 46% of people with bipolar disorder smoke compared to 33% of the general population.⁵⁹

However, a report by the Mental Health Foundation notes that '*Rates of smoking*

among people with schizophrenia remain stable at about 70- 74%, regardless of whether they are living in mental health units or within the community'.⁵⁹ In addition, premature death and smoking-related diseases, such as respiratory disorders and heart disease are more common among smokers with SMI than in the general population of smokers.⁵⁹

People with psychosis may lead more sedentary lives, eat less fruit and vegetables and are five times more likely to smoke heavily. In addition to lifestyle factors, antipsychotic drugs vary in their liability for metabolic side effects, such as weight gain, lipid abnormalities and disturbance of glucose regulation, and increase the risk of the metabolic syndrome, which is a predictor of Type 2 diabetes and CHD.⁵⁹

Approximately 40% of people with schizophrenia are obese and obesity is also common in people with bipolar disorders. People with schizophrenia appear to be at increased risk of impaired glucose tolerance and diabetes, and this is independent of treatment with the newer atypical antipsychotic drugs. Hypertension in people with schizophrenia is estimated at 19% compared with 15% in the general population.⁵⁹

The prevalence of hypertension amongst those with bipolar disease has been estimated at 35%.⁵⁹

Physical illness and two or more recent adverse life events increases risk of mental illness by six times compared to without physical illness.

Long-term conditions increase the risk of mental illness; those with diabetes have 2-3 times increased risk of depression which is associated with increased health care consumption by 50-75% and increased symptoms Those with chronic obstructive pulmonary disease (COPD) have 40-50% rates of depression and anxiety.

Simon G, *et al* (2005), Clinical and functional outcomes of depression treatment in patients with and without chronic medical illness *Psychological Medicine* 35:2:271-

⁵⁴ Rees S (2009). Mental ill health in the adult single homeless population: a review of the literature. London: Crisis.

⁵⁵ Campion J, Fitch C Guidance for the commissioning of public mental health services. www.jcpmh.info 2012

⁵⁶ WHO (2005). Mental Health Declaration for Europe. Facing the Challenges, Building Solutions euro.who.int

⁵⁷ Parks J, *et al* Morbidity and mortality in people with serious mental illness 2006

⁵⁸ Brown S. *et al* Causes of the excess mortality of schizophrenia. *British Journal of Psychiatry*, 177, 212–217 2000

⁵⁹ Information Centre for Health and Social Care. Indicators for quality improvement <https://mqi.ic.nhs.uk/>

The standardised mortality ratio for cardiovascular death for people with bipolar disorder has been estimated to be as much as twice that of the general population (but appears to be reduced if patients adhere to long term medication).⁶⁰

Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects. According to the Psychiatric Morbidity Survey, 16% of people with schizophrenia drink over the recommended limits of 21 units of alcohol for men and 14 units of alcohol for women a week.⁶¹ Bipolar affective disorder is also highly comorbid with alcohol and other substance abuse.

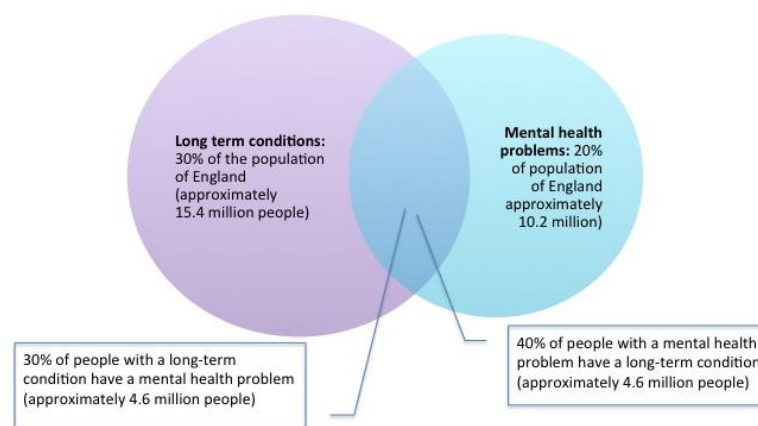
NICE clinical guidelines on psychosis and schizophrenia, and bipolar disorder, recommend physical health checks for diabetes, blood pressure, lipids, alcohol use, weight and smoking.^{60,62} NICE also recommend that people with psychosis or schizophrenia who smoke should be offered help to stop smoking, even if previous attempts have been unsuccessful.⁶²

3.4 Mental health and long-term conditions

The relationships between mental illness and other long-term conditions are well documented. It is estimated that at least 30% of all people with a long-term condition also have a mental health problem and about 46% of people with a mental health problem have a long-term condition (Figure 3.1).⁶³ Research has identified that mental health problems are strongly associated with excess mortality, not just in relation to increased risk of suicide, but also excess mortality due to physical poor health, including cardiovascular disease and cancer.

The relationships and associations are complex, people with mental health problems are more likely to live in deprived, as are people who have long term physical health conditions; there is also reduced access to and take up of resources which act to protect or promote health in these areas. Also a physical health problem may lead to a mental health problem, and vice versa, for example depression and stress have been identified as having a direct effect on the cardiovascular system and studies have identified that people with diabetes are two to three times more likely to have depression.⁶⁴

Figure 3.1: The overlap between mental health problems and long term conditions



Source: King's Fund [LTC-MH cost of comorbidities](#)

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

The co-existence of mental illness and long term conditions raises issues on how conditions are treated and managed in primary and secondary care. Research from Australia attributed 80% of excess mortality in people with mental illness to physical health problems, and that people with a

⁶⁰ NICE. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care 2006.

⁶¹ Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the HSCIC in 2009.

⁶² NICE. Psychosis and schizophrenia in adults: treatment and management, CG178, 2014.

⁶³ King's Fund (2012) Long-term conditions and mental health: the cost of comorbidities, [LTC-MH cost of comorbidities](#)

⁶⁴ Cimpean D, Drake RE (2011) treating co-morbid medical conditions and anxiety/depression, *Epidemiology and Psychiatric Sciences*, 20;2:141-50

mental illness were not benefitting to the same extent as the general population in advances in the management and treatment of long term conditions, so that the gaps in health outcomes were widening.

Co-morbidity also impacts the treatment and management costs of long term conditions. Analysis by the Kings Fund has estimated that poor mental health accounts for 12% to 18% of expenditure on long term conditions.⁶³

3.4 Health inequalities in relation to mental health services users

People with schizophrenia have a mortality of 2-3 times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. Mortality among mental health service users aged 19 and over in England was 4008 per 100,000 (83,390 deaths in total) compared to the general population rate of 1122 per 100,000.⁶⁵ This mortality rate was 3.6 times the rate of the general population in 2010/11.

People in contact with specialist mental health services had a higher death rate for most causes of death, but in particular:

- Nearly four times the general population rate of deaths from diseases of the respiratory system (at 142.2 per 100,000 service users, compared with 37.3 per 100,000 in the general population);
- Just over four times the general population rate of deaths from diseases of the digestive system (at 126.1 per 100,000, compared with 28.5 per 100,000 in the general population);
- 2.5 times the general population rate of deaths from diseases of the circulatory system (at 254.0 per 100,000 compared with 101.1 per 100,000 in the general population).

Within these disease areas specific conditions that accounted for a high proportion of deaths among service users (under the age of 75) were:

- Diseases of the liver 7.6 percent of deaths;
- Ischaemic heart diseases 9.9 percent of all deaths.

By age, the relative difference in mortality rates was largest among people aged 30 to 39; at almost five times that of the general population – 300 per 100,000 service users compared to 63 per 100,000 in the general population.

People with SMI have a lower life expectancy with between 8.0 and 14.6 life years lost for men and 9.8 to 17.5 life years lost for women.⁶⁶ Social factors such as low income, poor housing and unemployment can disproportionately affect people with severe mental illness and these factors are known to have a deleterious effect on physical health. People with mental health problems have the highest levels of unemployment among any disabled group.

⁶⁵ Health and Social Care Information Centre www.hscic.gov.uk

⁶⁶ Chang C *et al* Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental healthcare case register in London. PLoS ONE 2011, 6(5): e19590. Doi:10.1371/journal.pone.0019590.

4. Epidemiology of mental health

One person in 4 will experience mental illness during their lives, and whilst most recover some will experience varying degrees of disability and distress for long periods. For working age adults mental illness is common and disabling. The spectrum of illness ranges from depression and anxiety affecting about 14% in the UK as a whole, to less common psychotic illnesses.

The audit commission estimates that in the course of a year for a population of 1000 people, 300 will suffer from mental health problems, of which 230 will go to their GP, 102 will be diagnosed with mental illness, 24 will be referred to specialist outpatients and 6 will require hospital care.⁶⁷

Prevalence and incidence data alone is not enough to estimate the total health and social care needs of people with mental disorders, let alone the wider societal costs in terms of un- and underemployment, effect on carers, lost productivity and impacts on other public sector services. However, in order to inform commissioning decisions and planning for services, it is important we have an understanding of the potential level of need within the population. This section summarises our current understanding of the epidemiology of mental disorders in the UK.

4.1 Prevalence

The primary source of information on the prevalence of diagnosed, and undiagnosed psychiatric disorders amongst the English population are the national adult psychiatric morbidity surveys (AMPS). These were carried out in 1993, 2000 and 2007.^{17,68,69}

The main aim of the surveys was to collect data on mental health among adults aged 16 and over, living in private households. Each survey had a sample size around 10,000 and was designed to produce results representative of the English population at the level of NHS regions or age groups. The surveys used a two stage approach: Firstly, interviews included structured assessments, using diagnostic criteria and screening instruments for a range of mental disorders, as well as questions on general health, service use, risk factors and general health. Secondly, interviews were carried out on subsamples of the survey population by clinically trained interviewers.¹⁷

Table 4.1 summarises the key findings from the most recent national APMS in 2007. Common mental disorders (depression and anxiety) were the most commonly identified (16% survey population). There were also a large proportion of people with two or more identifiable conditions. (7% survey population).

Table 4.1: Prevalence of surveyed mental disorders in adults, national adult psychiatric morbidity survey 2007.

Condition	% adult population		
	Males	Females	All persons
Common mental disorder*	12.5	19.7	16.5
Current post traumatic stress disorder	2.6	3.3	3.0
Suicidal thoughts**	3.4	5.2	4.3
Suicide attempt**	0.5	0.9	0.7
Psychotic disorder**	0.3	0.5	0.4
Borderline personality disorder**	0.3	0.6	0.4
Antisocial personality disorder**	0.6	0.1	0.3
Two or more psychiatric disorders			

* Past week ** Past year

Source: *McManus et al 2009*

Prevalence of 'neurosis'

⁶⁷ Goldberg, D. and Huxley, P. Common Mental Disorders quoted in Finding a Place; A review of mental health services for adults, Audit Commission 1994, HMSO 1991

⁶⁸ Meltzer, H. *et al* The prevalence of psychiatric morbidity among adults living in private households, in OPCS Surveys of Psychiatric Morbidity in Great Britain 1995. London: HMSO 1995

⁶⁹ Singleton, *et al* Psychiatric morbidity among adults living in private households, 2000. London: TSO 2001

Neurotic disorders can negatively affect a person's ability to function effectively in the activities of daily living, such as going to work and school, caring for family, and taking care of basic needs. They include post-traumatic stress disorder, somatization disorders, anxiety disorder, panic disorder, phobias, dissociation disorder, obsessive compulsive disorder and adjustment disorder. People with disorders that are considered a neurosis or neurotic disorder do not have delusions or hallucination, which are symptoms of psychotic disorders.

According to the AMPS the most commonly reported neurotic symptoms amongst both men and women were sleep problems, fatigue, irritability and worry. The proportion of all adults experiencing these symptoms ranged from 29% for sleep problems to 19% for worry. The next most frequently occurring symptoms were depression, anxiety, poor concentration and forgetfulness.

The survey showed one in six adults were assessed as having a neurotic disorder (164 cases per 1000). The most prevalent disorder among the population was mixed anxiety and depressive disorder (88 cases per 1000). Generalised anxiety disorder affected 44 cases per 1000. The remaining disorders, which included depressive episode, phobias, obsessive compulsive disorder and panic, were less prevalent, ranging from 26 to 7 cases per 1000 adults.

Prevalence rates were usually higher among women than men for neurotic disorders. The prevalence rates of 'any neurotic disorder' showed variation by age, with the highest prevalence rates (nearly 200 per 1000) in people aged between 40 and 54 years; for males the rate peaked in the 45 to 49 age group (204 cases per 1000) whereas for women the rate peaked between 50 and 54 years.

Prevalence of personality disorders

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others. Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others.

The main symptoms, which worsen with stress, include being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger; avoiding other people and feeling empty and emotionally disconnected; having difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people and sometimes losing contact with reality.

The prevalence rate for any personality disorder in the AMPS was 54 per 1000 for men and 34 per 1000 for women. Obsessive compulsive disorder had the highest prevalence of any category of personality disorder, and was more common among men.

Prevalence of psychotic and severe affective disorders

Affective disorders are characterised by dramatic changes or extremes of mood; they include manic episodes (elevated, expansive, or irritable mood with hyperactivity, pressured speech, and inflated self-esteem) or depressive episodes (dejected mood with disinterest in life, sleep disturbance, agitation, and feelings of worthlessness or guilt), and often combinations of the two. In manic-depressive disorders, periods of mania and depression may alternate with abrupt onsets and recoveries.

The prevalence rate for a probable psychotic disorder in the AMPS was 5 per 1000 for women and 6 per 1000 among men. The survey appeared to show a concentration of cases among people aged 30 to 54 years, although the difference in prevalence was not statistically significant. The highest rate among women was observed in the 40 to 44 year group (12 per 1000). For men it was in the 30-34 age group (13 per 1000).

Lifetime prevalence: the proportion of individuals in a defined population who have had a given disease or attribute at any time in their lives.

Household surveys of this kind are likely to underrepresent some conditions, such as psychosis, where adults with the condition are more likely to be homeless or in an institutional setting. Additionally, adults living in private households with severe mental health disorders may be less available, able or willing to respond to surveys.

Research using a combination of identification and screening tools has shown lifetime prevalence of psychotic disorders in the general population to be higher than identified in the AMPS at 3.5%.⁷⁰ The same research showed condition specific lifetime prevalence as: schizophrenia 0.87%; schizoaffective disorder 0.32%; schizophreniform disorder 0.07%; delusional disorder 0.18%; bipolar I disorder 0.24%; major depressive disorder with psychotic features 0.35%; substance-induced psychotic disorders 0.42%; and psychotic disorders due to a general medical condition 0.21%.⁷¹

4.2 Annual incidence of psychosis

Incidence rates vary depending on population characteristics.⁴³ There is increasing evidence to link measures of social environment (social capital, social fragmentation), ethnic diversity and individual social experience over the life course (exposure to childhood neglect or abuse, adult social disadvantage, racial discrimination and alcohol or substance misuse) with the onset of psychotic disorders. Urban populations and those from specific black and minority ethnic groups have been shown to have higher incidence rates.⁴³

The annual incidence of psychosis in the population is important for determining levels of potential need. Table 4.2 outlines incidence rates for key psychotic disorder in England.

Table 4.2: Annual incidence of psychotic disorders in England (rate per 100,000 population)

Disorder	Number new cases per 100,000 population
Psychotic disorder	32
Schizophrenia	15
Affective psychosis	12
Bipolar disorder	4

Adapted from: Kirkbride et al 2012

4.3 Psychiatric comorbidity

Many people with a mental health problem are not just affected by one condition. Comorbidity of psychiatric disorders is associated with more severe symptoms, greater functional disability, longer duration of symptoms, and increased use of health services. Table 4.3 shows common mental health comorbidities.

Results from APMS found that of individuals diagnosed with at least one condition: 68.7% met the criteria for only one condition; 19.1% met the criteria for two conditions; and 12.2% met the criteria for three or more conditions. There were no statistically significant differences in the proportion of males and females with co-morbid conditions. For both genders the prevalence of co-morbidity decreased with age, with 16-24 year olds being most likely to have co-morbid conditions (12.4%) and just 1.5% of people aged 75 and over.¹⁷

⁷⁰ Perala et al 2007

⁷¹ <http://archpsyc.jamanetwork.com/article.aspx?articleid=209973>

Table 4.3: Common psychiatric comorbidities

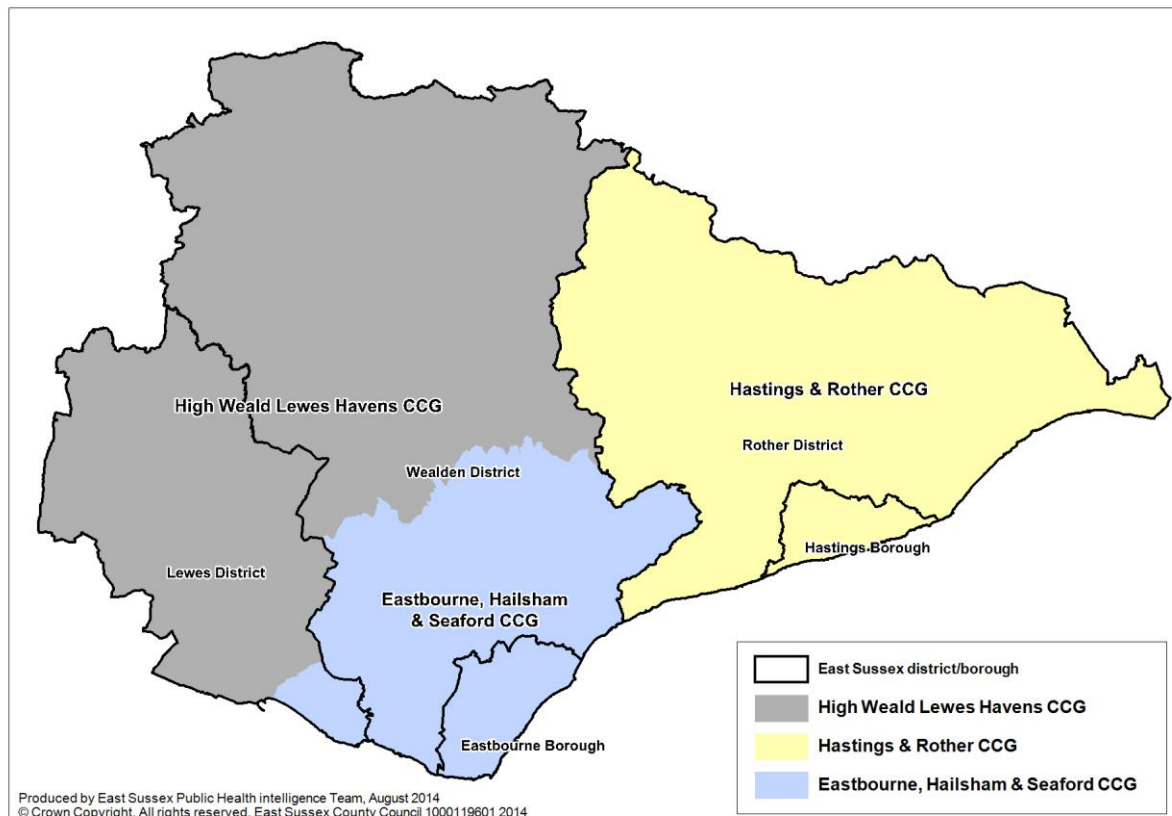
Mental health disorder	Psychotic disorder	ASPD	Panic disorder/ phobia	Depressive episode	BPD	OCD	Suicide attempt	PTSD	GAD	ADHD	Eating disorder
Psychotic disorder	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙
Antisocial personality disorder (ASPD)	⊙	■	⊙	⊙	⊙	⊙					
Panic disorder/phobia	⊙	⊙	■	⊙		⊙	⊙	⊙	⊙	⊙	
Depressive episode	⊙	⊙	⊙	■	⊙	⊙	⊙	⊙	⊙	⊙	
Borderline personality disorder (BPD)	⊙	⊙	⊙	⊙	■	⊙	⊙		⊙		⊙
Obsessive compulsive disorder (OCD)	⊙	⊙	⊙	⊙	⊙	■	⊙	⊙	⊙		
Suicide attempt	⊙	⊙	⊙	⊙	⊙	⊙	■		⊙		
Post traumatic stress disorder (PTSD)	⊙	⊙	⊙	⊙		⊙		■		⊙	
Generalised anxiety disorder (GAD)	⊙	⊙	⊙	⊙	⊙	⊙		⊙	■		
Attention deficit hyperactivity disorder (ADHD)	⊙	⊙	⊙	⊙				⊙		■	
Eating disorder	⊙				⊙						■

Source: McManus et al 2009

5. Estimated levels of mental illness in East Sussex

Map 5.1 illustrates the local authority and NHS geography of East Sussex. The county of East Sussex is comprised of three districts (Lewes, Rother and Wealden) and two boroughs (Eastbourne and Hastings). There are three clinical commissioning groups (CCGs) covering the county (Eastbourne, Hailsham and Seaford; Hastings and Rother; and High Weald Lewes Havens).

Map 5.1: East Sussex district, borough and CCG boundaries, 2015.



Source: East Sussex public health intelligence

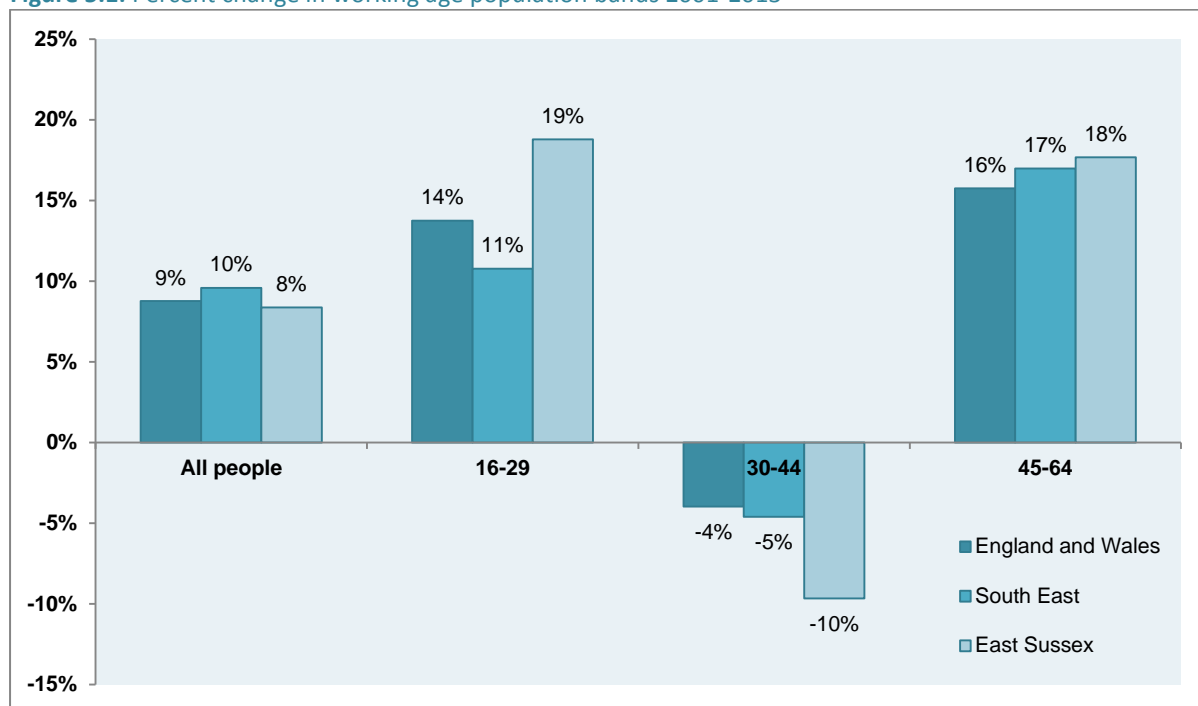
5.1 Local population

Over half a million people live in East Sussex, the population is older than the national profile with one in four being of pensionable age.⁷² The working age population represents 59% of the county's population, lower than the national (64%) and regional (63%) averages.

Since 2001 the total population has increased by 8% lower than the national (9%) and regional (10%) average. Over the same timeframe the increase in the working age population of the county was slightly higher at 9%. Growth in the county's working age population varies amongst the age groups (Figure 3.1).

⁷² ESiF East Sussex population estimates in brief 2014

Figure 5.1: Percent change in working age population bands 2001-2013



Source: East Sussex in Figures

Deprivation

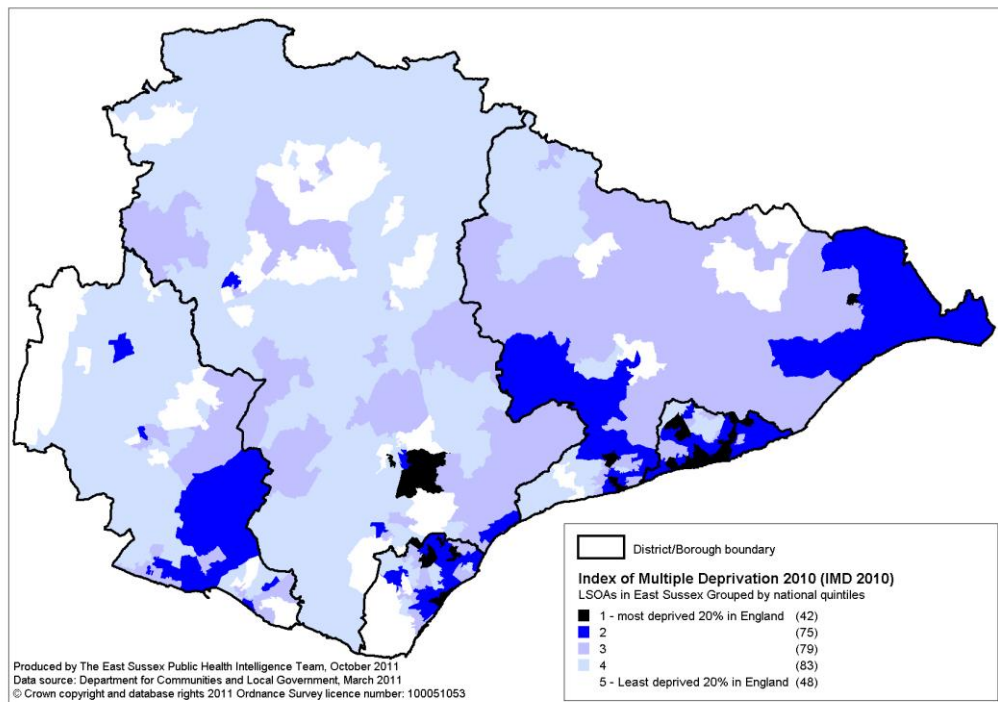
Deprivation is a key issue affecting the mental and physical health and life chances of the residents of East Sussex. On average people living in deprived areas, those of lower socio-economic groups and marginalised groups have poorer health and poorer access to health care than people resident in affluent areas and from higher socio-economic groups.

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct dimensions, or domains, of deprivation.

Communities and Local Government 2011

Using the Index of Multiple Deprivation 2010 (IMD2010) 42 (13%) of the counties 327 lower super output areas (LSOAs) are ranked within the 20% most deprived areas in England (Map 5.2). The most significant areas of deprivation are concentrated in the county's coastal towns. Hastings is the most deprived of the local authority areas. However, there are pockets of deprivation scattered across some of the smaller towns and the more rural parts of the county.

Map 5.2: Index of multiple deprivation 2010 for LSOAs in East Sussex grouped by national quintiles



Source: East Sussex public health intelligence team

Ethnicity

East Sussex is less ethnically diverse than nationally or regionally. In 2011 the proportion of the population from non-white Black and Minority Ethnic (BME) groups was 8%, compared to 20% nationally and 15% regionally. This pattern is reflected in the working age adult population with 4% of 15-64 year olds in East Sussex from BME groups, compared to 14% nationally and 10% regionally.

The rate of growth in the BME population is slower in East Sussex (3% increase since 2001) compared to the national (7%) and regional (6%) growth. The proportion of people born in other European countries is slightly lower in East Sussex (3%) than regionally and nationally (4%).⁷³

Other risk factors

Table 5.1 presents risk factors not already described in this section for East Sussex. These have been taken from the Public Health England (PHE) Severe Mental Illness profiling tool (SMIPT). This tool has been developed to support understanding and meet need. It provides in-depth analysis of a wide range of health related data in thematic profiles, prevalence, risk, prevention, early intervention, assessment, treatment, outcomes and service costs. For all indicators the East Sussex value is lower or no different to that of the national figure.

⁷³ East Sussex In Figures <http://www.eastsussexinfigures.org.uk/webview/welcome.html>

Table 5.1: Risk factors for severe mental illness

Indicator	Time Period	Age	East Sussex	England
Long-term unemployment: % of working age population	2013/14	16-64 yrs	0.7 (0.7-0.7)	0.9 (0.9-0.9)
Statutory homelessness: rate per 1000 households	2013/14	Not applicable	1.3 (1.2-1.5)	2.3 (2.3-2.3)
Children in poverty: % living in low income households	2012	<16 yrs	17.2 (16.9-17.4)	19.3 (19.2-19.3)
Looked after children: Rate per 10,000 <18 population	2013/14	<18 yrs	54.8 (50.4-59.5)	59.8 (59.4-60.3)
Children leaving care: Rate per 10,000 <18 population	2013/14	<18 yrs	20.0 (17.4-22.9)	26.5 (26.2-26.7)
Domestic abuse incidents recorded by the police: Rate per 1,000 population	2012/13	18+ yrs	13.7 (13.5-14.0)	18.8 (18.7-18.8)
Prisoner population: Number	Sep-13	All ages	632	
Violent crime: rate per 1,000 population	2013/14	All ages	8.4 (8.2-8.7)	11.1 (11.1-11.1)
English Language skills: % of people who cannot speak English / speak it well	2011	All ages	0.5 (0.5-0.4)	1.7 (1.7-1.7)
Population turnover (internal migration): Rate per 1,000 resident population	2012	All ages	72.7 (71.9-73.4)	92.6
Migrant GP registrations: Rate per 1,000 resident population	2012	All ages	5.4 (5.4-5.6)	9.6

Source: Public Health England fingertips.phe.org.uk/

Lower than England
No different to England
Higher than England

5.2 Estimated numbers

Prevalence

Table 5.2 presents estimated numbers of working age adults in East Sussex with mental health disorders. These estimates are based on the 2007 APMS survey and 2015 mid-year population estimates.

Table 5.2: Estimated numbers based on 2007 AMPS, East Sussex

Mental health disorder		Males	Females	All persons
National prevalence of CMD in past week				
	Mixed anxiety and depressive disorder	11,800	19,200	31000
	Generalised anxiety	5500	9600	15,100
	Depressive episode	3400	5000	8400
	All phobias	1300	3900	5200
	Obsessive compulsive disorder	1600	2400	4000
	Panic disorder	1500	2200	3700
	Any CMD	21,100	34,800	55,900
Personality disorders				
	Antisocial personality disorder	1100	200	1300
	Borderline personality disorder	300	1100	1400
Prevalence of psychotic disorder in the past year		400	1100	1500
Prevalence of probable psychosis		600	1100	1700
Prevalence adults screening positive for a possible eating disorder in the past year		6200	17,500	23,600
Prevalence (%) of self harm (lifetime) by age & sex				
	Face-to-face*	6000	6700	12,600
	Self-completion	7600	10,400	18,000
Prevalence of suicidal thoughts (lifetime)				
	Face-to-face	20,500	28,100	48,500
	Self-completion	24,300	35,600	59,900
Prevalence of suicide attempt (lifetime)				
	Face-to-face	6600	10,900	17,400
	Self-completion	7600	12,900	20,500
Probability of current PTSD given trauma since 16		14,900	13,800	28,800

* Face-to-face interview

** Self-completion questionnaire

Appendix 1 provides estimates for CCG locality level using the AMPS. However, although the APM surveys provide robust national level evidence about rates of mental disorders and variation at regional level there are limitations to applying crude prevalence rates at smaller areas. The sample size is too small to provide direct evidence about variation in prevalence within regions.⁷⁴ Application of crude national prevalence rates to local populations are likely to under or over represent the true number of cases depending on the socio-economic characteristics of the area in question. There are other data sources and models that provide additional insight into numbers of persons requiring support for mental health needs.

Primary care registers

More than 90% of people with mental health problems are managed in primary care, including approximately one in four people with psychosis.¹ According to the AMPS, a GP with a list of 2,000 patients would expect to treat 50 people with depression, 10 people with a serious mental illness such as schizophrenia or bipolar disorder, about 180 people with anxiety disorders and a further 180 or so with milder degrees of depression and anxiety.¹⁷

As part of the GP contract general practices obtain points for achievements against a range of indicators. The system is known as the Quality and Outcomes Framework (QOF) and is used for calculating financial payment. One of the achievements is forming registers of patients with specific diseases including one for people with depression and one for people with a serious mental illness (schizophrenia, bipolar disorder and other psychosis). From these registers, the prevalence of these conditions can be estimated bearing in mind that the registers count patients with a diagnosis, and there may be a high proportion of patients who have the disease but it is undiagnosed.

⁷⁴ Norfolk and Waveny 2013: Mental health needs assessment

The prevalence of mental illness calculated from GP QOF disease registers for each general practice has been available at a national level. However, detail on the characteristics of individual patients is not collated; hence age, gender, ethnicity, and deprivation status cannot be taken into consideration, so the register is simply the crude number and prevalence of people with mental ill health, unadjusted to account for local populations and structures within general practices. Practices with a high proportion of elderly patients and practices in deprived areas will tend to have a higher prevalence of disease (and generally a higher prevalence of undiagnosed disease).

The numbers of patients on registers from the QOF dataset for 2013/14 are as follows: 5206 people with serious mental health problems (prevalence 1.0%) and 31,221 with newly diagnosed depression (incidence 7.0%) (Table 5.3). The GP recorded prevalence of severe mental health in the county is higher than that found by the national AMPS. However, as discussed it is likely that the methodology of AMPS underestimated the prevalence of severe mental health disorders. Estimates for the prevalence of severe mental health disorders, but most commonly studies have found that one to three people in 100 are affected by schizophrenia and bipolar disorder.⁷⁵

Table 5.3: Number of patients on general practice mental health and depression registers, 2013/14 by CCG and locality

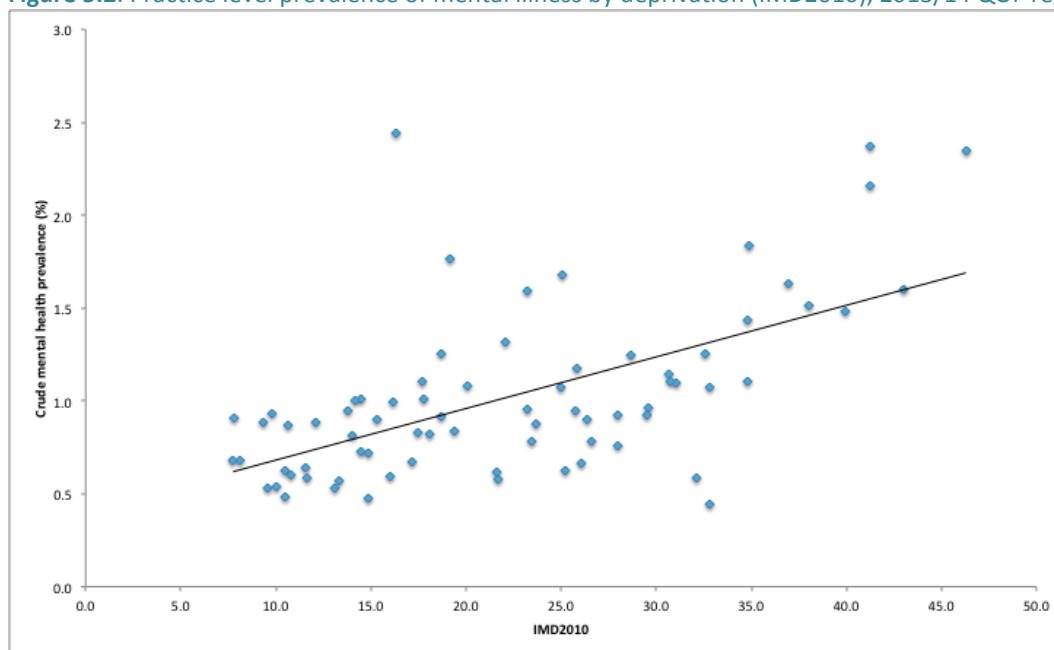
Area	Depression Register (ages 18+)	Depression prevalence (% age specific 18+)	Mental Health Register	Mental health prevalence (% all ages)
East Sussex	31221	7.0	5206	1.0
Eastbourne, Hailsham and Seaford	12286	7.6	1865	1.1
Central Eastbourne	5620	7.5	973	1.2
Eastbourne North	3582	9.3	372	0.8
Hailsham	1519	6.3	265	1.1
Seaford	1565	6.9	255	1.0
Hastings and Rother	10289	6.9	2054	1.1
Bexhill	2890	7.2	568	1.4
East Hastings	1561	6.7	236	1.0
Rural Rother	1757	5.7	243	0.6
St Leonards	2650	7.0	640	1.2
West Hastings	1431	8.2	367	1.7
High Weald Lewes Havens	8646	6.5	1287	0.8
Havens	2227	8.5	315	1.0
High Weald	4816	6.0	663	0.7
Lewes	1603	5.4	309	0.8

Source: HSCIC

Mental health prevalence varies between 0.8% in High Weald Lewes Havens CCG and 1.1% in Hastings & Rother and Eastbourne, Hailsham and Seaford CCGs, with the largest number of patients registered in Hastings & Rother CCG. At practice level the prevalence of mental illness is generally related to deprivation, with those practices with higher levels of deprivation recording higher numbers of patients with mental illness (Figure 5.2).

⁷⁵ Perala et al Lifetime prevalence of psychotic and bipolar I disorders in a general population Arch of Gen Psych 64:19 2007

Figure 5.2: Practice level prevalence of mental illness by deprivation (IMD2010), 2013/14 QOF registers



Source: HSCIC

Estimates of the incidence of depression within the population range from 3 to 6% of adults and the number of people identified with and requiring treatment for depression is estimated to increase by 17% in 2026.¹⁹ Mild depression accounts for 70%, moderate depression 20% and severe depression 10% of all cases.⁷⁶ Using the 2013/14 QOF register for newly diagnosed depression, this equates to approximately 3100 new cases of severe depression across East Sussex.

Incapacity benefit claimants

Of the 14,800 working age benefits claimants claiming disability living allowance in November 2014, 25% were claiming support for mental health disorders (Table 5.6). Psychosis and psychoneurosis accounted for 85% of claimants. Psychosis accounted for a higher proportion of male claimants (58%) than female (51%). This was reversed for psychoneurosis (27% male claimants and 35% female).

Table 5.5: Working-age (16-64) claimants for disability living allowance by disabling condition, November 2014

Condition	All persons	Males	Female
Total	14,800	7,700	7,090
Psychosis	2,000	1,100	950
Psychoneurosis	1,150	500	650
Personality Disorder	200	100	110
Dementia	50	30	20
Behavioural Disorder	200	100	80
Severely Mentally Impaired	150	100	50

Note: number have been rounded

Source: Nomis [official labour market statistics](#)

Incidence

The incidence of psychosis is the number of people who develop an illness for the first time, per year, in a given place. The PsyMaptic tool was developed by the University of Cambridge, the National

⁷⁶ NICE. Depression in adults quality standards 8. 2011.

Institute for Health Research and the Wellcome Trust. It provides data on the expected incidence of first episode psychosis at local authority level in England & Wales. The model is based on the socio-demographic characteristics of the population taking into account age, sex, ethnic group, population density and deprivation. Predictions are based on risk estimates, using empirical data from two large epidemiological studies of first episode psychosis in England, to predict the expected rate of disorder in other regions of England & Wales.⁷⁷ Table 5.6 presents estimated numbers and crude incidence rates for East Sussex for working age adults (16-64 years) in East Sussex by sex and ethnicity.

Table 5.6: Estimated annual number of new clinically relevant cases and crude incidence rate of psychotic disorder for 16-64 year olds, East Sussex

	All persons	Gender		Ethnicity	
		Female	Male	White British	BME
Case numbers (lower and upper limits)	56 (41-70)	22 (14-31)	33 (23-45)	45 (31-59)	3 (0-10)
Crude incidence rate (per 100,000 population)	18	14	21	16	50

Source: *PsyMaptic*

For psychotic disorders East Sussex has an estimated crude incidence rate of 18 per 100,000 population, with 56 new cases annually. The incidence rate and number of cases is higher in men. Although the absolute number of cases in non-White British ethnic groups is low (3) the estimated incidence rate is more than three times that of the rate for the White British population (50 per 100,000 v 16 per 100,000).

Table 5.7 models estimated district and borough values. The highest incidence rates are seen in Hastings Borough. However, because of population size, Hastings and Wealden District are estimated to have equal number of incident cases annually.

Table 5.7: Estimated annual number of new clinically relevant cases and crude incidence rate of psychotic disorder for 16-64 year olds by CCG

Local Authority		All persons	Gender		Ethnicity	
			Female	Male	White British	BME
Eastbourne	N (lower–upper limit)	12 (6-20)	5 (1-10)	7 (2-14)	9 (4-15)	1 (0-6)
	Incidence (per 100,000)	20	16	25	17	52
Hastings	N (lower–upper limit)	13 (6-21)	5 (1-11)	8 (3-14)	10 (5-16)	1 (0-7)
	Incidence (per 100,000)	22	17	27	19	56
Lewes	N (lower–upper limit)	9 (4-16)	4 (1-9)	6 (2-11)	8 (3-14)	0 (0-4)
	Incidence (per 100,000)	16	13	20	15	43
Rother	N (lower–upper limit)	8 (3-14)	3 (0-7)	5 (1-10)	7 (2-12)	0 (0-3)
	Incidence (per 100,000)	15	12	19	14	47
Wealden	N (lower–upper limit)	13 (7-22)	6 (2-11)	8 (3-15)	12 (6-19)	0 (0-4)
	Incidence (per 100,000)	15	12	18	14	41

Source: *PsyMaptic*

⁷⁷ [Kirkbride et al 2006](#), [Coid et al 2008](#)

The crude estimated annual incidence for all ages, by disorder is presented in Table 5.8. Note this is for the population as a whole and is not adjusted for population risk factors.

Table 5.8: Estimated annual incidence of psychotic disorders in East Sussex, all ages

Disorder	Number new cases per 100,000 population	Annual number of new cases East Sussex
Psychotic disorder	32	170
Schizophrenia	15	80
Affective psychosis	12	60
Bipolar disorder	4	20

Note: Figures have been rounded
Adapted from: Kirkbride et al 2012

5.3 Projected change

The population in East Sussex is projected to increase by four percent to 553,300 persons by 2027. This growth will mainly be amongst post-retirement age groups who may represent 29% of the population 2027. The working age population is projected to decline by almost 4%.⁷⁸

The Projecting Adult Needs and Service Information system (PANSI) provides information at a local authority level on the projected numbers, characteristics and care needs of people who may require additional support services, including those with mental health needs. Table 5.9 shows the projected numbers of persons with mental health needs in East Sussex between 2015 and 2030.

Table 5.9: East Sussex persons aged 18-64 predicted to have a mental health problem, by gender, projected to 2030

Mental disorder	Males aged 18-64				Females aged 18-64			
	2015	2020	2025	2030	2015	2020	2025	2030
Common mental disorder	18,400	18,600	18,700	18,700	30,200	30,400	30,500	30,300
Borderline personality disorder	440	450	450	450	920	930	930	920
Antisocial personality disorder	880	890	900	900	150	150	160	150
Psychotic disorder	440	450	450	450	770	770	770	770
Two or more psychiatric disorders	10,100	10,200	10,300	10,300	11,500	11,600	11,600	11,500

Source: PANSI

The number of persons with mental health needs requiring support is predicted to remain relatively constant between 2015 and 2030. This will differ between genders with a small increase in all categories in males (2%) and no real change for females. Appendix X presents PANSI estimates for districts and boroughs.

5.3 Suicide

Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

The Public Health Outcomes Framework (PHOF) Tool provides information on suicide rates (deaths

⁷⁸ ESiF: East Sussex demographic projections in brief 2014

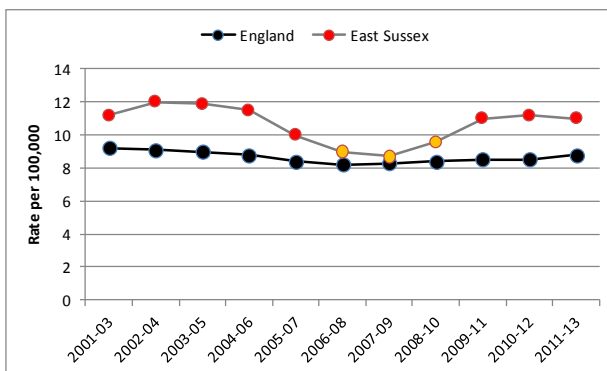
from suicide and injury of undetermined intent) for males, females, and all persons.⁷⁹ Both the number and the rates are given for three-year rolling periods between 2001-03 and 2010-12. The rates have been age-standardised which is a technique used to allow populations to be compared when the age profiles of the populations may be quite different.

Figure 5.3 illustrates that over the recorded period suicide rates in East Sussex have been higher than the national rate. This is true for males and females. Although there had been a downward trend in suicide in the county, since the 2006-08 period this has again begun to increase and most recent rates are significantly higher than the national rate.

Figure 5.3: East Sussex annual suicide rates by gender, 2001-3 to 2011-13

Suicide rate (Persons) East Sussex Directly age-standardised rate per 100,000

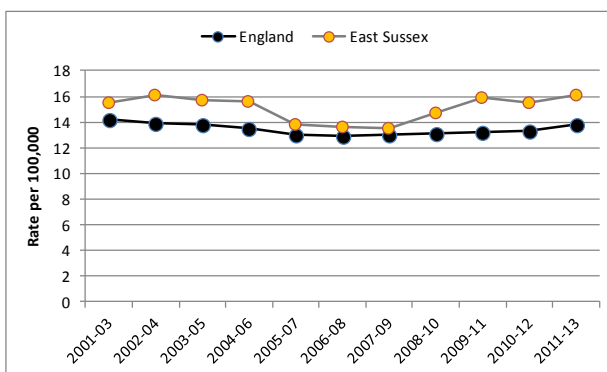
Period	East Sussex			South East England	
	Number	Rate	Significance	Rate	Rate
2001-03	163	11.2	R	9.0	9.2
2002-04	177	12.0	R	8.9	9.1
2003-05	177	11.9	R	8.7	9.0
2004-06	174	11.5	R	8.6	8.8
2005-07	154	10.0	R	8.2	8.4
2006-08	140	9.0	A	8.0	8.2
2007-09	134	8.7	A	8.1	8.3
2008-10	146	9.6	A	8.3	8.4
2009-11	167	11.0	R	8.5	8.5
2010-12	173	11.2	R	8.4	8.5
2011-13	174	11.0	R	8.8	8.8



Suicide rate (Males) East Sussex

Directly age-standardised rate per 100,000

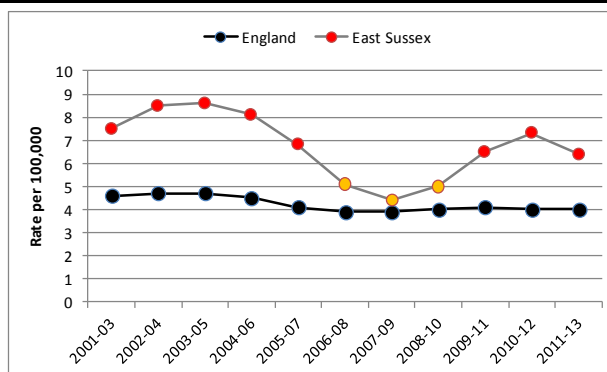
Period	East Sussex			South East England	
	Number	Rate	Significance	Rate	Rate
2001-03	104	15.5	A	13.8	14.2
2002-04	109	16.1	A	13.6	13.9
2003-05	108	15.7	A	13.3	13.8
2004-06	108	15.6	A	12.8	13.5
2005-07	99	13.8	A	12.3	13.0
2006-08	99	13.6	A	12.2	12.9
2007-09	100	13.5	A	12.4	13.0
2008-10	108	14.7	A	12.7	13.1
2009-11	118	15.9	A	12.8	13.2
2010-12	117	15.5	A	12.7	13.3
2011-13	123	16.1	A	13.6	13.8



Suicide rate (Females) East Sussex

Directly age-standardised rate per 100,000

Period	East Sussex			South East England	
	Number	Rate	Significance	Rate	Rate
2001-03	59	7.5	R	4.6	4.6
2002-04	68	8.5	R	4.6	4.7
2003-05	69	8.6	R	4.5	4.7
2004-06	66	8.1	R	4.7	4.5
2005-07	55	6.8	R	4.4	4.1
2006-08	41	5.1	A	4.1	3.9
2007-09	34	4.4	A	4.1	3.9
2008-10	38	5.0	A	4.2	4.0
2009-11	49	6.5	R	4.4	4.1
2010-12	56	7.3	R	4.3	4.0
2011-13	51	6.4	R	4.3	4.0



Source: East Sussex Public Health Intelligence

⁷⁹ <http://www.phoutcomes.info>

5.7 Summary

Many of the key population risk for mental illness are not as common in East Sussex as they are nationally. However, there is variation at small area level, most notably for deprivation and ethnic variation.

Household surveys, such as the English national adult psychiatric morbidity surveys (AMPS) provide the most information on the prevalence of diagnosed, and undiagnosed psychiatric disorders amongst the population. Using the information from the AMPS it is estimated there are approximately 55,600 people in East Sussex with a common mental health disorder; 2700 with a personality disorder and 1700 with probable psychosis. However, it is recognised that household surveys such as the AMPS may underestimate the prevalence of severe mental health disorders.

For psychotic disorders East Sussex has an estimated crude incidence rate of 18 per 100,000 population, with an estimated 56 new cases annually. The number of persons with mental health needs requiring support is predicted to remain relatively constant between 2015 and 2030.

Recorded mental health prevalence varies between 0.8% on High Weald Lewes Havens CCG and 1.1% in Hastings & Rother and Eastbourne, Hailsham and Seaford CCGs, with the largest number of patients registered in Hastings & Rother CCG. At practice level the prevalence of mental illness is generally related to deprivation, with those practices with higher levels of deprivation recording higher numbers of patients with mental illness.

Suicide rates for men and women have remained higher than the national rates for over a decade.

6. Provision of specialist mental health care in East Sussex

The provision of long-term mental health care for people with severe mental disorders has been, and still is, one of the major challenges for mental health systems reform in the last decades. Although mental health services have led the way in moving from in-patient focused service to community-based services there will always be a need for acute mental health services.

Acute mental health services work with those people who are experiencing, at risk of, or recovering from a mental health crisis.⁸⁰ These services:

- Meet the mental health needs of those people who cannot be managed by primary care and specialist community-based services;
- Include crisis resolution and home treatment services and inpatient services;
- Include a range of community-based supports that may be commissioned to complement treatment at home or in hospital.⁸⁰

The aim of acute care services is to support the patient and their families through what is often a frightening and distressing phase of their illness. Some people in acute care services will be detained under the Mental Health Act 1983, others will be informal or voluntary patients.

6.2 Acute mental health services

Sussex Partnership Foundation Trust (SPFT) provides acute mental health services for the population of East Sussex. Services to meet acute mental health need include crisis resolution and home treatment (CRHT), in-patient services and a range of community based support. People with poor mental health can be cared for at home if the environment is suitable, if there is capacity in the home treatment team to keep them safe and if they agree to be cared for at home. The aim of acute care is to support patients and carers, assessing and implementing care and identifying goals for recovery.

This section presents information from SPFT regarding inpatients during 2012/13 and 2013/14 and from the most recent SMIPT for Eastbourne, Hailsham and Seaford CCG, Hasting and Rother CCG and High Weald Lewes Havens CCG covering a range of time frames. Data are presented at East Sussex and CCG level, for locality detail see Appendices 3 and 4.

Crisis Resolution Home Treatment (CRHT)

When issues of risk, or intensity of care, move beyond the resources of the Community Mental Health Teams, patients can be referred to the Crisis Resolution Home Treatment (CRHT). The CRHT provide a rapid response to people deemed to be in mental health crisis in the community, who are typically referred by local GP's and other community based mental health services. The service aims to work

Acute care services

Crisis Resolution and Home Treatment team (CRHT) for treatment of acutely unwell people at home who would otherwise require hospital admission. The CRHT assesses the appropriateness of inpatient admissions and can facilitate supported discharge from secondary care.

Crisis House and recovery house provision for support in a residential setting for people in crisis who do not need to be admitted to hospital, but cannot be treated at home.

In-patient services provide care in a safe setting for patients in the most acute stage of illness when admission will help in a person's progress to recovery. There are at least four types of in-patient service, acute in-patient wards, psychiatric intensive care units (PICUs), rehabilitation units and specialist beds.

Acute day services provide an alternative to admission for people who are acutely unwell and are a means of facilitating early discharge and preventing readmission.

Place of safety provision often comprises a suite of rooms for the emergency psychiatric assessment of those detained by the police under S136 of the Mental Health Act. Police custody is sometimes used as a place of safety but guidance makes it clear that this should be on an exceptional basis only and that it is preferable for the person to be detained in a healthcare setting.

⁸⁰ Joint Commissioning Panel for Mental Health – Guidance for commissioners of acute care – inpatient and crisis home treatment

closely with in-patient clinicians and bed managers to support the timely, appropriate, discharge of patients back in to the community and organise consequent packages of care.

During 2013/14 the East Sussex CRHT based in Hastings and Eastbourne completed 987 episodes of care. (Table 6.1) The Hastings team largely provides support for patients from Hastings & Rother CCG (97%). The Eastbourne team provides care for patients largely from Eastbourne, Hailsham and Seaford (64%) and High Weald Lewes Havens CCGs (34%).

Table 6.1: East Sussex CHRT Episodes 2013/14 by CCG and Team

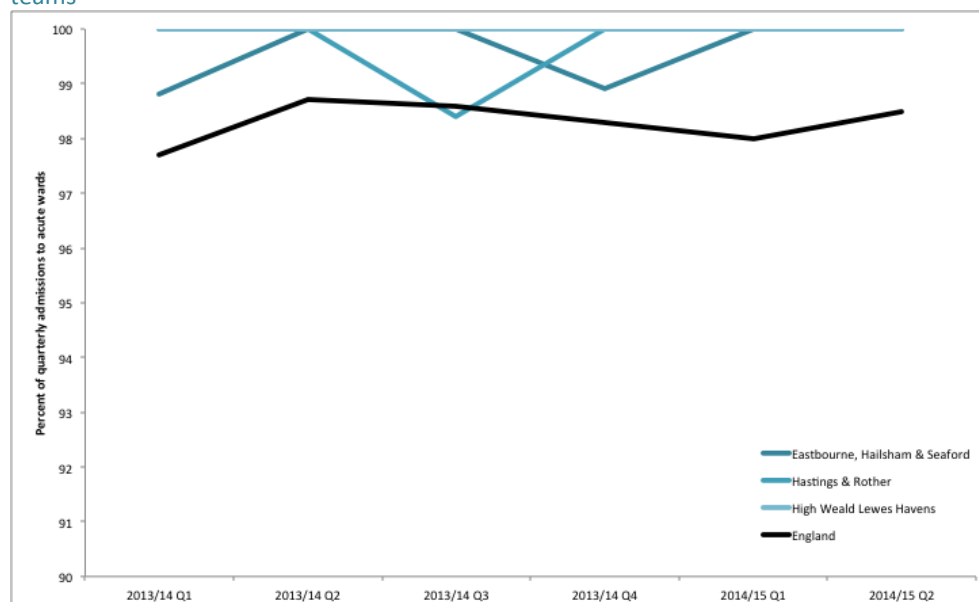
CCG	Team Name	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
Eastbourne, Hailsham and Seaford CCG	CRHT-Hastings					10
	CRHT-Eastbourne	92	82	81	101	356
Hastings and Rother CCG	CRHT-Hastings	118	109	95	100	422
	Eastbourne					7
High Weald Lewes Havens CCG	CRHT-Hastings					5
	CRHT-Eastbourne	48	49	45	45	187
East Sussex		261	244	226	256	987

Note: small numbers have been suppressed

Source: SPFT performance

CRHT team act as gatekeepers to care, either as an inpatient or at home. The proportion of admissions gate-kept⁸¹ by the CRHT is consistently higher in East Sussex CCGs than the national figure (Figure 6.1).

Figure 6.1: Gate kept admissions: % (quarterly) admissions to acute wards that were gate kept by the CRHT teams



Source: Public Health England fingertips.phe.org.uk/

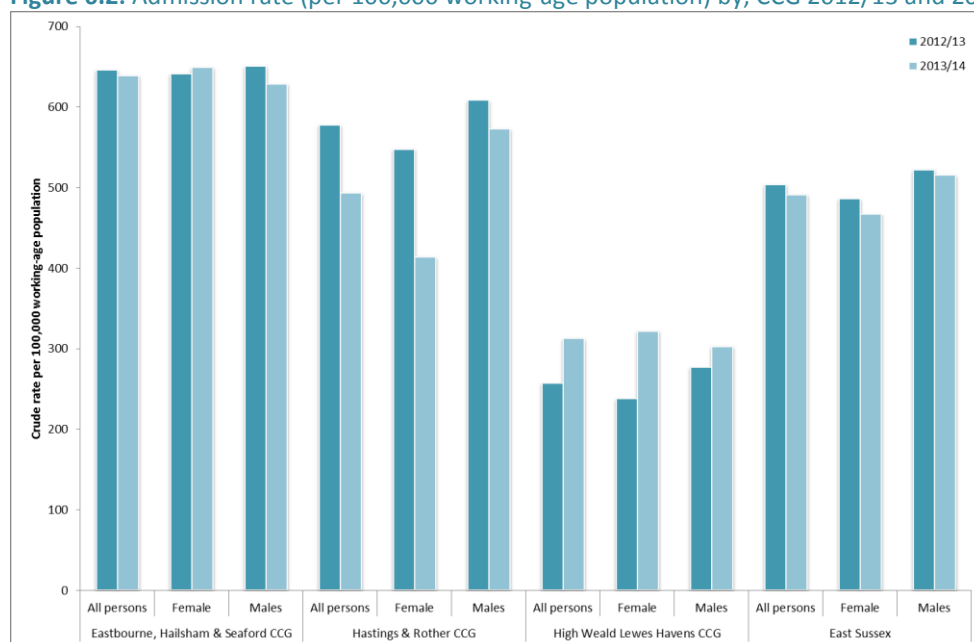
Acute admissions

⁸¹ An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.

In-patient services provide care in a safe setting for patients in the most acute stage of illness, when admission will help a person's recovery. There are at least four types of in-patient service, acute inpatient wards, psychiatric intensive care units (PICUs), rehabilitation units and specialist beds.

There were a total of 3015 acute admissions to SPFT from East Sussex CCG registered patients during 2012/13 (1527) and 2013/14 (1488). Admission rates (per 100,000 working-age population) were highest for both males and female in Eastbourne, Hailsham and Seaford CCG and lowest in High Weald Lewes Havens CCG (Figure 6.2).

Figure 6.2: Admission rate (per 100,000 working-age population) by, CCG 2012/13 and 2013/14

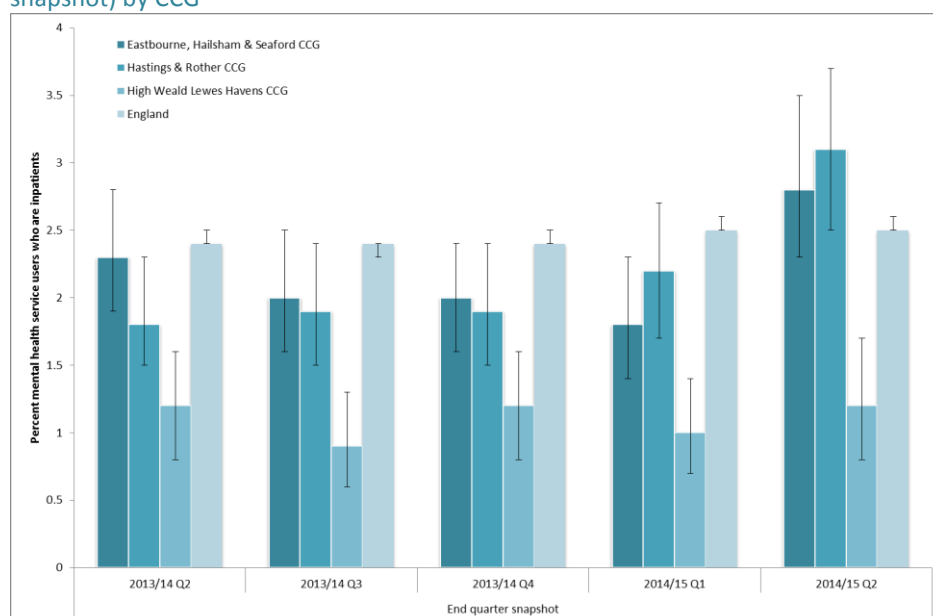


Source: SPFT performance data

Although admission rates for both females and males decreased slightly between 2012/13 and 2013/14, this pattern was reversed in High Weald Lewes Havens CCG where admission rates for both females and males increased. The largest increase was seen in females.

Eastbourne, Hailsham and Seaford CCG also had the highest proportion of mental health service users who were inpatients for the 2013/14 financial year (Figure 6.3). In the first two quarters of 2014/15 a higher proportion of patients from Hastings & Rother CCG were inpatients. However, apart from quarter two of 2013/14 the proportion of patients from these CCGs who were inpatients is below the national rate. The proportion of High Weald Lewes Havens mental health service users who were inpatients is consistently significantly below the national rate.

Figure 6.3: Percent of mental health service users who were inpatients in a psychiatric hospital (end of quarter snapshot) by CCG



Source: Public Health England fingertips.phe.org.uk/

Demographics of admitted patients

Males account for a slightly higher proportion of inpatient admissions (52%) than females across the county. This pattern is reversed only in Eastbourne, Hailsham and Seaford CCG (49% male: 51% female) and is more pronounced in patients from Hastings and Rother CCG, where 55% of admissions were male (Table 6.2)

Table 6.2: Percent of admissions by gender and CCG, 2012/13 and 2013/14 (under-65year old admissions)

CCG	All persons	Females	Male
Eastbourne, Hailsham and Seaford CCG	1301	51%	49%
Hastings And Rother CCG	1153	45%	55%
High Weald Lewes Havens CCG	536	49%	51%
East Sussex*	3015	48%	52%

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

The average age of working-age patients admitted to SPFT was 41 years (Table 6.3). There was no difference between males and females at East Sussex level. However, males from Eastbourne, Hailsham and Seaford CCG were on average two years older than females from the same CCG. Whereas males from High Weald Lewes Havens CCG were on average three years younger than females.

Table 6.3: Average age on admission by CCG, 2012/13 and 2013/14 (under-65year old admissions)

CCG	All persons	Females	Male
Eastbourne, Hailsham and Seaford CCG	41.6	40.6	42.6
Hastings And Rother CCG	40.1	40.4	39.9
High Weald Lewes Havens CCG	42.0	43.7	40.5
East Sussex*	41.0	40.9	41.1

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

The ethnic profile of East Sussex inpatients reflected that of the general population with four percent from black and minority ethnic groups (Table 6.4). This was slightly higher in Hastings and Rother CCG (6%) and lower in High Weald Lewes Havens CCG (2%).

Table 6.4: Ethnicity of inpatients by CCG, 2012/13 and 2013/14 (under-65year old admissions)

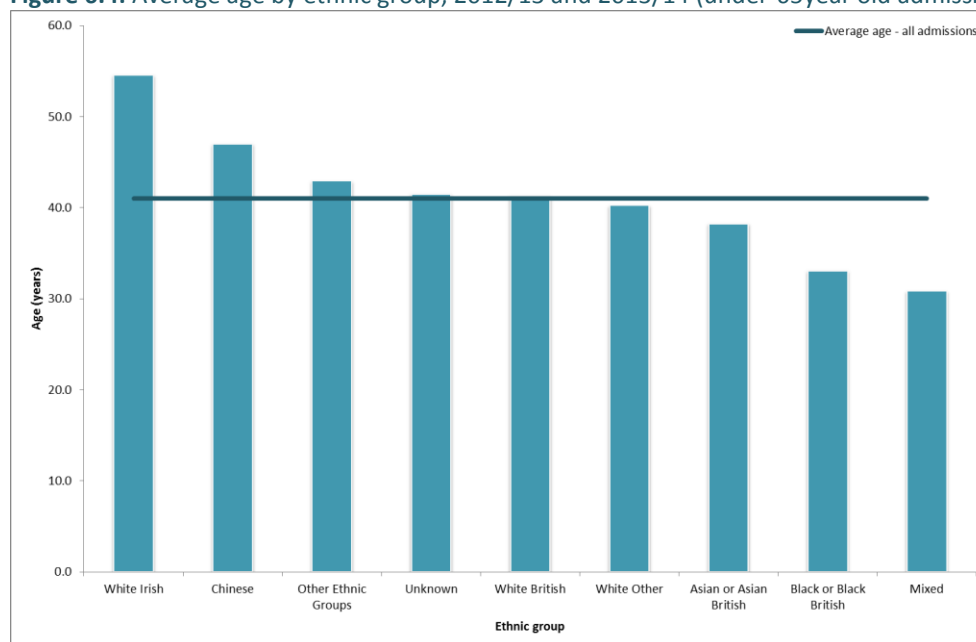
CCG	All White groups	BME groups	Unknown
Eastbourne, Hailsham and Seaford CCG	95%	4%	1%
Hastings And Rother CCG	92%	6%	3%
High Weald Lewes Havens CCG	94%	2%	3%
East Sussex*	94%	4%	2%

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

Figure 6.4 shows that the average age of patients from non-white ethnic groups was generally lower than the all admissions average, with the exception of those patients identifying as Chinese or from other ethnic groups. Those from mixed ethnicity groups are on average 10 years younger than the average. This also reflects the ethnic profile of the county, where those from mixed ethnic groups represent a higher proportion of the younger age groups.

Figure 6.4: Average age by ethnic group, 2012/13 and 2013/14 (under-65year old admissions)



Source: SPFT performance data

Reason for admission

A Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health patients based on their characteristics. A Mental Health Care Cluster is assigned using a decision tree or algorithm based on an assessment using the Mental Health Clustering Tool, undertaken by a care professional. Table 6.5 shows the proportion of inpatients by mental health care cluster. Patients assigned to psychotic (45%) and non-psychotic (40%) clusters account for most admissions.

Table 6.5: Diagnosis cluster on admission for under 65 year olds, 2012/13 and 2013/14⁸² (under-65year old admissions)

CCG	Common mental health disorders (α)	Non-psychotic (β)	Psychosis (χ)	Dual Diagnosis (δ)	Cognitive impairment or dementia complicated (ε)	Unassigned (ϕ)
Eastbourne, Hailsham and Seaford CCG	6%	38%	46%	5%	5%	15%
Hastings And Rother CCG	6%	39%	45%	7%	4%	17%
High Weald Lewes Havens CCG	6%	40%	50%	2%	2%	17%
East Sussex*	6%	40%	45%	5%	4%	16%

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

The average length of stay for patients, excluding periods of leave, is 31 days. This varies between 15 days for those assigned to common mental health disorder clusters to 58 for those in unassigned clusters (Table 6.6)

Table 6.6: Average length of stay (excluding leave) in days by diagnosis, 2012/13 and 2013/14 (under-65year old admissions)

	Common mental health disorders	Non-psychotic	Psychosis	Dual Diagnosis	Cognitive impairment or dementia complicated	Unassigned	All
Eastbourne, Hailsham and Seaford CCG	13	16	41	39	46	102	35
Hastings & Rother CCG	18	28	32	28	51	45	31
High Weald Lewes Havens CCG	11	17	29	3	80	19	25
East Sussex*	15	19	34	30	47	58	31

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

Admissions for psychosis

82

α 01 - Common mental health problems (low severity); 02 - Common mental health problems (low severity with greater need)

β 03 - Non-psychotic (moderate severity); 04 - Non-psychotic (severe); 05 - Non-psychotic disorders (very severe); 06 - Non-psychotic disorder of over-valued ideas; 07 - Enduring non-psychotic disorders (high disability); 08 - Non-psychotic chaotic and challenging disorders

χ 10 - First episode psychosis; 11 - Ongoing recurrent psychosis (low symptoms); 12 - Ongoing or recurrent psychosis (high disability); 13 - Ongoing or recurrent psychosis (high symptom & disability); 14 - Psychotic crisis; 15 - Severe psychotic depression; 17 - Psychosis and affective disorder - difficult to engage

δ 16 - Dual diagnosis

ε 18 - Cognitive impairment (low need); 19 - Cognitive impairment or dementia complicated (moderate need); 20 - Cognitive impairment or dementia complicated (high need); 21 - Cognitive impairment or dementia (high physical or engagement)

ϕ 0 - N/A – variance or unspecified

Almost half of admissions are due to psychosis (45%). When we examine the detail of the care clusters, patients assigned to on-going or recurrent psychosis care clusters 12 (high disability) and 13 (high symptom and disability) both account for almost a quarter of admissions (Table 6.7). However, for High Weald Lewes Havens patients this pattern differs, with care clusters 11 (on- gong psychosis, low symptoms) 14 (psychotic crisis) accounting for the highest proportion of admissions.

Table 6.7: Psychosis admissions by care cluster (%) , 2012/13 and 2013/14 (under-65year old admissions)

	% All admissions due to psychosis	% first episode	11 – On going recurrent psychosis (low symptoms)	12 – On going or recurrent psychosis (high disability)	13 – On going or recurrent psychosis (high symptom & disability)	14 - Psychotic crisis	15 - Severe psychotic depression	17 - Psychosis and affective disorder - difficult to engage
Eastbourne, Hailsham and Seaford CCG	46%	4%	16%	22%	29%	15%	3%	10%
Hastings & Rother CCG	45%	4%	17%	28%	22%	15%	3%	11%
High Weald Lewes Havens CCG	50%	3%	22%	19%	12%	22%	5%	16%
East Sussex*	45%	5%	18%	23%	24%	16%	4%	11%

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

Table 6.8 shows that across the two years 2012/13 and 2013/14 just over half admissions were male (51%).

Table 6.8: Psychosis admissions by gender (%) , 2012/13 and 2013/14 (under-65year old admissions)

	2012/13			2013/14		
	All admissions (n)	% Female	% Male	All admissions (n)	% Female	% Male
Eastbourne, Hailsham and Seaford CCG	654	50%	50%	647	51%	48%
Hastings & Rother CCG	622	47%	53%	531	36%	50%
High Weald Lewes Havens CCG	242	47%	53%	102	17%	25%
East Sussex*	1527	49%	51%	1488	47%	51%

* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

The ethnic profile of psychosis admissions was the same as for all mental health admissions and the East Sussex population generally, with 4% from BME groups (Table 6.9).

Table 6.9: Psychosis admissions by ethnicity (%) , 2012/13 and 2013/14 (under-65year old admissions)

	All admissions	White groups	BME groups	Unknown
Eastbourne, Hailsham and Seaford CCG	1295	95%	4%	1%
Hastings & Rother CCG	1130	93%	6%	1%
High Weald Lewes Havens CCG	299	95%	2%	3%
East Sussex*	2973	94%	4%	1%

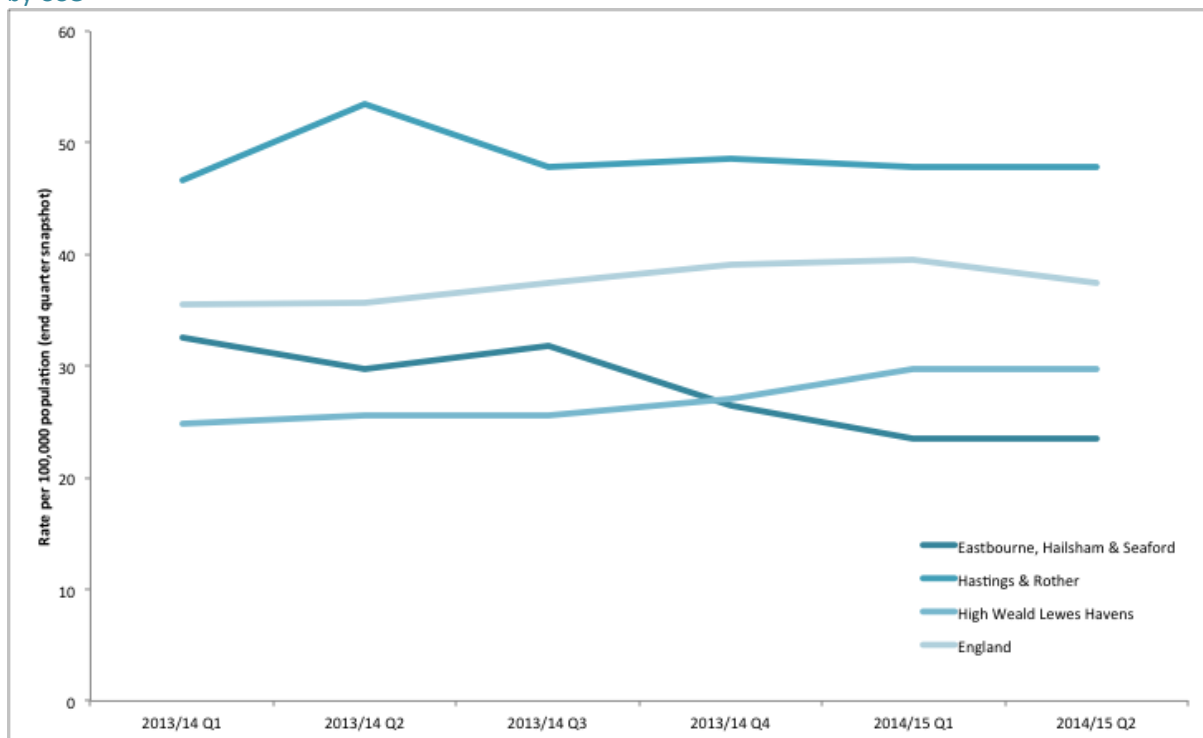
* includes East Sussex admissions with unknown CCG

Source: SPFT performance data

Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. Early intervention in psychosis provides quick diagnosis of the first onset of a psychotic disorder and appropriate treatment including intensive support in the early years. Patients being treated will normally be engaged with services over three years.⁶²

The rate of people being treated by the early intervention team is higher than the national rate in High Weald Lewes Havens CCG. However, it is lower than the national rate in the other CCGs.

Figure 6.x: Under-65 people being treated by Early Intervention teams (rate per 100,000 population aged 18+), by CCG

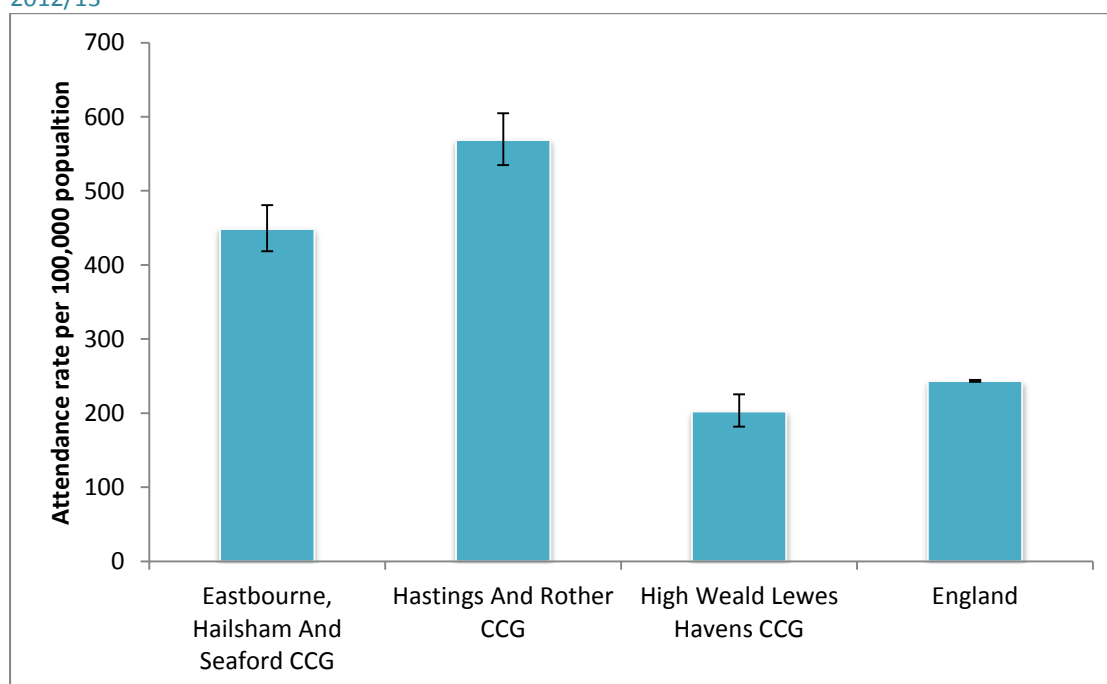


Source: Public Health England fingertips.phe.org.uk/

Attendance at accident and emergency

Figure 6.5 shows that the accident and emergency attendance rate for mental disorders is significantly higher in Hastings and Rother CCG (567 per 100,000 population) and Eastbourne, Hailsham and Seaford CCG (449 per 100,000) than England 243 per 100,000).

Figure 6.5: Attendances at A&E for a psychiatric disorder: Rate per 100,000 population, all ages, all persons, 2012/13



Source: Public Health England fingertips.phe.org.uk/

Emergency admissions and readmissions

Emergency admission rates are generally consistently highest in Hastings & Rother CCG and lowest in High Weald Lewes Havens CCG for mental and behavioural disorders and for persons with psychosis (Table 6.10). This reflects the deprivation profile of the CCGs, with the Hastings and Rother CCG population being relatively more deprived than the High Weald Havens population. This relationship with deprivation is not present for emergency admissions for self-harm.

Table 6.10: Emergency hospital admissions, age-standardised ratio by CCG, 2010/11 and 2011/12, 2011/12 and 2012/13, and 2012/13 and 2013/14

	Emergency hospital admissions due to mental and behavioural disorders, age-standardised ratio			Emergency hospital admissions for persons with psychosis, age-standardised ratio			Emergency hospital admissions relating to self-harm, age-standardised ratio	
	10/11 & 11/12	11/12 & 12/13	12/13 & 13/14	10/11 & 11/12	11/12 & 12/13	12/13 & 13/14	10/11 & 11/12	11/12 & 12/13
	rate (n)	rate (n)	rate (n)	rate (n)	rate (n)	rate (n)	rate (n)	rate (n)
Eastbourne, Hailsham and Seaford CCG	92 (550)	102 (600)	117 (750)	97 (1950)	104 (2150)	107 (2400)	96 (1000)	103 (500)
Hastings and Rother CCG	123 (750)	112 (650)	105 (650)	124 (2500)	115 (2350)	112 (2450)	107 (600)	89 (400)
High Weald Lewes Havens CCG	83 (450)	84 (450)	76 (450)	77 (1400)	79 (1500)	79 (1600)	102 (500)	109 (450)
East Sussex	100 (1700)	100 (1700)	100 (1850)	100 (5850)	100 (6100)	100 (6450)	100 (2100)	100 (1350)

Note: numbers have been rounded

Source: East Sussex public health intelligence <http://www.eastsussexjsna.org.uk/>

The proportion of all mental health admissions that were emergency admissions is higher in East Sussex CCGs (95%) than the England average (74%) (Table 6.11). This is also the case for emergency readmissions (East Sussex 17%, England 9%). However, data presented is only for two quarters and may not be representative of whole year activity.

Table 6.11: Emergency admissions: Percent of (quarterly) admissions and readmissions, which were emergency, all ages

Time Period	Admissions				Readmissions			
	Eastbourne, Hailsham and Seaford CCG	Hastings and Rother CCG	High Weald Lewes Havens CCG	England	Eastbourne, Hailsham and Seaford CCG	Hastings and Rother CCG	High Weald Lewes Havens CCG	England
2014/15 Q1	92.9	96.2	92.9	73.6	21.4	15.4	14.3	9.2
2014/15 Q2	93.8	95.5	100	73.5	12.5	22.7		9.3

Source: Public Health England fingertips.phe.org.uk/

Mental Health Act

The Mental Health Act is used to formally detain a patient for his or her own safety, or that of other people. The number of people in NHS funded specialist adult mental health services at the end of the Reporting Period who were subject to the Mental Health Act (rate per 100,000 aged 18+) is lower in East Sussex CCGs than nationally (Table 6.12). The average number of repeat detentions and repeat short-term orders reflect national figures across all CCGs.

Table 6.11: People subject to the Mental Health Act (rate per 100,000 population) and average number of repeat detentions and short term orders, all ages, 2012/13

Indicator	Eastbourne, Hailsham and Seaford CCG	Hastings & Rother CCG	High Weald Lewes Havens CCG	England
People subject to short-term orders under MHA during year: Rate per 100,000 population	15 (9.9-21.8)	19.3 (13.5-26.9)	8.4 (4.6-14.2)	31.5 (31.1-32.0)
Repeat detentions under MHA during year: Average detentions per person	1.2	1.2	1.3	1.2
Repeat short-term orders under MHA during year: Average orders per person	1.1	1.3	1.1	1.3

Source: Public Health England fingertips.phe.org.uk/

7. Spend

An average of £22.4 million per 100,000 population was spent on specialist mental health for adults in 2012/13 across the three East Sussex CCGs (Table 7.1). This compares to an English average of £26.8 million per 100,000 population. The CCG spend represents 9.6% of all spend on secondary care services across the county, less than the English average of 11.9%.

Of the total spend on mental health services, 8.9% (£20.1 million per 100,000 population) was spent on psychosis, less than half the English average of 17.7% (47.9 million per 100,000 population). Secondary care for psychosis accounts for 63% of the total spend in this area (64% across England).

Table 7.1: CCG spend on specialist mental health services, 2012/13

Indicator	Eastbourne, Hailsham and Seaford CCG	Hastings & Rother CCG	High Weald Lewes Havens CCG	England
Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	£21,082.7	£25,164.3	£21,082.7	£26,755.6
% spend on specialist mental health services: % of all secondary care service spend categorised as mental health (mapped from PCT)	9.2	10.4	9.2	11.9
% spend on psychosis: % of all mental health spend categorised as psychosis (mapped from PCT)	8.1	10.5	8.1	17.9
Spend on psychosis services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	£1706.3	£2632.5	£1706.3	£4789.0
Secondary Care spend on psychosis: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	£1107.0	£1585.7	£1107.0	£3050.7

Source: Public Health England fingertips.phe.org.uk/

The Spend and Outcome Tool, produced by PHE Knowledge and Intelligence Northern and Yorkshire, gives an overview of spend and outcome across key areas. The tool gives an understanding of the overall relationship between spend and outcomes, by identifying areas of significant variance, which are likely to require more in-depth analysis. The tool illustrates that for mental health indicators in East Sussex a low spend per head of population compared to England is mirrored by poor outcomes as defined by the mortality rate from suicide and undetermined injury and the proportion of GP mental health registers with a comprehensive care plan (Table 7.2 and Appendix 5).

Table 7.2: SPOT mental health outcome indicators by CCG.

	Eastbourne, Hailsham and Seaford CCG	Hastings & Rother CCG	High Weald Lewes Havens CCG	England
Mental health disorders: spend per head population	£172	£181	£172	£210
Mortality from suicide and injury undetermined: all ages, persons	12.3	9.4	9.5	8.1
% MH with comprehensive care plan (MH10)	83%	84%	85%	87%

Source: <http://www.yhpho.org.uk/>

8. Conclusion

Mental health problems constitute the largest single burden of disease nationally at almost a quarter of the total (23%). One person in four will experience mental illness during their lives, and whilst most recover some will experience varying degrees of disability and distress for long periods. For working age adults mental illness is common and disabling. The spectrum of illness ranges from common disorders such as depression and anxiety to less common psychotic illnesses.

Mental disorders comprise a broad range of problems, with different symptoms. Although there is no universal definition of severe mental disorders, the term usually refers to illnesses where psychosis occurs. Household surveys, such as the English national adult psychiatric morbidity surveys (AMPS) provide the most information on the prevalence of diagnosed, and undiagnosed psychiatric disorders amongst the population. However, they are likely to underrepresent conditions such as psychosis.

This work has shown East Sussex has an estimated crude incidence rate of 18 per 100,000 population for psychotic disorders, with 56 new cases annually. The number of persons with mental health needs requiring support is predicted to remain relatively constant between 2015 and 2030. Many of the key population risk for mental illness are not as common in East Sussex as they are nationally. However, there is variation at small area level, most notably for deprivation and ethnic variation.

Recorded mental health prevalence varies between 0.8% on High Weald Lewes Havens CCG and 1.1% in Hastings & Rother and Eastbourne, Hailsham and Seaford CCGs, with the largest number of patients registered in Hastings & Rother CCG. At practice level the prevalence of mental illness is generally related to deprivation, with those practices with higher levels of deprivation recording higher numbers of patients with mental illness.

Acute and emergency mental health activity reflect the recorded prevalence levels at CCG level, with Hastings and Rother CCG having consistently higher rates and High Weald Lewes Haven CCG having lower activity rates. This also reflects the relative deprivation in these CCGs, which is greatest in Hastings & Rother CCG. However, more work should be done to understand the reasons behind high levels of accident and emergency attendances and emergency admissions for mental health conditions.

Compared to national figures spend on mental health service in East Sussex is low and outcomes are poor. Patients with psychosis represent a high proportion of admissions, as is expected. However, The rate of people being treated by early intervention teams and the average spend on psychosis services are lower than the national rates suggesting that investing in prevention and early intervention services may reduce hospital activity. Early identification of those at risk of psychosis, schizophrenia and bipolar disorder would facilitate opportunities for early intervention. Any identification work must be followed by evidence- based support and treatment.

Commissioning acute mental health services cannot be seen as distinct or separate from commissioning mental health and well-being services in their entirety. There are many aspects of mental health and wellbeing that this work has not touched upon and further work is required to identify local need for services in these areas. These include:

- Impact of non-psychotic disorders
- Dementia
- Older people's mental health and wellbeing
- Dual diagnosis
- Self-harm
- Comprehensive review of service user, service provider and wider stakeholder views. Including a review of current support mechanisms and services available for carers of mental health service users.

The Joint Commissioning Panel for Mental Health has produced a guide on commissioning acute care services.¹ The ten key messages from this guide are outlined in the box. These focus on ensuring mental health services are of the highest quality, meet the needs of individuals, families and carers, and are available and accessible. In order to achieve this Commissioners should focus on preventing mental illness from worsening and enabling earlier access to appropriate care, working with service providers, users and carers. This will require:

- Increased support for the involvement of service users and carers in the planning, development and delivery of mental health services.
- Improved timely diagnosis of mental illness
- Commitment to the recovery model
- Ensuring services offer non-stigmatising support for people with mental illness.
- Improved capacity and capability in primary care to manage mental health problems as early as possible
- Work towards delivering parity of esteem between mental and physical health.

There is no real divide between mental health and physical health and yet services are separate and hard to access for many people. A holistic approach should be taken by mental health services, promoting good physical health and healthy lifestyles, targeted at those with severe and mental illness.

In line with NICE guidance (CG120), health professionals in all settings including primary care, secondary care, mental health services, CAMHS, accident and emergency departments and those in prisons and the criminal justice mental health liaison schemes, should routinely assess those with known substance misuse problems for psychosis and mental illness.

Evidence suggests that the act of a person taking their own life is often impulsive and dependent on different factors in addition to mental illness, such as the presence of a physically disabling or painful illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many of those who take their own life it is the combination of factors, which may be important. There is a need therefore to raise awareness of the issue of suicide and to audit and learn from cases

10 key messages for commissioning acute mental health services

1. Commissioners should have as their standard that they commission acute care services that they would recommend to family and friends.
2. There should be evidence of service user, patient and carer involvement in the commissioning, strategic direction, and monitoring of acute care standards.
3. Commissioners should commission a range of services in the acute pathway including inpatient beds, psychiatric intensive care unit beds, crisis resolution and home treatment teams and residential alternatives to inpatient admission.
4. Commissioners should ensure that sufficient resources are available within the acute care pathway to ensure patient safety, enable service user and patient choice and for individuals to be treated close to home, and that choice is facilitated through the roll-out of personal health budgets.
5. Facilities of an acute care service should be available 24 hours a day, 7 days a week.
6. Commissioners should expect clear criteria for entry and discharge from acute care.
7. Commissioners should ensure that the service provider collects, analyses and acts upon a range of agreed outcome data.
8. The full range of NICE approved interventions should be available for patients in the acute care pathway (see Appendix 5).
9. Clear standards for communication with primary care should be set and audited.
10. Commissioners must ensure that acute care pathway providers meet their statutory duties under the Mental Health Act and Mental Capacity Act in accordance with the relevant Codes of Practice, and that all care is underpinned by humanity, dignity and respect.

where people have taken their own lives. In order to do this we must:

- Work with key stakeholder to develop real time surveillance of information to enable better review and response to deaths from suicide.
- Support people who are bereaved by suicide.
- Ensure local trends in suicide continue to be audited in order to inform local delivery and action.

Public Mental Health is a priority; in 2008 the report from the UK's Chief Scientist gave the economic case for investment into mental health promotion. The report stated that keeping people healthy and away from mental illness services is better for people and the economy. However, when people do need help and treatment, this needs to happen quickly and efficiently.

Appendix 1: Estimated numbers of persons with mental disorders by CCG locality

Mental disorder	CCG	Eastbourne, Hailsham and Seaford					Hastings and Rother					High Weald Lewes Havens				
	Locality	Central Eastbourne	Eastbourne North	Hailsham	Seaford	EHS Total	Bexhill	East Hastings	Rural Rother	St Leonards	West Hastings	H&R Total	Havens	High Weald	Lewes	HWLH Total
Common mental disorder (past week)	Males	3200	1600	1100	900	6800	1500	1000	1400	1900	1000	6800	1300	3600	1400	6200
	Females	5200	2600	1800	1500	11100	2500	1600	2200	3000	1500	10800	2100	5700	2300	10000
	All persons	8400	4200	2800	2400	17800	4000	2600	3600	4900	2500	17700	3400	9300	3700	16400
Current PTSD	Males	700	300	200	200	1400	300	200	300	400	200	1400	300	700	300	1300
	Females	900	400	300	200	1900	400	300	400	500	300	1800	300	1000	400	1700
	All persons	1600	800	500	400	3300	700	500	700	900	500	3300	600	1700	700	3000
Suicidal thoughts (past year)	Males	900	400	300	300	1800	400	300	400	500	300	1900	400	1000	400	1700
	Females	1400	700	500	400	2900	700	400	600	800	400	2800	500	1500	600	2700
	All persons	2200	1100	700	600	4700	1100	700	1000	1300	700	4700	900	2500	1000	4300
Suicide attempt (past year)	Males	1300	600	400	400	2700	600	400	600	800	400	2700	500	1400	600	2500
	Females	2400	1200	800	700	5100	1100	700	1000	1300	700	4900	900	2600	1000	4600
	All persons	3600	1800	1200	1000	7700	1700	1100	1600	2100	1100	7600	1500	4000	1600	7100
Psychotic disorder (past year)	Males	800	400	300	200	1600	400	200	300	500	200	1600	300	900	300	1500
	Females	1300	700	400	400	2800	600	400	600	700	400	2700	500	1500	600	2500
	All persons	2100	1000	700	600	4400	1000	600	900	1200	600	4400	800	2300	900	4000
BPD (past year)	Males	800	400	300	200	1600	400	200	300	500	200	1600	300	900	300	1500
	Females	1600	800	500	500	3400	800	500	700	900	500	3300	600	1700	700	3100
	All persons	2100	1000	700	600	4400	1000	600	900	1200	600	4400	800	2300	900	4000
APD (past year)	Males	1500	800	500	400	3200	700	500	700	900	500	3300	600	1700	700	3000
	Females	300	100	100	100	600	100	100	100	100	100	500	100	300	100	500
	All persons	1600	800	500	400	3300	700	500	700	900	500	3300	600	1700	700	3000
Two or more psychiatric disorders	Males	1800	900	600	500	3700	800	600	800	1100	500	3800	700	2000	800	3400
	Females	2000	1000	700	600	4200	900	600	800	1100	600	4100	800	2200	900	3800
	All persons	3700	1900	1300	1100	7900	1800	1100	1600	2200	1100	7900	1500	4100	1600	7300

Appendix 2: Persons aged 18-64 predicted to have a mental health problem, by gender and local authority area, projected to 2030

Mental disorder	LA area	Males aged 18-64				Females aged 18-64			
		2015	2020	2025	2030	2015	2020	2025	2030
Common mental disorder	East Sussex	18,400	18,600	18,700	18,700	30,200	30,400	30,500	30,300
	Eastbourne	3,500	3,600	3,700	3,700	5,800	5,800	5,800	5,800
	Hastings	3,400	3,400	3,500	3,400	5,500	5,600	5,600	5,600
	Lewes	3,500	3,500	3,600	3,700	5,600	5,800	5,800	5,900
	Rother	2,900	2,900	2,900	2,900	100	100	100	100
	Wealden	5,100	5,100	5,100	5,100	8,500	8,500	8,400	8,300
Borderline personality disorder	East Sussex	440	450	450	450	920	930	930	920
	Eastbourne	90	90	90	90	180	180	180	180
	Hastings	80	80	80	80	170	170	170	170
	Lewes	80	80	90	90	170	180	180	180
	Rother	70	70	70	70	20	30	30	20
	Wealden	120	120	120	120	260	260	260	250
Antisocial personality disorder	East Sussex	880	890	900	900	150	150	160	150
	Eastbourne	170	170	180	180	30	30	30	30
	Hastings	160	160	170	170	30	30	30	30
	Lewes	170	170	170	180	30	30	30	30
	Rother	140	140	140	140	120	120	120	120
	Wealden	240	250	250	240	40	40	40	40
Psychotic disorder	East Sussex	440	450	450	450	770	770	770	770
	Eastbourne	90	90	90	90	150	150	150	150
	Hastings	80	80	80	80	140	140	140	140
	Lewes	80	80	90	90	140	150	150	150
	Rother	70	70	70	70	1,810	1,840	1,840	1,820
	Wealden	120	120	120	120	220	220	210	210
Two or more psychiatric disorders	East Sussex	10,100	10,200	10,300	10,300	11,500	11,600	11,600	11,500
	Eastbourne	2,000	2,000	2,000	2,000	2,200	2,200	2,200	2,200
	Hastings	1,900	1,900	1,900	1,900	2,100	2,100	2,100	2,100
	Lewes	1,900	1,900	2,000	2,000	2,100	2,200	2,200	2,200
	Rother	1,600	1,600	1,600	1,600	3,200	3,200	3,200	3,200
	Wealden	2,800	2,800	2,800	2,800	3,200	3,200	3,200	3,200

Appendix 3: East Sussex severe mental illness profile tool indicators

Indicator	Time Period	Age	East Sussex	England
Socioeconomic deprivation: overall IMD score	2011	All ages	20.2	21.5
Socioeconomic deprivation: % of people living in 20% most deprived areas	2012	All ages	13.0 (12.9-13.1)	20.4 (20.4-20.4)
Socioeconomic deprivation: % of people living in 20% most deprived areas	2013	All ages	13.0 (12.9-13.1)	20.4 (20.4-20.5)
Long-term unemployment: % of working age population	2013/14	16-64 yrs	0.7 (0.7-0.7)	0.9 (0.9-0.9)
Statutory homelessness: rate per 1000 households	2013/14	Not applicable	1.3 (1.2-1.5)	2.3 (2.3-2.3)
Children in poverty: % living in low income households	2012	<16 yrs	17.2 (16.9-17.4)	19.3 (19.2-19.3)
Looked after children: Rate per 10,000 <18 population	2013/14	<18 yrs	54.8 (50.4-59.5)	59.8 (59.4-60.3)
Children leaving care: Rate per 10,000 <18 population	2013/14	<18 yrs	20.0 (17.4-22.9)	26.5 (26.2-26.7)
Domestic abuse incidents recorded by the police: Rate per 1,000 population	2012/13	18+ yrs	13.7 (13.5-14.0)	18.8 (18.7-18.8)
Prisoner population: Number	Sep-13	All ages	632.0	
Violent crime: rate per 1,000 population	2013/14	All ages	8.4 (8.2-8.7)	11.1 (11.1-11.1)
English Language skills: % of people who cannot speak English / speak it well	2011	All ages	0.5 (-.5-0.4)	1.7 (1.7-1.7)
Population turnover (internal migration): Rate per 1,000 resident population	2012	All ages	72.7 (71.9-73.4)	92.6
Migrant GP registrations: Rate per 1,000 resident population	2012	All ages	5.4 (5.4-5.6)	9.6
New cases of psychosis: Estimated incidence per 100,000 aged 16-64 (mapped from LA)	2011	16-74 yrs	17.6 (13.0-22.2)	24.2 (23.8-24.7)
Social care mental health clients receiving services during the year: Rate per 100,000 population	2013/14	18-64 yrs	354.9 (333.9-376.9)	384.0 (381.9-386.1)
New social care assessments per year for mental health clients aged 18-64: Rate per 100,000 population	2013/14	18-64 yrs	146.6 (133.3-161.0)	265.3 (263.6-267.1)
Social care mental health clients in residential or nursing care during the year aged 18-64: Rate per 100,000 population	2013/14	18-64 yrs	38.3 (31.6-46.0)	31.9 (31.3-32.5)

Indicator	Time Period	Age	East Sussex	England
Social care mental health clients aged 18-64 receiving day care or day services: Rate per 100,000 population	2013/14	18-64 yrs	8.3 (5.4-12.3)	34.0 (33.4-34.6)
Carer assessments: People who care for an adult with a mental health condition and were assessed during the year per 100,000 population	2013/14	18+ yrs	85.0 (76.5-94.2)	64.3 (64.3-65.1)
CPA adults in employment: % of people aged 18-69 on CPA in employment	2012/13	18-69 yrs	5.2 (4.5-6.0)	8.8 (8.7-8.9)
CPA adults in settled accommodation: % of people aged 18-69 on CPA in settled accommodation	2012/13	18-69 yrs	35.1 (33.5-36.7)	58.5 (58.3-58.7)
Self directed payments: % social care mental health clients receiving direct payments	2013/14	18-64 yrs	28.6 (26.0-31.5)	10.7 (10.5-10.9)
Self directed support: % social care mental health clients receiving direct payments or have a personal budget	2013/14	18-64 yrs	65.1 (62.1-67.9)	28.4 (28.1-28.6)
Carers of mental health clients receiving services: carers receiving services or advice or information as % of mental health clients receiving community services	2013/14	18-64 yrs	34.0 (30.5-37.7)	19.5 (19.2-19.7)
Mortality from suicide and injury undetermined: Standardised rate per 100,000	2011 - 13	All ages	11.0 (9.4-12.8)	8.8 (8.6-8.9)
Excess under 75 mortality in adults with serious mental illness: Standardised mortality ratio	2012/13	18-74 yrs	279.4 (246.3-315.6)	347.2 (342.6-351.8)
Premature (<75) mortality in adults with serious mental illness: Rate per 100,000 population	2012/13	18-74 yrs	1290.1 (1132.2-1463.3)	1318.9 (1301.1-1336.9)

Appendix 4: Sussex Partnership Foundation Trust performance data by locality

Patient demographics

CCG and locality	2012/13											2013/14											Ethnicity (%)			
	All persons			Females				Male				All persons			Females				Male							
	Number	Average age (years)	Rate per 100,000	N	% total	Average age (years)	Rate per 100,000	N	% total	Average age (years)	Rate per 100,000	N	Average age	Rate per 100,000	N	% total	Average age (years)	Rate per 100,000	N	% total	Average age (years)	Rate per 100,000	White British/Irish	White other	BME	Unknown
EASTBOURNE, HAILSHAM AND SEAFORD CCG	654	41.8	646	330	50	41.1	641	324	50	42.5	651	647	41.4	639	334	52	40.0	649	313	48	42.8	629	92	3	4	1
Central Eastbourne	378	40.8	778	176	47	40.8	719	202	53	40.8	838	367	40.9	755	169	46	40.1	690	198	54	41.6	822	92	2	5	1
Eastbourne North	124	41.3	533	78	63	40.4	654	46	37	42.7	406	117	37.4	503	70	60	35.0	587	47	40	41.0	415	92	2	3	2
Hailsham	79	44.1	509	40	51	42.2	498	39	49	46.1	521	103	45.3	664	57	55	44.1	710	46	45	46.8	615	98	0	2	0
Seaford	73	45.3	526	36	49	43.1	514	37	51	47.5	538	60	45.1	432	38	63	42.7	543	22	37	49.1	320	85	8	5	2
HASTINGS AND ROTHER CCG	622	39.5	578	295	47	39.1	548	327	53	39.8	608	531	40.7	493	223	42	41.6	414	308	58	40.1	573	90	2	6	3
Bexhill	180	37.7	793	95	53	40.1	814	85	47	35.0	771	131	39.9	577	59	45	41.9	505	72	55	38.3	653	93	0	5	2
East Hastings	54	41.0	349	34	63	38.5	444	20	37	45.2	256	46	47.1	297	20	43	40.8	261	26	57	52.0	333	84	5	1	1
Rural Rother	54	39.7	259	32	59	39.9	302	22	41	39.4	215	61	39.1	293	33	54	41.8	311	28	46	35.9	273	88	2	3	8
St Leonards	202	40.8	702	64	32	39.2	455	138	68	41.6	939	183	41.9	636	67	37	43.9	476	116	63	40.8	790	88	2	8	3
West Hastings	127	39.5	640	70	55	37.7	710	57	45	41.7	570	110	38.0	554	44	40	37.8	446	66	60	38.1	661	91	3	5	2
HIGH WEALD LEWES HAVENS CCG	242	42.8	257	113	47	45.5	238	129	53	40.4	277	294	41.3	312	153	52	41.8	322	141	48	40.7	303	90	4	2	3
Havens	53	39.6	268	25	47	41.6	253	28	53	37.8	282	102	40.6	515	42	41	44.1	425	60	59	38.2	605	90	3	4	3
High Weald	113	42.2	212	52	46	45.7	193	61	54	39.2	232	124	40.2	233	71	57	37.5	264	53	43	43.8	202	92	3	3	2
Lewes	76	45.9	360	36	47	47.9	335	40	53	44.1	385	68	44.2	322	40	59	47.0	373	28	41	40.1	269	92	3	4	1
EAST SUSSEX	1527	41.0	504	743	49	41.0	486	784	51	41.0	522	1488	41.0	491	714	48	40.8	467	774	52	41.2	516	91	3	4	2
Unknown	23	38.8		10		45.0		13		38.5		32	34.6		8		31.9		24		36.2		80	9	6	6

Diagnosis: cluster on admission

CCG and locality	Common mental health disorders	Non-psychotic	Psychosis	Dual Diagnosis	Cognitive impairment or dementia complicated	Unassigned
EASTBOURNE, HAILSHAM AND SEAFORD CCG	6%	38%	46%	5%	5%	15%
Central Eastbourne	7%	36%	46%	6%	5%	13%
Eastbourne North	4%	43%	45%	3%	5%	15%
Hailsham	3%	41%	43%	3%	9%	21%
Seaford	5%	38%	47%	6%	3%	13%
HASTINGS AND ROTHER CCG	6%	39%	45%	7%	4%	17%
Bexhill	4%	34%	53%	7%	2%	13%
East Hastings	7%	52%	30%	2%	7%	22%
Rural Rother	5%	60%	26%	3%	7%	10%
St Leonards	7%	29%	54%	6%	4%	19%
West Hastings	6%	44%	34%	14%	2%	23%
HIGH WEALD LEWES HAVENS CCG	6%	40%	50%	2%	2%	17%
Havens	6%	53%	37%	3%	2%	10%
High Weald	6%	41%	48%	3%	2%	17%
Lewes	9%	30%	58%	0%	3%	24%
East Sussex	6%	40%	45%	5%	4%	16%
Unknown	6%	45%	42%	3%	4%	17%

Length of Stay

Row Labels	Common mental health disorders	Non-psychotic	Psychosis	Dual Diagnosis	Cognitive impairment or dementia complicated	Unassigned	All diagnoses
EASTBOURNE, HAILSHAM AND SEAFORD CCG	12.8	16.5	40.8	38.9	46.1	101.8	34.8
Central Eastbourne	13.4	16.4	41.6	32.0	36.5	33.7	33.4
Eastbourne North	11.5	23.0	45.1	19.8	29.1	35.4	29.6
Hailsham	9.8	17.5	43.4	73.8	77.5	189.4	55.0
Seaford	7.2	11.6	34.8	140.9	18.5	26.1	26.3
HASTINGS AND ROTHER CCG	18.1	28.2	31.7	27.7	51.1	44.7	31.5
Bexhill	13.9	18.3	32.8	56.5	31.7	128.5	41.1
East Hastings	9.3	64.5	15.8	4.5	67.0	11.9	26.0
Rural Rother	39.1	10.0	26.8	8.7	50.8	35.8	21.5
St Leonards	22.2	41.6	34.1	27.3	80.7	17.2	35.8
West Hastings	8.4	33.0	25.3	14.9	3.5	21.4	19.4
HIGH WEALD LEWES HAVENS CCG	11.5	17.0	29.2	3.0	80.2	19.4	24.9
Havens	8.3	12.1	25.5	6.1	51.0	8.3	19.7
High Weald	9.9	18.6	20.5	2.2	119.3	23.0	18.1
Lewes	11.3	13.5	20.4	8.1	79.0	12.3	21.1
East Sussex	14.6	18.8	34.0	29.8	46.6	57.9	30.7

Psychosis 2012/13 and 2013/14

	Psychosis total	All admissions	% psychosis	% first episode	11 – On going recurrent psychosis (low symptoms)	12 – On going or recurrent psychosis (high disability)	13 – On going or recurrent psychosis (high symptom & disability)	14 - Psychotic crisis	15 - Severe psychotic depression	17 - Psychosis and affective disorder - difficult to engage
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	519	1301	40%	4%	16%	22%	29%	15%	3%	10%
Central Eastbourne	303	745	41%	5%	17%	23%	25%	14%	4%	12%
Eastbourne North	95	241	39%	4%	17%	13%	42%	17%	2%	5%
Hailsham	65	182	36%	0%	12%	31%	32%	11%	3%	11%
Seaford	56	133	42%	7%	14%	23%	23%	18%	5%	9%
NHS HASTINGS AND ROTHER CCG	439	1153	38%	4%	17%	28%	22%	15%	3%	11%
Bexhill	146	311	47%	4%	19%	27%	21%	16%	3%	10%
East Hastings	25	100	25%	4%	8%	48%	8%	12%	8%	12%
Rural Rother	27	115	23%	4%	19%	15%	30%	26%	4%	4%
St Leonards	175	385	45%	3%	15%	29%	27%	13%	2%	10%
West Hastings	65	237	27%	6%	22%	23%	12%	17%	5%	15%
NHS HIGH WEALD LEWES HAVENS CCG	147	344	43%	3%	22%	19%	12%	22%	5%	16%
Havens	59	177	33%	8%	25%	12%	15%	25%	8%	5%
High Weald	74	181	41%	9%	28%	8%	20%	18%	1%	15%
Lewes	43	92	47%	5%	9%	12%	23%	30%	7%	14%
East Sussex *	1183	3015	39%	5%	18%	23%	24%	16%	4%	11%

* includes East Sussex admissions with unknown CCG

Psychosis – gender

	2012/13			2013/14		
	All admissions (n)	% Female	% Male	All admissions (n)	% Female	% Male
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	654	50%	50%	647	51%	48%
Central Eastbourne	378	47%	53%	367	45%	52%
Eastbourne North	124	63%	37%	117	56%	38%
Hailsham	79	51%	49%	103	72%	58%
Seaford	73	49%	51%	60	52%	30%
NHS HASTINGS AND ROTHER CCG	622	47%	53%	531	36%	50%
Bexhill	180	53%	47%	131	33%	40%
East Hastings	54	63%	37%	46	37%	48%
Rural Rother	54	59%	41%	61	61%	52%
St Leonards	202	32%	68%	183	33%	57%
West Hastings	127	55%	45%	110	35%	52%
NHS HIGH WEALD LEWES HAVENS CCG	242	47%	53%	102	17%	25%
Havens	53	47%	53%	124	134%	100%
High Weald	113	46%	54%	68	35%	25%
Lewes	76	47%	53%	16	5%	16%
East Sussex *	1527	49%	51%	1488	47%	51%

* includes East Sussex admissions with unknown CCG

Psychosis - ethnicity

	All admissions	White groups	BME groups	Unknown
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	1295	95%	4%	1%
Central Eastbourne	741	95%	5%	0%
Eastbourne North	240	95%	3%	2%
Hailsham	182	98%	2%	0%
Seaford	132	94%	5%	1%
NHS HASTINGS AND ROTHER CCG	1130	93%	6%	1%
Bexhill	307	95%	5%	1%
East Hastings	100	89%	10%	1%
Rural Rother	107	96%	3%	1%
St Leonards	379	91%	7%	2%
West Hastings	232	95%	3%	1%
NHS HIGH WEALD LEWES HAVENS CCG	299	95%	2%	3%
Havens	333	96%	2%	2%
High Weald	175	96%	2%	2%
Lewes	174	99%	1%	0%
East Sussex *	2973	94%	4%	1%

* includes East Sussex admissions with unknown CCG

Emergency admissions

	Emergency hospital admissions due to mental and behavioural disorders, age-standardised ratio						Emergency hospital admissions for persons with psychosis, age-standardised ratio						Emergency hospital admissions relating to self-harm, age-standardised ratio					
	2010/11 and 2011/12		2011/12 and 2012/13		2012/13 and 2013/14		2010/11 And 2011/12		2011/12 and 2012/13		2012/13 and 2013/14		2010/11 And 2011/12		2011/12 and 2012/13		2012/13 and 2013/14	
	n	rate	n	rate	n	rate	n	rate	n	rate	n	rate	n	rate	n	rate	n	rate
EASTBOURNE, HAILSHAM AND SEAFORD CCG	545	92	598	102	757	117	1966	97	2138	104	2402	107	988	96	489	103		
Central Eastbourne	273	92	315	117	390	132	1020	107	1140	119	1254	123	285	112	293	133		
Eastbourne North	117	87	129	96	166	108	370	80	391	82	505	95	83	67	94	85		
Hailsham	61	66	50	55	98	95	297	94	304	93	333	93	54	64	51	68		
Seaford	94	107	98	115	103	108	279	93	303	100	310	94	72	90	51	73		
HASTINGS AND ROTHER CCG	732	123	648	112	667	105	2510	124	2347	115	2463	112	583	107	418	89		
West Hastings	115	168	101	161	86	120	331	142	339	152	330	133	99	159	76	148		
St Leonards	221	140	176	115	208	122	728	135	668	123	744	127	179	124	135	108		
East Hastings	89	99	85	97	90	95	365	119	312	100	311	95	86	104	53	74		
Bexhill	204	135	191	131	193	119	686	133	650	125	695	124	130	95	101	84		
Rural Rother	103	81	90	73	90	55	404	93	378	86	383	80	89	77	53	52		
HIGH WEALD LEWES HAVENS CCG	443	83	439	84	446	76	1393	77	1476	79	1594	79	494	102	467	109		
Havens	165	150	150	139	142	117	451	120	513	133	578	138	166	165	168	189		
Lewes	118	99	133	112	109	834	332	82	358	86	337	84	119	109	99	103		
High Weald	160	53	158	53	195	593	610	59	605	57	639	56	209	75	200	82		
East Sussex	1720	100	1731	100	1870	100	5869	100	6124	100	6459	100	1571	100	1374	100		

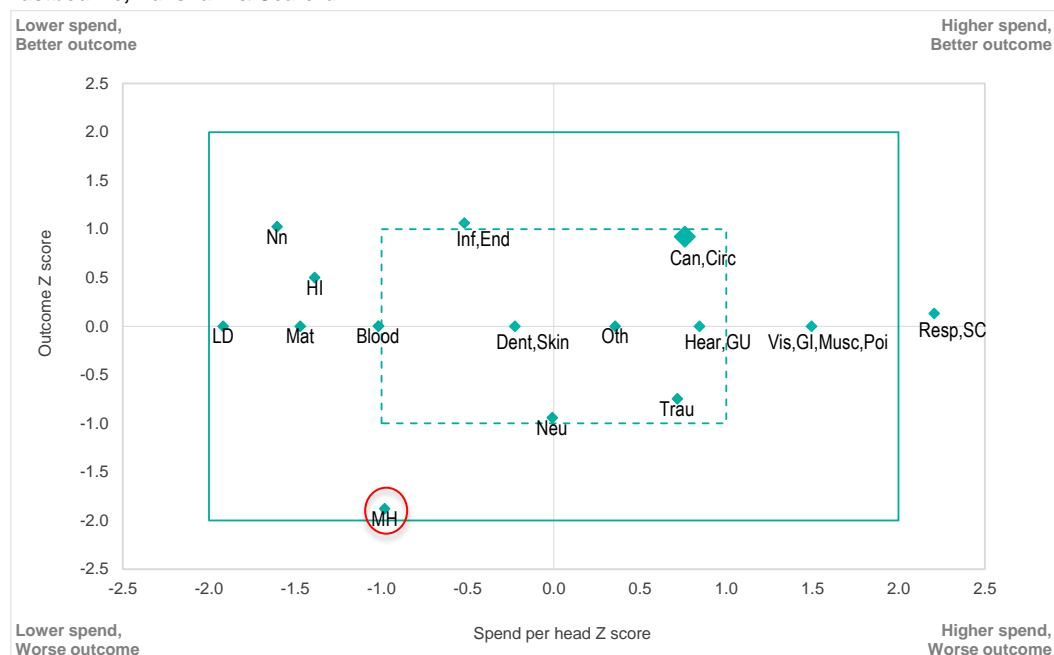
- includes East Sussex admissions with unknown CCG

Appendix 5: SPOT tool output for East Sussex CCGs

Each dot represents a programme budget category. The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Eastbourne, Hailsham & Seaford

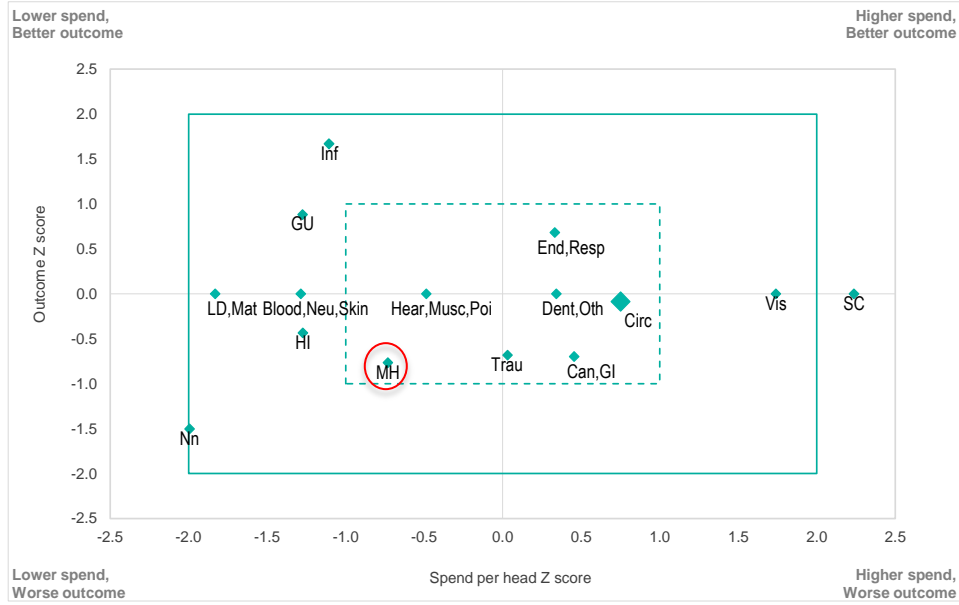


CCG chart quadrant key			
Inf	Infection	GI	Gastro Intestinal
Can	Cancers	Skin	Skin
Blood	Blood	Musc	Musculo Skeletal
End	Endocrine	Trau	Trauma and Inj.
MH	Mental Health	GU	Genito Urinary
LD	Learning Dis.	Mat	Maternity
Neu	Neurological	Nn	Neonates
Vis	Vision	Poi	Poisoning...
Hear	Hearing	HI	Healthy Individ.
Circ	Circulation	SC	Social Care
Resp	Respiratory Sys.	Oth	Other
Dent	Dental		

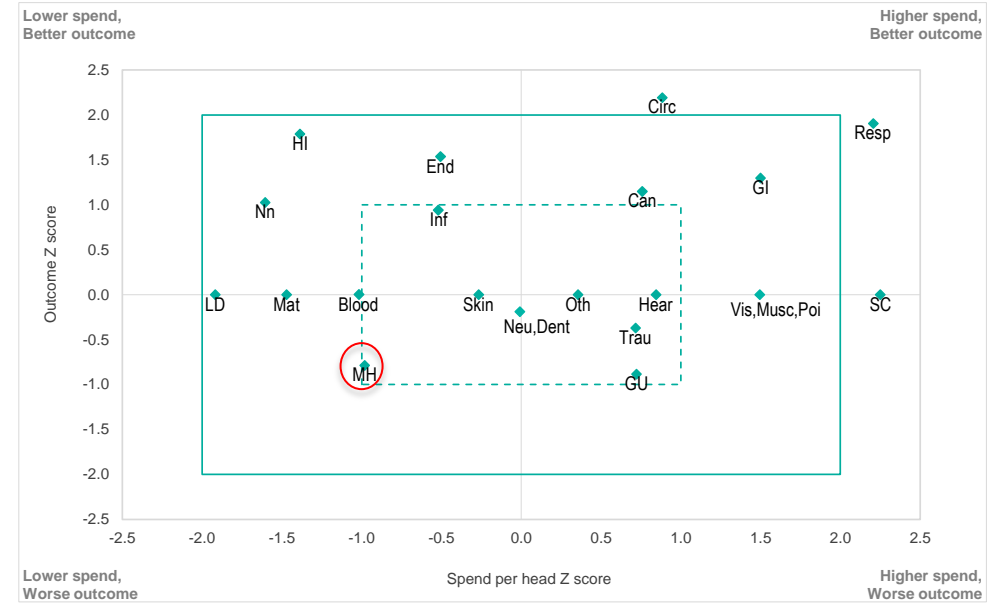
Z score:

A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further. Each dot represents a programme budget category.

Hasting & Rother



High Weald Lewes Havens



Appendix 6: Guidance published by the National Institute of Health and Care Excellence (NICE): specific conditions

Guidance	Areas Covered by recommendations
Common mental health disorders: identification and pathways to care CG123, 2011	<ul style="list-style-type: none"> • Improving access to services • Stepped care • Identification and assessment • Treatment and referral for treatment • Developing local care pathways
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. CG136, 2011	<ul style="list-style-type: none"> • care and support across all points on the care pathway • assessment and treatment under the Mental Health Act
Depression: the treatment and management of depression in adults. CG90, 2009	<ul style="list-style-type: none"> • care of all people with depression • recognition, assessment and initial management • recognised depression- persistent sub-threshold depressive symptoms or mild to moderate depression • persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression • complex and severe depression
Depression in adults with a chronic physical health problem: treatment and management. CG91, 2009	<ul style="list-style-type: none"> • care of all people with depression • recognition, assessment and initial management in primary care and general hospital settings • recognised depression in primary care and general hospital settings • complex and severe depression
Antenatal and postnatal mental health: clinical management and service guidance. CG45, 2007	<ul style="list-style-type: none"> • principles of care for all women with mental disorders during pregnancy and the postnatal period • prediction, detection and initial management of mental disorders • prevention of mental disorders • care of women with a mental disorder during pregnancy and the postnatal period • the organisation of services
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. CG113, 2011	<ul style="list-style-type: none"> • principles of care for people with generalised anxiety disorder (GAD) and panic disorder • stepped care for people with GAD and panic disorder
Social anxiety disorder: recognition, assessment and treatment of social anxiety disorder. CG159, 2013	<ul style="list-style-type: none"> • general principles of care in mental health and general medical settings • identification and assessment of adults • interventions for adults, children and young people with social anxiety disorder
Autism: recognition, referral, diagnosis and management of adults on the autism spectrum. CG142, 2012	<ul style="list-style-type: none"> • general principles of care • identification and assessment • interventions for autism, challenging behavior and co-existing mental disorders: identifying the correct interventions and monitoring their use • assessment and interventions for families, partners and carers • organisation and delivery of care

Guidance	Areas Covered by recommendations
Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. CG9, 2004	<ul style="list-style-type: none"> • care across all conditions
Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. CG72, 2013	<ul style="list-style-type: none"> • prerequisites of treatment and care for all people with ADHD • identification, pre-diagnostic intervention in the community and referral to secondary services • diagnosis of ADHD • post-diagnostic advice: treatment for children and young people; transition to adult services; treatment of adults with ADHD
Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. CG26, 2005	<ul style="list-style-type: none"> • care for all people with PTSD • recognition of PTSD • assessment and coordination of care • practical support and social factors, support for families and carers • the treatment of PTSD
Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. CG16, 2004	<ul style="list-style-type: none"> • respect, understanding and choice • staff training • triage, treatment, including psychological, psychosocial and pharmacological interventions • assessment of needs and risk
Longer-term care and treatment of self-harm. CG133, 2011	<ul style="list-style-type: none"> • general principles of care • primary care • psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks • longer-term treatment and management of self-harm • treating associated mental health conditions
Dementia: supporting people with dementia and their carers in health and social care. CG42, 2006	<ul style="list-style-type: none"> • principles of care for people with dementia • integrated health and social care • risk factors, prevention and early identification • diagnosis and assessment of dementia ☑ promoting and maintaining independence of people with dementia • interventions for people with dementia • inpatient dementia services • palliative care, pain relief and care at the end of life for people with dementia • support and interventions for the carers of people with dementia
Psychosis and schizophrenia in adults: treatment and management. CG178, 2014	<ul style="list-style-type: none"> • care across all phases • preventing psychosis • first episode psychosis • subsequent acute episodes of psychosis or schizophrenia and referral in crisis • promoting recovery and possible future care

Guidance	Areas Covered by recommendations
Core interventions in the treatment and management of schizophrenia in primary and secondary care. CG82, 2009	<ul style="list-style-type: none"> • care across all phases • initiation of treatment (first episode) • treatment of the acute episode • promoting recovery
The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. CG38, 2006	<ul style="list-style-type: none"> • general recommendations for the care of people with bipolar disorder • the assessment, recognition and diagnosis of bipolar disorder in adults • treatment setting and pathways to care • women with bipolar disorder who are planning a pregnancy, pregnant or breastfeeding
Antisocial personality disorder: treatment, management and prevention. CG77, 2009	<ul style="list-style-type: none"> • general principles for working with people with antisocial personality disorder • prevention of antisocial personality disorder – working with children and young people and their families • assessment and risk management of antisocial personality disorder • treatment and management of antisocial personality disorder and related and co-morbid disorders • psychotherapy and dangerous and severe personality disorder • organisation and planning of services
Borderline personality disorder: treatment and management. CG78, 2009	<ul style="list-style-type: none"> • general principles for working with people with borderline personality disorder • recognition and management in primary care • assessment and management by community mental health services • inpatient services • organisation and planning for services
Core interventions in the treatment of obsessive- compulsive disorder (OCD) and body dysmorphic disorder (BDD). CG31, 2005	<ul style="list-style-type: none"> • principles of care for all people with OCD or BDD and their families or carers • stepped care for adults, young people and children with OCD or BDD: awareness and recognition; recognition and assessment ☐ steps 3-5: treatment options for people with OCD or BDD ☐ step 6: intensive treatment and inpatient services for people with OCD or BDD • discharge after recovery
Violence: the short-term management of disturbed/ violent behaviour in in- patient psychiatric settings and emergency departments. CG25, 2005	<ul style="list-style-type: none"> • environment and alarm systems • prediction: antecedents, warning signs and risk assessment • training • working with service users ☐