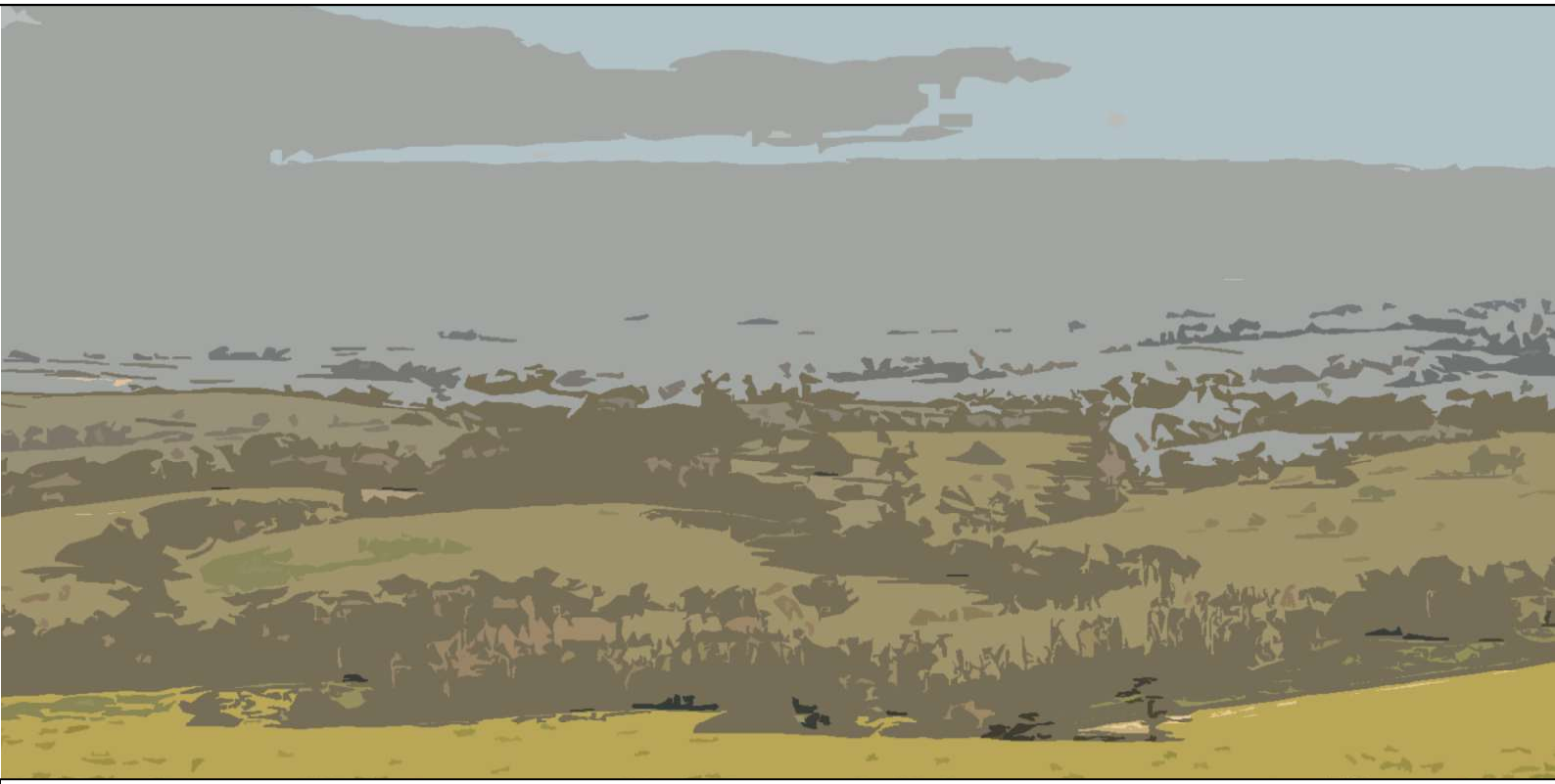
High Sheriff of West Sussex

COMMUNITY CONFERENCES' REPORT

MENTAL HEALTH MATTERS

February 2026



Dr Tim Fooks FRCGP

High Sheriff of West Sussex 2025/6



Executive Summary

The High Sheriff's Community Conferences (HSCC) on Mental Health were established to create a safe, practical and locally-grounded space for conversations about mental health across West Sussex. Bringing together voluntary and community organisations, statutory services, public health, education, emergency services and people with lived experience, the conferences were designed to complement the introduction of the NHS Neighbourhood Mental Health Service and Pathfinder service, while strengthening collaboration at neighbourhood level.

Since the conferences were convened, the Sussex Community Foundation's Improving Health Report (February 2026) has reinforced the scale of mental health inequalities across Sussex, particularly with regard those factors that are linked to deprivation, housing insecurity, isolation and access to services. The themes emerging from the HSCC conferences closely mirror these findings, underlining both the urgency of action and the value of locally informed solutions.

Although three consistent priority themes emerged — access to services, stigma, and men's mental health — the open, place-based, non-hierarchical structure of the conferences enabled a much wider range of interconnected issues to be explored. Participants repeatedly emphasised that mental health is inseparable from wider social conditions, and that fragmented systems can compound distress.

A strong and consistent message was the importance of community-based, relational support. Voluntary, faith and grassroots organisations are often the most trusted first point of contact. The "No Wrong Door" principle that is integral to the new NHS Neighbourhood Mental Health and voluntary sector Pathfinder services - welcoming and helping people wherever they first present - was widely endorsed.

Encouragingly, the conferences have already led to tangible outcomes. Strategic boards are reviewing findings; new partnerships are forming between statutory, voluntary and academic sectors; and locality-based actions are being progressed, including enhanced outreach, joint training, and strengthened referral pathways.

This report captures both the insights generated and some of the practical next steps now underway. Above all, it calls for a more connected, responsive and equitable system — one that builds on the remarkable commitment already present across West Sussex and translates shared learning into sustained, measurable change.

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Introduction

As the first medical High Sheriff of West Sussex, I chose mental health and well-being as a key theme for my year of office in 2025/26. During my 32 years as a West Sussex GP, approximately 25% of my consultations with patients were for mental health related problems. Most were for anxiety and depression but, during my term in office as High Sheriff in 2020 - the year of the Covid-19 pandemic - there was a significant increase in those experiencing difficulties with their mental health[1] which has persisted since.

My observations from my medical practice that the growth in mental ill-health need was accelerating was confirmed in the detailed analysis produced in the West Sussex Public Health Joint Needs Assessment for Mental Health 2024[2].

In addition, the Big Mental Health Report[3], produced by the charity Mind in 2024, described how mental health disorder rates remain challenging for all age groups post the pandemic. The report highlighted the need to provide quality mental health support on time, to tackle discrimination and stigma, to support young people who have been particularly affected and to address social factors which impact on mental health.

Most recently, the Improving Health Report from the Sussex Community Foundation (February 2026) has demonstrated that marked inequalities relating to mental ill-health continue to exist within both West and East Sussex.[4]

The combination of the all-age impact of the pandemic on mental health and the ongoing issues linked to deprivation, have created previously unseen levels of demand on NHS and voluntary sector mental health services.

This is also reflected in the ongoing level of Section 136 detentions which Sussex Police have to enact each day across Sussex (50-60 a month) in order to protect an individual with a mental health crisis.[5]

For the first four months of my role, therefore, I consulted widely meeting those working in almost every element of the mental health community in West Sussex - those with lived experience, the voluntary sector, NHS commissioners, providers, emergency services, civic leaders, and public health.

[1] https://www.mind.org.uk/about-us/our-policy-work/coronavirus-research/
[2]https://jsna.westsussex.gov.uk/assets/core/Cohort_Summary_West_Sussex_Public_Mental_Health_Needs_Assessment_2024_FINAL.pdf
[3] https://www.mind.org.uk › media › vbbdclpi › the-big-mental-health-report-2024-mind.pdf
[4] https://sussexcommunityfoundation.org/report/improving-health/
[5] A Section 136 order allows police to take a person from a public place to a "place of safety" if they appear to have a mental disorder and need immediate care or control. This is done to ensure the person's safety and to facilitate a mental health assessment, typically lasting up to 24 hours.

The complexity and challenge associated with meeting the increasing need remains great despite the tremendous commitment and compassion of all involved.

Many networks, with a variety of compositions, have been established in both West and East Sussex to coordinate care pathways but, through my consultation, it became clear that an opportunity for a mental health community from a specific locality to come together, share their expertise, develop new connections and creatively innovate would be very welcome.

The High Sheriff Community Conferences (HSCC), entitled Mental Health Matters, were therefore established with one to be held in each of the seven neighbourhoods of the county. These areas largely fit within the District and Borough borders. The timing of the conferences was aligned with the official launches of the new NHS Neighbourhood Mental Health service and the new Pathfinder service that is being jointly delivered by BHT Sussex and West Sussex Mind.

Each conference has been grounded in the personal realities of mental ill-health by a presentation given by an expert through lived experience. Further presentations discussed the strategic role of public health in suicide prevention, the impact of mental health cries on Sussex Police services and the trauma-informed approach that West Sussex Fire and Rescue Service used to support their staff.

The second half of each conference was designed so that the delegates could determine the topics to be discussed. Although there has been a particular focus on the problems of discrimination and stigma, accessing mental health care and the specific issues of men's mental health, the actual range of subjects covered, while not all encompassing, has been many and varied.



Figure 1 Discussion Table Topics

Over four hundred people attended the seven conferences and this report seeks to capture the essence of the discussions that were held and the recommendations made. A digest of some of the feedback that has been received, and action that is being undertaken, is included and the contact details of delegates, all of whom agreed to share their email addresses, are provided at the end of this document. The presentation slides are separate to this report but will be distributed with it. Finally, and most importantly, I am deeply grateful to all who participated in such a rich time of discussion and to Julia Mansergh and Sarah Fooks for their administrative support.

Dr Tim Fooks, High Sheriff of West Sussex

HS Community Conference Design

Each 2½ hour conference began with five presentations followed by 'Open Space' - a meeting technique through which the subjects to be discussed are determined by the attendees.

A table was then allocated to each topic and the discussion led by the nominator. Delegates were encouraged to either stay at one table or move from one discussion to another. Discussion notes, where provided, were collated by the organisers.

Presentations and Speakers:

1. Expert by lived experience - a personal journey.

Bognor	Leanne Nagle	West Sussex Mind
Shoreham	Dominic White	ANDYSMANCLUB
Crawley	Sean Orr	MENSHARE Listening Group
Chichester	Simon Pepper	MenWalkTalk
Worthing	Neil Kerr	Breakeven - Gambling Support
Horsham	Efrem Brynin	StrongMen - the Bereavement Charity for Men
Mid-Sussex	Ben Harragan	Angling Mental Health Initiative

2. Public Health Report: Neighbourhood mental health profile

Bognor	Libby Hill
Shoreham	Nadine Badawi/Rachel Jevons
Crawley	Segun Awolaran
Chichester	Rachel Jevons
Worthing	Rebecca Newell/Nicola Rosenberg
Horsham	Lovelyn Okwara/Rachel Jevons
Mid Sussex	Rachel Jevons

3. Update on new Neighbour Mental Health Team and new Pathfinder services

   See chart below

4. Sussex Police approach to managing Mental Health crises.

   Claire McNelis
   Dave Lyons

5. West Sussex Fire and Rescue Service - proactive management of traumatic experiences by staff.

   Chris Bowles
   Michael Gaunt

Venue	SPFT	VCSE	PCN	ICB
Bognor Regis	Fran Martinez	Kate Scales and Will Newman (WSx Mind)	John McCreanor	
Shoreham	Emma Lewington	Kim Anthony and Vikki Turpin (WSx Mind)		
Crawley	Graham Shephard	Suzie Mulhern (BHT Sussex)		
Chichester	Marylinda Gororo and Keisha Duggan-Rees	Kerrin Page (WSx Mind)		Amanda Walderman ICB
Worthing	Pat Mendes	Adam Howell (WSx Mind)		
Horsham	Davinder Ghuman	Suzie Mulhern (BHT Sussex)		
Mid Sussex	Nic Field	Suzie Mulhern (BHT Sussex)		

SPFT Sussex Partnership Foundation Trust

VCSE Voluntary Care Sector

PCN Primary Care Network

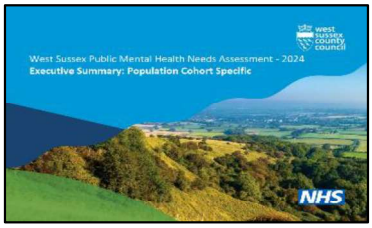
ICB Integrated Care Board

Presentations - Slides

See pdf documents in report folder











Notes from Conference Discussions

General Comments

These notes have been prepared from the records made at each of the discussion tables. Where the same topic was discussed at several conferences, they have been either combined into a single statement or grouped together. The index on the following page lists in which localities the topic featured. Where additional information has been provided, a reference is given.

These notes reflect a discussion between experts - those with lived-experiences and those who deliver services and provide support. Inevitably, there are some important topics that were not covered specifically at the tables. However, that so much could have been discussed, debated and concluded in the time available is, indeed, evidence for the extraordinary knowledge, expertise and wisdom that exists in the West Sussex health community: a priceless resource.

With regard the areas that they cover, these records inform, champion, challenge and recommend.

They can be used as a general reference or as a prompt for strategic or operational development.

They should not, however, be ignored.



Figure 2 HSCC Chichester *photo Gary Shipton*

Index of Topics - alphabetical and by locality

Mental Health issues linked to:	Locality[6]	Page
Care Leavers	WG	36
Children and Young People	SM, WG, MS	35
Co-Occurring Conditions	BR, Chi, WG	15
Deafness	MS	22
Eating Disorders	Chi	30
Ethnic Minority Communities	CY	19
Faith	CY	41
Flexible Access and **I**rregular Pathways into Community-Based Services	MS	12
Gambling	WG	26
Homelessness and Poverty	**ALL**	20
LGBTQ+	Chi	25
Loneliness	WG, HM, Chi	34
Men's Mental Health and Peer-Support Groups	**ALL**	17
Neighbourhood Mental Health Teams	**ALL**	11
Non-Medical **I**nterventions	CY, MS	42
New Pathfinder	**All**	12
Prisoners and Ex-Offenders	WG	27
Resilience development	BR, HM	37
Retirement: Transition from Employment	Chi	39
Rurality	Chi, HM	22
Self-Awareness	BR, CY	36
SEND/Neurodiversity	SM, Chi, MS	35
Sight Loss	Post-conference	23
Social Media	MS	31
Stigma	HM, MS	16
Suicide Prevention	**ALL**	13
Survivors of Sexual Abuse	Chi	29
Transition to Adulthood	MS	36
Trauma	BR, HM	37
Travellers	Chi, WG	28
Unpaid Carers	**ALL**	33
Veterans	BR, SM, Chi, WG, HM	18
Work	CY	38

[6] Locality Key: Bognor Regis (BR); Shoreham (SM); Worthing (WG); Crawley (CY); Chichester (Chi); Horsham (HM); Mid-Sussex (MS) *[NB in a very few cases, discussion notes were not submitted]*

Neighbourhood Mental Health Service (NMHS) and new Pathfinder

Neighbourhood Mental Health Teams (NMHT)

- NMHTs bring together primary care, specialist adult mental health, social care and voluntary sector partners into integrated, place-based teams.
- People with severe and enduring mental illness are referred into the Specialist Adult component of NMHT, with assessment within 28 days and movement between NMHT pathways as required.
- Individuals are not sent back to GPs or repeatedly reassessed, supported by shared electronic records and joint working across NMHT functions.
- Stronger embedding of NMHTs within the community and voluntary sector is needed, including links with organisations that are not formal NMHT partners.
- Housing is a major cross-cutting issue, requiring better operational links between NMHTs, housing services and wider support systems.

Pathfinder

- Pathfinder provides holistic psychosocial and recovery support for mild-moderate mental health difficulties.
- Support is delivered through groups and interventions offered face-to-face and online.
- Flexible engagement is available, including for people with no fixed abode.
- Clear communication and shared signposting is required so professionals and communities understand when and how to refer to Pathfinder.
- Priority action: add GP surgeries and key partner information to Pathfinder materials and online presence.

General Comments

- The system must make it explicit that people are entering through a “No Wrong Front Door”, while recognising the challenge of explaining a complex offer without overwhelming users.
- Clear communication and shared signposting across the system is essential, including access routes to NMHT, Pathfinder, West Sussex Talking Therapies and other services.
- Neighbourhoods are not uniform (e.g. Chichester city centre versus Midhurst / north of the Downs), requiring locally tailored models rather than a single template.

- Purposeful ground-level relationship building with community hubs and trusted local organisations (e.g. Midhurst Community Hub) is essential to reach people early.
- Digital exclusion and difficulties navigating the system can themselves be exclusionary, reinforcing the need for human access points and supported referral routes.

Priority actions to include

- strengthening links with housing and university wellbeing services;
- improving awareness of NMHT and Pathfinder across partners;
- developing a local network/framework to regularly bring organisations together.

Staying Updated and Involved

1. Join the monthly webinars
2. Sign up to the monthly newsletter
3. Watch previous webinars (scan the QR code)
4. Go to: www.sussex.ics.nhs.uk/community-mh-transformation for the latest updates, and to download frequently asked questions for the programme.
5. Email: spft.communitytransformation@nhs.net

Flexible Access & Irregular Pathways into Community-based Services

- High reach with rapid engagement: Community-based services (e.g., BHT and West Sussex Mind) now support thousands of people annually, with many accessing help within weeks rather than months, demonstrating the effectiveness of voluntary-sector led, non-clinical entry points.
- **Going where people already are:** Both organisations emphasise outreach into everyday community settings (foodbanks, community hubs, local groups, rural venues, GP practices), reflecting conference calls for services to act as hubs and capture people who would never attend traditional clinics.
- **Reducing bureaucratic barriers:** Flexible approaches that do not rely on fixed addresses or GP registration are critical for people who are homeless, transient, or in unstable housing, addressing a major gap highlighted in conference discussions.

- **Peer, volunteer and community-led support:** Strong use of peer mentors, volunteers and group activities mirrors conference themes on training staff in drop-in settings for mental-health signposting and building confidence in non-clinical helpers.
- **Short-term agility vs long-term need:** Services demonstrate impressive agility and rapid response, but conference feedback highlights risks from short-term funding and difficulties sustaining support for people with complex needs, neurodiversity, or medication changes.
- **Bridging informal and formal systems:** Hub-style, community-centred models (including social activities and practical support) complement acute services that struggle with missed appointments, helping people stay connected until — and alongside — clinical care.

Suicide Prevention

- **Suicide statistics:** Every four days, someone takes their life in West Sussex. Each suicide has a significant impact on at least 135 other people[7]. Men are three times more likely to take their life than women. Only a third of the referrals to mental health services are for men. Suicide is the leading cause of male mortality in those who are under 50 years.
- **West Sussex suicide rates** are falling overall, but remain higher than the national average for men, with highest risk in middle-aged men and increasing concern for younger men (now broadly 20-50); job types such as construction were highlighted.
- **Hyper-local and community-led solutions** are essential, recognising distrust of statutory services and the importance of locally trusted groups and informal settings.
- **West Sussex County Council small grants** for VCSE suicide prevention projects (up to £5,000) are welcomed [NB 2026 application period now closed]; with a total pot of £60k this will support around 12-15 initiatives, and further investment may be needed if oversubscribed.
- **Community capacity building** is key: training Mental Health First Aiders (shopkeepers, community members, homelessness sector), and peer supporters within clubs and groups to enable early conversations.

[7] Suicide Life Threat Behav 2019 Apr;49(2):529-534. How Many People Are Exposed to Suicide? Not Six Julie Cerel *et al*

- **Evidence-based training approaches** highlighted: ASSIST / LivingWorks (2-day and 90-minute courses), Olly's Future, and Samaritans' Rail Industry Suicide Prevention Programme[8] (reported 17% decline).
- **Veterans** require a direct approach (they prefer being explicitly asked about suicidal thoughts/plans) and face additional risks linked to homelessness and lack of housing 'points'.
- Strong **links between suicidality** and poor housing, domestic abuse and complex trauma, including male victims of domestic abuse (Mankind[9]) and very high need within services such as Crawley Open House and Pause.
- **Samaritans** report around 90% of calls relate to mental health, many involving suicide or suicide in progress, with growing numbers of young people contacting the service.
- **Men-focused VCSE provision** is vital, including Men Walk Talk, Andy's Man Club, Olly's Future, Life Cycles and Association for Male Health & Wellness; around 50% of men attending Andy's Man Club report suicidality.
- **Myth-busting resources** should be agreed and promoted system-wide, including Men Walk Talk Myth Busters and 'Debunking some myths about suicide - Practice Plan'[10].
- Need for **better data and intelligence**: cultural background of suicide victims is not routinely recorded (limiting understanding of rates among groups such as Travellers); attendees from all conferences should feed into the West Sussex Suicide Prevention Action Plan.

Specific project actions proposed:

1. Crawley Open House to partner with Grassroots to apply for grant; Pause[11] to also apply for grant;
2. Liaison & Diversion Service to be linked into the West Sussex Mental Health Oversight Board / Suicide Prevention Group / Multiple Compound Needs Board.
3. Alongside other agencies, such as Samaritans, promote use Papyrus HOPELINEUK for those under 35 considering, or at risk of considering, suicide.

[8] https://www.samaritans.org/how-we-can-help/workplace/rail-industry-suicide-prevention-programme/?gad_source=1&gad_campaignid=945644341
[9] https://mankind.org.uk/statistics/statistics-on-male-victims-of-domestic-abuse/
[10] https://www.practiceplan.co.uk/blog/debunking-some-myths-about-suicide/
[11] Pause is a national charity that works to improve the lives of women who have had - or are at risk of having - more than one child removed from their care, and the services and systems that affect them.

Co-Occurring Conditions

- Co-occurring conditions refer to the presence of both a mental health condition and a drug and/or alcohol use condition at the same time, where each influences and often worsens the other.
- The scale of the problem is substantial: 74% of people starting drug and alcohol treatment in 2024-25 had an identified mental health treatment need, and over one-third of people with serious mental illness have co-existing substance use conditions, with those not in contact with services at greatest risk of suicide.
- Dame Carol Black's independent review[12] in 2020, highlighted systemic failure, with people often excluded from mental health services until substance use is addressed, and excluded from substance use services until mental health problems are treated.
- Suicide data underline the risk: between 2010-2020, 47% of people in contact with mental health services who died by suicide had alcohol problems and 38% had drug problems.
- Mental health and substance misuse should be understood as interlinked, not separate, yet services are frequently commissioned and delivered in silos.
- People with co-occurring conditions often struggle to engage with support due to stigma, chaotic circumstances, and rigid service thresholds.
- Despite an existing local co-occurring conditions protocol for joint working between mental health and substance misuse services, substance misuse remains an exclusion criterion in many statutory services.
- Access barriers include complex referral processes, long waits, and significant challenges for people in rural areas.
- Non-statutory, community-based and non-12-step groups can play a crucial engagement role, particularly for people unwilling or unable to attend AA or NA.
- Lived-experience voices consistently call for genuine joined-up working and a 'no wrong door' approach so people receive help regardless of where they first present.

Four Recommended Actions

1. Develop lived experience/peer support
2. Ensure better access to physical places for support
3. Improve awareness of NHS 111 'select mental health option' for mental health crises
4. Educating - improving awareness of everyday services (taxi, barber, housing)

[12] www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black

Stigma

The Reality of Stigma

- Stigma remains pervasive: many people experiencing mental health difficulties already feel shame, fear of judgement and a loss of confidence.
- Stigma makes this worse, further discouraging disclosure and help-seeking all of which is compounded and exacerbated by trauma.
- Stigma operates as a reinforcing cycle: shame leads to silence, isolation, and worsening mental health over time, even where public attitudes appear more accepting.
- Stigma has not disappeared but has become less visible, continuing to influence how safe people feel to talk openly about distress.
- Some of the most harmful stigma occurs within systems and services, where people may feel disbelieved, doubted, dismissed, or not taken seriously. This is known as epistemic injustice where the contribution of an individual or group is not deemed credible.
- Mental health diagnoses can themselves become a source of stigma, sometimes overshadowing the individual and their wider identity.
- Confidence to speak up about lived experience depends on whether environments and cultures feel genuinely safe and supportive.
- Employer culture and leadership strongly influence stigma, with open, trusting workplaces enabling more honest conversations about mental health.

Reducing Stigma

- Treating people with dignity and respect is fundamental, focusing on the person rather than labels, and valuing individual stories and experiences.
- Providing epistemic justice through a presumption of credibility for those using services.
- Sensitive, trauma-informed, person-centred communication helps people feel understood, including explaining processes clearly, keeping people informed, and checking understanding.
- Training led by people with lived experience improves awareness of how stigma operates and strengthens compassionate responses across services.
- Peer groups and community spaces (especially with a focus on creativity) provide stigma-free environments where people are valued without judgement and can build confidence and connection.
- Raising community awareness and improving knowledge about who to talk to reduces isolation and supports earlier help-seeking.
- Changing mindsets: it's not about "What's wrong with you"(perceived as weak, vulnerable, dangerous, non-compliant etc) but "What's happened to you" (eg trauma).

Men's Mental Health & Peer Support Groups

- Men continue to find **it difficult to seek support**, with low awareness of available help and ongoing reluctance to open up, particularly among younger men (18-25) and older men.
- **Peer support groups** are highly valued but less well understood than counselling, creating a need to raise awareness of what peer support is, how it works, and why it is effective.
- Named men's peer support offers highlighted include Andy's Man Club, StrongMen, Men Walk Talk, Menshare Listening Group, Dad La Soul, Silver Bullet Group, Let's Go Fishing and Association for Male Health & Wellness.
- **Activity-based groups** work particularly well, with talking alongside doing (e.g. walking, fishing, fixing, creating, weight-loss groups) making conversations feel safer and more natural.
- **Sense of belonging, structure and purpose** are core benefits of men's groups, contributing to self-worth and feeling valued.
- **Humour** is a common and powerful engagement tool, helping reduce stigma and lower the barrier to difficult conversations.

Suggested Action

- **Peer-lived experience** is uniquely powerful and should be recognised as a central asset.
- Stronger networking between men's groups should be developed, including sharing details of the Sussex Peer Support Network and the Pan-Sussex Men's Mental Health Network (led by Andrea Potter)[13].
- Better **integration with statutory services** is critical: Pathfinder, NMHTs, commissioned services, VCSE networks and peer support groups should understand each other's roles and referral routes.
- **Improve visibility** and communication via Council and Local Information Online (CLIO), libraries, councils and community channels was strongly supported.

[13] Sussex Men's Mental Health Network information:

- The Network meets quarterly to bring together those who work with men across the county, more information here: https://www.sussexpartnership.nhs.uk/about-us/news-events/latest-news/mens-mental-health-growing-problem
- The group have a created a directory of men's support services available here: https://www.uok.org.uk/resource/mens-mental-health-local-directory/
- To join the network or add your service to the directory, contact andrea.potter@southdown.org or jenni.thomas@eastsussex.gov.uk

- **Reduce inequalities and access barriers** - including language barriers (e.g. Crawley Chagossian community) and lack of interpreter funding for small VCSE groups such as StrongMen.
- **Training and support for peer facilitators** and aligned services is needed so that grassroots identity is respected while enabling safe, integrated working (e.g. Andy's Man Club and NMHTs).

Veterans

- Veterans experience a wide range of mental health and wellbeing needs, often shaped by transition to civilian life, trauma, isolation, housing insecurity, and loss of purpose.
- Lived-experience voices emphasise the importance of community-based support, including mindfulness groups, wellbeing hubs, peer support, education-bridging programmes, and social and therapeutic horticulture (including provision specifically welcoming female veterans).
- Veterans often prefer to be asked directly about suicidal thoughts and plans, and open, straightforward conversations can be protective.
- Homelessness is a significant risk factor for veterans, with some unable to access housing due to points-based systems, which in turn increases suicidality.
- Isolation commonly occurs after service when veterans settle back into one place and lose the structured social networks of military life.
- Veterans represent a diverse population ("not all older men"), including younger people, women, and those with families, requiring tailored approaches.
- Education and retraining are central to recovery, with emphasis on recognising transferable skills rather than focusing solely on formal qualifications.
- Rurality creates additional barriers to accessing housing, clubs, peer groups, and services.
- Stronger linking of groups and services is needed, including a shared contact database and clearer referral pathways between statutory, voluntary, and veteran-led organisations.
- Awareness of existing specialist veteran services and community offers remains low and needs systematic improvement.

Suggested Actions

1. Establish a local Veterans & Families Hub (physical and virtual) bringing together mental health, housing, education, finance, peer support, and community activities under a 'no wrong door' model.
2. Improve communication and awareness of existing veteran-specific services and community offers through GP surgeries, libraries, hospitals, councils, events, and targeted direct communication to veterans.
3. Develop a coordinated veterans network with a shared contact database linking statutory services, voluntary organisations, and veteran-led groups.
4. Strengthen housing pathways for veterans, including priority routes, advocacy around points-based systems, and early intervention to prevent homelessness.
5. Expand access to purposeful activities and peer-led support (e.g., buddy systems, mindfulness, horticulture, skills-based training, self-defence, education bridging and retraining).

Ethnic Minority Communities[14]

Discussion lead by Ashwin Soni, DIVERSE Crawley

Summary

- Crawley is the most ethnically diverse district in West Sussex (over 26% ethnic minority population) and is projected to experience particularly high growth in demand for mental health services.
- People from ethnic minority communities experience poorer mental health outcomes due to racism, discrimination, stigma, language barriers, and lack of culturally sensitive services.
- Ethnic minority communities individuals are less likely to access mental health support through primary care and more likely to enter services via crisis routes such as police or courts.
- Black people are up to four to five times more likely to be detained under the Mental Health Act than White people, indicating serious systemic inequity.
- Specific risk groups include: Black men (psychosis), Black women (anxiety/depression, particularly in pregnancy), and older South Asian women (suicide risk).
- Trust in statutory services is low, with communities reporting feeling judged, misunderstood, or dismissed by professionals.

[14] https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/

- Community-based initiatives (e.g., coffee mornings and peer networking groups) show promise in engaging people who would not otherwise access services.
- Successful progress would be reflected in increased ethnic minority communities' access via GPs and self-referral, reduced crisis and detention pathways, and higher uptake of talking therapies.
- Cultural competence within the workforce, including targeted training and improved ethnic minority communities representation, is central to improving quality and trust.
- Faith and community organisations are often 'first responders' for mental distress and represent an under-utilised route for prevention, early intervention, and signposting.

Five Suggested Actions

- Appoint accountable leadership and dedicated ethnic minority communities outreach/recovery workers to represent communities and coordinate engagement.
- Co-design and commission services with ethnic minority communities-led and faith/community organisations, including provision of safe, non-clinical community venues.
- Implement mandatory, ongoing anti-racism and cultural humility training across all mental health and primary care staff, alongside diverse recruitment.
- Expand alternative access routes: self-referral, community referrals, translated materials, and high-quality interpreting services.
- Collect and use granular ethnicity data locally to monitor access, experience, and outcomes, and to guide targeted investment.

Homelessness, Poverty and Mental Health

- Temporary and unstable accommodation significantly worsens mental health, with high anxiety, loss of control, sleep disturbance, and increased exposure to crime and substance misuse; Arun, Worthing and Adur report particularly high pressure on temporary and emergency accommodation.
- Poverty, homelessness and suicide risk are closely linked, but suicidality is often framed as a safeguarding issue rather than a core public-health and mental-health concern, leading to fragmented responses.
- Evictions and tenancy loss are strongly associated with mental ill-health, domestic abuse, and financial crisis; rising "no-fault" evictions heighten risk of rapid deterioration and repeat homelessness.

- Trauma is endemic among people experiencing homelessness, including complex trauma, neurodiversity, substance dependence and histories of abuse; front-line staff also experience secondary trauma and need structured support and supervision.
- Holistic, wraparound support is essential, combining housing, mental health, substance misuse, domestic abuse, benefits, debt, and employment advice rather than siloed interventions.
- Tenancy sustainment and early prevention (e.g. mediation, budgeting help, mental-health input, and landlord engagement) are more effective and humane than crisis responses after eviction.
- Co-location of services works well (e.g. advice agencies, foodbanks, housing teams, and mental-health partners in shared venues), reducing barriers, stigma, and missed appointments.
- Single people remaining in unsafe or inappropriate relationships to retain housing represent a hidden risk group requiring proactive safeguarding and housing options.
- Temporary accommodation can be unsafe, with exposure to crime and substance misuse increasing relapse and cycling back into homelessness.
- Cultural and language barriers affect engagement for some Eastern European communities; alcohol misuse is common and requires culturally informed approaches.
- Better system navigation and communications are needed, including clearer public information, single points of access, and shared service directories across police, health, councils and VCSE partners.

Priority actions proposed:

1. expand high-quality affordable housing;
2. strengthen neighbourhood mental-health team links with homelessness services;
3. develop landlord forums;
4. support therapeutic or psychologically informed housing; and
5. invest in staff training (e.g. suicide safety-planning, trauma-informed practice).
6. develop a professional, multi-agency database or digital ‘mind-map’ linking homelessness, poverty, mental health, criminal justice, tenancy status, and wider social determinants. This should support real-time information sharing, blue-light and crisis responses, data analysis, and system planning (e.g. costs to social care and foster care, renters’ rights, and local economic factors such as land banking), with hosting options via council or library-based infrastructure.

Deafness: Improving Services for Deaf People

Access Difficulties

- Deaf people face multiple barriers to accessing mental health services, including communication obstacles, lack of accessible information, and limited specialist provision.
- Stigma and discrimination persist around both deafness and mental ill-health, compounding isolation and reluctance to seek help.
- Mental health difficulties among Deaf people are frequently under-recognised and under-diagnosed, leading to late or inappropriate intervention.
- A recent local suicide involving a Deaf person highlights the potentially fatal consequences of inaccessible services.
- Many professionals lack training in Deaf awareness and Deaf culture, resulting in misunderstandings and reduced quality of care.
- Interpreters are often unavailable in hospitals and mental health settings, delaying or preventing meaningful assessment and treatment.
- Using an interpreter in therapy is not always appropriate, particularly in small Deaf communities where confidentiality concerns may exist.
- Deaf people may require direct-access clinicians who can sign, or specialist Deaf mental health pathways.
- Deaf older adults experience all the challenges of ageing plus additional communication and access barriers, increasing risk of loneliness, dependence, and depression.
- Social isolation and limited access to peer networks can exacerbate anxiety, low mood, and loss of identity.

Priority actions

1. Partnership working with Deaf-led organisations and community advocates is essential to co-produce accessible services.
2. Improve Deaf awareness training,
3. ensure timely access to qualified interpreters or signing clinicians,
4. developing clear referral pathways to specialist Deaf mental health provision,
5. linking local Deaf representatives into ICB mental health leads and service managers.

Sight Loss and the impact on Mental Health

The following is taken from the **NHS Sussex Sensory Impairment Health Inequalities** report[15] (November 2025) which was submitted by 4Sight Vision Support to the HSCC organisers as they were unable to attend the conferences.

Key Findings

- 27% reported mental health conditions, commonly anxiety and depression.
- 22% experienced untreated mental health needs due to access barriers.
- Long waiting times and service navigation difficulties worsen psychological strain.
- Communication barriers heighten confusion, fear, and loss of control.
- Multimorbidity significantly increases emotional burden and care complexity.
- Inconsistent access to Low Vision Services creates inequality and distress.

Recommended Action

- Improve access to ECLO/Sight Care Advisors to provide early emotional support.
- Signpost to support services at diagnosis and discharge - 79% respondents were not signposted at diagnosis driving a sense of isolation.
- Develop integrated, person-centred care models to reduce mental health inequalities among people with visual impairment.



Figure 3 Mid Sussex HSCC in the Kings Weald Community Centre, Burgess Hill

[15] https://www.healthwatchwestsussex.co.uk/report/2025-11-20/nhs-sussex-sensory-impairment-health-inequalities-summary

Rurality and Mental Health

Rural Risk and Access Factors

- Rural and farming communities experience distinctive mental-health challenges linked to isolation, loneliness, geography, and occupational pressures, with stigma and personal pride remaining major barriers to help-seeking[16].
- Conference participants highlighted limited awareness of available services, reinforcing national findings that rural residents often do not know what support exists.
- A Healthwatch survey planned for the New Year will explore farmers' experiences of accessing health and social care and help identify local gaps.
- National research shows 73% of rural respondents experienced a decline in mental health in the past 12 months, and 62% of those seeking help found services hard or very hard to access.
- Transport barriers are significant: poor public transport, long distances, and unsuitable rural roads for buses restrict access to in-person support.
- Geographical isolation compounds difficulty accessing care, with nearly half of rural respondents reporting difficulty due to where they live filecite turn0file0.
- Digital exclusion is a growing problem: around 41% of rural respondents said internet or technology access impacts their ability to obtain mental-health support.
- The move towards online services risks widening inequalities for farmers and rural residents who have poor connectivity or low digital confidence.

Priority Actions

- Going into communities through outreach, pop-ups, and trusted local venues was strongly supported as a way to overcome stigma and access barriers.
- Engagement with farm clusters, allotments, and community settings such as Rock Farm [17] can provide informal, trusted routes to support and early intervention.
- Embedding mental-health conversations within men's health screening was suggested as a practical way to normalise discussion and detect problems earlier.
- Additional opportunities include working with police around firearm licensing concerns, learning from successful rural models elsewhere, and using CLIO3[18] to help identify and support rural populations.

[16] https://www.mhm.org.uk/rural-mental-health
[17] https://greenwellbeingalliance.org.uk/project/rock-farm/
[18] Council & Local Information Online (West Sussex County Council)

LGBTQ+ and Mental Health

- LGBTQ+ people experience higher rates of anxiety, depression, self-harm and suicidality due to minority stress, discrimination, and social exclusion.
- Chichester Pride plays an important community role, with potential to act as a gateway for support, but needs stronger collaboration with local statutory and voluntary services.
- Most specialist LGBTQ+ mental health provision is Brighton-centred, creating gaps for rural communities across West Sussex.
- Local, visible LGBTQ+ support spaces and peer meetings are needed, especially outside urban centres.
- Gay and bisexual men may experience additional barriers linked to masculine stigma, making engagement with men's mental health groups more complex.
- Rural mental health strategies must explicitly include LGBTQ+ residents, rather than treating rurality and LGBTQ+ identity as separate issues.
- Older LGBTQ+ adults (30+) may carry historic trauma from periods of greater stigma, affecting identity, safety, and mental health; similar issues persist for younger people.
- Global rollback of LGBTQ+ rights contributes to fear, hypervigilance, and worsening mental wellbeing locally.
- Trans and gender-diverse people often face distinct mental health stressors, suggesting the need for both shared and tailored support pathways.
- Increased risk of sexual abuse and exploitation within parts of the LGBTQ+ community requires trauma-informed responses.

Support and Action

  - Promote support services such as the Young People's Shop (11-25, Chichester) as valued entry points for young people questioning sexuality or gender.
- Other Priority actions suggested include:
  1. education regarding LGBTQ+ needed for parents and children,
  2. culturally competent training for services (including faith-sensitive care),
  3. stronger council involvement, and
  4. practical steps to make community spaces safer.
  5. Improve access to support and peer-to - peer meetings out of urban centres

Gambling

Discussion lead by Neil Kerr, Breakeven

Prevalence of gambling

- **Participation:** Roughly **half of UK adults gamble** in a year.
- **Problem gambling:** Around **0.4-0.5%** of adults meet criteria for problem gambling.
- **At-risk gambling:** Around **1.6-3.8%** show moderate or elevated risk of harm.
- **Harm exposure:** A larger group (~20%) may be adversely affected by gambling directly or through someone else's gambling.

Mental Health Consequences of Gambling

- Many people initially misinterpret gambling harm as a **financial problem rather than an addiction**, focusing on "breaking even" rather than recognising loss of control.
- Gambling typically follows a **cycle of before-during-after** (anticipation, dissociation/immersion, and shame or regret), reinforcing compulsive behaviour.
- Gambling addiction erodes **empathy and emotional availability** towards family and friends.
- It leads to **withdrawal from social and family life**, lethargy, and avoidance of activities that require effort.
- Work performance often declines, with **reduced productivity, concentration, and ambition**.
- Physical health and self-care deteriorate, including **poor diet, lack of exercise, neglected hygiene, and missed medical or dental care**.
- **Dishonesty and avoidance** increase, including missed appointments, broken commitments, and lying to conceal behaviour.
- Gambling is used as **escapism**, temporarily numbing distress but worsening underlying problems.
- A core driver is the **illusion of control and perceived advantage**, combined with the belief that a big win will solve everything.
- The **chasing-losses loop** is central to problem gambling and distinguishes it from social or recreational gambling.
- **Advertising, online gambling platforms, and gaming-style mechanics** normalise and intensify risk, particularly for vulnerable groups.

Recovery Considerations

- Recovery is supported by community connection,
- Peer-based programmes (e.g. Breakeven-style recovery models),
- Specialist signposting,

- Support for affected family members, and
- Targeted awareness for higher-risk groups such as people with ADHD.
- **Breakeven** is a UK charity providing free, confidential support for anyone harmed by gambling, including gamblers, family, friends, and colleagues. https://www.breakeven.org.uk/

Prisoners and Ex-Offenders

- Around 70% of people in prison have at least one mental health condition, with many experiencing worsening mental health after release due to lack of continuity of care.
- Ex-offenders often face multiple barriers on release, including lack of housing, employment challenges, stigma, and fragmented service pathways, which worsen mental health and increase vulnerability to crisis.
- There is a double stigma attached to being both an ex-offender and someone with a mental health need, reducing self-esteem and hindering access to support.
- Many people leave prison with few resources, no stable accommodation or bank account, and limited coordinated support, increasing risk of re-offending, homelessness, and escalating mental health problems.
- Mental health services and probation teams are often poorly coordinated, leaving individuals to navigate complex systems alone.
- Some ex-offenders struggle with institutionalisation, finding it difficult to adapt to life outside prison routines and structures.
- Addressing basic needs such as housing, income, and employment is central to improving mental health and reducing re-offending.
- Specialist voluntary sector organisations provide crisis support, housing assistance, peer mentoring, and skills training that can stabilise lives.
- There is limited routine data collection within mental health services about whether service users are ex-offenders, reducing system-wide understanding.
- Mental health difficulties among ex-offenders have a ripple effect on families and communities, not just the individual.

Suggested Actions

1. Improve data recording and coordination across mental health, probation, housing, and employment services.
2. Develop targeted anti-stigma activity addressing both criminal history and mental health.
3. Expand peer support and mentoring programmes for prison leavers.
4. Strengthen transitional support immediately on release (housing, benefits, ID, GP registration).
5. Promote multi-agency partnerships to address mental health, housing, and employment holistically.

Travellers and Mental Health Issues

Lead: Debbie Kimpton, Gypsy Traveller Liaison Officer, Chichester District Council

Key Issues

- Profound social exclusion across the social determinants of health (education, employment, housing, financial stability), leading to significantly poorer mental health outcomes.
- Very high suicide risk, particularly among Traveller men (around seven times higher than settled men), with suicide accounting for a substantial proportion of deaths in the Irish Traveller community.
- Entrenched stigma and taboo around mental health and suicide, reinforced by gendered expectations and cultural narratives; mental health often reframed as 'nerves' rather than illness.
- Low literacy and educational disadvantage, reducing awareness of mental health, rights, and how to access support; young Travellers often miss opportunities for early intervention.
- Deep mistrust of statutory services, compounded by discrimination, criminalisation, and the loss of traditional ways of life; services are frequently designed for the settled population rather than culturally aligned communities.
- Barriers to primary healthcare access, including registration challenges and poor continuity of care.
- Multiple and intersectional disadvantage, including LGBTQ+ Travellers and those in contact with the criminal justice system.
- Unresolved trauma and bereavement, often untreated and intergenerational.
- Shorter life expectancy and wider health inequalities compared with the general population.

Recommended Actions

1. Build culturally competent, trust-based engagement models through sustained partnerships with Traveller-led organisations and community outreach workers.
2. Improve access to primary and mental healthcare by simplifying GP registration processes, using flexible address policies, and expanding outreach clinics.
3. Target suicide prevention for Traveller men and boys through culturally tailored, male-focused peer support and early intervention programmes.
4. Address stigma through community-led education, myth-busting, and literacy-appropriate materials for young people and families.
5. Tackle structural exclusion across employment, housing, education, and financial inclusion, and ensure better disaggregated data collection to monitor outcomes.

Survivors of Childhood Sexual Abuse

Notes provided by Kathryn Slatter

- Childhood sexual abuse is often a hidden underlying cause of adult mental health problems, and if it is not recognised, the root cause of distress may remain untreated.
- Many survivors present with complex and severe mental health needs, including depression, anxiety, dissociative disorders, eating disorders, self-harm, and suicidality.
- Data from Lifecentre[19] indicate that around 30% of clients have attempted suicide and 60% experience suicidal ideation, far higher than general population rates.
- Lifecentre has seen a 56% increase in referrals in the past year, indicating rising demand for specialist trauma-informed support.
- Survivors frequently do not disclose abuse due to shame, fear of not being believed, and self-blame, despite the abuse not being their fault.
- Lack of routine enquiry about sexual trauma within mental health services may mean people are not identified or referred to specialist support that could be essential for recovery.
- When survivors access specialist trauma-informed therapy, outcomes are often described as life-changing.
- Greater awareness is needed within mental health organisations that childhood sexual abuse may sit beneath presenting symptoms.

[19] https://lifecentre.uk.com/impact

- Strong links with Neighbourhood Mental Health Teams are required for this work to be embedded and sustainably funded.
- Positive connections with the Integrated Care Board and Public Health provide an opportunity to develop coordinated pathways and commissioning solutions.

Suggested Actions

1. Embed routine, trauma-informed enquiry about childhood sexual abuse within mental health assessments, with clear pathways for specialist referral.
2. Strengthen and formalise partnerships between specialist sexual trauma services and Neighbourhood Mental Health Teams to enable integrated care.
3. Increase commissioning and sustainable funding for specialist trauma-informed therapy in response to rising demand.
4. Provide training for mental health professionals on recognising signs of sexual trauma, responding sensitively to disclosure, and avoiding re-traumatisation.
5. Develop clear information and signposting so survivors know where specialist help is available and how to access it.

Eating Disorders

This entry includes additional information from the NHS UK website[20].

- An eating disorder is a serious mental health condition in which people use control of food to cope with feelings or situations; this can involve eating too little, too much, or worrying excessively about weight and body shape.
- Anyone can develop an eating disorder, but teenagers and young adults are most commonly affected, and early support improves outcomes.
- Common eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), and other specified feeding or eating disorder (OSFED).
- Eating disorders can cause significant physical and psychological harm, including medical complications, emotional distress, and social withdrawal.
- Families and carers often need clear guidance and emotional support to help them understand how best to support someone with an eating disorder.

[20] https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/overview/

Recommendations

- GPs, nurses, and primary care professionals should receive improved training to recognise, assess, and refer eating disorders early.
- Schools and community settings should share knowledge about eating disorders, early warning signs, and long-term health effects to support prevention and early intervention.
- Services should provide holistic, trauma-informed care that addresses physical health, mental health, and social needs together.
- Continuity of care should be prioritised, with smooth transitions between services and ongoing follow-up rather than time-limited treatment only.
- People living with eating disorders should receive consistent reassurance that they are not alone and that recovery is possible, alongside clear signposting to support.

Useful Resources and Support Contacts (from Mind[21])

1. Beat Eating Disorders
2. Mind Helplines - Information and support by phone and email.
3. Samaritans - 24/7 emotional support
4. PAPYRUS HOPELINE247 - Under 35s suicide prevention support
5. First Steps ED - Support for people with eating disorders and their families.
6. Hub of Hope - Search tool for local and national mental health support.
7. Overeaters Anonymous Great Britain - Peer-led support groups.
8. YoungMinds Parents' Helpline - Advice and support for parents and carers.

Social Media and Mental Health

Exposure, Addiction and Early Experience

- Early exposure to online pornography (as young as age nine) highlights risks of unfiltered digital access and potential long-term effects on self-image, expectations of relationships, and emotional development.
- Quitting social media and dating apps (particularly reported by men) can increase confidence, reduce anxiety, and improve presence and engagement in real-world interactions.

[21]https://www.mind.org.uk/information-support/types-of-mental-health-problems/eating-problems/treatment-and-support/

- Instagram and similar platforms were described as addictive, with compulsive checking linked to mood disturbance, anxiety, and reduced wellbeing.
- The Smartphone Free Childhood[22] initiative was highlighted: "a movement of families who believe childhood's too short to scroll away."

Algorithmic Effects and Patterns of Use

- Algorithms strongly shape what users see, often amplifying emotionally charged, sensational, or appearance-focused content to maximise engagement.
- Problematic, addictive, or passive use (e.g. endless scrolling) is more strongly associated with anxiety and depression than total time spent online.
- A 2025 meta-analysis found a significant association between social media exposure and mental disorders in adolescents and young adults (aggregate correlation approximately r = 0.22), indicating a small-to-moderate but consistent relationship.

Gendered and Age-Related Impacts

- Teenage girls are particularly vulnerable to harms linked to body-image comparison, appearance pressures, and social validation.
- Boys and young men may experience improvements in wellbeing after reducing or stopping social media and dating app use.
- Older adults may experience anxiety, confusion, and loss of confidence when trying to adapt to rapidly changing digital technologies.

Wider Societal and Cultural Change

- The impact of AI and social media on society was compared to the scale of the Sexual Revolution, reflecting major shifts in relationships, identity, and social norms.
- Social media alters communication patterns, attention spans, and the nature of relationships, with potential consequences for empathy, depth of connection, and resilience.
- Possible national differences were noted, with declining screen time reported in the UK post-COVID compared with continued increases in the USA.

Risks and Protective Factors

- **Risks** include social comparison, cyberbullying, disrupted sleep, misinformation, exposure to harmful content, and reinforcement of negative self-beliefs.
- **Protective factors** include strong digital literacy, parental guidance, age-appropriate safeguards, and promotion of active, purposeful, and time-limited use.

[22] https://www.smartphonefreechildhood.org

- Social media can also provide benefits such as peer support, community building, and access to mental health information, supporting a balanced and nuanced approach.

Unpaid Carers

- Many unpaid carers are exhausted, isolated, and not identified as carers, and are often excluded from care planning and decision-making.
- Carers commonly experience secondary trauma, compassion fatigue, anxiety, depression, and sometimes suicidal ideation, alongside shame, guilt, and resentment.
- Carers frequently put their own needs last, feel they "do not count," and lack time to seek help.
- Broken or fragmented services and long waiting lists (e.g. CAMHS) increase pressure on carers, particularly where caring is long-term or fluctuates between crisis and stability.
- Spouse carers and parent carers of people with mental illness or dementia face unique emotional and relational strain.
- Young carers are often hidden; better identification by schools and employers is needed.
- Male carers face additional barriers, including stigma about help-seeking, smaller support networks, and discomfort with traditional talking groups.
- Activity-based and practical support (rather than discussion-only groups) works better for many male carers.
- Carers are at increased risk of financial hardship and often struggle with debts, benefits complexity, and navigating entitlements.
- Carers may be unable to maintain hobbies or friendships if they cannot leave the person they care for, increasing loneliness.
- Stigma attached to certain caring roles (e.g. mental health, substance misuse) reduces disclosure to friends and family, making carer groups and peer spaces especially important.

Recommendations

1. Carers are a form of frontline workforce in mental health and must be recognised as such across statutory and voluntary services.
2. Raise the profile of unpaid carers across organisations and strengthen alignment with services.

3. Improve carer identification and referral into Carers Support West Sussex.
4. Re-establish carers support counselling and befriending offers.
5. Develop affordable, activity-based support for male carers.
6. Provide speakers and navigators to improve clarity about services, benefits, and entitlements.
7. Ensure carers are routinely included in care planning (with consent).

Loneliness

The Complexity of Loneliness

- Loneliness is a subjective, unwelcome and persistent feeling arising from a mismatch between desired and actual relationships; it is distinct from social isolation and can occur even when people appear socially connected.
- Loneliness affects all ages, but particular risk groups include men, young people, carers, bereaved individuals, disabled people, and those living in rural locations.
- Loneliness has a profound impact on mental health, including reduced self-esteem, reduced self-belief, anxiety, depression, and increased suicide risk.
- It is associated with significant physical health risks and increased use of health and social care services.
- Stigma and misconceptions about who gets lonely prevent people from recognising loneliness in themselves and others.
- Creating a sense of belonging is central to alleviating loneliness; being needed, welcomed, and held in mind matters more than the frequency of contact.
- Connection is a key driver of resilience; supportive relationships protect against mental ill-health and aid recovery from adversity.
- Community and voluntary groups play a major role in tackling loneliness through befriending, activity-based groups, peer support, and social prescribing.
- Practical collaboration between organisations, including shared spaces, joint events, and shared directories, increases reach and sustainability.
- West Sussex already has strong foundations to build on, but gaps remain in coordination, awareness, and rural access.

Suggested Actions

1. Proactively identify people at risk of loneliness, particularly men, bereaved individuals, carers, and those in rural communities.
2. Reduce stigma through public messaging that loneliness is common, understandable, and reversible.

3. Expand and promote local directories and mapping of community groups (e.g., connectthedots.uk) and encourage participation in National Community Week (2-8 March 2026).
4. Support development of local hubs and shared community spaces, with organisations encouraged to co-locate activities and cross-refer.
5. Invest in befriending, peer support, and activity-based groups that create belonging rather than solely focusing on clinical responses.
6. Strengthen social prescribing pathways and links between primary care, councils, and voluntary organisations.
7. Ensure bereavement is treated as a high-risk trigger for loneliness, with routine signposting at points of contact.
8. Build on successful Horsham and wider West Sussex models and scale what already works.

Children and Young People's Mental Health

General Mental Health[23]

- High and growing prevalence: Around 12% of 5-17 year olds in West Sussex have a diagnosable mental health condition (≈15,300 young people), with emotional disorders affecting ~3.2% and particularly high rates of self-harm and crisis presentations among 10-24 year olds.
- Demand significantly exceeds capacity: Single Point of Access receives ~8,500 referrals annually (≈21% above expectation), while CAMHS Tier 3 manages 300-400 referrals per month and ~3,000 young people on caseload.
- Peak vulnerability around early adolescence (≈14 years): Eating disorders, self-harm, body image, identity, and social-media-related distress are common, highlighting the need for earlier prevention and school-based support.
- Early intervention and accessible community provision are essential: Youth services, safe spaces, outreach, peer support, and voluntary-sector activity reduce escalation and "firefighting," but coverage is inconsistent and has been eroded over time.

[23] https://jsna.westsussex.gov.uk/updates/public-mental-health-needs-assessment-2024/

SEND / Neurodiversity

- Neurodivergent children face disproportionate risk: Long waits for assessment, limited specialist provision, and variable school support contribute to anxiety, exclusion, and crisis presentations.
- Schools are pivotal for early identification: Strengthening pastoral care, Designated Safeguarding Lead networks, and mental-health-informed school cultures is critical.
- Alternative and flexible education pathways matter: Therapeutic or alternative provision (including vocational routes, Forest schools) can prevent disengagement and deterioration for SEND learners.

Transition to Adulthood (16-25)

- Transitions remain a major fracture point: ~6,150 young people aged 17-19 and ~10,880 aged 20-25 likely have mental health conditions; around 70% referred to transition panels previously received CAMHS input.
- Cliff-edge at 18: Young people do not suddenly acquire the skills to navigate adult systems, particularly those with additional vulnerabilities.
- **Priority actions:**
  1. Create age-spanning (0-25) mental health care.pathways,
  2. Provide clearer navigation,
  3. peer-led and community-based options, and
  4. practical support with housing, benefits, education, and employment alongside

Care Leavers

- High cumulative risk: Care leavers are more likely to experience trauma, poor mental health, poverty, homelessness, and substance misuse, especially where earlier support was inconsistent or absent.
- What works:
  1. Consistent relationships,
  2. strong personal advisers,
  3. trauma-informed services,
  4. stable housing
  5. integrated mental-health input through the transition to adulthood.
  6. Mentoring eg https://ylf.org.uk/care-leavers-offer/mentoring-care-leavers/

Developing and Maintaining Mental Resilience

Self-awareness

- Resilience begins with recognising signs in ourselves, including emotional fatigue, changes in behaviour, irritability, withdrawal, or loss of motivation.
- Mental resilience includes speaking up and viewing help-seeking as a strength, not a weakness.
- People differ in how they process experiences; resilience is personal, dynamic, and on a continuum, not a single fixed state.
- Reflection, curiosity about where we are in our own journey, and attention to self-care help individuals notice early warning signs.
- Asking simple, direct questions (e.g., "Are you OK?" followed by "Are you really OK?") and following up can open safe conversations.
- Language matters: service users should be asked how they prefer their mental health to be described and discussed.

Recognising the Impact of Trauma

- Trauma can arise from single major events (Type I) or from repeated, cumulative exposure (Type II), both of which affect mental health and ability to function.
- People may not wish to talk about the details of what happened; support does not require disclosure of trauma.
- Peer-delivered approaches such as Trauma Risk Management (TRiM) provide structured, confidential conversations to identify risk and guide people to appropriate support.
- Resilience and psychological symptoms can co-exist; someone may function well in some domains while struggling in others.
- Protective factors include optimism, cognitive flexibility, active coping, social support, physical wellbeing, and a personal moral compass.

Benefits of Being Active

- Physical activity supports emotional regulation, stress reduction, confidence, and sense of agency.
- Activity provides structure, routine, and positive coping, which are linked to resilient functioning.
- Community-based spaces for face-to-face activity (e.g., youth clubs, sports groups) act as protective environments.
- Mindfulness, relaxation, and movement-based practices are commonly used by highly resilient individuals.

- Prevention-focused approaches are more effective than relying solely on reactive responses.

Benefits of Being in Work

- Work is a major protective factor for mental health, providing structure, purpose, social connection, and financial stability.
- Barriers include benefits systems, low confidence, criminal records, housing instability, learning difficulties, and poor coordination between services.
- Being signed off from job-seeking is not always therapeutic and may increase isolation.
- Multi-agency working is needed to support people back into meaningful activity or employment.
- Emphasising transferable skills rather than formal qualifications can widen access to opportunities.

Suggested Actions

Self-awareness

1. Embed self-awareness and emotional literacy in schools, workplaces, and community settings.
2. Provide simple training on how to ask supportive questions and respond when someone opens up.
3. Co-produce guidance with people with lived experience on helpful language and approaches.
4. Promote self-care as a routine and legitimate part of everyday life.

Impact of Trauma

1. Expand peer-delivered trauma risk approaches (e.g., TRiM-style models) into community and voluntary sector settings.
2. Increase trauma-informed training across public and voluntary services.
3. Ensure people are not pressured to disclose trauma in order to receive support.
4. Develop clear, well-publicised pathways for early support after traumatic events.

Being Active

1. Invest in accessible, low-cost physical activity and wellbeing opportunities.
2. Re-establish and support community spaces for face-to-face connection.
3. Strengthen partnerships between activity providers and mental health services.
4. Promote activity as part of prevention and early intervention.

Work

1. Develop multi-agency pathways into work, training, or volunteering.
2. Review the impact of long-term sick notes and explore supported-return-to-activity approaches.
3. Create programmes translating transferable skills into employability.
4. Expand vocational training, education-bridging, and supported employment schemes.

Retirement: Transition from Employment

Key Risks

- Retirement can increase vulnerability to depression, particularly if unplanned or involuntary.
- Loss of work-related identity, status and routine may affect self-worth and purpose.
- Workplace social networks often diminish, increasing risk of isolation.
- Adjustment varies depending on health, finances, voluntariness and access to meaningful activity.

Protective Factors & Interventions

- Begin structured pre-retirement planning early, addressing purpose and social engagement — not just finances.
- Encourage phased retirement, mentoring and continued contribution where possible.
- Actively maintain social connections beyond the workplace.
- Promote volunteering, peer groups and community participation as core wellbeing strategies.
- Community models such as Men's Sheds provide structure, shared activity and belonging, helping reduce isolation after retirement.

West Sussex Men's Sheds and Shedders

Locality	Group Name	Contact Details
Southbourne	Southbourne Men in Sheds	southbournemensshed@gmail.com
Selsey	Selsey Men's Shed	m.c.webb46@gmail.com
Chichester	Chichester Men's Shed	https://www.chichestermensshed.org/
Littlehampton (East)	Littlehampton Men in Sheds	leminsshed@gmail.com
Littlehampton (West)	Littlehampton & District Men's Shed West	shed@ladswest.org.uk
Ferring	Ferring Men in Sheds	https://ferringmis.org
East Preston	East Preston Men's Shed	admin@epmis.org
Worthing	Men in Sheds Worthing	meninshedsworthing@gmail.com
Lancing & Sompting	Lancing & Sompting Men in Sheds	sheds@northlancing.org
Henfield / Small Dole	Henfield Community Shed	info@henfieldshed.org.uk
Shipley	Shipley Men in Sheds (Shedders)	www.HorshamShipleyCommunityProject.org
Pulborough	Pulborough Shedders	info@pulboroughshedders.org
Petworth	Petworth Men's Shed	info@mensshedpetworth.org.uk
Southwater	Southwater Men in Sheds	https://southwatershed.org.uk/
Horsham	Horsham Men in Sheds	admin@mens-shed-horsham.org.uk
Billingshurst	Billingshurst Men's Shed	billimensshed@outlook.com
Crawley	Crawley Men's Shed	shed@crawley.gov.uk
Crawley (CMRS)	Men's Shed CMRS	cmrs.secretary@gmail.com
Burgess Hill	Burgess Hill Men in Sheds	epalmer@openpm.co.uk
Forest Row (East Sussex border)	The Shed at Forest Row	theshedforestrow@gmail.com

Faith and Mental Health

Taken from conference notes prepared by Rev Andrew Fadoju

- Faith and belief systems can be an important source of meaning, hope, identity, and resilience, supporting mental wellbeing at both individual and community levels.
- Many faith communities already provide grassroots mental health support (listening, pastoral care, befriending, practical help), representing a substantial but under-recognised asset.
- Faith groups are often absent from local authority mental health strategies, despite their extensive community reach.
- There is a need to create sanctuary spaces for safe, respectful conversation about mental health within faith and belief communities.
- Avoiding difficult or controversial topics can cause harm; open and honest dialogue within faith settings may increase understanding and reduce stigma.
- Some faith communities have experienced heightened strain due to national and international events, affecting identity, visibility, and psychological safety.
- Faith communities could act as trusted referral and signposting points for people with mental health needs, particularly those with a religious background.
- Mental health services and faith groups have mutual learning opportunities, combining clinical knowledge with community-based relational support.
- A stronger role for faith within the cultural narrative of mental wellbeing may help shift systems from crisis-driven responses toward supporting people to live well.

Suggested Actions

1. Embed faith groups within local mental health systems by including them in policy development, partnership forums, and community mental health networks.
2. Encourage two-way referral and learning pathways between mental health services and faith communities, recognising faith settings as trusted entry points and sources of early support.
3. Support faith communities to create safe sanctuary spaces for open conversation about mental health, with access to basic mental health awareness training and clear signposting routes.

Non-Medical Interventions for Improving Mental Health

Nature-related (Green/Blue Social Prescribing)

- Nature-based interventions improve mental health by increasing 'nature connectedness', which is strongly associated with greater happiness and lower anxiety and depression.
- Green and blue spaces (parks, woodlands, rivers, coasts, gardens) are linked to improved mood, reduced stress, and increased life satisfaction.
- Active engagement with nature brings greater benefits than passive exposure, including gardening, walking, conservation activities, and community food-growing.
- Green social prescribing links people to local nature-based activities such as walking groups, community gardening, and therapeutic horticulture.
- Airtime CIC delivers nature-based wellbeing programmes across Surrey and Sussex, with pilot groups for women, young people, and middle-aged adults; sustained funding is needed.
- Nature-based programmes reduce isolation and loneliness and build a sense of belonging and community.
- Pop-up and outreach models help reach people who may not engage with traditional services.
- De Jong scale can be used to measure emotional and social loneliness and help demonstrate impact.[24]
- Green and blue spaces should be safe, accessible, and welcoming to maximise mental-health benefit.
- **Action:** Include nature-based wellbeing and green social prescribing within the next Health and Wellbeing Strategy.

Alternative Therapies (Complementary / Holistic Approaches)

- Alternative and holistic approaches can complement clinical care and widen choice for people.
- Talking and therapeutic activities outside clinical environments can feel less stigmatising and more accessible.
- Social prescribing can be used to increase access to holistic alternatives.
- Examples include walking therapies, cold-water or cold-exposure approaches, yoga, mindfulness, and breathwork.

[24] The De Jong Gierveld short scales for emotional and social loneliness: tested on data from 7 countries in the UN generations and gender surveys Jenny De Jong Gierveld, Theo Van Tilburg
PMCID: PMC2921057 PMID: 20730083

- Many approaches aim to support the body's natural regulation systems and reduce stress responses.
- There is interest in learning from research, studies, and books exploring holistic models of mental health.
- Alternative approaches may reduce over-reliance on medication for some people.
- These interventions often combine physical activity, relaxation, and social connection.
- Community-based delivery supports engagement and continuity.
- **Action:** Improve visibility and availability of holistic alternatives through social-prescribing pathways.

Wellness Therapies (Movement, Play, Creativity, Community)

- Wellness therapies focus on movement, play, creativity, and shared experience.
- Wellness activities can reduce isolation and strengthen informal support networks.
- Designed to be accessible, non-clinical, and engaging. Supports emotional expression and social connection.
- Example: St Ed's Community Garden[25] and the Burgess Hill community gardening project aim to build stronger community connections.
- Example: 'Power is Bananas' [26] is an immersive movement experience programme which uses pop-up events with music and playful interaction. Approach combines physical movement, creativity, humour, and community.
- Small-grant funding for local pilots. (e.g. WSCC up to £5,000 - NOW CLOSED)
- **Action:** Encourage development and scaling of community-led wellness projects.

[25] https://stedwardsburgesshill.uk/thegardenproject/
[26] https://powerisbananas.com/

Social, Therapeutic and Horticultural Organisations in West Sussex

Organisation	Key Activities / Focus
Tuppenny Barn, Southbourne	Horticulture, food growing, volunteering, nature connection, wellbeing activities
The Healing Garden, East Grinstead	Therapeutic engagement with nature and horticulture-based learning
Sustainable Sussex (Sussex-wide)	Sustainability projects, outdoor wellbeing, community gardening
Full Circle Farms Sussex Ltd (incl. Garden Army initiative, West Hoathly)	Nature-based activities and therapeutic horticulture programmes
Petworth Community Wellbeing Garden	Therapeutic horticulture supporting isolation, disability and mental health challenges
West Hoathly & Halland Community Garden	Horticultural activity and social support for people with mental and physical health challenges
Grow Chichester Community Garden	Regular therapeutic gardening sessions to improve wellbeing
Rock Farm, Steyning. Horsham area	Community gardening and therapeutic horticulture experiences
Crawley Horticultural Society	Inclusive community gardening and social engagement
Mannings Heath Horticultural Society	Community gardening and social connection
Burgess Hill Horticultural Society	Community-based gardening and social activity
Haywards Heath Horticultural Society	Gardening promotion, community involvement and wellbeing

Feedback & Organisation-Specific Next Steps

The following is a sample of the feedback, action taken and recommendations that have been received from a wide-range of those who participated in the conferences.

Kerrin Page, CEO, West Sussex Mind

Thank you very much indeed for sharing this very impressive report. Two outcomes:

1. We have agreed to receive the report and consider the outcomes at the West Sussex Mental Health, Learning Disability and Autism (MHLDA) Board, and also at the West Sussex Community Transformation Partnership. This will hopefully help give a strategic push to the work, but also give us a place to keep the new steps under review.
2. By understanding which themes were discussed in each locality we will be able to take forward some of the learning through to the neighbourhood mental health teams, who it appears are aligning more with broader neighbourhood health meetings in the future.

Suzie Mulhern, Senior Manager of Operations, West Sussex Mental Health Support Services, BHT Sussex

At the Crawley conference, we had constructive discussions about improving access for marginalised communities, with a follow-up meeting arranged to continue work on outreach and engagement. In Horsham, conversations explored the different elements of the NMHTs, including the contribution of VCSE partners and SPFT colleagues. Across the conferences in Horsham, Crawley and Mid-Sussex, I found the dialogue consistently fruitful and insightful. They provided valuable opportunities to network with local community organisations, share resources, and strengthen partnerships. Thank you, to the organisers, for planning and delivering such well-organised and well-attended events.

Claire McNelis, Mental Health Lead, Sussex Police

The conferences brought partners together to see the wider context of the mental health challenges facing both the system and the community. They reinforced the importance of collaboration to improve understanding, service delivery and access to care. Hearing different perspectives across a patient's journey, alongside examples of preventative work, demonstrated a strong shared commitment to improving support. Contributing a policing perspective was especially valuable, highlighting the demand and complexity officers encounter. The events provided a constructive platform for partnership working, and it would be highly beneficial to see them continue in the future.

Paul Turner, Head of Service, Community Services, Mid Sussex District Council

Thank you for such an excellent Mid Sussex Conference. The engagement with local groups—particularly those supporting men's mental health—was especially insightful.

As outcomes: the Mid Sussex Partnership Board will, subject to availability, receive a presentation from NHS Pathfinder on new services and access routes. Mental health will feature prominently at the next Local Community Network meeting I chair (March/April), promoting awareness and collaboration. Several groups we met have also been invited to join our Health and Wellbeing Network, strengthening ongoing partnership working and ensuring local voices help shape future provision.

Liz Burt, Community Development Team Leader, Horsham District Council

What I have found particularly useful are the 'suggested actions', some of which I will be taking to our ICT and Local Community Network meetings, as 'mental health' is one of the priority areas identified. There are some actions here that we could potentially look to action in our area. Thank you, not only for concentrating on this important issue during your time as High Sheriff but also the immense work that has gone into visiting, researching, coming alongside services, connecting, organising conferences and now producing this excellent report which brings it all together in a helpful document.

Dr Moitree Banerjee, Head of School of Law, Business and Psychology, Reader in Clinical Psychology, University of Chichester

I wanted to express my sincere and heartfelt gratitude for the Mental Health Matters conference. These were powerful events that brought the community together and showcased the extraordinary work already taking place across our region. I left with a renewed sense of hope and optimism about what we can achieve collectively. From the University's perspective, we are now working closely with West Sussex Mind to develop joint research bids, focusing on community-led projects grounded in lived experience. The conferences have created an inspiring and supportive platform that will continue to strengthen collaboration and drive meaningful, lasting change across our communities.

Kathryn Slatter, CEO, Lifecentre

Thank you so much for Mental Health conference in Chichester. I found the event to be really useful, particularly as the discussions were so outcomes focused, and the networking and connections were really positive.

Amy Warman, Primary Care Network Development Manager (Crawley), Neighbourhood Management Lead (Crawley), Alliance for Better Care

As the lead for the Crawley Integrated Neighbourhood Team, I have taken away (along with other members of the team that were present) the importance of representation of the Crawley community in these spaces, and has generated a lot of conversation around what meaningful engagement looks like.

Gabrielle Gardner, Shine for Life[27]

Firstly, sincere thanks for bringing together so many voices across the mental health sector. Attending Horsham and Burgess Hill was both humbling and inspiring. I reconnected with my former counsellor, learned about the WSCC suicide prevention fund and have since submitted a proposal through Shine for Life CIC. New connections—including the Sussex Men's Mental Health Network, StrongMen and local partners—are already bearing fruit. The ripple effect is tangible, and I'm deeply grateful.

Vito Mastrolonardo, Director, Directorate of Students, Support & Information Services, University of Chichester

Thank you for organising this valuable networking event. It was encouraging to see the breadth of mental health support across our community. A particularly useful connection was with the West Sussex Neighbourhood Mental Health Team. Following discussions with Marylinda Gororo, we are planning joint internal training with specialist services to strengthen understanding and collaboration, which I am confident will deepen links with the University. A continuing concern, however, is students' difficulty accessing GP appointments. As GPs remain the main gateway to external mental health services, limited access presents an ongoing barrier for some students seeking support.

Frontline Services Officer (DA), Hourglass[28]

Thank you for inviting Hourglass to the conference. I've connected with Alzheimer's Society to learn more about Dementia Friends, understand the lived experience of dementia, and explore better support for domestic abuse victims where dementia is involved. I also gathered Pathfinder details for potential mental health referrals.

[27] Shine for Life is a well-established, Community Interest Company offering Equine and Nature Assisted Therapy in West Sussex since 2006.

[28] Hourglass operates a Community Response hub across the Sussex area, with a team of dedicated Independent Domestic Violence Advocates (IDVAs) and Domestic Abuse Support Workers, providing tailored support for older victim-survivors of abuse in East Sussex, West Sussex and Brighton and Hove.

Phil Packer MBE FRSA, Founder and CEO, The British Inspiration Trust (BRIT)

Thank you for the opportunity to attend the Mental Health conferences. Two themes stand out. First, student engagement through volunteering, charity partnership and civic responsibility generated strong interest, with charities keen to build closer relationships with institutions. This has led to plans for an event at Arundel Castle supporting the University of Chichester's BRIT County Initiative to strengthen collaboration. Second, the conferences enabled valuable relationship-building with charity CEOs locally (and nationally), particularly in suicide prevention, mental health and veterans' support, including assistance to the Mary How Trust. I am truly grateful for these positive outcomes which would not have happened without your Conferences.

Neville De Moraes, Henfield Community Shed

One outcome of the conference is that we met again with Pulborough Shed. Back in 2020 they were looking to open up and visited us. We were able to guide them by providing them with several policy documents and with procedures for dealing with Health and Safety, safeguarding and training. It was really heartening to see that they had established a workshop and were now operating as a fully functioning organisation. We will be keeping in touch with them, sharing views, experiences and ideas for further engaging our communities.

Doug / Leigh / The BBBB Team, Brothers', Bikes, Bangers & Brews CIC[29]

We've been truly impressed by the commitment, compassion, and collaborative spirit shown at the events we've attended — it's exactly the kind of joined-up approach needed to address the challenges our communities face. As a new Chichester-based social enterprise dedicated to men's mental health and wellbeing, the conferences have reinforced and energized our mission. We've drawn valuable insights from the discussions on stigma, male-specific barriers, community-led support, and integrating practical activities with therapeutic elements.

[29] Brothers', Bikes, Bangers & Brews CIC www.bbbbhub.org

The Office of High Sheriff

The Office of High Sheriff is over 1,000 years old and is the oldest continuous secular office under the Crown. Originating in Saxon times, the 'Shire Reeve' was responsible to the Sovereign for law enforcement, administration of justice, and the collection of taxes within the county. The Sheriff could raise the "hue and cry" to pursue offenders and mobilise the "posse comitatus", the county's armed force.

Today, the High Sheriff is appointed by the Monarch by Warrant of the Privy Council to uphold and support the Judiciary, the maintenance of law and order, and the strengthening of communities. The office is normally held for one year, although the current High Sheriff also served during the pandemic, becoming the first in Sussex to serve twice since 1551.

The role is distinct from that of the Lord-Lieutenant, who is the personal representative of the Sovereign in the county.

High Sheriffs are nominated locally, formally appointed through the ancient "pricking" ceremony, and take office after making a sworn Declaration. The role is independent, non-political, and unpaid.

Alongside formal duties such as supporting High Court Judges, attending Royal visits, and proclaiming a new Sovereign, modern High Sheriffs focus on encouraging and supporting voluntary, charitable, and statutory organisations, particularly those within the justice system, including policing, prisons, probation, and mental health services.



Figure 4 Dr Tim Fooks, The High Sheriff, with the Limitless Youth Football Club in Bewbush, Crawley