Mental Health Needs Assessment 2026

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Contents

AI: Some information in our Joint Strategic Needs Assessment (JSNA) products may have been summarised with the help of artificial intelligence tools. Everything is carefully checked by our team to make sure it's accurate.

About this needs assessment

What this needs assessment covers

- Mental health needs across the life course, including:
  - Children and young people's mental health
  - Perinatal mental health
  - Adult mental health
- Patterns and trends in mental health need, including common mental health conditions, suicidal thoughts, self-harm, and severe mental illness
- Inequalities in mental health, by deprivation, age, gender and population group
- Access to services, including diagnosis, waiting times and gaps between need and support
- Service user voice and lived experience, where available, to inform understanding of access, experience and outcomes

What this needs assessment does not cover in detail

This document does not provide in-depth analysis of:

- Special educational needs and disabilities (SEND), including social, emotional and mental health needs (see the Suffolk SEND Needs Assessment)
- Specific behavioural risk or protective factors such as physical activity, substance use or obesity (see relevant Suffolk JSNA profiles, including physical activity and healthy weight needs assessment)
- Detailed physical health pathways, including pregnancy-related physical health (see the Suffolk Healthy Pregnancy profile)
- Dementia and associated risk factors (see the Suffolk Dementia Profile, produced in April 2025)

How this fits within Suffolk's JSNA

- This Mental Health Needs Assessment (MHNA) forms part of the wider Suffolk Joint Strategic Needs Assessment (JSNA)
- It should be read alongside other JSNA products to gain a whole-system view of mental health, its wider determinants, and the opportunities for prevention, early intervention and integrated care across Suffolk. It is intended to support the new Norfolk and Suffolk ICB mental health strategy, alongside a similarly occurring mental health needs assessment being produced for Norfolk.

Health system geography and data boundaries

- This needs assessment was developed during a period of NHS organisational change. Much of the NHS and mental health service data available at the time of analysis relates to the former Suffolk and North East Essex Integrated Care Board (SNEE ICB) footprint. From 1 April 2026, Suffolk became part of the Norfolk and Suffolk Integrated Care Board (NSICB) footprint. Where relevant, the geography and time period for datasets are described within the document.

A note on language used within this needs assessment:

- This document aims to use language that is respectful, person-centred and aligned with the preferences of communities and population groups where possible. However, some terminology reflects the wording used within national datasets, clinical coding systems or statutory reporting requirements, and may not always reflect preferred community language.

JSNA-on-a-page summary

Headlines | Mental health in Suffolk

Mental ill health affects a substantial proportion of Suffolk's population across the lifecourse, with marked inequalities by deprivation, age and complexity of need

Adults

High prevalence, poorer outcomes for those with the greatest need

Common mental disorders

High prevalence of depression and anxiety, particularly in **working-age adults** and more **deprived communities**

Older adults (65+)

Around **1 in 4** identified with a mental health condition

Severe Mental Illness (SMI)

Nearly 5x higher risk of dying before age 75 compared with the general population

Suffolk statistically significantly worse than England (**excess under 75 mortality rate in adults with severe mental illness, 2021-23**)

Poor physical health, delayed access and unmet need drive inequalities for people with SMI

Children, Young People (CYP) and Families

Growing need and crisis-level pressure

- Suffolk **above England** and among **highest peer areas** for CYP needing specialist mental health support
- **15-19 year olds: 1 in 9** flagged with a mental health condition
- **Highest rate of emergency self-harm admissions** in the East of England

Children in Care

Around **4 in 10** have emotional wellbeing concerns

Families and intergenerational need

Social work assessments (2024/25)

- **24%** identify mental health concerns about the **child**
- **44%** identify mental health concerns about a **parent**

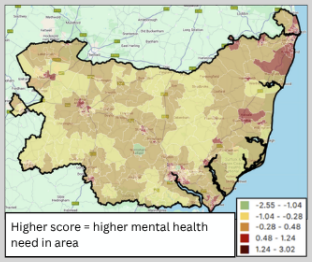
Mental health need often affects whole families, not individuals in isolation

Inequalities and Place

Need is not evenly distributed

- Higher need in **more deprived communities**
- Elevated risk in **coastal** and **urban** areas
- Worse outcomes despite **lower recorded service use**

Indices of Deprivation: Mental health indicator by Suffolk LSOA in 2025



Access and System Pressure

Access, demand and capacity

- **Specialist CYP services**: demand exceeds capacity; long waits increase crisis risk
- **Care-experienced pathways**: sustained pressure on trauma-informed provision
- **Talking therapies**: most seen within standards, but significant numbers wait longer
- **Adult social care**: rising number supported primarily for mental health needs

Key message

Lower service use masks significant unmet need. Improving outcomes in Suffolk requires earlier identification, integrated physical and mental healthcare, and targeted action to reduce inequalities - particularly for people with severe mental illness, young people in crisis, and families facing multiple disadvantages

Executive Summary

In this needs assessment, need is defined from a public health perspective as the capacity to benefit from effective intervention, recognising that population mental health need extends beyond diagnosed illness to include prevention, early identification, and support for people at risk of poorer outcomes.

Mental ill health affects a substantial proportion of Suffolk's population across the lifecourse. Common mental disorders have a high prevalence among working-age adults, and mental health need persists into older age, with mental ill health among children and young people continuing to grow. While need is present across all communities, there is a clear and persistent inequality gradient - mental health need is consistently higher in more deprived areas, and among people experiencing multiple social disadvantages. This reinforces the importance of prevention-focused and place-based approaches.

Adults with severe mental illness (SMI) experience particularly poor outcomes. In 2021–23, people with SMI in Suffolk were almost five times more likely to die before the age of 75 than compared to the general population without SMI. Excess premature mortality refers to how much higher the risk of dying before the age of 75 is for people with severe mental illness compared with the general population. In Suffolk, this risk is statistically significantly worse than the England average and has persisted over time. Importantly, this excess risk is not primarily driven by suicide but largely reflects higher rates of preventable physical health conditions including cardiovascular disease, respiratory disease, liver disease and cancer alongside barriers to timely and effective healthcare. Premature mortality among adults with SMI in Suffolk has increased significantly over time, rising by over a third between 2015–17 and 2021–23, with the most marked increases occurring during and after the COVID-19 pandemic. Although rates remain lower than England and the East of England, this upward trend indicates worsening outcomes for this population. These findings point to longstanding issues in physical health prevention and management, early identification, continuity of care, and the integration of mental and physical health services.

Despite this, Suffolk consistently reports lower levels of recorded mental health service use than England, including fewer referrals to secondary care and lower inpatient admission rates. These favourable indicators do not translate into better outcomes, particularly for people with SMI. Instead, this suggests unmet need through delayed access, under-identification, or pathways that do not consistently reach those at highest risk. This also strengthens the case for more proactive population health management and better integration of mental health, physical health, and social care.

Mental health need among children and young people in Suffolk is also high and sustained. Suffolk is statistically significantly above the England average and among the highest of its peer areas (local authorities with similar population size, demographics and socioeconomic characteristics) for children and young people requiring specialist mental health support. Evidence highlights that investment in early relationships and infant mental health delivers substantial long-term mental health and economic benefits, reinforcing the importance of prevention across the lifecourse[1]. Furthermore, this Mental Health Needs Assessment (MHNA) recommends that Integrated Care Boards (ICBs) commission transition models that prioritise continuity, youth-friendly care and shared responsibility across services, as this represents a

concrete, evidence-led action to reduce avoidable disengagement and worsening mental wellbeing during a known high-risk period.

Suffolk also has the highest rate of emergency hospital admissions for intentional self-harm in the East of England, indicating ongoing crisis-level need despite comparatively high referral and service contact rates. Children in care remain a particularly vulnerable group, with around four in ten experiencing emotional wellbeing concerns.

Educational and wider determinants of health raise concern for future mental health outcomes. Although early years indicators are relatively strong, Suffolk's statistically significantly higher numbers of secondary school absence, special educational needs, lower attainment, and young people not in education, employment or training (NEET) signify emerging risks that may translate into poorer mental health in adulthood.

Social work assessment data for children in need within Suffolk highlights substantial intergenerational mental health need. In 2024/25, mental health concerns were identified in nearly one quarter of assessments in relation to the child and in almost half of assessments in relation to a parent. This reinforces the close links between parental mental health, family functioning, and child wellbeing, and the importance of whole-family and trauma-informed approaches.

Among adults, common mental disorders remain widespread, with population health management data showing high prevalence of diagnosed common mental disorder across the Suffolk and North East Essex ICB geographic footprint, particularly in more deprived communities. Diagnoses peaks in mid-life, aligning with pressures related to employment, caring responsibilities, and long-term conditions. Mental health diagnosis also remains significant in older age, with over 5% of adults over the age of 80 having one or more of the following mental health conditions – depression, anxiety, low mood or serious mental illness in the last 2 years, and deprivation-related inequalities persisting into later life. This could also be a positive – with more of the population coming forward for diagnosis meaning more can potentially be treated.

Across services, access standards are not consistently met. There is evidence of sustained pressure in talking therapies, and specialist children's services, with demand exceeding capacity in several areas. Long waits, particularly for trauma-informed and relationship-based support, increase the risk of escalation and crisis. Adult social care data show a gradual increase in the number of people supported for mental health needs, reflecting ongoing demand and the intersection between mental health, disability, and social care dependency.

Overall, this mental health needs assessment describes system pressure and high/increasing need, with unmet need and inequalities masked by relatively low recorded service use. Improving outcomes will require a stronger focus on prevention, early identification, and integrated care, particularly for people with SMI, children and young people, and families facing multiple disadvantages.

Recommendations

The recommendations arising from this needs assessment align with national evidence, including the House of Commons Health and Social Care Committee's report on Community Mental Health Services, and reflect Suffolk's specific population needs and system challenges. They are intended to inform the development of all strategic plans across Norfolk and Suffolk and to support the system to prioritise prevention, early intervention, and integrated care across the life course.

1. Strengthen early intervention and crisis prevention for children and young people

Strengthen early intervention and crisis prevention for children and young people through a whole-system approach linking education, health, early help and social care. Suffolk has the highest rate of emergency hospital admissions for intentional self-harm in the East of England and rising indicators of emotional wellbeing need. Greater emphasis should be placed on prevention, resilience-building and earlier support within community and education settings, alongside targeted support for adolescents and young adults, children living in deprived communities, and groups with higher referral rates such as girls and young women. It is recommended that self-harm admissions particularly in East Suffolk are audited to identify areas where these individuals could be better supported.

Keyword tags: CYP; early intervention; self-harm; crisis prevention; adolescents; girls; deprived areas

Summary slide deck: Slide 9

2. Improve mental health support for care-experienced children and families

Improve access to timely, trauma-informed mental health support for children in care, adopted children and families experiencing intergenerational mental health challenges, recognising the impact of adverse childhood experiences (ACEs) on mental health and wellbeing – particularly for higher-risk groups such as young carers. High levels of emotional wellbeing concerns among children in care and parental mental health concerns in social work assessments highlight the importance of family-centred and relationship-based approaches.

Keyword tags: LAC; trauma-informed; families; intergenerational MH

Summary slide deck: Slide 8

3. Strengthen perinatal mental health support

Strengthen identification and support for perinatal mental health needs. Modelled estimates suggest that around one in four women giving birth may experience a mental health condition during pregnancy or the postnatal period. Improved identification, timely access to specialist support and integrated pathways across maternity, primary care and mental health services are essential to improve outcomes for mothers and infants.

Keyword tags: perinatal; maternal MH; pregnancy; postnatal

Summary slide deck: Slide 4

4. Improve early identification and access to support for adults with common mental health conditions

Improve early identification and timely access to appropriate support for adults experiencing common mental health conditions. National survey evidence suggests that many adults experiencing symptoms of depression or anxiety have not received a professional diagnosis or support. Strengthening proactive identification in primary care, community settings and workplace environments must be matched with accessible, sufficient follow-on support across primary care, community and voluntary sector provision, to improve early access and reduce escalation into crisis services.

Keyword tags: common mental health conditions; depression; early identification; primary care

Summary slide deck: Slide 12

5. Reduce inequalities in mental health outcomes through targeted, place-based approaches

Reduce inequalities in mental health outcomes through targeted, place-based approaches. The MHNA highlights higher levels of mental ill health in deprived and coastal communities, alongside increased risks among groups such as carers, people experiencing homelessness, Gypsy, Roma and Traveller communities, veterans, refugees and asylum seekers, LGBT+ people and those in contact with the criminal justice system.

This should include strengthening prevention and community resilience through action on wider determinants of mental health – such as poverty, employment, housing, social relationships and access to trusted support, alongside improving emotional wellbeing and coping skills.

This should explicitly address ethnic inequalities, structural and systemic bias, and disproportionate routes into care, drawing on Suffolk PHM data, alongside user voice and national evidence. Commissioning and service delivery should prioritise inclusive and targeted approaches to improve access and outcomes.

Keyword tags: inequalities; deprivation; coastal; inclusion health

Summary slide deck: Slide 5

6. Improve access, waiting times and system capacity across mental health services

Ensure mental health services have sufficient capacity to meet demand and provide timely access to care. Evidence across community mental health services, talking therapies, children and young people's services and adult social care indicate sustained system pressures and waiting times across some pathways. Workforce planning, integrating services, and redesigning pathways should facilitate timely access, continuity of care and reduce reliance on crisis services.

Keyword tags: access; waiting; capacity; Talking Therapies; workforce

Summary slide deck: Slide 17

7. Improve mental health intelligence, data integration and pathway transparency

Strengthen mental health intelligence across Suffolk by improving the use of population health management (PHM) data, including better use of secondary care mental health service data, linking data across primary care, secondary mental health services and social care, and mapping local care pathways. This should support better identification of unmet need and ensure system capacity aligns with population need.

Data quality should be improved, particularly within Norfolk and Suffolk NHS Foundation Trust (NSFT) datasets, with a clear link to the implementation of the new Electronic Patient Record (EPR), ensuring data is fit for population health management, service planning and evaluation, not only contracting purposes.

Keyword tags: PHM; pathways; unmet need

8. Plan for the mental health needs of an ageing population

Plan for the mental health needs of an ageing population. Referral rates to secondary mental health services among adults aged 65 and over are lower than for younger groups and have declined in recent years. As Suffolk's population ages, demand for integrated support for later-life mental health conditions, including depression, anxiety, dementia-related mental health needs, loneliness and social isolation, is likely to increase.

Keyword tags: ageing; older adults; loneliness; later-life MH

Summary slide deck: Slide 17

9. Address gender differences in mental health need and help-seeking

Recognise and address gender differences in mental health need and service engagement. Evidence suggests higher service use among females in children and young people's services alongside lower help-seeking among men despite poorer outcomes such as higher suicide rates. Gender-informed approaches may help improve engagement, prevention and early intervention.

Keyword tags: gender; help-seeking; men; suicide prevention; girls; CYP

Summary slide deck: Slide 9

10. Reduce premature mortality for people with severe mental illness (SMI)

Strengthen integrated physical and mental healthcare for people living with severe mental illness (SMI), with a focus on reducing premature mortality. This should include improving uptake of annual physical health checks and cancer screening, targeted smoking cessation and cardiovascular risk management, and proactive outreach approaches.

Greater focus is needed on what happens after health checks, including access to appropriate follow-on care, treatment and support, and evaluation of impact on health outcomes, not just uptake. Reducing premature mortality among people with SMI should be a shared system ambition.

People experiencing mental health crisis should be able to access timely, appropriate and therapeutic support, ensuring the right care is provided at the right time and reducing reliance on inappropriate or avoidable escalation.

Population health management approaches should be used to identify people at risk and ensure coordinated support across primary care, mental health services and public health.

Keyword tags: SMI; premature mortality; health checks; smoking; CVD; PHM

Summary slide deck: Slide 13

Definitions and key terminology

This section details some key terms used in the needs assessment. Definitions are provided to support clarity and consistency.

Term	Explanation
Antisocial personality disorder (ASPD)	The diagnostic criteria for ASPD describe a pattern of impulsive, aggressive and irresponsible behaviour, and a disregard for the rights of others, emerging in childhood or early adolescence[2,3]
Borderline personality disorder (BPD)	Defined as a pervasive pattern of instability in interpersonal relationships, self-image, and emotional regulation, coupled with marked impulsivity. People meeting diagnostic criteria for BPD may have severe difficulties with sustaining relationships and experience high rates of self-harm and suicidal behaviour[3,4]
CAMHS	Child and Adolescent Mental Health Services (CAMHS) support young people experiencing poor mental health, and work with schools, charities, and local authorities
Clinical Interview Schedule – Revised (CIS-R)	The CIS-R is a structured, interviewer-administered assessment used in the APMS to measure symptoms of common mental health conditions. It assesses non-psychotic symptoms experienced in the week prior to interview and produces: • individual symptom scores • a total score indicating overall severity A CIS-R score of 12 or more is conventionally used to indicate the presence of a CMHC, at a level where primary care recognition is likely to be warranted. A score of 18 or more indicates more severe symptoms likely to require clinical intervention
Common mental health conditions (CMHCs)	Common mental health conditions are typically high-prevalence, non-psychotic conditions such as depression, anxiety disorders, phobias, panic disorder and obsessive–compulsive disorder. In this needs assessment, CMHCs are primarily reported using data from the Adult Psychiatric Morbidity Survey (APMS)[5] Within Population Health Management data, a mental health flag indicates if people have one or more of these mental health conditions: depression, anxiety, low mood, or serious mental illness
Deprivation	Deprivation is measured using the Index of Multiple Deprivation (IMD), a national measure based on income, employment, education, health, crime, housing and environment. Deprivation is a key driver of mental health inequalities and is used throughout this assessment to explore variation in need and outcomes[6]
Emotional wellbeing	Emotional wellbeing is a component of mental health and relates to how people experience and manage their emotions, feel about their lives, and cope with challenges. It includes positive factors such as resilience, purpose, social connection and life satisfaction. Good emotional wellbeing can be present even where a person has a diagnosed mental health condition
Housing Affordability Ratio	Ratio of median house price to median gross annual residence-based earnings (A higher ratio indicates that on average, it is less affordable for a resident to purchase a house in their local authority district)
Inequality and inequity	• Inequality refers to measurable differences in mental health outcomes, risk factors or access to services between

	population groups (for example by deprivation, age, gender or ethnicity) • Inequity refers to differences that are unfair and avoidable, often driven by wider social and economic conditions This needs assessment focuses on identifying inequalities that may indicate inequitable experiences of mental health need or access to support
Lived experience	Lived experience refers to the knowledge and insight gained by people who have personal experience of mental ill health, caring for someone with mental ill health, or using mental health services. Where available, lived experience evidence is used alongside quantitative data in this needs assessment
LSOA	Lower layer Super Output Areas (LSOAs) are made up of groups of Output Areas (OAs), usually four or five. They comprise between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons
Mental health	Mental health refers to a person's emotional, psychological and social wellbeing. It influences how people think, feel, behave, cope with stress, relate to others and function in daily life. Mental health exists on a continuum, from good mental wellbeing to severe mental ill health, and can fluctuate over time
Mental ill health	Mental ill health refers to difficulties with mental health that affect a person's thoughts, feelings or behaviour and may impair day-to-day functioning. This includes both common mental health conditions (such as anxiety and depression) and severe mental illness (such as psychosis). Mental ill health can be temporary or long-term and varies in severity over time
Mental wellbeing (population level)	Mental wellbeing refers to the overall mental health of a population, shaped by social, economic, environmental and community factors as well as individual characteristics. This needs assessment takes a whole-population approach, recognising that improving mental wellbeing and preventing mental ill health requires action beyond health services alone
NHS England statistical neighbours (peer groups)	NHS England statistical neighbours, sometimes referred to as peer groups, are local authorities identified as having similar demographic and population characteristics. They are calculated using Census 2021 data and measures of similarity based on factors such as age profile, ethnicity and educational attainment. Statistical neighbours are used to support benchmarking and comparison of outcomes and service use between areas with broadly similar populations. For this needs assessment, Suffolk's nearest statistical neighbours are: Lincolnshire, Derbyshire, Kent, Staffordshire, Nottinghamshire, East Sussex, Somerset, Norfolk, Shropshire, Essex, Worcestershire, Gloucestershire, West Sussex, Hampshire and Wiltshire.
Premature mortality	Refers to deaths that occur early, typically defined as dying before the age of 75. It is a key measure of population health, highlighting deaths that could be potentially avoided or delayed through public health interventions, lifestyle changes, or better healthcare[7]

Prevention and early intervention	Prevention refers to actions that reduce the risk of mental ill health occurring, while early intervention focuses on identifying and supporting people at an early stage to prevent escalation. This includes support provided outside of clinical services, such as in schools, workplaces and communities **Primary prevention** stops diseases or injuries before they start by avoiding hazards, changing risky behaviours, and boosting resistance. Examples include: • laws and rules banning hazardous products (like asbestos) or enforcing safety measures (such as seatbelts and bike helmets) • education on healthy habits (good diet, regular exercise, not smoking) • immunisation against infections **Secondary prevention** targets diseases or injuries that have already occurred by enabling early detection and treatment, promoting habits to prevent recurrence, and helping individuals regain their health and function. Examples include: • Regular screenings (e.g., mammograms for breast cancer) • Daily low-dose aspirin, diet, and exercise for heart attack or stroke prevention • Modified work schedules for safe return of injured or ill employees **Tertiary prevention** reduces the impact of ongoing illness or injury by helping people manage chronic health problems and improve function, quality of life, and longevity. Examples include rehab programs for heart disease or stroke, chronic disease management, support groups, and vocational rehabilitation[8]
Public health definition of need	Need is defined as a capacity to benefit from a health intervention, where a person with an illness or condition can experience an improvement in health, functional status or quality of life through effective, accessible care
Self-harm	Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress[9]
Service access and utilisation	Service access refers to whether people can obtain appropriate mental health support when they need it, while utilisation describes actual use of services. Differences between need and service use may indicate unmet need, barriers to access or gaps in provision
Severe mental illness (SMI)	The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI[10]
Suicidal ideation	Suicidal ideation refers to contemplation of self-harm or ending one's life and is a critical mental health concern with potentially fatal

	consequences if not promptly recognised and managed. The condition may arise in individuals of any age or background and is commonly associated with psychiatric disorders, including depression, schizophrenia, bipolar disorder, and substance use disorders[11]

What's the issue?

Mental health is a major and growing public health issue, affecting people across the life course and contributing substantially to inequalities in health, wellbeing and life expectancy. Common mental health conditions such as depression and anxiety affect around one in five adults at any given time in England, while severe mental illness (SMI), including conditions such as psychosis and bipolar disorder, affects a smaller proportion of the population but is associated with profound impacts on physical health, quality of life and premature mortality[5].

Nationally, reported levels of mental distress, suicidal thoughts and self-harm have increased over the past decade, particularly among children, young people and younger adults[5]. At the same time, many people experiencing symptoms of mental ill health do not receive timely or appropriate support. Survey data shows a gap between population-level need and access to diagnosis or treatment, reflecting potential barriers to help-seeking, variation in service availability, and the fact that not all distress requires or benefits from clinical intervention. Together, this points to the need for a balanced system that supports prevention, early intervention and recovery, alongside effective care for those with more severe or enduring conditions.

The government in December 2025 launched an independent review into mental health conditions, as well as ADHD and autism, with the interim report available as of April 2026. The review recognises that current systems of support have not kept pace with rising need, resulting in significant impacts on individuals, families, communities and the wider economy. It highlights longstanding gaps in access, long waiting times, inequalities in diagnosis and support, and ongoing debate about the balance between medicalisation, diagnosis and non-clinical forms of support[12,13].

The review will examine trends in prevalence, drivers of rising demand, and inequalities across the life course, covering children, young people and adults. It will consider the role of diagnosis, clinical practice and medication, alongside prevention, early intervention, resilience and alternative models of support both within and beyond the NHS. The aim is to inform national policy, including the 10 Year Health Plan, and to support a shift from hospital-based care to community-based, preventative and earlier interventions[12].

People living with SMI experience markedly poorer physical health and significantly shorter life expectancy than the general population, largely due to preventable and treatable physical conditions[14,15]. Closing this mortality gap is a longstanding national priority, however progress has been slow[16].

In Suffolk, the overall picture is complex - the county is on average less deprived than England and has comparatively low levels of crime and violence. Rates of referral to secondary mental health services, inpatient admissions and overall service contact are generally lower than national averages. However, these comparatively favourable indicators do not consistently translate into better outcomes.

Evidence presented in this needs assessment shows that adults with severe mental illness in Suffolk face a particularly high risk of dying before the age of 75, with excess premature mortality statistically significantly worse than the England average in recent years. This gap is large, persistent and unlikely to be due to chance alone. When considered alongside lower recorded levels of service use, this raises important questions about early identification of

need, access to care, and the effectiveness of support for managing long-term mental and physical health risks.

50% of mental health problems are established by age 14, and 75% by age 24[17,18]. Suffolk also faces significant challenges relating to self-harm and crisis. Suffolk has the highest rate of emergency hospital admissions for intentional self-harm among upper-tier local authorities in the East of England. This is evident despite relatively high levels of referral and service contact among children and young people, and relatively low levels of deprivation.

Demographic change also adds additional pressure - Suffolk has an older age profile than England overall, and the older population is projected to grow rapidly over the coming decades, particularly among those aged 75 and over. Mental ill health does not disappear in later life, and many people age with long-term mental health conditions, or develop new ones. Older adults may experience depression, anxiety, loneliness and mental health needs alongside physical multi-morbidity, increasing the importance of integrated, age-appropriate mental health support.

Deprivation remains a key driver of poorer mental health, with higher levels of need concentrated in specific communities, including coastal and urban areas. Certain population groups face heightened risk, including people experiencing socioeconomic disadvantage, those with long-term physical health conditions, people involved in the criminal justice system, individuals experiencing homelessness, carers, and lesbian, gay, bisexual, transgender, queer or questioning, plus all other sexual orientations and gender identities (LGBTQ+) communities.

User voice evidence is integrated throughout this needs assessment rather than presented as a standalone chapter. This reflects a deliberate methodological approach, embedding lived experience insights alongside quantitative data and evidence within each life course section. Where relevant, local and national user voice sources are included, with links to the original research and the full user voice document to support further exploration.

Overall, the evidence shows that while Suffolk performs relatively well on some high-level indicators, significant mental health need persists, and outcomes for some groups – particularly people with severe mental illness and those experiencing crisis and self-harm – are poor. Addressing these issues requires a whole-system approach that strengthens prevention and early intervention, improves access and continuity of care, and better integrates mental and physical health support across the life course.

Literature review

The following is a summary of the main review. For the full accessible analysis of the evidence base please refer to the full literature review.

Intentions of review

This rapid review aims to provide an assessment of the current evidence base on risk and protective factors influencing mental health outcomes across the lifespan. By focusing on risk and protective factors, this rapid review intends to deliver timely and relevant insights to inform current practices, policies, and planning.

It is recognised that a significant volume of literature exists outside the parameters of this review. Exclusions have been made to maintain a focused and manageable scope.

Intervention studies are not included, ensuring the review remains clear in its scope. While interventions are important, they represent a separate research field centred on outcomes and effectiveness.

For a broad overview, the National Institute for Health and Care Excellence (NICE) provides Clinical Knowledge Summaries providing evidence on specific mental health conditions including:

- Definitions
- Prevalence
- Complications
- Diagnosis (what to screen, how to screen)
- Management of condition
- Prescribing information

Methodological and contextual considerations

Correlation not causation

Most studies included in this review used cross-sectional or qualitative designs, meaning they can identify patterns and associations but cannot prove causality (i.e. that one factor directly causes another).

Despite these limitations, the findings presented in this review offer valuable and broadly generalisable insights that are likely to be relevant to Suffolk's communities, mental health professionals, and commissioners. As such, they can meaningfully shape current practices, inform policy, and guide future planning.

Absence of evidence is not evidence of absence

It is important to acknowledge that this review can only reflect what is present in the available literature. Where a particular risk or protective factor does not appear in the findings, this should not be taken to mean it is unimportant or unsupported- only that it was not identified within the scope of the studies reviewed. Similarly, where a particular population group is not discussed, this does not imply they are unaffected or less likely to experience disproportionate mental health outcomes. It may instead reflect gaps in research attention, funding, or data availability. It is also worth noting that the available literature drawn on in this review largely focuses on common mental disorders, with limited discussion of severe mental illness. This is reflective of the broader evidence base rather than a deliberate omission and should not be taken to diminish the significance of severe mental illness or the experiences of those affected. This gap in the evidence base does suggest there may be value to local evaluation.

This review aims to organise and summarise the existing evidence base as objectively as possible. With this in mind, it's important to note that the landscape of risk and protection is broader than this review can capture.

Language caveat

It is recognised that "mental ill-health" is widely considered the most inclusive and appropriate umbrella term for describing the many ways mental health difficulties can present. However, the studies and sources drawn on throughout this review use a range of terminology- including "mental disorders", "mental health conditions", "mental illness" and "psychiatric disorders". As the scope of a rapid literature review requires synthesising findings across a broad evidence base these terms are used interchangeably throughout to ensure consistency and readability. It is acknowledged that different terms may carry different meanings and connotations, and no single term will fully capture everyone's experience.

Similarly, when the review refers to groups facing additional or disproportionate risk, terms used are those provided within the original papers being discussed. Where it is helpful, definitions have been included to offer clarity. It is recognised that language in this area is continually evolving, and the aim throughout is to be as respectful and inclusive as possible.

Life course approach

This review covers the full lifespan, from birth to older age, reflecting the fact that mental health risks and protective factors shift across different stages of life.

As Suffolk's population ages, there will be a growing need for preventative approaches that support mental wellbeing in later life and ensure the timely identification and management of mental health conditions alongside physical health needs. This demographic context makes the findings of this review particularly valuable.

Nevertheless, the findings relating to children and young people should not be overlooked. Many of the risk and protective factors identified in earlier life have lasting effects that shape mental health outcomes in later years. Supporting prevention and early intervention across the whole life course can therefore not only improve outcomes now but also help reduce the future burden of mental ill health as Suffolk's population continues to age.

The interconnected nature of risk and protective factors

It is important to note that many studies discussed in this review highlight the interconnected nature of both risk and protective factors. Risk factors were shown to rarely operate in isolation; they frequently co-occur and compound one another. Similarly, protective factors often exert mediating or buffering effects, reducing the impact of risk factors on mental health outcomes. This underscores a critical message: addressing a single factor in isolation is unlikely to achieve meaningful change. To see real impact, all areas must be considered and addressed together through coordinated, holistic approaches.

Key findings

Theme 1: Relational and social environment

This theme explores how relationships and social connections shape mental health across the life course- from early parent-child bonds through to social networks in later life. It also considers how these factors play out for groups who may be particularly affected by mental ill-health. Importantly, it looks not just at whether connections are present, but at how they are experienced, recognising that the quality and warmth of relationships matters most.

Children and young people

Parental mental health

- Parental mental health has consistently been identified as a risk factor, conferring a broad vulnerability to mental health difficulties in children and young people, rather than being associated with specific challenges[19–24]
- Both maternal and paternal mental health independently influence outcomes- children with one affected parent face roughly double the risk of mental ill-health, and triple the risk when both parents are affected[22–24]
- These effects are not solely genetic - parents with mental illness may be more likely to display critical or hostile interaction styles, which can act as a stressor during early childhood and predict later mental health difficulties[20]

Family climate

- How well parents are coping emotionally and practically influences the parent-child relationship, family cohesion, and children's mental health outcomes[22,25,26]
- Negative relationships with both mothers and fathers in childhood predict depressive symptoms that can persist into adulthood[27,28]
- Family conflict, instability, and low warmth create a self-reinforcing cycle - parental stress worsens conflict, which deepens a child's difficulties, which feeds back into household tension[25]
- Financial hardship and precarious employment increase parental stress, reducing capacity for warm and consistent parenting, which in turn predicts children's internalising (defined as emotional difficulties like anxiety and sadness that are felt inwardly rather than shown outwardly) and externalising symptoms (defined as behavioural difficulties like aggression, defiance, and hyperactivity that are directed outward and visible to others)[22,26,29]
- Warm, communicative parent-child relationships act as a protective buffer - even against socioeconomic disadvantage[25,28,30,31]

Adverse childhood experiences (ACEs)

- Adverse childhood experiences (ACEs) are associated with an increased risk of psychiatric diagnoses over time[32–36]
- Exposure to multiple ACEs more than triples the odds of any psychiatric disorder by age 18[37]
- A history of ACEs is linked to elevated risks of self-harm, suicidal behaviour, anxiety and depression in later life[35,38]
- However, the impact of ACEs is not deterministic- experiencing them does not mean negative mental health outcomes are inevitable. Evidence highlights several protective factors that can buffer their effects:
    1. Interpersonal connection- including stable relationships with family, peers, and trusted adults[25,39]
    2. School connectedness at age 11 significantly weakened the relationship between childhood adversity and internalising (defined as emotional difficulties like anxiety and sadness that are felt inwardly rather than shown outwardly) and externalising symptoms (defined as behavioural difficulties like aggression, defiance, and hyperactivity that are directed outward and visible to others) at age 14[35]
    3. Physical activity independently predicted greater mental health resilience, though effects were modest and stronger for boys[31]

4. Self-esteem, emotional regulation, optimism, and peer support conferred the strongest promotive effects on resilience across life satisfaction and internalising outcomes[31]
5. Goal orientation, self-confidence, social competence, social support, and family cohesion were associated with lower mental health problems[39]

Peer relationships

- Loneliness before age 11 was a strong modifiable predictor of chronic depressive symptoms persisting into adulthood[27]
- Worsening peer relationships in childhood and early adolescence directly predict poor mental health in later life[21,25,27]
- All forms of bullying harm mental health, with verbal bullying showing the largest effect and younger children disproportionately affected[31,32,40–42]
- The effects of bullying extend into adulthood, with increased anxiety, depression, and psychiatric disorders at age 26[43]
- School connectedness moderates the harmful impact of both traditional bullying and cyberbullying on depression, suicidal behaviour, and self-esteem[40]

Adults

Loneliness and social isolation

- Adults who are socially isolated consistently experience poorer mental wellbeing independent of cultural contexts[44] or socioeconomic circumstances[45]
- Loneliness independently predicts more severe depressive symptoms, and chronic loneliness carries an elevated risk of major depression that can persist for over a decade[44]

Social relationships

- Deteriorated social networks and negative social environments are among the strongest predictors of poor mental health outcomes in adults[46]
- Poor quality relationships with family, peers, and neighbours increase the risk of adults experiencing depression, internalised symptoms (defined as emotional difficulties like anxiety and sadness that are felt inwardly rather than shown outwardly) and functional somatic complaints (defined as physical complaints like headaches, stomach-aches, or fatigue that often arise from or are worsened by emotional distress rather than a clear medical cause)[47,48]
- Social exclusion through sickness or disability increased risk of mental health decline[49]
- Low levels of social support for specific groups in need- including those with type 2 diabetes[50] and postpartum anxiety[51]- was shown to increase risk of poorer mental health outcomes
- Equally, social support was shown to be a protective against negative mental health outcomes in adults[52]
- Positive, supportive relationships actively protect mental health, serving as a buffer even when mental health difficulties are already present[46]
- Community involvement was also shown to reduce depression over time[44]
- Social exclusion through sickness or disability increased risk of mental health decline[49]

Older adults

Loneliness and social isolation

- Adults aged 65 years or over that reported loneliness were more than twice as likely to experience depressive symptoms than those who did not report loneliness[53]
- Recent widowhood nearly quadrupled the risk of developing a new mental health condition, whilst never having married doubled the risk[54]
- Absence of religious affiliation was associated with a 66% increase in risk of developing a mental health condition, possibly due to the loss of structured social networks, loneliness, and community belonging[54]

Quality of relationships

- A higher number of social activities was paradoxically linked to increased depressive symptoms in the northern European region, possibly reflecting overcommitment and fatigue[53]
- Frequent or sustained grandchild caregiving is associated with elevated depressive symptoms among adults aged 65–74, suggesting rewarding roles can become burdensome when demands are prolonged[53]
- Satisfaction with social activities and networks was shown to protect against depression in older adults - perceived quality of engagement mattered more than the volume of social activities attended and networks made[53]

Groups facing additional risk

Sexual and gender minority young people

- Sexual and gender minority (SGM) is used as an umbrella term for youth who identify as either a sexual minority (SM), a gender minority (GM), or both. Each are defined as follows:
  - **Sexual minority (SM)** youth are those who identify as gay/lesbian, bisexual, pansexual, or asexual but do not identify as transgender, non-binary, gender fluid, or other gender.
  - **Gender minority (GM)** youth are those who identify as transgender, non-binary, gender fluid, or other gender AND also identify with a non-heterosexual sexual orientation.
- Family rejection is consistently associated with depression, anxiety, and suicidality, while family acceptance is protective - the quality of family relationship was shown to matter more than the disclosure of identity itself[55–58]
- Being called by one's chosen name across family, school, and social contexts is associated with reduced depression and increased self-esteem for gender minority young people[56,58]
- School connectedness, teacher support, feeling safe, and the presence of gay-straight alliances are associated with lower mental health risk[55,56,58]
- Larger social networks - both online and offline - are linked to fewer suicidal thoughts and attempts among gender minority individuals[57]
- General peer support is more consistently protective than identity-specific support[56]

Autistic individuals

- Bullying can have a particularly severe impact for autistic individuals, leading to depression, anxiety, low self-esteem, loneliness, and suicidal ideation[59]

Children and young people in residential and foster care

- Social support from multiple sources is consistently associated with better mental health for children and young people in residential and foster care, with at least two strong social

network domains (defined as distinct groups of relationships in a young person's life, such as birth family, carers, and friends) necessary for a meaningful protective effect[39,60]
- Emotional closeness and security with caregivers moderates the development of wellbeing, particularly in the first six months of placement - strong caregiver bonds can weaken the link between past trauma and current distress[60]

Young carers

- Children of parents with mental illness are more likely to take on caring responsibilities, and this combination of parental mental illness and caregiving can compound their risk of developing mental health difficulties themselves[61]

Migrants

- Social isolation, loneliness, and experiences of racism and microaggressions increase the risk of depression and anxiety[62]. This is especially true for older migrants who lack social networks or language skills[63]
- Older migrants who reunite with adult children may experience unmet expectations of emotional support, leading to feelings of disconnection and depression[63]
- Gender matters: being female, unmarried, and lacking social support are risk factors for poor mental health among South Asian migrants[64]. For older migrants, familiar domestic roles can give women a sense of purpose, while men without partners often struggle with boredom and loss of identity[63]
- Family support and cohesion protect mental health, and warm, attentive parenting benefits children's wellbeing. However, parent–child conflict (often linked to cultural differences) can increase depression and lower self-esteem in young people[62,63,65]
- Connecting with others from the same cultural background helps reduce stress and build belonging[63]. Learning the host country's language is one of the most consistently protective factors, reducing isolation and improving access to services[62–64]

Refugees

- Social isolation and discrimination compound the effects of pre-existing trauma, while having friends and social connections in the host country protects against depression[62].
- For refugee children, everyday stressors like discrimination and peer difficulties can fully account for the link between past trauma and ongoing mental distress[66]
- Supportive family relationships are protective, but generational tensions (often driven by cultural differences) can be a source of risk[62,67]
- Women may face particular vulnerabilities, including undisclosed gender-based violence, childcare responsibilities that limit help-seeking, and in some cases, male control over access to healthcare[62,64]
- Religious practice and cultural identity can play a protective role, though findings vary by context[62,66]. Host country language proficiency remains one of the strongest and most consistent protective factors[62,67]
- Engagement with both one's own ethnic community and the wider host community is associated with better mental health[67]

Ethnic minority communities

- Racial and ethnic discrimination, marginalisation and victimisation were associated with an increased risk of poor mental health[21,33,41,68–70]

So what?

- Evidence from Theme 1 shows that the quality of relationships is a consistent and influential determinant of mental health outcomes across the life course. Family relationships, peer connections and wider social ties shape both exposure to risk and access to protection, affecting how adversities such as poverty, discrimination and trauma translate into mental health outcomes.
- The findings indicate that mental health is produced within relational contexts rather than at the level of isolated individuals. Parental mental health, caregiver–child relationships and social connectedness operate as interacting mechanisms within wider family and community systems, with effects that can accumulate over time and across generations.
- While many upstream drivers of poor mental health sit in social and economic conditions that lie beyond the direct control of mental health services, relationships represent a key pathway through which risk and protection are mediated. This has implications for how prevention, early support and intervention are designed, particularly the need to align individual-level support with approaches that recognise family, relational and social dynamics.

Theme 2: Socioeconomic and environmental factors

This theme examines how socioeconomic and environmental conditions shape mental health across the life course- from childhood poverty and neighbourhood deprivation through to financial insecurity in later life. It also considers how these factors play out for groups who may be particularly affected. Importantly, it looks not just at whether disadvantage is present, but at how it accumulates and intersects, recognising that economic hardship rarely operates in isolation but can be compounded through housing, employment, the physical and digital environment, and the wider structures people navigate daily.

Children and young people

Economic disadvantage

- Economic disadvantage is consistently associated with poorer mental health in children and young people, regardless of how hardship is measured[26,31,68,70–74]
- Poverty operates indirectly through increased parenting stress, which raises adolescent risk of depression and anxiety[26]
- Poverty rarely acts alone- when combined with other disadvantages, the effects on mental health don't just add up, they amplify each other. For example, girls from low-income families saw sharper rises in depression and anxiety than would be expected from looking at the effects of being a girl, or growing up in a low-income household, separately[71]
- The link between economic disadvantage and wellbeing varies across ethnic groups and may even reverse for some minority groups, suggesting that poverty carriers different social meaning across communities[68]

Neighbourhood deprivation and structural disadvantage

- Neighbourhood deprivation is a consistent risk factor for poor mental health[21,37,75–77]
- For anxiety and suicidal ideation, the relationship with neighbourhood opportunity may reverse, with higher rates in more affluent areas, possibly due to academic pressure and greater access to care[77]. However, it's important to note that this pattern is not reflected in suicide data.

- The link between deprivation and mental health difficulties was stronger when reported by parents compared to teachers, suggesting school-based monitoring alone may underestimate need[76]

Social exclusion

- Multiple forms of social exclusion - including relational exclusion, educational exclusion, food insecurity, housing insecurity, poor healthcare access, caregiver underemployment, poorly built environment - are significantly associated with poorer mental health outcomes in children and young people, especially when they co-occur[33,78]
- Gender-diverse young people, those in rural areas, those from lower socioeconomic backgrounds, and those from non-English-speaking households were disproportionately affected by social exclusion[78]

Physical environment

- Polluted, littered or poorly maintained green spaces have reduced mental health benefits; neglected built environments actively undermine wellbeing[79]
- Adolescents recognised environmental inequalities and linked them to feelings of powerlessness and distress about their place in society[79,80]
- Access to green space and outdoor activity is associated with better mental health in children and young people[27,79–81]

Digital environment

- Young people describe social media as amplifying existing pressures rather than being a direct cause of distress[80]
- Commercial platform design, including algorithmic promotion of passive scrolling, food and gambling advertising, access to pornography, and unregulated mental health apps, shapes the conditions in which children engage online[29]
- The type of digital use matters more than time spent. Passive scrolling and appearance comparison are linked to low mood, body dissatisfaction and self-harm, whereas active communication and creative engagement are linked to better wellbeing[21,41,80,82–84]

Adults

Economic disadvantage

- Financial hardship, income inequality, material deprivation and housing insecurity each contribute to worse mental health in adults[46–48,52,85–90]
- A clear income gradient exists. Lower income is associated with progressively higher risk of mental health problems[46,52,85,87,89]
- Material deprivation - the inability to afford basic necessities - is the key mechanism through which economic disadvantage harms mental health; employment alone without meeting basic needs is insufficient[46,52,85]
- Income inequality at the local level was more damaging to mental health than exposure to acute crises such as COVID-19[86]
- People with low incomes were shown to spend time in different places than those with higher incomes (referred to as economic segregation in daily mobility) this was shown to widen mental health inequalities between income groups[90]

Housing and neighbourhood

- Dissatisfaction with housing quality, fuel poverty, and living in damp housing were all linked to mental health decline in adults[45,88,91]

- Adults living alone reported more frequent depression and significantly higher suicidal ideation, but trust and interpersonal networks reduced these risks[92]
- Gentrification harms long-term residents' mental health through financial pressure, social isolation, dispossession, and erosion of community identity; even the anticipation of displacement causes significant distress[93]
- Home ownership is consistently associated with better mental health compared to all other housing tenures[45,94]
- Feeling safe in one's neighbourhood was protective for mental health outcomes in adult[45,95]

Employment

- The quality and security of work (not just whether someone has a job) is a consistent determinant of adult mental health[49,52,85,96–100]
- Employment was shown to damage mental health through four key pathways: financial instability, temporal uncertainty, marginal status, and employment insecurity[96]
- In-work poverty (employment but below the poverty line) was associated with increased risk of diagnosed mental health disorders[85]
- Midlife unemployment was associated with declining mental health, those with permanent sickness or disability showed increased risk of deterioration[49]
- Prolonged unemployment during transition to adulthood prevented improvements in mental health outcomes[100]
- High demands at work, low control of work and low workplace social support were shown to negatively affect mental health in employed adults[98,99]

Older adults

Economic disadvantage

- Financial difficulty was significantly associated with higher depressive symptoms among adults aged 80 and above[53]
- How well older people felt they could manage on their income was important for mental wellbeing, beyond absolute income levels[101]
- The mental health impact of economic disadvantage in later life is not fixed but can be reduced through stronger social safety nets and more equitable resource distribution[101,102]

The built environment

- Low neighbourhood walkability increased loneliness, which was associated with poorer mental health[103]
- Perception of safety, housing quality, interior design and home facilities all affected mental health[103]
- Green and blue spaces (parks, gardens, lakes, beaches) were consistently associated with better mental health outcomes, including reduced antidepressant use, though quality and design mattered more than total area[103]

Groups facing additional risk

Ethnic minority communities

- Mental health inequalities among ethnic minority communities are driven by structural conditions (economic opportunity, neighbourhood environment) and relational factors (discrimination, social support) which determine stress exposure, rather than individual vulnerability alone[104]

Migrants

- Unemployment, poverty, and low-quality employment increase the risk of psychological distress, with significantly greater effects for those with a migrant background - particularly women. Growing up in the host country does not fully remove this added vulnerability[64,97,105,106]
- For older migrants, unrecognised qualifications limit employment and create dependency on adult children, with consequences for mental health[63]
- Unstable or culturally unsuitable housing is linked to acculturative stress, while stable housing that allows familiar routines and cultural practices is protective[63]
- Limited host-country language skills make everyday tasks, social connection, and healthcare access harder - leading to isolation and depression. Relying on family members to interpret at medical appointments can compromise privacy and autonomy[63,64]
- Lower educational attainment is associated with greater psychological distress, though the relationship varies across ethnic groups[64,105]

Refugees

- Refugees report elevated rates of Post Traumatic Stress Disorder (PTSD), depression, and anxiety, though most do not meet clinical thresholds after resettlement[66,67]
- Employment, income, and job satisfaction are each associated with better mental health[67]
- Stable, community-based housing and access to basic needs (food, water, healthcare) are protective[67]. For children, the safety and quality of the resettlement setting matter significantly[66]
- Holding a permanent or protected visa is strongly linked to better mental health, providing the safety and certainty needed for recovery[67]
- Host-country language proficiency is consistently protective[67], while language difficulties are a key everyday stressor for children[66]
- Evidence for a direct link between education and refugee mental health was found to be insufficient[67]

LGBTQ+ populations

- LGBTQ+ young people living in the most rural areas reported significantly lower social support, which was in turn associated with higher depression, higher anxiety and lower wellbeing[107]
- Access to affirmative therapy, financial security, inclusive education policies and LGBTQ+ community resources were all linked to better outcomes[58]

Gypsy, Roma and Traveller communities

- Gypsy, Roma and Traveller communities experience significantly worse mental health than the general population, driven by socioeconomic deprivation, discrimination and barriers to care. Structural factors include issues with housing, education, employment and widespread discrimination, poor physical health and barriers to healthcare compound these difficulties[108]

People with intellectual disability

- Area-level deprivation and geographic remoteness was shown to interact with existing intellectual disability-related vulnerabilities to increase risk of mental illness[109,110]
- Within this population group, serious mental illness onset was specifically associated with living in outer regional, remote or very remote areas[109]

So what?

- Evidence from Theme 2 shows that socioeconomic and environmental conditions are fundamental determinants of mental health, operating as active drivers of risk and resilience rather than as background context.
- Economic hardship, poor housing, insecure employment and deprived neighbourhoods do not operate independently. They accumulate and reinforce one another, producing compound disadvantage that deepens over time and, in some cases, across generations.
- The evidence suggests that mental health outcomes are shaped not only by the presence of disadvantage, but by whether basic needs are met and people experience security and stability in their daily lives.
- These findings indicate that mental health outcomes cannot be understood solely at the individual level. Material and structural conditions influence both exposure to stressors and people's capacity to cope with them, affecting need, demand and trajectories across the life course.
- Addressing mental health effectively therefore requires attention to the social and economic contexts in which people live, alongside individual-level support, rather than approaches that treat mental distress as detached from housing, employment, income or access to basic resources.

Theme 3: Health behaviours

This theme examines how everyday health behaviours - including diet, physical activity, sleep, substance use, and screen time - influence mental health across different stages of life. It also considers how these patterns affect different population groups disproportionality. Rather than pointing to any single behaviour as decisive, the evidence highlights how context, culture, and the wider circumstances of people's lives shape the way these behaviours relate to mental health.

Children and young people

Diet and nutrition

- Skipping breakfast was associated with higher odds of anxiety and depression in adolescents; skipping three or more days per week increased the odds of depressive symptoms, and five or more days increased the risk of depressive mood[111]
- Irregular breakfast consumption was linked to co-occurring anxiety and depression, independent of other dietary behaviours such as energy drink consumption[111]
- Health-conscious or vegetarian diets at a young age were associated with increased risk of persistent high depression symptoms across adolescence and young adulthood[27]
- Eating breakfast in a stable, familiar environment - particularly with family - appeared protective against anxiety and depression[111]

Physical activity

- Inactive young people were more likely to experience depression and mental confusion and report anger and fatigue[112]
- Physical activity was shown to be a protective factor for adolescent mental health[31,38,41,83,112]
- Physically active young people living with obesity showed greater vigour than inactive peers living with overweight, supporting inclusive, non-stigmatising approaches to activity provision[112]

- However, while physical activity likely plays a helpful role in supporting adolescent mental health, it is not a silver bullet - its benefits may be modest and are unlikely to be enough on their own to address the broader mental health challenges young people face[21,41]

Alcohol, tobacco and vape use

- Tobacco, electronic cigarettes, vaping devices, and alcohol are identified as major commercial determinants of young people's mental health. Early exposure is associated with increased prevalence of anxiety, depression, and addictive behaviours[29,38]
- Maternal alcohol consumption during pregnancy was associated with a substantially increased risk of the child developing depression in adulthood, suggesting prenatal health behaviours may shape mental health trajectories decades later[74]

Sleep

- Sleep difficulties in early childhood are a significant behavioural risk factor for later mental health problems[22,38]
- Child sleeping difficulties remained a significant predictor of externalising symptoms (defined as behavioural difficulties like aggression, defiance, and hyperactivity that are directed outward and visible to others) at age four, even after accounting for other factors. Maternal sleep difficulties were also associated with children's externalising symptoms, likely through impaired parenting capacity, reinforcing the importance of a whole-family approach to sleep[22]
- Many young carers describe feeling tired and under pressure- the physical demands of caring on a child or young person combined with a lack of sleep can result in exhaustion[113,114]

Adults

Physical activity

- Adults with high physical activity levels were associated with reduced risk of depression and anxiety compared to adults with low physical activity levels[115]
- More minutes spent on sport or recreational physical activity corresponded to a lower probability of mental ill-health, highlighting physical activity as one of the most actionable protective factors[87]
- Even moderate or vigorous activity once per week was significantly associated with higher quality of life, and reduced sitting time was independently associated with improved wellbeing. Leisure activities - sport, walks, gardening, and social sports clubs- were most likely to enhance wellbeing[116]
- The steepest benefits came at lower activity volumes: the greatest gains were observed in moving from sedentary to moderately active, with diminishing returns at higher levels[115]
- People often started exercising for perceived physical benefits but maintained activity because of the mental health benefits, suggesting interventions should promote the immediate psychological gains of exercise[116]

Sleep

- Adults with healthy sleep patterns were roughly three times less likely to develop depression and twice less likely to develop anxiety[117]
- A U-shaped relationship between sleep duration and depression was identified: both short and long sleep durations, as well as fragmented sleep, were associated with increased

odds of depression. Six to eight hours of unfragmented sleep predicted the best outcomes[118]

- Good sleep habits could partly counteract both genetic predisposition to mental health problems and the effects of other unhealthy lifestyle factors[117]

Older adults

Physical activity

- Older people who did flexibility exercises one to four days a week were less likely to develop depression[103]

Smoking

- Smoking was consistently linked to higher stress and depression in older adults[103]
- People who had never smoked regularly had fewer depressive symptoms, though this association only held for those aged 65-74, suggesting smoking's impact on mental health may vary across stages of later life[53]

Screen time

- Television viewing was the screen activity most consistently linked to poorer mental health in older adults, particularly at six or more hours per day, while interactive digital tools (messaging apps, social networking) were associated with reduced loneliness[119]
- Older adults appeared less susceptible to problematic smartphone use than younger populations, suggesting greater self-regulation. The key is what older adults do on screen, not simply screen time[119]
- High digital isolation was associated with an increased risk of depression, following a dose–response pattern. Email isolation showed the strongest individual association[120]
- Counterintuitively, younger older adults (≤75 years), those with higher education, and those with fewer chronic diseases were more vulnerable to the mental health effects of digital isolation, possibly due to greater psychological reliance on digital connectivity[120]

Groups facing additional risk

Immigrants

- Relationship between health behaviours and mental health is shaped by racial and cultural context, and interventions need to account for how health behaviours interact with race, culture, and lived experience[105]

So what?

- Evidence from Theme 3 shows that everyday behaviours - including diet, physical activity, sleep and patterns of digital engagement- are associated with mental health outcomes across the life course.
- Physical activity, particularly among those who are least active, is linked to better mental health; healthy sleep patterns are associated with lower risk of depression and anxiety; and the *type* of screen use appears more relevant than total time spent. These relationships are generally modest in size and operate alongside wider social and material influences.
- No single behaviour acts as a decisive protective factor. The evidence indicates that behavioural influences on mental health are cumulative, context-dependent, and most relevant where multiple healthy patterns are sustained together and supported by stable living conditions.
- These findings highlight that behavioural factors should not be treated as stand-alone solutions to mental health need. Attention to behaviours such as activity, sleep and technology use is most appropriate where it forms part of a broader response that also

addresses the social, economic and environmental conditions shaping people's capacity to adopt and maintain healthier patterns.

Theme 4: Psychological factors

This theme explores how the way people think, feel about themselves, and cope with challenges shapes their mental health across the life course. It considers how these inner strengths and vulnerabilities play out differently at each life stage and for groups who may be particularly affected. It explores the psychological skills and qualities (such as self-belief, emotional coping and sense of identity) that sit behind how people experience and respond to the pressures they face.

Children and young people

Emotional regulation

- Emotional regulation refers to how a person manages and responds to their emotional experiences- the ability to cope with, adjust, and navigate feelings as they arise.
- Emotional regulation is a strong predictor of both mental health difficulties and wellbeing[70], but it sits within a broader system of interacting factors rather than above it[22,25]
- A child's temperament - particularly emotional reactivity and shyness- was shown to shape early risk, with more reactive or shy children at greater risk of anxiety and mood difficulties from as young as age four[22]
- Neuroticism (a trait describing how prone a person is to experiencing negative emotions like anxiety, worry, fear, anger, and sadness) is a major predictor of adolescent depression, alongside rumination (repetitive negative thinking) and negative self-reference bias (the tendency to process information about oneself through a negative lens), while wellbeing is driven by different factors such as perceived stress and attributional style (the pattern the brain tends to follow when making sense of why things happen to an individual- both good and bad) - suggesting that reducing depression and promoting wellbeing may require distinct approaches[83]
- These traits don't operate alone- they interact with parental mental health, family stress, and wider social circumstances to shape outcomes[22,25]
- Child sociability appeared to offer some protection[22]
- Early intervention to build emotional coping skills can shift outcomes, particularly where temperamental vulnerability is present[22]

Internal psychological resources

- Empathy was associated with slightly greater mental health difficulties, suggesting it can become a source of distress without adequate coping resources[70]
- Internal psychological strengths (including self-esteem, self-efficacy, and optimism) were shown to be protective against poor mental health outcomes, outperforming protective effects of external and social factors in children[31].
- Psychological strengths including resilience, self-efficacy, optimism, emotional intelligence, adaptability, and grit were associated with better coping and reduced depressive symptoms among UK university students, with self-compassion linked to help-seeking behaviour[38]
- Self-esteem was especially protective for children in the most deprived neighbourhoods[75,121]

Thinking skills and motivation

- Higher IQ at age eight and better attention control at age ten were each independently associated with reduced risk of chronic depressive trajectories across adolescence and young adulthood[27]
- Problem-solving, goals/aspirations, and prosocial behaviour (voluntary actions intended to benefit or help others) predicted subjective wellbeing, though with smaller effect sizes than emotional regulation[70]
- An enhanced reward response was identified as key protective factors for offspring of parents with depression[19]

Identity formation and navigation

- Identity formation (navigating pressures around gender, sexuality, culture, and race) was experienced as complex and high stakes by young people. Social media intensified these challenges. Marginalised groups faced significant identity-related pressures. All of which were shown to influence mental health outcomes[80]
- Threats to identity (including racial hostility and experiences undermining belonging) were among the strongest predictors of anxiety and depression[33,41]
- Peer relationships, victimisation, and exposure to marginalisation, all of which shape identity, predicted worse future mental health[21,68]
- Culturally and linguistically diverse adolescents began secondary school with higher symptom levels but showed a crossover pattern by Year 10, suggesting that the psychological experience of navigating a minority cultural identity shifts over time[71]

Adults

Internal psychological resources

- Negative self-appraisals - including low parenting confidence, low self-belief, and low self-esteem - were consistently linked to postpartum anxiety, with low maternal self-efficacy the single greatest predictor. Repetitive negative thinking, avoidance, and unhelpful coping strategies were also implicated[51]
- Self-esteem, self-efficacy, mindfulness, and self-compassion were the four most robust individual-level mediators shaping how much a person's mental health affects their overall wellbeing[122]
- Optimism strongly predicted wellbeing, and small, simple exercises - such as writing down three pleasurable things each day or briefly viewing images of wild nature - could meaningfully improve how people feel. Optimism can be developed through approaches such as CBT[116]
- Self-efficacy, psychological empowerment, and mindfulness were key protective factors for office-based workers post-pandemic. Personality traits were stronger predictors of burnout than the pandemic lockdown itself, reinforcing the centrality of internal psychological factors[99]
- The psychological resources people need depend on the type of adversity: in acute crises, cognitive reframing and rapid recovery matter most; under chronic adversity, social support and diverse coping strategies; in stable conditions, self-esteem and close relationship quality. Cognitive reframing was consistently helpful; emotion suppression was actively harmful[122]

Life satisfaction

- Higher life satisfaction showed a strong stepwise relationship with mental wellbeing - at each level of increased satisfaction, wellbeing improved[45,46]

Older adults

Subjective health perception

- How older adults felt about their own health (regardless of actual health) was one of the two most important factors supporting wellbeing advantage[101]

Lifelong learning

- Having the opportunity to learn new things was linked to better wellbeing among adults aged 80+, highlighted as an under-researched but potentially important area for the oldest age groups[101]

Appreciation of surroundings

- The ability to appreciate one's surroundings modestly but meaningfully contributed to feelings of purpose and engagement among adults aged 80+, reflecting psychological capacities - curiosity, openness, and present-moment awareness - that can be nurtured[101]

Groups facing additional risk

Sexual and gender minority young people

- Internalised homophobia (negative beliefs, attitudes, and feelings about homosexuality) showed consistent associations with depression, anxiety, and PTSD[56]
- Among gender minority young people, internalised transphobia (negative beliefs, attitudes, and feelings about being transgender) and shame was associated with anxiety, depression, and suicidal ideation[56,57]
- Emotion-oriented coping, emotion regulation deficits, anxious personality traits, and feelings of burdensomeness were associated with poorer outcomes. Notably, generic psychological coping skills appeared more important than identity-specific strategies[56]
- Concealment of sexual identity was associated with depression and social anxiety, though evidence was mixed. For gender minority populations, concealment was largely unrelated to mental health outcomes, suggesting its impact is context-dependent rather than universally detrimental[56,57]
- Positive coping skills, problem-solving, and self-efficacy were protective - associated with increased wellbeing and reduced depression, anxiety, self-injury, and suicidal ideation. Acceptance-based coping partially reduced the relationship between sexual orientation and depression[56,58]
- Sexual identity integration (defined as the developmental process of accepting, consolidating, and aligning one's sexual orientation) was protective against depression, but only when maintained at consistently high levels over twelve months. Pride in transgender/gender diverse identity was negatively associated with depression. Self-care, self-acceptance, and gender positivism were associated with increased wellbeing[56–58]
- Resilience, personal mastery, and perceived competence were consistently protective against depression and PTSD. Psychological resilience significantly moderated the association between everyday discrimination and both depression and suicidal ideation among gender minority populations [56–58]

- Help-seeking beliefs, spirituality, healthy activities, caring about school achievement, and effective conflict management were all associated with reduced mental health difficulties among LGBTIQ+ adolescents[58]

Refugees

- Cognitive coping strategies- particularly cognitive reappraisal, positive appraisal, and positive reframing - had strong evidence of association with good mental health. Self-efficacy, psychological resilience, and a sense of coherence were also consistently protective[67]

Migrants

- Fear of physiological decline, loss of independence, and feelings of burdensomeness were prominent psychological concerns. Dependence on adult children due to limited host-country knowledge led to loss of agency and self-esteem. The interplay between individual coping and structural barriers was a defining feature[63].
- Older unforced migrants drew on a range of psychological coping strategies including family/friend contact, social media to maintain homeland connections, community activities, religious coping, mindfulness, and reminiscing[63]

So what?

- Evidence from Theme 4 indicates that psychological processes- including how people regulate emotions, perceive themselves, and cope with stress - play an important role in shaping mental health outcomes across the life course.
- Internal psychological resources such as self-esteem, self-efficacy, emotional regulation and optimism are associated with better mental health outcomes and appear to mediate how individuals respond to adversity. However, their effects are context-dependent and closely linked to wider social, relational and material conditions.
- The evidence suggests that psychological factors do not operate in isolation, nor do they offset sustained structural disadvantage. Rather, they form part of a wider system through which risks and protective influences are experienced and translated into mental health outcomes.

Theme 5: Cross-cutting themes

This theme examines the cross-cutting factors that influence mental health across the life course but do not sit neatly within a single domain. It brings together evidence on how physical health conditions, environmental exposures, gender and deprivation each shape mental health risk and resilience. Importantly, these themes do not operate in isolation - they interact and overlap, meaning that people exposed to multiple factors often face compounded disadvantage. Understanding these connections is essential for developing responses that address the underlying drivers of mental health need, not just its symptoms.

Physical health conditions

Chronic conditions and functional impairment

- Chronic physical health conditions and suboptimal physical health are leading predictors of worse mental health[21,31]
- Chronic illness, disability and household dependency increase mental health risk for both the affected individual and their carers[46]
- Having two or more chronic diseases increases depression risk; pain shows a dose-response relationship with depressive symptoms[53]

- Sensory impairment (poor hearing or vision) and hospital stays in the previous 12 months are independent risk factors for depression in older adults[53]
- Having no functional limitations due to health is protective for mental health in older age[53,123]

Cardiovascular disease and metabolic risk

- Body Mass Index (BMI) is associated with increased risk of mental health difficulties, with risks elevated at both extremes of the weight spectrum[87,124]
- Patients with type 2 diabetes have nearly double the rate of diagnosed mental disorders; key risk factors include obesity, neuropathy, diabetes complications, and elevated C-reactive protein[50]
- Patients with acute coronary syndrome, heart failure and cardiac implantable devices are 2-4 times more likely to die by suicide, with highest risk in the first 3-12 months post-event[125]
- Coronary artery disease and myocardial infarction were associated with an increased risk of major depressive disorder and mania; heart failure was linked to bipolar disorder and schizophrenia; atrial fibrillation was linked to generalised anxiety disorder. The direction of the association was shown to run from cardiac disease to psychiatric outcome, not the reverse[126]

Preterm birth

- Babies born before 28 weeks gestation are more likely to develop major depression and anxiety disorders in adulthood. Extremely preterm children who also experience peer relationship difficulties and emotional regulation problems in early childhood (ages 2-4) are particularly likely to develop depression as adults. These risks remains after adjusting for socioeconomic background, confirming extreme prematurity as an independent physical health risk factor[74]
- Moderately preterm birth (29-36 weeks) does not carry the same elevated risk; the vulnerability is concentrated in extreme prematurity[74]
- Birth weight itself does not predict adult mental health; gestational age is the critical factor[74]

Environment

Climate change

- Climate change is already contributing to mental health and wellbeing impacts across the life course, with effects expected to intensify[127]
- Eco-anxiety is consistently associated with psychological distress, anxiety, depression and stress symptoms across age groups and nationalities[128]
- Acute climate hazards (flooding, heatwaves, wildfires, drought) and slower-onset changes increase rates of distress, anxiety, depression, PTSD, sleep problems, substance misuse and suicide risk[129]
- Flooding carries particularly strong evidence of long-term mental health consequences, with symptoms often persisting for years[129]
- Displacement, service disruption, income loss, insurance difficulties, property damage and erosion of community cohesion all contribute to poorer mental health outcomes[129]
- Groups facing additional risk include people in deprived areas, children and young people, farmers, emergency responders, and those with pre-existing conditions[129]

- Clinical interventions (Cognitive Behavioural Therapy- CBT, trauma-focused therapies, Acceptance and Commitment Therapy (ACT)) and digital interventions can reduce symptoms following climate-related distress[129]
- Social support, community networks and effective recovery processes are protective buffers[129]

Disasters and pandemics

- Post-traumatic stress symptoms gradually decline after disasters, but depression and anxiety remain chronically elevated for years, requiring sustained intervention[130]
- Children and adolescents report significantly higher rates of depression and anxiety than adults at all post-disaster time points[130]
- Ethnic minority status, pre-existing psychiatric illness, direct disaster exposure, injury, property loss and displacement are recurring risk factors[130]
- Social support, community engagement, higher education, employment and positive coping strategies are protective[130]

Pollution

- **Noise pollution:** Exposure to road, rail and air traffic noise is associated with modestly elevated risk of psychiatric disorders. Noise annoyance predicts depression, anxiety and sleep disturbance over five years[131]
- **Air pollution:** PM2.5 and NO_2 are linked to depression, anxiety, dementia, and in children, psychosis and suicide-related outcomes[132]
- Beyond observational links, Mendelian randomisation studies- which uses random genetic variation to strengthen causal inference- provide evidence of genetic causal links between PM2.5 and depression/anxiety, and between NO_2 and schizophrenia, mediated partly through changes in brain structure[133]
- **Light at night:** Artificial light at night is associated with depressive symptoms, mood and anxiety disorders, manic relapses in bipolar disorder and suicidal behaviours, primarily through disruption of circadian rhythms[134]

Gender differences

This section uses 'gender' as its primary framing term. While a number of the included studies measured biological sex (male or female) as their variable rather than gender, the overarching finding of this review is that the observed disparities between men and women are predominantly shaped by social and structural conditions (employment, income, caregiving roles, discrimination, and social expectations) rather than by biological sex alone. Where specific findings relate to biological mechanisms, such as hormonal pathways across the reproductive lifespan, this is noted explicitly.

Internalising and externalising symptoms

- Females consistently show higher rates of internalising difficulties (defined as emotional difficulties like anxiety and sadness that are felt inwardly rather than shown outwardly), while males present more with externalising difficulties (defined as behavioural difficulties like aggression, defiance, and hyperactivity that are directed outward and visible to others)[21,22,28,31,41,47,53,60,67,70–74,87,103,112]
- This pattern appears across childhood[22,72], adolescence [21,28,31,41,70,71,73,112], adulthood[47,74,87,99] and older age[53,103]
- The divergence is replicated across specific population groups including institutionalised young people[60], refugees[67] and people with type 2 diabetes[50].

Gender disparities

- The mental wellbeing gap between men and women is largely driven by women's disproportionate exposure to socioeconomic disadvantage, gender-based violence and unequal caregiving burdens[46,47,97,98,135,136]
- Gendered housework inequality is associated with somatic symptoms (defined as physical complaints like headaches, stomach-aches, or fatigue that often arise from or are worsened by emotional distress rather than a clear medical cause) in women and psychological distress in both partners[47]
- Female caregivers of dependent adults have nearly double the odds of distress compared with males[89]
- Low social support during pregnancy and postpartum consistently predicts depression and anxiety, with role strain persisting up to eight years after childbirth[44,136]
- Oestrogen plays a role in mood regulation, with heightened vulnerability at menarche, the premenstrual period, the puerperium (period after childbirth during which the birthing persons body recovers and returns to its pre-pregnancy state) and menopause[135]
- Women in the perimenopausal stage are around 40% more likely to experience depressive symptoms; many report increased anxiety, irritability and reduced confidence[137,138]
- Physical symptoms of menopause (sleep disruption, hot flushes, fatigue) further affect emotional wellbeing; awareness of menopause-related mental health difficulties remains limited[137,138]
- The perinatal period is a time of elevated risk for depression and anxiety, with implications for maternal wellbeing and child development[139]
- Women are generally more likely to seek help, maintain social networks and engage with health services, supporting earlier identification[139]
- Gender equality is itself protective: women with non-traditional gender ideologies had fewer anxiety symptoms a decade later; men in non-traditional childcare roles showed fewer depressive symptoms[47]
- Leisure time, disproportionately limited for women with caregiving responsibilities, is independently protective against common mental disorders[135]

Gender and intersecting disadvantage

- First-generation non-EU migrant women in low-quality employment show the highest risk of common mental disorders of any group studied[64,97]
- Within Roma and Traveller communities, enforced gender roles, early marriage and domestic violence contribute to women's worse outcomes[108]
- Among older migrants, gender shapes the migration experience: women may benefit from continuity of domestic roles, while men migrating without partners are more vulnerable to purposelessness[63]
- Among people living with HIV, women show significantly higher odds of anxiety; those with a transgender identity show more than double the odds[140]
- Among people with intellectual disabilities, male sex is specifically associated with serious mental illness onset[39,109]
- Community empowerment interventions benefit men and women through different pathways: collective control for men, social connection for women[141]
- Unhealthy health behaviour clustering is disproportionately concentrated among younger, less educated men[142]

The renewed Women's Health Strategy for England

- Around 1 in 4 women have a common mental health condition compared to 1 in 7 men, and women are disproportionately affected by eating disorders, self-harm, PTSD, and maternal suicide[143–145]
- The Renewed Women's Health Strategy for England frames these disparities as products of systemic under-recognition, medical misogyny, and a healthcare model that fails to listen - 84% of women reported not being listened to by healthcare professionals[143,146]
- Mental health risks are elevated among young women, lesbian, gay and bisexual women, women from deprived communities, Black and Asian women, women experiencing rough sleeping, survivors of partner abuse, and those with hormonally linked conditions[143]
- Proposed actions include expanding NHS Talking Therapies and community mental health provision, accelerating Mental Health Support Teams in schools, investing in Early Support Hubs and Family Hubs, embedding routine maternal mental health assessment into all health visiting reviews, and commissioning research into how reproductive transitions affect mental health[143]
- The strategy argues that structural drivers - paternalistic care, dismissal of symptoms, fragmented services, and failure to recognise mental health as embedded in reproductive and ageing pathways - must be addressed to enable earlier intervention and reduce crisis-driven care[143]

Men's Health: A Strategic Vision for England

- Mental ill health is rising among men, suicide remains the leading cause of death for men under 50, and men are less likely to seek help - often due to stigma and gendered expectations around self-reliance. Substance misuse, alcohol use, and risk-taking behaviours are important overlapping contributors[147]
- Mental health risks are elevated among men in deprived and coastal areas, South Asian men, Gypsy, Roma and Traveller men, LGBTQ+ men, autistic men and those with SEND, men experiencing homelessness, and men in the criminal justice system[147]
- Proposed actions include expanding access through neighbourhood health centres and digital routes, using trusted settings like workplaces and sports clubs to engage men, developing a Premier League partnership on suicide prevention, improving health worker training to recognise male distress, and investing in community-based men's health programmes[147]
- The strategy argues that social norms around masculinity - self-reliance, reluctance to discuss emotions, and avoidance of services - must be addressed to enable earlier intervention and reduce crisis-driven care[147]

Deprivation

Deprivation and mental health

- Deprivation is associated with higher prevalence of common and severe mental health conditions, increased exposure to adversity and trauma, and reduced access to timely support[148–150]
- Socioeconomic disadvantage interacts with unemployment, poor housing, physical ill health and social isolation to contribute to mental health inequalities throughout life[151]
- The relationship is bidirectional: deprivation increases the risk of mental ill health, while mental ill health contributes to further disadvantage through effects on employment, income and housing[152]

So what?

- Evidence from Theme 5 shows that mental health is not shaped by single factors in isolation. Physical health conditions, environmental exposures, gender and deprivation each carry independent risks, and these operate across the life course rather than within discrete stages of life.
- The impact of these factors is most pronounced where they intersect. Overlapping exposures - such as deprivation, chronic illness and caregiving responsibility - combine to produce compounded disadvantage that is greater than the sum of individual risks. These dynamics recur across multiple themes in the evidence and are not confined to particular services or age groups.
- The findings indicate that mental health outcomes cannot be fully understood through single-issue lenses. Presentations such as distress following physical illness, anxiety after environmental disruption, or delayed help-seeking shaped by gendered expectations reflect interacting structural, social and health-related factors rather than isolated causes.
- This evidence highlights the importance of approaches that recognise compounding disadvantage and cross-cutting drivers of mental health need. Addressing mental health effectively may require coordination across traditionally separate domains, including physical health, environment, social conditions and inequality, rather than responses focused solely on individual symptoms or behaviours.

Conclusion

Overall, this rapid review set out to identify what the current evidence tells us about the risk and protective factors that shape mental health across the lifespan. Five clear messages emerge.

1. Relationships matter. From the earliest parent-child bond through to social connections in later life, the quality of people's relationships is one of the most consistent influences on mental health - and one of the most amenable to support.
2. Mental health is rooted in material conditions. Poverty, poor housing, insecure work, and deprived neighbourhoods do not simply sit alongside mental health difficulties, they actively drive them. Addressing someone's practical circumstances is not a precursor to mental health support; it is part of it.
3. Everyday behaviours make a meaningful difference. Regular physical activity, healthy sleep, and mindful use of technology each contribute to better mental health. These are areas where even modest supported changes can produce real benefits.
4. People's inner resources shape how they respond to adversity. Self-esteem, emotional regulation, optimism, and effective coping skills act as a buffer against hardship at every stage of life and importantly, these capacities can be built and strengthened.
5. Risks rarely travel alone. Physical illness, environmental exposure, gender inequality, and deprivation interact and compound one another, meaning that those facing multiple disadvantages carry a burden far greater than any single risk factor would suggest.

Running through all of these findings is a consistent thread: the factors that harm mental health are largely the same factors that drive wider inequality, and they accumulate across the life course. This may have direct implications for Suffolk's ageing population, where the long-term effects of earlier disadvantage will increasingly shape demand for support in later years.

For practitioners, commissioners, and policymakers, the message is both challenging and hopeful. Challenging, because it calls for responses that reach beyond individual treatment

into the social, economic, and environmental conditions in which people live. Hopeful, because at every life stage, modifiable protective factors exist - in relationships, in communities, in services, and in people themselves - that can be actively strengthened. The evidence consistently shows that well-timed, well-targeted support can interrupt cycles of disadvantage and build resilience, even in the face of significant adversity.

Cross cutting causes and risk factors

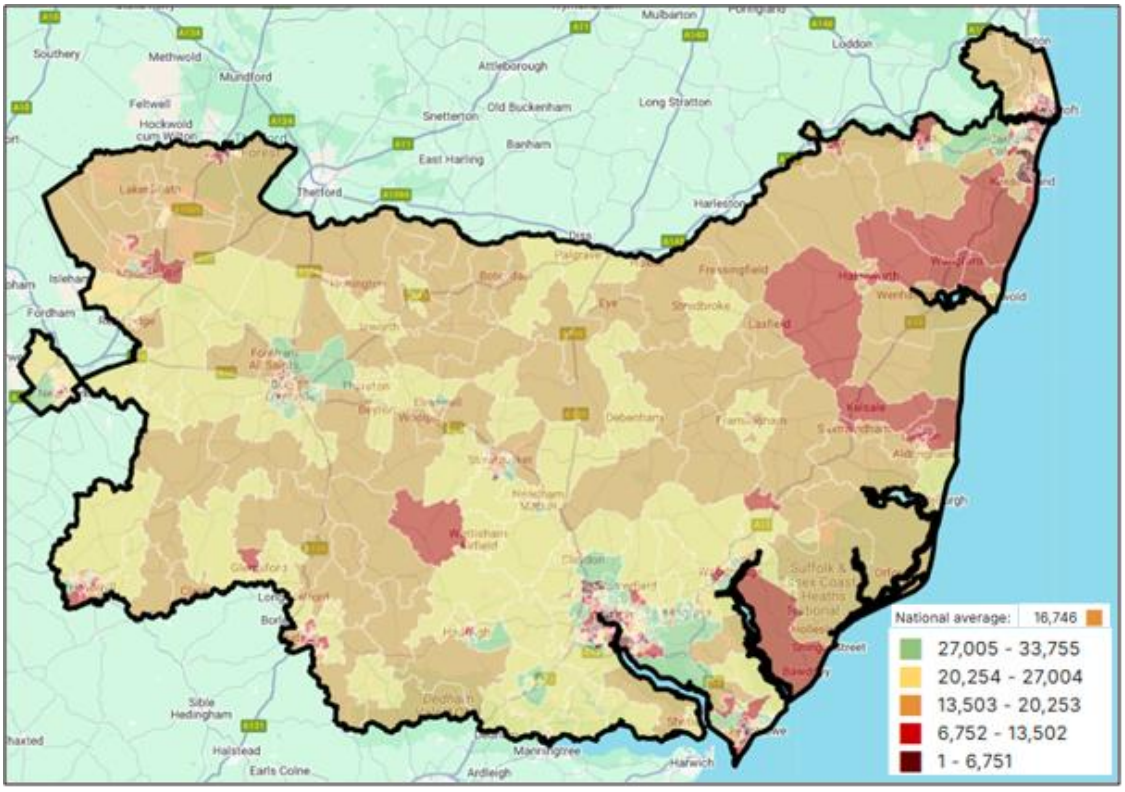
This section brings together a small number of cross-cutting causes and risk factors that influence mental health outcomes across the life course and cut across multiple population groups. These themes are highlighted here because they have not been explored in detail elsewhere in the assessment, with age-specific impacts considered in following sections.

Socio-economic deprivation

Evidence in the full rapid literature review emphasises a strong link between deprivation and poorer mental health. People living in more deprived areas experience higher rates of both common and severe mental health conditions, greater exposure to adversity, and more barriers to accessing timely support [148–150]. This relationship runs in both directions: deprivation increases mental health risk, and poor mental health can deepen [152].

Suffolk is less deprived than England on average, ranking in just outside the top third of upper-tier local authorities nationally in the 2025 Indices of Multiple Deprivation (IMD). However, this overall position masks significant inequalities within Suffolk. Around 5% of Suffolk's Lower-layer Super Output Areas (LSOAs) are within the most deprived 10% across England (shown in figure 1), highlighting the presence of concentrated areas of deprivation alongside more affluent areas. These inequalities are important in understanding patterns of mental health need that are not apparent from county-level averages alone.

Figure 1. Index of Multiple Deprivation 2025 (IMD) Rank (1= most deprived, 33,755= least deprived), Suffolk Lower Layer Super Output Areas (LSOAs)



Source: Local Insight, Ministry of Housing, Communities and Local Government, 2025

In Suffolk, this highlights that mental health need is not evenly distributed across the population. While county level indicators suggest favourable outcomes compared to the England average, targeted and place-based approaches are necessary to address the burden of mental ill health experienced by people living in more deprived areas.

IoD 2025 Mental Health Indicator

The Indices of Deprivation (IoD) 2025 Mental Health Indicator provides a measure of levels of mental ill health across smaller geographic areas in Suffolk. This indicator combines four data sources: suicide mortality, hospital admissions for mental health conditions, antidepressant prescribing rates, and incapacity benefits for mental health reasons. This creates a modelled estimate of the prevalence of mood (affective) and stress-related disorders in the local population. While no single data source provides a complete picture of mental health need, these four components together capture a substantial proportion of people experiencing common mental health disorders.

The map reveals considerable geographic variation in mental health need across Suffolk's 539 Lower Layer Super Output Areas (LSOAs) in 2025. The indicator scores range from -2.18 to 2.58, with higher scores indicating worse mental health outcomes and a mean score of approximately -0.28 across the county. Areas shaded in darker red (scores of 1.24-3.02) represent the most affected communities, while areas in green (scores of -2.55 to -1.04) indicate relatively better mental health. Approximately 15-20% of Suffolk's LSOAs show scores above 0.48, indicating areas of elevated mental health need.

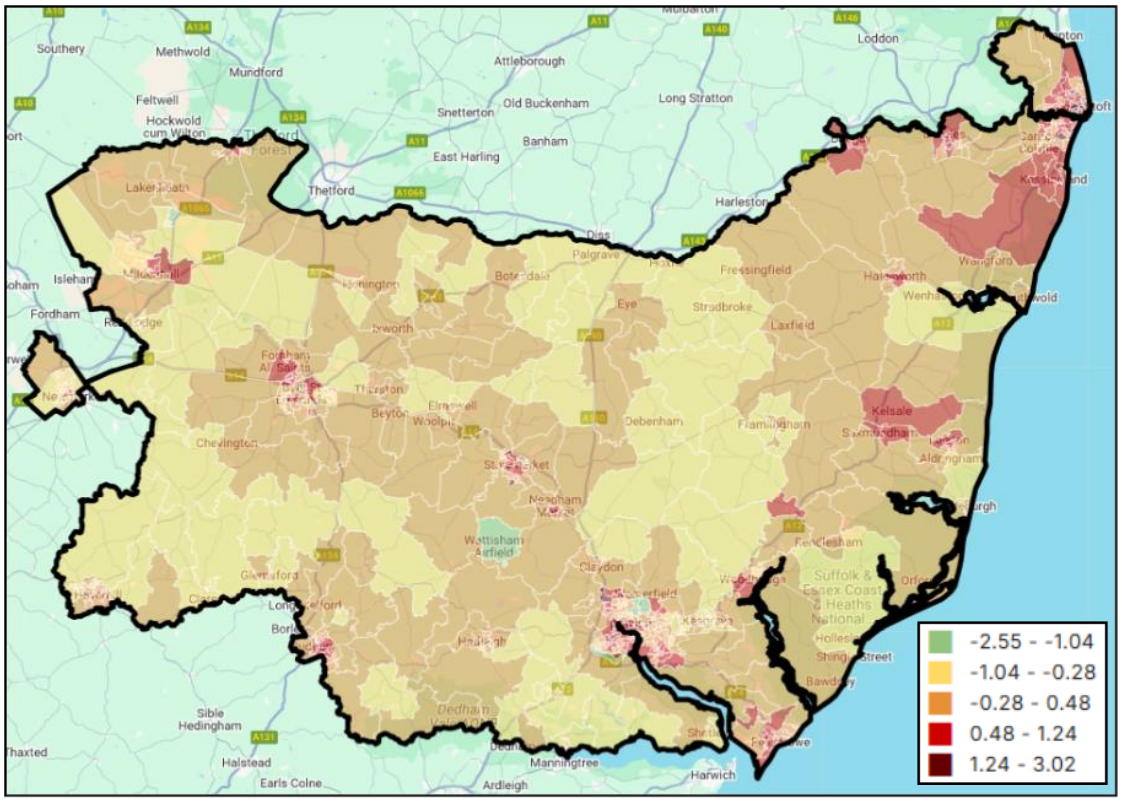
Several distinct patterns emerge from the data across the county:

- **Coastal communities:** A concentration of high mental health need appears along Suffolk's coastal areas, particularly around Lowestoft and Felixstowe. Lowestoft contains some of the highest-scoring LSOAs in the county for mental health need, including the following LSOAs: Lowestoft, Kirkley & Pakefield (2.58), Lowestoft, Harbour & Normanston (2.43), and Lowestoft Pakefield (2.32). Similarly, coastal Felixstowe areas had elevated scores, with the following LSOAs: Felixstowe South East scoring 1.89 and Felixstowe Walton at 1.62.
- **Urban centres:** Ipswich contains several LSOAs with high mental health indicator scores, particularly in the central and eastern parts of the town. Notable examples include Ipswich Central 007C (2.34), Ipswich 011B (Holywells) (2.11), Ipswich 016D (Gainsborough, Greenwich & Orwell) (2.00), and Ipswich 013A (Belstead Hills) (1.95). Other urban areas also showed higher need, including parts of Haverhill such as Haverhill South (2.11) and Haverhill East (1.76), and Newmarket areas including Newmarket East (1.78). This pattern is consistent with the deprivation gradients observed in other mental health indicators.
- **Rural-urban divide:** There is a clear gradient between urban and rural areas, with more rural communities in western and central Suffolk generally experiencing better mental health outcomes. LSOAs with the lowest scores (below -1.5) are predominantly found in affluent rural villages and market towns in West Suffolk, rural communities in Mid Suffolk, and villages in East Suffolk. Examples of areas with particularly low scores include Kedington & Hundon (-2.18), Clare, Cavendish & Glemsford (-2.01), and Thurston & Hessett (-1.98).
- **West Suffolk:** The western part of the county, including areas around Bury St Edmunds, predominantly show yellow to green shading, demonstrating comparatively lower levels of mental health need. This includes areas such as Bury St Edmunds North East (-1.89),

Pakenham, Woolpit & Elmswell (-1.82), and numerous rural village LSOAs with scores below -1.0.

This geographic variation in mental health need reflects the complex relationship between socioeconomic deprivation, community characteristics, access to services, and local risk factors. The concentration of relatively poorer mental health in coastal communities is particularly notable and may reflect factors including economic decline, social isolation, ageing populations with limited local opportunities for younger residents, and reduced access to employment and services. The data shows that 8 of the 10 highest-scoring LSOAs in Suffolk are in coastal locations, with 5 in Lowestoft alone.

Figure 2. Indices of Deprivation 2025: Mental health indicator, Suffolk Lower Layer Super Output Areas (LSOAs)



Source: Local Insight (2025)

Taken together, the deprivation profile and the IoD 2025 mental health indicator demonstrate that mental health need in Suffolk is unevenly distributed and closely correlated with socioeconomic inequality. While Suffolk performs relatively well on many headline indicators compared to England, this masks substantial unmet need in specific communities and places

This has important implications for planning and commissioning, as universal approaches alone are unlikely to reduce inequalities in mental health outcomes. Targeted, place-based strategies are needed to address the higher burden of mental ill health in deprived and coastal communities, improve access to earlier support, and reduce the risk of more severe and enduring mental illness. In addition, addressing the wider social determinants of mental health, including poverty, housing, employment, and community wellbeing, will be essential to narrowing inequalities and improving population mental health outcomes in Suffolk.

Gender differences

The rapid literature review highlighted that gender shapes how mental distress is experienced and expressed throughout life. Women tend to show higher rates of depression and anxiety, while men are more likely to present with substance misuse and behavioural difficulties. These differences are largely driven by social conditions - including income inequality, caregiving burdens, exposure to violence and workplace factors- rather than biology alone, though hormonal changes during the perinatal period and menopause also play a role.

The rapid literature review also highlighted recent national policy attention on gender and mental health through both the Men's health strategy (2025) and the Women's Health Strategy for England (2026). The Men's Health Strategy identified mental ill health as a major national concern, noting that suicide remains the leading cause of death for men under 50 and that men are less likely to seek help due to stigma and gendered expectations. Substance misuse, alcohol use and risk-taking behaviours were identified as important overlapping contributors to poor mental health among men[153].

Similarly, areas in Suffolk, such as Lakenheath, Mildenhall, Rendlesham, Ipswich Central and Lowestoft Harbour, have a majority male population linked to the armed forces, ports, and transient jobs. Men here face higher rates of early mortality from issues like cardiovascular disease and are less likely to seek early mental health support, leading to poorer outcomes. These trends highlight the need for targeted local prevention strategies that consider gender, employment, and health risks.

The Women's Health Strategy similarly recognised that women and girls experience mental health differently across the life course. Women are more likely to experience common mental health conditions, eating disorders, post-traumatic stress disorder, self-harm and suicide attempts, while factors such as domestic abuse, caregiving responsibilities, reproductive health, menopause and socioeconomic inequality can increase risk and affect access to support. The strategy also highlighted the importance of reducing inequalities in women's health outcomes, particularly for women from ethnic minority and deprived communities[154].

Climate change and mental health

Climate change is already affecting mental health in Suffolk and beyond. The rapid review of evidence emphasises that extreme weather events like flooding and heatwaves, as well as longer-term environmental shifts, are linked to increased anxiety, depression, post-traumatic stress and sleep problems. Worry about climate change itself (sometimes called eco-anxiety) is a growing concern, particularly among younger people. Those living in more deprived areas, people with existing health conditions, and workers in land-based or emergency roles face higher risks.

In Suffolk, climate risks are expected to worsen, with average temperatures projected to rise by 2.97°C by 2070; the UK has already seen a 1.24°C increase in the past decade. More frequent heatwaves and extreme weather will heighten mental health concerns, especially among vulnerable groups, highlighting the need for coordinated climate and mental health strategies.

Overall, climate change and mental health interact as overlapping public health challenges, with implications for health services, emergency planning, social care and community resilience. Anticipating and addressing these impacts is essential for safeguarding population mental health in Suffolk.

What do the statistics show?

Children and young people's mental health in Suffolk

1. **Mental health need among children and young people is high and increasing**, with growing numbers experiencing anxiety, depression and emotional distress, particularly during adolescence

The proportion of school pupils with social, emotional and mental health needs in Suffolk has more than doubled from 1.8% in 2015/16 to 3.8% in 2024/25; following national trends seen between the APMS between 2017 to 2023

2. **Demand for mental health support has risen sharply**, contributing to increased referrals and longer waiting times for specialist services, indicating unmet need and pressure across the system

For Suffolk's children and young people, new referrals to secondary mental health services per 100,000 have more than doubled between 2017/18 to 2022/23

3. **Inequalities emerge early**, with higher levels of mental health need among children and young people living in more deprived areas, and among those experiencing adverse childhood experiences, neurodiversity or wider social disadvantage

Attended contacts with community and outpatient mental health services per 100,000 for Suffolk's young people aged under 18 years of age were statistically significantly highest in the most deprived quintile, and more than 40% higher than the rate for the least deprived quintile in 2022/23

4. **Adolescence is a critical period**, with rising levels of emotional distress and self-harm, particularly among teenage girls, underlining the importance of early intervention and prevention

Attended contacts with community and outpatient mental health services per 100,000 for females under 18 years of age in Suffolk was almost double the rate for males under 18 years of age in 2022/23

5. **Schools, families and community settings play a vital role** in promoting resilience, identifying emerging need and providing early support alongside specialist services

The importance of children and young people's mental health is underpinned by evidence that most mental health conditions originate in childhood and adolescence. The Five-Year Forward View for Mental Health (2016) highlighted that half of all lifetime mental health conditions emerge by age 14, rising to 75% by age 24[18,155]. More recent meta-analysis of 192 epidemiological studies worldwide found slightly lower but still substantial percentages, confirming that the majority of mental illness is established by the mid-20s[156]. This evidence emphasises the window of opportunity for early intervention during childhood and adolescence, when timely support can prevent the development of more severe and persistent mental ill health in adulthood.

The impact of untreated child and adolescent mental ill health extends beyond the individual and their family. Children and young people with mental health conditions are seven times more likely to miss more than 15 days of school over a term, and this persistent absenteeism reduces educational attainment with long-term consequences for life chances and exam outcomes[157]. Young adults aged 16-25 with mental health conditions are nearly five times more likely to be economically inactive compared to their peers[157].

Across England, demand for children and young people's mental health services has increased dramatically, with a 152% increase in referrals between June 2019 and June 2025. Despite efforts to reduce waiting times, 320,000 children and young people were waiting for services at the end of March 2024, with the longest 10% of waits being approximately two and a half years for first contact[157].

Lived experience insight: Children and young people

- Young people emphasise the importance of accessible support in schools and communities
- Trusted adults who listen and provide early support are highly valued
- Experiences of anxiety and emotional distress are common in everyday settings such as school and college

"What would help us most is getting a school therapist – someone that just listens."

These findings reinforce the importance of early intervention and accessible support outside specialist services.

Source: Suffolk lived experience engagement (Healthwatch Suffolk, Suffolk User Forum and partners).

National data

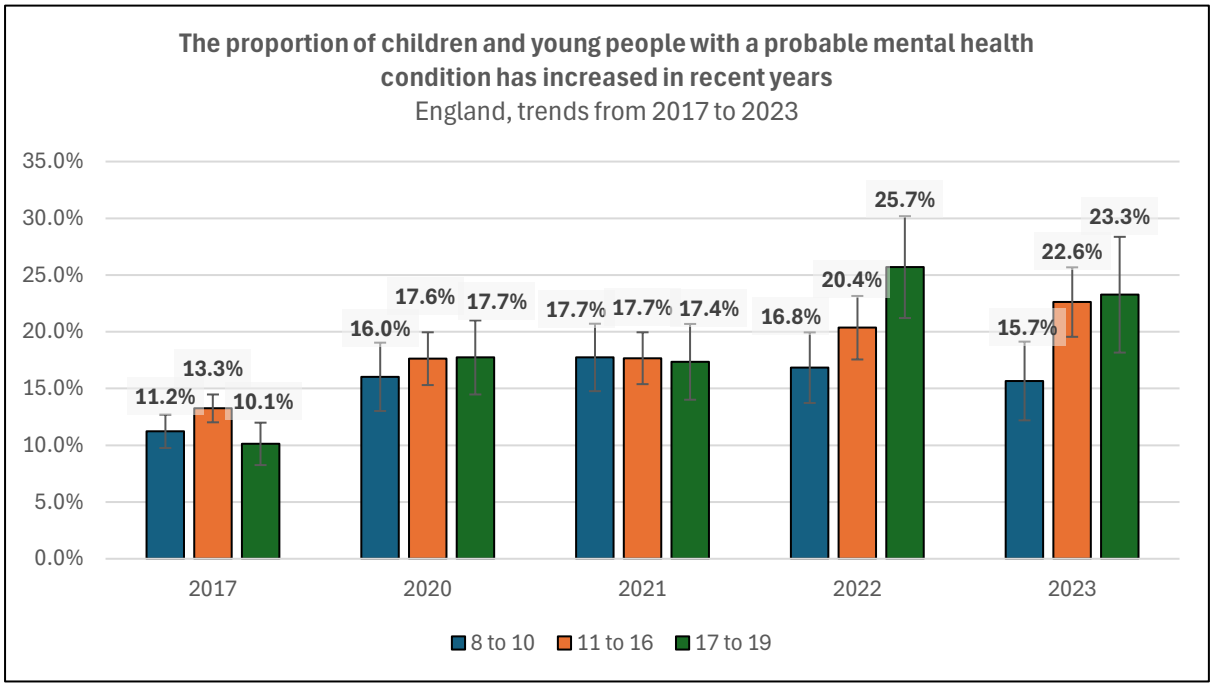
National surveys of children and young people's mental health show substantial increases in probable mental disorders in recent years. The NHS survey of children and young people's mental health, first conducted in 2017 with follow-ups in 2020, 2021, 2022, and 2023, provides insight into the scale and distribution of mental health need among children and young people across England[158].

Rising prevalence

The proportion of children aged 8 to 16 with a probable mental disorder increased from 12.5% in 2017 to 20.3% in 2023. The largest rise occurred among 17 to 19-year-olds, where rates increased from 10.1% in 2017 to 17.7% in 2020, then increased further to 25.7% in 2022 before

decreasing marginally to 23.3% in 2023. Increases were also seen across all age groups between 2017 and 2020, coinciding with the Covid-19 pandemic. While rates among 11 to 16-year-olds and 17 to 19-year-olds remain higher in 2023 compared to pre-pandemic levels, there was no difference in rates among 8 to 10-year-olds between 2017 and 2023.

Figure 3. Proportion of children and young people with a probable mental health condition in England, trend from 2017 to 2023

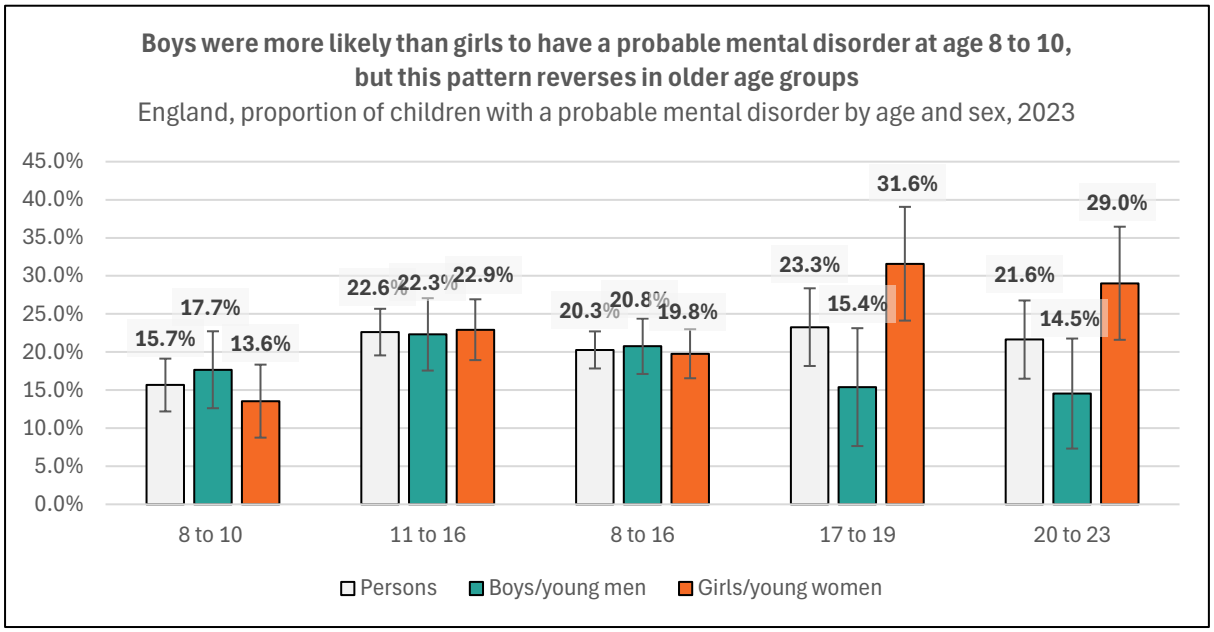


Source: NHS Digital, Children and Young People's Mental Health in England 2023, Table 1.2

Sex differences

Mental health patterns differ by age and sex. Among younger children aged 8 to 10, boys were more likely than girls to have a probable mental disorder in 2023 (17.7% compared with 13.6%). This pattern reversed in older age groups, with girls aged 17 to 19 substantially more likely (39.1%) to have a probable mental disorder than boys (23.1%). This sex difference among older teenagers is particularly pronounced and contrasts with the pattern seen in younger children.

Figure 4. Proportion of children and young people with a probable mental health condition in England, by age and sex, 2023



Source: NHS Digital, Children and Young People's Mental Health in England 2023, Table 1.2

Percentage of looked after children whose emotional wellbeing is a cause for concern

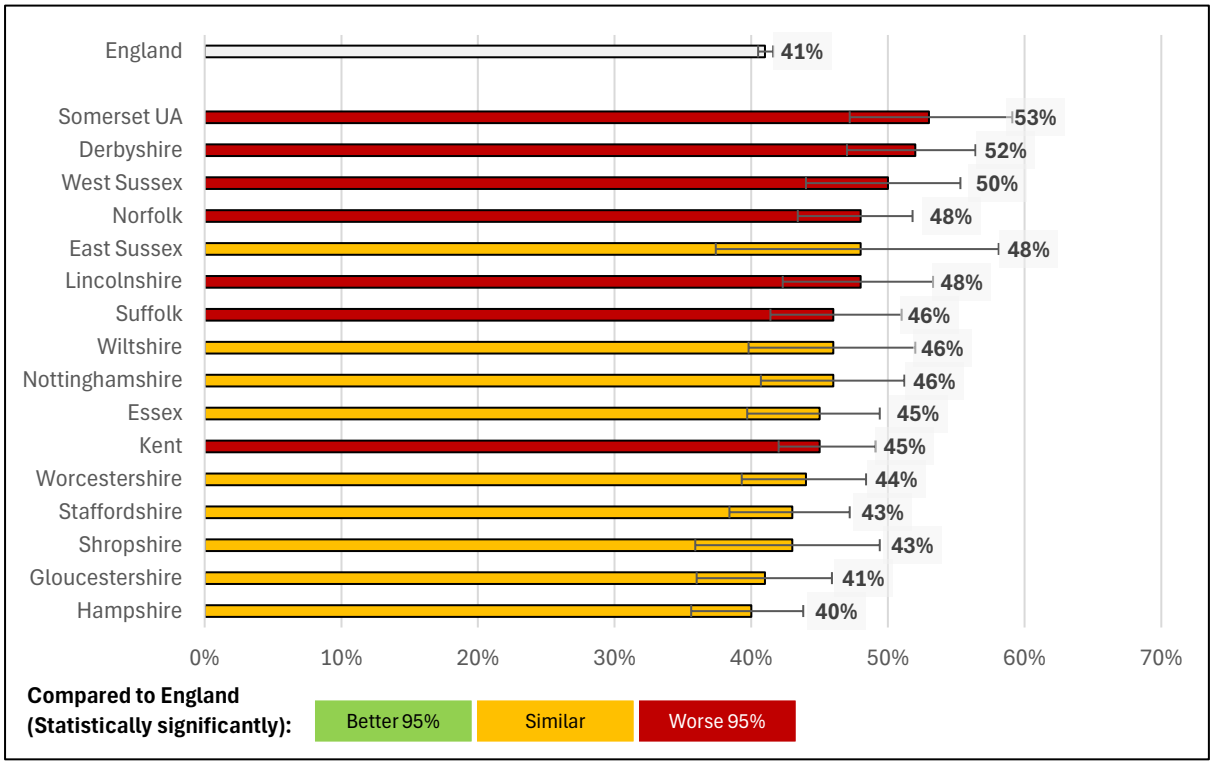
Looked after children (also known as children in care) are among the most vulnerable groups for mental ill health, having often experienced trauma, abuse, neglect, or family breakdown before entering care. This indicator measures the proportion of children in care aged 5 to 16 who have been in care for at least 12 months and have a Strengths and Difficulties Questionnaire (SDQ) score of 17 or over, indicating emotional wellbeing concerns.

In 2023/24, 46.0% of children in care in Suffolk (191 children) had emotional wellbeing concerns based on SDQ scores, placing Suffolk statistically significantly above the England average of 41.0%. More recent internal Suffolk data for 2024/25 indicates a reduction to 42.0% (170 children) with SDQ scores causing concern. While this figure is not yet published on Fingertips, it suggests a potential improvement in emotional wellbeing outcomes compared with the previous year. The average SDQ score has remained stable at 15, consistent with recent years.

The highest proportions of children in care with emotional wellbeing concerns across Suffolk's NHS peers were in Somerset (53%), Derbyshire (52%), and West Sussex (50%). The lowest proportions were in Hampshire (40%), Gloucestershire (41%), and Staffordshire and Shropshire (both 43%).

The range across peer areas was substantial from 40% to 53%; indicating considerable variation in either the emotional wellbeing of children in care or potentially differences in diagnosis across areas.

Figure 5. Percentage of looked after children (children in care) whose emotional wellbeing is a cause for concern, Suffolk and NHS England peers, 2023/24



Source: Office for Health Improvement and Disparities (2025)

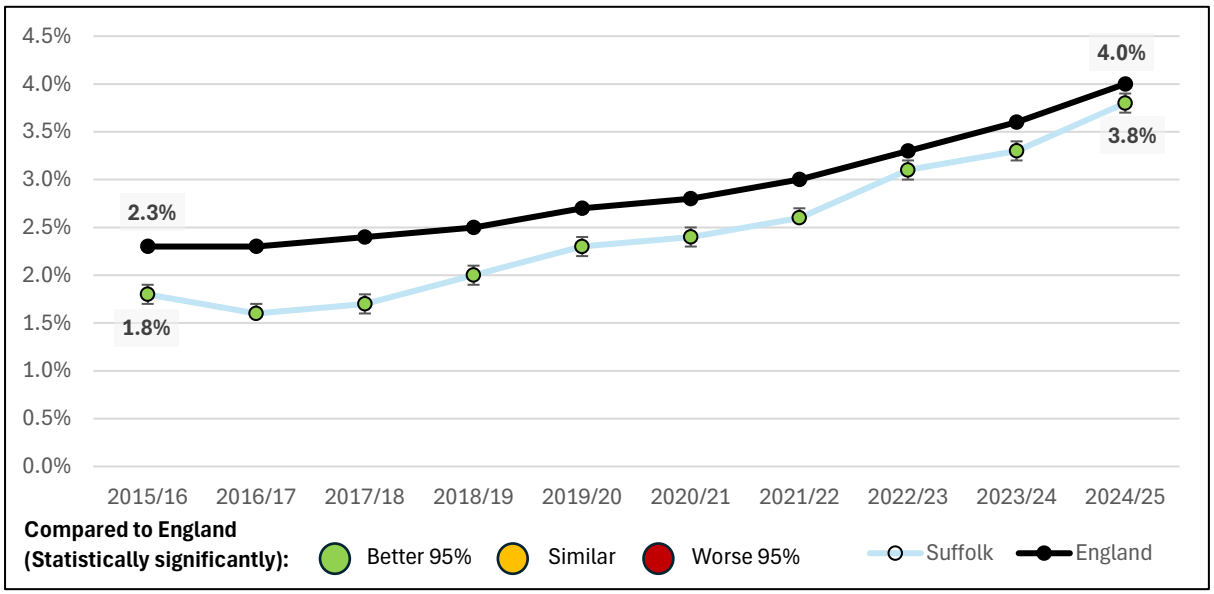
School pupils with social, emotional and mental health needs

Children with learning or physical disabilities have an increased risk of developing mental ill health compared to the general population[159]. This indicator measures the number of school children with Special Educational Needs (SEN) who are identified as having social, emotional and mental health (SEMH) as their primary type of need, expressed as a percentage of all school pupils.

Suffolk has experienced a sustained increase in the proportion of school pupils with SEMH needs over the past decade. The percentage more than doubled from 1.8% in 2015/16 (1,825 pupils) to 3.8% in 2024/25 (3,899 pupils). The rise has been particularly steep since 2019/20, with the rate increasing from 2.3% to 3.8% over the previous five years.

This upward trend mirrors the national pattern, with England's rate increasing from 2.3% in 2015/16 to 4.0% in 2024/25. Throughout this period, Suffolk has consistently had statistically significantly lower rates than the England average, though the gap has narrowed from 0.5 percentage points in 2015/16 to 0.2 percentage points in 2024/25. Every area nationally, including all of Suffolk's peer authorities, has experienced statistically significant increases over the previous five years, indicating this is a widespread national trend rather than a local trend.

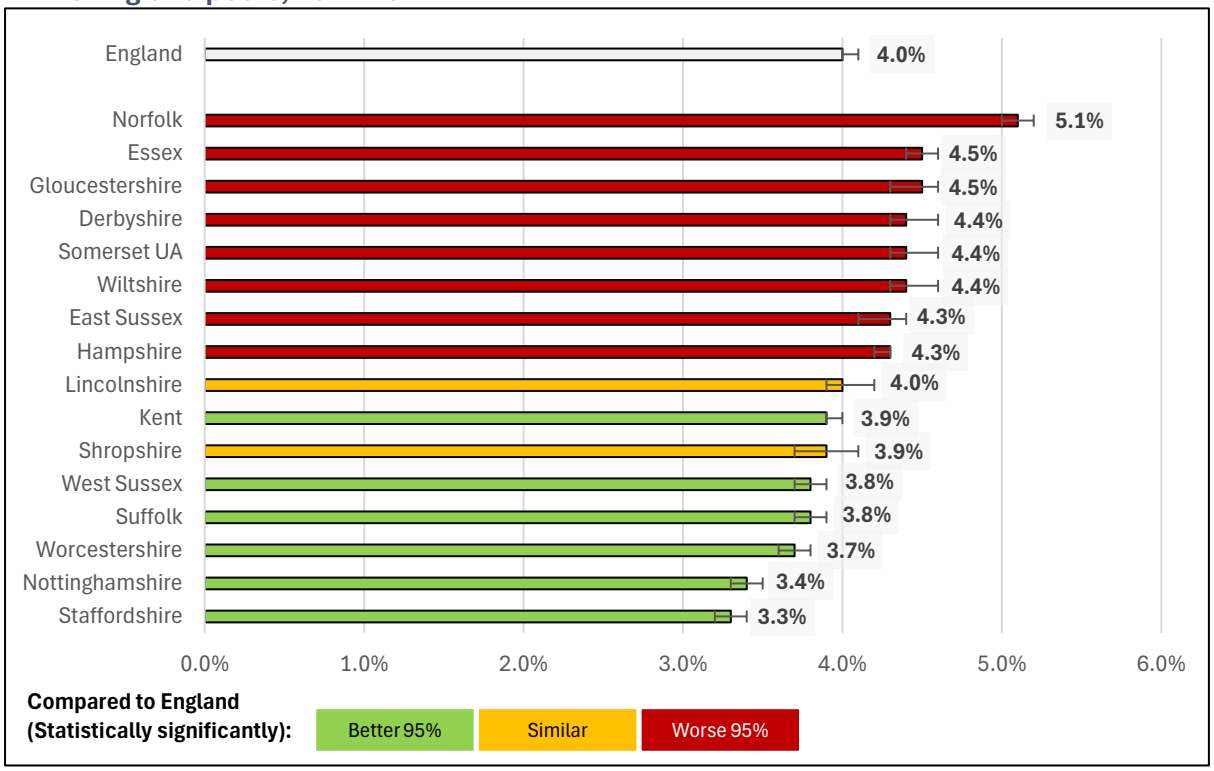
Figure 6. School pupils with social, emotional and mental health needs, Suffolk and England, 2015/16 to 2024/25



Source: Office for Health Improvement and Disparities (2025)

In 2024/25, 3.8% of school pupils in Suffolk (3,899 children) were identified as having SEMH as their primary SEND need. The highest proportions were in Norfolk (5.1%), Essex (4.5%), and Gloucestershire (4.5%). The lowest proportions were in Staffordshire (3.3%), Nottinghamshire (3.4%), and Worcestershire (3.7%).

Figure 7. School pupils with social, emotional and mental health needs, Suffolk and NHS England peers, 2024/25



Source: Office for Health Improvement and Disparities (2025)

The rise in identified SEMH needs among Suffolk school pupils from 1,825 children in 2015/16 to 3,899 in 2024/25 represents a substantial increase in demand for specialist educational and mental health support. This more than doubling reflects increasing prevalence of mental ill health among children (consistent with national survey data), improved identification in schools or by families, and/or changing thresholds for SEND support.

While Suffolk's rate remains below the England average and most NHS peer areas, this may indicate more conservative identification practices or potential under-identification rather than a genuine lower need. Nearly 4,000 school pupils in Suffolk have identified SEMH needs requiring coordinated support across education and health services, including school-based interventions, educational psychology, and specialist Child and Adolescent Mental Health Services (CAMHS). The sustained upward trend indicates continued pressure on services to meet growing needs. More information is available in the SEND Needs Assessment for Suffolk, published in 2024 and updated with 2025 data.

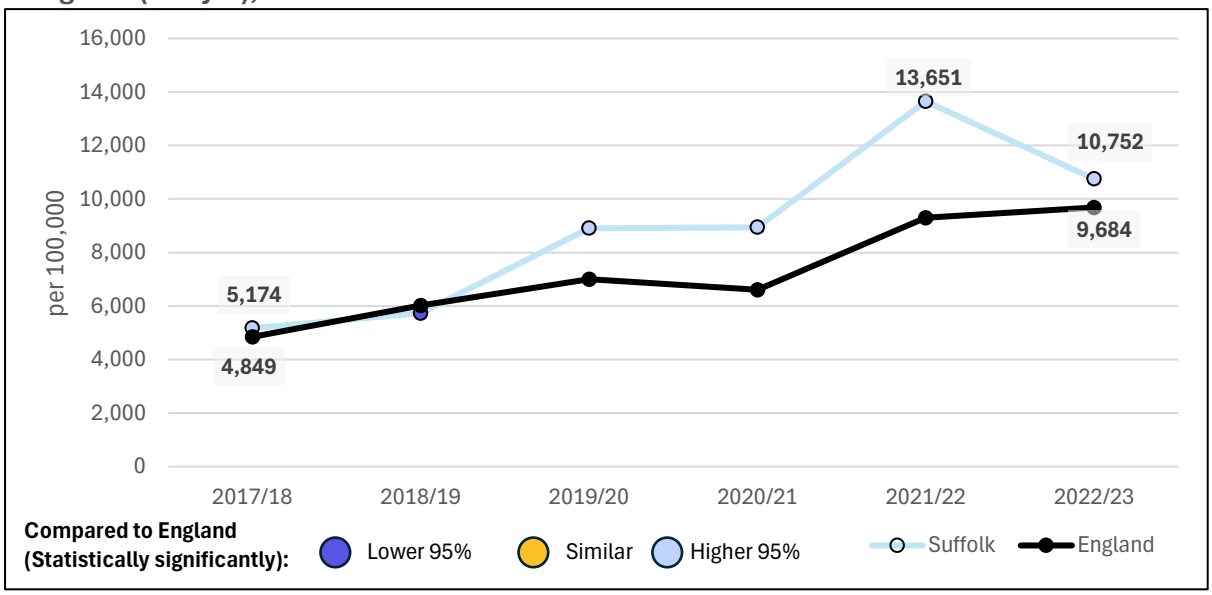
New referrals to secondary mental health services, per 100,000 (<18 yrs)

Referral rates to secondary mental health services provide a measure of demand and help assess whether local service capacity can meet the mental health needs of the population. For children and young people, referral rates reflect the prevalence of mental ill health, the capacity of primary care and universal services to manage needs, and local pathways into specialist CAMHS.

Suffolk has experienced substantial increases in referral rates for children and young people under 18 to secondary mental health services over the past six years. The rate more than doubled from 5,174 per 100,000 in 2017/18 (7,580 referrals) to a high of 13,651 per 100,000 in 2021/22 (20,325 referrals). Referral rates declined to 10,752 per 100,000 in 2022/23 (16,210 referrals), though remained more than double the 2017/18 baseline, mirroring the national pattern. Throughout this period, Suffolk's referral rates have been consistently statistically significantly higher than the England average.

The increase from 2019/20 onwards coincides with the Covid-19 pandemic and reflects both increasing mental health need among children and young people, as well as potentially increased help-seeking or changes in referral pathways during this period.

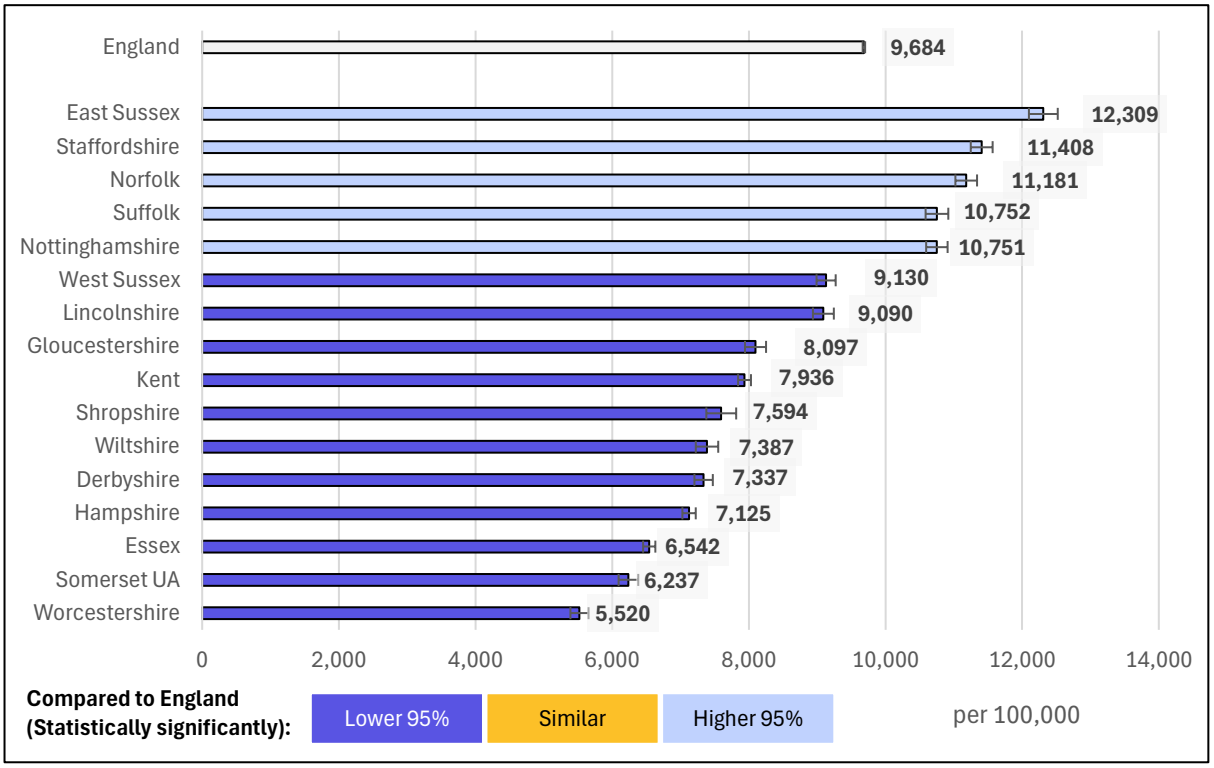
Figure 8. New referrals to secondary mental health services per 100,000, Suffolk and England (<18 yrs), 2017/18 to 2022/23



Source: Office for Health Improvement and Disparities (2025)

In 2022/23, Suffolk had a referral rate of 10,752 per 100,000 for children under 18 (16,210 referrals), placing Suffolk 4th highest among the 15 NHS England peer areas and statistically significantly higher than England. The large variation across peer areas ranging from 5,520 to 12,309 per 100,000 may reflect differences in local mental health need, thresholds for referral or differing pathways, service capacity and configuration, or help-seeking behaviours.

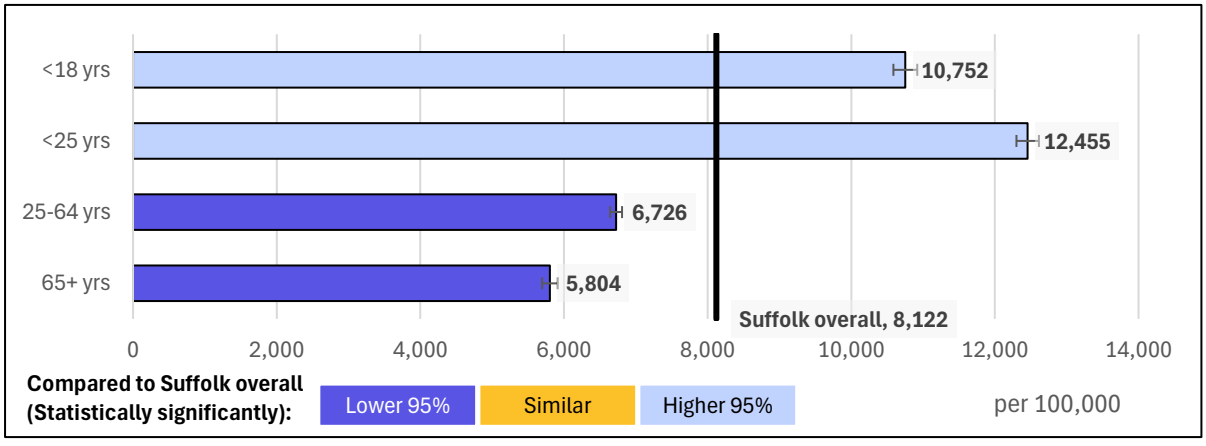
Figure 9. New referrals to secondary mental health services per 100,000 (<18 yrs), Suffolk and NHS England peers, 2022/23



Source: Office for Health Improvement and Disparities (2025)

When examining all-age referral patterns in Suffolk, children and young people under 18 have higher referral rates relative to their population size. The under 18s referral rate (10,752 per 100,000) was higher than the overall Suffolk rate (8,122 per 100,000) and higher than rates for working-age adults (6,726) and older adults (5,804). Young people under 25 had even higher rates at 12,455 per 100,000, showing that adolescence and early adulthood represent a period of particularly high mental health service need. However, referral levels reflect patterns of access, help-seeking and service pathways as well as underlying mental health need.

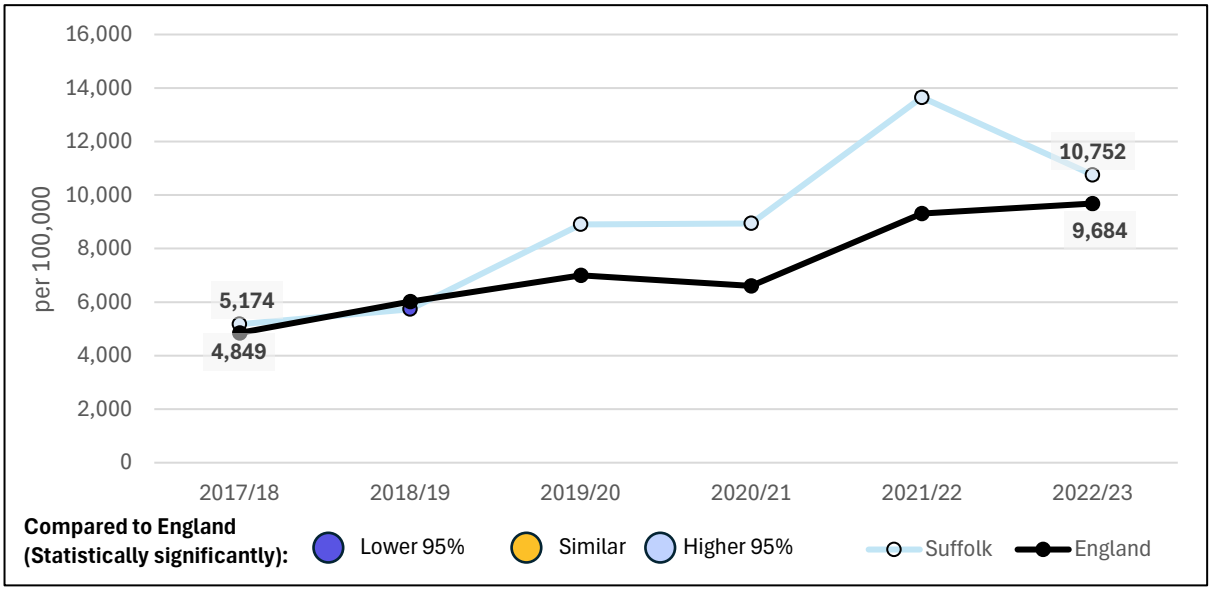
Figure 10. New referrals to secondary mental health services per 100,000 (<18 yrs), by age group, Suffolk, 2022/23



Source: Office for Health Improvement and Disparities (2025)

The more than doubling of referral rates for children and young people between 2017/18 and 2022/23 also shows increases in demand on CAMHS and related services. With over 16,000 referrals in 2022/23, this places pressure on assessment, triage, and treatment services.

Figure 11. New referrals to secondary mental health services per 100,000 (<18 yrs), Suffolk and England, 2017/18-22/23

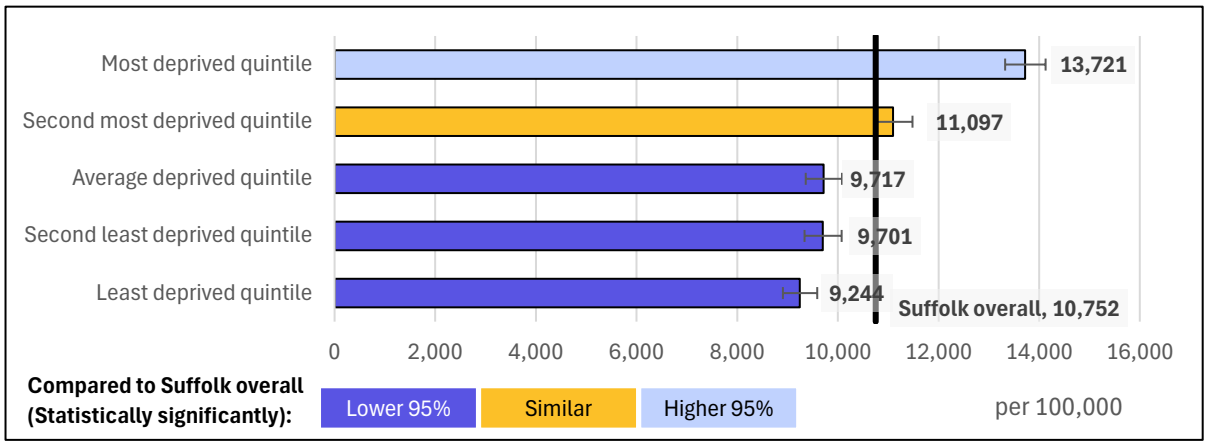


Source: Office for Health Improvement and Disparities (2025)

Suffolk's position as the 4th highest among peer areas and above the England average indicates relatively high levels of identified mental health need among children and young people requiring specialist treatment. This is consistent with Suffolk's rates of self-harm admissions among 10-24 year olds and rising numbers of pupils with SEMH needs, presenting a picture of growing mental health challenges facing young people in Suffolk.

Rates varied substantially by deprivation - children and young people living in the most deprived quintile in Suffolk had the highest referral rate (13,721 per 100,000), compared with 9,244 per 100,000 in the least deprived quintile. Referral rates decreased progressively with lower levels of deprivation, indicating statistically significantly higher demand for specialist mental health support among children and young people in more deprived areas.

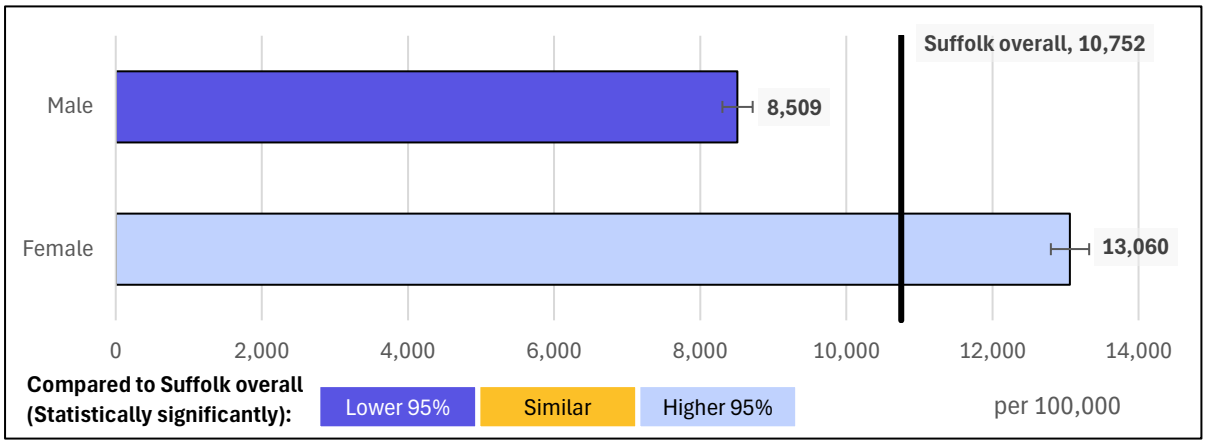
Figure 12. New referrals to secondary mental health services per 100,000 (<18 yrs), Suffolk LSOA11 deprivation quintiles (IMD2019), 2022/23



Source: Office for Health Improvement and Disparities (2026)

Marked differences were also observed by sex. Females had a substantially higher referral rate (13,060 per 100,000) than males (8,509 per 100,000), reflecting well-established gender differences in the presentation, identification and help-seeking behaviour for mental health difficulties during childhood and adolescence.

Figure 13. New referrals to secondary mental health services per 100,000 (<18 yrs), Suffolk males and females, 2022/23



Source: Office for Health Improvement and Disparities (2026)

Attended contacts with community and outpatient mental health services, per 100,000 (<18 yrs)

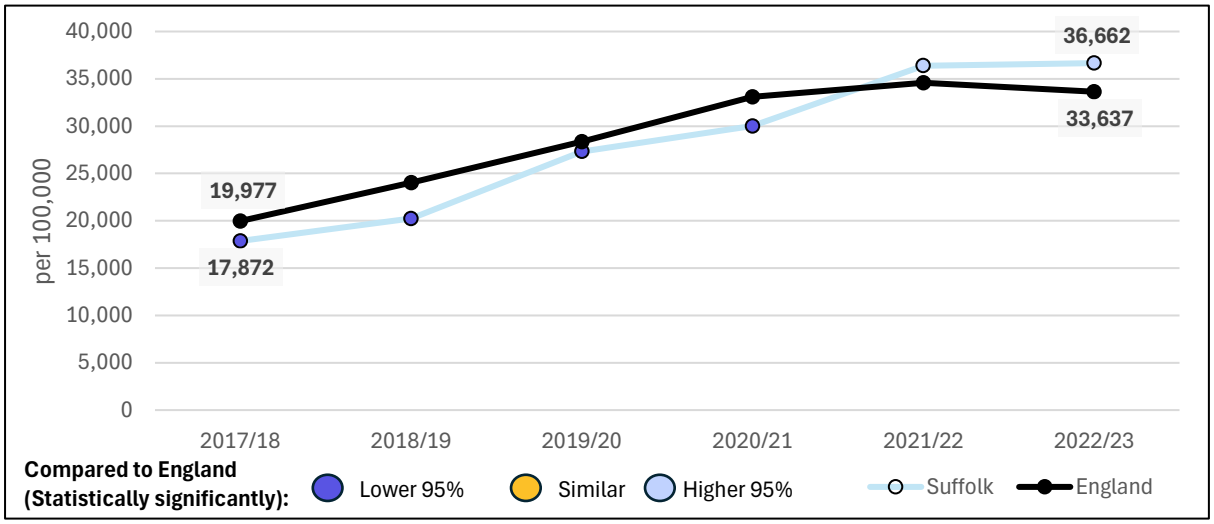
This indicator measures the rate of attended contacts with secondary mental health services in community and outpatient settings. It reflects ongoing service activity rather than unique individuals, as one person can have multiple contacts within a year. This rate provides insight into the level of mental health service demand in the county, and whether current service provisions can meet population need.

Suffolk has experienced statistically significant increases in contact rates for children and young people under 18 with secondary mental health services over the past six years. The rate has more than doubled from 17,872 per 100,000 in 2017/18 (25,970 total contacts) to 36,662 per 100,000 in 2022/23 (55,290 total contacts).

This upward trend mirrors the national pattern, with England's rate increasing from 19,977 per 100,000 in 2017/18 to 33,637 per 100,000 in 2022/23. Between 2017/18 to 2020/21, Suffolk's rate has been statistically significantly lower than the rate for England, but in the previous two years (2021/22 and 2022/23), Suffolk's rate has been statistically significantly higher than the rate for England.

Increased contact rates reflect higher service activity but may represent rising need, expanded access, or greater clinical complexity rather than improved outcomes alone. These trends should be interpreted alongside prevalence and crisis data to understand whether provision is meeting population need.

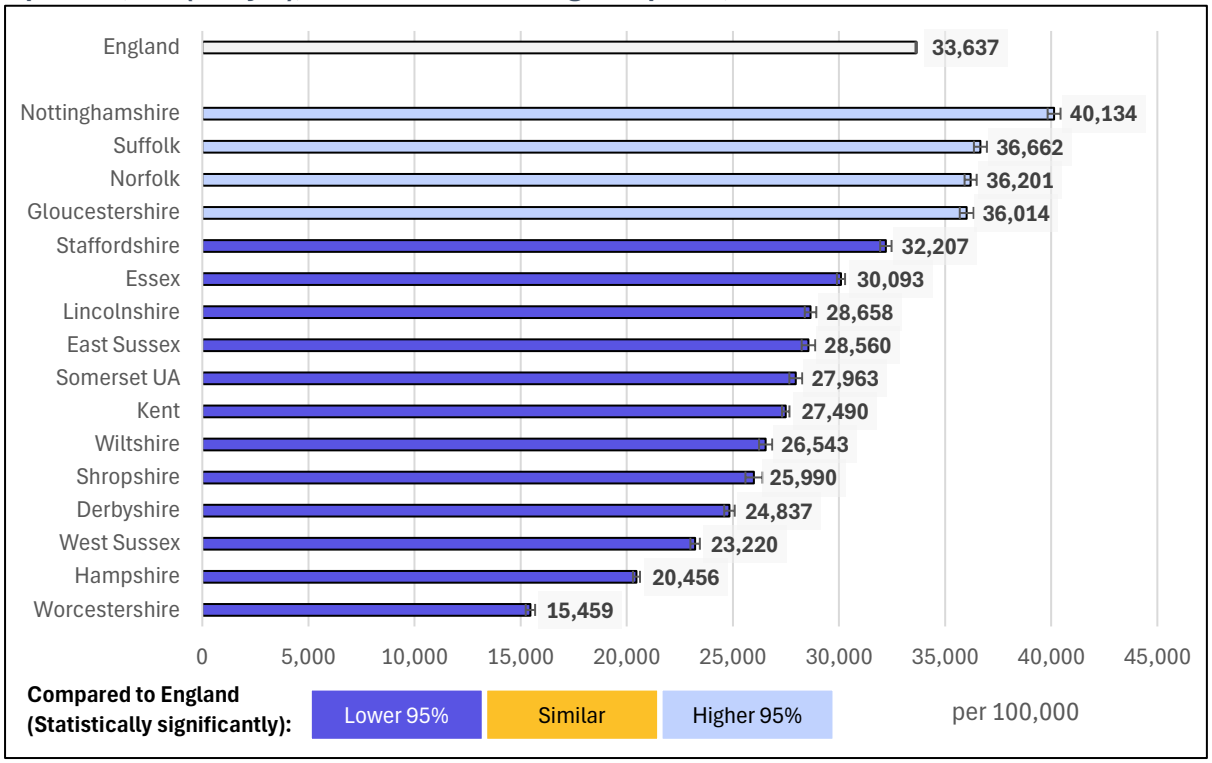
Figure 14. Attended contacts with community and outpatient mental health services per 100,000 (<18 yrs), Suffolk and England, 2017/18-22/23



Source: Office for Health Improvement and Disparities (2025)

In 2022/23, Suffolk had a contact rate of 36,662 per 100,000 for children under 18 (55,290 contacts), placing Suffolk 2nd highest among NHS England peer areas.

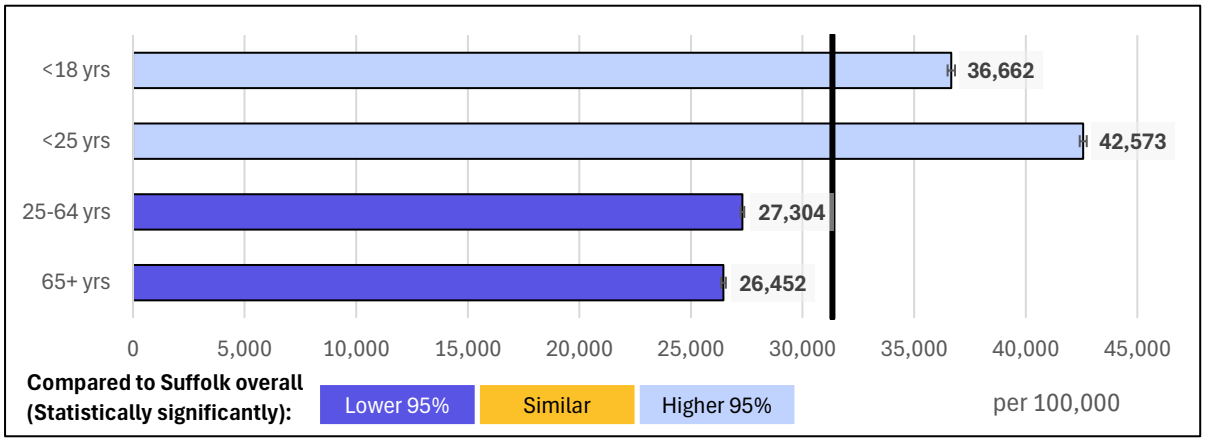
Figure 15. Attended contacts with community and outpatient mental health services per 100,000 (<18 yrs), Suffolk and NHS England peers, 2022/23



Source: Office for Health Improvement and Disparities (2025)

When exploring all-age contact patterns in Suffolk, children and young people under 18 had statistically significantly higher contact rates than the overall population. The under 18s contact rate (36,662 per 100,000) was higher than the overall Suffolk rate (31,337 per 100,000) and also statistically significantly higher than rates for working-age adults (27,304) and older adults (26,452). Young people under 25 had the highest contact rate at 42,573 per 100,000, indicating continued service engagement during adolescence and early adulthood.

Figure 16. Attended contacts with community and outpatient mental health services per 100,000 by age group, Suffolk, 2022/23

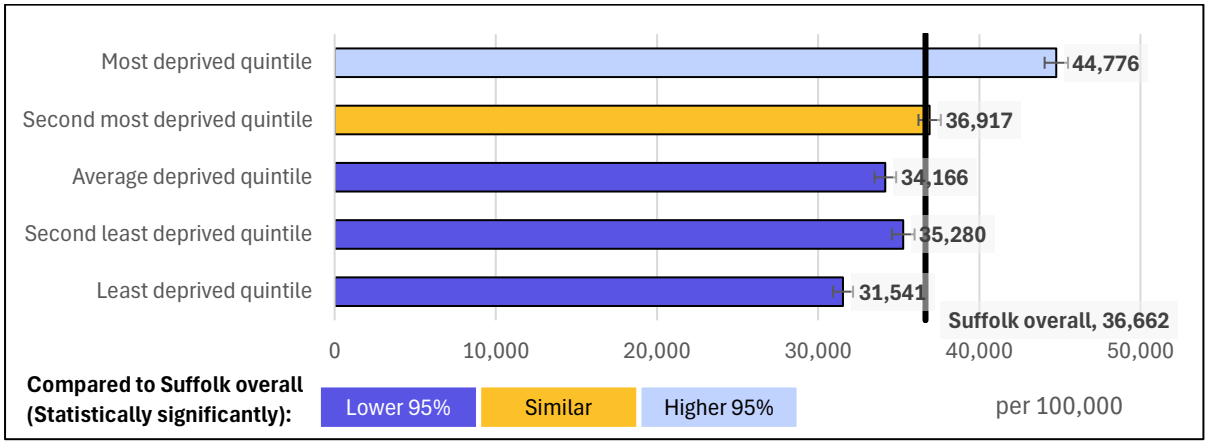


Source: Office for Health Improvement and Disparities (2025)

Higher contact rates in younger age groups are consistent with national evidence showing increasing prevalence of mental health conditions, particularly anxiety, depression and self-harm, during adolescence and early adulthood. These patterns likely reflect both rising underlying need and sustained service engagement during a period of peak incidence, rather than inappropriate use of services.

Patterns of inequality were also evident for attended contacts. Overall, Suffolk recorded 36,662 attended contacts per 100,000 under 18s (55,290 total contacts). Children and young people living in the most deprived quintile in Suffolk also experienced the highest rate of contact (44,776 per 100,000), compared with 31,541 per 100,000 in the least deprived quintile. This suggests that higher levels of need in more deprived communities translate into both referrals and into ongoing service use.

Figure 17. Attended contacts with community and outpatient mental health services per 100,000 (<18 yrs) by Suffolk LSOA11 deprivation quintiles (IMD2019), 2022/23

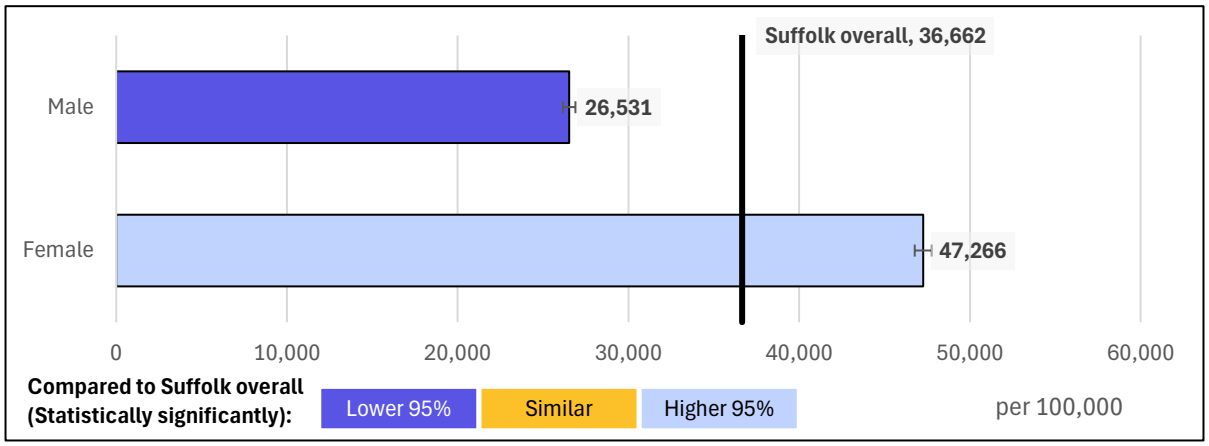


Source: Office for Health Improvement and Disparities (2026)

Females had nearly double the rate of attended contacts (47,266 per 100,000) compared with males (26,531 per 100,000), reinforcing evidence that adolescent girls, in particular, experience high levels of mental health need and account for a disproportionate share of service demand.

Contact rates for children and young people doubling between 2017/18 and 2022/23, represents substantial increases in CAMHS activity and service demand. Suffolk's position as the second highest among peer areas also indicates high levels of ongoing mental health service engagement. This elevated contact rate, combined with high referral rates, suggests that once children and young people access CAMHS, they require sustained support with multiple appointments.

Figure 18. Attended contacts with community and outpatient mental health services per 100,000 (<18 yrs), Suffolk males and females, 2022/23



Source: Office for Health Improvement and Disparities (2026)

My Health, Our Future – Knowing Works CIC findings

Findings from Knowing Works CIC My Health, Our Future Phase 9 research indicate ongoing pressures on children and young people's wellbeing in Suffolk. On average, young people locally report lower happiness and higher anxiety than 16–24 year olds nationally. 16% of students said they rarely or never feel close to others, and just over half do not achieve recommended sleep levels, with lower sleep strongly associated with reduced wellbeing. Social media use continues to rise, with 46% of students using it for four or more hours on a typical school night; higher usage is associated with poorer wellbeing and sleep outcomes.

Bullying and safety concerns remain prominent, with 31% of students reported feeling unsafe in their community due to bullying, increasing to 41% among those with additional support needs. More than two in five students had witnessed at least one form of potential sexual harassment or violence in school or college, including unwanted sexual touching and the sharing of sexual images. These findings highlight the interaction between safety, social connection, sleep, digital behaviours and mental health, reinforcing the importance of whole-school approaches and targeted support for vulnerable groups.

Children and young people – population health management data

Population health management data from the Optum Pathfinder tool provides additional insight into the distribution of recorded mental health need among children and young people, with this snapshot filtered for ages 0–18 (inclusive) years and Suffolk residents within the historic Suffolk and North East Essex ICB area. This analysis covers the 12 months to 30 November 2025 and **includes individuals with a new mental health flag, indicating if people have one or more of the following mental health conditions – depression, anxiety, low mood or serious mental illness. Event has occurred in the last 2 years and not previous to that.**

Data for Waveney is excluded, as GP practices in this area fall within Norfolk and Waveney ICB at the time of writing.

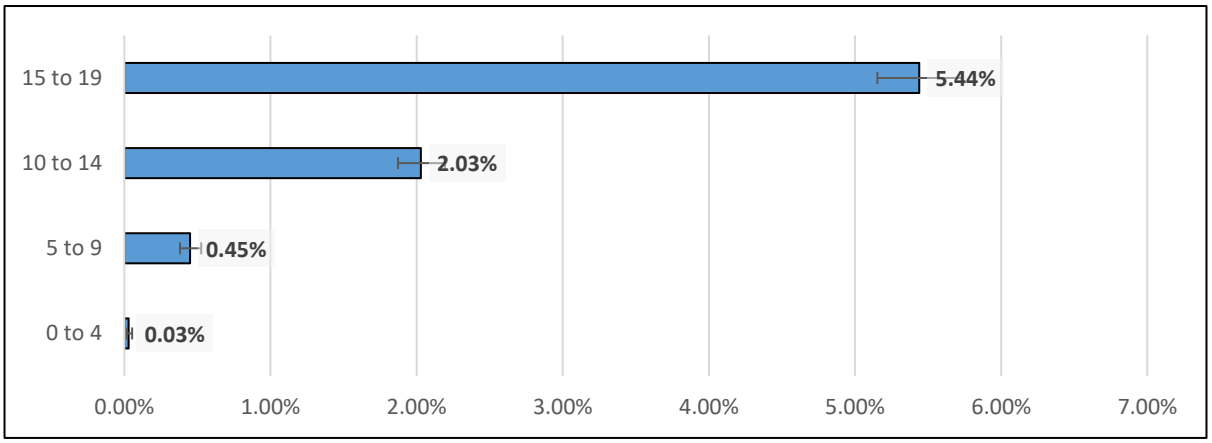
For this age group, recorded mental health need increases sharply with age:

- 15–19 year olds have the highest prevalence, with 5.44% (1,938 individuals) flagged with a mental health condition in the last two years
- 10–14 year olds show a prevalence of 2.03% (744 individuals)
- Prevalence is much lower in younger children, at 0.45% for those aged 5–9 and negligible among under-5s

It is important to note that mental health need in the early years often presents differently from adolescence and adulthood. Among children under five, concerns are more commonly related to social and emotional development, attachment, communication, and behavioural regulation, rather than formally diagnosed mental health conditions. As a result, recorded prevalence in younger age groups is likely to under-represent underlying need, which may instead be identified through early years services, health visiting, education, or family support pathways.

This steep age gradient aligns with national survey data and service activity indicators, reflecting increasing identification, help-seeking, and diagnosis during adolescence.

Figure 19. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by age groups, 12 months until 30th November 2025



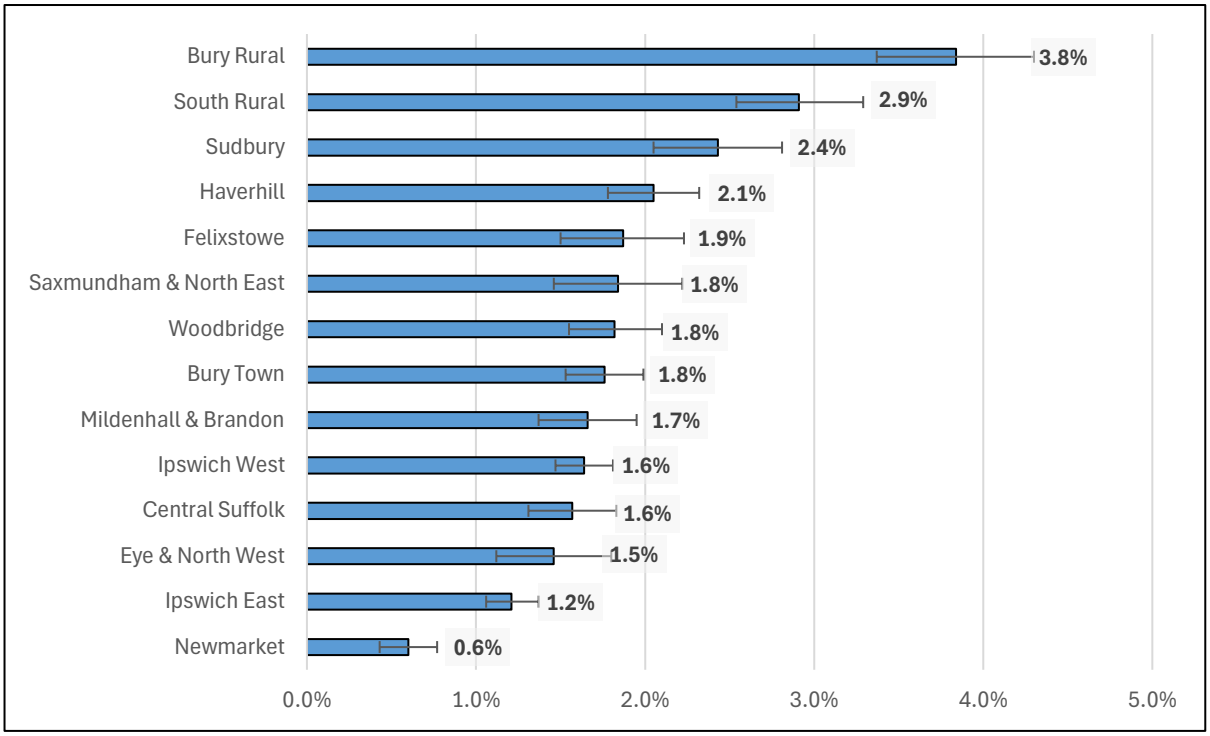
Source: Optum Pathfinder (2026)

There is notable variation across Integrated Neighbourhood Teams (INTs), suggesting uneven distribution of recorded need:

- Highest prevalence is seen in Bury Rural (3.8%) and South Rural (2.9%)
- Lower prevalence is observed in Eye & North West (1.5%), Ipswich East (1.2%) and Newmarket (0.6%)

These differences may reflect a combination of underlying need, health-seeking behaviour, deprivation, service accessibility, referral practices, and recording behaviour rather than true variation in prevalence alone.

Figure 20. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Integrated Neighbourhood Team (INT), SNEE registered patients aged 0-18 (inclusive) years of age, 12 months until 30th November 2025

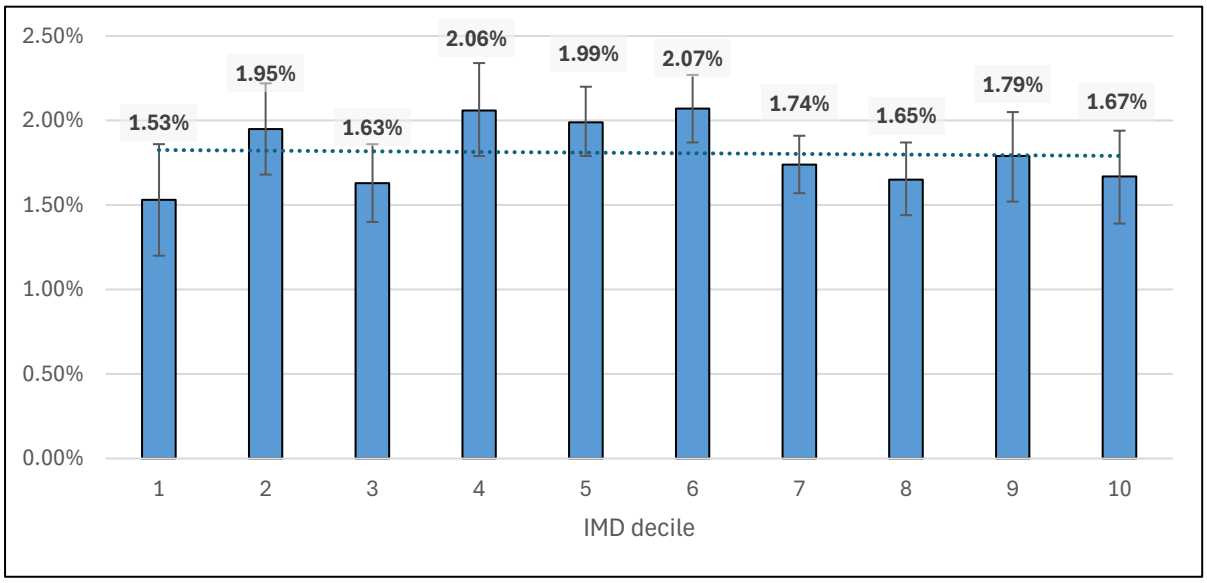


Source: Optum Pathfinder (2026)

A deprivation gradient is not as evident:

- Children and young people living in the most deprived deciles have a statistically similar recorded prevalence (1.53% in IMD decile 1)
- Prevalence remains statistically similar across deprivation deciles, with a high of 2.07% in decile 6, and lower values in decile 8 (1.65%) and decile 10 (1.67%)

Figure 21. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Index of Multiple Deprivation Decile (2025), SNEE registered patients aged 0-18 (inclusive) years of age, 12 months until 30th November 2025



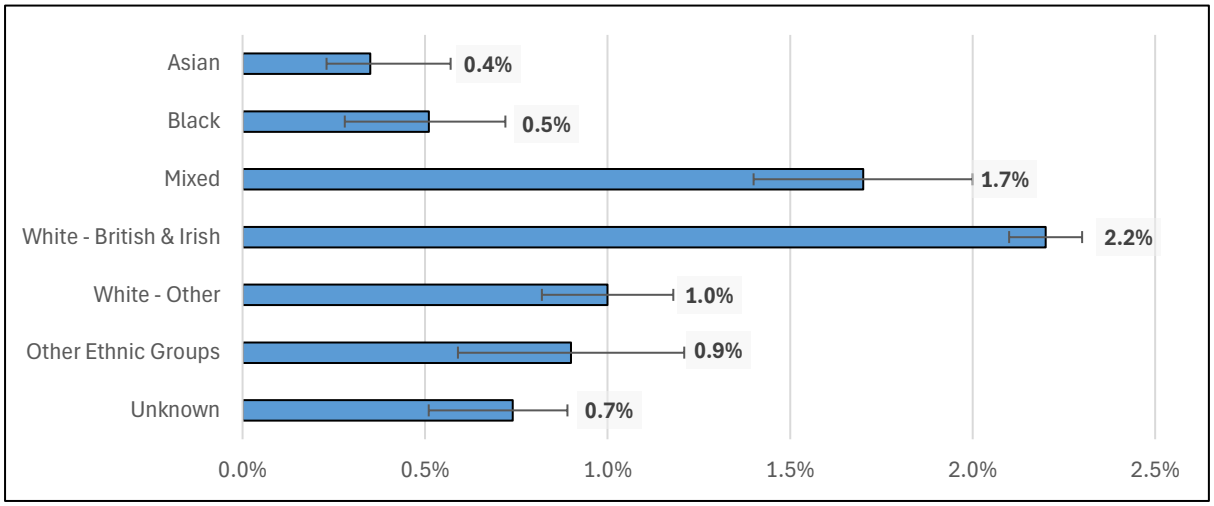
Source: Optum Pathfinder (2026)

Recorded prevalence varies by ethnic group:

- Highest prevalence is seen among White British & Irish children (2.2%) and those of Mixed ethnicity (1.7%)
- Much lower prevalence is recorded among Asian (0.4%) and Black (0.5%) children

These differences are likely to be influenced by under-identification, cultural barriers to help-seeking, and variation in access to or engagement with services, rather than lower underlying need alone.

Figure 22. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by ethnic group, SNEE registered patients aged 0-18 (inclusive) years of age, 12 months until 30th September 2025



Source: Optum Pathfinder (2026)

This analysis reflects recorded mental health need, not population prevalence. The mental health flag captures those who have been identified within health systems and may therefore underestimate unmet need, particularly among younger children, minority ethnic groups, and communities with barriers to accessing care. However, the data provides useful insight into where identified need is concentrated, supporting place-based planning and targeted early intervention.

Overall, the findings reinforce evidence from Fingertips and national surveys that adolescence is a critical period for mental health, that deprivation strongly shapes risk, and that inequalities in identification and access persist across communities in Suffolk.

Factors affecting children and young people's mental health

Children and young people's mental health is shaped by multiple factors. These have been grouped by individual development and characteristics, family circumstances, and broader community and structural influences. Understanding these risk and protective factors can assist with identifying vulnerable populations and inform prevention and early intervention strategies.

Individual

Early childhood development: Suffolk demonstrates strong performance on early childhood development indicators. In 2024/25, 83.7% of children achieved a good level of development at age 2 to 2½ years (5,125 children), statistically significantly higher than the England average of 81.4%. Early developmental progress is protective for later mental health, with children who experience developmental delays at increased risk of emotional and behavioural difficulties[160,161]. By the end of Reception, 67.5% of Suffolk children achieved a good level of development (4,910 children), statistically similar to the England average (67.7%). While this represents most children, approximately one-third not achieving expected development levels may be at elevated risk of later difficulties including mental ill health.

Special educational needs and disabilities (SEND): Suffolk has almost 1 in 5 (19.6%) of pupils identified with SEND in 2024/25 (21,819 pupils), statistically similar to the England average but significantly increasing over the past five years, mirroring national trends. As noted previously in this needs assessment, children with SEND - particularly those with social, emotional and mental health needs - experience substantially higher rates of ill mental health. National data shows that 57% of children with SEND had probable mental health disorders compared to 13% without SEND[162].

Physical health and activity: Suffolk performs relatively well on childhood obesity and physical activity measures in comparative terms. Reception-age overweight and obesity combined prevalence was 23.5% in 2024/25 (1,565 children), statistically similar to England. Year 6 overweight and obesity combined prevalence was 33.6% (2,480 children), statistically significantly lower than England's 36.2% - but of course, even while lower than the national average, 1 in 3 10-11 year old children living with obesity is incredibly high. Physical activity levels among children and young people were 47.3% in 2023/24, statistically similar to England (47.8%), though this means more than half of young people are not meeting activity guidelines. Childhood obesity and physical inactivity are associated with poorer mental health including low self-esteem, depression, and anxiety[163], while physical activity is protective for mental wellbeing[164].

School engagement and attendance: Primary school persistent absence was 14.1% in 2023/24 (6,952 pupils), statistically significantly lower than England (14.6%). However, secondary school persistent absence was 27.7% (11,526 pupils), statistically significantly higher than England (25.6%). This deterioration in attendance during secondary school is of concern, as persistent absence is both a potential indicator of underlying mental ill health and a risk factor for poor outcomes[165]. Disengagement from school due to anxiety, bullying, mental ill health, or other factors, can create a cycle of educational underachievement and worsening wellbeing.

Educational attainment: Suffolk's average Attainment 8 score was 43.3 in 2023/24, statistically significantly lower than the England average of 45.9 and placing Suffolk in the fourth (second lowest) quintile nationally. Lower educational attainment is associated with increased risk of ill mental health and reduced life opportunities[166]. The relationship is bidirectional meaning mental health difficulties can impair educational performance, while poor academic achievement can contribute to stress, low self-esteem, and reduced prospects[166].

Not in education, employment or training (NEET): In 2023/24, 5.5% of 16-17 year olds in Suffolk were NEET or their activity was unknown (881 young people), statistically similar to England (5.4%), with no statistically significant improvement over the previous five years. Young people who are NEET face substantially elevated risks of poor mental health[167,168]. This group requires support to re-engage with positive activities and address any underlying mental health barriers[169].

Youth justice involvement: Suffolk had 122.2 first-time entrants to the youth justice system per 100,000 young people aged 10-17 in 2024 (87 young people), statistically similar to England (137.7) but significantly decreasing over the past five years. Young people in contact with the youth justice system experience can extremely high rates of ill mental health[170]. The decreasing trend is positive, though those who do enter the system remain a vulnerable group requiring coordinated support.

Involvement with youth justice can be stigmatising. In addition, this vulnerable group of children are also more likely than other 10-17-year-olds in Suffolk to have special educational needs, low education attendance, engagement and attainment, being care experienced and having experience of (or witnessing) domestic abuse. Suffolk Youth Justice Service work to divert and prevent children from committing offences through early intervention. This has resulted in decreasing rates of first-time entrants (a child becomes a first-time entrant when they receive their first caution or court sentence). The latest (Oct 2024 – Sep 2025) Suffolk first time entrant rate published by the Youth Justice board is 112 per 100,000 10-17-year-olds, which is lower than all comparator groups (and the lowest it has been since measurement began).

Very young mothers: 45 girls aged 12-17 gave birth in Suffolk in 2024, representing 0.8% of all deliveries, statistically significantly higher than the England average of 0.6%. While numbers are small, very young mothers face challenges including interrupted education, social isolation, poverty, and elevated mental health risks. As highlighted in the perinatal section, teenage mothers face increased risks of perinatal ill mental health.

Table 1. Factors affecting children and young people's mental health: individual factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Child development: percentage of children achieving a good level of development at 2 to 2 1/2 years	2024/25	5,125	83.7%	81.4%	60.3%	97.5%
School readiness: percentage of children achieving a good level of development at the end of Reception	2023/24	4,910	67.5%	67.7%	59.6%	77.1%
Pupils with special educational needs (SEN)	2024/25	21,819	19.6%	19.6%	14.1%	24.8%
Reception prevalence of overweight (including obesity) (4-5 yrs)	2024/25	1,565	23.5%	23.5%	32.4%	17.0%
Year 6 prevalence of overweight (including obesity) (10-11 yrs)	2024/25	2,480	33.6%	36.2%	45.6%	23.6%
Percentage of physically active children and young people	2023/24	-	47.3%	47.8%	34.5%	62.1%
Persistent absentees - Primary school	2023/24	6,952	14.1%	14.6%	21.7%	9.2%
Persistent absentees - Secondary school	2023/24	11,526	27.7%	25.6%	35.9%	17.7%
Average Attainment 8 score	2023/24	-	43.3	45.9	36.1	58.3
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	2023/24	881	5.5%	5.4%	22.0%	0.9%
First time entrants to the youth justice system	2024	87	122.2	137.7	316.1	62.7
Deliveries to women aged 12 to 17	2023/24	45	0.8%	0.6%	-	-

Compared to England (Statistically significantly): Better 95% | Similar | Worse 95%

Quintiles: Best | | | | Worst

Source: Office for Health Improvement and Disparities (2025)

The individual factors affecting Suffolk's children and young people's mental health demonstrates positive outcomes for some indicators regarding early childhood development, childhood obesity prevention, and primary school attendance, but concerning patterns in secondary school engagement, educational attainment, and NEET rates. The high and rising prevalence of SEND, elevated secondary school absence, and lower than average educational attainment demonstrate that a proportion of Suffolk's young people face challenges that may contribute to or reflect mental health difficulties.

Family

Family circumstances profoundly influence children and young people's mental health. Poverty, housing instability, parental conflict, domestic abuse, and involvement with child services are all significant risk factors for child ill mental health.

Child poverty: Suffolk has lower child poverty rates compared to the England average. In 2023/24, 17.2% of children under 16 lived in absolute low-income families (22,884 children), statistically significantly lower than the England average (19.1%). Similarly, 22.6% of pupils

were eligible for free school meals in 2024/25 (23,349 children), statistically significantly lower than England (25.7%).

While these rates are more favourable than the England average, they have been increasing over the past five years. Poverty is strongly associated with child mental ill health, with children in low-income families experiencing higher rates of emotional and behavioural difficulties[171]. The rising trend means that more children are being exposed to the stress, instability, and reduced opportunities associated with financial hardship, which can impact their mental wellbeing both immediately and across their lives.

Housing affordability and homelessness: Suffolk's housing affordability ratio (ratio of median house price to median gross annual residence-based earnings) was 7.9 in 2024 (with a median house price of £282,500), close to the average across England (7.7) and placing Suffolk in the middle quintile. Housing unaffordability creates financial pressure on families and can lead to insecure or unsuitable housing, both of which affect children's wellbeing[172]. In 2022/23 in Suffolk, 15.6 per 1,000 households with dependent children were owed a duty under the Homelessness Reduction Act (1,302 households), statistically similar to England (16.1). 477 households in Suffolk were in temporary accommodation in 2024/25, with a rate of 1.4 per 1,000 – statistically significantly lower than the rate across England (5.2 per 1,000), however the rate across Suffolk has been statistically significantly increasing over the previous five years. Housing instability and homelessness have severe impacts on children's mental health, causing disruption to education, social relationships, and family life, and exposing children to unsuitable and stressful living conditions[172].

Domestic abuse: Suffolk has a statistically significantly lower rate of reported domestic abuse-related incidents and crimes compared to England. In 2023/24, the rate was 21.5 per 1,000 population, placing Suffolk in the lowest quintile nationally. Exposure to domestic abuse can have profound and lasting effects on children's mental health, with children who witness or experience domestic abuse at significantly elevated risk of depression, anxiety, post-traumatic stress disorder, and behavioural problems[173]. While Suffolk's lower rates are positive, domestic abuse remains substantially under-reported, and any level represents children experiencing trauma that can have long-term mental health consequences.

Children in care and child protection: Suffolk also had statistically significantly lower rates of children in care and on child protection plans compared to England. In 2023/24, there were 62 children in care per 10,000 (930 children, 104 of which were unaccompanied asylum seeking children), statistically significantly lower than England (70 per 10,000), with rates not statistically significantly changing over the previous five years. In 2020/21, 32.6 per 10,000 children were on child protection plans (498 children), statistically lower than England (41.4 per 10,000), and also not statistically significantly changing over the previous five years.

As previously mentioned, 46% of Suffolk's children in care have emotional wellbeing concerns based on SDQ scores representing nearly half of this vulnerable population. Children in care and those on child protection plans have experienced abuse, neglect, or family breakdown, resulting in high rates of mental ill health.

Care leavers: Young people leaving care experience poorer mental health and wellbeing outcomes than their peers, which can reflect the cumulative impact of early adversity, trauma, and disrupted relationships.[174–176] Care leavers are more likely to experience conditions such as anxiety and depression, often alongside reduced access to informal support networks, which

can increase feelings of loneliness and isolation. These outcomes are shaped not only by individual experience but by wider determinants of health including housing stability, education, employment, financial security, and social connectedness. Challenges across these areas are often interdependent, meaning difficulties in one domain can reinforce and sustain poor mental wellbeing over time.

The transition from care into adulthood is recognised as a critical period, often described as a "cliff edge", where structured support reduces while expectations for independence increase. Evidence and local feedback in Suffolk highlight that care leavers may experience difficulties accessing timely and appropriate mental health support, including long waiting times and challenges navigating services[1]. Young people emphasise the importance of relationship-based, trauma-informed, and personalised support that continues beyond the point of leaving care[2].

Suffolk's Leaving Care Service and programmes such as Staying Close reflect this approach, providing ongoing support across housing, education, employment and wellbeing; however, lived experience suggests that access, consistency and coordination of support remain important factors influencing mental health outcomes for care leavers Suffolk Leaving Care Local Offer is available online.

Table 2. Factors affecting children and young people's mental health: family factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Children in absolute low income families (under 16s)	2023/24	22,884	17.2%	19.1%	40.2%	4.7%
Children eligible for free school meals	2024/25	23,349	22.6%	25.7%	47.2%	10.2%
Affordability of home ownership	2024	£ 282,500	7.9	7.7	22.8	4.0
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	2022/23	1,302	15.6	16.1	35.8	7.5
Domestic abuse related incidents and crimes	2023/24	-	21.5	27.1	9.9	43.2
Children in care	2023/24	930	62	70	191	25
Children on child protection plans: Rate per 10,000 children <18	2020/21	498	32.6	41.4	9.3	171.7

Compared to England (Statistically significantly): Better 95% | Similar | Worse 95% | Lower 95% | Similar | Higher 95%

Quintiles: Low | | | | High

Source: Office for Health Improvement and Disparities (2025)

[1] Note this feedback was collated separately to the main voice consolidation for the mental health needs assessment.
[2] Note this feedback was collated separately to the main voice consolidation for the mental health needs assessment.

The profile of family factors affecting Suffolk's children and young people's mental health is relatively favourable compared to England, with statistically significantly lower rates of child poverty, domestic abuse, and child protection involvement rates. However, the statistically significant increases in child poverty and free school meal eligibility over recent years are concerning and may contribute to worsening child mental health outcomes. While absolute numbers of children experiencing the most severe family adversity (care, child protection, homelessness) are lower than national averages, these remain highly vulnerable populations who may have complex mental health needs. The approximately 23,000 children in poverty, 1,300 households with children facing homelessness, and 930 children in care all represent large populations within the country who may require targeted mental health support.

Intergenerational mental health need: evidence from social care assessments

Evidence from statutory social care assessments provides insight into the intergenerational nature of mental health need in Suffolk. Published Social Work Assessment Factors data for 2024/25 show that mental health concerns are frequently identified at the point when children and families first come into contact with services.

In Suffolk, mental health concerns relating to a parent were identified in 44.4% of assessments, while 24.0% identified concerns about the child's mental health. A further 4.9% of assessments noted mental health concerns relating to another person in the household. The proportion of assessments identifying mental health concerns relating to both children and parents were statistically significantly higher than regional and national averages, highlighting the substantial level of mental health-related need presenting within children's social care assessments locally.

Table 3. Factors identified at the end of assessment by local authority, children in need, Suffolk, East of England, England, 2025

	Mental health: concerns about child		Mental health: concerns about parent		Mental health: concerns about other person	
	No.	%	No.	%	No.	%
England	90,400	17.6%	171,780	33.5%	23,600	4.6%
East of England	7,040	19.9%	14,200	40.2%	1,590	4.5%
Suffolk	1,075	24.0%	1,989	44.4%	220	4.9%

Source: Department for Education (2026)

This data reflects the professional judgement of social workers based on information gathered during assessment and does not represent clinical diagnoses. They capture mental health concerns at the point of first assessment and do not reflect changes over time or needs that may emerge later during a child's involvement with social care.

Adverse childhood experiences (ACEs), including abuse, neglect, parental mental illness, domestic abuse and caring responsibilities, are strongly associated with poorer mental health across the lifecourse. Young carers and children experiencing disrupted early attachment are particularly vulnerable, with evidence showing ACEs impose a substantial societal burden, reinforcing the need for prevention, early support and trauma-informed approaches to reduce inequalities[177].

Nevertheless, the findings highlight the extent to which children's needs are often embedded within wider family contexts where parental mental health difficulties are present. This reinforces evidence from the wider literature that parental mental ill health can increase risks for children's emotional wellbeing, development and longer-term mental health outcomes, and that addressing mental health needs in isolation may limit the effectiveness of interventions.

Recent national analysis from the Office for National Statistics further reinforces the bidirectional and intergenerational nature of mental health. Children aged 5 to 16 living with a parent experiencing mental ill health are significantly more likely to experience mental health difficulties themselves, with the probability of hospital presentation for mental health issues nearly doubling when a mother is affected (from 2.23% to 3.92%) and increasing similarly where fathers are affected[178]. The relationship is also reciprocal: parental mental ill health is substantially more likely where children experience mental health difficulties, with the probability of maternal mental ill health almost tripling and paternal mental ill health nearly quadrupling in these circumstances[178]. The analysis also highlights wider impacts, including poorer educational outcomes, with children experiencing mental ill health achieving lower attainment and higher absence at school[178]. Together, this evidence underscores the dynamic, two-way relationship between parent and child mental health and the importance of whole-family approaches to prevention and intervention.

Lived experience insight: Early help and family context

- People value support that is practical, timely and reduces isolation
- Early support and signposting can prevent escalation of mental health difficulties
- Family context and wider support networks play an important role in mental wellbeing

"The support that worked for me… lessened my sense of isolation."

These findings reinforce the importance of early intervention and whole-family approaches.

Source: Suffolk lived experience engagement (Healthwatch Suffolk, Suffolk User Forum and partners).

Perinatal mental health

1. **Perinatal mental health needs affect a substantial proportion of women in Suffolk**, with model-based estimates indicating that many experience depression, anxiety or related conditions during pregnancy or the first year after birth

The estimated prevalence of perinatal mental health conditions for women in Suffolk in 2019 was 26.2%

2. **Early access to maternity care is critical for identifying perinatal mental health needs**, yet not all women in Suffolk access maternity services early in pregnancy, potentially delaying support

75.9% of pregnant women completed their booking appointment within 10 weeks, which was statistically significantly higher than the England figure in 2023/24; however almost 1 in 4 Suffolk mothers did not receive their booking appointment within 10 weeks in 2023/24

3. **Access to specialist perinatal mental health services remains limited relative to estimated need**, suggesting that a proportion of women with moderate to severe conditions may not be receiving timely, specialist care

Suffolk's access rate per 1,000 to specialist perinatal mental health services was statistically significantly higher than the England rate between 2020/21 to 2022/23

4. **The proportion of deliveries to women from ethnic minority groups is increasing**, highlighting the importance of culturally appropriate, equitable perinatal mental health support

11.3% (640) of all deliveries were to women from ethnic minority groups in Suffolk in 2023/24

5. **Parental mental health has important implications for child outcomes**, with evidence linking parental depression and anxiety to increased emotional and behavioural difficulties in early childhood

6. **Addressing wider risk factors**, including socioeconomic stress, parental mental health, and early life environments, is essential to improving perinatal mental health and reducing longer-term demand on services

Early childhood, parental mental health and emerging mental health risk

Recent national research highlights the importance of the early home environment and parental mental health as foundational influences on children's emotional and behavioural development. Government analysis shows that almost all children under two are exposed to screens daily, with higher screen time associated with poorer language development and increased emotional and behavioural difficulties[179].

Furthermore, secure parent and infant relationships are foundational to emotional regulation, resilience and long-term mental health[1]. Evidence indicates that insecure attachment in infancy is associated with increased risks of anxiety and depression across the lifecourse and over-representation in child protection, care and youth justice systems. Despite this, access to specialised parent–infant mental health support remains limited, with only a small proportion of families in need currently reached[1]. National evidence suggests that investment in parent–infant relationship services deliver substantial long-term social and economic returns, reinforcing the importance of early intervention as part of a preventative mental health system[1].

Parental mental health is also independently associated with children's outcomes. Children of primary caregivers experiencing symptoms of depression or anxiety were significantly more likely to show indicators of emotional or behavioural problems. Around 41% of children of caregivers with depression symptoms and 46% of those with caregiver anxiety symptoms had possible emotional or behavioural difficulties, compared with around 22–23% among children whose caregivers did not report these symptoms[179]. Children of caregivers with depression also experienced higher average daily screen time[179].

The research also demonstrates clear socioeconomic inequalities in early protective factors. At age two, children in higher-income households were substantially more likely to be read to daily than those in lower-income households, reinforcing the link between deprivation, early developmental experiences and later mental health risk[179].

These findings underline the importance of perinatal and early years mental health support, not only to improve parental wellbeing but also to reduce the emergence of emotional and behavioural difficulties in early childhood. They reinforce the need for integrated approaches spanning perinatal mental health services, health visiting, early years provision and family support, particularly in more deprived communities.

Healthwatch Suffolk: Maternal mental health experiences in Suffolk

Healthwatch Suffolk's 2023 survey of maternal mental health experiences highlights significant gaps in identification, continuity and support during pregnancy and the postnatal period. Almost two in five respondents experienced mental health difficulties for the first time during pregnancy, and nearly one in three reported a pre-existing mental health condition. Despite this, many parents described not being asked about their mental health by professionals, particularly at the six-to-eight-week postnatal GP check, with almost half reporting that mental health was not mentioned at all. Delays in accessing specialist support, inconsistent information about medication risks, and poor continuity between maternity, health visiting and primary care services were recurrent themes, contributing to distress, loss of trust in services and, for some, prolonged or escalating mental health difficulties.

Data on perinatal mental health

Estimated prevalence of perinatal mental health conditions

Pregnancy and the period after birth can be both exciting and challenging for new parents. For some women, mental health conditions may develop during pregnancy or existing conditions may worsen. The impact of untreated perinatal mental illness can be severe and long-lasting, affecting not only the mother but also the baby and wider family if not identified early and managed effectively.

Evidence demonstrates that maternal depression and anxiety can affect infant mental health, perinatal psychiatric disorders are associated with increased risks to both mother and child, and psychotic illness in pregnancy is linked to increased risks of pre-term delivery, stillbirth, and neurodevelopmental disorders[180]. Over the past two decades, psychiatric disorder has contributed to 15% of all maternal deaths in pregnancy and up to six months postpartum, with suicide remaining one of the leading causes of maternal mortality in the UK[180].

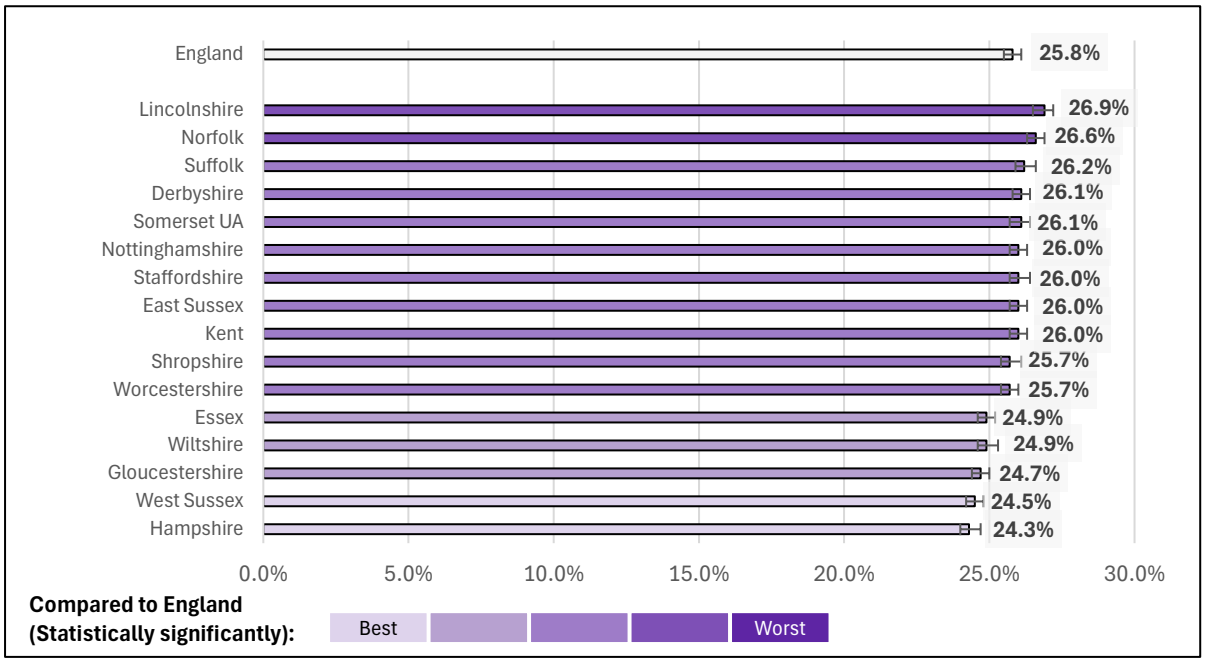
This indicator provides model-based estimates of the prevalence of perinatal mental health conditions among women aged 15-55 years who gave birth, based on local age and deprivation structures. Perinatal mental health conditions include common mental disorders (depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, antenatal and postnatal depression), personality disorders, eating disorders, severe mental illness (bipolar disorder, psychosis, schizophrenia), and perinatal psychosis (a rare, but severe mental illness that emerges suddenly during pregnancy or in the first few weeks after childbirth). The estimates are essential for designing and commissioning appropriate perinatal mental health services that reflect local need.

The most recent available data is from 2019. In that year, Suffolk had an estimated prevalence of 26.2% of women experiencing perinatal mental health conditions meaning approximately one in four women who gave birth were estimated to have a mental health condition during the perinatal period - equating to approximately 1,877 women in Suffolk.

Suffolk's estimated prevalence was statistically similar to the England average of 25.8% and ranked in the upper half of NHS England peer areas, placing Suffolk 3rd among the 15 peer authorities.

The highest estimated prevalence rates among similar authorities were in Lincolnshire (26.9%), Norfolk (26.6%), and Suffolk (26.2%). The lowest rates were in Hampshire (24.3%), West Sussex (24.5%), and Gloucestershire (24.7%). It should be noted that this data is modelled, not observed and that these overall differences in modelled rates are small.

Figure 23. Model-based estimated prevalence of perinatal mental health conditions for Suffolk and NHS England peers, 2019



Source: Office for Health Improvement and Disparities (2025)

Early access to maternity care

Early access to maternity care is important for both maternal and infant health and wellbeing. The first appointment with a midwife (known as a 'booking appointment') should ideally occur before the woman is 10 weeks pregnant. This early booking appointment enables several critical activities including scheduling ultrasound scans, identifying women who may need additional care due to medical history or social circumstances, discussing antenatal screening, taking baseline health measurements, identifying risk factors such as smoking, and importantly, discussing mood and mental health.

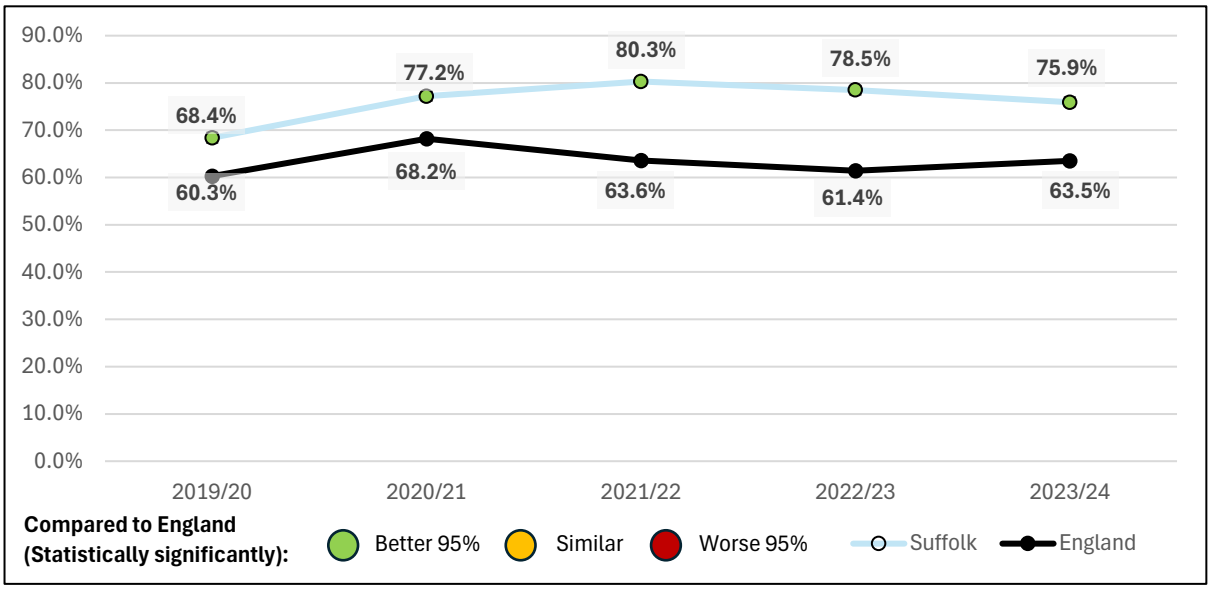
The NHS states that is best to see your midwife or doctor as early as possible to get the information you need to have a healthy pregnancy, with the booking appointment between 8 to 12 weeks. Early booking is particularly important for perinatal mental health, as it provides an opportunity to identify existing mental health conditions, discuss previous mental health history, assess current mood and wellbeing, and arrange appropriate support or referrals where needed. Women who have their booking appointment/first appointment with a midwife later than the first 10 weeks of pregnancy may miss crucial opportunities for mental health assessment and intervention during a period when early support can make a significant difference to outcomes.

The proportion of pregnant women having their first appointment with a midwife within 10 completed weeks statistically significantly increased from 68.4% in 2019/20 to a high of 80.3% in 2021/22. Performance then statistically significantly decreased since, to 75.9% in 2023/24, though this remains 7.5 percentage points higher than the 2019/20 baseline.

Throughout this period, Suffolk has been statistically significantly higher compared to the England average. In 2023/24, Suffolk's rate of 75.9% of booking appointments being completed within 10 weeks was 12.4 percentage points higher than England (63.5%).

However, timely access should be considered alongside continuity of carer, which evidence shows is critical for perinatal mental health outcomes, particularly for women experiencing inequalities, as it supports trust, early identification of need, and sustained mental health support across pregnancy and the postnatal period[181].

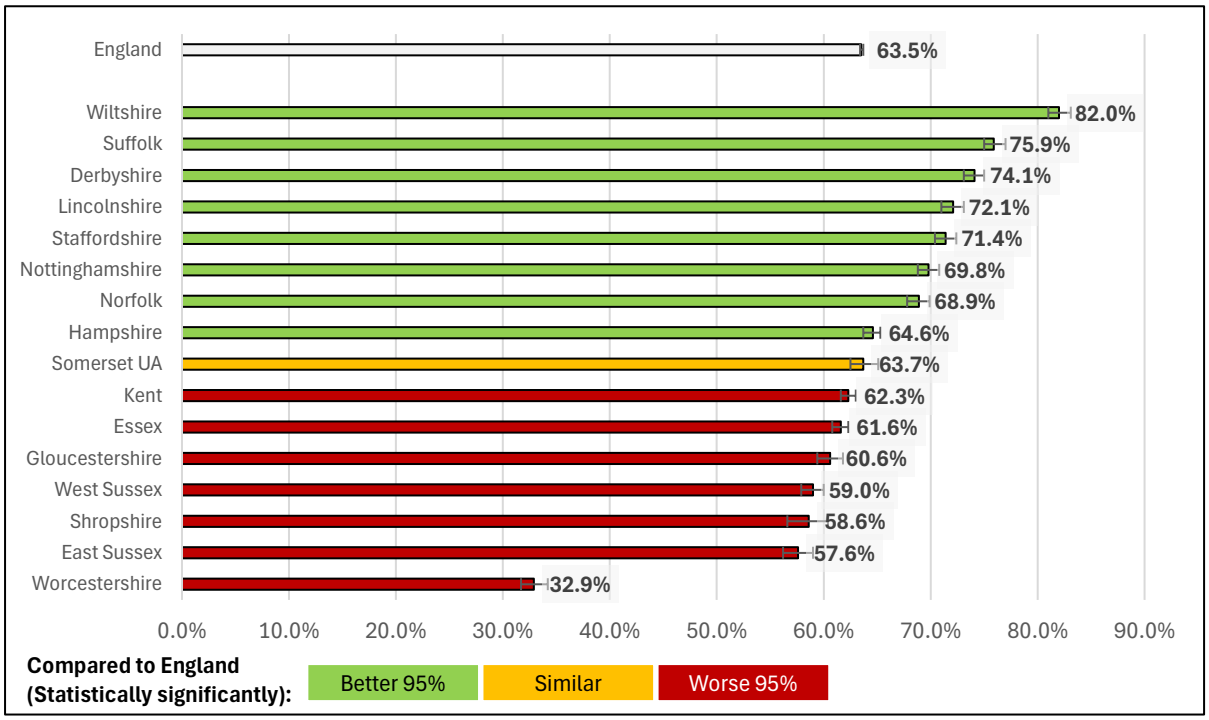
Figure 24. Early access to maternity care, Suffolk and England, 2019/20 to 2023/24



Source: Office for Health Improvement and Disparities (2024)

Within Suffolk's NHS England peer group in 2023/24, Suffolk demonstrated the second-highest value at 75.9% of women accessing booking appointments within 10 weeks. Only Wiltshire performed better at 82.0%. The peer group showed considerable variation, ranging from Worcestershire's 32.9% to Wiltshire's 82.0%, a difference of 49 percentage points.

Figure 25. Early access to maternity care, Suffolk and NHS England peers, 2023/24



Source: Office for Health Improvement and Disparities (2024)

Access rate to specialist perinatal mental health services

Specialist perinatal mental health services provide assessment and treatment for women experiencing moderate to severe mental ill health during pregnancy and up to one year after birth. These services offer specialist interventions beyond what can be provided in primary care or general mental health services, including psychological therapies, psychiatric assessment and medication management, and support for women with severe mental illness or perinatal psychosis. Access to specialist perinatal mental health services is necessary for women with more complex or severe conditions, given the serious consequences of untreated perinatal mental illness for mothers, babies, and families.

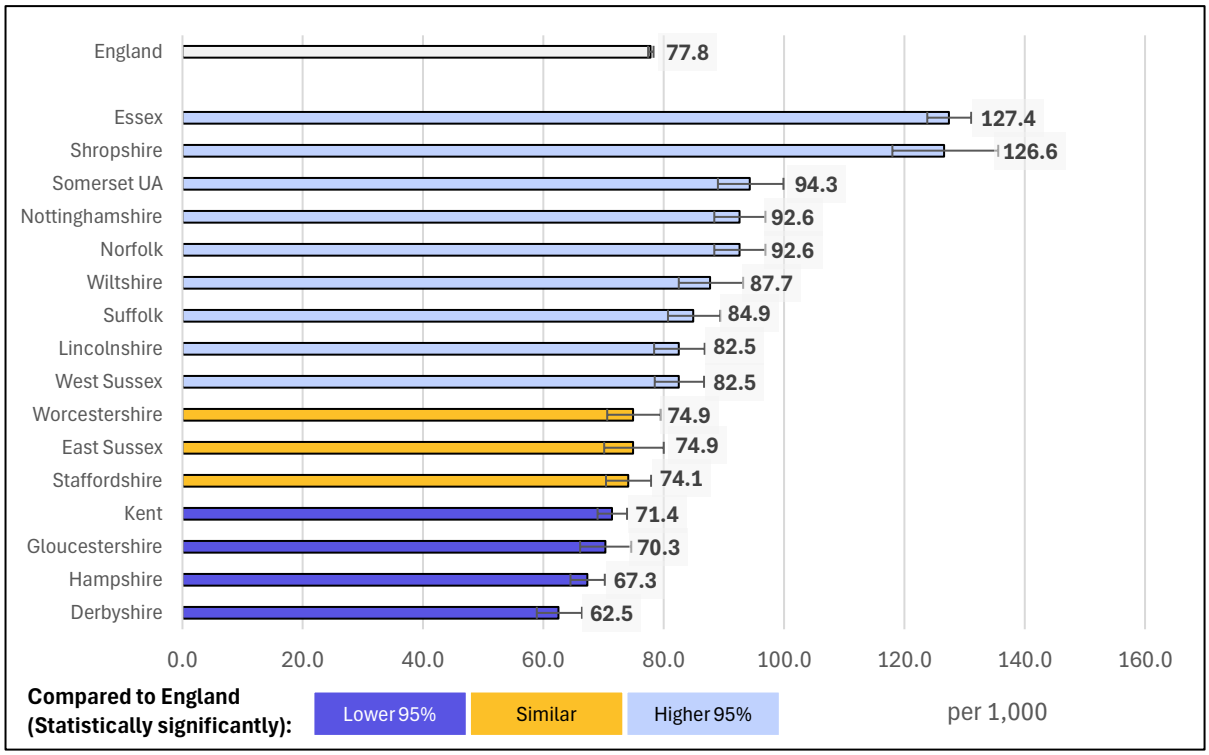
This indicator measures the directly age-standardised rate of access to specialist community perinatal mental health services per 1,000 women having a delivery. It reflects the interaction between the prevalence of perinatal mental ill-health in the community, the capacity of primary care to manage needs, and the activity levels and capacity of local specialist perinatal mental health services.

Data for this indicator combines three years (2020/21 to 2022/23) to provide more robust estimates. Suffolk had an access rate of 84.9 per 1,000 women having a delivery, meaning approximately 85 per 1,000 women in Suffolk who gave birth accessed specialist perinatal mental health services during this period. This equated to approximately 1,495 women in Suffolk across the three-year period, or approximately 500 women per year.

Suffolk's access rate was almost 10% above the England average of 77.8 per 1,000 and ranked 7th among the 15 NHS England peer areas. The highest access rates were observed in Essex (127.4 per 1,000) and Shropshire (126.6). The lowest access rates were in Derbyshire (62.5), Hampshire (67.3), and Gloucestershire (70.3).

The substantial variation across peer areas ranging from 62.5 to 127.4 per 1,000 likely reflects differences in service capacity and configuration, referral thresholds and pathways, prevalence of perinatal mental health conditions across the country, and the balance between primary care, mental health services, and specialist perinatal services in managing perinatal mental health needs.

Figure 26. Directly standardised access rate per 1,000 to specialist perinatal mental health services, Suffolk and NHS peers, 2020/21 to 2022/23



Source: Office for Health Improvement and Disparities (2025)

Deliveries to women from ethnic minority groups

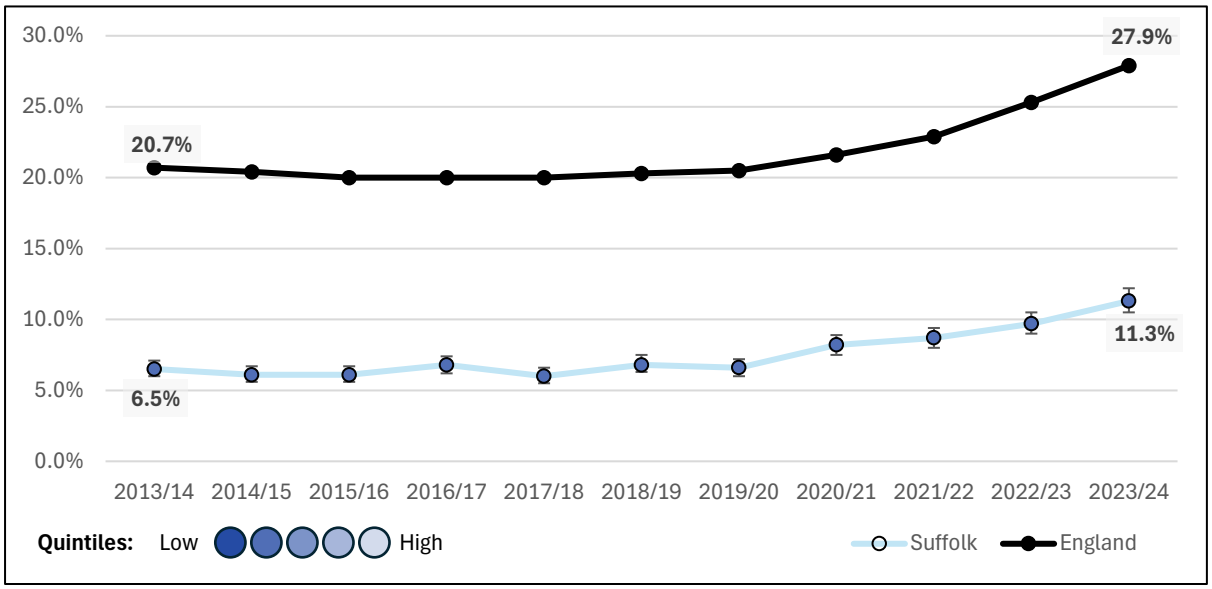
Understanding the ethnic groups of women giving birth is important for perinatal mental health service planning and delivery. Evidence shows that women from ethnic minority groups can experience specific maternal health inequalities, with South Asian and Black women more likely to have babies born preterm or small for gestational age, and higher stillbirth rates, and South Asian women at increased risk of perineal tears[182].

Cultural factors, language barriers, experiences of discrimination and differences in help-seeking behaviours may also affect how women from ethnic minority groups access and experience perinatal mental health services.

Suffolk has experienced a statistically significant increase in the proportion of deliveries to women from ethnic minority groups over the past decade. In 2013/14, 6.5% of deliveries were to women from ethnic minority groups. This proportion has statistically significantly increased to 11.3% in 2023/24, an increase of over 70% over the period. The most notable increase occurred from 2020/21 onwards, with the proportion rising from 8.2% to 11.3% over three years.

Throughout this period, Suffolk has had statistically significantly lower proportions than the England average, which increased from 20.7% in 2013/14 to 27.9% in 2023/24. However, the gap has narrowed slightly, from 14.2 percentage points in 2013/14 to 16.6 percentage points in 2023/24.

Figure 27. Percentage of deliveries to women from ethnic minority groups, Suffolk and England, 2013/14 to 2023/24

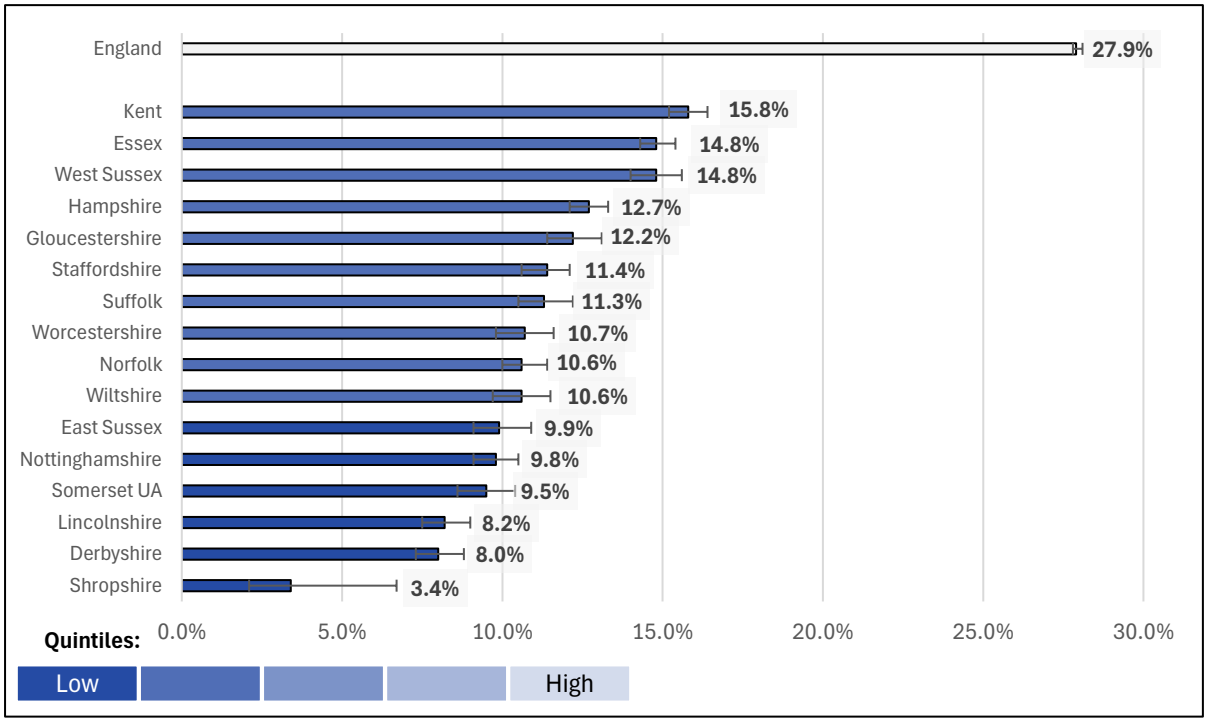


Source: Office for Health Improvement and Disparities (2025)

In 2023/24, Suffolk had 11.3% of deliveries to women from ethnic minority groups, equivalent to 640 women. Suffolk ranked 8th among its 15 NHS England peer areas, placing it in the middle of the peer group.

All peer areas had statistically significantly lower proportions of deliveries to ethnic minority women compared to the England average of 27.9%, reflecting the predominantly rural and less ethnically diverse nature of these counties compared to urban areas.

Figure 28. Percentage of deliveries to women from ethnic minority groups, Suffolk and NHS England peers, 2023/24



Source: Office for Health Improvement and Disparities (2025)

Factors affecting perinatal mental health

Various individual, family, and community-level factors influence perinatal mental health. Understanding these risk and protective factors helps identify women who may benefit from additional support and informs service planning.

Individual

Several individual-level factors are associated with increased risk of perinatal mental ill health, including teenage pregnancy, pregnancy complications, multiple births, premature birth, smoking and substance use, and adverse birth outcomes.

Teenage pregnancy and births: Suffolk has a statistically significantly higher under 18s birth rate (4.5 per 1,000 in 2023) compared to England (3.0 per 1,000), with 57 births to under 18s. The under 18s conception rate was 14.6 per 1,000 in 2022, statistically similar to England (13.9). Teenage mothers face challenges including higher rates of social disadvantage, interrupted education, and increased risk of perinatal mental ill health.

Pregnancy complications: Ectopic pregnancy is a serious condition that usually results in hospital admission. Pelvic inflammatory disease (PID) is a clinical syndrome referring to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. Ectopic pregnancy can be traumatic and is associated with grief, anxiety, and depression. Suffolk's admission rate for ectopic pregnancy was 89.1 per 100,000 women in 2023/24, statistically similar to the England average of 95.8 per 100,000.

Health behaviours in pregnancy: Smoking and obesity in pregnancy are risk factors for both physical and mental health complications. Data on smoking in early pregnancy and obesity in early pregnancy for Suffolk is not currently available. However, smoking status at time of delivery shows Suffolk performing statistically significantly better than England, with 4.9% of mothers smoking at delivery in 2024/25 compared to 6.1% nationally. This represents 306 women and indicates relatively good performance on supporting smoking cessation during pregnancy, with a statistically significant downward trend over the previous five years.

Multiple births: Multiple births are associated with increased stress, practical challenges, and higher rates of postnatal depression. Suffolk's multiple birth rate was 14.3 per 1,000 maternities in 2023 (94 multiple births), statistically similar to the England average of 14.5 per 1,000.

Premature births: Premature birth (before 37 weeks gestation) is associated with increased parental stress, anxiety, and depression due to infant health concerns, separation during neonatal care, and uncertainty about outcomes. Suffolk's premature birth rate was 75.8 per 1,000 live births in 2020-22 (1,572 premature births), also statistically similar to England (77.0 per 1,000).

Ethnicity: As discussed previously, Suffolk has a statistically significantly lower proportion of deliveries to women from ethnic minority groups (11.3% in 2023/24) compared to England (27.9%). Women from ethnic minority backgrounds may face specific barriers to accessing perinatal mental health support and experience particular risk factors including discrimination, and cultural or language barriers.

Adverse birth outcomes: Stillbirth and low birth weight are traumatic events associated with grief, depression, anxiety, and post-traumatic stress. Suffolk's stillbirth rate was 4.1 per 1,000

births in 2021-23, statistically similar to England (4.0 per 1,000). Low birth weight of term babies affected 3.0% of births in Suffolk in 2024 (171 babies), identical to the England average.

Breastfeeding: Breastfeeding is generally protective for maternal mental health[183], though difficulties with breastfeeding can contribute to stress and low mood. Suffolk's breastfeeding prevalence at 6-8 weeks was 54.0% (3,420 infants), slightly below the England average of 55.6%.

Overall, Suffolk's profile on individual-level risk factors is broadly similar to England, with some positive indicators including lower smoking status at time of delivery. The lower proportion of births to mothers from ethnic minority backgrounds means that while the number requiring culturally appropriate support is smaller than in more diverse areas, ensuring services are accessible and responsive to these women remains important.

Table 4. Factors affecting perinatal mental health: individual factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Under 18s conception rate	2022	180	14.6	13.9	34.4	5.1
Ectopic pregnancy admissions rate / 100,000	2023/24	-	89.1	95.8	234.3	42.2
Smoking in early pregnancy	2023/24	-	-	13.6%	-	-
Obesity in early pregnancy	2023/24	-	-	26.2%	-	-
Multiple births	2023	94	14.3	14.5	5.4	25.3
Under 18s birth rate	2023	57	4.5	3.0	10.9	0.7
Premature births (less than 37 weeks gestation)	2020-22	1,572	75.8	77	106.8	52.3
Deliveries to women from ethnic minority groups	2023/24	640	11.3%	27.9%	2.1%	74.5%
Smoking status at time of delivery	2024/25	306	4.9%	6.1%	13.2%	2.2%
Stillbirth rate	2021-23	-	4.1	4.0	6.9	1.5
Low birth weight of term babies	2024	171	3.0%	3.0%	5.2%	1.7%
Breastfeeding prevalence at 6 to 8 weeks	3,420	54.0%	55.6%	-	-	-

Compared to England (Statistically significantly):

Better 95% | Similar | Worse 95%

Quintiles:

Low | | | | High

Source: Office for Health Improvement and Disparities (2025)

Family

Family circumstances and stressors influence perinatal mental health. Domestic abuse, financial pressures, and infant health concerns can all contribute to maternal distress during the perinatal period.

Domestic abuse: Domestic abuse is a risk factor for perinatal mental ill health and can escalate during pregnancy and after birth. Women experiencing domestic abuse are at increased risk of depression, anxiety, post-traumatic stress disorder, and self-harm. Suffolk's reported rate of domestic abuse related incidents and crimes was 21.5 per 1,000 in 2023/24,

lower than the England average of 26.1 per 1,000, placing Suffolk in the lowest quintile nationally. While this lower rate is positive, domestic abuse remains under-reported, and pregnant women and new mothers experiencing abuse require safe pathways to disclose and access support through maternity and perinatal mental health services.

Housing affordability: Financial stress and housing insecurity are risk factors for perinatal mental ill health. The affordability of home ownership, measured as the ratio of median house prices to median earnings, was 7.9 in Suffolk in 2024 (median house price £282,500), close to the England average of 7.7 and placing Suffolk in the middle/third quintile nationally. This indicates significant housing affordability challenges that may contribute to financial stress for families during the perinatal period.

Infant health concerns: Infant illness requiring hospital admission is a significant source of stress, anxiety, and depression for parents. Suffolk has notably higher rates of hospital admissions among very young infants. The admission rate for babies under 14 days was 132.5 per 1,000 live births in 2023/24 (750 admissions), statistically significantly higher than the England average of 88.7 per 1,000. Emergency admissions for children aged 0 to 4 years were also statistically significantly higher in Suffolk at 431 per 1,000 (2,955 admissions) compared to England's 387.0 per 1,000.

Emerging local analysis of emergency admissions among children under five suggests that respiratory illness is a major contributor to this pattern. Early findings indicate that lower respiratory tract infections (LRTIs), particularly unspecified bronchiolitis and Respiratory syncytial virus (RSV) bronchiolitis, account for a substantial proportion of admissions, with the highest rates seen in infants aged 0–3 months and 3–6 months. This age profile aligns closely with the elevated admission rates observed in the earliest weeks of life. Admissions also show strong seasonality, peaking in autumn and early winter, and are more common among male infants than females. While deprivation contributes to risk, early findings suggest that high admission rates are observed across both more and less deprived areas, indicating that deprivation alone does not fully explain the pattern.

Table 5. Factors affecting perinatal mental health: family factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Domestic abuse related incidents and crimes	2023/24	-	21.5	26.1	9.9	43.2
Affordability of home ownership	2024	£282,500	7.9	7.7	22.8	4.0
Admissions of babies under 14 days	2023/24	750	132.5	88.7	679.2	16.3
Emergency admissions (0 to 4 years)	2023/24	2,955	431	387.0	1,000	105.0

Compared to England (Statistically significantly):

Better 95% | Similar | Worse 95%

Quintiles:

Low | | | | High

Best | | | | Worst

Source: Office for Health Improvement and Disparities (2025)

Community and structural

Broader community characteristics and structural factors shape the environment that women experience pregnancy and early parenthood, which influences their mental health and wellbeing.

Population mental health: The underlying prevalence of mental health conditions in the community provides context for perinatal mental health diagnosed. Depression prevalence from the Quality and Outcomes Framework (QOF) was 14.8% in Suffolk in 2024/25 (100,367 people), statistically significantly higher than the England average of 14.3%. However, the incidence of new depression diagnoses was 1.0% in 2024/25, statistically significantly lower than England's 1.4%. Higher prevalence combined with lower incidence may reflect good identification and ongoing management of depression in primary care. The overall mental health QOF prevalence was 1.0% in Suffolk in 2024/25 (8,191 people), identical to the England average.

Social isolation and loneliness: Loneliness is a risk factor for perinatal mental ill health, particularly for new mothers who may experience isolation following birth. In Suffolk, 6.4% of adults reported feeling lonely often or always in 2022/23-2023/24, statistically similar to the England average of 7.0% (higher among younger age groups across England). Pregnant women and new mothers may be particularly vulnerable to social isolation, especially in rural areas with limited transport and community connections.

Access to healthy assets: The Access to Healthy Assets and Hazards Index measures access to health-promoting resources (such as green spaces, leisure facilities, GP surgeries) and exposure to health hazards (such as fast-food outlets, gambling establishments). Suffolk scored 10.6% in 2024 (81,600 people with poor access), better than the England average of 20.9% and placing Suffolk in the second lowest (best) quintile nationally. This indicates good access to health-promoting environments, which can support wellbeing during pregnancy. However, geographic and socioeconomic inequalities exist within Suffolk, particularly between urban and rural areas and between more and less deprived communities, meaning some groups may experience poorer access to supportive environments and services.

Air pollution: Exposure to air pollution during pregnancy is associated with adverse birth outcomes and may affect maternal mental health. Suffolk's fine particulate matter (PM2.5) concentration was 7.0 $\mu g/m^3$ in 2023, identical to the England average and placing Suffolk in the middle quintile nationally. This indicates average air quality that is unlikely to be a major differentiating factor for perinatal mental health compared to other areas.

Deprivation: Socioeconomic deprivation is one of the strongest predictors of perinatal mental ill health, with women in deprived areas facing multiple stressors including financial hardship, poor housing, unemployment, and limited social support. Suffolk's average Index of Multiple Deprivation (IMD) score was 18.8 in 2025, statistically significantly lower (better) than the England average of 21.8 and placing Suffolk in the second lowest (least deprived) quintile nationally. However, as already demonstrated throughout this needs assessment, there is considerable internal variation in levels of deprivation across the county, with more deprived areas likely to have substantially elevated perinatal mental health needs compared to more affluent areas of the county.

Table 6. Factors affecting perinatal mental health: community and structural factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Depression: QOF prevalence	2024/25	100,367	14.8%	14.3%	7.1%	23.5%
Depression: QOF incidence - new diagnosis	2024/25	-	1.0%	1.4%	0.6%	3.8%
Loneliness: Percentage of adults who feel lonely often or always	2022/23 - 23/24	-	6.4%	7.0%	12.7%	4.2%
Mental health: QOF prevalence (All ages)	2024/25	8,191	1.0%	1.0%	0.6%	1.7%
Access to Healthy Assets & Hazards Index	2024	81,600	10.6%	20.9%	99.3%	1.3%
Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	2023	-	7.0	7.0	9.2	4.4
Deprivation score (IMD 2025)	2025	-	18.8	21.8	43.5	6.1

Compared to England (Statistically significantly):

Higher 99.8% | Similar | Lower 99.8%

Quintiles:

Best / Low | Worst / High

Source: Office for Health Improvement and Disparities (2025)

Adult mental health

1. **Common mental health conditions are widespread among adults**

Around 1 in 5 adults at any point in time across England experience a common mental health condition, reflecting high underlying need within the adult population. This has also increased over time, as 10 years ago, in 2016, 1 in 6 adults were experiencing a common mental health condition at any point in time

2. There is a substantial **gap between need and clinical recognition**.

Among adults who are currently experiencing the symptoms of a common mental health condition across England, according to the APMS **fewer than one in three have ever received a professional diagnosis**, and **fewer than one in five** report a diagnosis in the past 12 months, indicating significant unmet need and barriers to access

3. **Mental health inequalities are pronounced**, with a strong **social gradient**. Adults living in more deprived areas are significantly more likely to experience common mental health conditions than those in less deprived areas, highlighting the necessity of place-based, and preventative approaches

Using population health management data for Suffolk and North East Essex ICB, in September 2025, 38.3% of individuals living in IMD decile 1 (the most deprived areas) had one or more indicators of depression, anxiety, low mood or serious mental illness in primary or secondary care records, compared to 28.5% from IMD decile 10 (the least deprived areas)

4. **Younger adults experience the highest levels of distress**, particularly **young women**, who report higher rates of suicidal thoughts, suicide attempts and self-harm. Although prevalence declines with age, mental health need remains present across all adult age groups

Using the APMS for England, over one third (36.3%) of women aged 16 to 24 experience suicidal thoughts, and nearly one in three (31.7%) self-harm, compared to one quarter (26.0%) and one in six (15.4%) of men in the same age group, respectively

5. **Suffolk's ageing population is likely to increase demand** for later-life mental health and wellbeing support, including for depression, anxiety, loneliness, dementia-related mental health needs and mental/physical multi-morbidity

Using 2025 sub-national population projections, the 85 and over population is expected to increase by 52.2%, and the 65-84 population in Suffolk is expected to increase by 23.6% by 2047

6. Despite relatively positive community safety indicators in Suffolk, several population groups are at **higher risk of poor mental health**, including people in contact with the criminal justice system, carers, people experiencing homelessness, Gypsy, Roma and Traveller communities, veterans, refugees and asylum seekers, and LGBTQ+ people. These groups often face multiple and overlapping disadvantages, underlining the need for targeted and inclusive mental health approaches

How widespread are mental health conditions?

Mental health conditions are common in England, with national survey data providing context for understanding the scale and distribution of mental health need, though it should be noted that these surveys provide national and regional estimates rather than local authority-level data.

England – Adult Psychiatric Morbidity Survey

Common mental health conditions (CMHCs) include conditions such as depression, anxiety, panic disorder, phobias, and obsessive-compulsive disorder[158].

Prevalence estimates for common mental health conditions (CMHCs) in this needs assessment are from the Adult Psychiatric Morbidity Survey using the Clinical Interview Schedule – Revised (CIS-R). The CIS-R assesses non-psychotic symptoms experienced in the week prior to interview. Adults with a CIS-R score of 12 or more are classified as having a CMHC, indicating severity of symptoms at a level where primary care recognition is likely to be warranted. Diagnoses are generated using International Classification of Disease 10th revision (ICD-10) criteria, allowing comparability across APMS survey waves.

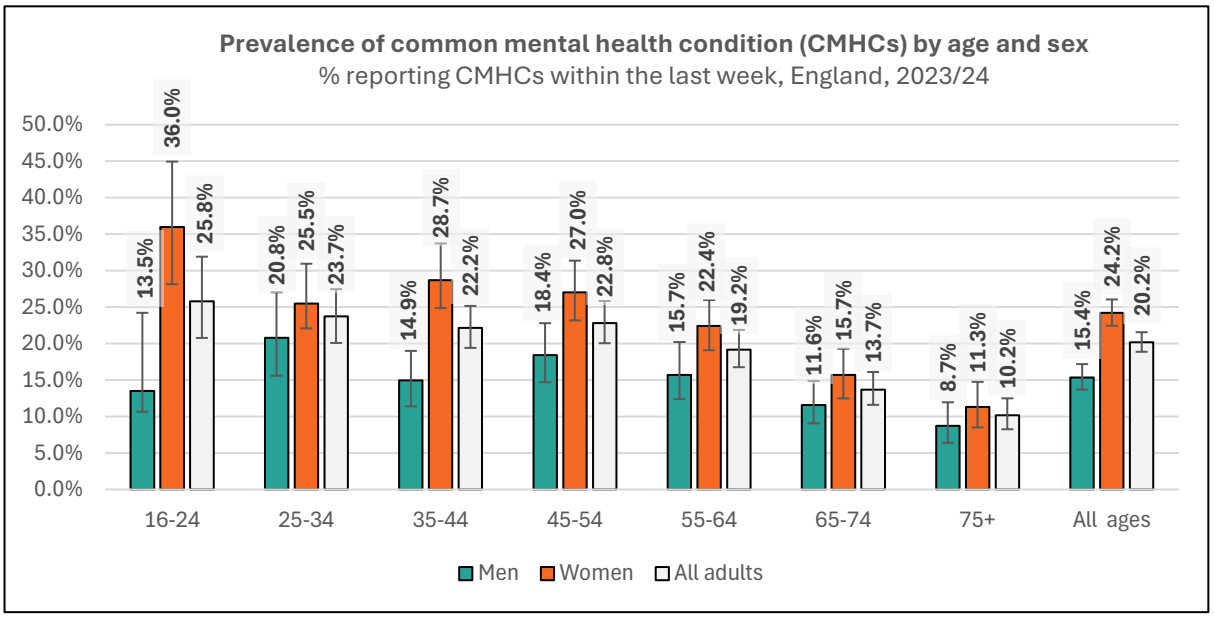
The APMS also refers to the point prevalence of common mental health condition symptoms; these estimates reflect the proportion of adults experiencing symptoms at a level consistent with a CMHC in the week prior to interview, rather than the proportion with a recorded clinical diagnosis.

This differs from prevalence based on diagnosed conditions recorded in health care data, which depends on help-seeking behaviour, access to services, diagnostic thresholds and recording practices. As a result, diagnosed prevalence is typically lower than symptom-based prevalence and does not capture unmet need.

The APMS provides the most robust national estimate of population mental health need at a point in time, including people who have not sought help or received a diagnosis. However, the presence of symptoms does not always indicate a confirmed mental health condition or need, as similar symptoms may also be associated with physical health conditions, stressors, or other life circumstances.

According to the 2023/24 Adult Psychiatric Morbidity Survey, one in five adults aged 16 and over (20.2%) had symptoms of a CMHC in the week before being surveyed. CMHCs have become more widespread over time, with prevalence of symptoms rising by approximately one-fifth in both men and women between 1993 and 2023/24[158]. The symptoms of CMHCs are more common among women than men across all age groups, with the difference most pronounced among those aged 16 to 24.

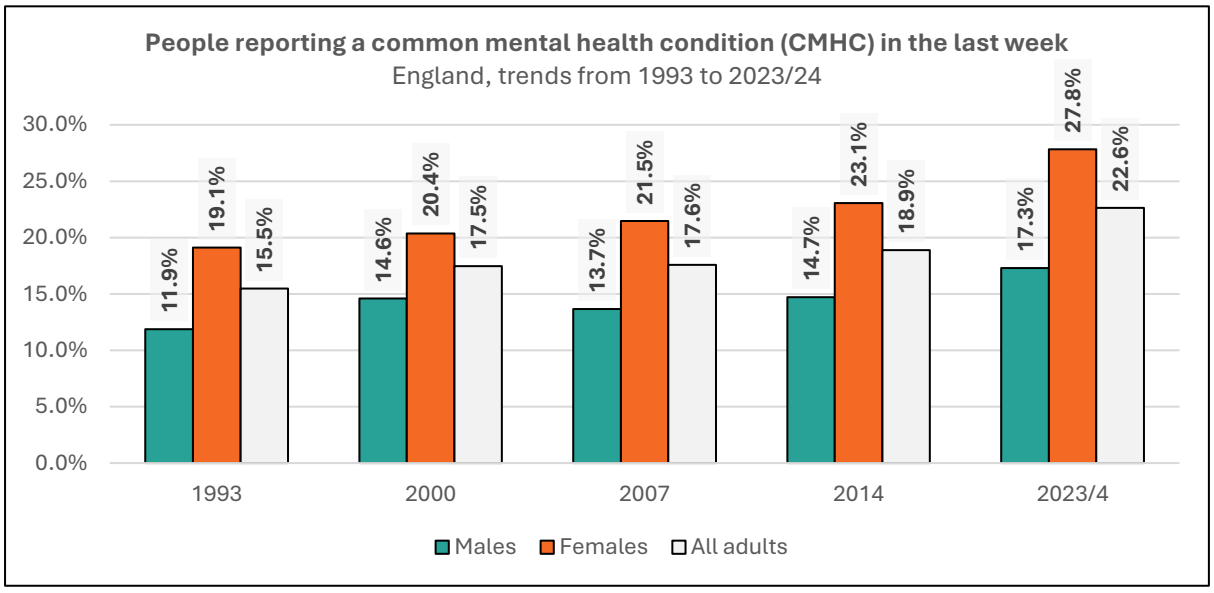
Figure 29. Percentage of people reporting symptoms of a common mental health condition (CMHC) in the last week by age and sex in England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.3

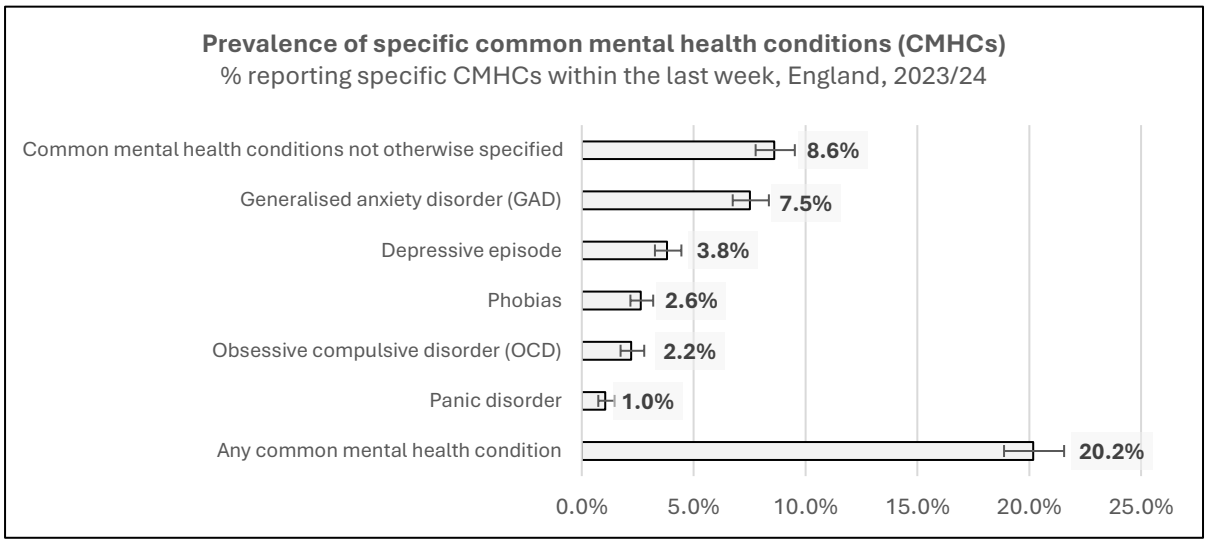
Generalised anxiety disorder was the most reported CMHC of people surveyed in the past week (7.5%), followed by depressive episodes (3.8%).

Figure 30. Percentage of people reporting symptoms of a common mental health condition (CMHC) in the last week, England, 1993 to 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.4

Figure 31. Prevalence of specific common ICD-10 mental health conditions (CMHCs) derived from CIS-R, all adults, England, 2023/24

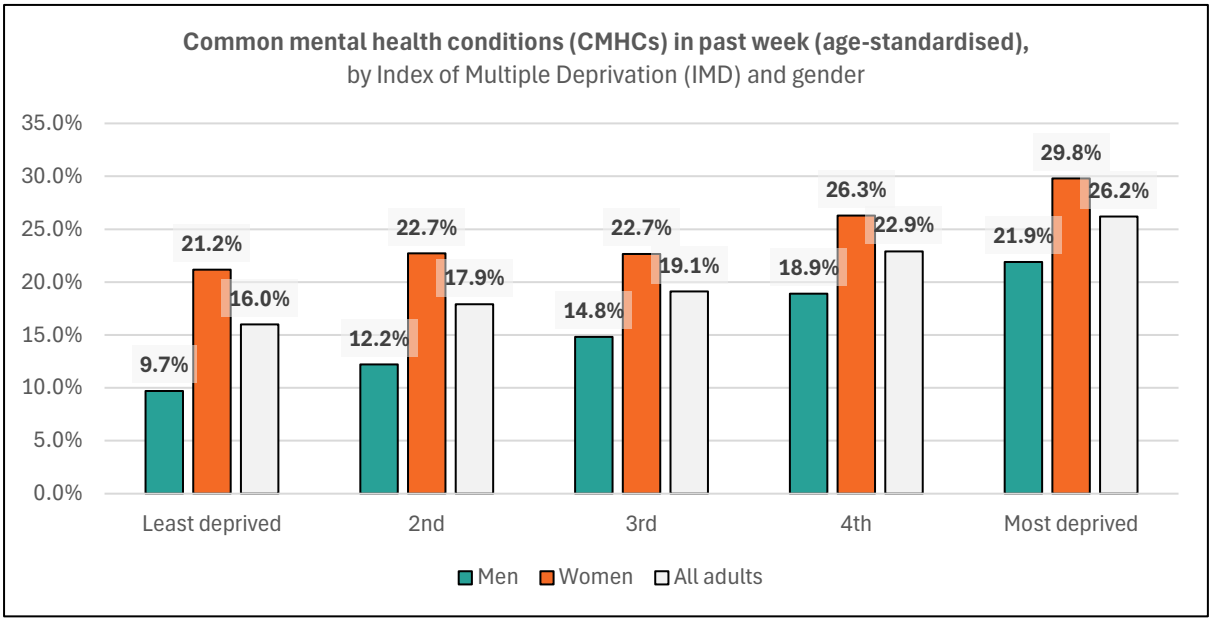


Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.3

There is a clear social gradient in common mental health conditions across England. The prevalence of experiencing symptoms of any CMHC in the past week increases steadily with deprivation for men, women and adults overall.

Among all adults, prevalence of self-reported common mental health condition symptoms in the last week rises from 16.0% in the least deprived areas to 26.2% in the most deprived. This gradient is particularly pronounced for men, where prevalence of self-reported common mental health condition symptoms more than doubles from 9.7% in the least deprived quintile to 21.9% in the most deprived. Women have higher prevalence of common mental health conditions symptoms than men across all deprivation quintiles, increasing from 21.2% in the least deprived areas to 29.8% in the most deprived.

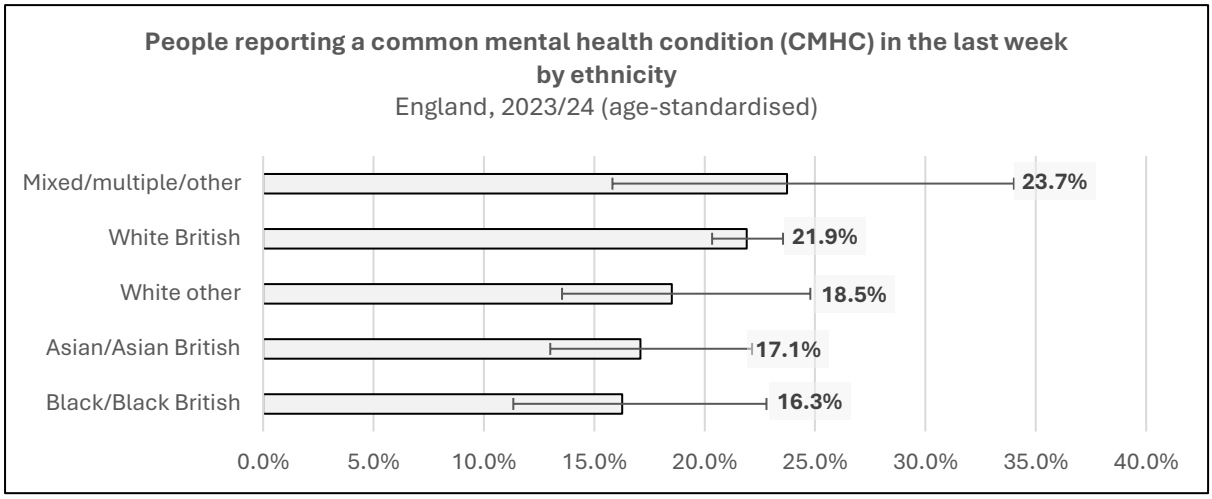
Figure 32. People reporting symptoms of a common mental health condition (CMHC) in the last week by Index of Multiple Deprivation (IMD) quintile and gender, England, age-standardised, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.9

People identifying as Mixed/multiple/other ethnic groups had higher rates of CMHCs (23.7%) compared to White British people (21.9%), although figures for each group were statistically similar due to overlapping 95% confidence intervals.

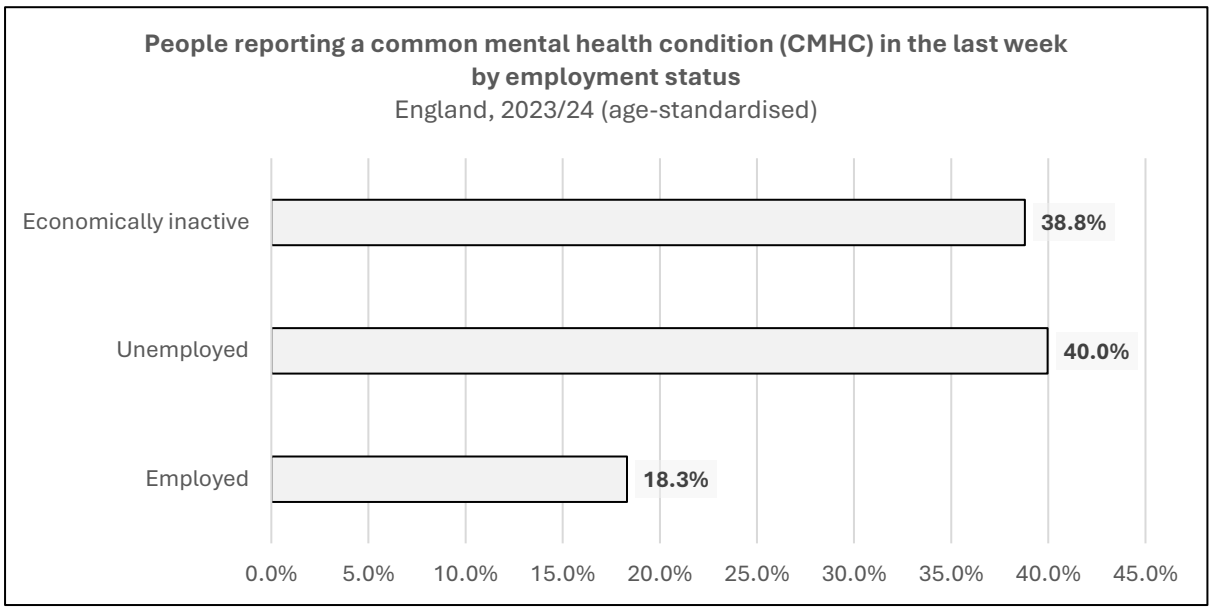
Figure 33. People reporting symptoms of a common mental health condition (CMHC) in the last week by ethnicity, England, age-standardised, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.6

Reported symptoms of CMHCs are also more common among people who are economically inactive (38.8%) or unemployed (40.0%) compared to those in full-time employment (18.3%).

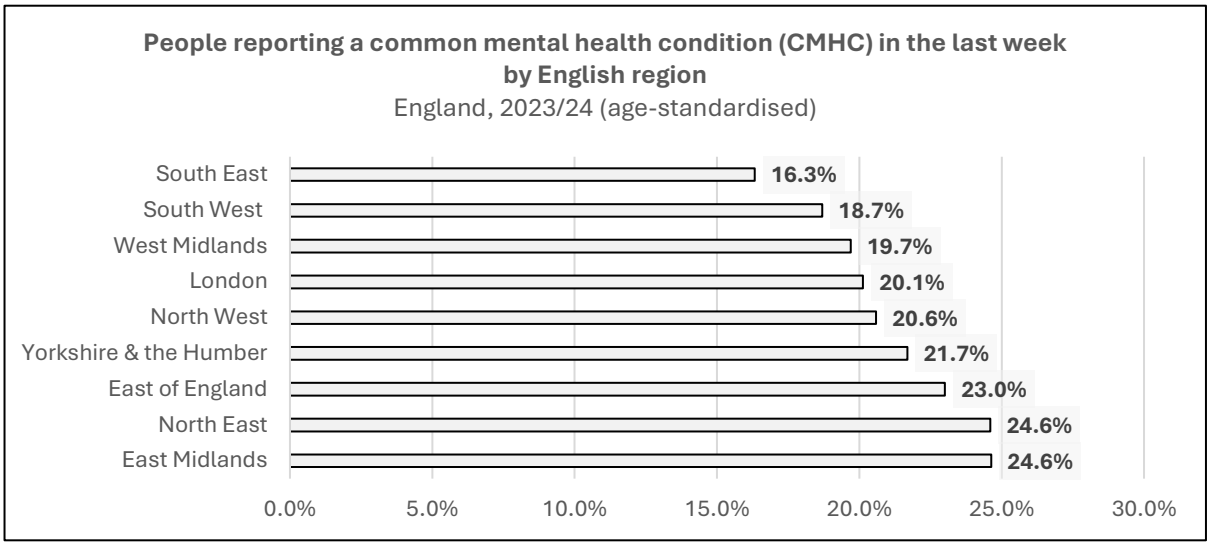
Figure 34. People reporting symptoms of a common mental health condition (CMHC) in the last week by employment status, England, age-standardised, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.7

Regional variation exists, with CMHCs least common in the South East and South West (16.3% and 18.7% respectively) and most common in the East Midlands and North East (both 24.6%). Data from the 2023 GP Patient Survey found that 13% of patients reported having ill mental health, with higher self-reported prevalence also in parts of the North of England, the South West, and the Midlands.

Figure 35. People reporting symptoms of a common mental health condition (CMHC) in the last week by English region (age -standardised), 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.10

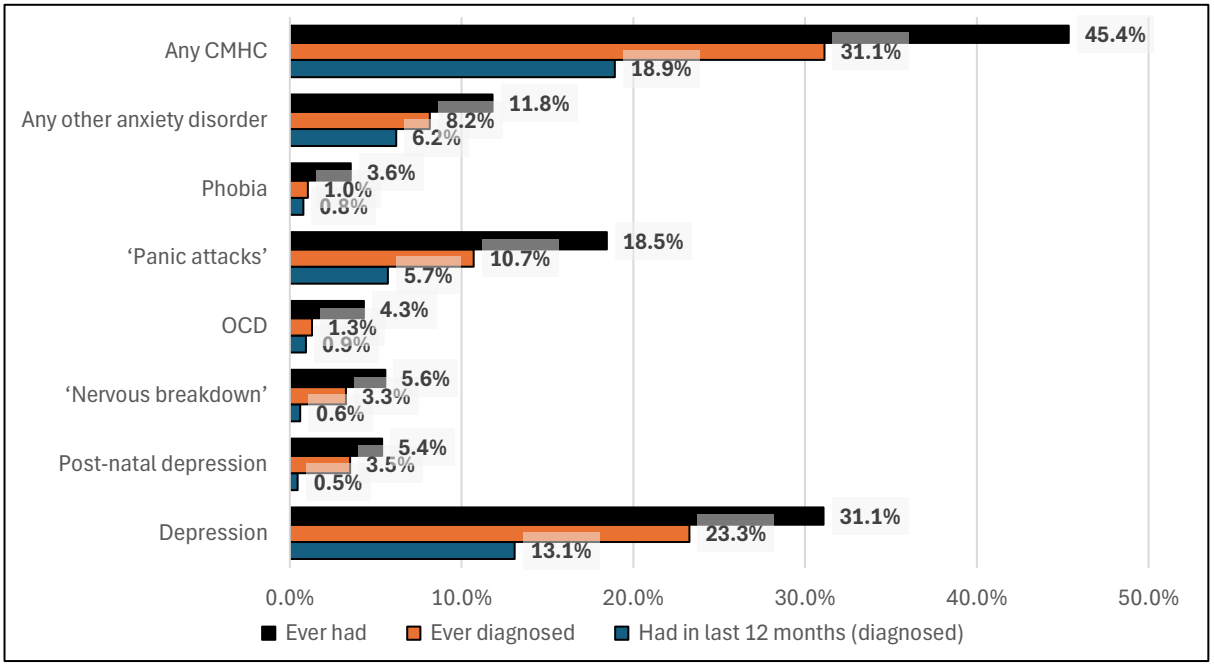
Self-diagnosed and professionally diagnosed common mental health conditions

Among adults who report experiencing the symptoms of a common mental health condition in the past week, APMS 2023/24 data show a marked gap between current need and having ever received a formal, clinical diagnosis. Fewer than one in three report ever having being diagnosed with a CMHC, and fewer than one in five report a diagnosis in the past 12 months. This pattern is consistent across individual conditions and is particularly pronounced for anxiety-related disorders such as OCD, phobias and panic attacks.

However, the presence of symptoms at a single point in time does not necessarily mean a need for diagnosis or clinical treatment. Symptoms captured by the APMS include a wide spectrum of severity and duration, and some may reflect current distress or normal psychological responses to life events, such as bereavement, rather than conditions requiring medical intervention. Clinical thresholds, individual coping strategies, and personal preferences all influence whether a diagnosis may be sought or received.

These findings indicate a complex picture; while a proportion of people with recent symptoms may not require formal diagnosis or treatment, the scale of the difference between symptom prevalence and diagnosis also indicates that some individuals who could potentially benefit from assessment, support or intervention may not be accessing services. This highlights the need for a balanced system offering timely clinical care alongside prevention and early support, as well as reducing barriers to help-seeking where need is present.

Figure 36. Any CHMC in past week: Self-diagnosed CMHC, professional diagnosed CMHC, and presence of professional diagnosed CMHC in past 12 months, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 1.12

Other mental disorders

The Adult Psychiatric Morbidity Survey (APMS) provides national prevalence estimates for several mental disorders beyond common mental health conditions. While local data for Suffolk is not available, these national estimates provide useful context for understanding the breadth of mental health need.

Post-traumatic stress disorder (PTSD): Overall, 5.7% of adults had symptoms suggestive of PTSD, with the highest rates among young people aged 16-24 (11.4%). Rates decreased progressively with age, to 0.5% among those aged 75 and over. PTSD develops following exposure to traumatic events and can have severe and persistent impacts on functioning and wellbeing.

Personality disorders: Screening positive for antisocial personality disorder affected 2.4% of adults, with peak rates in those aged 35-44 (3.5%). Borderline personality disorder affected 2.5% of adults, with substantially higher rates among young people aged 16-24 (6.1%) and also decreasing with age. Both conditions are associated with functional impairment and complex treatment needs.

Attention Deficit Hyperactivity Disorder (ADHD): Among adults, 13.9% reported four or more ADHD characteristics in the past six months, with the highest rates in young people aged 16-24 (25.0%). A further 1.9% reported all six characteristics. These high rates among young adults reflect increasing recognition of ADHD persisting into adulthood, with implications for educational attainment, employment, and mental health.

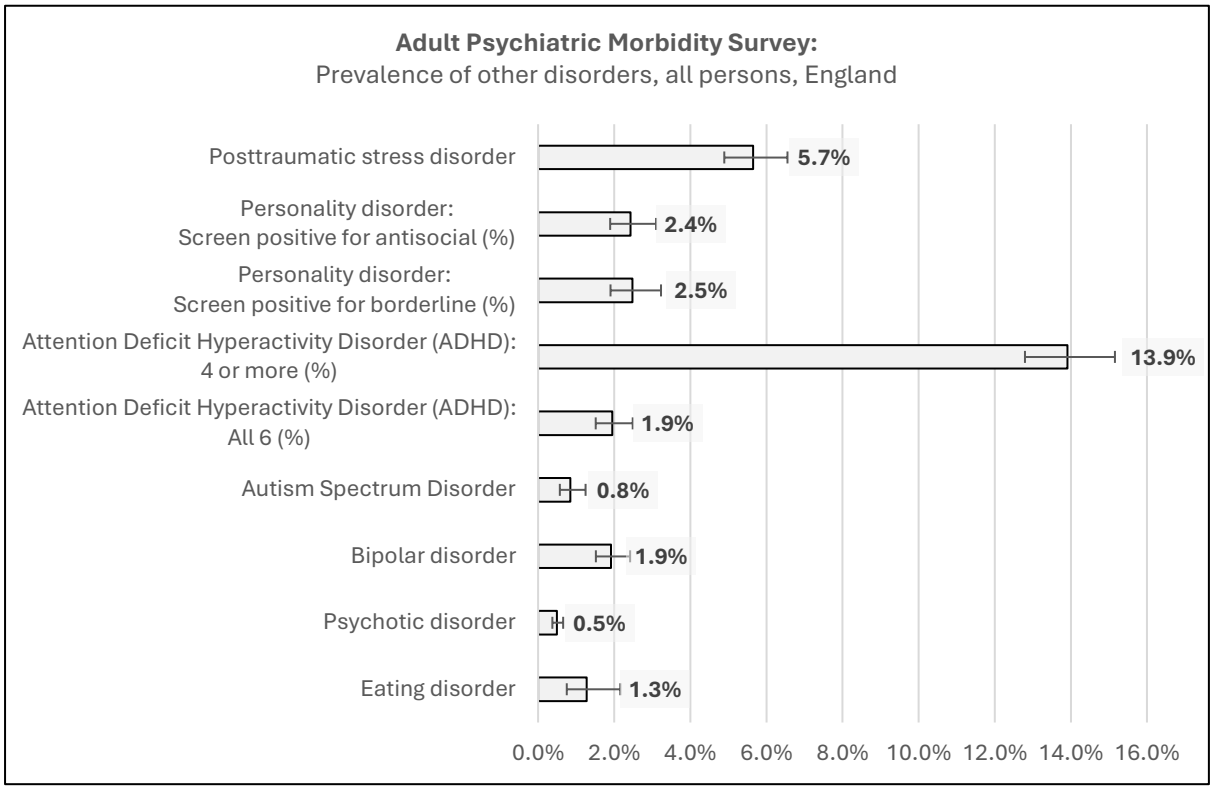
Autism Spectrum Disorder: Overall prevalence was 0.8%, with higher rates among younger adults aged 16-34 (1.5%). Autism is associated with increased vulnerability to co-occurring mental health conditions including anxiety and depression.

Bipolar disorder: Approximately 1.9% of adults screened positive for bipolar disorder, with similar rates across age groups between 16-44.

Psychotic disorder: Overall, 0.5% of adults experienced psychotic disorder in the past year, with rates relatively stable across age groups.

Eating disorders: Among adults, 1.3% experienced an eating disorder in the past year, with the highest rates among those aged 25-34 (2.2%) and 45-54 (2.1%).

Figure 37. Prevalence of other mental disorders from the Adult Psychiatric Morbidity Survey, all persons, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Data tables: 3, 8, 9, 10, 11, 12 13

Limiting physical health condition

Mental and physical health ill health frequently co-exist. People with severe symptoms of CMHCs were more likely to have physical health conditions, with 32.9% reporting conditions such as high blood pressure, asthma, cancer, or epilepsy, compared to 12.6% of those with few or no CMHC symptoms. Participants in the APMS were coded as having a limiting health condition if they reported having one or more physical health condition in the past 12 months that had been diagnosed by a doctor and that this had limited their ability to carry out day-to-day activities.

Problem debt

National data also shows a strong association between problem debt and CMHCs. Adults with problem debt were more than twice as likely to experience any common mental health condition (39.0%) compared to those without problem debt (18.4%). The association was particularly pronounced for specific disorders: those with problem debt were over twice as likely to have generalised anxiety disorder (15.2% vs 6.8%), almost 3 times more likely to experience depressive episodes (9.4% vs 3.2%), and over 4 times more likely to have phobias (8.6% vs 2.1%).

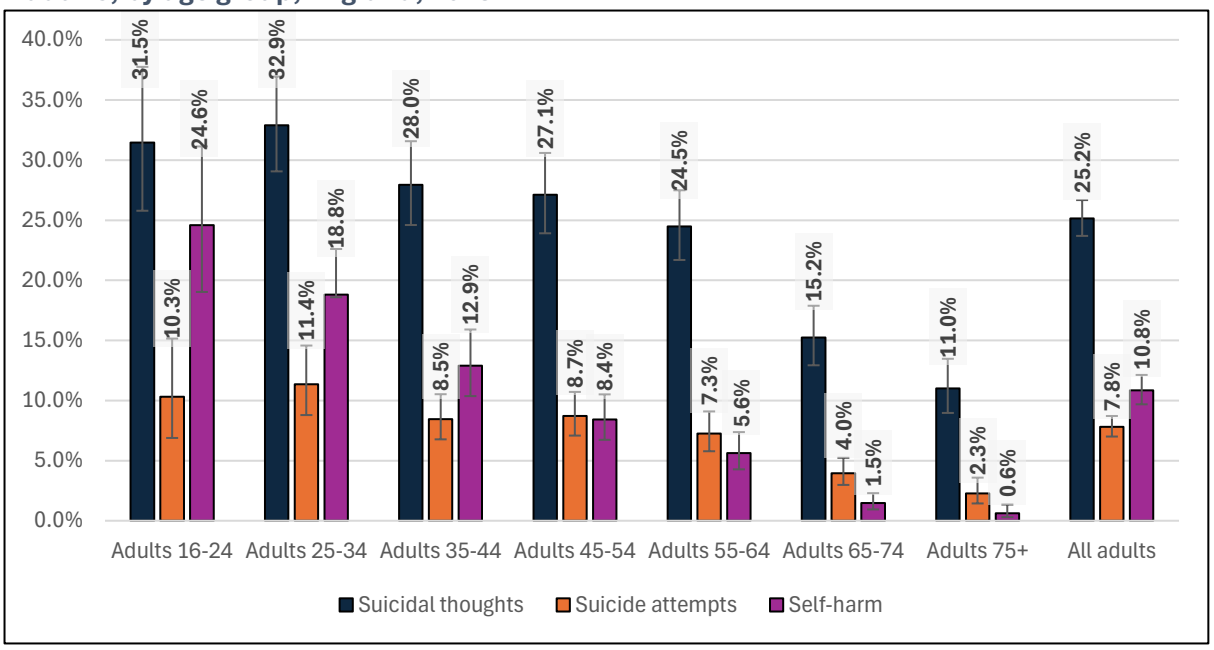
Suicidal thoughts, suicide attempt and self-harm

The APMS also shows suicidal thoughts, suicide attempts and self-harm are common among adults, with clear differences by age and gender. Overall, around one quarter (25.2%) of adults reported having experienced suicidal thoughts, while 7.8% reported a suicide attempt and 10.8% reported self-harm.

The prevalence of suicidal thoughts, suicide attempts and self-harm is highest among younger adults, particularly those aged 16–34. Almost one in three (31.5%) of adults aged 16–24 and 25–34 (32.9%) report suicidal thoughts, and approximately one in ten report a suicide attempt. Self-harm is especially prevalent in younger age groups, affecting around one quarter (24.6%) of 16–24 year olds, before declining steadily with age. Across all measures, prevalence falls sharply in older age groups, particularly among those aged 65 and over.

There are notable gender differences, with women reporting higher levels of suicidal thoughts, suicide attempts and self-harm than men overall, with the largest gender gap seen for self-harm. Among women aged 16–24, over one third report suicidal thoughts (36.3%) and nearly one third report self-harm (31.7%), compared with around one quarter (26.0%) and one sixth of men (15.4%), respectively. Suicide attempts are also more common among women than men across most age groups, although levels converge in later life.

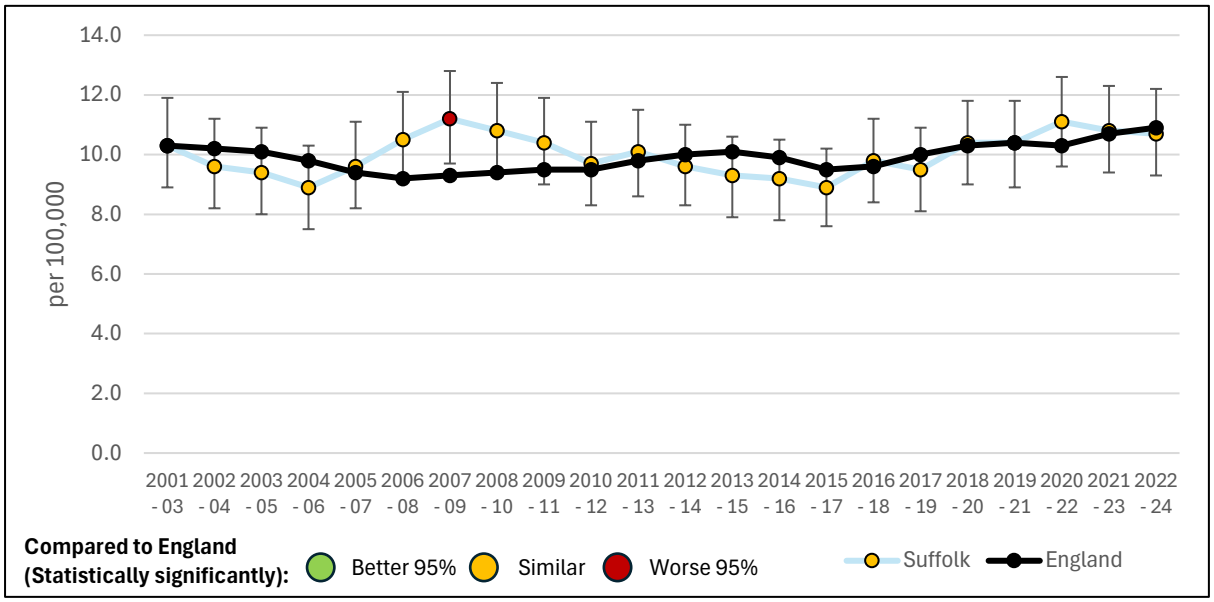
Figure 38. Prevalence of suicidal thoughts, suicide attempts and self-harm among adults, by age group, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 4. Suicidal Thoughts, Suicide Attempts and Self-Harm

While APMS data describe the prevalence of suicidal thoughts and behaviours, suicide mortality provides a complementary measure of the most severe outcomes. In Suffolk, the suicide rate has remained broadly stable over the long term and is statistically similar to the England average in each time period excluding 2007-09. In the most recent period (2022–24), the suicide rate in Suffolk was 10.7 per 100,000 (215 deaths), comparable to the England rate of 10.9 per 100,000.

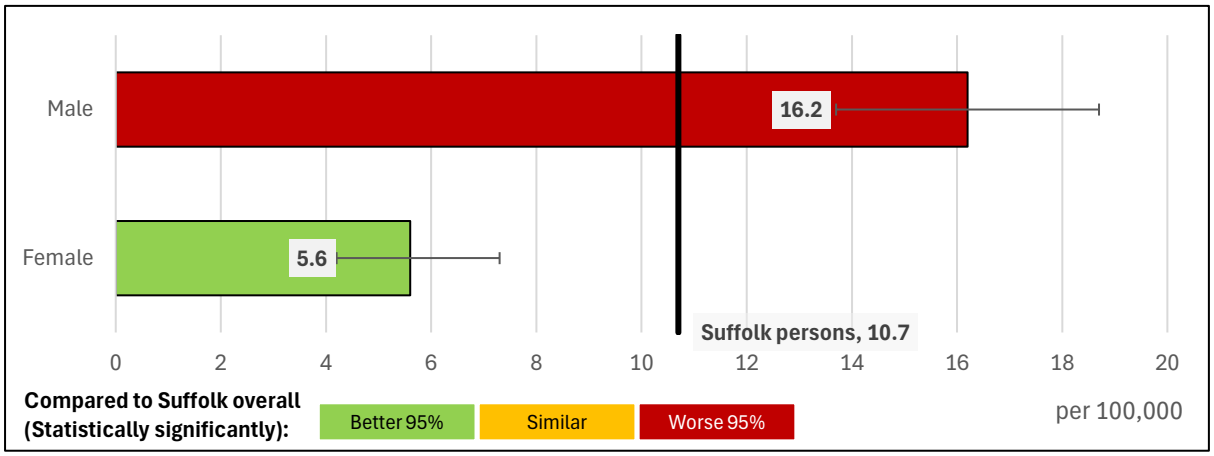
Figure 39. Suicide rate, directly standardised rate per 100,000, Suffolk and England, 2001-03 to 2022-24



Source: Office for Health Improvement and Disparities (2025)

As is seen nationally, suicide mortality in Suffolk is markedly higher among men than women. In 2022–24, the suicide rate among men in Suffolk was 16.2 per 100,000 compared with 5.6 per 100,000 among women. APMS findings show that women report higher levels of suicidal thoughts, attempts and self-harm, highlighting divergence between non-fatal suicidal behaviours and suicide mortality.

Figure 40. Suicide rate, directly standardised rate per 100,000, Suffolk males and females, 2022-24



Source: Office for Health Improvement and Disparities (2025)

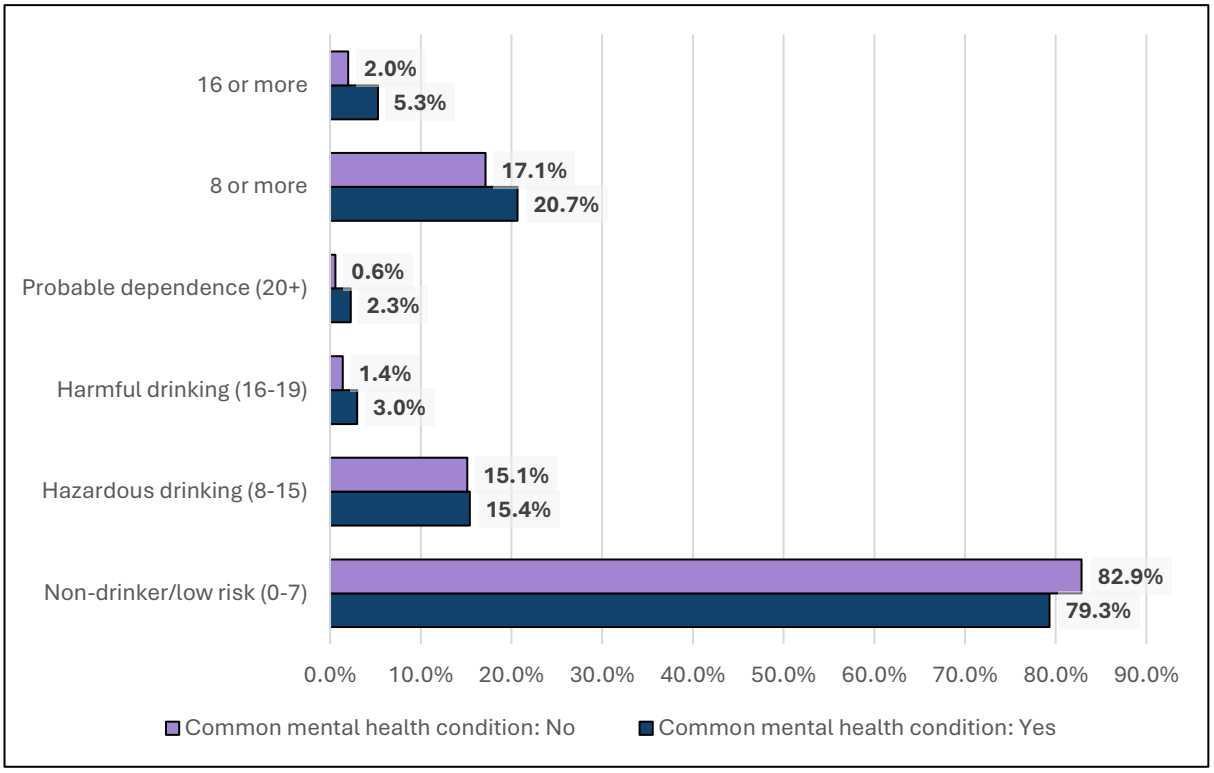
Taken together, these findings indicate that while Suffolk does not have a statistically significantly higher overall suicide rate than England, suicidal ideation and self-harm remain common, particularly among younger adults and women. The mismatch between higher reported distress and self-harm in women and higher suicide mortality in men reinforces the importance of gender and age-specific approaches to suicide prevention, early intervention, and mental health support.

Alcohol dependence

Data from the APMS for England reveals significant associations between alcohol misuse and both physical and mental health conditions. The Alcohol Use Disorders Identification Test (AUDIT) categorises drinking risk: scores of 0-7 indicate low risk, 8-15 hazardous drinking requiring brief intervention, 16-19 harmful drinking or mild dependence warranting extended intervention, and 20+ probable dependence requiring specialist treatment.

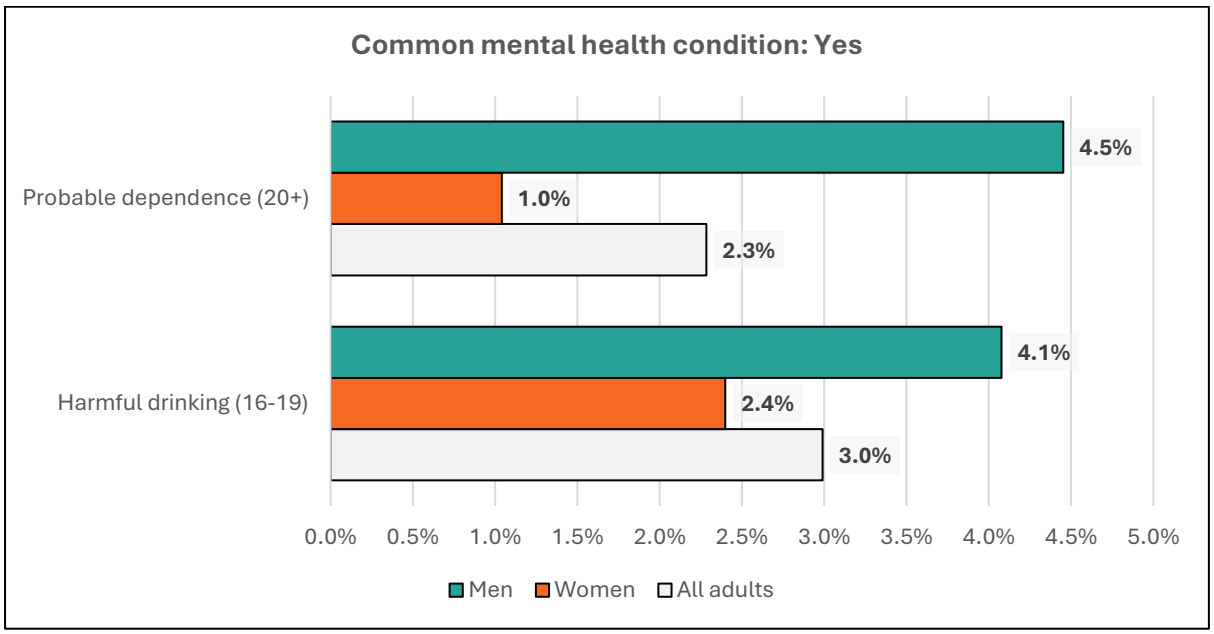
The association between alcohol misuse and symptoms of common mental health conditions was particularly clear. Among men with common mental health conditions, 8.5% scored 16+ on AUDIT compared to just 2.9% without mental health conditions, Women with common mental health conditions also had higher rates (3.4% vs 1.0%). Overall, adults with common mental health conditions were more likely to have any level of alcohol misuse, with 20.7% scoring 8+ compared to 17.1% of those without mental health conditions. 5.3% of adults with common mental health conditions scored 16+, indicating harmful drinking or dependence, compared to just 2.0% of those without.

Figure 41. Harmful and dependent drinking in the past year (age-standardised) by common mental health condition Yes/No, all adults, Alcohol Use Disorders Identification Test (AUDIT), England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 5. Alcohol: hazardous, harmful and dependent patterns of drinking - Data tables, Table 5.8

Figure 42. Harmful and probable dependent drinking in the past year (age-standardised) for adults reporting a common mental health condition: Yes, by men, women and all adults, Alcohol Use Disorders Identification Test (AUDIT), England, 2023/24



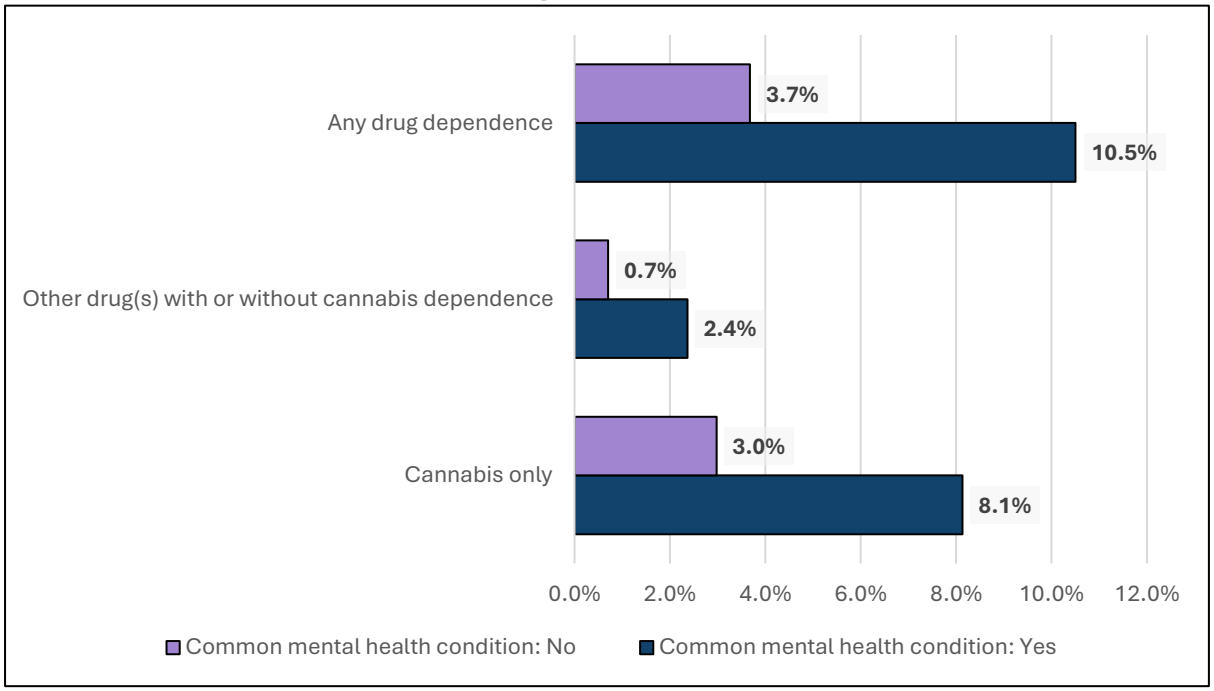
Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 5. Alcohol: hazardous, harmful and dependent patterns of drinking - Data tables, Table 5.8

Drug dependence

Drug dependence is more common among adults with common mental health conditions than those without. Among men with common mental health conditions, 13.1% showed drug dependence compared to 5.1% without. For women, the difference was even more pronounced: 8.4% compared to 2.2% - nearly 4 times higher. Cannabis-only dependence was most common, affecting 8.1% of adults with mental health conditions compared to 3.0% without. Dependence on other drugs (with or without cannabis) affected 2.4% of those with mental health conditions compared to 0.7% without - more than three times higher. Overall, adults with common mental health conditions were almost three times more likely to show any drug dependence (10.5% vs 3.7%).

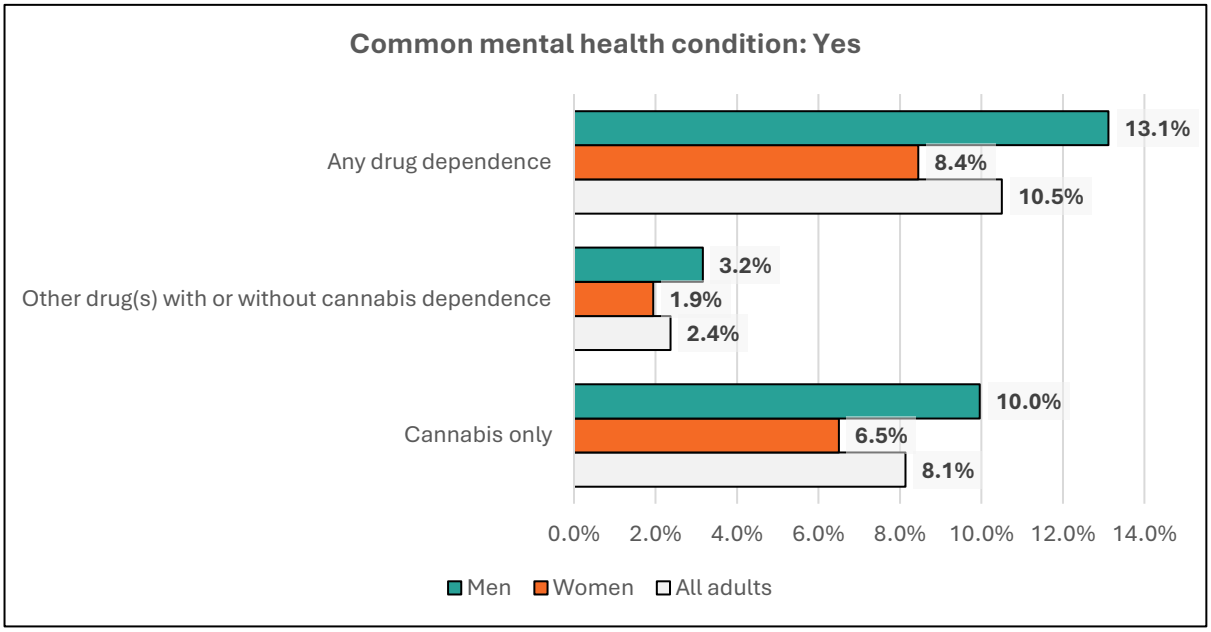
National Drug Treatment Monitoring System data for Suffolk states three in four people starting substance misuse treatment in Suffolk have an identified mental health treatment need, a pattern that has remained consistently high over recent years (70–74% of new presentations since 2022).

Figure 43. Drug dependence in the past year (age-standardised) by common mental health condition Yes/No, all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 6: Drug use and dependence – Data tables. Table 6.12

Figure 44. Drug dependence in the past year (age-standardised) for adults reporting a common mental health condition: Yes, by men, women and all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 6: Drug use and dependence – Data tables. Table 6.12

Gambling behaviour

Using the Problem Gambling Severity Index (PGSI), the APMS for England also shows a clear relationship between problem gambling and both physical and mental health conditions, with differences by gender. While most adults either do not gamble or gamble without reported harm, a higher prevalence of moderate to high-risk gambling is seen among people with common mental health conditions.

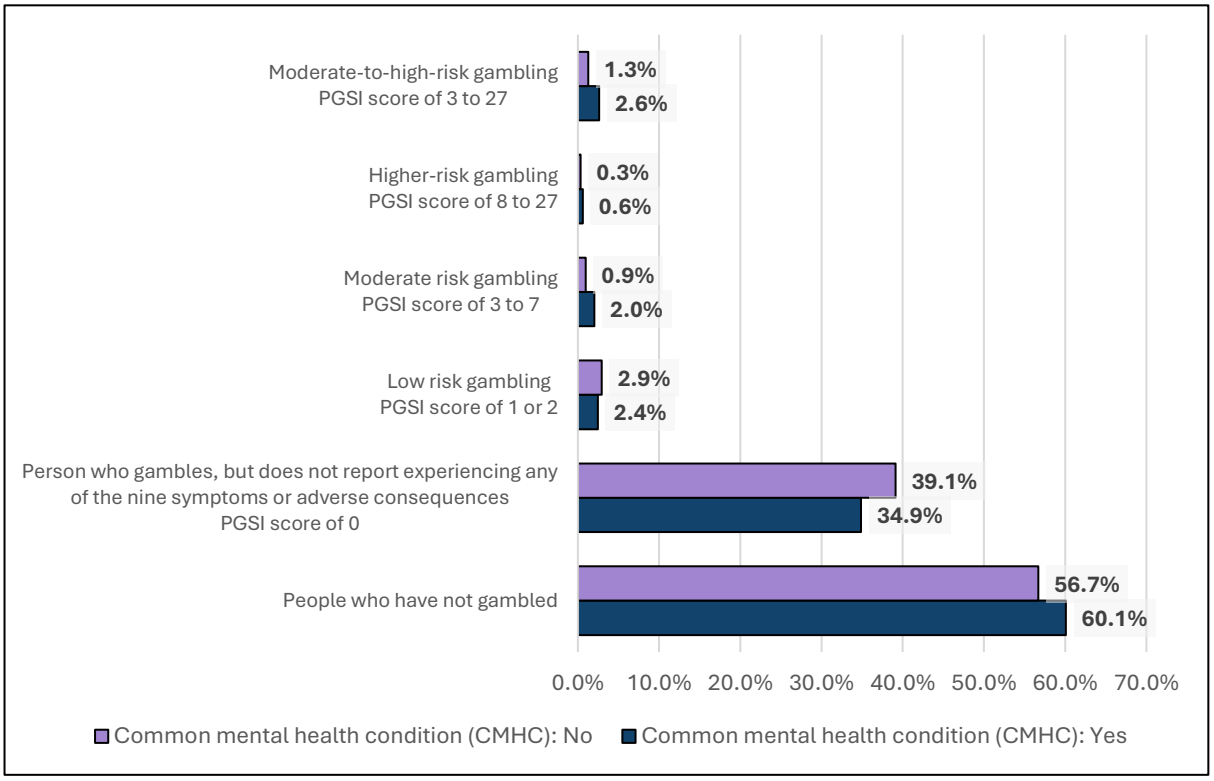
Among all adults, the proportion experiencing moderate- to high-risk gambling (PGSI score 3-27) is twice as high among those with a CMHC compared with those without (2.6% vs 1.3%).

These inequalities are more pronounced among men. Men with a CMHC are more than twice as likely to experience moderate- to high-risk gambling than men without a CMHC (4.4% vs 1.7%), and higher-risk gambling (PGSI 8–27) is also more common in this group.

Among women, overall levels of gambling and problem gambling are lower than among men; however, the same pattern of inequality remains. Women with a CMHC are around twice as likely to experience moderate- to high-risk gambling compared with women without a CMHC, although absolute prevalence remains relatively low.

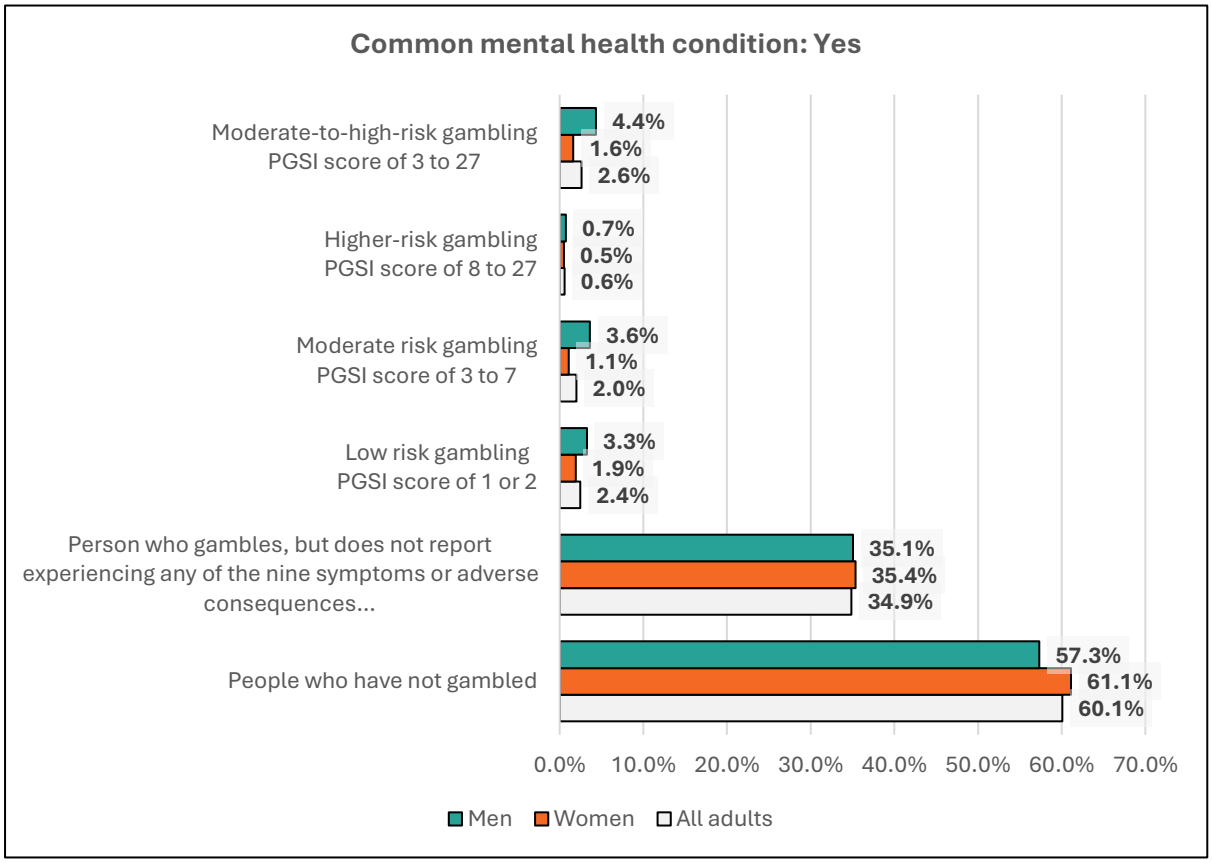
Across all groups, people with CMHCs are also less likely to gamble without harm (PGSI score of 0) and more likely to report gambling-related adverse consequences. This highlights problem gambling as both a mental health inequality issue, as well as potentially contributing to worsening mental health, financial stress and social harm.

Figure 45. Problem Gambling Severity Index (PGSI) scores (age-standardised) by common mental health condition Yes/No, all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 7. Gambling Behaviour – Data tables. Table 7.8

Figure 46. Problem Gambling Severity Index (PGSI) scores (age-standardised) for adults reporting a common mental health condition: Yes, by men, women and all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, 7. Gambling Behaviour – Data tables. Table 7.8

Modelled estimates suggest that gambling-related harm represents a non-trivial source of unmet need in Suffolk. It is estimated that:

- around 1,700 adults may benefit from brief advice or low-intensity support
- over 12,500 adults may benefit from extended brief interventions, such as motivational interviewing
- around 2,100 adults may require structured psychosocial interventions
- approximately 2,300 adults may benefit from psychologist-led CBT
- around 400 adults may require intensive residential treatment for gambling disorder

While most people will benefit from low-intensity or brief interventions, the presence of a smaller group requiring intensive specialist treatment highlights the importance of a tiered, proportionate approach to gambling support, with strong links to mental health services.

Emotional wellbeing (ONS subjective wellbeing measures)

While not a direct measure of mental ill-health, ONS subjective wellbeing indicators provide an important measure of population-level emotional wellbeing and psychological resilience, which are closely associated with mental health outcomes.

Subjective wellbeing is a recognised indicator of population mental health and emotional wellbeing, capturing how people experience and evaluate their lives. The Office for National Statistics (ONS) measures wellbeing using four self-reported questions on life satisfaction, sense of worthwhileness, happiness, and anxiety. Although these measures do not indicate the presence of mental illness, they are strongly associated with mental health outcomes, resilience, and future risk of poor mental health.

Respondents rate each measure on a scale from 0 to 10. Scores of 0–4 indicate low wellbeing for life satisfaction, worthwhileness and happiness, while scores of 6–10 indicate high anxiety.

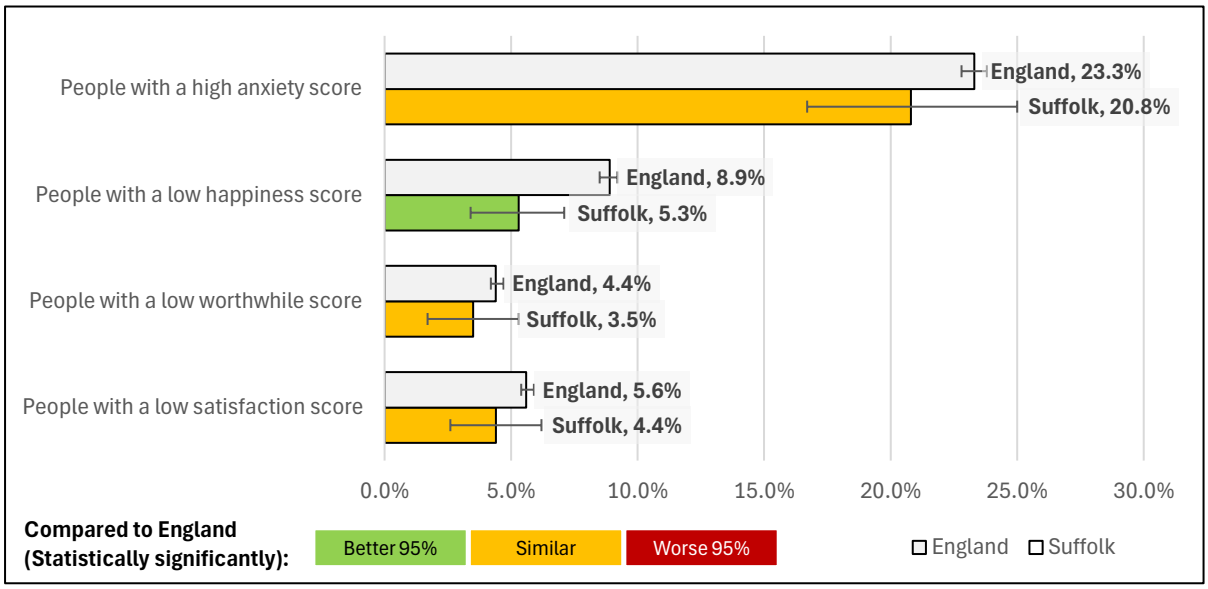
Based on the latest data available, in 2022/23, Suffolk's emotional wellbeing profile was generally positive when compared with national benchmarks:

- **Life satisfaction**: 4.4% of residents reported low life satisfaction, statistically similar to England (5.6%) and the East of England (5.2%)
- **Feeling worthwhile**: 3.5% reported a low sense of worth, again statistically similar to regional and national averages
- **Happiness**: 5.3% reported low happiness, which was statistically significantly lower than England (8.9%), representing Suffolk's strongest relative outcome
- **Anxiety**: 20.8% reported high anxiety, statistically similar to England (23.3%)

Overall, Suffolk residents report comparatively good emotional wellbeing across all four ONS measures, particularly for happiness. However, these population-level findings sit alongside evidence from other indicators showing substantial levels of mental health need, highlighting that relatively positive average wellbeing can coexist with significant inequalities and unmet need within specific population groups.

Analysis at lower-tier local authority level is limited due to disclosure control, with several Suffolk districts and boroughs value's suppressed because of small sample sizes.

Figure 47. Low personal wellbeing (self-reported wellbeing) measures for Suffolk and England, 2022/23



Source: Office for Health Improvement and Disparities (2024)

Common mental health conditions

Depression: Quality Outcomes Framework incidence and prevalence

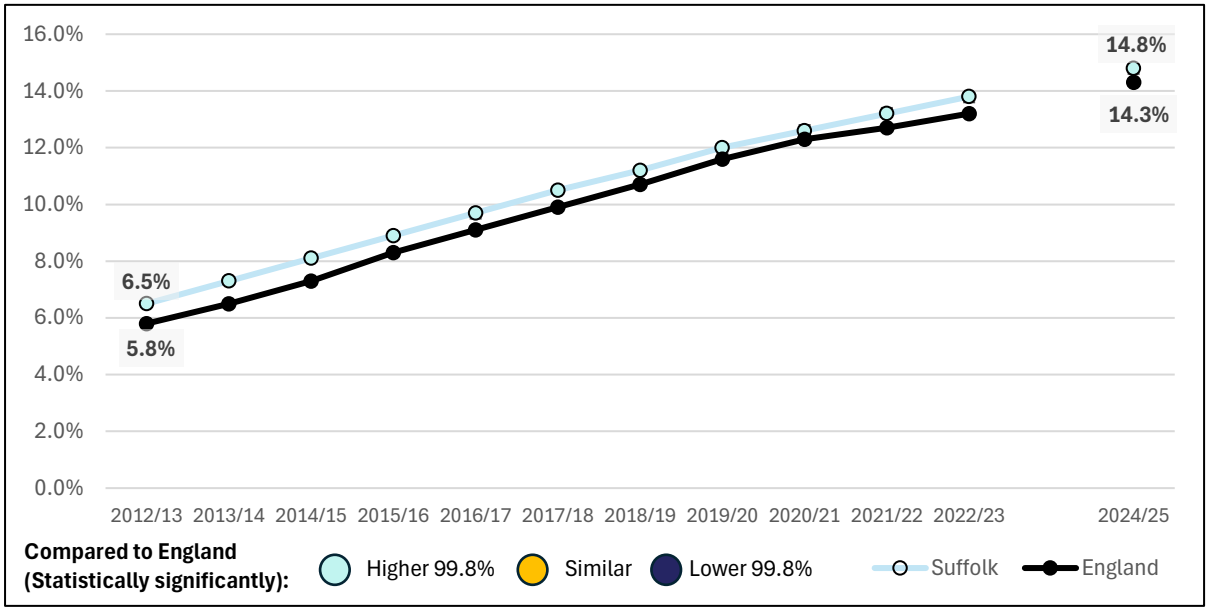
Depression affects different people in different ways, but it can include some or all of the following symptoms: feelings of sadness and hopelessness; losing interest in things; feeling tearful; feeling constantly tired, sleeping badly; having no appetite. It can result in significantly reduced quality of life for the person, their family and carers[184].

Depression is responsible for 12% of the global burden of non-fatal disease and is expected to be the world's second most disabling disease by 2020 (after cardiovascular disease). It is also responsible for 109 million lost working days every year in England at a cost of £9billion[184].

Recorded depression prevalence in Suffolk has risen steadily over the past decade, increasing from 6.5% in 2012/13 to 14.8% in 2024/25. Over this period, the number of adults on GP registers with a depression diagnosis increased from around 40,000 to more than 100,000. This increase is likely to reflect both rising recorded need and positive changes in identification, recording and help-seeking.

Across all years, Suffolk's recorded prevalence of depression has been statistically significantly higher than the England average, which rose from 5.8% to 14.3% over the same period. This gap suggests higher diagnosed prevalence, greater detection, or differences in population need, risk and service engagement compared with England overall.

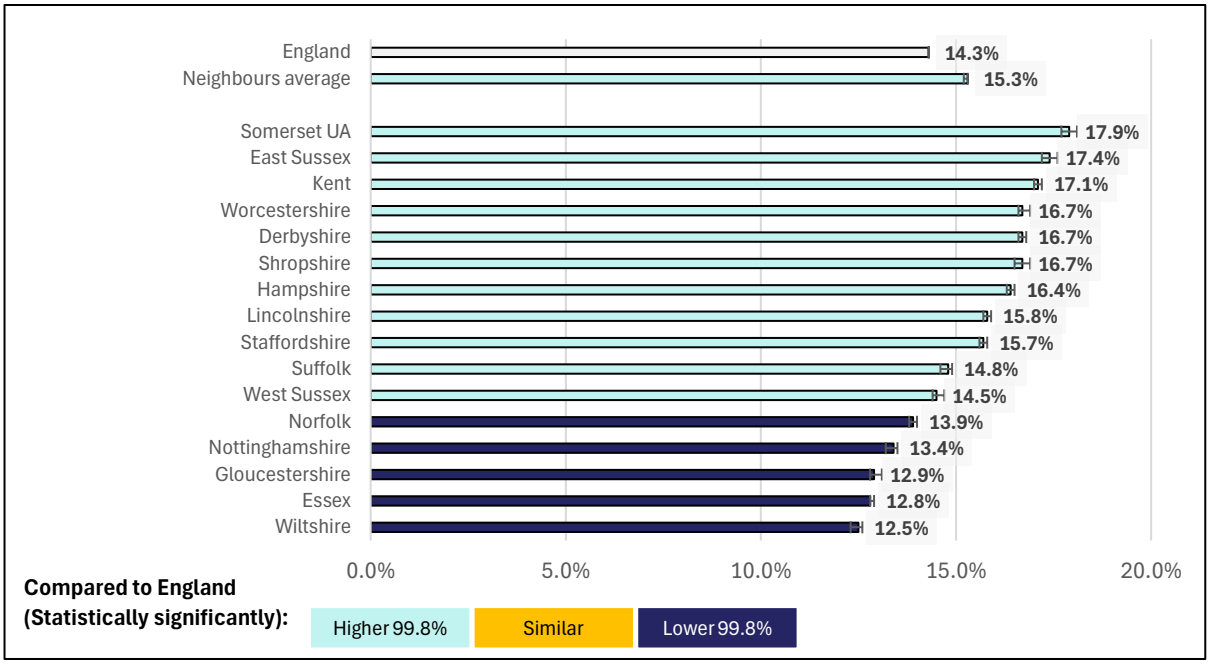
Figure 48. Depression: Quality outcomes framework prevalence (18+ yrs), Suffolk and England, 2013/14 to 2024/25



Source: Office for Health Improvement and Disparities (2025)

In 2024/25, Suffolk's recorded depression prevalence (14.8%) was below the average for its NHS England peer group (15.3%), ranking statistically significantly lower than many local authorities in the peer group such as Somerset, East Sussex and Kent, but statistically significantly higher than areas including Norfolk, Essex and Wiltshire. This indicates that while Suffolk remains above the national average, it sits in the mid-range among statistical neighbours.

Figure 49. Depression: Quality outcomes framework prevalence (18+ yrs), Suffolk and NHS England peers, 2024/25



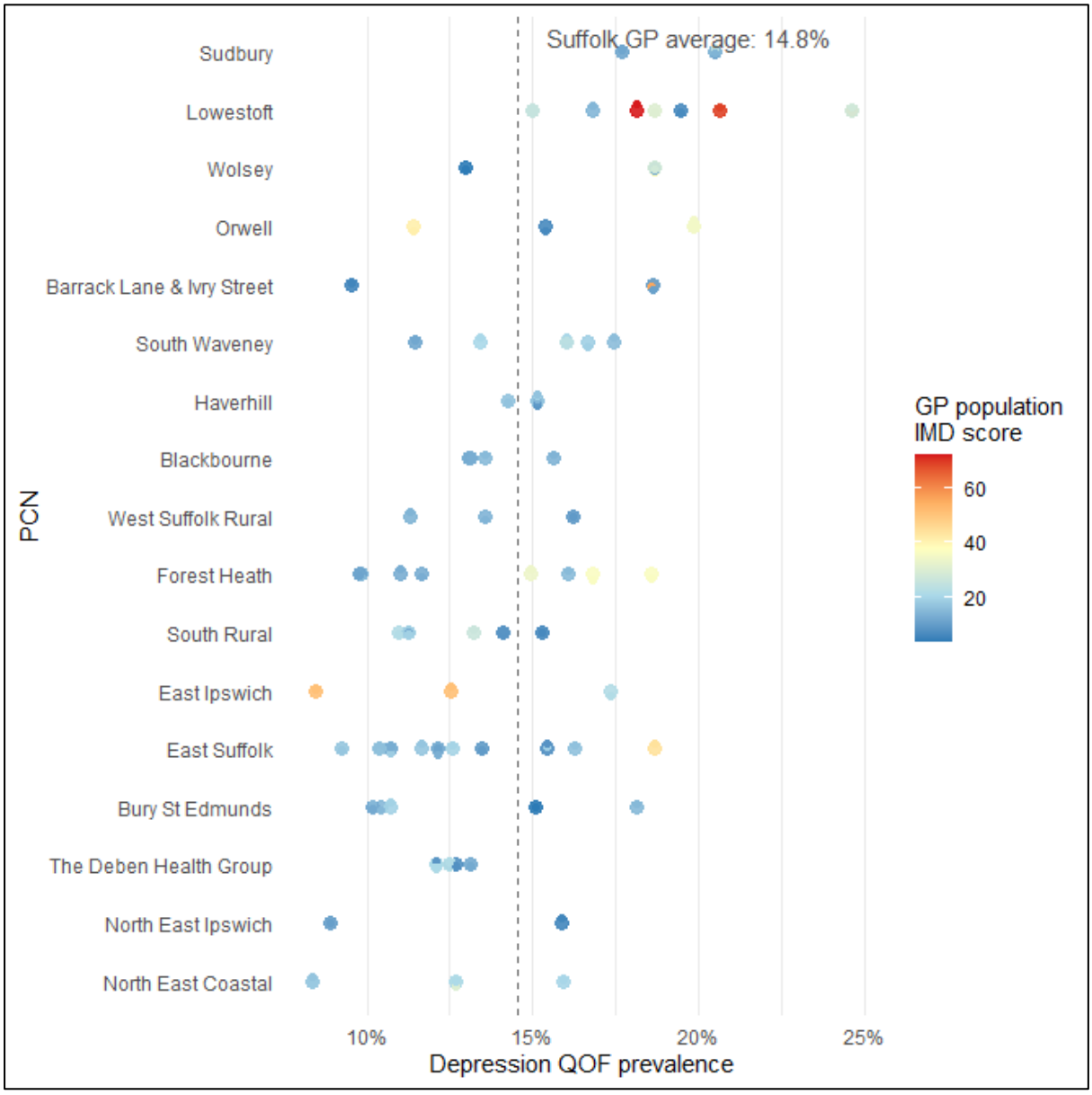
Source: Office for Health Improvement and Disparities (2025)

The following figure shows variation in recorded depression prevalence between GP practices across Suffolk's Primary Care Networks (PCNs) in 2024/25. Each point represents an individual practice, with colour indicating the level of deprivation (IMD scores) for GP practices population-weighted averages based on the deprivation scores of registered patients' residential LSOAs, rather than the deprivation level of the GP practice location itself. The dashed line shows the Suffolk GP average of 14.8%.

There is considerable variation between practices, with recorded prevalence ranging from around 8% to over 20%. Practices within the same PCN also show noticeable differences, indicating that variation exists at a more local level than the PCN geography alone. Some of this variation may reflect differences in population characteristics such as age, deprivation and long-term health conditions, while some may relate to differences in help-seeking behaviour, diagnosis and recording practices in primary care.

Higher levels of recorded prevalence are generally seen in practices serving more deprived populations, particularly within urban areas such as Lowestoft and parts of Ipswich, although this relationship is not uniform. The visualisation highlights the importance of considering both population need and local practice context when interpreting depression prevalence data and planning mental health support across the system.

Figure 50. Depression: Quality outcomes framework prevalence (18+ yrs) and GP registered patients' Index of Multiple Deprivation (IMD) score 2025, Suffolk GPs grouped by Primary Care Network (PCN) area, 2024/25

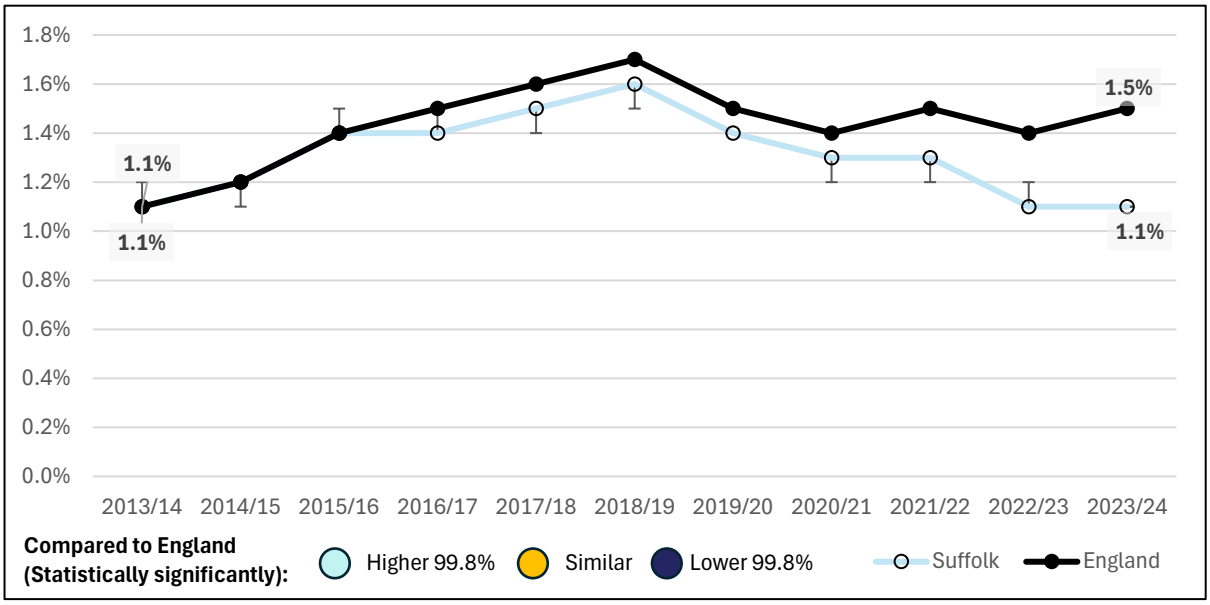


Source: Office for Health Improvement and Disparities (2025)

This data represents diagnosed and recorded depression in primary care, rather than the full population prevalence of depressive symptoms, and should be interpreted alongside survey-based measures such as the APMS when assessing overall mental health need.

The following indicator presents the percentage of patients aged 18 and over with depression recorded on practice disease registers for the first time in the financial year. In Suffolk in 2023/24, there were 7,366 individuals aged 18 and over with a new depression diagnosis, 1.1% of patients registered with the practice. This percentage was statistically significantly lower than the incidence of depression in 2017/18 (1.5%), and also statistically significantly lower when compared to the value across England in 2023/24 (1.5%).

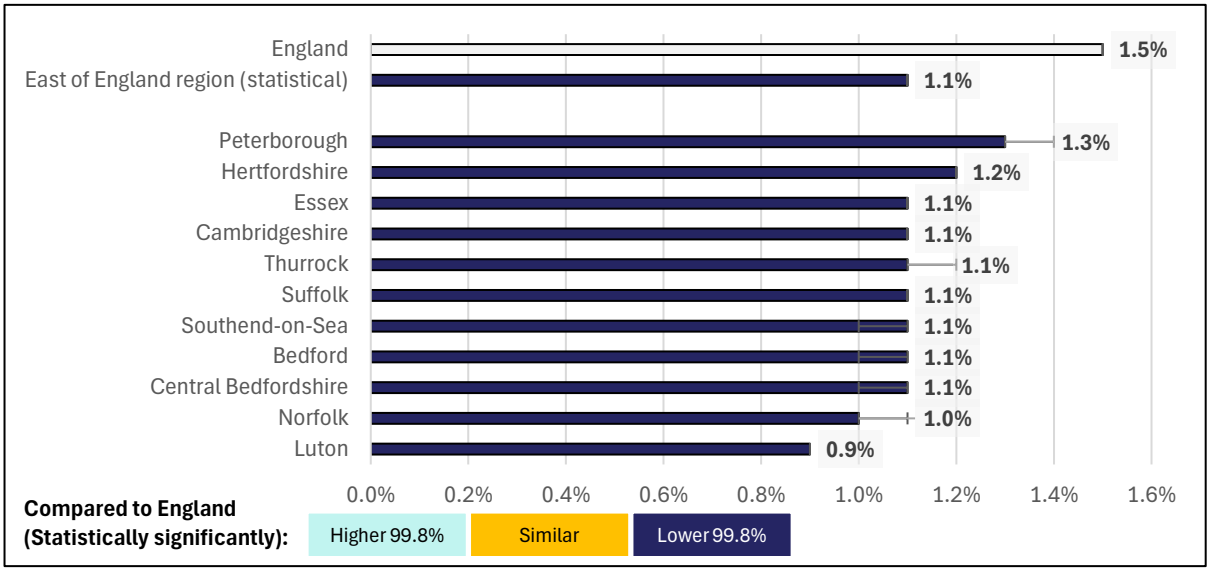
Figure 51. Depression: Quality outcomes framework incidence – new diagnosis (18+ yrs), Suffolk and England, 2013/14 to 2023/24



Source: Office for Health Improvement and Disparities (2024)

The depression incidence for adults aged 18 years and over varies across the East of England region. Each upper tier local authority in the East of England has a statistically significantly lower percentage of new adults being added to practice disease registers in 2023/24 with a depression diagnosis compared to England (1.5%).

Figure 52. Depression: Quality outcomes framework incidence – new diagnosis (18+ yrs), Suffolk and East of England region neighbours, 2023/24



Source: Office for Health Improvement and Disparities (2024)

Severe mental illness

Although this section is located within the adults chapter, many indicators on severe mental illness are presented across all age groups. This reflects the fact that referral thresholds, pathways and service pressures span the lifecourse, and patterns of access in one age group can influence demand and capacity elsewhere in the system.

Mental ill health can affect anyone and have a significant effect on the lives of individuals, their families, communities, and wider society. Together with substance misuse, all mental illness accounts for 21.3% of the total morbidity burden in England[185,186]. Mental ill health is associated with many forms of inequalities, which people living with severe mental illness (SMI) are particularly vulnerable to experiencing and are largely driven by complex and interrelated factors[185]. The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as SMIs[10].

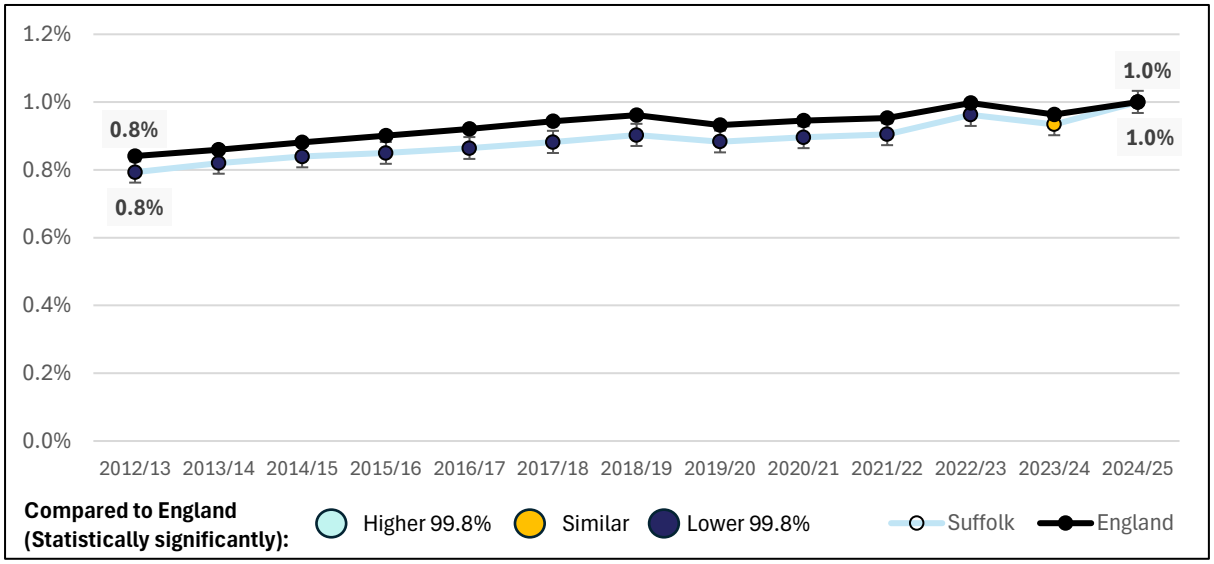
The PHE Strategy 2020-25 identified Better Mental Health as a key priority, aiming for measurable improvements. This includes supporting the NHS with mental health initiatives from the NHS Long Term Plan, such as suicide prevention and new care models for individuals with SMI[185].

Mental Health: Quality Outcomes Framework prevalence

The following data includes the percentage of patients with schizophrenia, bipolar affective disorders and other psychoses as recorded on practice disease registers in Suffolk in 2024/25. The registers included are patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses to avoid a generic phrase that is open to variations in interpretation.

In Suffolk in 2024/25, 8,191 (1.0%) of registered patients had a diagnosis of schizophrenia, bipolar affective disorder, or other psychoses, statistically similar to the prevalence across England (1.0%). This prevalence across Suffolk has statistically significantly increased from 0.8% (6,014 individuals) in 2012/13, to 1.0% in 2024/25.

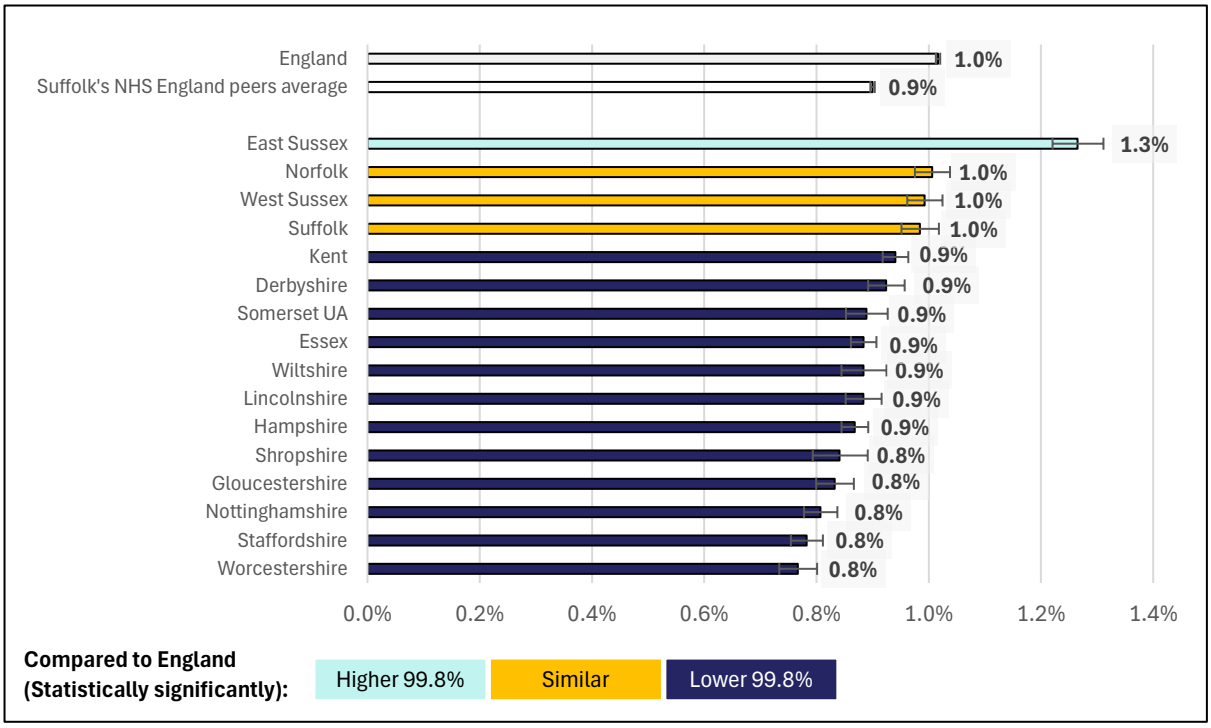
Figure 53. Mental health: Quality Outcomes Framework – percentage of Suffolk patients with schizophrenia, bipolar affective disorder, and other psychoses, Suffolk and England, 2012/13 to 2024/25



Source: Office for Health Improvement and Disparities (2025)

Across the Suffolk's NHS England peers, many upper tier local authority areas report a statistically significantly lower percentage of patients registered with a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses in 2024/25. Suffolk, West Sussex, and Norfolk (all 0.9%) have a statistically similar percentage to the England average (1.0%), while East Sussex (1.3%) has a statistically significantly higher percentage of patients registered with a diagnosis of either schizophrenia, bipolar affective disorder, or other psychoses in 2024/25.

Figure 54. Mental health: Quality Outcomes Framework – percentage of Suffolk and East of England region patients with schizophrenia, bipolar affective disorder, and other psychoses, 2024/25



Source: Office for Health Improvement and Disparities (2025)

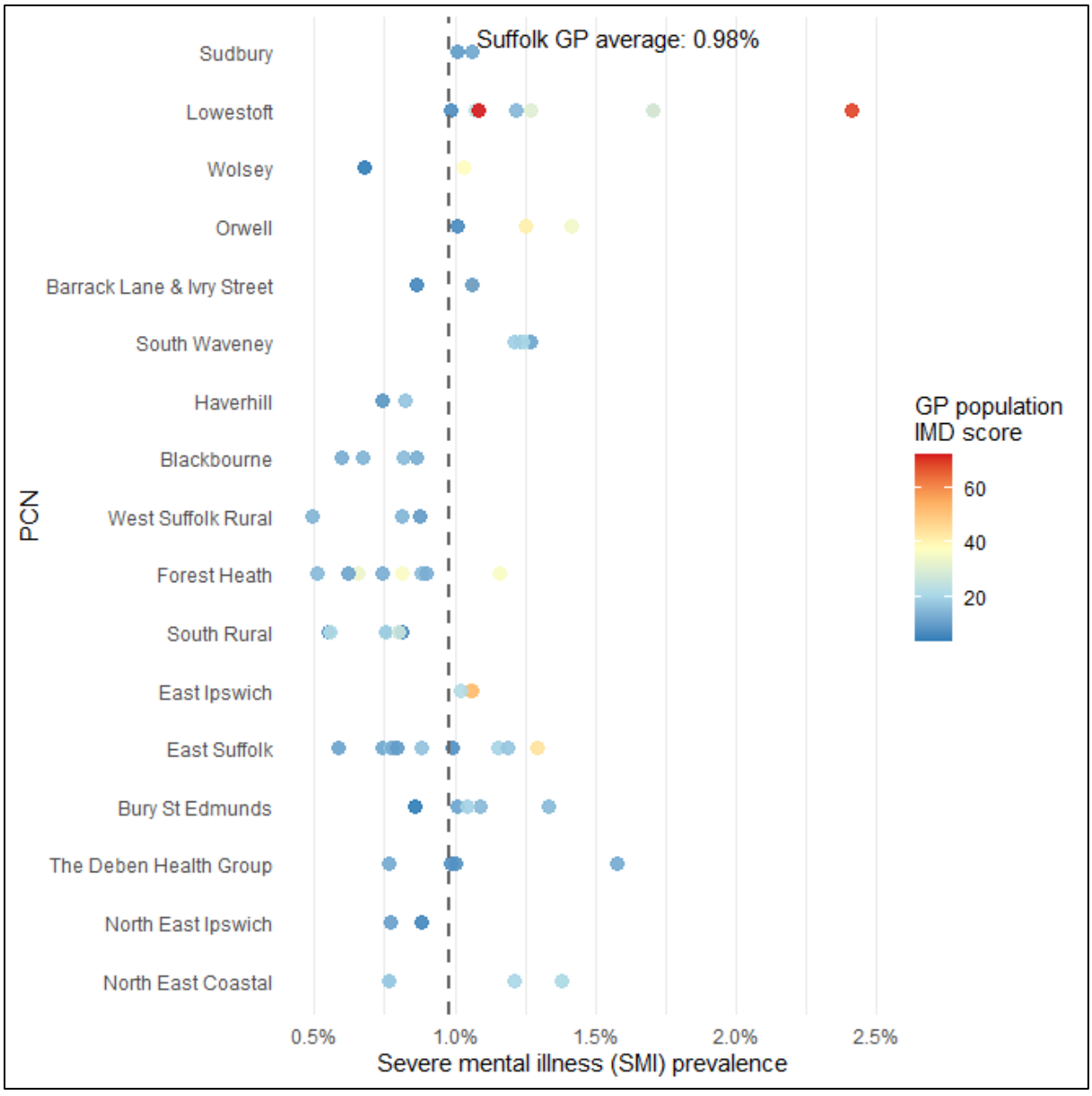
Improving uptake of physical health checks for people with severe mental illness is a key opportunity to address the substantial inequalities in premature mortality observed in Suffolk. National evidence indicates that despite policy focus, people with SMI continue to face significant barriers to accessing routine physical health checks and cancer screening[187]. While the overall evidence base remains limited, randomised controlled trials have shown that targeted case-management approaches can significantly improve uptake of physical health checks and screening among people with SMI, particularly for those facing social disadvantage and fragmented care[16]. This highlights the importance of proactive, models of care rather than reliance on standard invitation-based approaches to address inequalities in physical health outcomes for people with SMI.

Recorded prevalence of severe mental illness across Suffolk GP practices in 2024/25 averages 0.98%, but varies noticeably between practices, ranging from around 0.5% to over 2%. Most practices cluster close to the Suffolk average, though a small number report substantially higher prevalence. Variation is visible both between and within Primary Care Networks (PCNs), suggesting that local population characteristics and differences in diagnosis, case-finding or recording practices may influence the size of practice registers.

IMD scores shown for GP practices are population-weighted averages based on the deprivation scores of registered patients' residential LSOAs, rather than the deprivation level of the GP practice location itself. Practices serving more deprived populations tend to show higher SMI prevalence, particularly within urban areas such as Lowestoft and parts of Ipswich. This pattern is consistent with wider evidence that severe mental illness is more common in communities experiencing greater socioeconomic disadvantage.

Compared with depression prevalence, the range of variation across practices is narrower in absolute terms, reflecting the lower overall prevalence of SMI. While depression registers show larger differences between practices and PCNs, the SMI data still highlights important local variation and a similar tendency for higher prevalence in more deprived practice populations.

Figure 55. Mental Health: QOF prevalence (% of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers) and GP registered patients' Index of Multiple Deprivation (IMD) score 2025, Suffolk GPs grouped by Primary Care Network (PCN) area, 2024/25

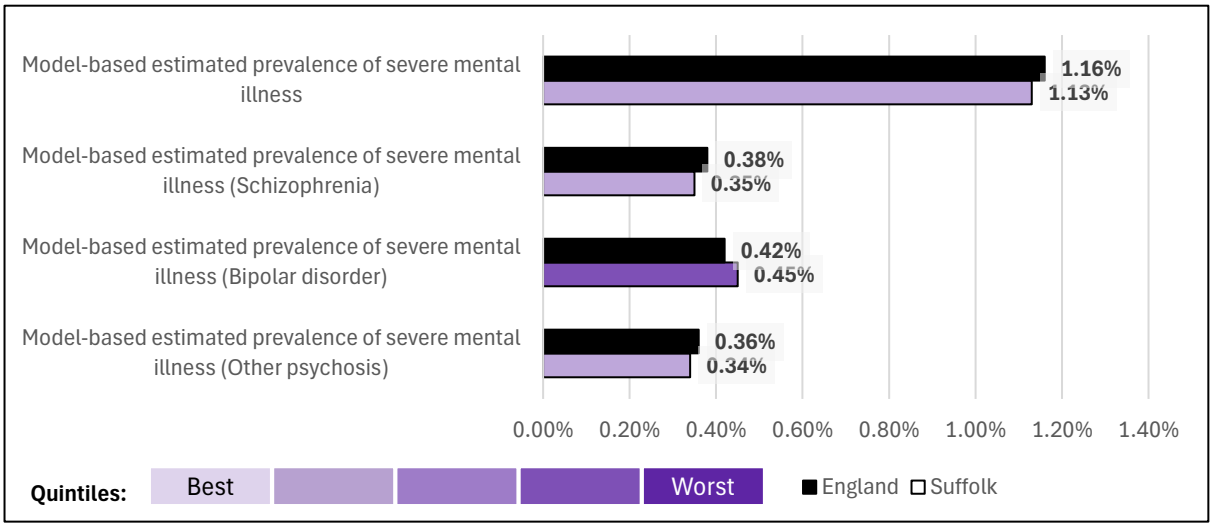


Source: Office for Health Improvement and Disparities (2025)

New model-based estimates published by the Office for Health Improvement and Disparities in April 2026 provide an updated view of the expected prevalence of severe mental illness (SMI), defined as schizophrenia, bipolar disorder and other psychoses. These estimates are derived using a large national primary care dataset and a multivariable model incorporating age, sex, ethnicity and deprivation, applied to local population structures.

In Suffolk, an estimated 7,335 people aged 14 and over were living with SMI in 2023 (1.13%), slightly below the England average (1.16%). Condition-specific estimates suggest that bipolar disorder accounts for the largest proportion (0.45%), followed by schizophrenia (0.35%) and other psychoses (0.34%). While overall prevalence is not markedly different from regional and national patterns, these estimates provide a more comprehensive picture of expected need, including individuals who may not be in contact with services.

Figure 56. Model-based estimated prevalence of severe mental illness (schizophrenia, bipolar disorder, and other psychoses), Suffolk and England, 2023



Source: Office for Health Improvement and Disparities (2026)

This reinforces earlier findings in the needs assessment that recorded service use and diagnostic registers may under-represent the true level of need, particularly where barriers to access or engagement with services exist.

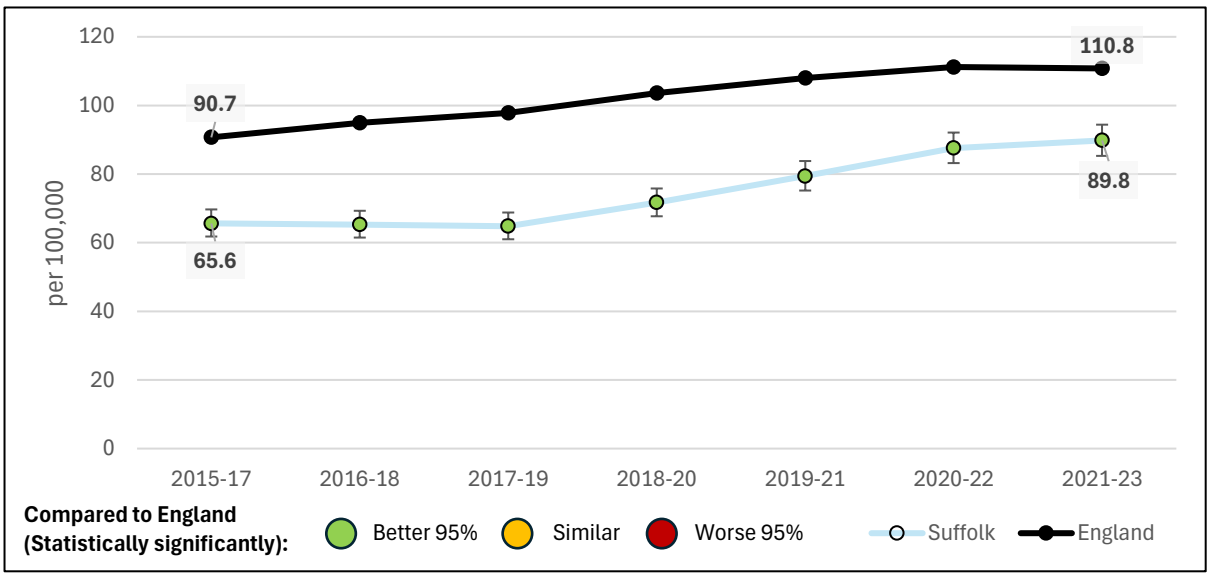
Premature mortality in adults with severe mental illness (SMI)

Premature mortality in adults with severe mental illness (SMI) is a key indicator of health inequality. In this context, premature mortality refers to all-cause deaths occurring before the age of 75 among adults with recent contact with secondary mental health services. Evidence consistently shows that people with SMI face substantially higher rates of poor physical health, including smoking, obesity, diabetes, cardiovascular disease and respiratory conditions, leading to significantly reduced life expectancy compared to those without SMI. While suicide remains an important concern, most excess premature deaths among people with SMI are attributable to preventable physical health conditions.

Between 2015-17 and 2021-23, Suffolk experienced a statistically significant upward trend in premature mortality rates among adults with SMI. The age-standardised mortality rate increased by over a third, from 65.6 deaths per 100,000 population in 2015-17 (1,100 deaths)) to 89.8 per 100,000 in 2021-23. The most substantial increase in Suffolk occurred during and after the COVID-19 pandemic, with rates rising from 71.7 per 100,000 in 2018-20 to 87.6 per 100,000 in 2020-22, and further to 89.8 per 100,000 (1,550 deaths) in 2021-23.

Throughout this period, Suffolk's premature mortality rate remained statistically significantly lower than the England average. By 2021-23, Suffolk's rate of 89.8 per 100,000 was 19% lower than the England rate of 110.8 per 100,000 and 6% lower than the East of England regional rate of 95.3 per 100,000.

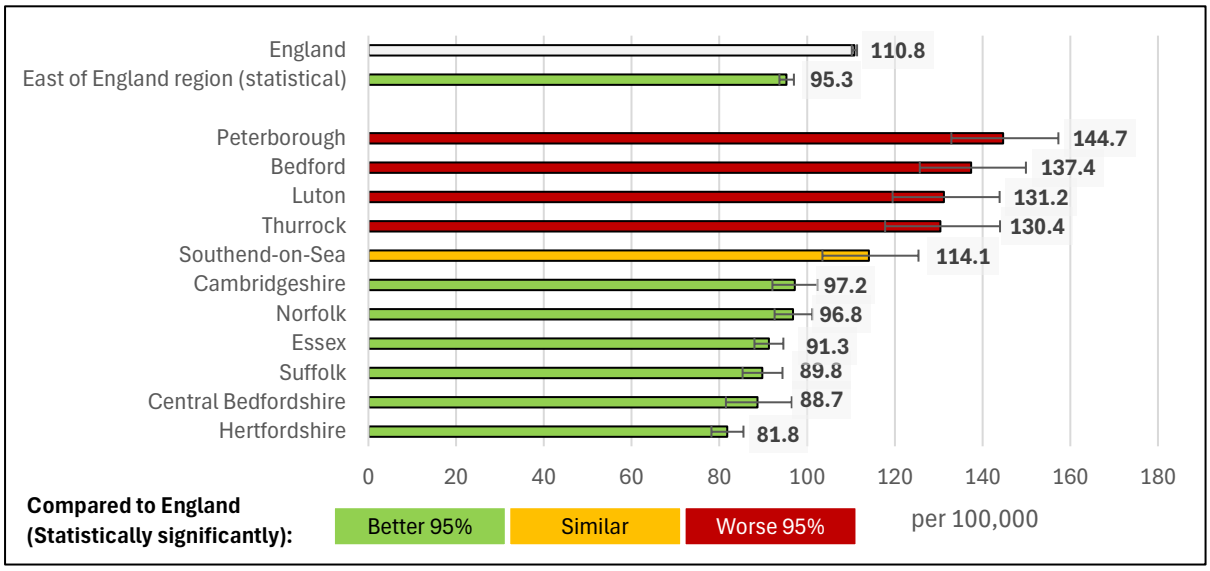
Figure 57. Premature mortality in adults with severe mental illness (SMI) per 100,000, Suffolk and England, 2015-17 to 2021-23



Source: Office for Health Improvement and Disparities (2025)

Within the East of England in 2021-23, Suffolk had the fourth lowest premature mortality rate among upper tier local authorities. The highest rates were observed in Peterborough (144.7 per 100,000), Bedford (137.4 per 100,000), Luton (131.2 per 100,000) and Thurrock (130.4 per 100,000) - all statistically significantly higher than England and Suffolk's rates.

Figure 58. Premature mortality in adults with severe mental illness (SMI) per 100,000, Suffolk and East of England region neighbours, 2021-23

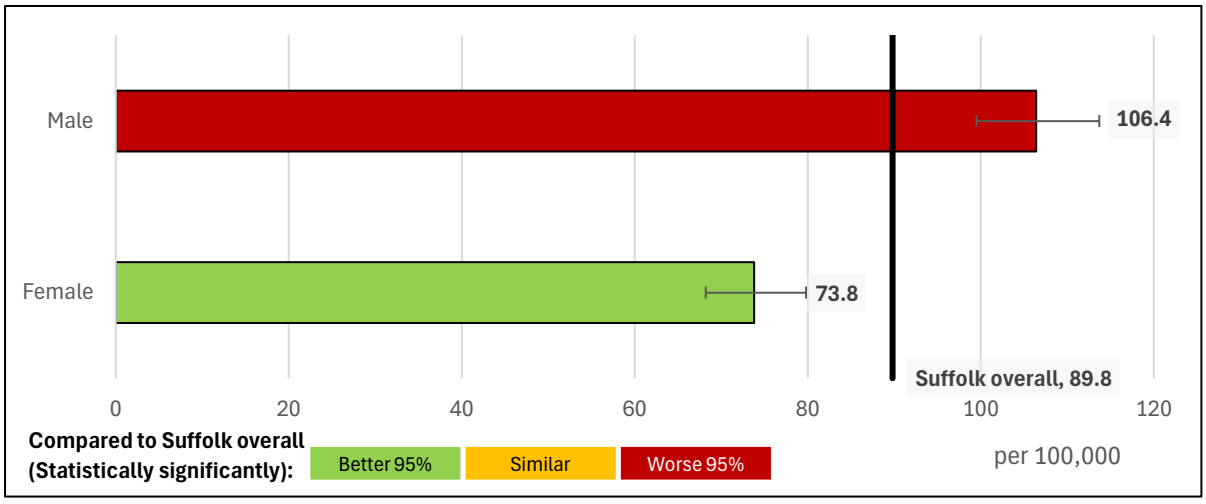


Source: Office for Health Improvement and Disparities (2025)

While Suffolk's relative position is more favourable than the England average, the sustained upward trend is concerning and highlights the ongoing challenges in addressing the physical health inequalities in this population. National evidence shows that excess mortality in people with SMI is driven predominantly by preventable health conditions rather than suicide, particularly cardiovascular disease, respiratory disease, cancer and metabolic conditions[15].

In 2021-23, there was a large gender disparity in premature mortality rates among adults with SMI in Suffolk. Males had a rate of 106.4 deaths per 100,000 population, which was 44% higher than the rate for females (73.8 per 100,000). This may reflect multiple factors including higher rates of co-morbid substance misuse among males with SMI, greater prevalence of cardiovascular disease risk factors, lower engagement with preventative health services, and potentially different help-seeking behaviours.

Figure 59. Premature mortality in adults with severe mental illness (SMI) per 100,000, Suffolk males and females, 2021-23



Source: Office for Health Improvement and Disparities (2025)

Excess under 75 mortality rate in adults with severe mental illness (SMI)

While premature mortality describes the number or rate of deaths before the age of 75 among adults with severe mental illness, the excess under-75 mortality rate shows how much higher (or lower) the risk of dying prematurely is for people with severe mental illness (SMI) compared with adults without SMI.

This indicator therefore measures the mortality gap between people with and without severe mental illness. It is expressed as a percentage, where a positive value indicates that adults with SMI experience a higher risk of premature death than the general population. Adults with SMI are defined as those who had contact with secondary mental health services in the five years preceding death.

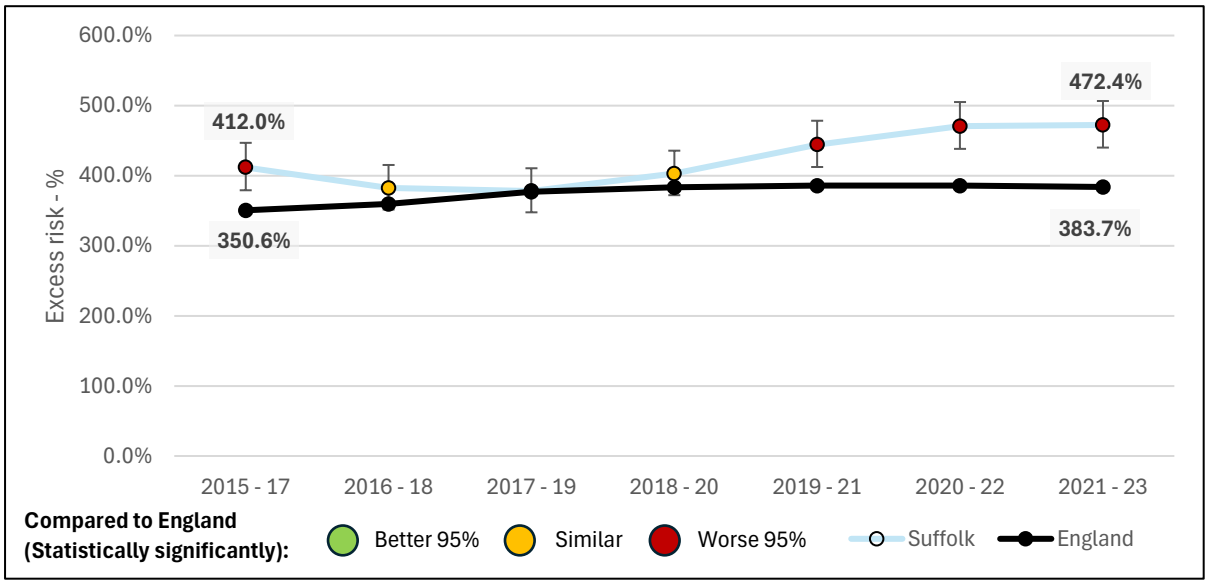
Excess premature mortality reflects the combined impact of poorer physical health, higher exposure to health risk factors, barriers to accessing timely healthcare, and wider social disadvantage experienced by people with SMI.

Premature mortality in adults with severe mental illness (SMI) is a critical indicator of health inequalities. People with SMI face increased likelihood of poor physical health, including higher rates of smoking, obesity, diabetes, cardiovascular disease and respiratory conditions, leading to significantly reduced life expectancy compared to the general population.

Between 2015-17 and 2021-23, Suffolk's excess mortality among adults with SMI has remained statistically similar. While the excess mortality rate increased from 412.0% in 2015-17 to 472.4% in 2021-23 – this change was not statistically significant. This indicates that adults with SMI in Suffolk had a risk of premature death nearly five times higher than would be expected for adults without a SMI.

Notably, between 2019-21 and 2021-23, Suffolk's excess under 75 mortality in adults with SMI was statistically significantly higher than the England average in each of the last 3 periods.

Figure 60. Excess under 75 mortality rate in adults with severe mental illness (SMI), Suffolk and England, 2015-17 to 2021-23



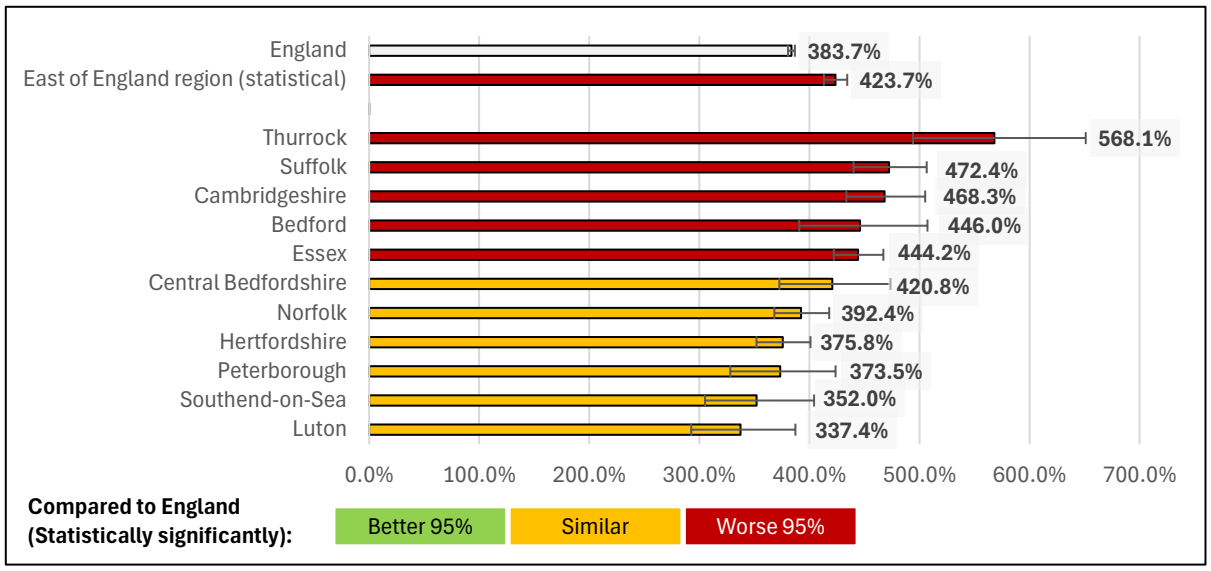
Source: Office for Health Improvement and Disparities (2025)

Within the East of England in 2021-23, Suffolk had the second highest excess mortality rate among upper tier local authorities, exceeded only by Thurrock (568.1%). The lowest rates in the region were observed in Luton (337.4%), Southend-on-Sea (352.0%), and Peterborough (373.5%).

Excess mortality is a relative measure comparing mortality rates in people with severe mental illness (SMI) to the general population. Suffolk's comparatively high excess figure likely reflects both elevated mortality among people with SMI and the county's relatively low premature mortality rate in the general population. In areas where general population mortality is higher, the relative gap may appear smaller even if outcomes for people with SMI remain poor.

Therefore, Suffolk's high excess mortality should not be interpreted simply as poorer performance relative to other areas, but as evidence of a substantial mortality gap requiring focused action on physical health, prevention, and access to care for people with SMI.

Figure 61. Excess under 75 mortality rate in adults with severe mental illness (SMI), Suffolk and East of England region neighbours, 2021-23



Source: Office for Health Improvement and Disparities (2025)

Lived experience insight: Carers and system coordination

- Carers supporting people with severe mental illness report emotional strain and lack of recognition
- Many describe limited involvement in care planning and decision-making
- There is a need for clearer information about conditions, treatment and support available

"It has taken a physical, mental, and emotional toll on my life."

These insights highlight the importance of integrated, person- and family-centred care.

Source: Suffolk lived experience engagement (Healthwatch Suffolk, Suffolk User Forum and partners).

Cause-specific excess premature mortality in adults with severe mental illness

Cause-specific analysis shows that excess premature mortality among adults with severe mental illness in Suffolk is driven primarily by cardiovascular disease.

In 2021–23, excess under-75 mortality due to cardiovascular disease among adults with SMI in Suffolk was 385.0%, meaning that people with SMI were almost four times more likely to die prematurely from cardiovascular causes than adults without SMI. This was statistically significantly higher than the England average (290.3%), reflecting a significant physical health inequality for this population.

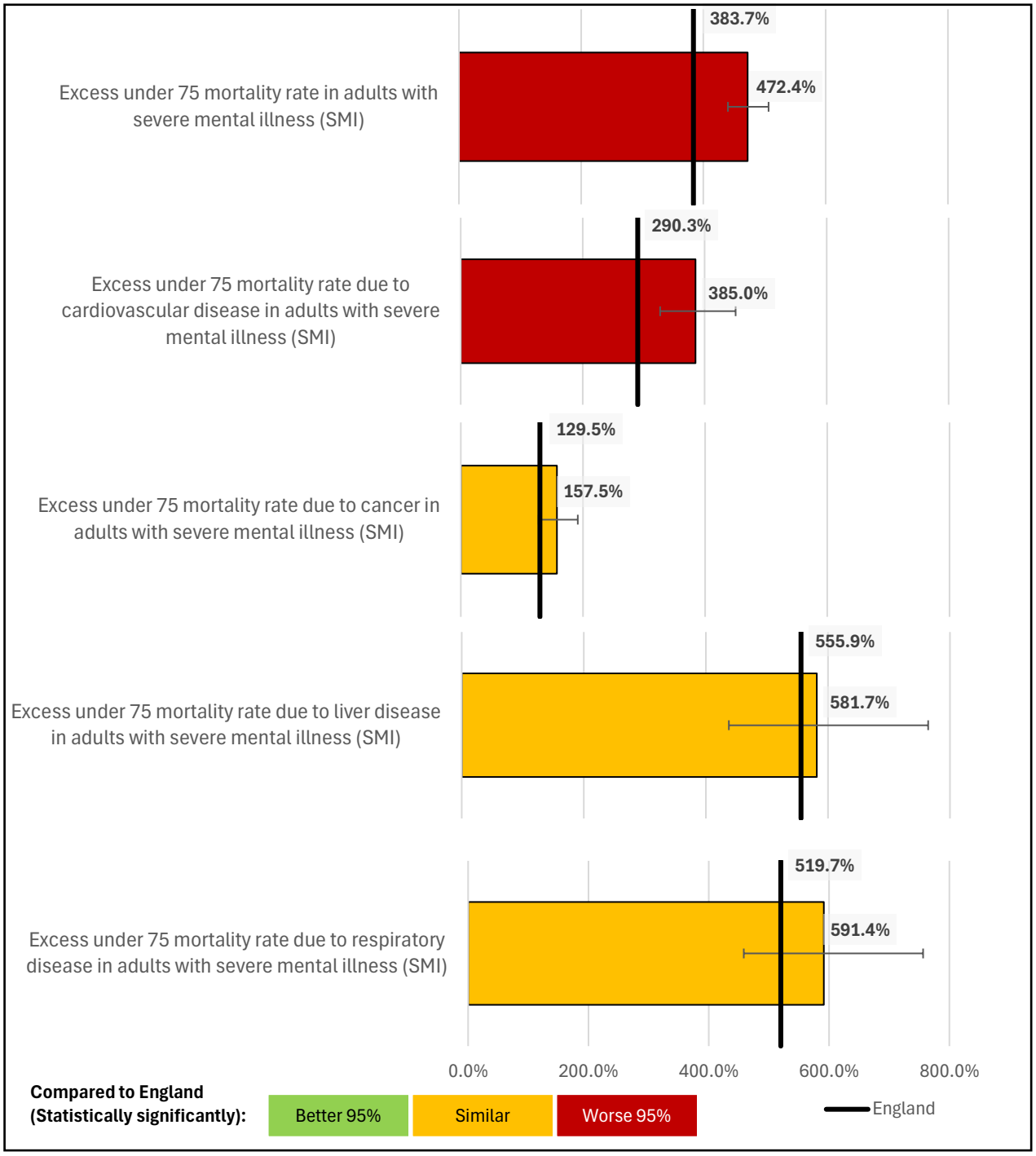
This statistically significantly higher excess mortality rate reflects a wider inequality gap in Suffolk between adults with and without SMI in cardiovascular health outcomes, potentially driven by Suffolk's general population having relatively good cardiovascular health while adults with SMI continue to face substantial cardiovascular risk factors including smoking, metabolic side effects of antipsychotic medication, and barriers to preventative care.

Excess premature mortality due to cancer was higher in Suffolk at 157.5%, although statistically similar when compared with 129.5% across England. While lower than for cardiovascular and respiratory causes, this still indicates a higher risk of early cancer death among adults with SMI, potentially reflecting later diagnosis, lower screening uptake, or barriers to timely treatment.

The largest relative inequalities were observed for liver disease and respiratory disease. In 2021–23, excess under-75 mortality due to liver disease among adults with SMI in Suffolk was 581.7%, compared with 555.9% in England (also statistically similar). Excess mortality due to respiratory disease was similarly high at 591.4%, again statistically similar to the England average of 519.7%. These findings are consistent with higher prevalence of smoking, alcohol-related harm, substance misuse, and long-term respiratory conditions among people living with severe mental illness.

These cause-specific indicators demonstrate that Suffolk’s overall excess premature mortality in adults with SMI is not driven by a single condition, but by multiple physical health risks. The high excess mortality from cardiovascular, liver and respiratory disease highlights the importance of prevention, early detection, and sustained physical health management for people with SMI, including smoking cessation, alcohol and substance misuse support, metabolic monitoring, and equitable access to screening and treatment.

Figure 62. Excess under 75 mortality rate in adults with severe mental illness (SMI), due to cardiovascular disease, cancer, liver disease, respiratory diseases, Suffolk and England, 2021-23



Source: Office for Health Improvement and Disparities (2025)

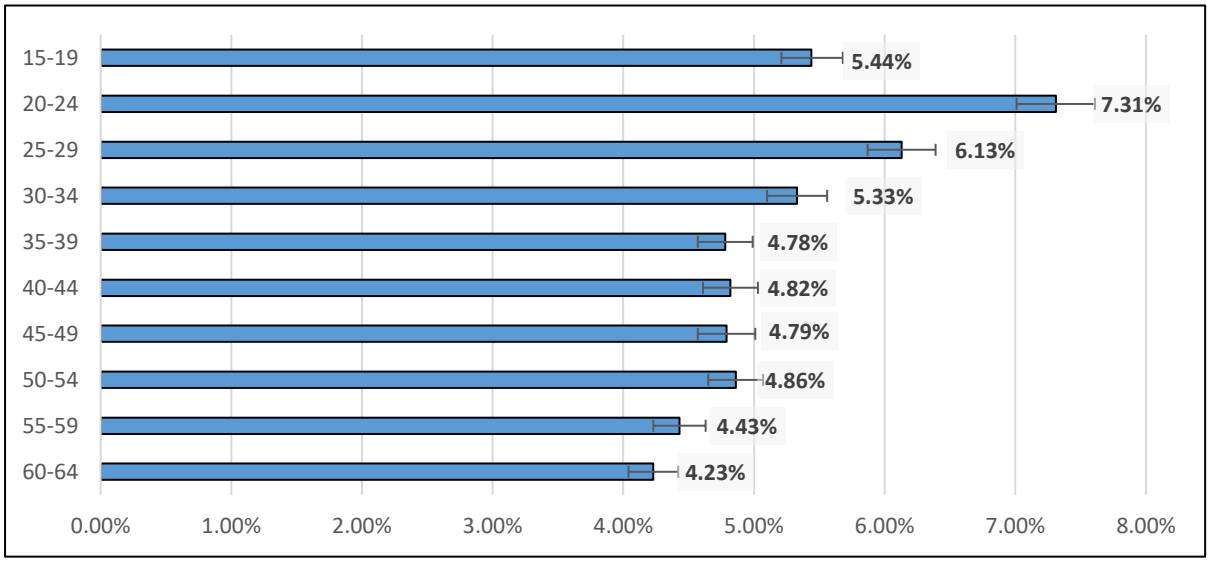
Adult mental health – population health management data

Population health management data from the Optum Pathfinder tool provides further insight into the distribution of recorded mental health need among adults aged 18–64 years across the Suffolk and North East Essex ICB area. This analysis covers the 12 months to 30 November 2025 and includes individuals with a **new mental health flag, indicating if people have one or more of the following mental health conditions – depression, anxiety, low mood or serious mental illness. Event has occurred in the last 2 years and not previous to that.**

Recorded mental health need is highest in early adulthood:

- Prevalence is highest at 7.3% among 20–24 year olds and 6.1% of 25-29 year olds
- Levels remain statistically similar between the ages of 35-39 (4.8%) to 60-64 (4.2%)

Figure 63. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by age groups, 12 months until 30th November 2025



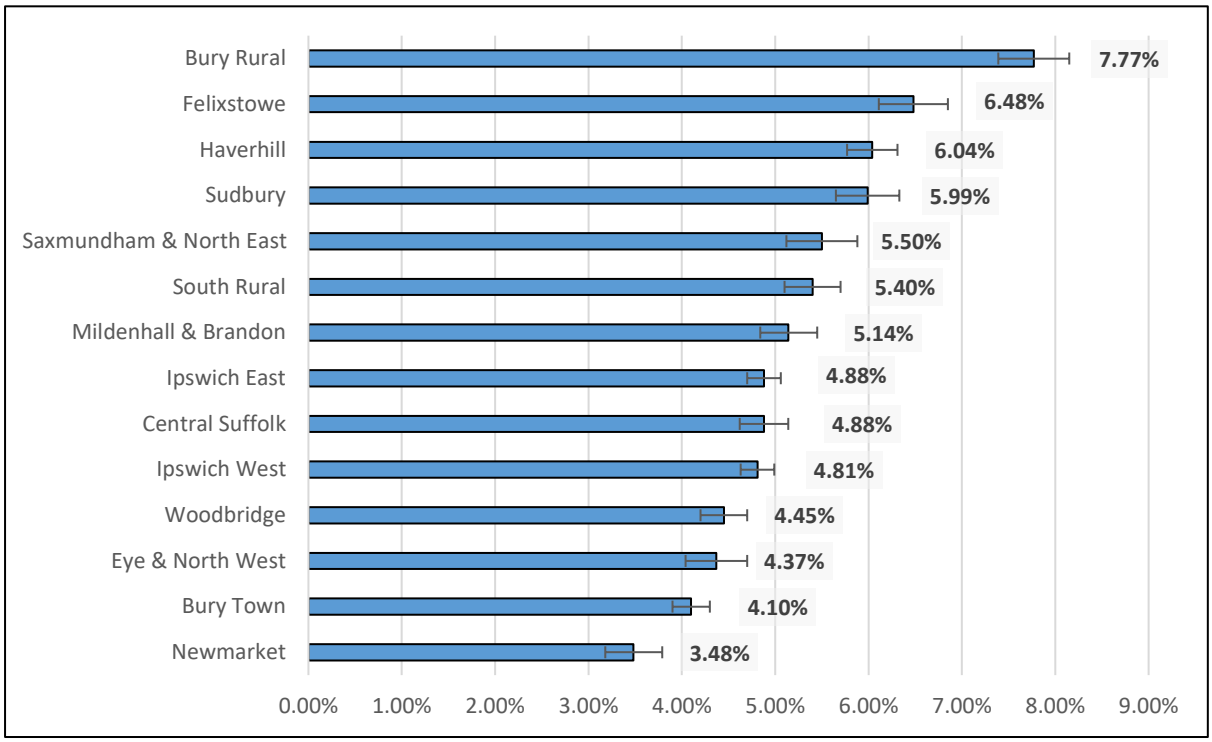
Source: Optum Pathfinder (2026)

Across Suffolk and North East Essex ICB, recorded mental health need among working-age adults is substantial. There is marked variation across INTs:

- The highest prevalence is observed in Bury Rural (7.78%), Felixstowe (6.5%) and Haverhill (6.0%)
- The lowest prevalence is seen in Bury Town (4.1%) and Newmarket (3.5%)

Coastal and more deprived communities, particularly Felixstowe and Haverhill, consistently show higher recorded mental health need. Urban centres such as Ipswich East and West sit closer to the system average but still show high absolute numbers of adults with recorded need.

Figure 64. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Integrated Neighbourhood Team (INT), SNEE registered patients aged 18-64 years of age, 12 months until 30th November 2025



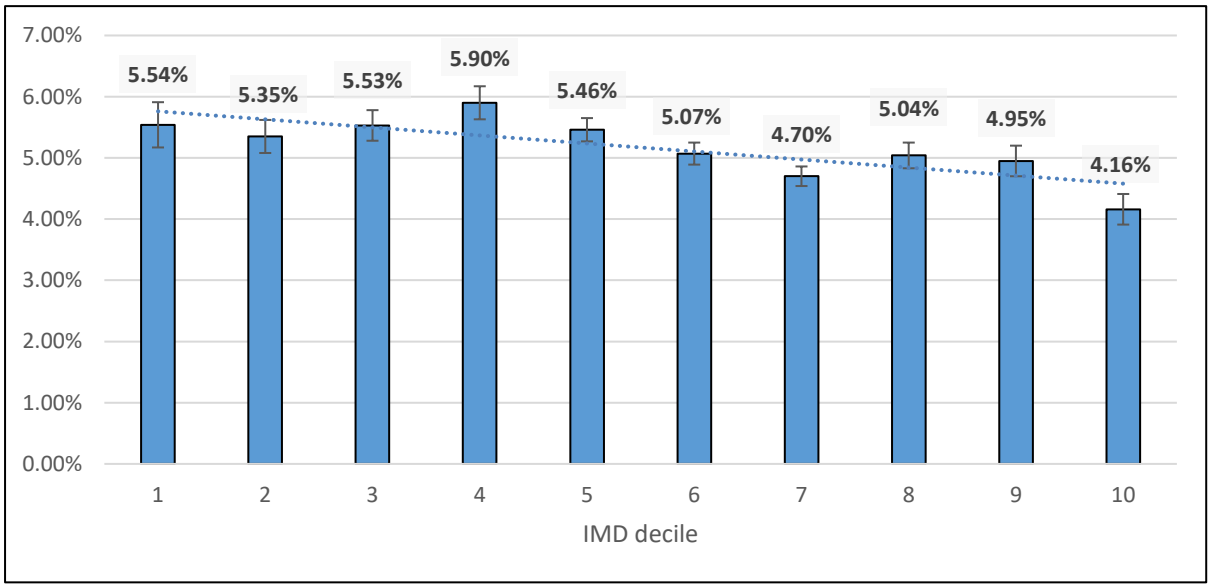
Source: Optum Pathfinder (2026)

Similar to the children and young people data, a deprivation gradient is again evident:

- Adults living in the most deprived areas have higher recorded prevalence (5.54% in IMD decile 1, highest in IMD decile 4 at 5.90%)
- Prevalence steadily decreases with lower deprivation, falling to 4.16% in the least deprived decile

This gradient mirrors national evidence that socioeconomic disadvantage increases exposure to mental health risk factors and contributes to persistent inequalities in mental health outcomes.

Figure 65. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Index of Multiple Deprivation Decile (2025), SNEE registered patients aged 18-64 years of age, 12 months until 30th November 2025



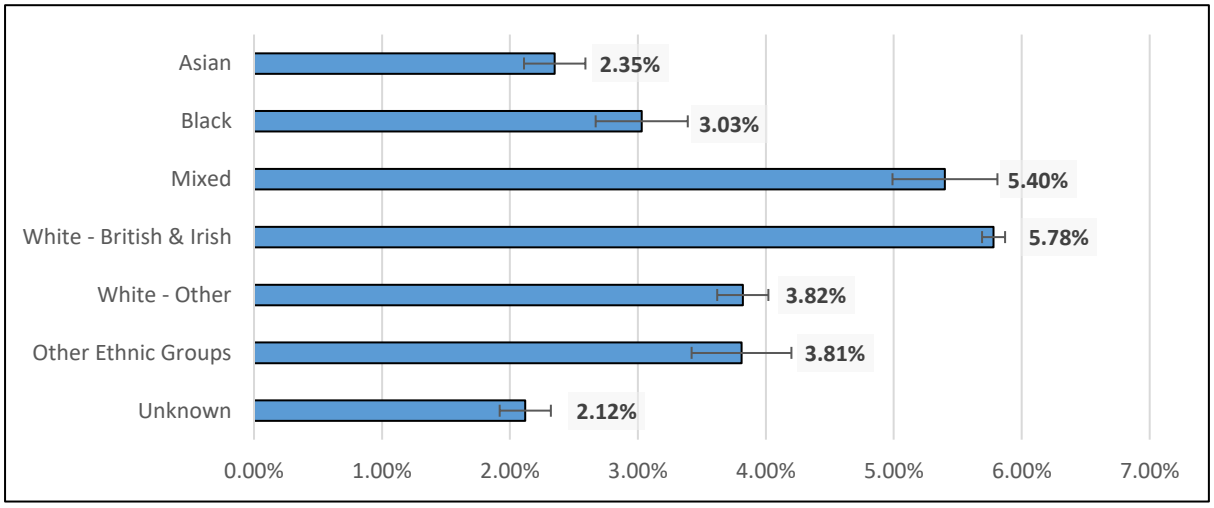
Source: Optum Pathfinder (2026)

Recorded mental health need also varies by ethnic group:

- The highest prevalence is recorded among White British & Irish adults (5.8%) and those of Mixed ethnicity (5.4%)
- Much lower prevalence is recorded among Asian (2.4%) and Black adults (3.0%)

As with CYP data, these differences may be influenced by under-identification, cultural barriers to help-seeking, and variation in access to diagnosis and care, rather than reflecting true underlying prevalence.

Figure 66. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by ethnic group, SNEE registered patients aged 18-64 years of age, 12 months until 30th November 2025



Source: Optum Pathfinder (2026)

This analysis of Population Health Management data for SNEE ICB registered patients aged between 18-64 years of age reflects recorded mental health need within health systems, not the actual population prevalence. The mental health flag within PHM captures individuals who have been identified and coded at any point, and likely underestimates unmet need, particularly among minority ethnic groups and populations who are less likely to engage with services. Similarly, it may also include individuals with historical or lower-level needs who are not currently experiencing active symptoms.

Despite these caveats, the data provides insight into where identified mental health need is the overlapping SNEE ICB and Suffolk geography, highlighting associations with deprivation, geography, and age, and reinforcing the scale of demand facing mental health services across Suffolk and North East Essex ICB.

Factors affecting adult mental health

Mental health does not exist in isolation but is influenced by a combination of individual circumstances, behaviours, environmental factors, and experiences. Understanding these factors helps identify populations at higher risk and informs prevention and intervention strategies. The following sections examine key factors associated with mental health outcomes across health, substance use, crime and safety, housing and employment, and service experiences.

Health

Physical health and mental health are closely related, with each influencing the other. People with mental health conditions are more likely to experience physical health problems, while those with physical health conditions or disabilities face increased risk of mental health difficulties[5].

Learning disability: Using the Quality and Outcomes Framework (QOF), the proportion of people with a learning disability in Suffolk is estimated at 0.63% in 2024/25 (5,264 people), compared to 0.59% across England. However, despite the close percentage, Suffolk's prevalence is statistically significantly higher than England when accounting for population structure and has been significantly increasing over the past five years. People with learning disabilities experience substantially higher rates of ill mental health than the general population, with estimates suggesting 36-43% of adults with learning disabilities experience mental ill health compared to around 15-20% of the general population[188]. This increased risk reflects multiple factors including biological vulnerabilities, adverse life experiences, social isolation, communication difficulties, and barriers to accessing appropriate mental health support[188].

Physical activity: Suffolk performs well on physical activity, with 70.3% of adults classified as physically active in 2023/24, statistically significantly higher than the England average of 67.4%. Physical activity is protective for mental health, with evidence showing it reduces symptoms of depression and anxiety, improves mood and self-esteem, and supports recovery from mental ill health[189]. Suffolk's higher levels of physical activity may contribute to better population mental health, though this protective effect may be offset by other risk factors.

Overweight and obesity: Suffolk has a statistically significantly higher proportion of adults classified as overweight or obese compared to England. In 2023/24, 67.2% of adults in Suffolk were overweight (including obesity) based on adjusted self-reported height and weight, statistically significantly higher than the England average of 64.5%. Obesity is associated with mental health - people with mental health conditions are at increased risk of obesity due to factors including medication side effects, reduced physical activity, and stress-related eating, while obesity itself is associated with increased risk of depression, anxiety, and low self-esteem[190]. The elevated rates of overweight and obesity in Suffolk are a risk factor for both poor physical and mental health that require support through prevention and weight management services working collaboratively with mental health services.

Table 7. Factors affecting adult mental health: health factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Learning disability: QOF prevalence (All ages)	2024/25	5,264	0.6%	0.6%	0.2%	1.0%
Percentage of physically active adults	2023/24	-	70.3%	67.4%	48.9%	80.6%
Overweight (including obesity) prevalence in adults (using adjusted self-reported height and weight) (18+ yrs)	2023/24	-	67.2%	64.5%	77.2%	42.6%

Compared to England (Statistically significantly): Higher 99.8% | Similar | Lower 99.8% | Better 95% | Similar | Worse 95%

Source: Office for Health Improvement and Disparities (2025)

Drugs and tobacco

Substance use and mental health are also closely related. Mental ill health can lead to substance use as a form of self-medication, while substance use can trigger or exacerbate mental health difficulties[191].

Opiate and crack cocaine use: Suffolk has an estimated prevalence of opiate and/or crack cocaine use of 6.00 per 1,000 adults aged 15-64 in 2022/23, statistically significantly lower than the England average of 8.50 per 1,000. This represents a better position compared to the national picture, however, people who use opiates and crack cocaine experience substantially elevated rates of mental ill health including depression, anxiety, post-traumatic stress disorder, and psychosis[192].

Suffolk's performance on supporting people with dual diagnosis (co-occurring substance use and mental ill health) is relatively strong, with 80.6% of clients entering drug treatment with mental health needs also receiving mental health treatment, higher than the England average.

Smoking: Suffolk's smoking prevalence among adults was 10.5% in 2024, statistically similar to the England average of 10.4%. Smoking rates are substantially higher among people with mental health conditions, with estimates suggesting that people with mental ill health are twice as likely to smoke as the general population. Rates may be even higher among those with severe mental illness[193]. Local data also shows that smoking prevalence among adults with a long-term mental health condition was 20.8% in 2024/25, around double the prevalence observed in the overall adult population, although statistically significantly lower than the England average of 24.0%.

Smoking contributes to the significant health inequalities experienced by people with mental health conditions and is a major factor in their reduced life expectancy. As shown in the severe mental illness section, premature mortality rates among people with SMI in Suffolk increased from 65.6 per 100,000 in 2015-17 to 89.8 per 100,000 in 2021-23. While it is not possible to attribute this increase to changes in smoking prevalence specifically, smoking remains a critical underlying risk factor contributing to the persistently high levels of early mortality observed among people with SMI. Even when smoking rates have declined, long-term exposure,

higher levels of dependence, and lower quit success mean that smoking continues to exert a disproportionate impact on health outcomes in this population.

Addressing smoking among people with mental health conditions through tailored cessation support integrated with mental health services is important for reducing both physical and mental health inequalities.

Table 8. Factors affecting adult mental health: alcohol, drugs and tobacco factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Estimated prevalence of opiate and/or crack cocaine use	2022/23	2,757	6.0	8.5	30.0	2.6
Smoking prevalence in adults with a long-term mental health condition (aged 18 and over) – current smokers (GPPS)	2024/25	-	20.8%	24.0%	37.2%	12.2%
Smoking prevalence in adults (aged 18 and over) - current smokers (APS)	2024	-	10.5%	10.4%	20.8%	5.0%

Compared to England (Statistically significantly): Better 95% | Similar | Worse 95%

Source: Office for Health Improvement and Disparities (2025)

Crime, safety and violence

Crime, safety and exposure to violence are important determinants of adult mental health, with links to trauma, anxiety, depression, substance misuse and long-term psychological harm. Experiences of domestic abuse and violent crime increase the risk of poor mental health outcomes[194].

Domestic abuse: Reported rates of domestic abuse related incidents and crimes in Suffolk (21.5 per 1,000 population, 2023/24) are in the lowest national quintile, and notably statistically significantly below the England average (27.1 per 1,000). This suggests lower reported exposure to domestic abuse at a population level, although it remains important to recognise that domestic abuse is often underreported and continues to have serious consequences for mental health among those affected.

Violent crime: Suffolk also has a comparatively low rate of violent crime, with 23.3 violence offences per 1,000 population in 2024/25, placing it in the lowest quintile nationally and statistically significantly below the England average of 31.4 per 1,000. This indicator has shown a statistically significant downward trend over the past five years, indicating sustained improvement in community safety.

Reoffending: Reoffending levels in Suffolk are statistically similar to the national picture. In 2022/23, over 1 in 4 (26.5%) of offenders in Suffolk reoffended, placing the county in the middle national quintile and close to the England average (26.2%). This suggests that, while overall crime levels are relatively low, ongoing challenges remain as part of the rehabilitation process. Reoffending is closely linked to mental health need, substance misuse, housing instability and social exclusion, highlighting the importance of integrated approaches between criminal justice, mental health and wider support services[195].

These indicators suggest that Suffolk benefits from comparatively low and improving levels of violent crime and domestic abuse, which may support better population mental health outcomes. However, the persistence of reoffending at average levels points to continued need for targeted mental health support for people in contact with the criminal justice system, alongside preventative and trauma-informed approaches for those affected by violence and abuse.

Table 9. Factors affecting adult mental health: crime, safety and violence factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Domestic abuse related incidents and crimes	2023/24	-	21.5	27.1	9.9	43.2
Violent crime - violence offences per 1,000 population	2024/25	18,166	23.3	31.4	14.5	67.9
Reoffending levels: percentage of offenders who reoffend	2022/23	1,006	26.5%	26.2%	15.1%	40.2%

Quintiles: Low | | | | High

Source: Office for Health Improvement and Disparities (2025)

Home, housing and employment

Secure employment, stable housing, and being free from financial hardship are fundamental determinants of mental health and wellbeing. Unemployment, homelessness, and poverty are strongly associated with increased risk of ill mental health, while mental health difficulties can create barriers to sustainable employment and housing[196].

Long-term unemployment: Suffolk has a statistically significantly lower rate of long-term Jobseeker's Allowance claimants compared to England. In 2023, 0.6 per 1,000 working-age population were long-term claimants (281 people), statistically significantly lower than the England average of 0.9 per 1,000, and this rate has been decreasing over the past five years – primarily due to the ongoing rollout of Universal Credit (UC), which is replacing income-based JSA, as well as other legacy benefits[197]. However, unemployment alone does not capture the full picture of labour market exclusion.

Unemployment is strongly associated with poor mental health, with unemployed people experiencing higher rates of common mental disorders compared to those in full-time employment[198].

The Get Suffolk Working plan, aligned to the national Get Britain Working White Paper (2024), recognises health-related economic inactivity as a key challenge and brings together partners across work, health and skills systems to improve employment outcomes. Strengthening integration between mental health services, primary care, employment support and skills provision will be important in addressing both the causes and consequences of work-limiting mental ill health.

Fuel poverty: Suffolk's fuel poverty rate was 11.1% in 2023 (38,629 households), statistically similar to the England average of 11.4% and placing Suffolk in the middle quintile nationally. Fuel poverty is the inability to afford adequate heating and associated with both physical and mental ill health including stress, anxiety, and depression.

Cold homes can exacerbate existing mental health conditions and create financial stress that impacts wellbeing[199]. With over 38,000 households affected, fuel poverty represents a significant source of stress and potential mental health risk for a large portion of Suffolk's population.

Homelessness - temporary accommodation: Suffolk has a statistically significantly lower rate of households in temporary accommodation compared to England. In 2023/24, 1.1 per 1,000 households were in temporary accommodation (382 households), statistically significantly lower than the England average of 4.6 per 1,000. This figure has also been significantly increasing over the past five years. Homelessness and temporary accommodation are associated with high rates of mental ill health[200]. People experiencing homelessness have substantially elevated rates of depression, anxiety, psychosis, and substance use disorders[200]. The instability, overcrowding, and unsuitability of temporary accommodation can trigger or exacerbate mental health difficulties, particularly for children and families.

Homelessness - statutory duties: Suffolk has a statistically significantly lower rate of households owed a duty under the Homelessness Reduction Act compared to England. In 2023/24, 11.9 per 1,000 households were owed a duty (4,036 households), lower than the England average of 13.4 per 1,000. This rate has been statistically significantly decreasing over the past five years, indicating improved prevention of homelessness. While this is positive, over 4,000 households remained at risk of or experiencing homelessness, representing a large portion of the county's population with elevated mental health needs requiring coordinated support across services.

Suffolk's housing and employment factors represent a mixed picture, with lower long-term unemployment and decreasing statutory homelessness positive indicators that may contribute to better population mental health. However, the increasing use of temporary accommodation is concerning and represents a growing population at risk of mental health difficulties. Fuel poverty affecting over 38,000 households represents widespread financial stress that may also impact mental wellbeing.

Table 10. Factors affecting adult mental health: home, housing and employment factors for Suffolk and England

Indicator	Period	Suffolk Count	Suffolk Value	England Value	England Worst/ Lowest	England Best/ Highest
Long term claimants of Jobseeker's Allowance	2023	281	0.6	0.9	3.3	0.1
Fuel poverty (low income, low energy efficiency methodology)	2023	38,629	11.1%	11.4%	21.3%	6.2%
Homelessness: households in temporary accommodation	2023/24	382	1.1	4.6	51.9	0.2
Homelessness: households owed a duty under the Homelessness Reduction Act	2023/24	4,036	11.9	13.4	30.6	3.6

Compared to England (Statistically significantly): Better 95% | Similar | Worse 95%

Quintiles: Best | | | | Worst

Source: Office for Health Improvement and Disparities (2025)

"Military personnel and veterans can face unique risks and challenges to their mental health. Being exposed to highly stressful situations, long periods away from home and the difficulty of adjusting to civilian life can all affect your mental health. You may experience problems at the time or even years later"[201].

Serving personnel

Serving members of the Armed Forces are a distinct occupational group with specific mental health risks and protective factors. The Ministry of Defence (MoD) highlight that mental health care can be provided to serving UK Armed Forces personnel in the primary care setting by the patient's own Medical Officer, similar to a General Practitioner (GP), or by specialist mental health clinicians at MOD Specialist Mental Health Services; this includes community mental health services at MOD Departments of Community Mental Health (DCMH) for outpatient care or admissions to hospital as an in-patient[202].

MoD data on the location statistics for UK regular armed forces reports that as of the 1st April 2025, Suffolk had 2,790 serving personnel, predominantly Regular Army (72%) and with the greatest numbers of personnel in Mid Suffolk.

Whilst Suffolk level data on the prevalence of poor mental health in UK Armed Forces personnel was not available, the MoD notes that nationally in 2024/25[202]:

- 12.3% of UK Armed Forces personnel were seen in military healthcare for a mental health related reason
- 1.9% of UK Armed Forces personnel were seen by a specialist mental health clinician in 2024/25
- Females sought help more than males, similar to that seen in the UK general population
- The rate of PTSD among UK Armed Forces remains low at around 3 in 1,000 personnel
- The overall rate of personnel seen for any mental health related reason remained broadly comparable to the UK general population. The rate of those needing specialist mental health treatment was lower in the UK armed forces than that seen in the UK general population

Data available on suicide[203] (published in March 2026) found that suicide is a rare event in the UK Armed Forces and is consistently lower than the UK general population - with the rate for the latest 20-year period (2006-2025) being 8 per 100,000 personnel. However, this still represents 277 deaths by suicide - 255 male and 22 female.

Suffolk also hosts a substantial United States Air Force (USAF) presence, principally associated with RAF Lakenheath and RAF Mildenhall (Mildenhall's 48th Fighter Wing hosts nearly 7,000 active-duty personnel). USAF personnel and their families are an established part of local communities, with many living off-base in surrounding towns and villages rather than within military accommodation.

Mental health care for serving USAF personnel and their dependants is primarily provided through US military health systems based on or linked to the local bases, including on-site mental health services. As a result, these populations do not routinely access NHS mental health services for their own clinical care.

However, the impacts of poor mental health among serving personnel (both UK and US) are not confined to military settings. Many personnel live with partners and families in civilian communities rather than on military bases, particularly later in their service. Mental health difficulties can therefore affect family wellbeing, parenting, employment, social participation and use of community services. Spill-over impacts may be felt in schools, workplaces, housing

services and wider community settings, even where the individual's formal healthcare is delivered by the Armed Forces.

Reservists and personnel approaching discharge may also have increased contact with NHS and local authority services, making continuity of care and system awareness particularly important during periods of transition.

Veterans

A veteran is defined as someone that has served at least one day in the armed forces. Data from the ONS indicates that as of the 2021 census, there were nearly 31,000 veterans residing in Suffolk, over 1 in 3 (36.4%) lived in East Suffolk.

Whilst most of Suffolk's veterans were aged 65 and over (59.0%), 32.2% were aged 40-64, and 8.8% were under 40. It is important to recognise that many veterans experienced deployments linked to Northern Ireland, the Gulf, Iraq and Afghanistan, rather than earlier conflicts. This represents a demographic shift away from very elderly cohorts and towards veterans who may be of working age, have dependent children, and live independently in the community. A 2026 study forecasting the support needs of the veteran community in Great Britain noted that the number of disabled younger veterans is likely to rise, and as in wider society, researchers expect a growing proportion of disabilities to be mental-health related.

King's College London[204] reports that people who have served in the UK Armed Forces are often referred to as being "mad, bad and sad" - a media led stereotype. This narrative can be damaging to the health and wellbeing of personnel, reduces their employment prospects post-service, and increases stigma. The same report also asserts that the vast majority of those who have served do not experience mental health problems during or after service. However, in a later stage of the study conducted in 2014-16, there was a modest increase in PTSD (from 4% to 6%), with the greatest increase in the ex-serving personnel who had previous experience of combat deployments to Iraq or Afghanistan (17%).

Further research[205] indicates that Members of the British Armed Forces who were physically injured while fighting in Afghanistan are more likely to experience poor mental health compared to their colleagues who did not experience a physical injury during deployment. This highlights that mental health needs are often compounded by wider issues such as physical injury and chronic pain as just two examples.

Implications for the local system

Although healthcare responsibility differs between serving personnel and veterans, both groups have mental health needs that intersect with families, communities and local services. A populations approach requires:

- visibility of Armed Forces and veteran communities within local needs assessment
- awareness among universal services of the potential mental health impacts of service and transition
- recognition that mental health outcomes are shaped by housing, employment, relationships and community connection, not solely clinical care.

Suffolk's rural geography may present additional barriers for some Armed Forces and veteran communities, including access to services, social isolation and transport challenges. As a result, mental health needs among serving personnel, veterans and their families may present in universal and community services rather than specialist settings, reinforcing the importance of local awareness, identification and referral pathways.

Suffolk has an established **Armed Forces Covenant** and a mixed Armed Forces community. Veterans in Suffolk primarily rely on NHS and community-based provision. Specialist mental

health support is available through **Op COURAGE** which covers Suffolk alongside neighbouring areas, working in partnership with Norfolk and Suffolk NHS Foundation Trust and local voluntary sector organisations.

Older adults' mental health

Suffolk has an older age profile than England overall, with a higher proportion of residents in later working age and older age groups, and comparatively fewer younger adults. Population projections indicate that this demographic shift will continue over the next two decades, with particularly strong growth expected among those aged 75 and over, including the 80–84, 85–89 and 90 and over age groups. This has important implications for mental health need and service planning, as the prevalence, presentation and complexity of mental ill health changes across the life course.

Available national indicators provide limited but important insight into mental health service use among older adults in Suffolk. Taken together, these data suggest lower levels of referral and inpatient activity compared with the wider population, alongside sustained use of community and outpatient services.

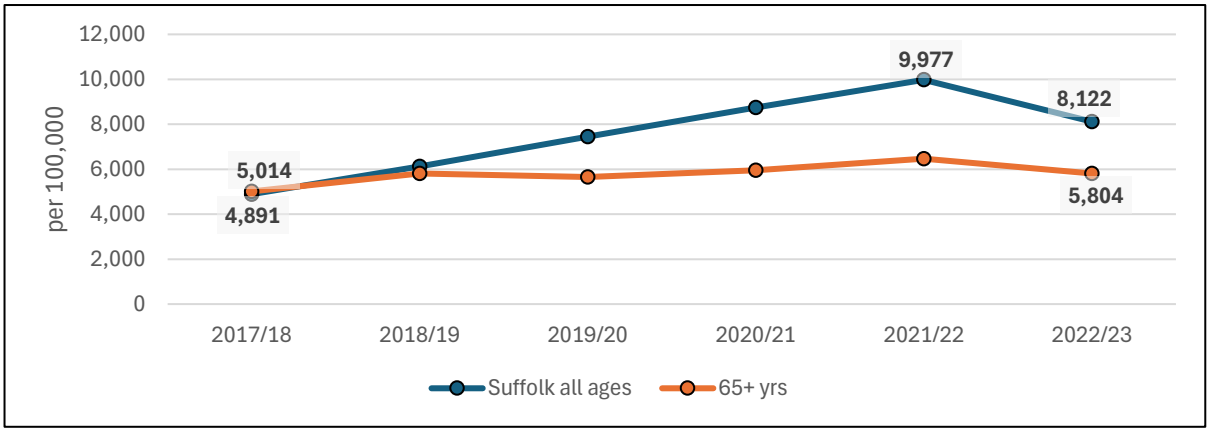
Some of the service and system pressures affecting older adults' mental health in Suffolk relate to the wider dementia care pathway. Insights from Norfolk and Suffolk NHS Foundation Trust (NSFT) indicate that delays in dementia diagnosis are not solely driven by mental health services, but also depend on access to acute diagnostic investigations such as brain scans. Younger onset dementia is also an underserved pathway, with risks of delayed diagnosis, inappropriate or out-of-area placements, and limited access to age-appropriate post-diagnostic support.

Care homes also form a critical part of the wider mental health and dementia care system. Variation in staff confidence, training and access to specialist mental health in-reach support can influence whether behavioural or psychological symptoms of dementia are managed within the care setting or escalate into crises requiring emergency services, hospital admission or specialist mental health intervention. Further detail on dementia prevalence, service use and care pathways in Suffolk is available in the Dementia Profile (2025).

Referrals to secondary mental health services

Between 2017/18 and 2022/23, referral rates for adults aged 65 and over were consistently lower than the all-age Suffolk rate. In 2022/23, the referral rate for older adults was 5,804 per 100,000, compared with 8,122 per 100,000 across all ages. After peaking in 2021/22, referral rates declined in 2022/23, reflecting a broader post-pandemic pattern.

Figure 67. New referrals to secondary mental health services per 100,000, all ages and adults aged 65 and over, Suffolk, 2017/18 to 2022/23

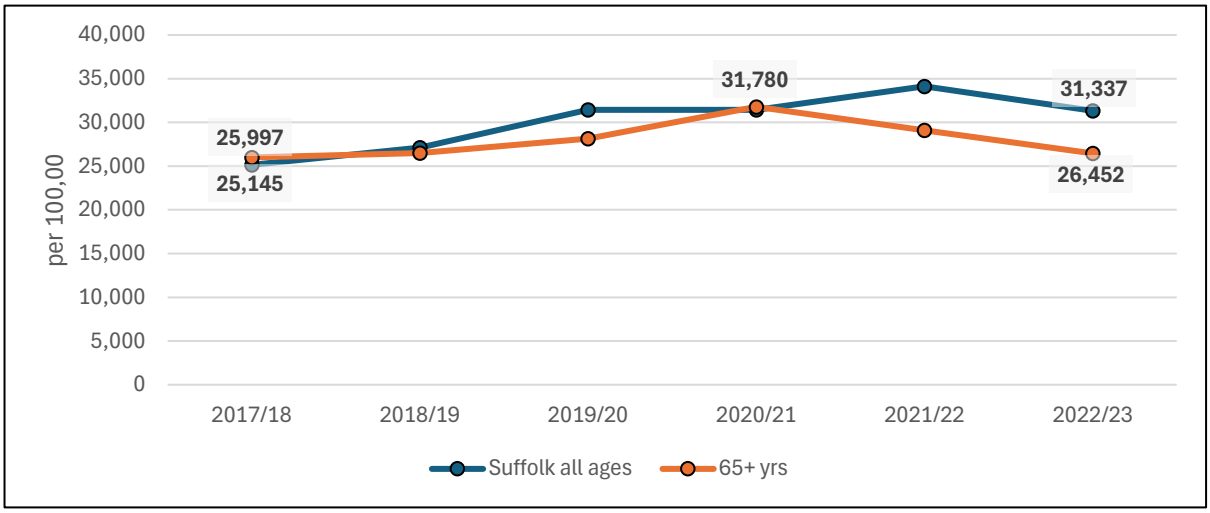


Source: Office for Health Improvement and Disparities (2026)

Community and outpatient contacts

Rates of attended community and outpatient mental health contacts among older adults were broadly similar to, and in some years higher than, the all-age rate. Contacts increased steadily to a peak in 2020/21 (31,780 per 100,000), before falling to 26,452 per 100,000 in 2022/23. This suggests that older adults make use of community and outpatient mental health services at levels similar to the overall population.

Figure 68. Attended contacts with community and outpatient mental health services per 100,000, all ages and adults aged 65 and over, Suffolk, 2017/18 to 2022/23

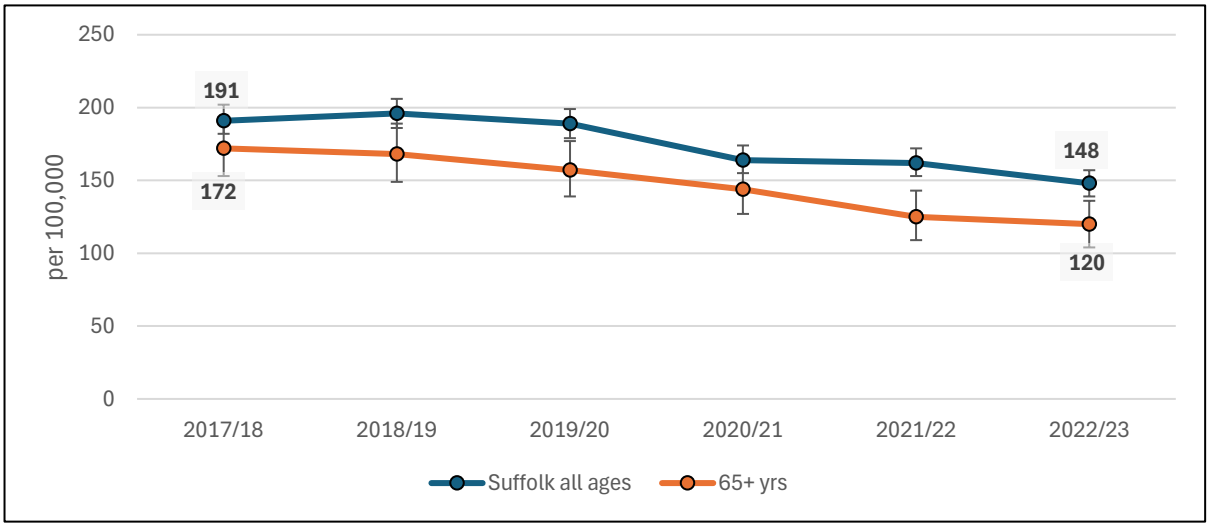


Source: Office for Health Improvement and Disparities (2026)

Inpatient admissions

Inpatient stays for older adults declined steadily over the period. In 2022/23, the inpatient rate for those aged 65 and over was 120 per 100,000, lower than the all-age rate of 148 per 100,000; declining admission rates may reflect a range of factors including service configuration, access, and need.

Figure 69. Inpatient stays in secondary mental health services per 100,000, all ages and adults aged 65 and over, Suffolk, 2017/18 to 2022/23



Source: Office for Health Improvement and Disparities (2026)

Interpretation and future need

Despite Suffolk's older population profile and projected growth in the oldest age groups, older adults currently have lower referral and inpatient admission rates to secondary mental health services than younger age groups. This may reflect a combination of factors, including different help-seeking behaviours, alternative care pathways (such as primary care, social care or dementia services), and potential under-recognition of mental health conditions in later life.

As Suffolk's population continues to age, demand for age-appropriate, integrated mental health support is likely to increase, particularly for conditions associated with later life, including depression, anxiety, dementia-related mental health needs, loneliness and social isolation. This reinforces the importance of preventative approaches that support mental wellbeing in older age, alongside timely identification and management of mental health needs.

Healthwatch Suffolk: Ageing Well

Healthwatch Suffolk's Ageing Well in Suffolk report from November 2024, based on feedback from over 400 residents, highlights the strong link between mental wellbeing, social connection and access to local services in later life. Social isolation emerged as a significant driver of poor mental health, with some older adults reporting antidepressant prescribing linked primarily to loneliness rather than clinical depression. Access to suitable and reliable transport was consistently identified as essential to maintaining wellbeing, particularly in rural areas, yet remains a key barrier for many. These findings underline the role of social determinants and community infrastructure in preventing deterioration in older adults' mental health and reducing avoidable demand on clinical services.

Older adult's mental health – population health management data

Population health management data from the Optum Pathfinder tool provides additional insight into recorded mental health need among adults aged 65 years and over across Suffolk and North East Essex ICB. This analysis covers the 12 months to 30 November 2025 and includes individuals with a **new mental health flag, indicating if people have one or more of the following mental health conditions – depression, anxiety, low mood or serious mental illness. Event has occurred in the last 2 years and not previous to that**.

As with other PHM analyses in this assessment, data excludes individuals registered with GP practices in Waveney, which falls outside Suffolk and North East Essex ICB.

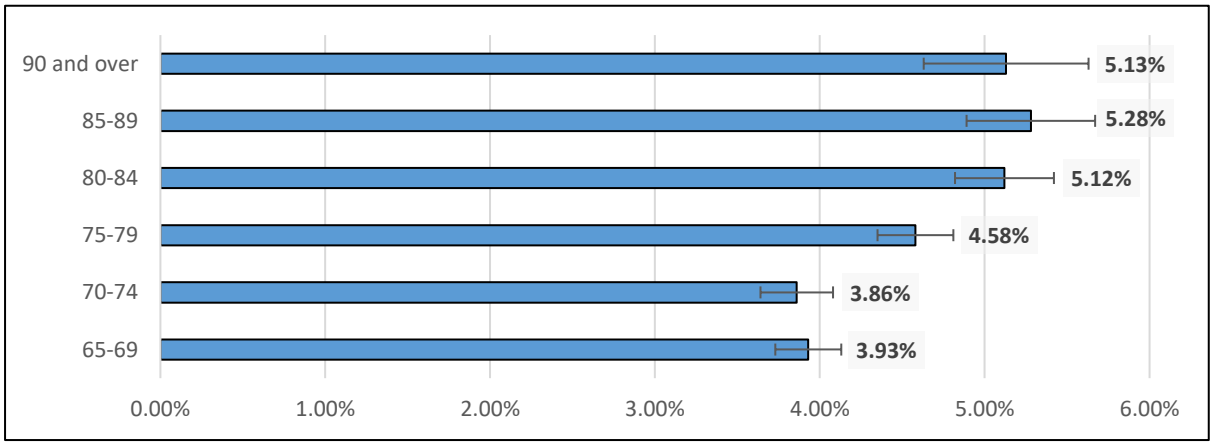
Across the system, recorded mental health need among older adults remains high. Around one quarter of people aged 65 and over have a mental health flag recorded in health data, demonstrating that mental ill health is not confined to working-age populations and continues to affect large numbers of people in later life.

Within the 65 and over population, prevalence is highest in the youngest older age groups and gradually declines with increasing age:

- The highest recorded prevalence is among those aged 85–89 (5.3%) and statistically significantly higher for those in the older age groups (75-79, 80-84, 85-89 and 90 and over), when compared to younger older adults (aged 65 to 69 and aged 70 to 74)

This pattern may reflect a combination of factors, including changing help-seeking behaviour, differences in identification and diagnosis at older ages, and the increasing likelihood that mental health symptoms become subsumed within physical health or cognitive decline in the oldest age groups.

Figure 70. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by age groups, 12 months until 30th November 2025



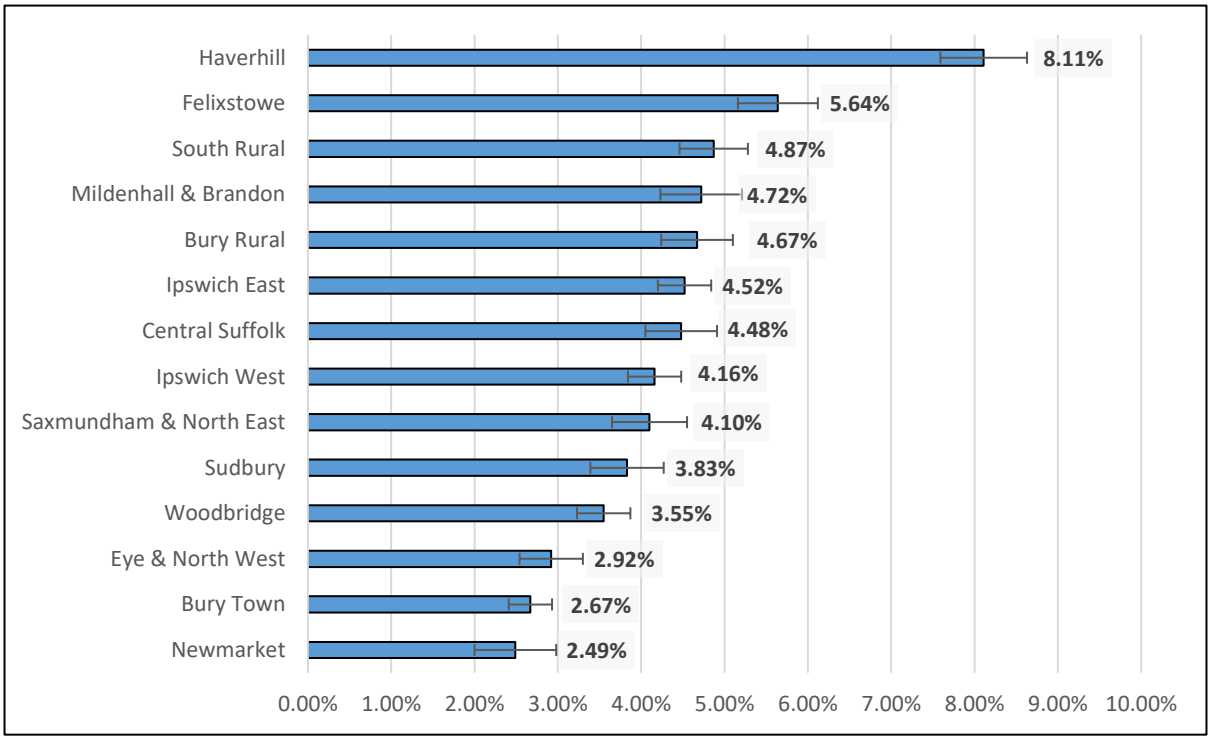
Source: Optum Pathfinder (2026)

There is variation across SNEE ICB's Integrated Neighbourhood Team (INT) areas:

- The highest prevalence is observed in Haverhill (8.1%), Felixstowe (5.6%), South Rural (4.9%) and Mildenhall & Brandon (4.7%)
- Lower prevalence is seen in areas such as Eye & North West (2.9%), Bury Town (2.7%) and Newmarket (2.5%)

These patterns broadly align with socioeconomic and demographic differences across the system, with more deprived communities tending to show higher recorded need among older residents.

Figure 71. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Integrated Neighbourhood Team (INT), SNEE registered patients aged 65 years of age and over, 12 months until 30th November 2025



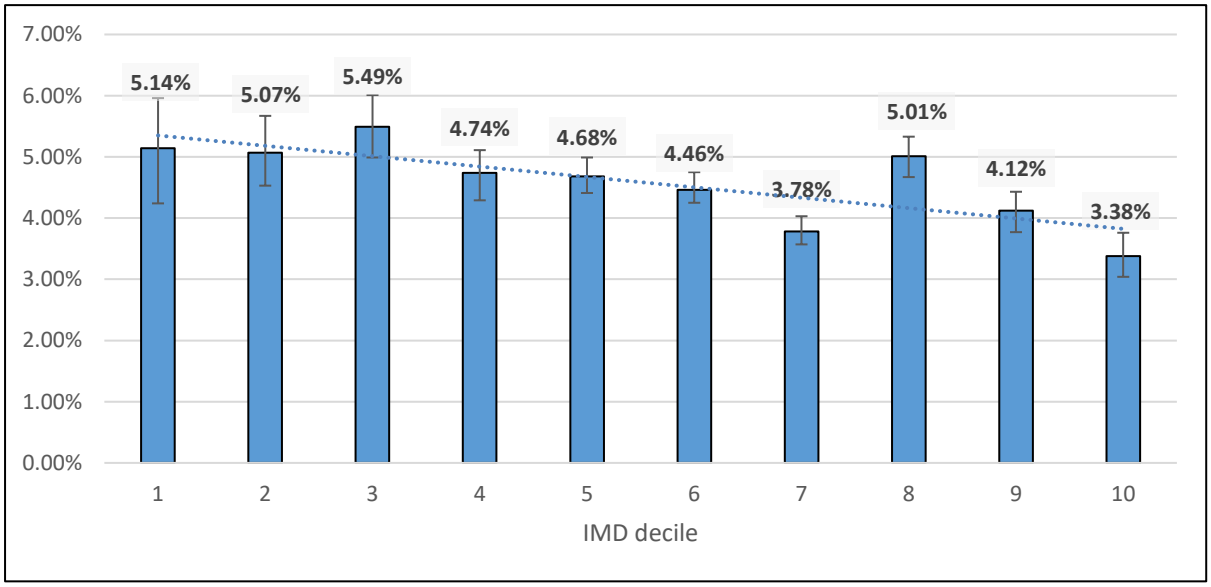
Source: Optum Pathfinder (2026)

Among older adults across SNEE ICB, the socioeconomic gradient is also evident:

- Nearly one in twenty older adults living in the most deprived areas have a recorded mental health condition in the previous two years (5.1% in IMD decile 1)
- Prevalence declines across the IMD deciles, decreasing to around 3.4% in the least deprived decile (decile 10)

This shows that the relationship between deprivation and mental ill health persists into later life, compounding other age-related risk factors such as long-term physical conditions and social isolation.

Figure 72. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by Index of Multiple Deprivation Decile (2025), SNEE registered patients 65 years of age and over, 12 months until 30th November 2025



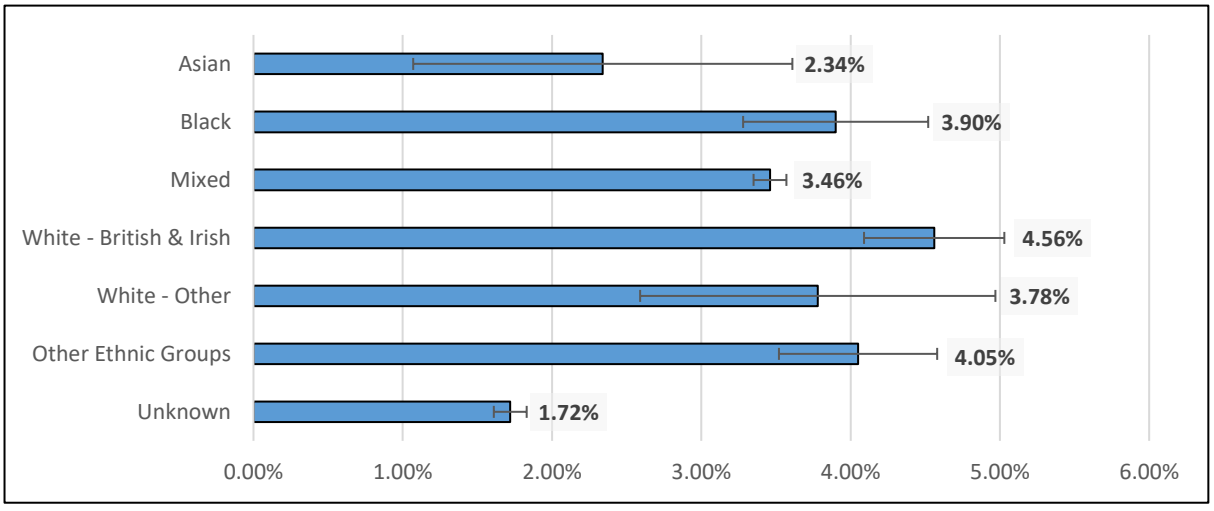
Source: Optum Pathfinder (2026)

Differences in recorded prevalence are also apparent by ethnicity:

- Highest prevalence is recorded among White British & Irish (4.6%) and Other Ethnic Groups (4.1%) older adults
- Lower recorded prevalence is seen among Asian (2.3%), Mixed (3.5%) and White – Other (3.8%) ethnic groups

As with younger age groups, these differences are likely influenced by under-diagnosis, cultural barriers, and variation in access to services, rather than reflecting true differences in underlying mental health need.

Figure 73. Suffolk and North East Essex ICB Population Health Management data: New Mental health flag: Yes, by ethnic group, SNEE registered patients 65 years of age and over, 12 months until 30th November 2025



Source: Optum Pathfinder (2026)

This analysis also reflects identified and recorded mental health need, not true prevalence. Mental ill health in older adults is often under-recognised, particularly where symptoms overlap with physical illness, frailty or cognitive impairment. Social isolation, loneliness and bereavement may also contribute to mental distress that does not result in diagnosis or coding.

Despite these limitations, the findings highlight that a substantial proportion of older adults already known to health services are experiencing mental health difficulties, with clear inequalities by deprivation and place. As Suffolk's population continues to age, this reinforces the importance of age-appropriate mental health support, integrated physical and mental healthcare, and preventative approaches that address loneliness, isolation and long-term conditions in later life.

Services

Service data

Physical health inequalities among people with severe mental illness

In Suffolk, improving the physical health of people living with severe mental illness is supported through a collaborative model between primary care, secondary mental health services and the voluntary sector. The Suffolk SMI Physical Health Team works with primary care practices to ensure that people on the SMI register receive their annual physical health checks, including outreach to individuals who may not engage with routine invitations. As of March 2026, around 4,365 people in Suffolk were recorded on primary care SMI registers, with approximately 37% under secondary mental health services. Performance on annual SMI physical health checks is relatively strong, with around 71% of people receiving a completed check in 2025/26, compared with 59% nationally. Following these checks, individuals can be referred to the Healthy Together peer support programme delivered by Suffolk User Forum, which provides practical and peer-led support to address physical health needs and wider wellbeing goals. This integrated approach highlights the importance of linking clinical screening with ongoing community-based support to address the significant physical health inequalities experienced by people with SMI.

Primary care

Indicators published by the Office for Health Improvement and Disparities in April 2026 provide further insight into the quality of primary care management for people with mental health conditions, including severe mental illness and depression.

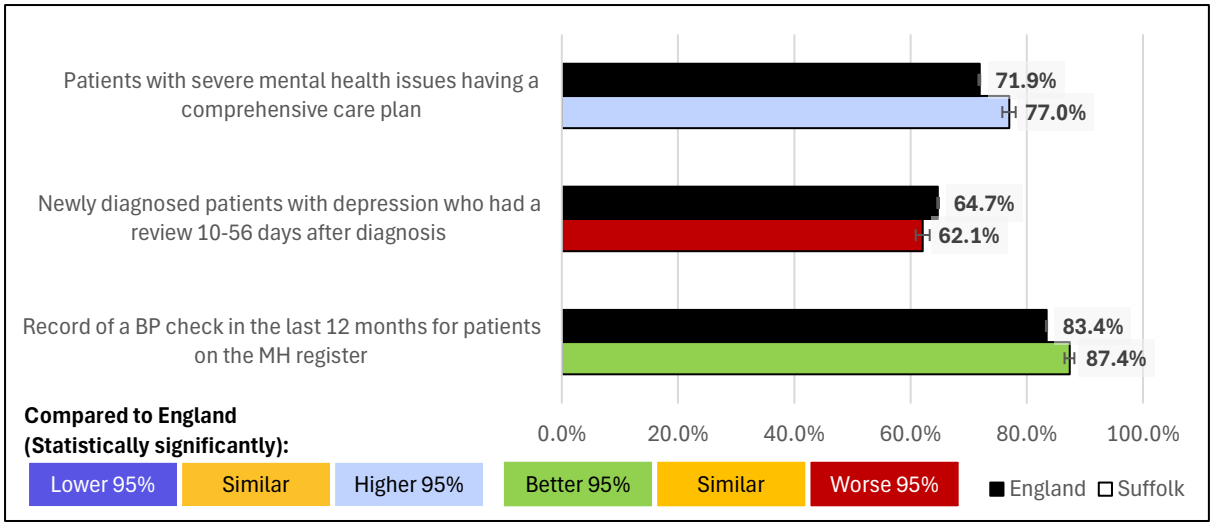
In 2024/25, 77.0% of patients on the mental health register in Suffolk had a documented comprehensive care plan (4,294 people), statistically significantly higher than the England average (71.9%). This suggests comparatively strong performance in care planning within primary care, which is particularly important given that a substantial proportion of people with SMI are managed primarily in these settings. The proportion has also statistically significantly increased over recent years, indicating continued improvement.

For newly diagnosed depression, 62.1% of patients in Suffolk received a follow-up review within 10–56 days (3,959 people), statistically significantly below the England average (64.7%), although performance has improved over the previous five years. Early follow-up is a key component of effective depression management, supporting treatment adherence and reducing the risk of relapse, and this may represent an area for further improvement.

In contrast, physical health monitoring for people with mental illness appears strong. In 2024/25, 87.4% of patients on the mental health register had a blood pressure check recorded in the previous 12 months (4,875 people), statistically significantly higher than both the East of England (83.9%) and England (83.4%) averages. This is particularly important given the elevated risk of cardiovascular disease among people with SMI.

Overall, these indicators suggest that primary care in Suffolk is performing well in several aspects of mental health management, particularly in care planning and physical health monitoring. However, there remain opportunities to strengthen early follow-up for people newly diagnosed with depression, alongside continued efforts to ensure consistent, high-quality care across all patient groups.

Figure 74. Primary care mental health quality and outcomes indicators, Suffolk and England, 2024/25



Source: Office for Health Improvement and Disparities (2026)

Secondary care

Mental health treatment and service use – APMS indicators

National data from the 2023 Adult Psychiatric Morbidity Survey indicate that many adults reporting symptoms of a common mental health condition are not receiving formal treatment. Among adults who met the APMS threshold for a common mental health condition based on self-reported symptoms in the previous week, 55.4% reported receiving no mental health treatment in the past 12 months, meaning fewer than half accessed medication or psychological therapy of any form. Treatment rates were lowest for those with common mental health conditions not otherwise specified, where 69.2% received no treatment.

It is important to interpret these findings with caution. The APMS identifies current symptoms, not all of which will meet clinical thresholds for diagnosis or require medical or psychological intervention. For some individuals, symptoms may be transient, situational, or part of normal psychological responses to life events, where formal treatment may not be necessary or appropriate.

Among those who did receive treatment, medication was most common. Over one in three (36.0%) of adults with symptoms of a common mental health condition in the past week received medication (either alone or combined with therapy), while 16.2% received psychological therapy (alone or combined with medication). Medication-only treatment was the most frequent approach (28.4%), followed by psychological therapy only (8.5%), with 7.7% receiving the combination of medication along with psychological therapy.

Treatment patterns varied by condition type, with people with phobias having the highest treatment rates, with almost two in three (65.6%) receiving some form of treatment, including 30.4% receiving psychological therapy. Those with depressive episodes also had high treatment rates (62.2%), with 27.3% receiving psychological therapy. In contrast, people with panic disorder had lower treatment rates (52.7% receiving any treatment), as did those with generalised anxiety disorder (55.3%).

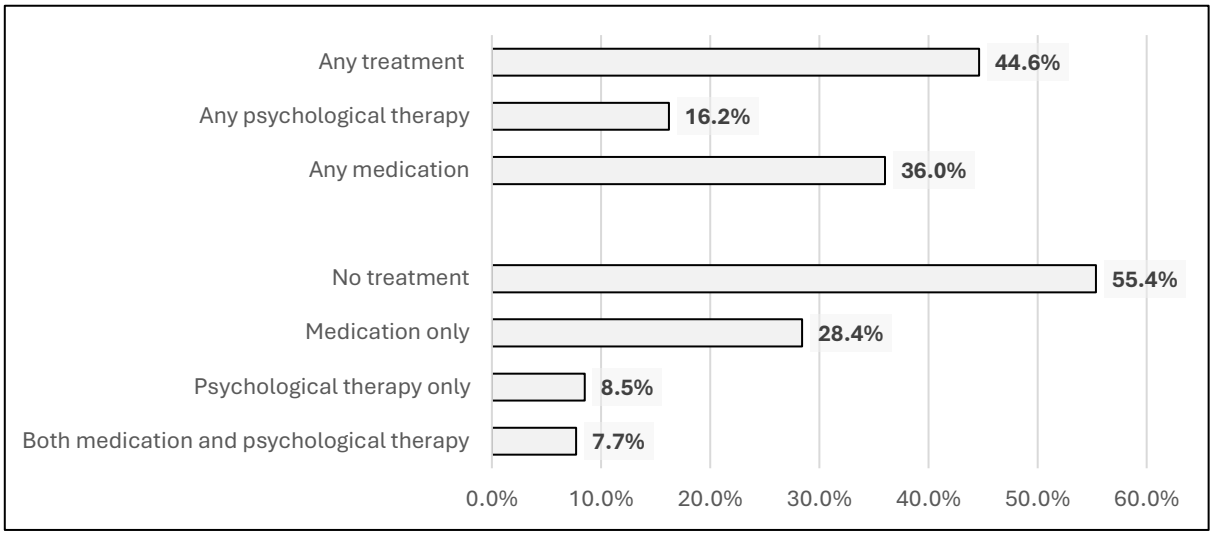
This national pattern may show substantial unmet need, with over half of people experiencing symptoms of common mental health conditions receiving no treatment. In Suffolk, this

demonstrates the need for accessible pathways to both medication management and psychological therapies, ensuring capacity meets demand, and reducing barriers to treatment access.

Psychotropic medications are drugs that affect the brain and nervous system, altering mood, thoughts and behaviour, and are used to treat conditions such as depression, anxiety, psychosis or ADHD[206].

Among adults with symptoms of common mental health conditions, 36.0% were currently taking psychotropic medication, compared to just 12.5% of all adults. The most used medications were antidepressants (33.5% of those with any common mental health condition) and drugs used primarily to treat anxiety (30.2%).

Figure 75. Treatment currently received for any common mental health condition in past week, all adults, England, 2023/24

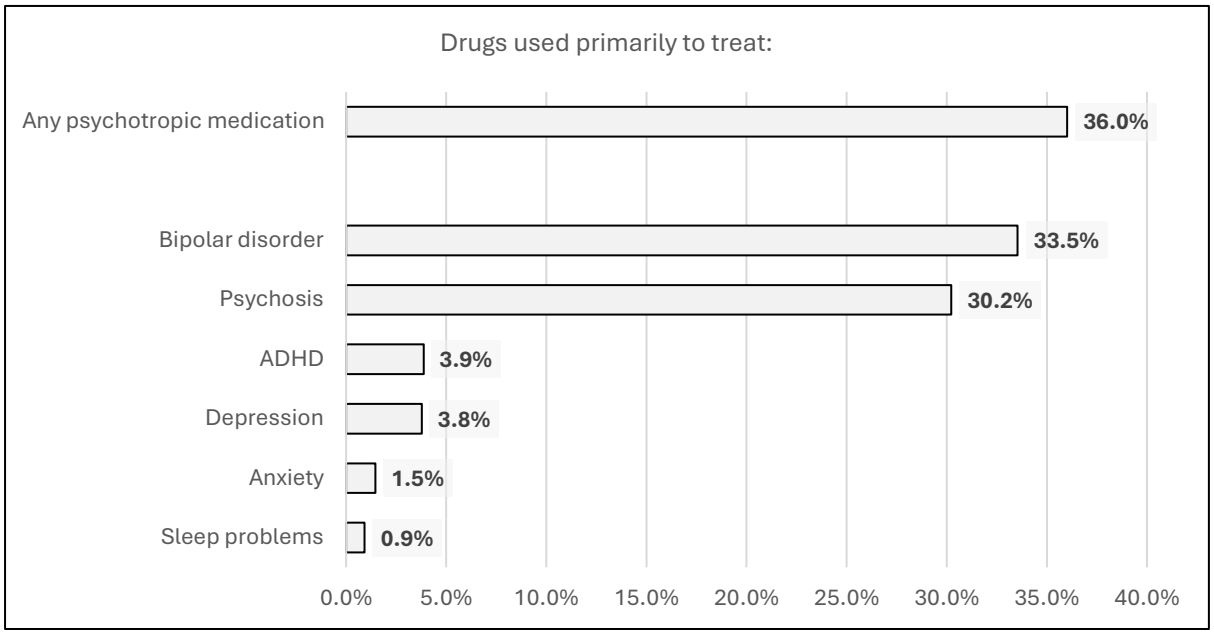


Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 2.2

Medication use varied by specific condition. Those with phobias had the highest medication rates (56.1%), with 51.0% taking antidepressants and 49.3% taking drugs used to treat anxiety. People with obsessive compulsive disorder also had high medication rates (53.0%), with half taking antidepressants (50.1%) and 45.1% taking drugs used to treat anxiety. Those with depressive episodes had similar patterns (51.8% on any medication), while people with panic disorder had lower rates (41.3%).

A small proportion of people with symptoms of common mental health conditions were taking medications typically prescribed for more severe conditions: 3.8% were taking antipsychotics and 3.9% mood stabilisers for bipolar disorder. Additionally, 1.5% were taking ADHD medications, reflecting the overlap between ADHD and common mental health conditions, while 0.9% were taking medication for sleep problems.

Figure 76. Type of psychotropic medication and substance dependence medication currently taken for any common mental health condition (CMHC) in past week, all adults, England, 2023/24



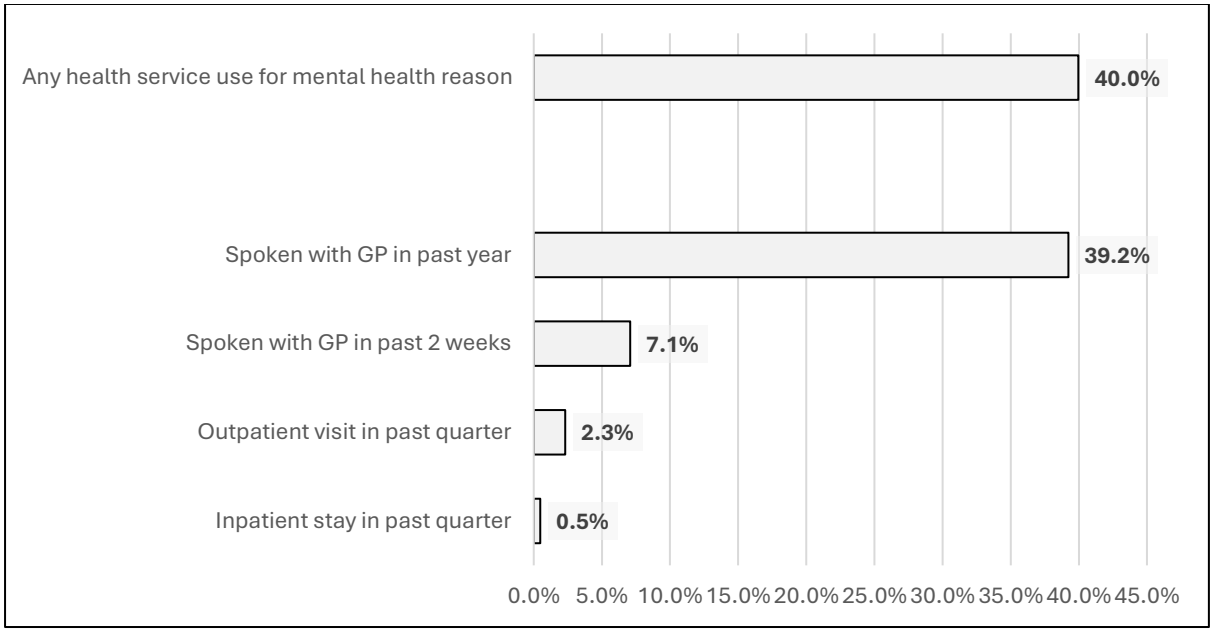
Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 2.4

The 2023/24 APMS suggests that contact with health care services for mental health reasons is limited among adults reporting symptoms consistent with a common mental health condition. 40.0% of adults with CMHC symptoms in the previous week report using any health service for a mental or emotional problem in the past year, compared with 13.5% of all adults. However, these findings reflect self-reported symptoms in a one-week period rather than confirmed diagnoses, and not all individuals experiencing symptoms will require or seek formal support. The data therefore indicates that a proportion of people experiencing current symptoms are not in contact with services, suggesting potential unmet need.

Primary care is the main point of contact, with nearly two in five adults with symptoms of a CMHC (39.2%) reporting speaking with a GP about a mental health problem in the past year, but recent contact is much lower, with only 7.1% reporting GP contact in the past two weeks. Use of secondary care services is comparatively rare, with fewer than 4% of adults with symptoms of a CMHC reporting an outpatient visit for mental health reasons in the past quarter, and inpatient stays are uncommon (0.5%), reflecting the high threshold for specialist and inpatient care or the low level of care needed by most people who have symptoms of CMHC at any point in time.

Overall, the APMS data highlights that most adults with current symptoms of CMHCs are not accessing health care services, and that when services are used, they are predominantly GP-led, with limited use of secondary care.

Figure 77. Health care services used for a mental or emotional problem for symptoms of any common mental health condition (CMHC) in past week, all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 2.8

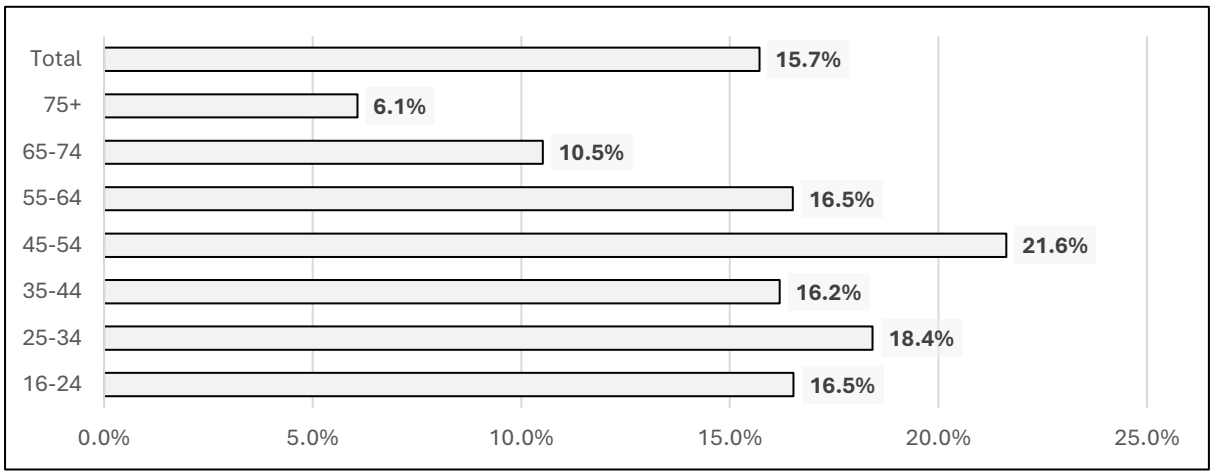
There is also substantial variation in mental health treatment access by age and gender, with 84.5% of adults receiving no treatment for mental or emotional problems in the past year, meaning only 15.7% accessed medication or psychological therapy. This reflects that many adults in the general population will not require treatment but also indicates that a proportion of people experiencing mental health symptoms are not in receipt of formal support, highlighting potential unmet need.

Treatment rates were notably higher among women (19.2%) than men (11.5%) reflecting both higher prevalence of mental health problems among women, and potentially greater help-seeking behaviour.

Treatment rates also varied considerably by age, those aged 45-54 have the highest treatment rates (21.6%) while older adults aged 75 and over had the lowest (6.1%). Working age adults (25-64) generally had higher treatment rates than younger adults (16-24) and older adults (65 and over).

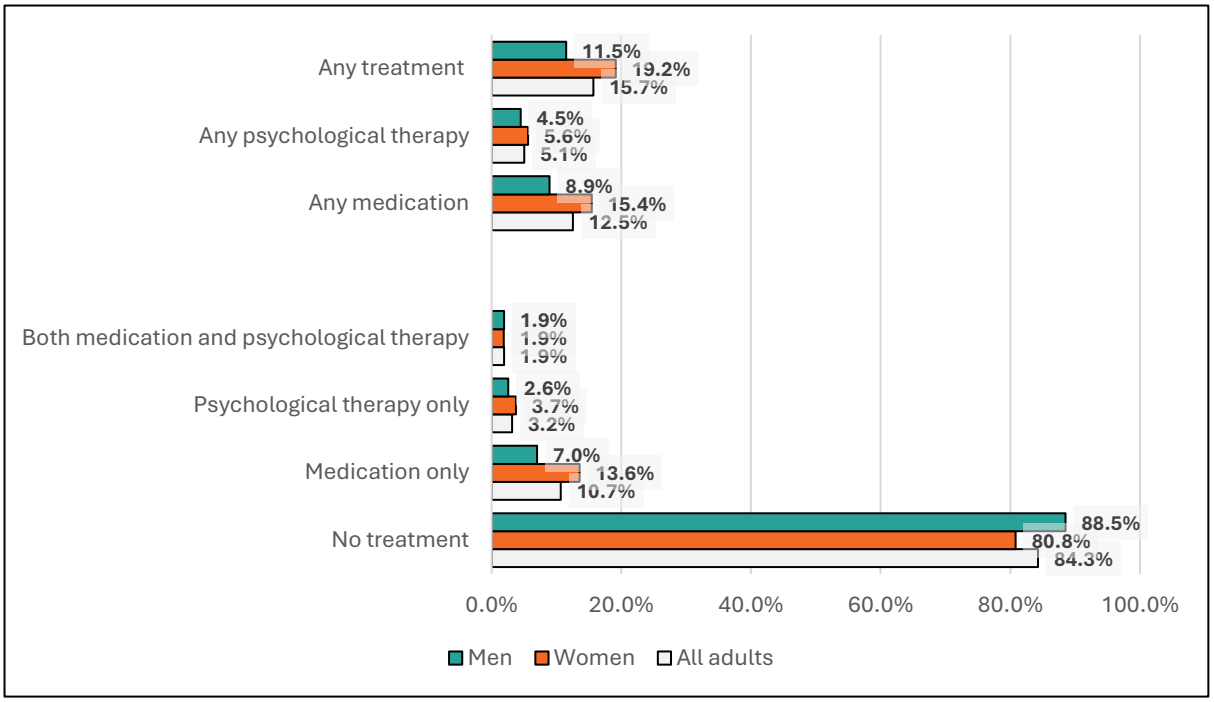
Women had consistently higher treatment rates than men across all ages – the gap was most pronounced in the 16-24 age group, where 24.3% of women received treatment compared to just 6.4% of men. Among those aged 45-54, 27.0% of women received treatment compared to 6.1% of men. The gender difference narrowed in older age groups, with both men and women having low treatment rate among those aged 75 and over.

Figure 78. Treatment for mental or emotional problem, any type of treatment (medication or psychological therapy), by age group, all adults, England, 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 2.14

Figure 79. The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, Suffolk and England, 2020/21 to 2023/24



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2023/24, Table 2.14

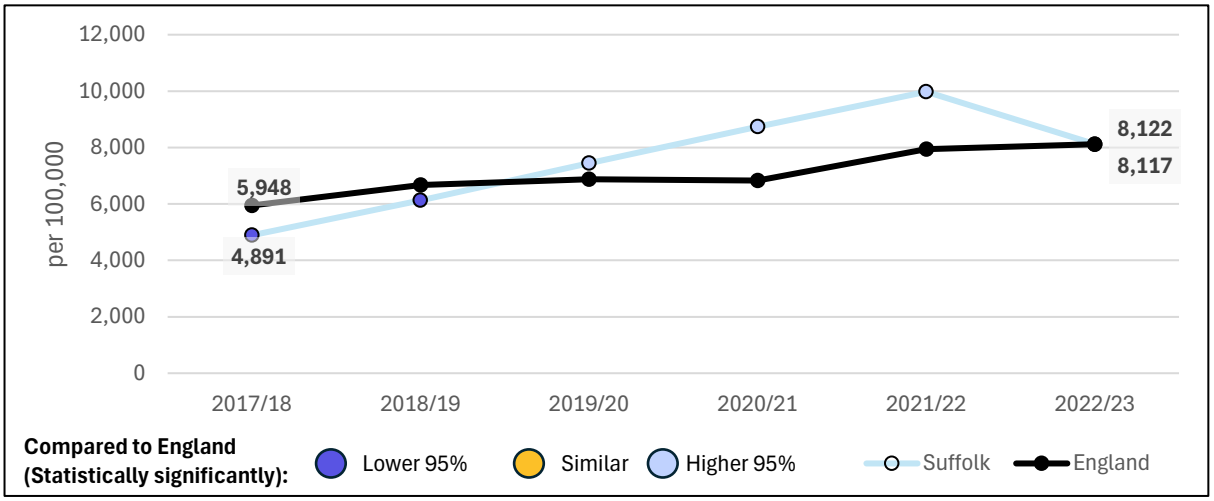
New referrals to secondary mental health services

This indicator measures the rate of new referrals opened to secondary mental health services within a year, standardised for age and sex, and counts referral activity rather than unique individuals, as a person may be referred more than once in the same period.

The rate of new referrals to secondary mental health services provides local health and care systems with a measure of demand for specialist mental health support. It reflects the volume of people presenting with needs assessed as requiring secondary care intervention, rather than support that can be met within primary care or community-based services. Referral rates are influenced by the underlying incidence and prevalence of mental ill health in the population, clinical thresholds and pathways, and help-seeking behaviour, rather than by secondary care capacity itself. Where demand exceeds available capacity, this is more likely to be reflected in increasing waiting times and caseload pressures rather than reduced referral rates.

In Suffolk in 2022/23, there were 61,140 new referrals to secondary mental health services. This produced a rate of 8,122 per 100,000 – statistically similar to the England average over the same period (8,117 per 100,000).

Figure 80. New referrals to secondary mental health services, per 100,000 (All ages), Suffolk and England, 2017/18 to 2022/23



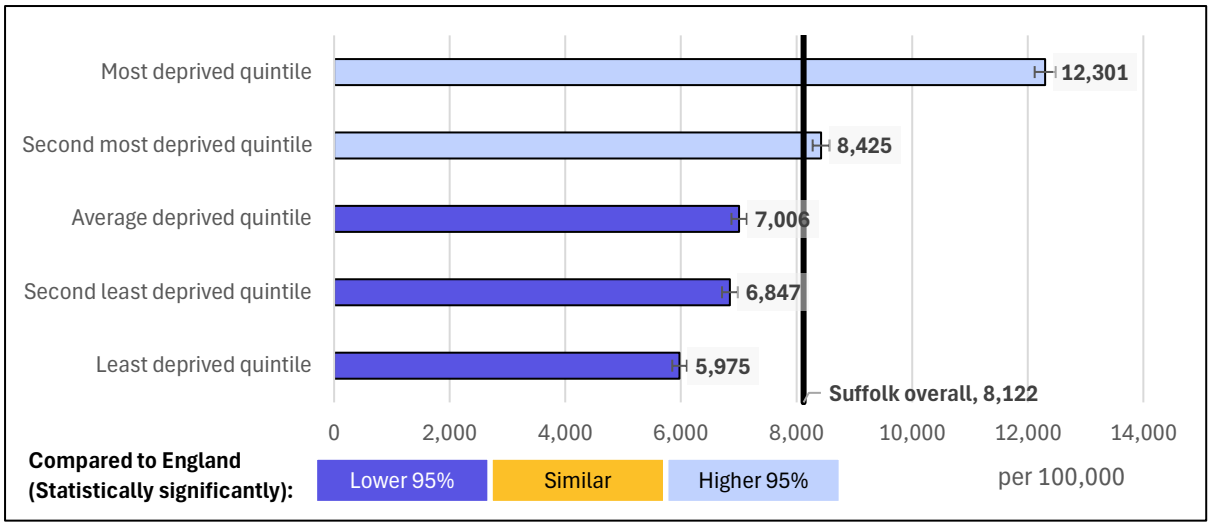
Source: Office for Health Improvement and Disparities (2025)

In 2022/23, there was a clear deprivation gradient in new referrals to secondary mental health services across Suffolk. The most deprived quintile had a rate of 12,301 referrals per 100,000 population, statistically significantly higher than the Suffolk overall rate of 8,122 per 100,000 and more than double the rate in the least deprived quintile (5,975 per 100,000).

This pattern was consistent across all deprivation quintiles, with referral rates decreasing progressively as deprivation levels decreased. The second most deprived quintile had 8,425 referrals per 100,000, while the average and second least deprived quintiles had rates of 7,006 and 6,847 per 100,000 respectively.

All quintiles except the most and second most deprived had rates statistically significantly lower than the England average, suggesting that while Suffolk overall has lower referral rates than England, deprivation remains a strong predictor of secondary mental health service need.

Figure 81. New referrals to secondary mental health services, per 100,000 (All ages), Suffolk deprivation quintiles (2019), 2022/23



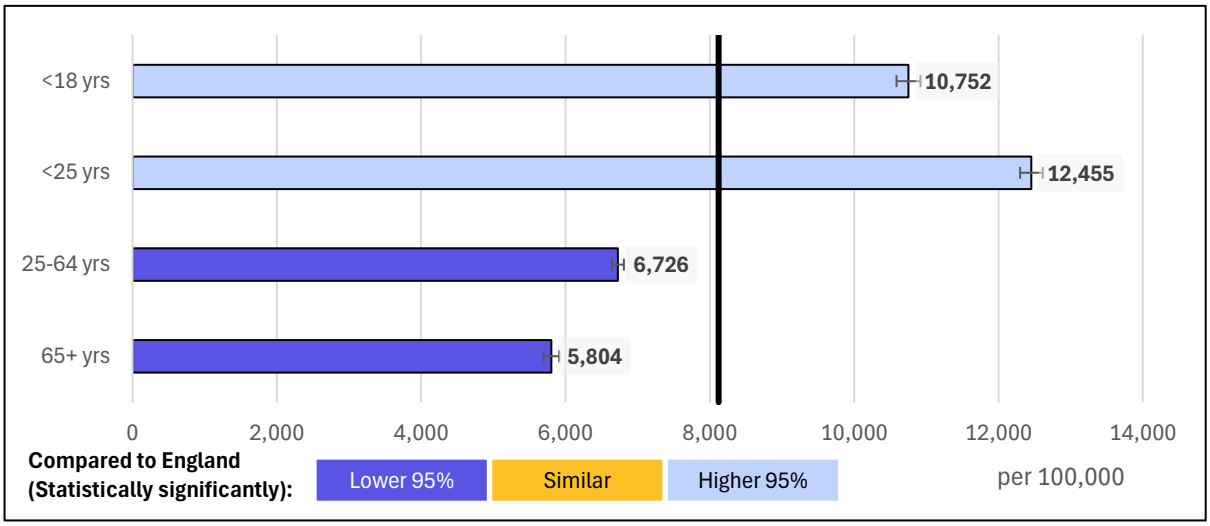
Source: Office for Health Improvement and Disparities (2025)

In 2022/23, there was significant variation in referral rates to secondary mental health services across age groups in Suffolk. Children and young people aged under 18 years had the highest rate at 10,752 referrals per 100,000 population (16,210 new referrals overall), followed by all individuals aged under 25 years at 12,455 per 100,000 (24,690 new referrals overall). Both these rates were statistically significantly higher than the Suffolk overall rate of 8,122 per 100,000 and statistically significantly higher than the England average for all age groups.

Working-age adults (25-64 years) had a referral rate of 6,726 per 100,000 (25,375 new referrals total), which was lower than the overall Suffolk rate and statistically significantly lower than England. Older adults aged 65 and over had the lowest referral rate at 5,804 per 100,000 (11,080 new referrals), also statistically significantly lower than the England (all-age) average.

The substantially elevated rates among younger age groups, particularly for those under 18 and under 25, highlight the considerable burden of severe mental illness affecting children, young people and young adults in Suffolk. This confirms the importance of early intervention services and age-appropriate mental health support for these populations, given 50% of mental health problems are established by age 14, and 75% by age 24[17]. The lower rates in older adults may reflect genuine lower incidence, different help-seeking behaviour, or potential underdiagnosis in this age group in Suffolk.

Figure 82. New referrals to secondary mental health services, per 100,000 by age group, Suffolk, 2022/23



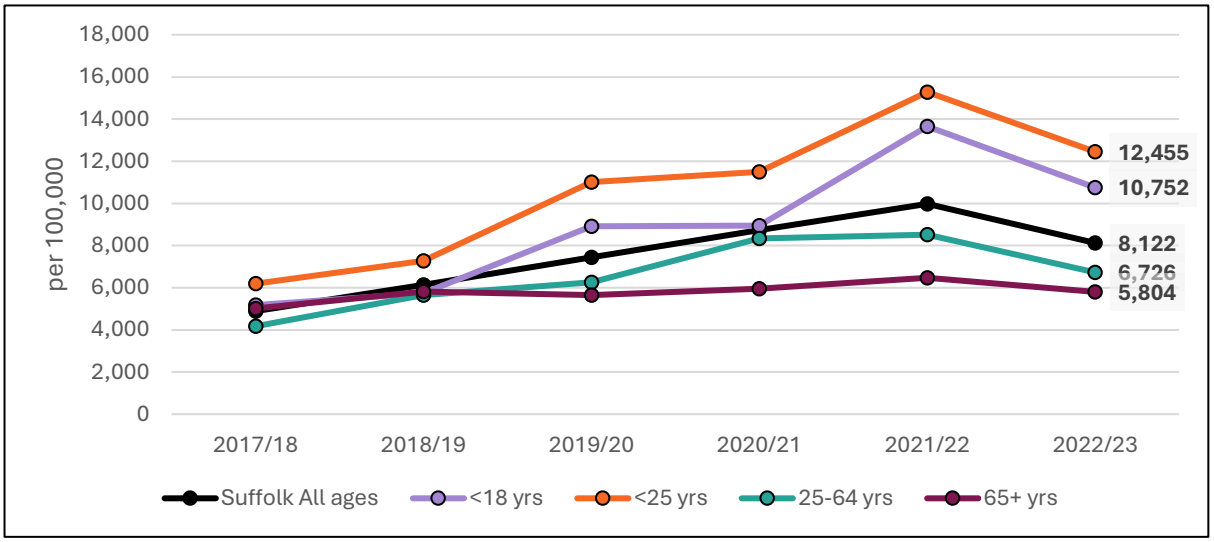
Source: Office for Health Improvement and Disparities (2025)

Trends over time show that increases in new referrals to secondary mental health services in Suffolk have not been uniform across age groups. Between 2017/18 and 2021/22, referral rates rose across all ages, with a particularly steep increase among children and young people. Rates for those under 18 increased from 5,174 per 100,000 in 2017/18 to a peak of 13,651 per 100,000 in 2021/22, while rates for those under 25 rose from 6,192 to 15,282 per 100,000 over the same period. These sharp increases coincide with the COVID-19 pandemic and likely reflect a combination of worsening mental health, increased recognition of need, and changes in help-seeking behaviour among younger populations.

In contrast, referral rates among working-age adults (25–64 years) rose more moderately, peaking at 8,514 per 100,000 in 2021/22 before falling back to 6,726 per 100,000 in 2022/23. Older adults aged 65 and over showed the smallest increase over time, with rates remaining relatively stable compared with other age groups, rising from 5,014 per 100,000 in 2017/18 to 6,470 per 100,000 in 2021/22, before decreasing to 5,804 per 100,000 in 2022/23.

Overall, while referral rates have declined since their pandemic-related peak, they remain substantially higher than pre-pandemic levels for children, young people and young adults. This suggests a sustained increase in demand for specialist mental health support among younger age groups, reinforcing the need for early intervention and youth-focused services, while also highlighting potential unmet need or differing help-seeking patterns among older adults.

Figure 83. New referrals to secondary mental health services, per 100,000 by age group, Suffolk, 2017/18 to 2022/23



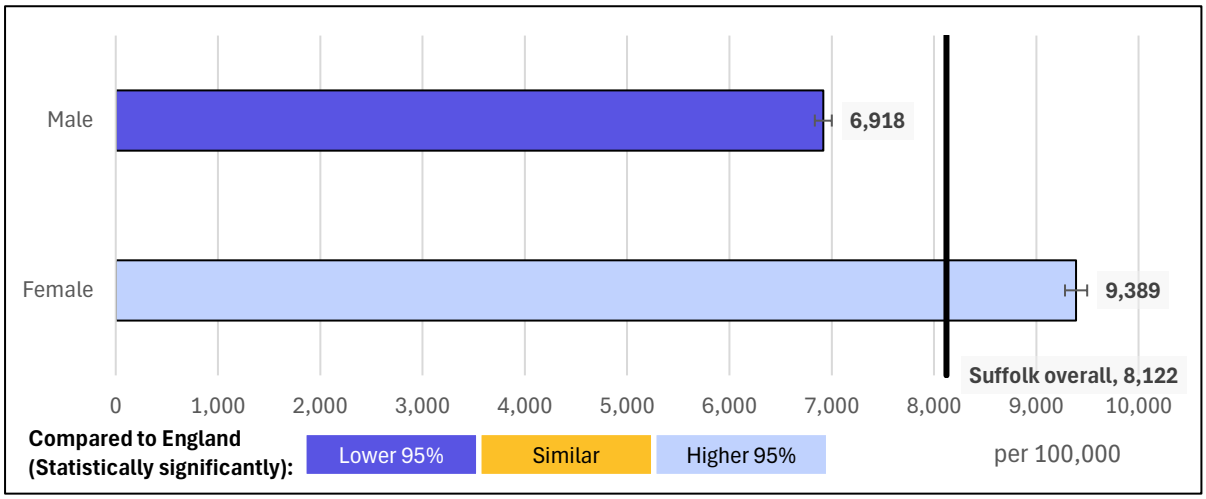
Source: Office for Health Improvement and Disparities (2025)

In 2022/23, there was also a notable difference in referral rates to secondary mental health services between males and females of all ages in Suffolk. Females had a statistically significantly higher rate 9,389 per 100,000 population, compared to males at 6,918 per 100,000 – a difference of 35.7%.

The female referral rate was higher than the Suffolk overall rate of 8,122 per 100,000 and statistically significantly higher than the England average. In contrast, the male referral rate was statistically significantly lower than both the Suffolk overall and England average.

This gender disparity in referrals could reflect many different factors, including a genuine difference in the prevalence of severe mental illness between sexes, variations in help-seeking behaviour (women may be more likely to seek professional help for mental health concerns[207]), or differences in symptom presentation that may influence referral patterns. Understanding these gendered differences is essential to ensure equitable access to services, and to tailor interventions for male and female populations in Suffolk.

Figure 84. New referrals to secondary mental health services, per 100,000 by sex (all ages), Suffolk, 2022/23



Source: Office for Health Improvement and Disparities (2025)

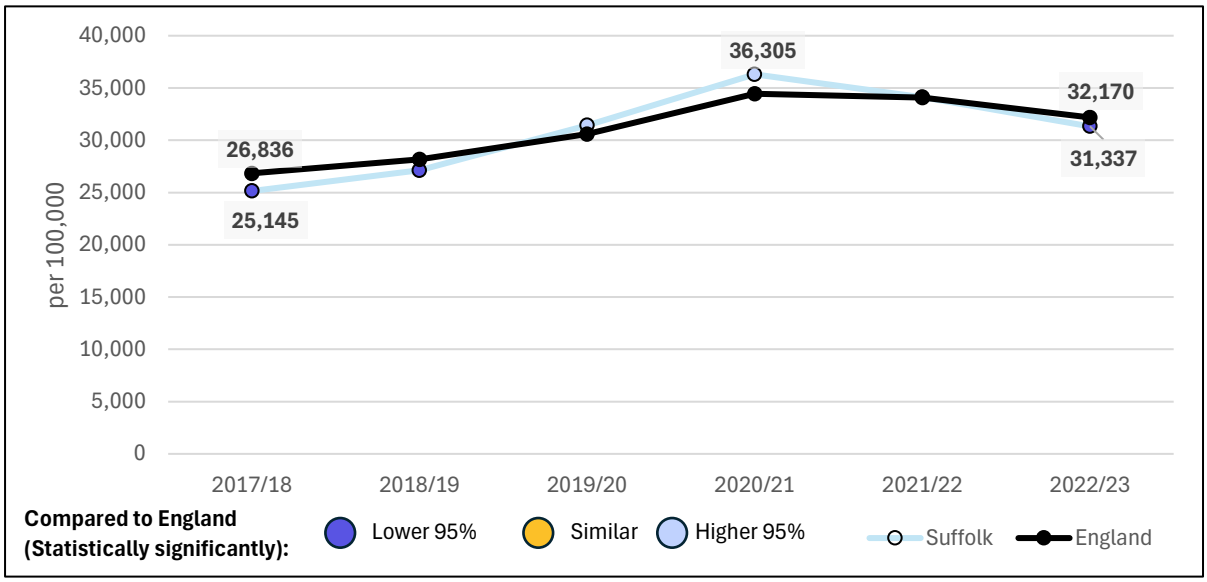
Attended contacts with community and outpatient mental health services

The following data is the number of attended contacts with secondary mental health services. One person can have multiple attended contacts in each financial year, and all their attended contacts are included in this indicator. This is a measure of activity, not the patients in receipt of that activity.

Between 2017/18 and 2022/23, Suffolk experienced fluctuations in the rate of attended contacts with secondary mental health services. The rate increased from 25,145 per 100,000 population in 2017/18 to a peak of 36,305 per 100,000 in 2020/21. This peak coincided with the Covid-19 pandemic and may reflect increased mental health need during this period, as well as changes in service delivery patterns.

Following the highest value in 2020/21, contact rates declined over the subsequent two years to 31,337 per 100,000 in 2022/23. Suffolk's rate in 2022/23 at 31,337 per 100,000 (for 238,375 total attended contacts with community and outpatient mental health services) was statistically significantly lower than the England value at 32,170 per 100,000.

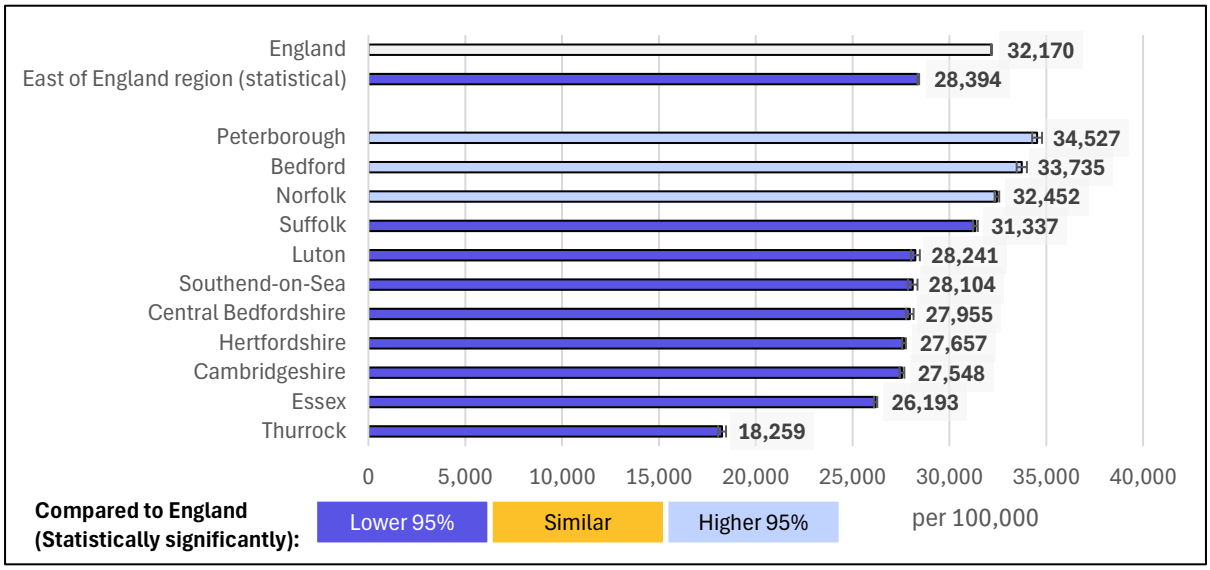
Figure 85. Attended contacts with community and outpatient mental health services, per 100,000 (All ages), Suffolk and England, 2017/18 to 2022/23



Source: Office for Health Improvement and Disparities (2025)

Suffolk's rate of 31,337 attended contacts per 100,000 population was statistically significantly higher than the East of England regional average (28,394) in 2022/23. Within the East of England, there was considerable variation across upper tier local authorities. Suffolk ranked in the middle of the region, with rates ranging from 18,259 per 100,000 in Thurrock (the lowest) to 34,527 per 100,000 in Peterborough (the highest).

Figure 86. Attended contacts with community and outpatient mental health services, per 100,000 (All ages), Suffolk and East of England region neighbours, 2022/23



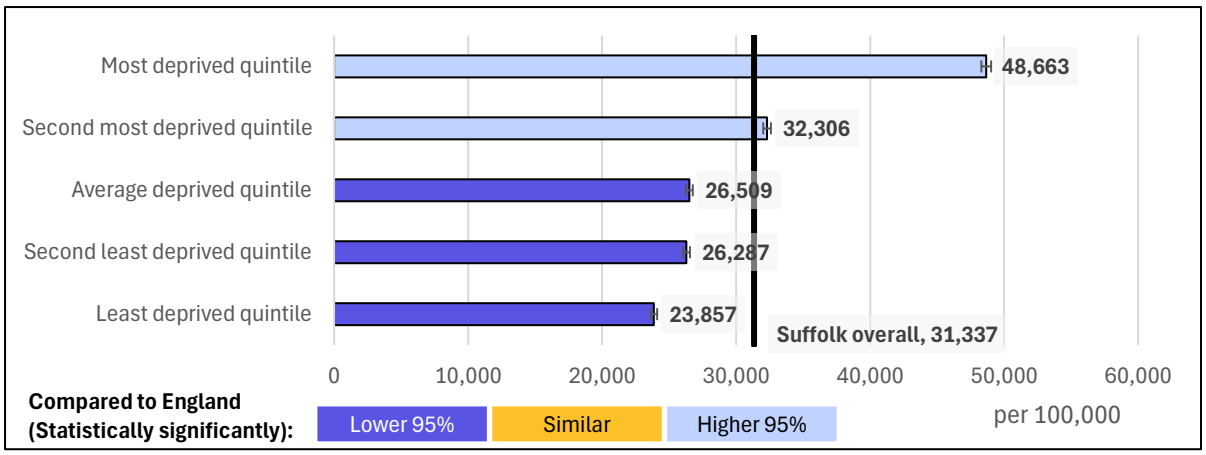
Source: Office for Health Improvement and Disparities (2025)

In 2022/23, there was a clear deprivation gradient in attended contacts with community and outpatient mental health services across Suffolk. The most deprived quintile had a rate of 48,663 contacts per 100,000 population - more than double the rate in the least deprived quintile (23,857 per 100,000) and 55% higher than the Suffolk overall rate of 31,337 per 100,000.

Contact rates decreased progressively across deprivation quintiles, from 32,306 per 100,000 in the second most deprived quintile to approximately 26,000-27,000 per 100,000 in the middle and second least deprived quintiles. The least deprived areas had the lowest rate at 23,857 per 100,000.

This deprivation gradient shows that people living in the most deprived areas of Suffolk have higher rates of referral to secondary mental health services and also generate more service activity once engaged with services. This may reflect greater complexity and severity of mental health conditions in deprived communities, which require more intensive and sustained support.

Figure 87. Attended contacts with community and outpatient mental health services, per 100,000 (All ages), Suffolk deprivation quintiles (2019), 2022/23

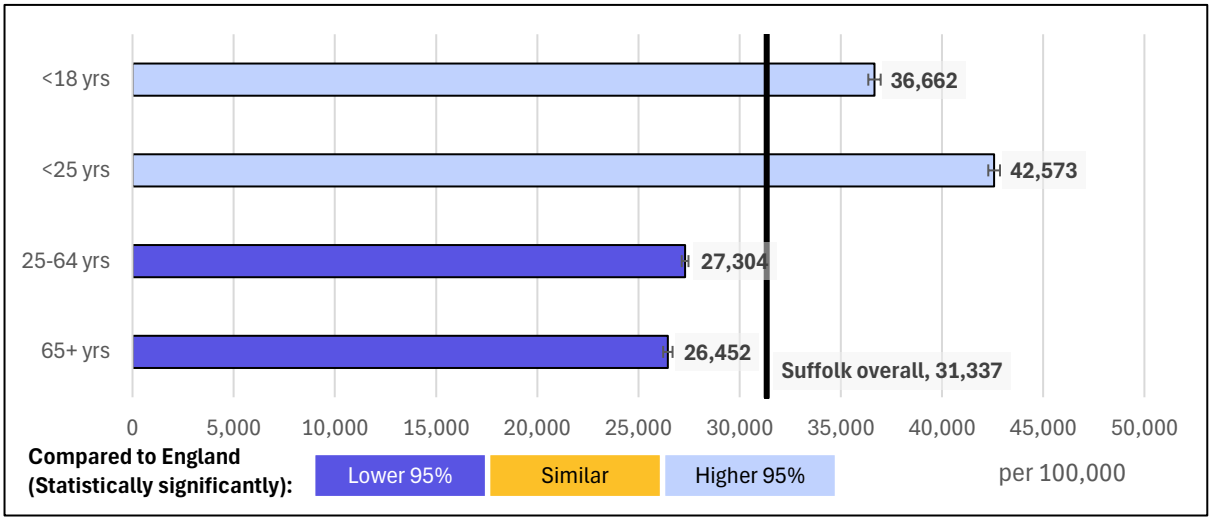


Source: Office for Health Improvement and Disparities (2025)

In 2022/23, younger age groups in Suffolk generated higher rates of attended contacts with secondary mental health services compared to adults. Those under 25 years had the highest rate at 42,573 contacts per 100,000 population, followed by those under 18 years at 36,662 per 100,000. Both rates were statistically significantly higher than the Suffolk overall rate of 31,337 per 100,000.

In contrast, working-age adults (25-64 years) and older adults (65+ years) had similar and statistically significantly lower rates at 27,304 and 26,452 per 100,000 respectively, between 13-15% below the overall rate for Suffolk. The higher contact rates among younger age groups correspond with higher referral rates within these populations, indicating that children, adolescents, and young adults not only utilise secondary mental health services more frequently, but also tend to require more sustained and intensive support following their engagement with these services.

Figure 88. Attended contacts with community and outpatient mental health services, per 100,000 by age group, 2022/23

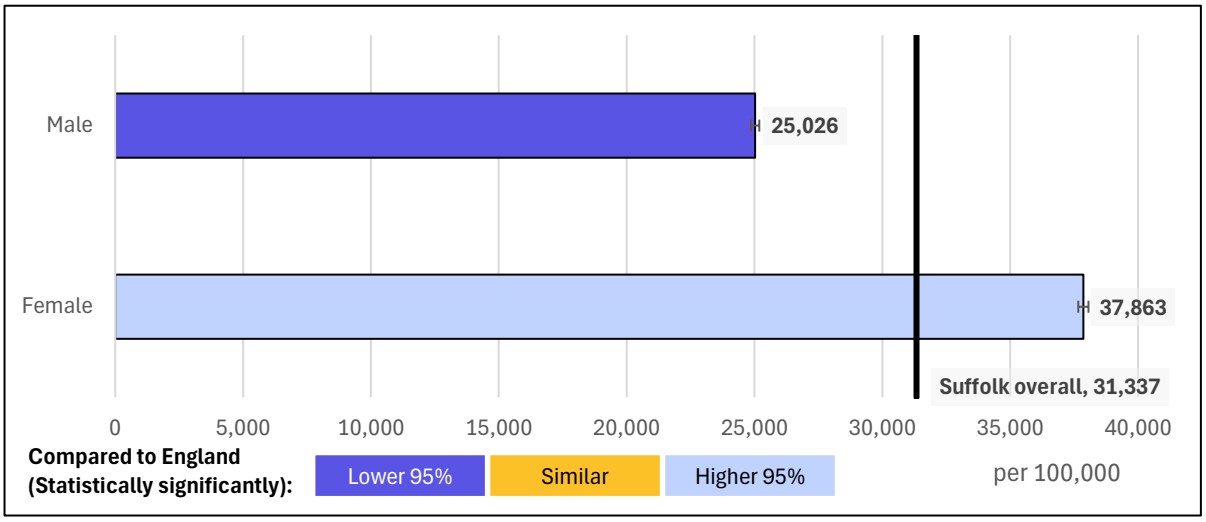


Source: Office for Health Improvement and Disparities (2025)

In 2022/23, there were also substantial gender differences in attended contacts with secondary mental health services in Suffolk. Females had a rate over 50% higher compared to males, with 37,863 contacts per 100,000 population, compared to males at 25,026 per 100,000.

This gender disparity in service activity in Suffolk is even more pronounced than the difference observed in referral rates (where females had a 36% higher rate than males). This suggests that while females access secondary mental health services at higher rates compared to males, they also generate more contacts once engaged with services. This may reflect differences in the types or severity of mental health conditions experienced by women, greater persistence with treatment, or different patterns of service utilisation.

Figure 89. Attended contacts with community and outpatient mental health services, per 100,000 by age group, 2022/23



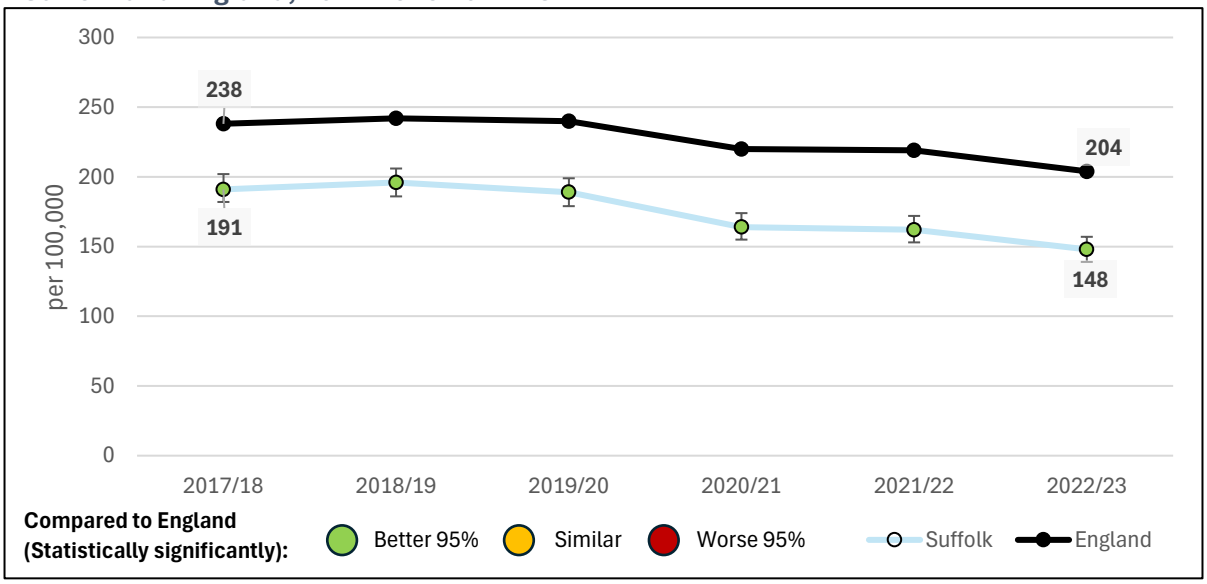
Source: Office for Health Improvement and Disparities (2025)

Inpatient stays in secondary mental health services

Between 2017/18 and 2022/23, Suffolk experienced a statistically significant decline in the rate of inpatient stays in secondary mental health services. The rate decreased by over 20% from 191 per 100,000 population in 2017/18 to 148 per 100,000 in 2022/23. The most notable decline occurred during the COVID-19 pandemic, with rates falling from 189 per 100,000 in 2019/20 to 164 per 100,000 in 2020/21 and continuing to decline.

Throughout this period, Suffolk's rate remained consistently and statistically significantly lower than both the England average and the East of England regional rate. By 2022/23, Suffolk had a rate of 148 per 100,000 (1,105 inpatient stays in total) compared to England (204) and the East of England (172).

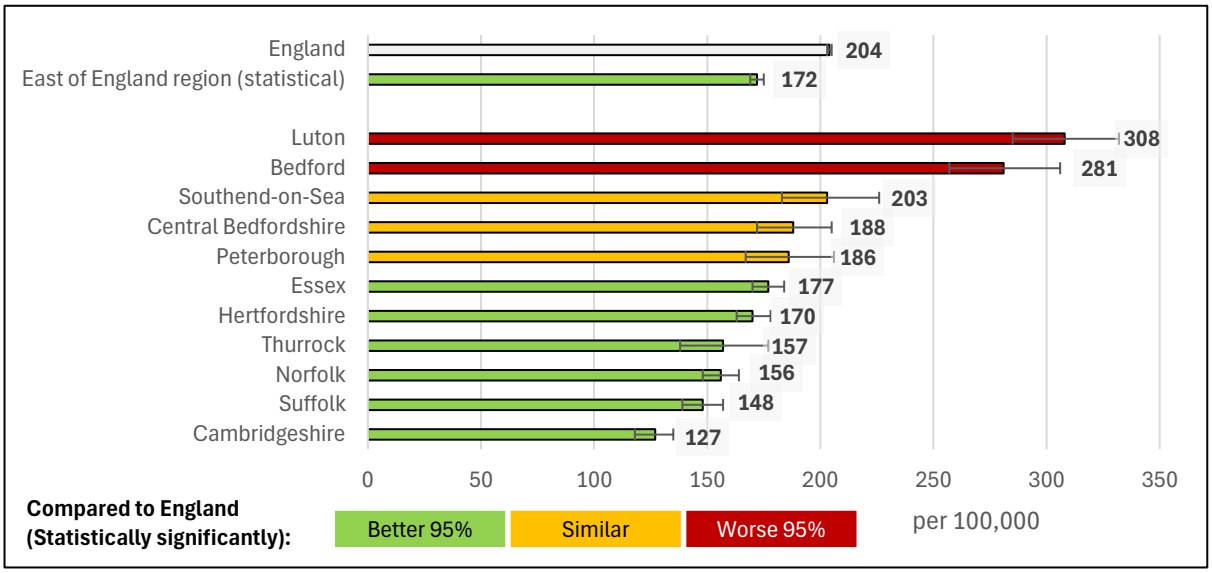
Figure 90. Inpatient stays in secondary mental health services, per 100,000 (All ages), Suffolk and England, 2017/18 to 2022/23



Source: Office for Health Improvement and Disparities (2025)

Within the East of England in 2022/23, Suffolk had the second lowest inpatient stay rate among upper tier local authorities, with only Cambridgeshire recording a lower rate (127 per 100,000). The highest rates were observed in Luton (308 per 100,000) and Bedford (281 per 100,000)—more than double Suffolk's rate.

Figure 91. Inpatient stays in secondary mental health services, per 100,000 (All ages), Suffolk and East of England region neighbours, 2022/23



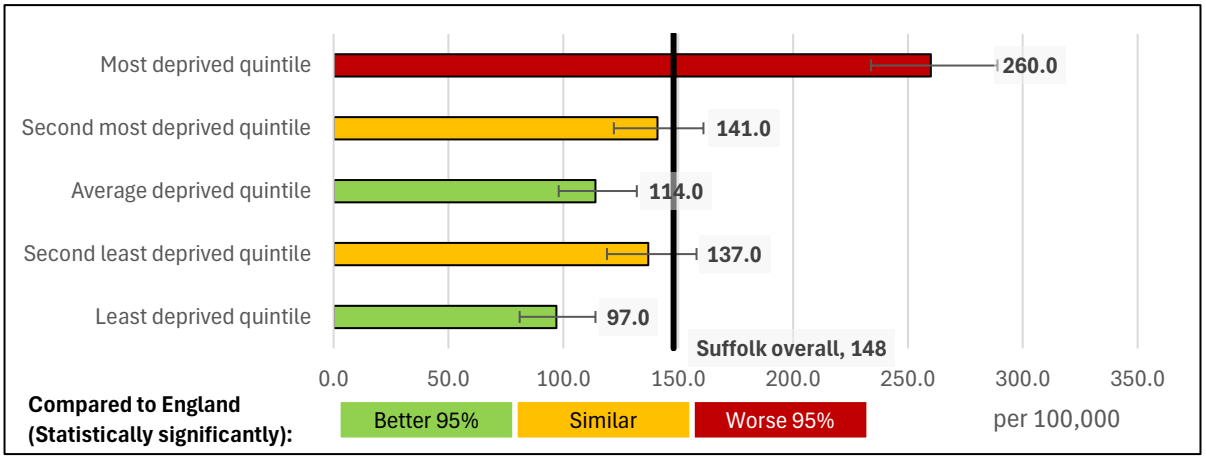
Source: Office for Health Improvement and Disparities (2025)

The relatively low and declining inpatient stay rate in Suffolk may reflect several factors including effective community mental health services preventing hospital admissions, differences in thresholds for admission across the region, variations in the prevalence or severity of severe mental illness, or potentially unmet need where individuals requiring inpatient care are not accessing it.

In 2022/23, there was also a clear deprivation gradient in inpatient stay rates across Suffolk. The most deprived quintile had a rate of 260 per 100,000 population, which was 76% higher than the Suffolk overall rate of 148 per 100,000 and nearly three times the rate in the least deprived quintile (97 per 100,000).

Rates declined progressively across deprivation quintiles, from 141 per 100,000 in the second most deprived quintile to 114 and 137 per 100,000 in the middle quintiles, falling to 97 per 100,000 in the least deprived areas. This pattern is consistent with the deprivation gradients observed in referrals and attended contacts, further demonstrating that individuals in more deprived communities experience greater severity of mental ill-health requiring inpatient admission, in addition to higher overall service demand.

Figure 92. Inpatient stays in secondary mental health services, per 100,000 (All ages), Suffolk deprivation quintiles (2019), 2022/23

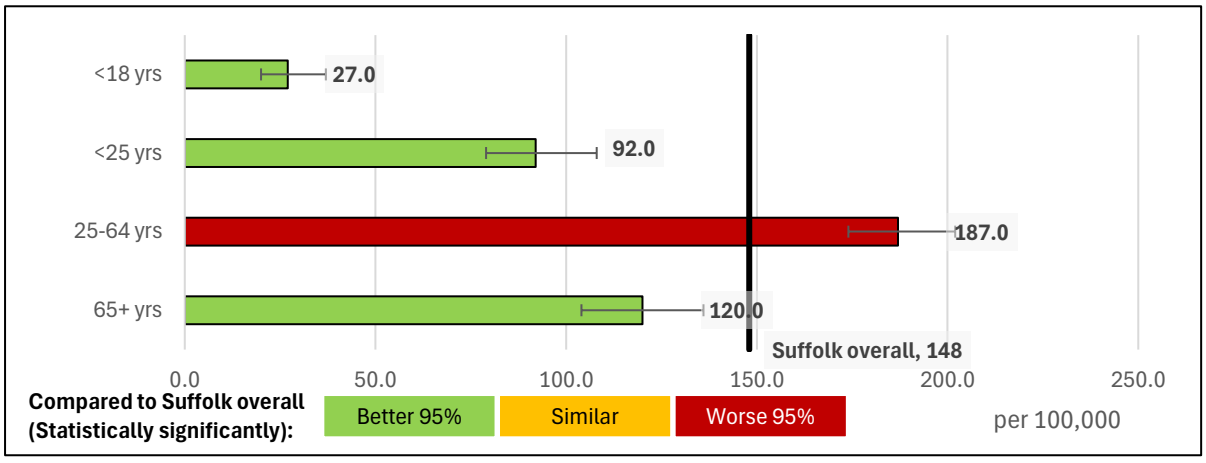


Source: Office for Health Improvement and Disparities (2025)

In 2022/23, working-age adults (25-64 years) had the highest rate of inpatient stays at 187 per 100,000 population. Older adults aged 65 and over had a rate of 120 per 100,000, while younger age groups had statistically significantly lower rates. Those under 25 years in Suffolk had a rate of 92 per 100,000, and children and young people under 18 had the lowest rate at just 27 per 100,000, less than one-fifth of the overall Suffolk rate.

This age pattern differs markedly with the patterns observed for referrals and attended contacts, where younger age groups had the highest rates. The substantially lower inpatient admission rates among children and young people, despite their higher service engagement, may reflect less severe presentations, more effective community-based interventions for this age group, different clinical thresholds for admission, or the limited availability of age-appropriate inpatient beds. The peak in working-age adults suggests this group experiences the most severe mental health crises requiring hospital admission.

Figure 93. Inpatient stays in secondary mental health services, per 100,000, by age group, Suffolk, 2022/23



Source: Office for Health Improvement and Disparities (2025)

Dual diagnosis/co-occurring mental health and substance use disorders

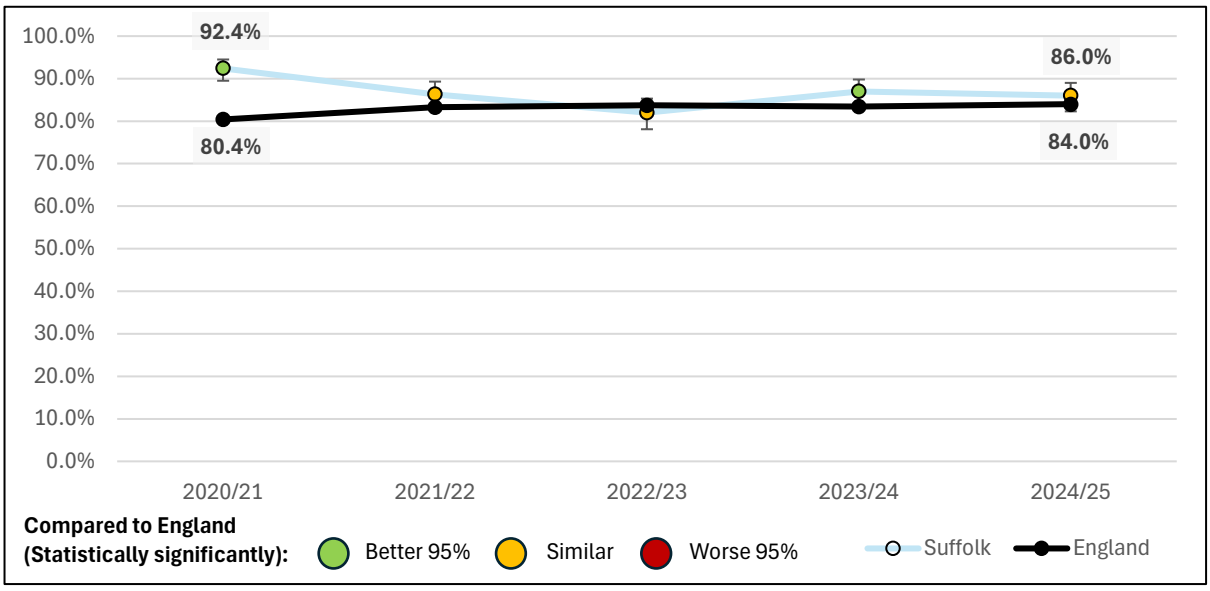
Co-occurring mental health and substance use disorders are often referred to as dual diagnosis. They are common, and present significant treatment challenges. People with alcohol use disorders frequently experience mental health conditions including depression, anxiety, PTSD, and other disorders. Treatment addressing both conditions simultaneously is associated with better outcomes than treating each condition in isolation.

The following indicator measures the proportion of clients entering alcohol treatment who were identified as having a mental health treatment need and were receiving treatment for their mental health at the time of entry into alcohol services. It reflects the extent to which mental health needs are being addressed among people seeking help for alcohol problems.

In 2020/21, 92.4% of clients in Suffolk entering alcohol treatment with identified mental health needs were receiving mental health treatment – statistically significantly higher than the England average of 80.4% in the same year.

The proportion statistically significantly decreased to 82.0% in 2022/23 but increased again to 86.0%, and statistically similar to the England value (84.0%) in 2024/25.

Figure 94. The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, Suffolk and England, 2020/21 to 2024/25



Source: Office for Health Improvement and Disparities (2026)

Within Suffolk's NHS England peer group in 2024/25, Suffolk ranked fourth highest of local authorities for this indicator. Suffolk's rate of 86.0% was close to the highest-performing areas including Somerset (90.6%) and Derbyshire (91.8%). The lowest-performing areas were Lincolnshire (79.1%), Wiltshire (79.2%) and Kent (81.0%).

Figure 95. The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, Suffolk and NHS England Peers, 2024/25

Source: Office for Health Improvement and Disparities (2026)

Performance for Suffolk on this indicator is positive, with 86.0% of people entering alcohol treatment who have mental health needs also receiving mental health treatment, suggesting good coordination between alcohol and mental health services in the county.

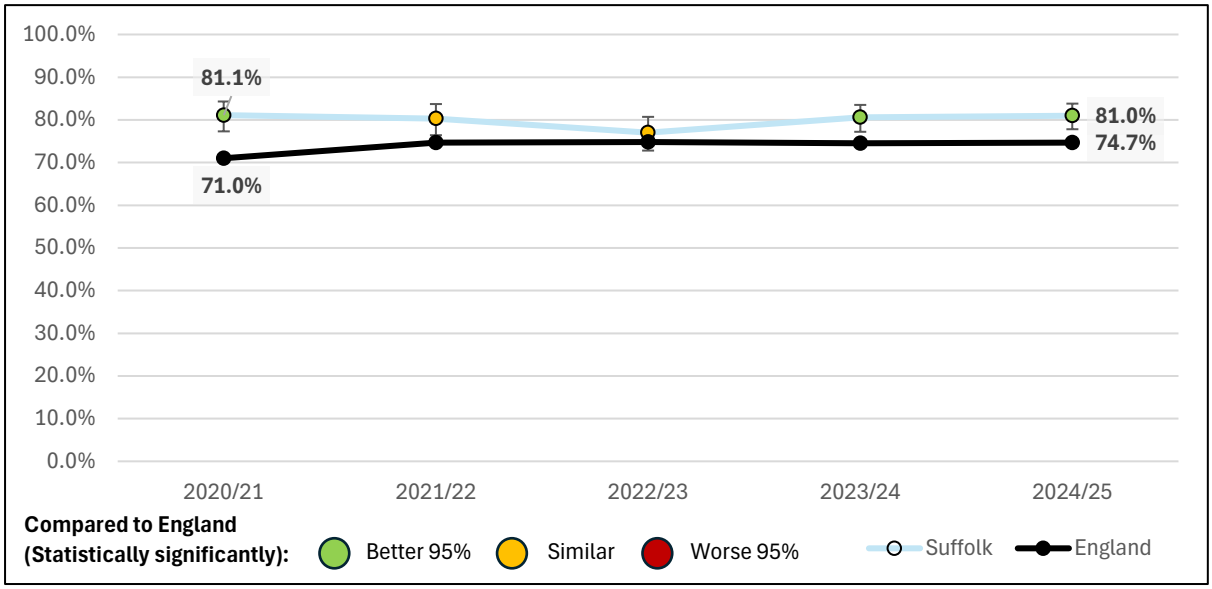
Similar to alcohol treatment, people with drug use disorders frequently experience co-occurring mental health conditions.

This indicator measures the proportion of clients entering drug treatment who were identified as having a mental health treatment need and were receiving treatment for their mental health at the time of entry into drug services.

Suffolk has consistently performed well on this indicator since 2020/21, with percentages statistically significantly higher than the England average throughout the period (excluding 2022/23). In 2020/21, 81.1% of clients entering drug treatment with identified mental health needs were receiving mental health treatment, compared to the England average of 71.0%, a difference of 10 percentage points.

The proportion declined slightly to 77.0% in 2022/23 before recovering to 81.0% in 2024/25. Throughout this period, England's performance has remained stable between 71-75%. In 2024/25, Suffolk's rate of 81.0% was 6.3 percentage points higher, and statistically significantly higher than the England average of 74.7%.

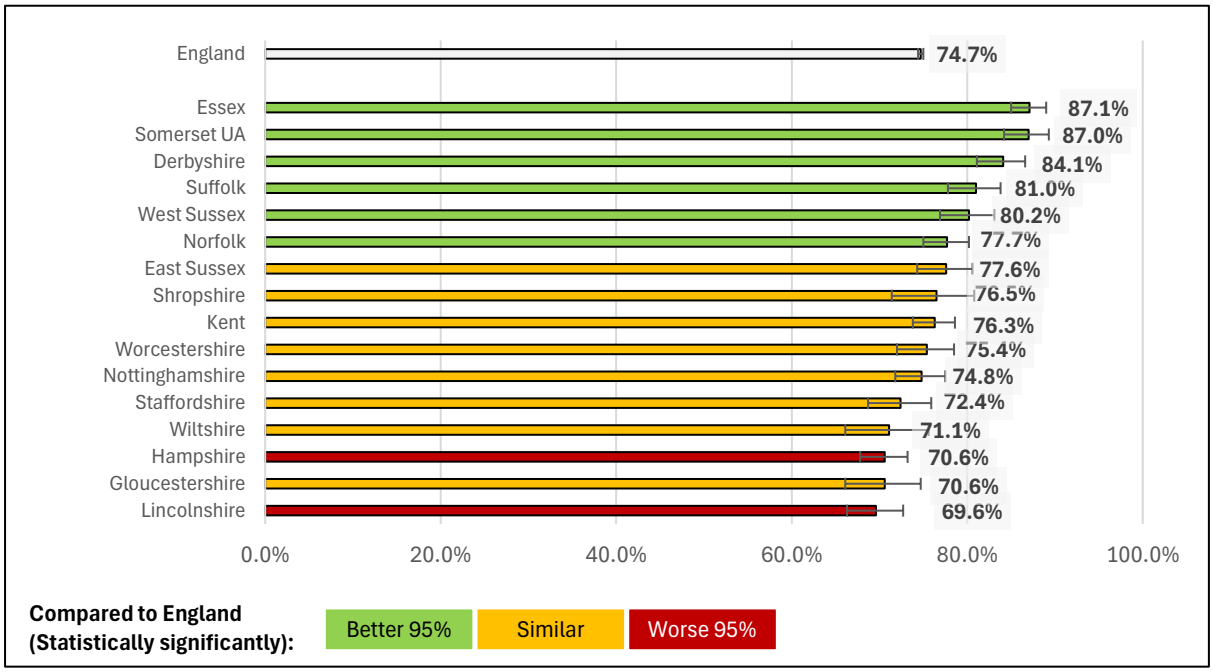
Figure 96. The proportion of clients entering drug treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, Suffolk and England, 2020/21 to 2024/25



Source: Office for Health Improvement and Disparities (2026)

Within Suffolk's NHS England peer group in 2024/25, Suffolk ranked in the upper third of local authorities for this indicator. Suffolk's rate of 81.0% placed Suffolk 4thth among the 15 peer areas. The highest-performing areas were Essex (87.1%), Somerset (87.0%), and Derbyshire (84.1%). The lowest-performing areas were Lincolnshire (69.6%), Gloucestershire (70.6%), and Hampshire (70.6%).

Figure 97. The proportion of clients entering drug treatment identified as having a mental health treatment need, who were receiving treatment for their mental health, Suffolk and NHS England Peers, 2024/25



Source: Office for Health Improvement and Disparities (2026)

Suffolk's performance also shows good integration between drug treatment and mental health services, with approximately four in five clients with mental health needs receiving concurrent mental health treatment. This is statistically significantly better than the national average and reflects effective coordination between services locally. However, around one in five clients (19%) with identified mental health needs entering drug treatment are not receiving mental health treatment.

In addition, 14.0% of clients entering alcohol treatment with identified mental health needs are not receiving mental health treatment in Suffolk in 2024/25. Both gaps may be due to waiting lists for mental health services, clients choosing not to access mental health support, difficulties navigating multiple services, or people preferring to focus on their alcohol or drug treatment issues first. Evidence shows that treating mental health and alcohol or drug problems together leads to better outcomes than addressing each separately[208]. Maintaining and improving Suffolk's performance requires continued joint working between substance misuse and mental health services, reducing waiting times, and ensuring coordinated care pathways that address both conditions simultaneously for people with dual diagnosis.

Hospital admissions for drug-related mental and behavioural disorders

Drug dependence frequently co-exists with other health and social challenges including ill mental health and homelessness, making it a complex issue requiring coordinated responses across health, social care, and criminal justice systems.

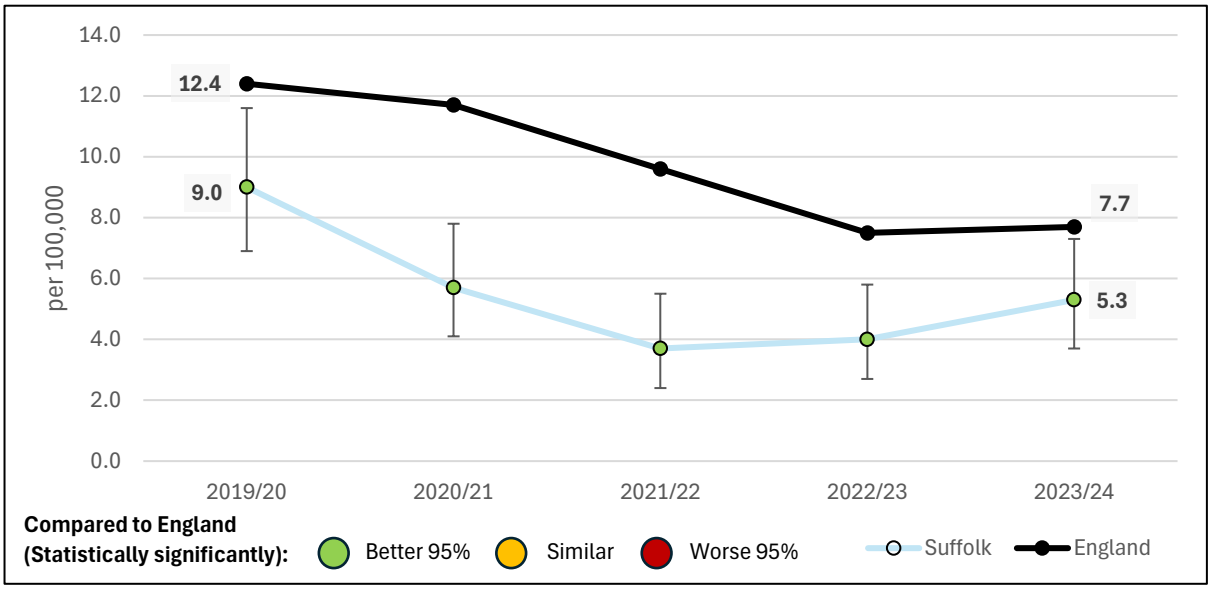
Hospital admissions for drug-related mental and behavioural disorders provide an indicator of severe or acute substance-related mental health need that has resulted in inpatient care. This indicator is based on NHS Hospital Episode Statistics and includes admissions with a primary diagnosis of mental and behavioural disorders due to psychoactive substance use. These admissions may occur in acute hospital settings or specialist mental health inpatient services, and therefore reflect a range of crisis presentations, including acute intoxication, withdrawal, and severe substance-related mental health symptoms. This indicator captures only those whose needs escalate to inpatient admission, representing the most severe end of the spectrum and does not reflect the wider burden of unmet need in the community.

Strong drug and alcohol services, including harm reduction initiatives, community-based treatment programmes, and early intervention, can help manage drug misuse more effectively and prevent hospital admissions. This indicator includes admissions related to mental and behavioural disorders caused using various substances including opioids, cannabinoids, sedatives, cocaine, stimulants, hallucinogens, and multiple drug use.

Suffolk has experienced a decline in hospital admissions for drug-related mental and behavioural disorders over the five-year period from 2019/20 to 2023/24, although the rate remains statistically similar when comparing 2019/20 to 2023/24. The rate decreased from 9.0 per 100,000 population in 2019/20 to 3.7 per 100,000 in 2021/22 – more than halving. After reaching this low point, rates increased slightly to 4.0 per 100,000 in 2022/23 and 5.3 per 100,000 in 2023/24, though remained below the 2019/20 baseline.

Throughout this period, Suffolk's rates have been statistically significantly lower than the England average each year. England has also experienced a declining trend, falling from 12.4 per 100,000 in 2019/20 to 7.7 per 100,000 in 2023/24 - a 38% decrease.

Figure 98. Hospital admissions per 100,000 for drug-related mental and behavioural disorders, Suffolk and England, 2019/20 to 2023/24

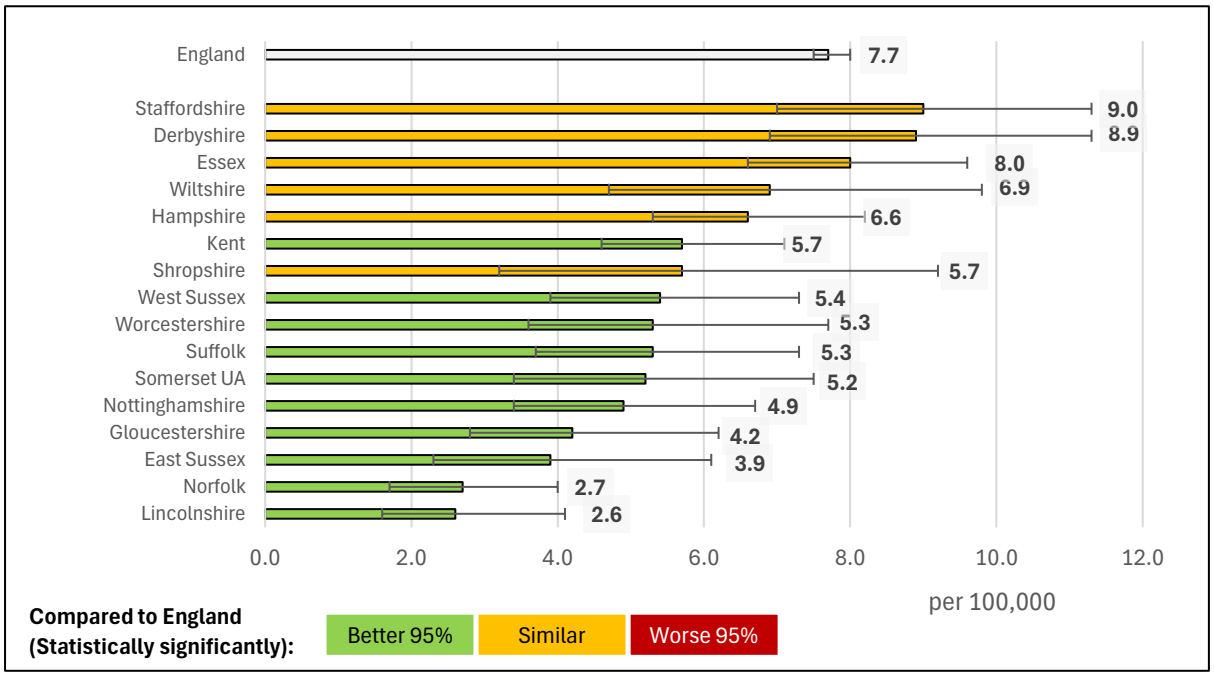


Source: Office for Health Improvement and Disparities (2025)

Within Suffolk's NHS England peer group in 2023/24, Suffolk ranked in the middle of local authorities with a rate of 5.3 per 100,000. Suffolk's performance was identical to Worcestershire and similar to several other peer areas including West Sussex (5.4) and Somerset (5.2).

The highest admission rates were observed in Staffordshire (9.0 per 100,000), Derbyshire (8.9), and Essex (8.0), but all statistically similar to the England average. The lowest rates were in Lincolnshire (2.6 per 100,000), Norfolk (2.7), and East Sussex (3.9).

Figure 99. Hospital admissions for drug-related mental and behavioural disorders, Suffolk and NHS England Peers, 2023/24



Source: Office for Health Improvement and Disparities (2025)

Suffolk's decline in drug-related mental and behavioural disorder admissions is positive, with rates falling from 9.0 to 5.3 per 100,000 between 2019/20 and 2023/24. Suffolk's performance remains statistically significantly below the England average throughout this period – however the slightly increase from the 2021/22 low point (3.7 per 100,000) warrants continued monitoring.

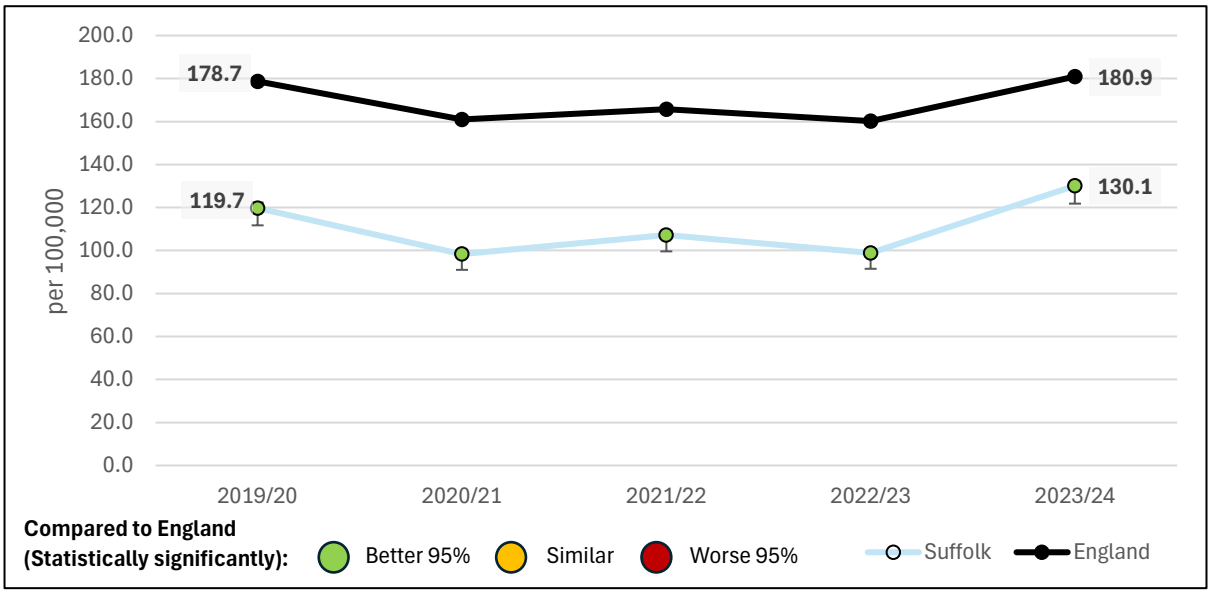
Variation across Suffolk's NHS peer areas (ranging from 2.6 to 9.0 per 100,000) may reflect differences in local drug use patterns, service provision, treatment pathways, or admission thresholds.

Hospital admissions where drug-related mental and behavioural disorders were a factor
This indicator captures a broader measure of drug-related harm than the primary diagnosis indicator, including all hospital admissions where drug-related mental and behavioural disorders were recorded as either the primary or a secondary diagnosis. This provides a more comprehensive picture of the burden of drug misuse on hospital services and reflects the complex health needs of people who use drugs, who often present with multiple co-morbidities.

Suffolk has experienced fluctuating rates of hospital admissions where drug-related mental and behavioural disorders were a factor over the five-year period from 2019/20 to 2023/24. The rate decreased from 119.7 per 100,000 population in 2019/20 to 98.3 per 100,000 in 2020/21, before increasing to 107.2 per 100,000 in 2021/22. Rates declined again to 98.8 per 100,000 in 2022/23, then increased markedly to 130.1 per 100,000 in 2023/24 - the highest rate in the time series and almost 10% higher than the 2019/20 baseline.

Throughout this period, Suffolk's rates have been consistently and statistically significantly lower than the England average. England has also shown fluctuation for this indicator over the previous five years, declining from 178.7 per 100,000 in 2019/20 to 160.2 per 100,000 in 2022/23, before rising to 180.9 per 100,000 in 2023/24.

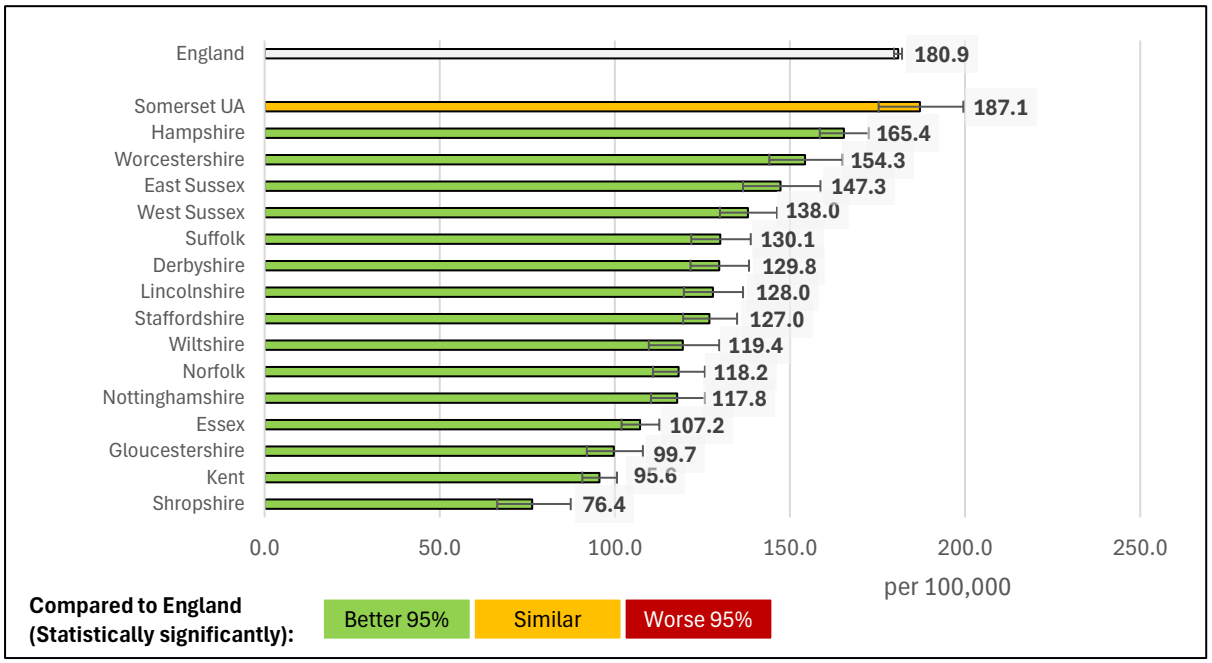
Figure 100. Hospital admissions per 100,000 where drug-related mental and behavioural disorders were a factor, Suffolk and England, 2019/20 to 2023/24



Source: Office for Health Improvement and Disparities (2025)

Within Suffolk's NHS England peer group in 2023/24, Suffolk ranked in the middle of local authorities with a rate of 130.1 per 100,000. The highest admission rates were observed in Somerset (187.1), Hampshire (165.4), and Worcestershire (154.3). The lowest rates were in Shropshire (76.4), Kent (95.6), and Gloucestershire (99.7).

Figure 101. Hospital admissions per 100,000 where drug-related mental and behavioural disorders were a factor, Suffolk and NHS England peers, 2023/24



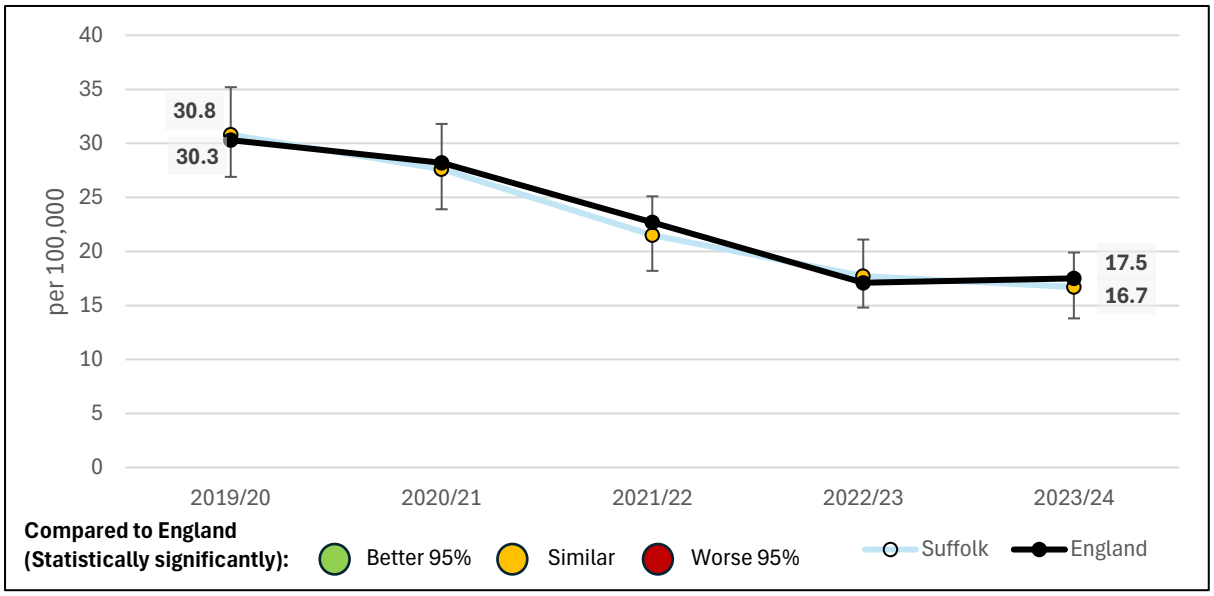
Source: Office for Health Improvement and Disparities (2025)

Hospital admissions for poisoning by drug misuse

This indicator looks at all hospital admissions with a primary diagnosis of poisoning by drugs that are listed as controlled under the Misuse of Drugs Act 1971; including both intentional and unintentional poisoning. Drug dependence often co-exists with other health disparities, particularly poor mental health and homelessness, making it a complex public health challenge.

Suffolk's rate of hospital admissions for poisoning by drug misuse in 2019/20 was 30.8 per 100,000 and has statistically significantly decreased – almost halving to 16.7 per 100,000 in 2023/24. A similar trend can be seen nationally, with the rate across England statistically significantly decreasing from 30.3 per 100,000 in 2019/20 to 17.5 per 100,000 in 2023/24. In each year's worth of data from 2019/20, Suffolk's rate of hospital admissions for poisoning by drug misuse has been statistically similar to the value across England.

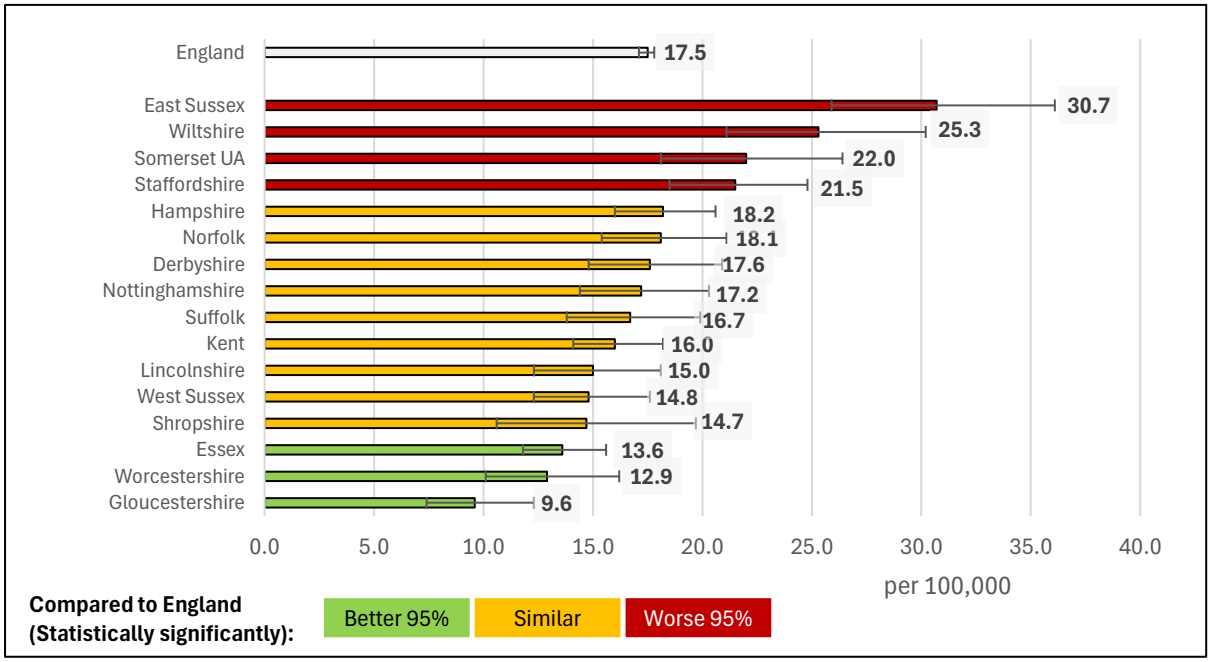
Figure 102. Hospital admissions per 100,000 for poisoning by drug misuse, Suffolk and England, 2019/20 to 2023/24



Source: Office for Health Improvement and Disparities (2025)

When compared with Suffolk's NHS England peers, Suffolk's rate of 16.7 per 100,000 is statistically similar to the national average and places the county in the middle of comparator areas. Other upper tier local authorities such as East Sussex (30.7) and Wiltshire (25.3) are statistically significantly higher/worse compared to the England figure, whereas areas such as Essex, Worcestershire and Gloucestershire have statistically significantly lower rates per 100,000 of hospital admissions for poisoning by drug misuse in 2023/24.

Figure 103. Hospital admissions per 100,000 for poisoning by drug misuse, Suffolk and NHS England peers, 2023/24



Source: Office for Health Improvement and Disparities (2025)

Emergency hospital admissions for intentional self-harm (all ages)

Self-harm is a significant public health concern and an important indicator of mental distress within a population. Self-harm is defined as an intentional act of self-poisoning or self-injury, irrespective of the type of motivation or degree of suicidal intent[209]. Across England, self-harm results in approximately 110,000 hospital admissions each year, with 99% being emergency admissions.

The public health significance of self-harm extends beyond the immediate episode. Following an act of self-harm, there is a significant and persistent risk of future suicide, with the risk raised 49-fold in the year after self-harm and increasing with age at initial presentation[209]. People who present to Accident & Emergency following self-harm have a subsequent suicide rate of 0.7% in the first year - 66 times the suicide rate in the general population. After 15 years, 4.8% of males and 1.8% of females who presented with self-harm had died by suicide[210]. Additionally, one in six people who self-harm will have a repeat attendance at A&E within the year, and self-harm is one of the top five causes of acute medical admission[209].

Beyond the risk of death, self-harm can cause serious long-term physical health consequences including damage to organs from poisoning, permanent damage to tendons and nerves from cutting, and scarring. Self-harm is also poorly understood in society, with people who self-harm often subject to stigma and hostility, which can create barriers to accessing appropriate support[211].

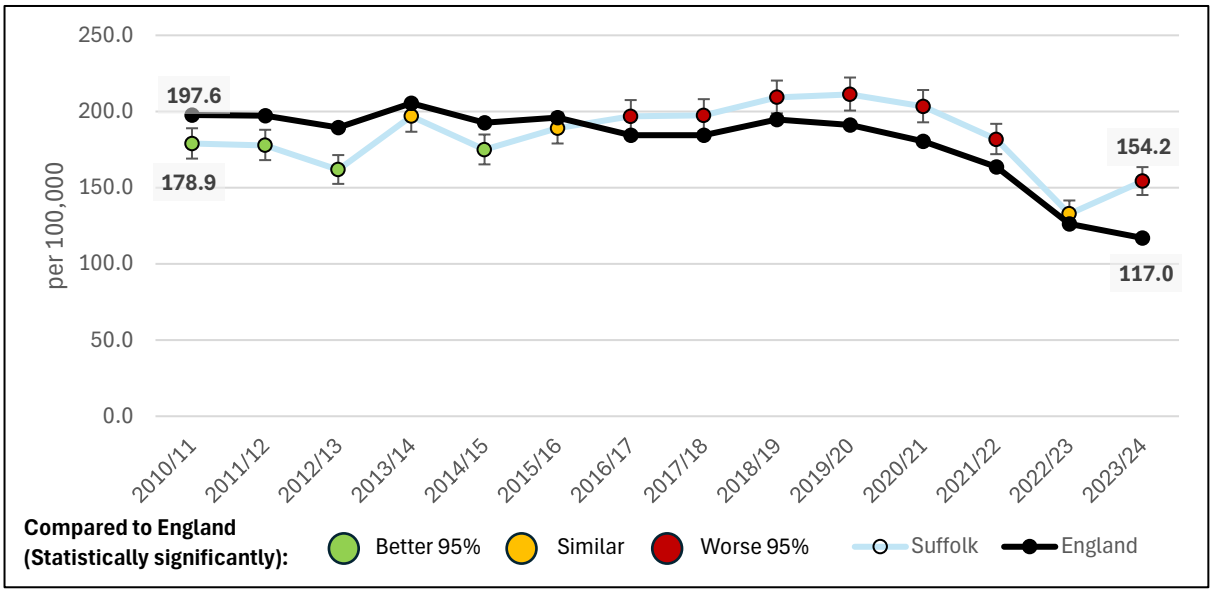
Certain groups are at heightened risk of self-harm, including women (who have rates two to three times higher than men), young people (10-13% of 15-16 year olds have self-harmed in their lifetime[209]), older adults (who are more likely to self-harm with suicidal intent), people with drug and alcohol problems, LGBTQ+ individuals, people from South Asian ethnicities, those living in socially deprived urban areas, and people in prison settings[209]. Wider determinants including education, housing, unemployment rates, social isolation, trauma exposure, and family experiences all contribute to self-harm risk[212–214].

Monitoring hospital admissions for self-harm allows local health systems to assess the burden of severe mental distress, evaluate prevention programmes, aid service improvement, and ensure appropriate provision of care for this population.

Rates of emergency hospital admission for intentional self-harm in Suffolk increased steadily over the decade prior to the Covid-19 pandemic. Between 2010/11 and 2019/20, the rate rose from 178.9 to 211.2 per 100,000, before peaking at 203.3 per 100,000 in 2020/21. This long-term rise was followed by a marked decline during and immediately after the pandemic, with rates falling to 132.8 per 100,000 in 2022/23 - a reduction of around 35% from the 2020/21 level and the lowest rate observed across the time series. In 2023/24, the rate increased again to 154.2 per 100,000 (1,135 admissions), remaining below pre-pandemic levels but indicating a reversal of the recent downward trend.

Across this period of fluctuation, Suffolk's rate has generally been higher than the England average. Suffolk was statistically significantly below or similar to England up to 2016/17; however, from 2016/17 onwards, Suffolk's rate was statistically significantly higher than England in every year except 2022/23, when rates were statistically similar. While both Suffolk and England saw declines during the pandemic, England has not shown the same degree of post-pandemic increase observed in Suffolk.

Figure 104. Emergency hospital admissions for intentional self-harm, Suffolk and England, all ages, 2010/11 to 2023/24

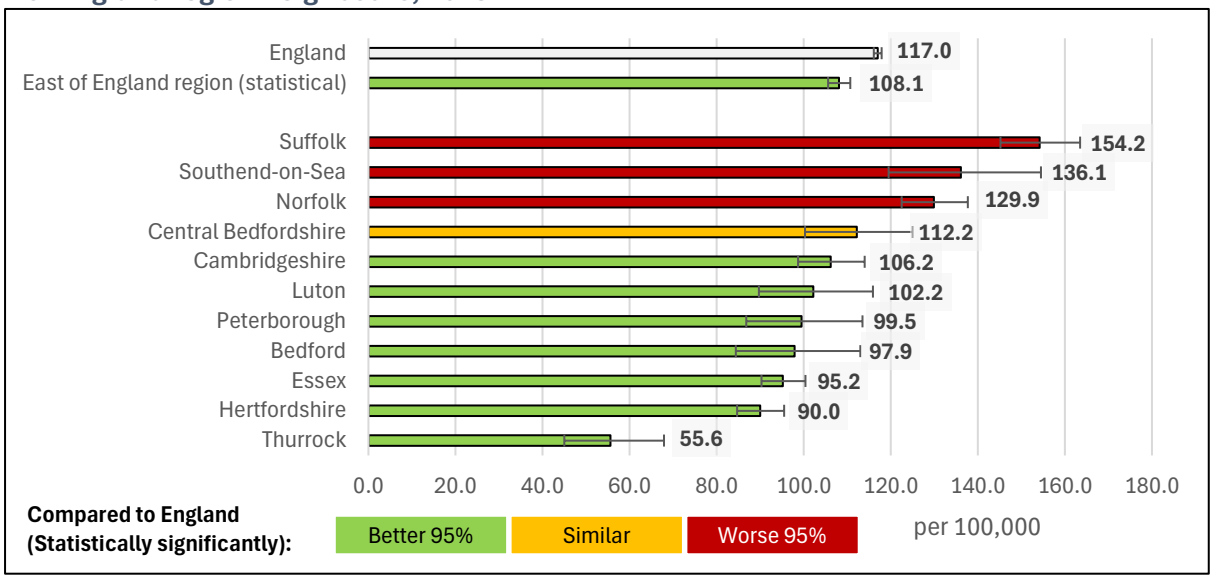


Source: Office for Health Improvement and Disparities (2025)

Across the East of England in 2023/24, Suffolk had the highest rate of emergency hospital admissions for self-harm among all upper tier local authorities. Suffolk's rate of 154.2 per 100,000 (1,135 total admissions) was substantially higher than most other areas in the region - only Southend-on-Sea approached Suffolk's rate at 136.1 per 100,000.

The lowest rates in the region were observed in Thurrock (55.6 per 100,000), Hertfordshire (90.0 per 100,000), and Essex (95.2 per 100,000). Suffolk's rate was nearly three times higher than Thurrock's and 71% higher than Hertfordshire's, demonstrating considerable variation across the region.

Figure 105. Emergency hospital admissions for intentional self-harm, Suffolk and East of England region neighbours, 2023/24



Source: Office for Health Improvement and Disparities (2025)

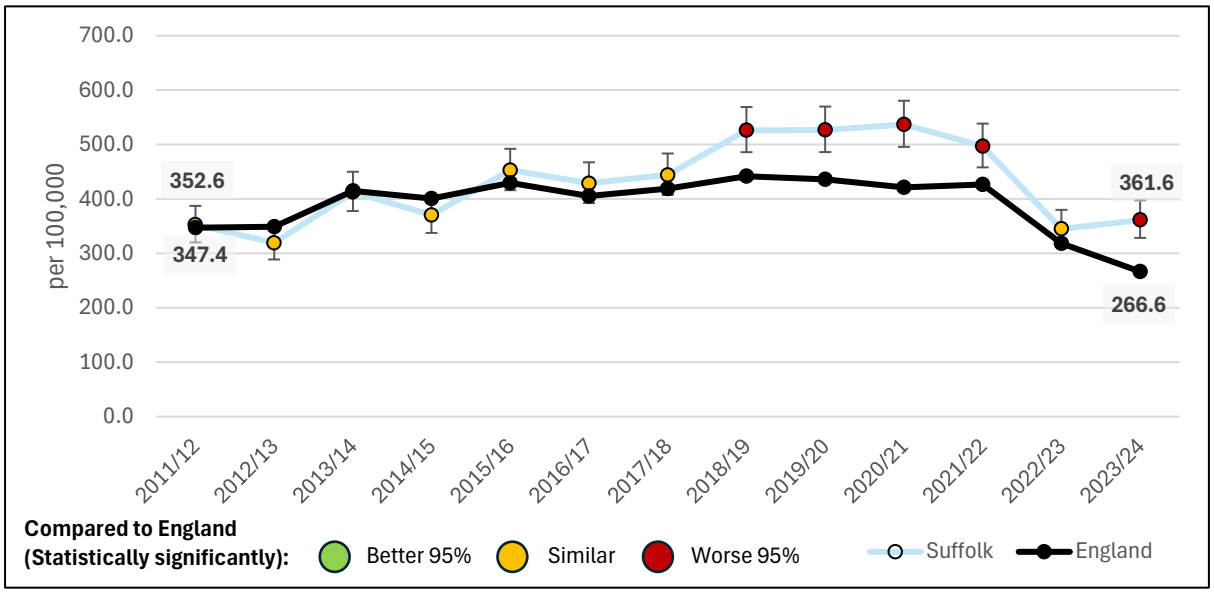
Hospital admissions as a result of self-harm (10 to 24 years)

In 2023/24, young people aged 10-24 years accounted for 440 of Suffolk's 1,135 total self-harm admissions - 39% of all cases, despite representing a much smaller proportion of the population (15.7% of the total Suffolk population are aged 10 to 24 in mid-2024).

Between 2011/12 and 2021/22, Suffolk experienced an upward trend in self-harm admission rates among 10-24 year olds. Rates increased from 352.6 per 100,000 in 2011/12 to a high of 536.9 per 100,000 in 2020/21. At the 2020/21 peak, Suffolk's rate was 45% higher than the England average (369.2 per 100,000).

Similar to the all-ages pattern, there was a marked decline in 2022/23, with rates decreasing to 345.1 per 100,000 - the lowest point in the time series. Rates increased in 2023/24 to 361.6 per 100,000, though remaining below pre-pandemic levels. Despite this recent reduction, Suffolk's rate in 2023/24 (361.6 per 100,000) remained statistically significantly higher than the England average (266.6 per 100,000).

Figure 106. Hospital admissions as a result of self-harm (10 to 24 years), rate per 100,000, Suffolk and England, 2011/12 to 2023/24

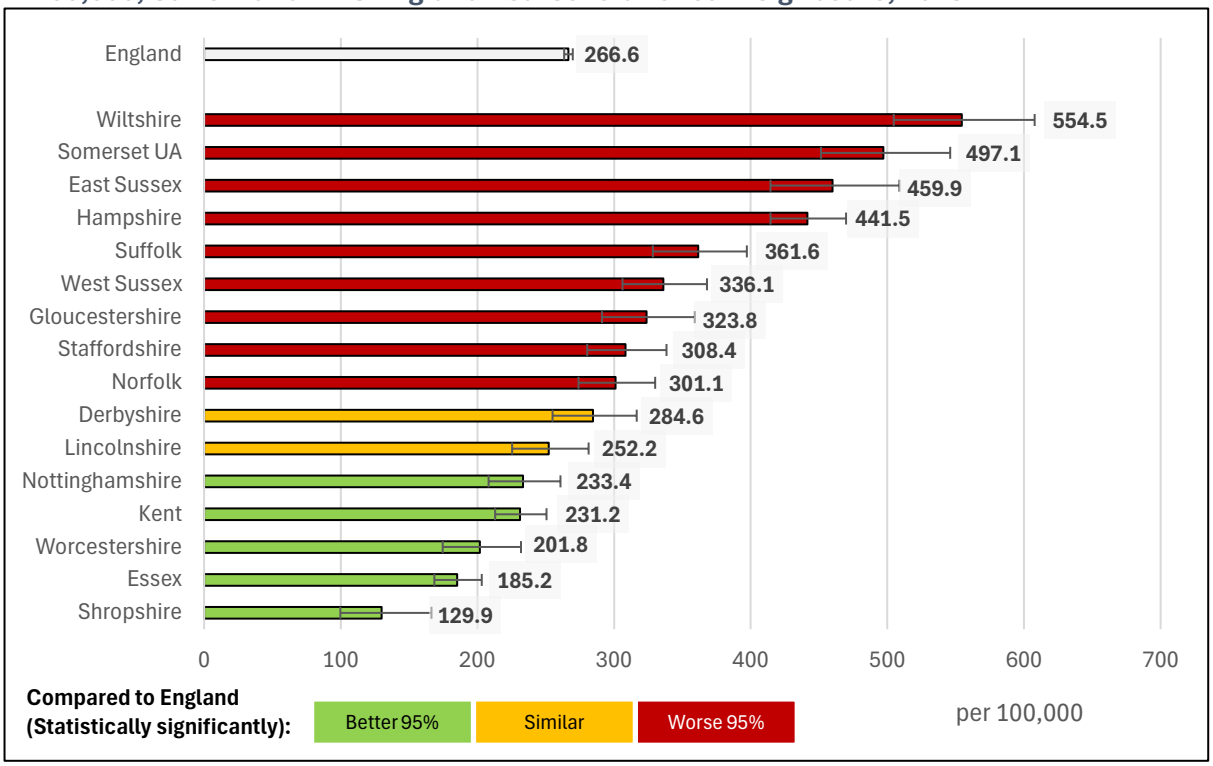


Source: Office for Health Improvement and Disparities (2025)

The rate of hospital admissions for self-harm for 10-24 year olds in Suffolk being statistically significantly higher than the England average is primarily driven by the admission rates in East Suffolk, with a rate of 533.0 per 100,000 (205 admissions/46.6% of Suffolk admissions for 10 to 24 year olds) being statistically significantly higher than the England average. All other districts and boroughs in Suffolk had a rate statistically similar to the England average in 2023/24.

Within the East of England in 2023/24, Suffolk had the highest rate of self-harm admissions among 10-24 year olds across all upper tier local authorities, and was fifth highest out of 16 NHS England statistical neighbours. The large variation in rates across upper tier local authorities in England represents a stark disparity in young people's mental health crises across the country.

Figure 107. Hospital admissions as a result of self-harm (10 to 24 years), rate per 100,000, Suffolk and NHS England nearest statistical neighbours, 2023/24

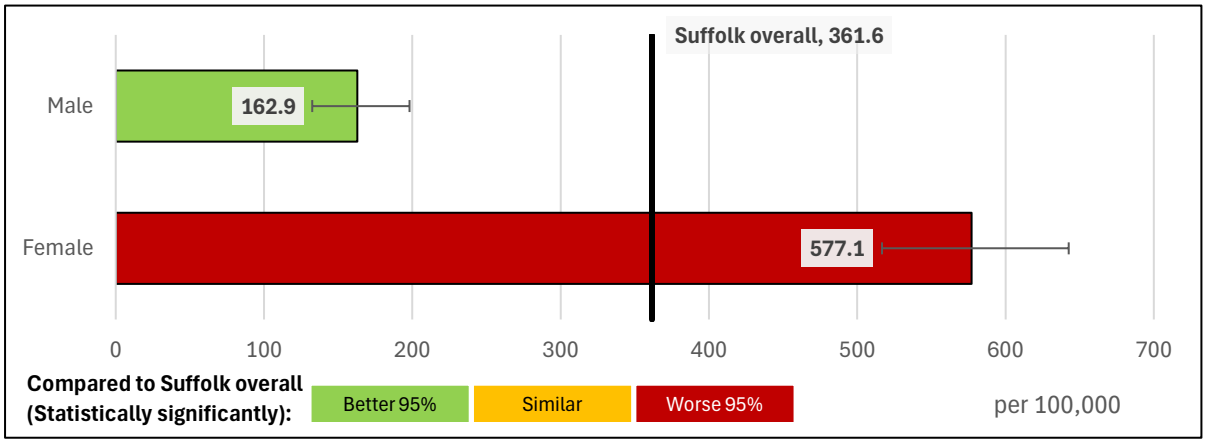


Source: Office for Health Improvement and Disparities (2025)

In 2023/24, there was a gender gap in self-harm admissions among young people in Suffolk. Females had a rate of 577.1 per 100,000 (340 admissions) more than 3 times higher than the male rate of 162.9 per 100,000 (100 admissions). The female rate was 60% above the overall rate for this age group (361.6 per 100,000), while the male rate was 55% below it.

This difference reflects national patterns where young women and girls are at higher risk of self-harm requiring hospital admission. The elevated rate among young females may reflect differences in methods of self-harm, higher rates of certain mental health conditions including depression and anxiety, greater exposure to specific stressors which may include social media pressures and body image concerns, and potentially different help-seeking behaviours.

Figure 108. Hospital admissions as a result of self-harm (10 to 24 years), rate per 100,000, Suffolk males and females, 2023/24



Source: Office for Health Improvement and Disparities (2025)

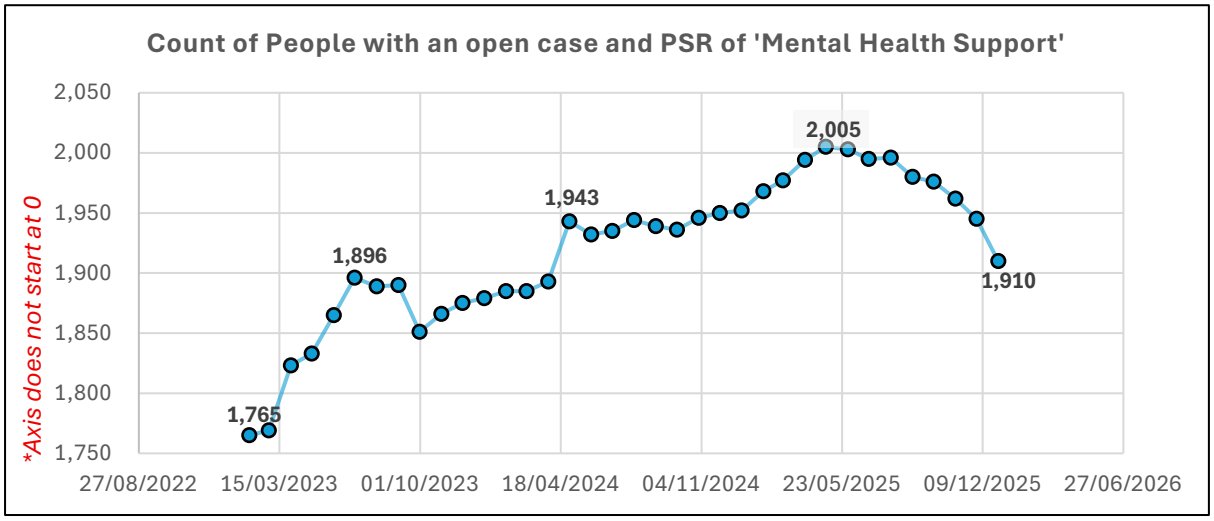
Suffolk adult social care data

Adult social care plays an important role in supporting people with mental health needs, particularly those with complex, long-term conditions that affect daily functioning, independence and wellbeing. Local authority data for Suffolk shows a substantial and sustained cohort of adults known to social care services where mental health has been recorded as a primary support reason.

Between January 2023 and December 2025, the number of people with an open adult social care case where mental health was recorded as a primary support reason increased steadily. In January 2023, 1,765 people were recorded with an open case, rising to a peak of just over 2,000 people in spring 2025. Although numbers declined slightly in the latter part of 2025, they remained consistently higher than at the start of the period, with 1,910 people recorded in December 2025.

Overall, this pattern suggests a growing and sustained level of demand for adult social care support linked to mental health needs, rather than short-term fluctuation. The relatively small month-to-month variation indicates a stable cohort of people requiring ongoing support.

Figure 109. Case Referrals with a Mental Health Support Primary Support Reason, Suffolk Adult Social Care, January 2023 – December 2025



Source: Suffolk County Council – Adult Social Care Data (2026)

The dataset includes both short-term and long-term mental health primary support reasons and also captures whether mental health remains the person's latest recorded primary support reason. For the Suffolk caseload over the previous three years, 85.9% of individuals on the caseload had a long-term primary support reason, with 14.1% having a short-term primary support reason. This highlights that, for many individuals, mental health needs are enduring and often persist even where other support needs emerge over time.

Using referral start dates to estimate duration of involvement shows that a significant proportion of people have been known to adult social care services for multiple years, reflecting the chronic and relapsing nature of many mental health.

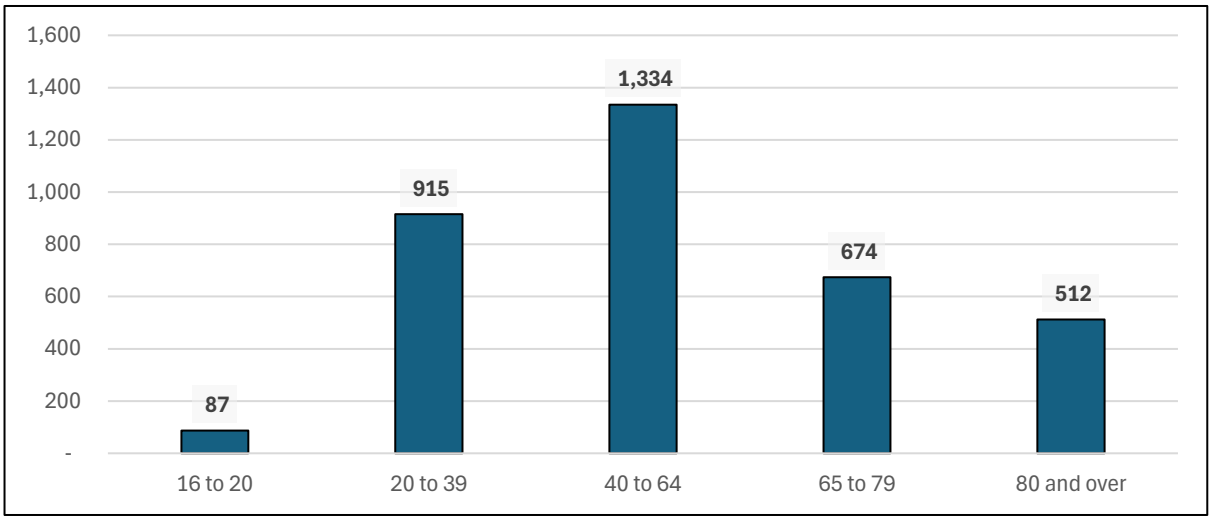
Adults receiving social care support where Mental Health Support was recorded as a primary support reason span a wide age range, with demand concentrated in working-age adults but remaining substantial in later life. Between January 2023 and December 2025:

- 40–64 year olds form the largest group, with 1,334 individuals, accounting for the greatest share of mental health–related social care referrals
- Adults aged 20–39 also represent a significant proportion (915 individuals), reflecting ongoing support needs among younger working-age adults
- Older adults account for a sizeable minority of cases:
    - 674 people aged 65–79
    - 512 people aged 80 and over

While fewer referrals occur among older age groups compared with working-age adults, the presence of over 1,100 people aged 65 and above highlights the importance of mental health within older people's social care. This reflects the interaction between mental health, physical health, cognitive decline, bereavement, and social isolation in later life. However, adult social care data may not capture the full extent of need, as some individuals with complex health-related needs may instead receive health-funded care packages (for example through NHS Continuing Healthcare), meaning their support is recorded within health rather than local authority systems.

Younger adults aged 16–20 make up a relatively small group (87 individuals), indicating that transition-age mental health support within adult social care is limited but present. This group often sits across service boundaries between children's services, adult social care and specialist mental health provision, highlighting the importance of coordinated transition planning.

Figure 110. Suffolk adult social care data: case referrals with a Mental Health Support Primary Reason, age groups, January 2023 - December 2025



Source: Suffolk County Council – Adult Social Care Data (2026)

NHS England guidance is explicit that fragmented age-based service models increase the risk of disengagement and poorer outcomes for young people, including within mental health pathways, and expects systems to prevent drop-off at transition points[215]. Commissioners should therefore require CAMHS and adult mental health services to operate explicit, jointly accountable transition arrangements, with early planning from early adolescence, named care

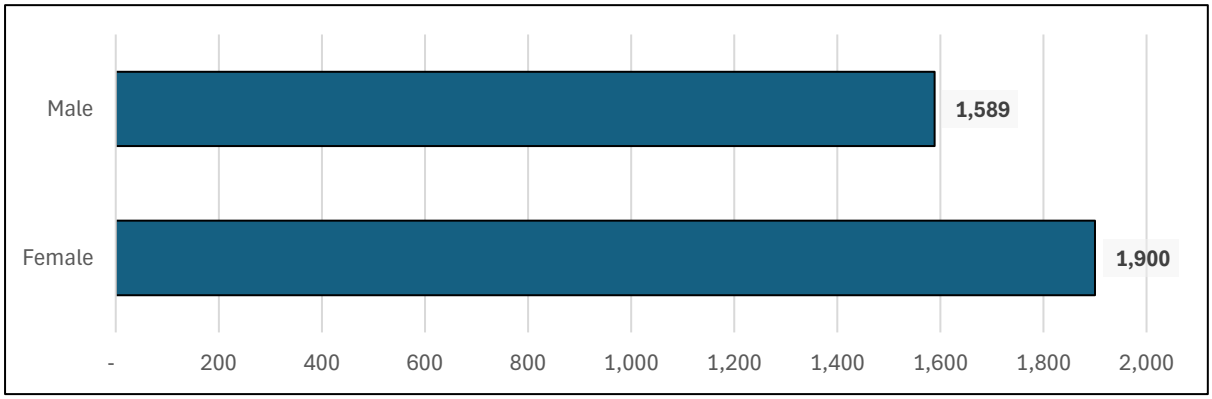
coordination, and continuity that is based on developmental need rather than fixed age cut-offs[215].

Women account for a slightly higher proportion of adults receiving social care support for mental health:

- Female: 1,900 individuals (54.5%)
- Male: 1,589 individuals (45.5%)

This pattern is consistent with evidence such as the Adult Psychiatric Morbidity Survey (APMS) showing higher prevalence of common mental health conditions among women, as well as higher likelihood of accessing support services. However, the substantial proportion of men indicates the mental health–related social care need among males, particularly in working-age and older adult groups.

Figure 111. Suffolk adult social care data: case referrals with a Mental Health Support Primary Reason, sex, January 2023 - December 2025



Source: Suffolk County Council – Adult Social Care Data (2026)

There is also variation in the number of adults with a mental health primary support reason across Suffolk's Integrated Neighbourhood Teams.

The highest numbers are seen in:

- Lowestoft: 429 individuals (12.3%)
- IP1 & IP2: 419 individuals (12.0%)
- IP3 & IP4: 329 individuals (9.4%)
- Bury Town: 272 individuals (7.8%)

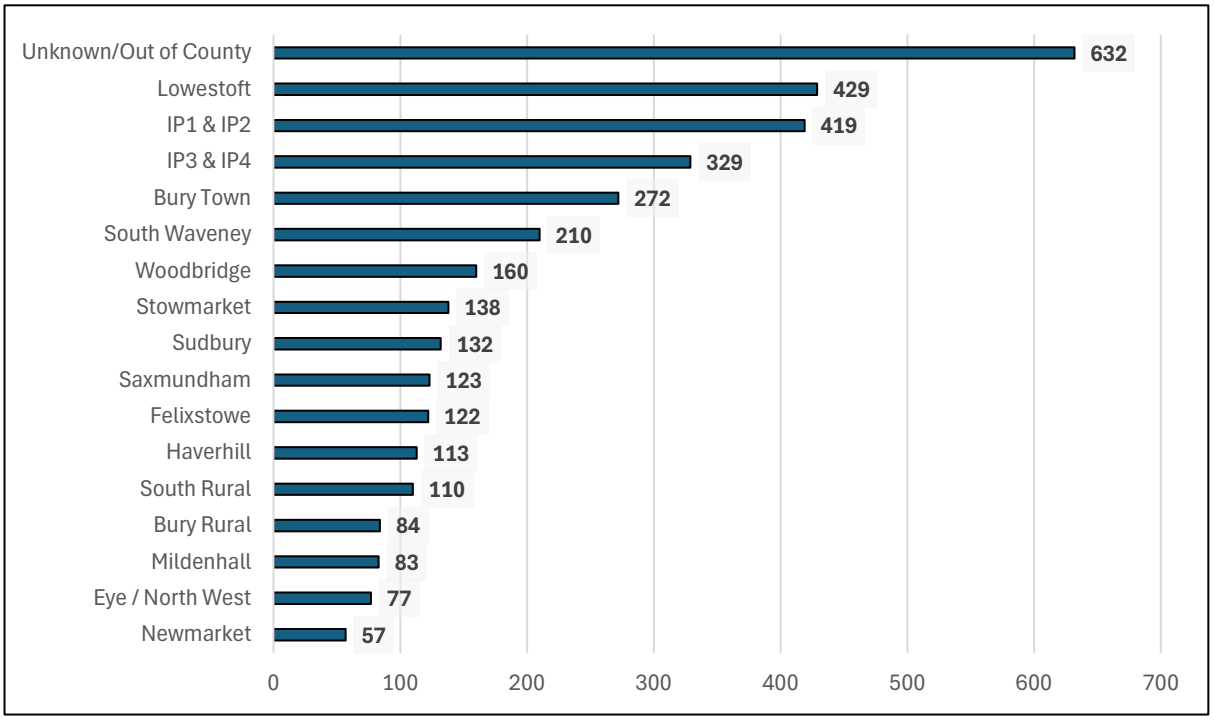
Together, these urban and coastal areas account for a substantial proportion of Suffolk's mental health–related social care activity. This aligns with patterns of deprivation, population density, and higher mental health need identified elsewhere in the needs assessment.

Rural and market town areas generally show lower numbers, including:

- Eye / North West (77; 2.2%)
- Bury Rural (84; 2.4%)
- Mildenhall (83; 2.4%)
- Newmarket (57; 1.6%)

A notable proportion of cases (632 individuals; 18.1%) are recorded as Unknown or Out of County. This may reflect data quality issues, restricted records, or individuals whose address information was unavailable or suppressed, and should be considered when interpreting this geographic data.

Figure 112. Suffolk adult social care data: case referrals with a Mental Health Support Primary Reason, Integrated Neighbourhood Team (INT), January 2023 - December 2025



Source: Suffolk County Council – Adult Social Care Data (2026)

The age and geographic profile of adults receiving social care support for mental health highlights several key issues such as mental health–related social care demand not being confined to older age, with the greatest volume among working-age adults. In addition, a substantial number of older adults require mental health support through social care, reinforcing the importance of integration with older people's services and dementia pathways.

Demand is also unevenly distributed geographically, with urban and coastal areas experiencing the highest levels of need, and slightly higher female representation mirrors wider mental health prevalence patterns but does not diminish the scale of need among men.

Together, this Suffolk Adult Social Care data underscores the need for place-based, age-appropriate, and integrated approaches to mental health support across adult social care, community mental health services, and wider system partners.

Access and waiting time standards

Alongside the Department of Health and Social Care, NHS England have established access and waiting time standards for mental health in some service areas:

- NHS Talking Therapies – for anxiety and depression
- Children and Young People (CYP) with an Eating Disorder (ED)
- Early intervention in Psychosis
  From 2024, data has been published on waiting times for all age (children, young people, adult and older adult) community mental health services

Lived experience insight: Access and waiting for support

- People report uncertainty about how to access mental health support and difficulty navigating complex service pathways
- The period between seeking help and receiving treatment is described as particularly challenging
- Limited support is often available while waiting, increasing the risk of deterioration

"I make an appointment with my GP… secondary care says I don't meet the criteria and tells me to go back to my GP."

These insights help explain patterns of delayed access and unmet need identified in service data.

Source: Suffolk lived experience engagement (Healthwatch Suffolk, Suffolk User Forum and partners).

NHS Talking Therapies, for anxiety and depression

NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies/IAPT) was the first part of the national mental health programme to implement a referral to treatment waiting time standard in 2015/16. The programme is designed to provide timely, evidence-based psychological therapies for people with anxiety disorders and depression.

National access standards require that:

- 75% of patients should have a first appointment within 6 weeks of referral
- 95% should have a first appointment within 18 weeks of referral

Data from the national NHS Talking Therapies dashboard (page 10, published September 2025) show that in Suffolk and North East Essex Integrated Care Board (SNEE ICB):

- There were 35,645 referrals in 2024/25
- 23,360 people accessed services in total
- There were 12,105 finished courses of treatment
- **22,145 people accessed services within 6 weeks of referral (94.8%)**
- **23,350 people accessed services within 18 weeks of referral (99.9%)**

This indicates that the service met the national waiting time standards, with most patients seen within recommended timeframes. Most patients accessed treatment quickly, with 18,285 referrals seen within 28 days and a further 4,605 within 29–56 days. Only a very small number of referrals (45) waited longer than 90 days.

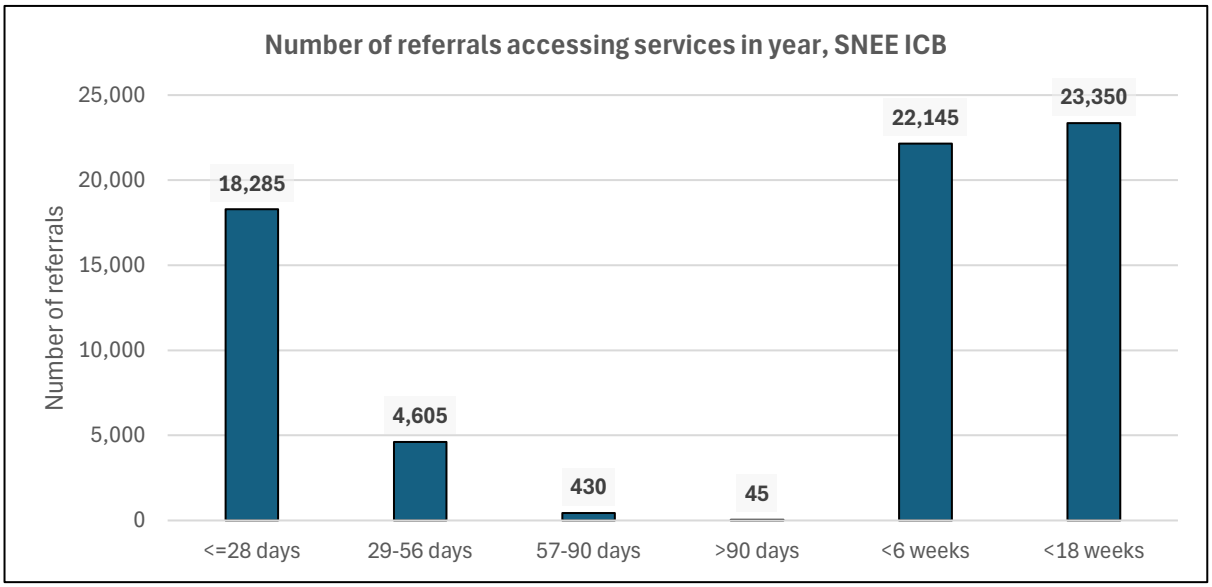
The mean wait (days) for referrals accessing services for SNEE ICB was 18.8 days, shorter/better than the England average figure in 2024/25 of 21.5 days.

For Norfolk and Waveney ICB:

- There were 39,130 referrals in 2024/25
- 30,065 people accessed services in total
- There were 16,285 finished courses of treatment
- **29,685 people accessed services within 6 weeks of referral (98.7%)**
- **30,060 people accessed services within 18 weeks of referral (99.9%)**

The mean wait (days) for referrals accessing services for Norfolk and Waveney ICB was 11.8 days, shorter/better than the England average figure in 2024/25 of 21.5 days and the SNEE ICB figure of 18.8 days.

Figure 113. Number of referrals accessing services in year, Suffolk and North East Essex ICB, 2024/25



Source: NHS England (2026)

Overall, performance against waiting time standards for NHS Talking Therapies in SNEEICB appears strong. However, waiting time compliance alone does not capture the full picture of access or unmet need. High levels of population prevalence of common mental health conditions, combined with evidence from APMS that many people with symptoms are not in contact with services, suggest that demand for timely psychological support remains substantial.

Equity of access and outcomes

Analysis of 2023/24 NHS Talking Therapies data for Ipswich & East Suffolk and West Suffolk sub-ICB areas highlights important variations in access, engagement and outcomes across age and gender groups.

By age, outcomes were strongest among people aged 65–74, who were more likely than younger age groups to attend their first treatment session, complete a course of treatment, and achieve both recovery and reliable recovery. In contrast, children and young people (0–17) and those aged 75 and over were less likely to be referrals at caseness (a referral that scores highly on measures of depression and/or anxiety, classifying them as a clinical case) and had lower

rates of treatment completion, suggesting potential barriers to sustained engagement for these groups.

By gender, males were less likely than females to attend their first treatment session, be referrals at caseness, and complete treatment once started. This pattern is consistent with wider national evidence indicating lower engagement with talking therapies among men. People recorded as having "not known" gender also showed lower attendance at first treatment compared to those recorded as indeterminate, which may reflect data quality issues or additional barriers to engagement.

These findings suggest that while NHS Talking Therapies services in SNEE ICB perform well against national waiting time standards, inequalities in engagement and outcomes remain across demographic groups. Addressing these differences will be important to ensure equitable access to, and benefit from, timely psychological therapies across the whole population.

Children and young people (CYP) with an Eating Disorder (ED)

NHS England has established a national access and waiting time standard for children and young people with eating disorders. The standard states that:

- 95% of CYP with an **urgent referral** for eating disorder treatment should begin within 1 week of the referral being made
- 95% of CYP with a **non-urgent referral** for eating disorder treatment should begin that treatment within 4 weeks of the referral being made

Until 2022/23, performance against this standard was monitored through a bespoke Children and Young People with Eating Disorders (CYP ED) data collection. This collection was retired at the end of 2022/23, and from 2023/24 onwards the standard has been monitored using the Mental Health Services Data Set (MHSDS). This change prevents direct comparability with earlier years and means that performance must now be compared using a wider set of MHSDS measures. Latest MHSDS data for Suffolk and North East Essex ICB for the period September to November 2025 indicates that access standards for children and young people eating disorder services are not consistently being met, particularly for urgent referrals.

- Only 50% of urgent referrals for children and young people with eating disorders entered treatment within one week, below the 95% national standard
- For routine referrals, 87% entered treatment within four weeks, also below the national standard
- At the end of the reporting period, 95 CYP aged 0–18 were waiting for eating disorder treatment, including:
    - 25 urgent cases still waiting, and
    - 75 routine cases waiting for treatment
- A proportion of children and young people were experiencing prolonged waits, with:
    - 20 urgent referrals and
    - 35 routine referrals waiting more than 12 weeks for treatment

Table 11. Children and young people with eating disorders – access and waiting times Suffolk and North East Essex, Norfolk and Waveney ICB, September - November 2025

Indicator	Value	
National access standards	SNEE ICB	N&W ICB
Urgent referrals entering treatment within 1 week (%)	50%	67%
Routine referrals entering treatment within 4 weeks (%)	87%	67%
Activity during reporting period		
Referrals entering treatment (all)	65	45
Urgent referrals entering treatment	20	10
Routine referrals entering treatment	45	35
Waiting list at end of period		
Total CYP waiting for eating disorder treatment	95	50
Urgent referrals waiting	25	5
Routine referrals waiting	75	40
Waiting >12 weeks (urgent)	20	5
Waiting >12 weeks (routine)	35	10

Source: Mental Health Services Data Set (MHSDS), NHS England, (2026)

These figures suggest sustained pressure on CYP eating disorder services, with delays affecting both urgent and routine cases. Given the clinical risks associated with eating disorders, particularly for children and young people, delays in access to treatment may increase the likelihood of deterioration, escalation to crisis services, or inpatient admission.

Early intervention in psychosis (EIP)

Early intervention in psychosis (EIP) services aim to identify and treat people experiencing a first episode of psychosis as early as possible, to improve long-term clinical and social outcomes. Evidence shows that timely access to EIP, alongside delivery of a full NICE-recommended package of care, can reduce symptom severity, improve recovery, and lower the risk of relapse and hospital admission.

EIP access and waiting time standard is “two-pronged” and both conditions must be met for the standard to have deemed to have been achieved:

1. A maximum wait of 2 weeks from referral to start of treatment

and

2. Treatment delivered in accordance with NICE guidelines and quality standards for psychosis and schizophrenia in children and young people or adults

In November 2025, EIP services in Suffolk and North East Essex had an active caseload of 205 people, defined as open referrals with at least one attended contact during the reporting period. During the same month, 215 open referrals recorded valid EIP-related clinical activity.

Of these, 165 referrals were linked to activity coded as NICE-concordant, indicating delivery of care aligned with national quality standards for psychosis and schizophrenia. This suggests that while most people open to EIP services are receiving care consistent with NICE guidance, a proportion of service users may not yet be receiving the full recommended package of interventions.

The difference between the total number of open referrals with EIP activity and those with NICE-concordant activity highlights an important quality dimension of the EIP standard. Meeting the two-week waiting time target alone is not sufficient; sustained delivery of evidence-based psychological, pharmacological, physical health, and family interventions is essential to improving outcomes and reducing longer-term demand on acute and inpatient services.

Table 12. Early Intervention in Psychosis activity and quality indicators, Suffolk and North East Essex, and Norfolk and Waveney ICBs, November 2025

Indicator	SNEE ICB	N&W ICB
EIP caseload (open referrals with attended contact)	205	395
Open referrals with any EIP clinical activity	215	390
Open referrals with NICE-concordant EIP activity	165	315
Proportion receiving NICE-concordant activity	76.7%	79.7%

Source: Mental Health Services Data Set (MHSDS), NHS England, (2026)

Community mental health services – all age (children, young people, adult and older adult)

In community mental health services for adults and older adults, national monitoring has increasingly shifted away from simple contact counts towards measures that reflect whether meaningful clinical activity has taken place. These measures aim to capture whether individuals receive timely assessments, care planning and therapeutic or social interventions following referral.

Across the Suffolk and North East Essex ICB, large numbers of people receive ongoing support through community mental health services. During the most recent reporting period, 9,185 people in SNEE and 11,160 in Norfolk and Waveney ICB accessed services and received two or more care contacts within the year, indicating sustained engagement with services for individuals with complex or enduring mental health needs.

Emerging performance measures also track the time from referral to a second contact, which provides an indication of how quickly people receive meaningful follow-up after entering services. For SNEE ICB, the median wait was 29 days, compared with 40 days for Norfolk and Waveney ICB. However, waiting times are longer for some individuals: the 90th percentile wait reached 113 days in SNEE and 140 days in Norfolk and Waveney, indicating that a minority of people experience more prolonged waits.

At the end of the reporting period, 1,695 referrals in SNEE and 2,035 in Norfolk and Waveney were still waiting for a second contact. Among those still waiting, the longest waits were substantial, with the 90th percentile reaching 291 days in SNEE and 394 days in Norfolk and Waveney, highlighting ongoing pressures within community mental health pathways.

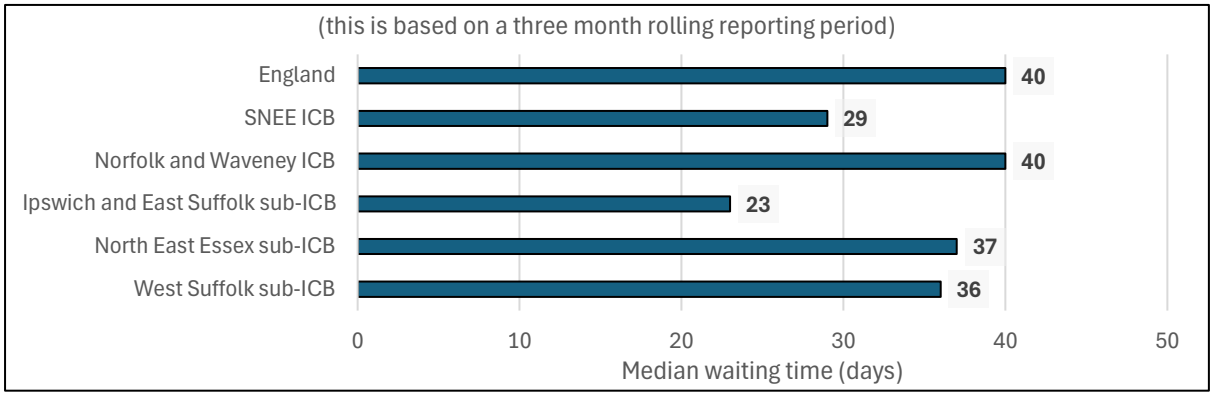
Table 13. Community mental health services activity and quality indicators, Suffolk and North East Essex ICB, November 2025

Indicator	SNEE ICB	N&W ICB
People with 2+ contacts (annual)	9,185	11,160
Referrals receiving a second contact (3-month RP)	1,370	1,515
Median wait to second contact	29 days	40 days
90th percentile wait	113 days	140 days
Referrals still waiting for second contact	1,695	2,035
90th percentile wait for those still waiting	291 days	394 days

Source: Mental Health Services Data Set (MHSDS), NHS England, (2026)

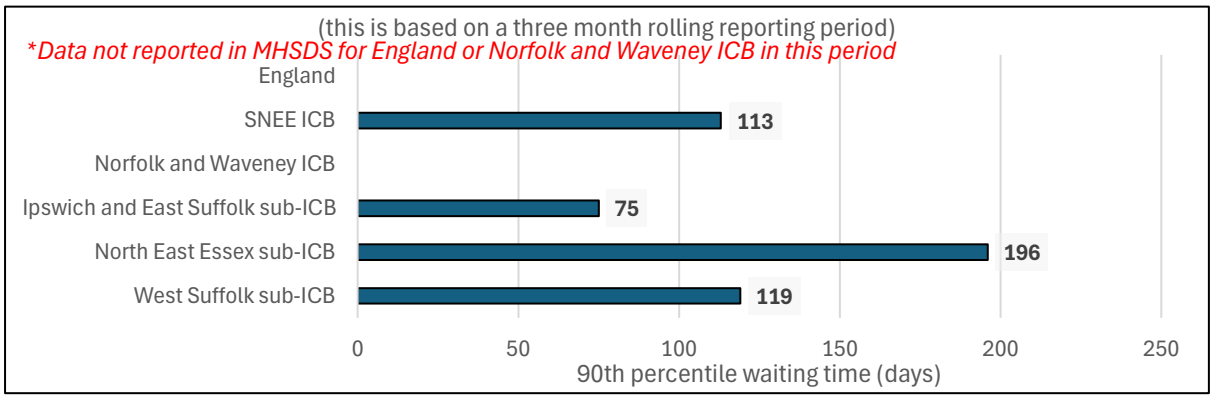
Together, the data highlights high demand, variable access, and ongoing system pressures within community mental health services, reinforcing the needs for capacity, workforce and pathway development.

Figure 114. Median waiting time between referral and second contact for referrals accessing community mental health services for adults and older adults with SMI, which received the second contact within the reporting period, England, ICBs/sub-ICBs, November 2025



Source: Mental Health Services Data Set (MHSDS), NHS England, (2026)

Figure 115. 90th percentile waiting time between referral and second contact for referrals accessing community mental health services for adults and older adults with SMI, which received the second contact within the reporting period, England, ICBs/sub-ICBs, November 2025



Source: Mental Health Services Data Set (MHSDS), NHS England, (2026)

Mental health neighbourhood centres

Mental Health Neighbourhood Centres (MHNCs) are an emerging NHSE development, locally led by NSFT, with early plans for several sites across Suffolk and Norfolk. The programme represents a notable future shift towards more place-based, preventative, and accessible models of support.

While the MHNC model is still forming, their anticipated role in strengthening local access, managing demand, and improving community outcomes should be recognised as a future opportunity for Suffolk's mental health system. The MHNA therefore highlights local patterns and inequalities that can support ongoing planning as the model develops.

Specialist mental health support for children in care and adopted children

Specialist therapeutic mental health support for children in care and adopted children in Suffolk is delivered through two commissioned services. Connect, jointly commissioned by Suffolk County Council and the Suffolk & North East Essex Integrated Care Board (SNEE ICB), provides specialist therapeutic interventions for children in care and adopted children living in Suffolk, excluding Waveney. The service supports children and young people up to the age of 18 with moderate to severe mental health needs, using trauma-informed, relationship-based approaches tailored to care-experienced lives.

In parallel, Children, Families and Young People's Looked After and Adopted Children Service (CFYP LAAC) Waveney provides therapeutic support for children in care and adopted children up to age 18 living in the Waveney locality. This service delivers Tier 2 interventions focused on emotional, relational and behavioural needs within a multi-agency framework. Together, these services form the core specialist mental health offer for care-experienced children across Suffolk.

Key service pressures and issues

Available service intelligence highlights several shared and system-wide challenges:

- **Demand exceeding capacity**: Both services experience sustained demand that exceeds funded capacity. In Connect, caseloads frequently operate above commissioned levels, limiting flexibility and placing pressure on clinicians delivering intensive, relationship-based interventions.
- **Waiting times**: Assessment waiting times regularly exceed the 28-day target in Connect, with waits during 2024–25 ranging from approximately 16 to 48 days. In Waveney, reported waits to assessment are around 6–8 weeks, with longer pathways to treatment in some cases. Delays pose risks for children in care, whose mental health needs can escalate quickly without timely support.
- **Access to specialist therapies**: Demand for trauma-focused and creative therapies (including art psychotherapy, EMDR and DDP) continues to outstrip capacity. Waiting times for these interventions can extend to 9–12 months during periods of high pressure, reducing opportunities for stabilisation and increasing placement disruption risk.
- **Psychiatry capacity**: Limited specialist psychiatry capacity represents a significant bottleneck, affecting the timeliness of assessments, medication reviews and urgent appointments, and increasing reliance on onward referrals to other specialist services.

- **Engagement and continuity**: DNA rates in Connect are reported at around 10–15%, particularly for follow-up appointments. This reflects structural barriers common for care-experienced children, including placement instability, emotional dysregulation, transport challenges and competing professional demands.
- **Hidden workload**: A substantial proportion of clinical time is spent on non-direct activity such as consultations, residential home support, formulation meetings and multi-agency liaison. This activity is not always fully captured in routine data, meaning headline caseload figures may underestimate true service demand.
- **Data quality and monitoring**: Inconsistent data systems, particularly in Waveney, limit the reliability of routine performance and outcomes reporting. While use of routine outcome measures is improving, gaps remain in system-wide monitoring of impact.

Together, these issues indicate that specialist mental health provision for care-experienced children in Suffolk is operating under sustained pressure, with capacity constraints affecting access, timeliness and continuity of care. The challenges are structural rather than short-term and highlight the importance of reviewing commissioning arrangements, strengthening psychiatry capacity, improving data quality, and ensuring that service models reflect the complexity and instability often experienced by children in care.

Service mapping

Children and young people (ages 0-25 years)

Summary

Figure 116 shows a high level infographic mapping the Suffolk Mental Health Services Pathway for Children and Young People (ages 0-25 years). Key findings show that:

Public sector:

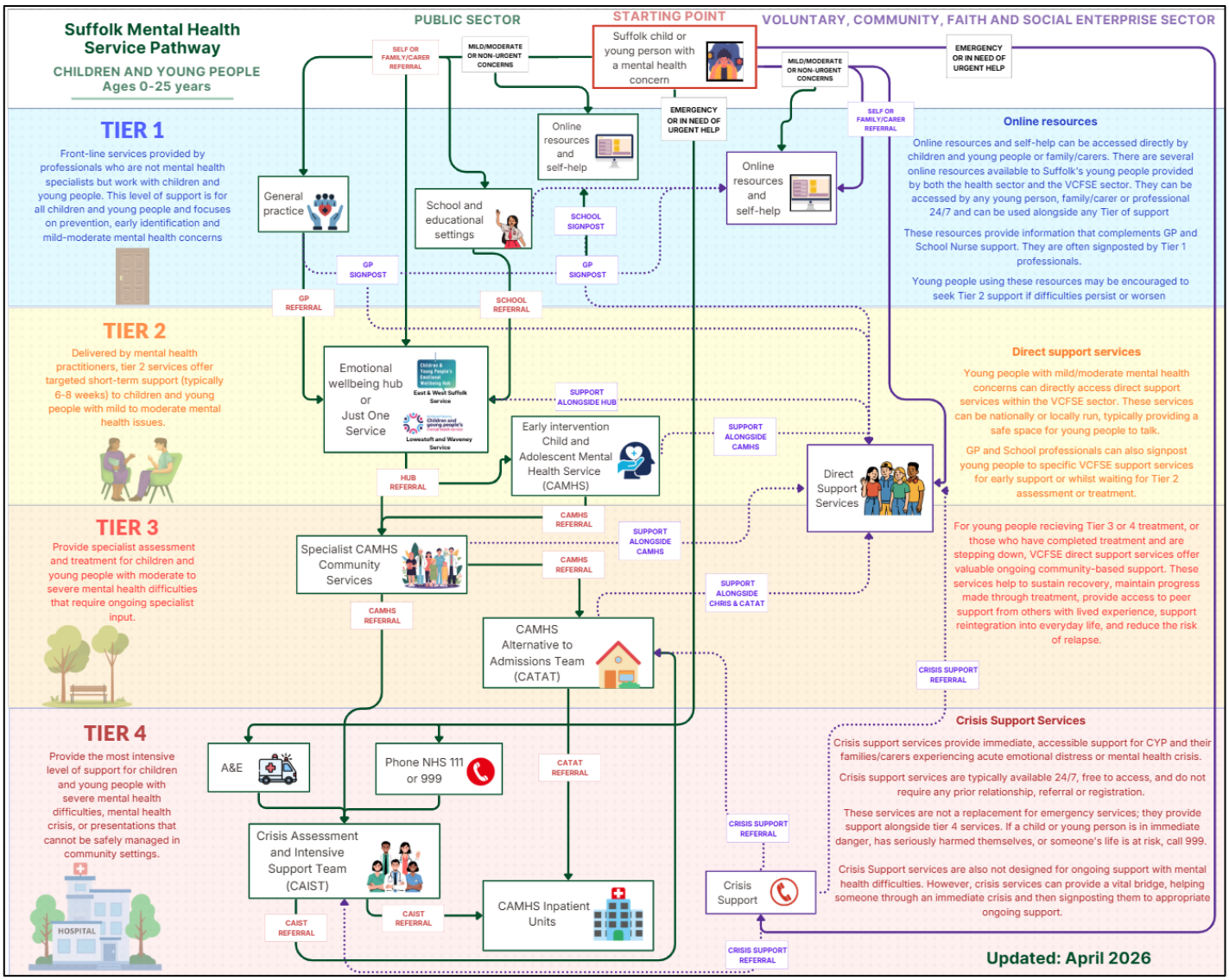
- There are five main entry points to public sector services for children and young people with mental health concerns:
    - For mild/moderate mental health concerns children and young people or a family/carer can access mental health services initially through:
        - Online resources and self-help
        - Their local GP practice
        - School and educational professionals
        - Direct online referrals to the Emotional Wellbeing Hub (East or West Suffolk residents) or Just One Service (Lowestoft or wider Waveney residents)
    - For emergency, crisis or urgent support children and young people can access help directly without referral through phoning NHS 111and selecting the mental health option, calling 999, or attending their closest A&E
- The Tier 2 services - Emotional Wellbeing Hub or Just One Suffolk - act as a single point of access for children and young people and can refer on to Tier 1, 2 or 3 services depending on need.
- Tier 3 services can only be accessed through a healthcare professional referral.
- Tier 4 services should be accessed for urgent and emergency support. Young residents can access these services through attending A&E or phoning NHS 111 or 999 or through voluntary, community, faith and social enterprise (VCFSE) crisis support. Tier 3 services may also refer children and young people when necessary.

VCFSE sector:

- All VCFSE services can be accessed directly by children and young people and their families/carers with no referral from statutory services.
- Suffolk children and young people have access to several VCFSE mental health services. These have been organised into three categories to clarify their role and integration within overall mental health pathways:
- Online resources and self-help:
    - Designed for universal access and independent use
    - Provide information, psychoeducational materials, peer forums, and guided self-help techniques that young people and families can access anonymously
    - Provide information that complements Tier 1 support and will usually be signposted by health professionals as good resources for general mental wellbeing
    - Can be accessed 24/7 and can be used alongside any tier of support
- Direct support services:

    - Provide interactive support for children and young people and their families/carers who need more than online resources or self-help, but who are not in immediate crisis.
    - Includes counselling, therapeutic youth work, one-to-one mentoring, group programmes, drop-in provision, and peer support networks.
    - Can be accessed alongside statutory provision or when stepping down in level of care, helping to sustain recovery, maintain progress made through treatment, provide access to peer support from others with lived experience, support reintegration into everyday life, and reduce the risk of relapse.
    - Delivered by a range of organisations, from national charities to grassroots community groups established to meet local need.
- Crisis support services
    - Provide immediate, accessible support for children and young people and their families/carers experiencing acute emotional distress or mental health crisis.
    - Typically, available 24/7, free to access, and do not require any prior relationship, referral or registration.
    - These services are not a replacement for emergency services; they provide support alongside tier 4 services. If a child or young person is in immediate danger, has seriously harmed themselves, or someone's life is at risk, call 999.
    - Not designed for ongoing support with mental health difficulties. However, can provide a vital bridge, helping someone through an immediate crisis and then advocating and assisting them to appropriate ongoing support.

Figure 116. Suffolk Mental Health Service Pathway for Children and Young People ages 0-25 years



Adult (aged 18+ years)

Evidence from local engagement highlights that:

- People report difficulty navigating mental health services
- Waiting periods between referral and treatment are particularly challenging
- Young people value accessible support in schools and trusted adults
- Carers often feel excluded from care planning and lack information
- Some communities experience barriers to accessing support

Source: Suffolk lived experience engagement (Healthwatch Suffolk, Suffolk User Forum and partners).

Summary

Figure 117 presents a high level infographic mapping the Suffolk Mental Health Pathway for Adults Ages 18+ years. Key findings show that:

Public sector

- There are four main entry points for Suffolk residents with a mental health concern
    - For common and general wellbeing information residents can access an array of public sector provided online resources and self-help
    - For mild/moderate mental health concerns residents can access mental health services initially through GP practices
    - Suffolk wellbeing provides NHS talking therapies which can be accessed through self-referrals for common mental health problems such as anxiety or depression
    - For emergency, crisis or urgent support residents can access help directly without GP referral through phoning NHS 111and selecting the mental health option, calling 999, or attending their closest A&E
- Non-urgent secondary care can only be access via a GP referral
- Tertiary care can only be accessed via a referral from acute inpatient mental health services or criminal justice services
- Specialist care for specific demographic groups such as mother's or birthing people, veterans or those in the armed forces, and older adults with dementia concerns is available at secondary and tertiary levels of care and can be accessed via a GP referral.
- The pathway is flexible and multidirectional, based on need level. Residents with changing needs may be referred and move from one level of care to another.

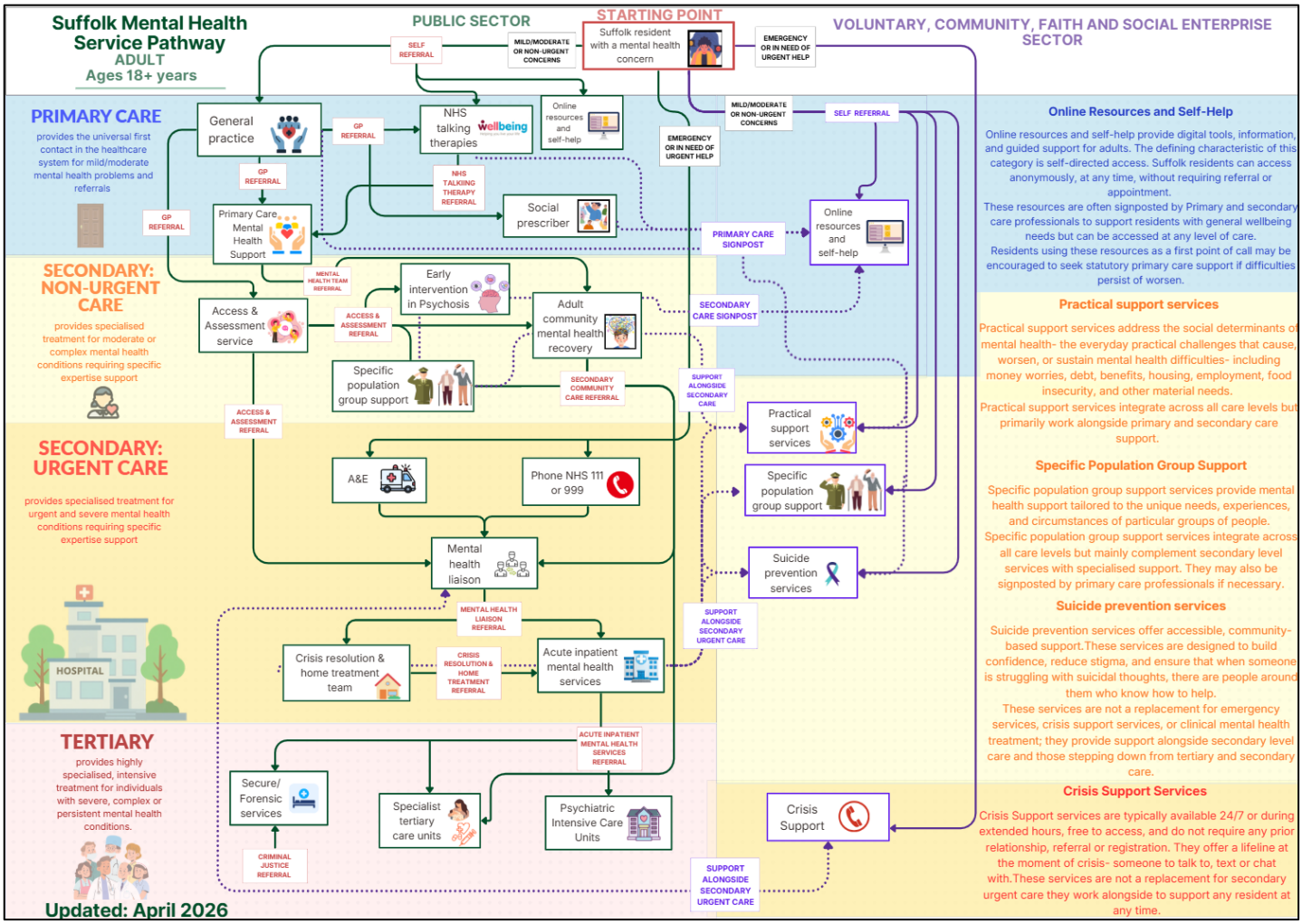
VCFSE sector

- All VCFSE services can be accessed directly by Suffolk adults with no referral from statutory public sector services.
- Suffolk adults have access to several VCFSE mental health services. These have been organised into five categories to clarify their role and integration within overall mental health pathways:
- Online resources and self-help:
    - Designed for universal access and independent use

    - Provide information, psychoeducational materials, peer forums, and guided self-help techniques that residents can access anonymously
    - Provide information that primary care support and will usually be signposted by health professionals as good resources for general mental wellbeing
    - Can be accessed 24/7 and can be used alongside any level of public sector support
    - May be locally commissioned but open to use to all triaged via VCFSE
- Practical support services:
    - Address the social determinants of mental health- the everyday practical challenges that cause, worsen, or sustain mental health difficulties.
    - Help with money worries, debt, benefits, housing, employment, food insecurity, and other material needs.
    - Integrate across all care levels but primarily work alongside primary and secondary care support.
- Specific population group services
    - Provide mental health support tailored to the unique needs, experiences, and circumstances of particular groups of people.
    - Staff and volunteers understand the specific experiences, language, and challenges of the population they serve.
    - Specific population group support services integrate across all levels of the mental health system. They mainly complement secondary level services with specialised support but may also be signposted by primary care professionals if necessary.
- Suicide prevention services
    - Complement statutory public sector provision and Suffolk Public Health initiatives by offering accessible, community-based support that reaches people who may not engage public sector services.
    - Provide education, training, safety planning tools, and specialist support to help prevent suicide and support those affected by it.
    - Provide support, information and guidance for people who have been bereaved by suicide
    - Include free training programmes that teach people how to recognise warning signs and have supportive conversations, digital tools like safety planning apps, and specialist bereavement support for those who have lost someone to suicide.
    - Designed to build confidence, reduce stigma, and ensure that when someone is struggling with suicidal thoughts, there are people around them who know how to help.
    - These services are not a replacement for emergency services, crisis support services, or clinical mental health treatment; they provide support alongside secondary level care and those stepping down from tertiary and secondary care. If an adult is in immediate danger, has seriously harmed themselves, or someone's life is at risk, call 999.
- Crisis support services

- Provide immediate, accessible support for adults experiencing acute emotional distress or mental health crisis.
- Typically, available 24/7, free to access, and do not require any prior relationship, referral or registration.
- These services are not a replacement for emergency services; they provide support alongside secondary urgent care services. If and adult is in immediate danger, has seriously harmed themselves, or someone's life is at risk, call 999.
- Not designed for ongoing support with mental health difficulties. However, can provide a vital bridge, helping someone through an immediate crisis and then advocating and assisting them to appropriate ongoing support.

Figure 117. Suffolk Mental Health Service Pathway Adults Aged 18+ years



Conclusion

Mental health need in Suffolk is shaped by a complex interaction of social, economic, physical and environmental factors across the life course. While many indicators in Suffolk compare favourably with regional and national averages, the needs assessment identifies persistent and widening inequalities affecting people living in deprivation, coastal communities, children and young people, people with severe mental illness, carers, and those experiencing multiple disadvantage.

The findings highlight the importance of prevention, early intervention and integrated, person-centred approaches that address both mental and physical health. Demand for support is increasing across multiple parts of the system, including community mental health services, children and young people's services, adult social care, and primary care. At the same time, there are opportunities to strengthen earlier identification, improve access and continuity of care, and make better use of population health management and lived experience insight to target support more effectively.

Improving mental health outcomes in Suffolk will require continued collaboration across health, social care, education, housing, employment services, the voluntary and community sector, and local communities themselves. The recommendations within this needs assessment provide a framework to support a more preventative, equitable and coordinated mental health system for Suffolk's population.

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Appendix A: Mental Health Needs Assessment (MHNA) process

Overview

This Mental Health Needs Assessment (MHNA) was developed between December 2025 and May 2026 to provide a comprehensive, evidence-based understanding of mental health need across Suffolk. The assessment draws on a combination of quantitative data, national and local research, and lived experience evidence to inform system-wide planning and commissioning.

Governance and steering group

The MHNA was overseen by a multi-agency steering group, bringing together partners from public health, health services, local authority services, and the voluntary, community, faith and social enterprise (VCFSE) sector.

Steering group members contributed to the development of the needs assessment through:

- Reviewing draft chapters and findings
- Providing data, intelligence and contextual insight
- Supporting interpretation of findings
- Contributing to the development and refinement of recommendations

Steering group membership:

- Sara Dunling-Hall (Suffolk County Council) – Consultant Lead
- Mabel Okoeki (Suffolk County Council)
- Andrew Crowe (Suffolk County Council)
- Elinor Bally (Suffolk County Council)
- Katie Sargeant (Suffolk County Council)
- Anna Crispe (Suffolk County Council)
- Nicola Roper (Suffolk County Council)
- Laura Melville (Suffolk County Council)
- Natacha Bines (Suffolk County Council)
- Cath Byford (Norfolk and Suffolk NHS Foundation Trust)
- Joseph Jason (Norfolk and Suffolk NHS Foundation Trust)
- Eugene Staunton (Suffolk and North East Essex Integrated Care Board)
- Lee Watson (Norfolk County Council)
- Ezra Hewing (Suffolk Mind)
- Sarah Potter (Suffolk Family Carers)
- Jayne Stevens (Suffolk User Forum)
- Susan Balaam (Healthwatch Suffolk)
- Michael Ogden (Healthwatch Suffolk)
- Nancy Merfeld (4YP)
- Andy Vowles (Cambridge Health Consulting)

Analytical approach

The MHNA integrates multiple sources of evidence, including:

- National and local datasets (including NHS, OHID and local authority data)
- Population Health Management (PHM) data
- Published literature and national policy

- Local service data and performance metrics
- Lived experience and engagement findings

A separate literature review and user voice summary document have been produced alongside the main needs assessment, with key findings incorporated into the report.

Key roles and contributions

- Lead author: Andrew Crowe
- Literature review lead: Elinor Bally
- User voice and lived experience: Katie Sargeant and Mabel Okoeki
- Review and quality assurance: Natacha Bines and Anna Crispe
- Consultant lead: Sara Dunling-Hall

Steering group members provided ongoing input throughout the process, including reviewing drafts and contributing data, insights and feedback.

Outputs

The MHNA is supported by a suite of accompanying outputs:

- Full Mental Health Needs Assessment report
- Literature review document
- Power BI data dashboard
- Lived experience (user voice) summary report
- Service mapping

Working across Suffolk and Norfolk

This MHNA was developed in close collaboration with Norfolk colleagues, reflecting the formation of the Norfolk and Suffolk Integrated Care Board (ICB) on 1 April 2026 and the development of a joint Norfolk and Suffolk mental health strategy. Norfolk County Council is also producing a Mental Health Needs Assessment as part of its JSNA. While this assessment focuses on Suffolk, joint working has supported alignment of evidence, interpretation and emerging priorities across the shared ICB footprint. Statutory responsibility for JSNAs remains with individual Health and Wellbeing Boards; therefore, Suffolk and Norfolk have produced separate needs assessments in line with their respective statutory footprints.

Limitations

This needs assessment draws on the best available data and evidence at the time of analysis and publication. However, several limitations should be noted – much of the quantitative data reflects recorded need and service use, which may under-represent the true prevalence of mental health conditions, particularly among underserved or less visible groups. Some datasets are subject to time lags, meaning they not fully capture recent changes in demand or service delivery. Variations in data quality, coding practices and definitions across sources may also affect comparability. In addition, while lived experience evidence has been included, it may not fully represent the diversity of experiences across all Suffolk communities. These limitations highlight the importance of ongoing data development, local intelligence, and engagement to complement and update this assessment over time.

Appendix B: Example Needs Assessment Action Plan

The appendix includes an action plan developed in response to the Suffolk Health and Housing Needs Assessment. This is presented as an example of how needs assessment recommendations can be translated into targeted, coordinated action. Its inclusion has been agreed with relevant stakeholders to support learning and inform future implementation approaches arising from this mental health needs assessment.

RECOMMENDATION 1	
H&HNA Recommendations	For Suffolk housing and health strategic leaders/decision makers: For existing housing:

1. Provide additional funding opportunities for upgrading and retrofitting Suffolk's homes with the worst energy efficiency ratings to prevent ill health. This can be achieved through
(a) joined-up awareness raising campaigns on available grants and subsidies,
(b) support for residents and landlords to apply for them, (c) lobbying (or requesting) government for area based, funded schemes
Rationale - Grants and subsidies are available for those on the lowest incomes to improve insulation, heating systems and appliances to improve affordability, comfort, and health. However, it is recognised that many are not eligible for financial support or are unable to complete the forms. Given the significant retrofitting costs, additional support is required to improve existing Suffolk housing. In addition, there is an increasing focus on the impact of air quality on health.

Action 1.a Mapping Exercise	Action 1.b Interpretation	Action 1.c Communication Planning
Timeframe:	Timeframe:	Timeframe:
Lead:	Lead:	Lead:
Mapping exercise to include. 1. Grants available locally & nationally 2. Awareness campaigns – locally & nationally 3. Mapping of grants to include information on how/where a citizen would access the grant 4. Other support that is available – social prescribing, community teams etc 5. Strategic system wide plans that are linked to health & housing (inequalities, climate change, clinical pathways etc) 6. Feedback from residents and grant officers about current grant processes (building an evidence base of lived experience)	**Understand what the mapping is telling us** Overlay the detailed information from the HHNA & the engagement activities undertaken during the HHNA process Who is & isn't accessing funding? What for(measures)? How many applications are there? Why do people not complete the process? Are we optimising the funding opportunities for Suffolk? If not, why not. Questions to consider ? where are the gaps & overlaps in each of these maps ? how do we maximise the impact of what we have available ? do we need/how do we fill any gaps	**Develop a communication/lobbying plan** Identify key messages from mapping exercises. Identify alignment to ICB/LA strategic plans Identify the new Govt's direction of travel (PESTLE model) to identify alignment against emerging policy Identify opportunities for lobbying e.g. – simpler grant process for residents Easy read information Upfront knowledge about the system to manage expectations. Use of social media / videos?

7. What additional support is there to facilitate the most vulnerable to access grants – what is the reach and scope of such services.		
OUTPUT 1. Grants Map document 2. Awareness campaign Map 3. Strategic roadmap that shows where H&H are a feature of a system led plan/program	**OUTPUT** Gap analysis document	**OUTPUT** Lobbying plan including who is best placed/most influential to deliver aspects of the plan
Resource Requirement: People	**Resource Requirement:** People	**Resource Requirement:** People
NOTES – info from meeting not yet included above Collate information from residents on their housing condition and how to help them navigate support to achieve a warmer home. E.g E-form to capture which eligible schemes they are available form including benefits, what measures you are looking for		

Health and Housing
Needs Assessment A