



Norfolk
County Council

Mental Health Needs Assessment 2026

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1 Executive Summary

Mental health and wellbeing in Norfolk are shaped by the cumulative effects of early life experiences, socioeconomic conditions, physical health, family circumstances, and the environments in which people live, work and age. A life course approach suggests that vulnerability to mental ill-health builds over time, with inequalities established early and often widening across generations. This Mental Health Needs Assessment (MHNA) brings together national and local evidence to understand the patterns of mental health need in Norfolk, reveal gaps in current data, and highlight opportunities for prevention and early intervention.

Nationally, mental ill-health has increased over the past decade, particularly among young adults and those experiencing financial insecurity. Evidence from the Department of Health and Social Care's Independent Review into Mental Health Conditions, ADHD and Autism interim report indicates that this reflects a genuine increase in psychological distress, particularly among young people, including rising population prevalence and functional impairment among those affected. The interim report states that these patterns are not well explained by reduced stigma or lower reporting thresholds alone and were evident prior to the Covid-19 pandemic. The review also highlights that current systems often interpret different kinds of distress through a medical lens, meaning a wide range of difficulties rooted in social, educational or environmental pressures are framed as clinical need, which may lead to inappropriate treatment. Alongside this, national evidence from Mind and the Centre for Mental Health shows how increasing living costs, insecure employment, and shrinking public services have eroded protective factors for mental wellbeing, particularly for lower-income households. Norfolk's own economic landscape mirrors these national trends: median annual earnings in Norfolk remain below the England average for both men and women, meaning more households are exposed to financial strain – a well-evidenced contributor to mental ill-health.

Across the life course, the MHNA identifies clear and consistent risk factors: deprivation, poverty, housing instability, childhood adversity, chronic illness, and lack of social connections. These determinants do not operate in isolation — in Norfolk they cluster in specific communities, particularly in Norwich and Great Yarmouth, where levels of deprivation are higher than regional and national profiles. This means some individuals and families are exposed to overlapping pressures that compound vulnerability and create persistent inequality.

In the perinatal period, around 27% of mothers who give birth in Norfolk experience perinatal mental illness — higher than the national modelled estimate. Younger mothers carry greater risk. Norfolk also has a consistently higher rate of early pregnancy obesity than England, which increases vulnerability to both physical complications and poor mental health. Evidence of paternal and co-parent mental illness is growing nationally, but local data on this is minimal, meaning a substantial proportion of need is invisible in routine datasets.

Among children and young people, mental health need is high and, in some indicators, worsening. National survey data indicates ~20% prevalence of probable mental illness among 8–16-year-olds, but local Flourish data shows that 40% of Norfolk pupils report low wellbeing, with the steepest declines in Year 8. Self-harm among children and young people is a significant issue, with Norfolk's hospital admission rate for 10–24-year-olds statistically

significantly higher than the England average. Vulnerability is concentrated among children with SEN/SEMH needs (higher in Norfolk than nationally), looked after children, asylum-seeking children, and young carers. These patterns reflect a combination of early adversity, school pressures, barriers to inclusive practice and timely support, and socioeconomic disadvantage.

For working-age adults, the burden of mental illness is influenced heavily by economic and social conditions. Norfolk's depression prevalence has more than doubled in the past decade, aligning with national patterns of rising distress linked to insecure employment and high living costs. Lower local wages and high rates of rural and coastal deprivation amplify these pressures. The Small Area Mental Health Index (SAMHI) reveals pockets of high antidepressant prescribing, raising questions about access to talking therapies, capacity within primary care, and unmet prevention needs.

Among older adults, mental health intersects strongly with long-term conditions, frailty, pain, sleep disruption, caregiving responsibilities, loneliness and poverty. Norfolk's older demographic profile means these pressures affect a large and growing population segment. Loneliness is projected to rise by 30–40% over the next 15 years in some districts. Dementia prevalence is higher than national averages, yet diagnosis rates remain comparatively low, suggesting unmet need and barriers to access to diagnostic services. Older adults are less likely to seek help for mental health difficulties, meaning data on prevalence likely underestimates the true extent of need.

Across all age groups, inequalities in mental health closely reflect inequalities in material circumstances. The MHNA identifies several areas where mental health need is likely under-represented, particularly for co-parents, young adults and carers, not because of low help-seeking, but because local data collection is limited. For older adults, national and local evidence indicates that distress often does not translate into help-seeking, highlighting the concept of unmet felt need described in Bradshaw's taxonomy.

A key challenge is the lack of granular local data, including:

- perinatal paternal/co-parent mental health
- 18–25 mental health and transitions
- detailed ethnicity and deprivation breakdowns
- neurodiversity prevalence

Despite these limitations, the evidence clearly shows that improving mental health outcomes in Norfolk requires whole-system action that strengthens protective factors, reduces structural inequalities, and embeds prevention across the life course.

2 Introduction

Mental health and wellbeing are shaped throughout the life course, beginning before birth and continuing through childhood and adulthood. This health needs assessment explores the mental health and wellbeing of perinatal populations, children and young people, working age adults and older adults in Norfolk. It brings together national and local data to understand patterns of need, identify groups at higher risk of poor mental health, and highlight factors that support resilience and positive wellbeing.

The World Health Organisation defines mental health as “a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community.” Throughout this report, three terms are used:

- **Mental wellbeing** (positive functioning)
- **Mental illness** (diagnosed and undiagnosed mental health difficulties)
- **Mental health and wellbeing** (the continuum spanning both wellbeing and illness)

Mental health and wellbeing exist on a continuum, from positive mental wellbeing to severe mental illness.¹ **Mental illness**, as used in this report, refers to the full range of undiagnosed and diagnosed mental illness.² **Mental wellbeing** refers to the presence of positive emotional, psychological and social functioning such as the ability to manage stress, form relationships and engage meaningfully in daily life.³ In instances where survey sources apply their own definitions, original terminology has been retained and interpreted in line with the broader definitions set out above.

Mental health and wellbeing are influenced by a complex interplay of individual, social and environmental factors. While some risk and protective factors are strongly linked with mental health and wellbeing outcomes, this does not always mean one causes the other, as is the case in **causal relationships**. Nevertheless, **associations**, which are relationships that are not proven to be directly causal can also help identify risk or protective factors and guide timely interventions.

2.1 Understanding Mental Health Need

Many people experiencing mental illness do not access services, and routine data often only reflect those who reach crisis point or present to health or care professionals. As such, recorded data is likely to underestimate the true extent of need.

This health needs assessment draws on Bradshaw’s classification of need⁴, which includes:

- **Normative need** — identified by professionals or based on standards
- **Felt need** — needs experienced by individuals but not always expressed
- **Expressed need** — needs evidenced by people actively seeking help
- **Comparative need** — needs identified by comparing groups with similar attributes

Felt need is particularly important in mental illness but can be difficult to capture, especially in groups less likely to seek help from services. Thus, data may under-represent the level of felt need of mental illness. Some individuals may also only access care from community or private providers, whose data may not be public. This report mostly captures expressed need based on available data such as self-reported behaviours and recorded mental illness.

As such, the data in this assessment should be considered a partial representation of the true scale of mental health need.

2.2 A Life Course Approach

This health needs assessment takes a life course approach, recognising that mental health and wellbeing is not static but develops over time through the interactions of biological vulnerability, including genetic influences, and a range of experiences, exposures and transitions.^{5 6 7} These experiences begin before birth and continue through childhood, adolescence, adulthood and later life.⁸ At each stage, an individual's own experience and environment influence how they develop emotionally, how they cope with challenges, and what support they may need.⁹ A life course perspective allows us to examine how early risk and protective factors influence mental health outcomes across the lifespan.

This report focuses on four key population groups:

- **The perinatal population:** people during pregnancy and the first year after birth, including mothers and their partners or co-parents.¹⁰
- **Children and Young People (CYP):** from birth to the age of 18, including infants, school-aged children and adolescents. Young adults are defined as those aged 18–25 years; while they are legally adults, this age group is recognised as a key transition period for mental health and wellbeing.
- **Working age adults:** people aged 18 to 64 years. While age thresholds vary across datasets, this assessment adopts an 18–64 definition to align with legal adulthood and mental health service pathways.
Older adults: defined as those aged 65 and over, in line with age thresholds commonly used by national organisations such as NHS England, the Office for National Statistics and the Association of Directors of Public Health.

Analysing mental health across the life course helps identify where needs are most concentrated, where inequalities exist and where earlier intervention could reduce longer-term impacts.

2.3 Burden of Mental Illness

Mental illness is a significant contributor to poor health nationally and locally.¹¹ In 2023, mental illness accounted for 17% of all years lived with disability globally.¹² Local burden of disease estimates show an even more pronounced impact, indicating that mental illness accounted for 23% of years lived with disability, and was ranked first as a cause of years lived with disability in England and the East of England. An estimate specifically for Norfolk is not available.¹³

Mental illness can significantly impact child development, as well as an individual's ability to live well, work, study, and take part in family or community life. This highlights the large burden of mental illness on individuals and society, and the need for population-wide approaches to improve mental health and wellbeing in Norfolk. Key components of these approaches include prevention, early intervention and the promotion of mental wellbeing across the life course, beginning in the perinatal period and childhood.

Evidence suggests that around half of lifetime mental health disorders begin by the age of 14, and three quarters by the age of 24.¹⁴ The consequences of poor mental wellbeing, including self-harm and suicide, represent the acute end of the mental health spectrum and

can emerge early in life. These outcomes highlight the importance of creating strong foundations for lifelong mental health and wellbeing, from the earliest stages of childhood and beyond.

2.4 Approach to Mental Health and Wellbeing

This needs assessment takes a population-level approach, considering the full spectrum of mental health and wellbeing. It goes beyond need captured through formal diagnosis and highlights the importance of early, appropriate support.

The needs assessment does not review services in detail but rather provides a population-level overview of mental health and wellbeing needs, highlighting where unmet need exists and where future action may be most effective.

Each chapter begins with key findings and explores the relationship between mental health need, risk factors and protective factors, including examples of evidence-based interventions. It is important to note that risk and protective factors rarely occur in isolation. Individuals often experience multiple, overlapping influences that may interact in complex ways. For example, someone may face several risk factors such as poverty, poor housing, and family adversity, while also having protective factors like supportive relationships. Understanding the cumulative and interactive effects of these factors is essential for identifying opportunities for early action.

2.5 Data Sources and Modelling

This needs assessment draws on a wide range of national, regional and local datasets, supplemented by modelled estimates, where direct prevalence data is not available.

National data sources include large population surveys such as the Mental Health of Children and Young People Survey series, NHS Digital datasets, the Adult Psychiatric Morbidity Survey, Office for Health Improvement and Disparities (OHID) Fingertips indicators, Office for National Statistics (ONS) data releases, and national data on risk factors including obesity and smoking. These sources provide consistent information for understanding national patterns and benchmarking Norfolk against England. Flourish, a locally commissioned pupil survey based on the national The Schools and Students Health Education Unit (SHEU) survey, was used to understand wellbeing and experiences among children and young people in Norfolk.

Geographical footprint

This needs assessment was produced during a period of transition in Integrated Care Board (ICB) boundaries. The primary analytical footprint is Norfolk County Council, and data is presented at this level where available. However, for some datasets, the available geography at the time of analysis was specified as “Norfolk and Waveney registered [NHS Primary Care] and resident”. In these instances, the available geography has been clearly labelled.

Modelling Approach

Where direct prevalence data was unavailable, modelled estimates were used based on demographic weighting of national prevalence figures, ONS mid-year population estimates and relevant sociodemographic characteristics. This approach allows for local estimation in the absence of routine local prevalence data. While providing useful approximations of likely

need, this approach is limited by the availability and quality of input data and should be interpreted with caution, particularly where local contextual factors may differ significantly from national averages.

Confidence intervals are included to highlight uncertainty. Due to limitations in some datasets (e.g. under-reporting, small sample sizes, or missing demographic details), data presented may not fully reflect the true level of need, especially for underserved or underrepresented groups.

Microsoft Copilot was used to support drafting the executive summary, which was reviewed by the authors.

3 Perinatal Mental Health and Wellbeing in Norfolk

This chapter focusses on the perinatal period, defined as the period from pregnancy to one year after birth. This period has been selected as the starting point for the needs assessment due to strong evidence that early experiences play a critical role in shaping long-term mental health.^{15 16}

The perinatal period is recognised as a time of significant emotional and psychological changes.¹⁷ For mothers, it has been linked to both physical and psychological changes.¹⁸ This period is also important for a child's emotional development, parent-infant attachment, and helps lay the foundations for lifelong mental wellbeing.^{19 20} While many adapt well, others may be more vulnerable to experiencing mental illness.²¹ This chapter includes data on factors known to influence perinatal mental illness and protective factors for maternal mental wellbeing. Although national and local data remain limited, the chapter also recognises the growing evidence on paternal or co-parent mental health and wellbeing during this period.

3.1 Key findings

- Modelled prevalence suggests 27% (~2,120 in 2019) of women in Norfolk who have given birth experience a perinatal mental illness.
- Nationally, whilst rates of maternal deaths 6 weeks and 1 year postpartum are low, suicide was the leading cause in 2021–2023 (0.8 per 100,000) having increased compared with previous years.
- Younger mothers face higher risk, with around 40% of mothers aged under 25 experiencing perinatal mental illness.
- Up to one in four fathers may experience depression in the months following birth.
- Early pregnancy obesity remains statistically significantly higher in Norfolk (28.3%) than nationally (26.2%).
- Breastfeeding and skin-to-skin contact support maternal wellbeing and bonding, and paternal and co-parent mental health plays an important role but is under-recognised in pathways.

Gaps and Data Limitations

- Local perinatal mental illness prevalence is not routinely reported, particularly for paternal and co-parent mental health, and local understanding relies on modelled estimates derived from national datasets.

- Self-harm and substance use in pregnancy are largely self-reported, and likely under-ascertained. National estimates also exclude regions with low counts.

Why this matters in Norfolk

The perinatal period is recognised as a time of significant emotional and physical change which can place stress on parents, particularly mothers, and can affect infants, wider family members, and society.^{22 23} Depression is one of the common mental illnesses that occurs during the perinatal period.²⁴ Symptoms of perinatal depression may be difficult to distinguish from typical emotional changes but the distinguishing features are:^{25 26}

- Persistent and marked low mood, sadness and irritability
- Hopelessness
- Feelings of guilt and worthlessness
- Social withdrawal

Symptoms of maternal depression during the perinatal period have been associated with poor behavioural, attachment and cognitive outcomes in infants.²⁷ Untreated perinatal mental illness can affect a mother's ability to care for herself and her infant, as well as increase the risk of long-term adverse outcomes for the child.^{28 29}

Paternal or co-parent mental health also has an important influence on child development. Evidence shows that paternal mental illness during the perinatal period is associated with negative impacts on children's social, emotional, behavioural and language development.³⁰ Perinatal mental illness has broader economic and societal impacts; in 2014, the total cost in the UK was estimated at £8.1 billion, which included £1.2 billion annually to the NHS and social services.³¹

3.2 National Context

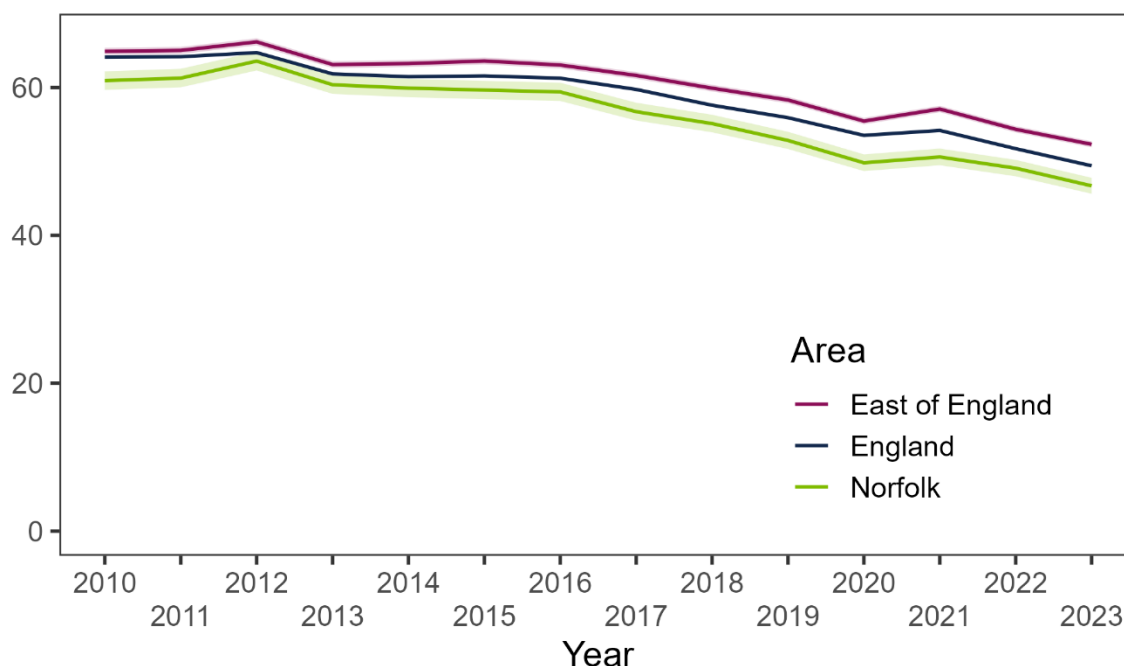
National data on perinatal mental illness remains limited. Modelled estimates from 2019 using Clinical Practice Research Datalink (CPRD) data suggest that nationally, 25.8% of women aged 15–55 who gave birth had a diagnosis or symptoms of perinatal mental illness recorded in their GP records.^{32 33}

While maternal mental health is often the primary focus, emerging evidence shows that the mental health of fathers and co-parents also plays an important role in family wellbeing.³⁴ The term 'co-parent' refers to any partner or parental figure involved in raising or caring for the baby, regardless of biological relationship, for example, separated parents or same-sex partners. A meta-analysis of studies from 1980 to 2009 estimated that 10% of fathers experienced depression during the perinatal period, with prevalence rising to over 25% between 3 and 6 months postpartum.³⁵

Birth trends have also shifted. In England, the number of live births per 1,000 women aged 15–44 (the General Fertility Rate) declined from 64.1 per 1,000 women in 2010 to 49.4 per 1,000 women in 2023 (Figure 1).³⁶

General fertility rate

Birth rate per 1,000 females
aged 15 to 44 years



Source: OHID Fingertips

Figure 1: General fertility rate per 1,000 females aged 15–44 in England, East of England and Norfolk from 2010 to 2023. Shaded areas show 95% confidence intervals.

Maternal mortality rates for deaths occurring between 6 weeks and one year after the end of pregnancy have increased nationally and were significantly higher in 2021–2023 compared with 2018–2020.³⁷ The leading cause of these late maternal deaths was psychiatric, which includes suicide and deaths related to drugs/alcohol.³⁸ Since direct prevalence data is limited, these patterns in maternal mortality may indicate a growing burden of perinatal mental illness, particularly in the postpartum period. More robust prevalence data is needed to understand this picture.

3.3 Local Data on Mental Health and Wellbeing

Local prevalence data for perinatal mental illness is not routinely collected. A modelled estimate applying national prevalence to Norfolk's demographic profile suggests that 26.6% of pregnant women in Norfolk in 2019 experienced a perinatal mental illness, significantly higher than the national model-based estimate of 25.8%.^{39 40} This corresponds to an estimated 2,119 women in the county. There was no statistically significant change in the model-based estimate for Norfolk between 2016 and 2019.⁴¹

In 2022, Norfolk's general fertility rate was 49.1 per 1,000 women aged 15–44, close to the national average of 51.9.⁴² Rates have declined locally from 60.9 per 1,000 in 2010.⁴³ If the modelled estimate for mental illness remains stable, a lower fertility rate would still represent a substantial proportion of women needing support. However, this assumes the prevalence model remains valid over time; local data is not available to confirm whether prevalence has changed over time.

3.4 Risk and Protective Factors

Perinatal mental health and wellbeing are influenced by a combination of biological, behavioural and social factors.⁴⁴ Some factors increase vulnerability to mental illness during pregnancy and the postnatal period, while others can buffer against risk and support resilience. These influences can be grouped into individual, family and wider societal factors.

Adverse childhood experiences (ACEs) are recognised contributors to poorer mental health outcomes across the life course. Several indicators in this chapter relate to ACE-associated risk factors, such as domestic abuse and substance use in early pregnancy. These factors can have intergenerational implications and are therefore considered within a whole family context, recognising the potential for parental experiences of adversity to affect both maternal and co-parent mental health and early child development.

Individual factors

History of mental illness

A history of mental illness is a significant risk factor for experiencing perinatal mental illness. Women with pre-existing depression and/or anxiety before pregnancy are more likely to experience symptoms during pregnancy and the postpartum period.⁴⁵ A systematic review and meta-analysis also found that mothers with a family history of psychiatric disorders had almost twice the risk of developing postpartum depression compared with those without such history, suggesting that both personal and familial mental health history contribute to increased vulnerability.⁴⁶

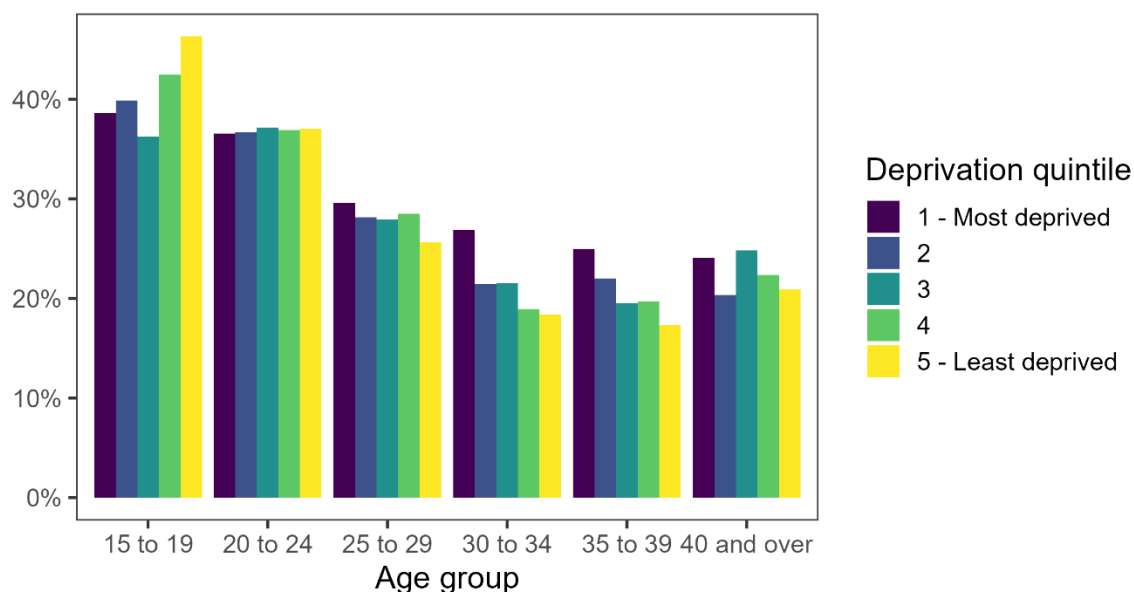
Age

Younger mothers, particularly those aged under 25, are more likely to experience mental illness (Figure 2).^{47 48} National estimates suggest that 40% of mothers in this age group will experience a perinatal mental illness.⁴⁹

Women of childbearing age make up a smaller proportion of Norfolk's population (16.7%) compared with England (19%).⁵⁰

Perinatal mental health conditions

Estimated prevalence (2016)

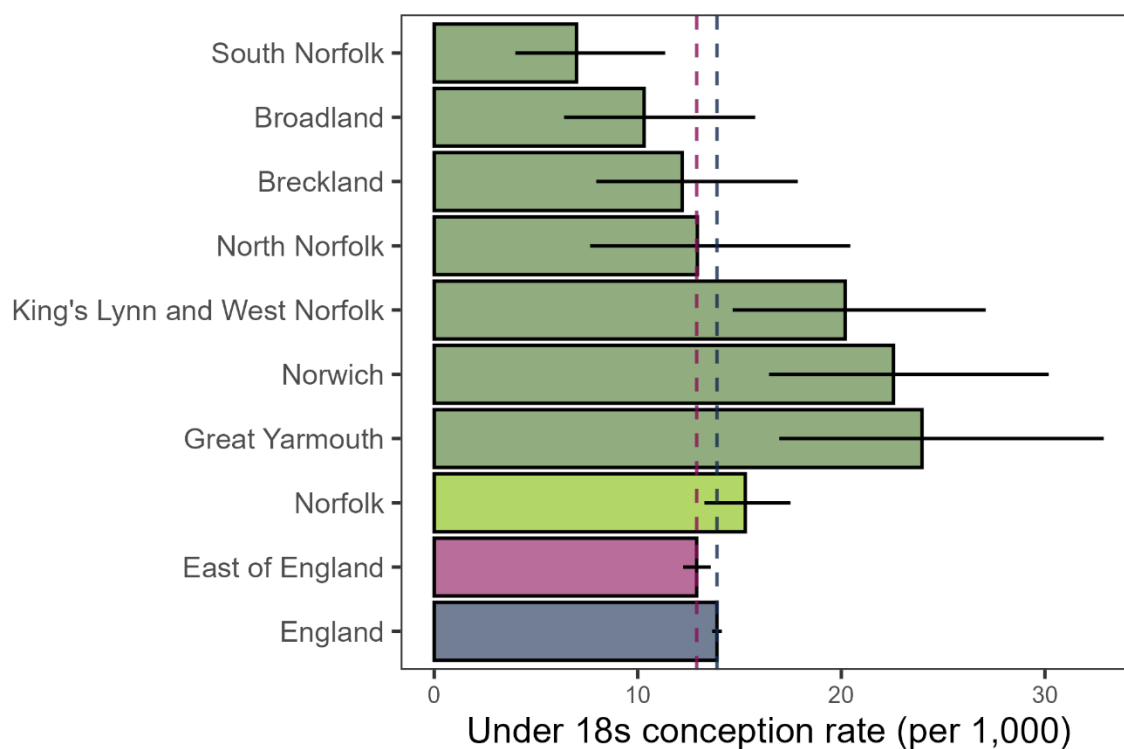


Source: OHID Fingertips, based on Clinical Practice Research Datalink (CPRD)

Figure 2: Estimated prevalence of perinatal mental health conditions across age groups and deprivation quintiles (based on the Index of Multiple Deprivation) in England in 2016.

In Norfolk, the number of live births for women aged under 18 has declined with national trends, falling from 11.3 per 1,000 females aged 15–17 in 2009 to 3.5 per 1,000 in 2022, similar to the national figure of 3.4 per 1,000 in 2022.^{51 52} However, conception rates vary between districts, although there is uncertainty around the rates at district level (Figure 3). This suggests that although overall rates have declined, younger mothers remain a locally relevant group who may be at increased risk of perinatal mental illness.

Under 18s conceptions



Source: OHID Fingertips

Figure 3: Conception rate of women under 18 across England, East of England, Norfolk and its different districts in 2021. Error bars show 95% confidence intervals.

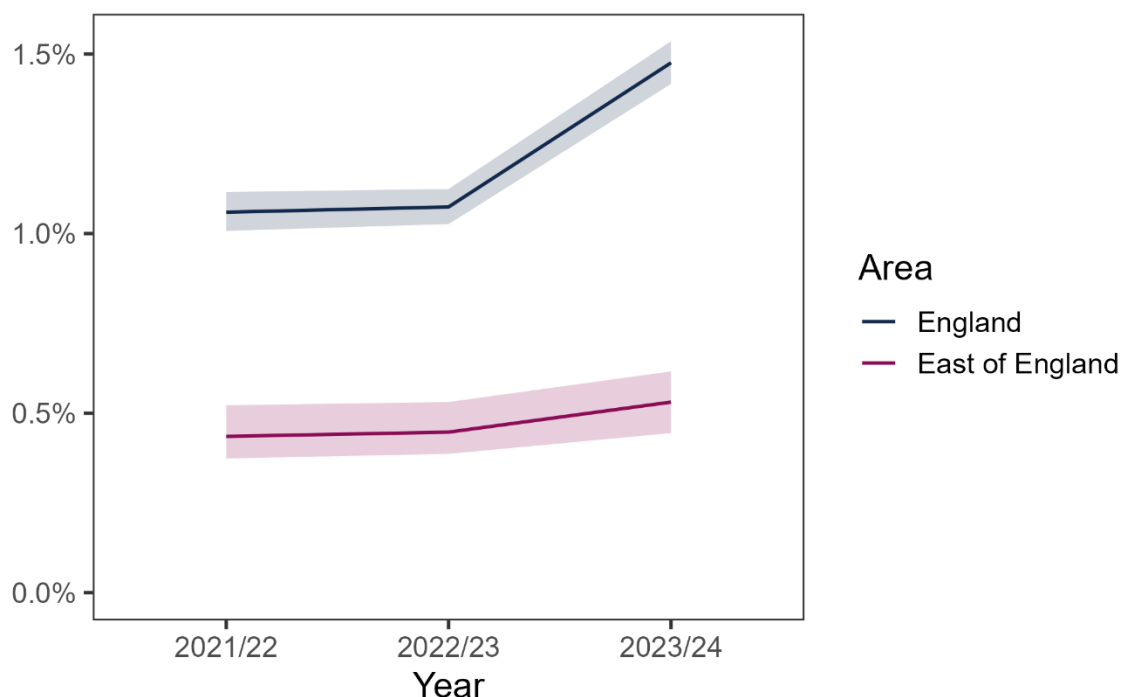
Physical health and health behaviours

Physical health and health behaviours during pregnancy are closely associated with mental health outcomes. Obesity is a recognised risk factor for both physical complications during pregnancy, including gestational diabetes and pre-eclampsia, and perinatal depression.⁵³ In 2023/24, 28.3% of women in Norfolk were recorded as obese in early pregnancy, significantly higher than the national average of 26.2%.^{54 55}

Substance use, alcohol consumption and smoking are also associated with poorer perinatal mental health outcomes, with evidence of a bidirectional relationship: mental illness can increase the likelihood of substance use, while substance use can exacerbate or trigger mental illness.^{56 57} Data on substance use is limited to regional level. In 2023/24, 0.5% of women in the East of England self-reported drug misuse in early pregnancy, lower than the England average of 1.5%.^{58 59} Drug use during pregnancy appears to be increasing nationally (Figure 4) while trends in the East of England remain comparatively stable.

Drug misuse in early pregnancy

% with drug misuse



Source: OHID Fingertips

Figure 4: Drug misuse in early pregnancy in East of England and England between 2021/22 and 2023/24. Shaded areas show 95% confidence intervals.

Alcohol use during early pregnancy is decreasing regionally.⁶⁰ In 2023/24, 1.6% of women in the East of England self-reported alcohol use in early pregnancy, significantly lower than the national average of 2.4% and a reduction from 8.1% in 2021/22.^{61 62}

Smoking during pregnancy is associated with an increased risk of depression both during and after birth as well as adverse outcomes such as low birth weight.^{63 64} In Norfolk, 13.9% of women smoked during early pregnancy in 2023/24, similar to the national average of 13.6%.⁶⁵ Locally, this figure is significantly lower than the 17.8% in 2022/23.⁶⁶ More information on smoking in Norfolk can be found in the Smoking and Tobacco Control JSNA.⁶⁷

It is important to note that data on substance use, smoking and alcohol consumption during pregnancy are likely to underestimate true prevalence as they are self-reported and collected early in pregnancy, for example at an appointment within the first 14 weeks of pregnancy.^{68 69} Pregnant women may have taken up smoking, using drugs or drinking alcohol at a later date or may not have disclosed their smoking status. Data quality of problematic drug use, alcohol intake and smoking during pregnancy is also limited by incomplete data collection in some regions. The national estimate does not include data from regions with low numbers and below data completeness thresholds.⁷⁰

Health literacy

Wider protective factors also include access to timely and appropriate healthcare. Health literacy, such as awareness of symptoms and available support underpins help-seeking and informed decision-making during the perinatal period.⁷¹

Parent-infant interaction and bonding

Early bonding and parent-infant interaction act as protective factors for maternal mental wellbeing. Breastfeeding and skin-to-skin contact are associated with improved maternal mental wellbeing and support bonding between mother and infant.⁷² Mothers who breastfeed up to 6 months postpartum are more likely to report fewer symptoms of depression and are more likely to bond with their infants.⁷³ Nationally, 55.6% of mothers breastfed their infants at 6 to 8 weeks in 2024/25, compared with 53.4% in Norfolk.⁷⁴ Breastfeeding can also be a source of stress for some women and families.⁷⁵ Difficulties with feeding can negatively impact parental mental health and increase feelings of guilt or inadequacy. Women experiencing perinatal mental illness are also more likely to report difficulties with breastfeeding.⁷⁶

Daily skin-to-skin contact may reduce maternal anxiety symptoms postpartum.⁷⁷ In England, 64.2% of mothers reported engaging in skin-to-skin contact after birth in 2017/18.⁷⁸

The first 1001 days from conception to age 2 represent a critical period that shapes infant's emotional development, and where early caregiver and infant relationships strongly influence lifelong mental health. Evidence shows sensitive, responsive caregiving supports emotional resilience, stress regulation and adaptive coping whereas insecure or disorganised attachment is linked to poor coping strategies, emotional dysregulation and an increased risk of persistent mental and physical health problems across the life course.⁷⁹

Family and relational factors

Partner relationships and family context

Supportive partner relationships can contribute to good perinatal emotional wellbeing and mental health.⁸⁰ While marriage or civil partnership status may influence access to emotional and practical support, poor quality of marital relationships can negatively impact perinatal mental health.^{81 82} In England in 2024, 52.9% of maternities were registered within a marriage or civil partnership, compared with 42.7% of maternities registered outside marriage or civil partnership with joint registration, and 4.4% with sole registration.⁸³ A significant proportion of births were therefore jointly registered by parents outside formal partnerships, reflecting varied family structures.⁸⁴ These variations highlight the importance of inclusive support systems that recognise and respond to diverse family contexts.

Domestic abuse

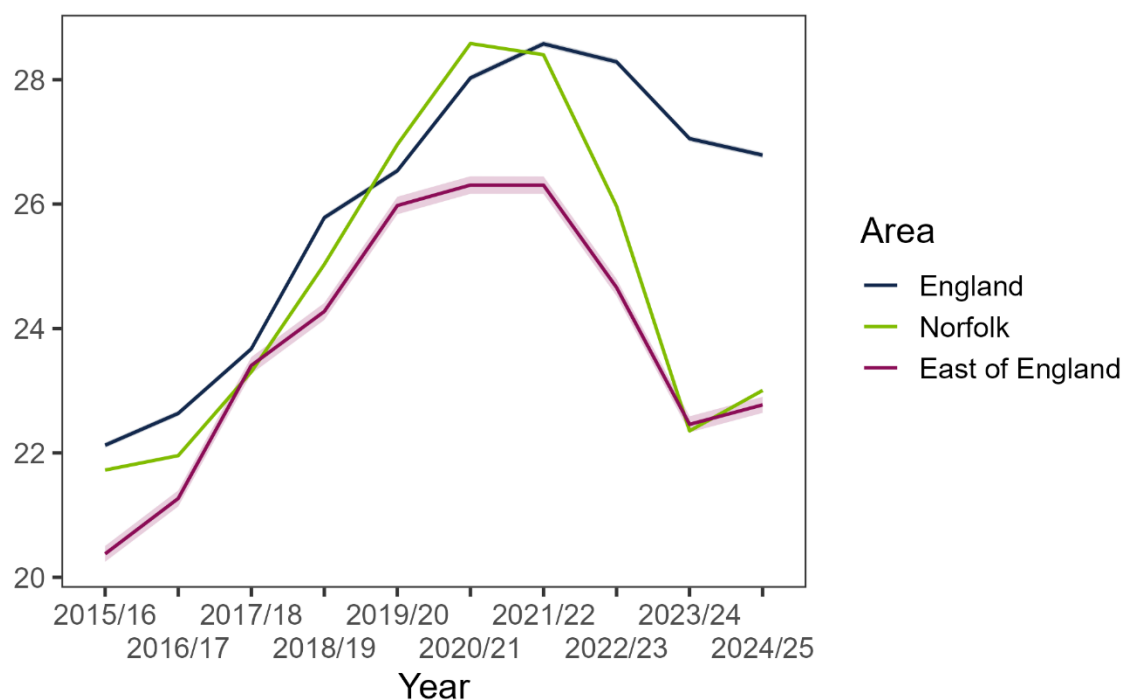
Domestic abuse during pregnancy is strongly associated with mental illness. Women who experience domestic abuse during pregnancy have a three-fold increased likelihood of postpartum depression, anxiety and PTSD.⁸⁵ In 2024/25, the reported rate of domestic abuse-related incidents was 23.0 per 1,000 people aged 16+ in Norfolk, compared with 26.8 per 1,000 nationally (Figure 5).⁸⁶ Although Norfolk's reported rate is lower than the national average, it is not clear whether this is statistically significant.

The Crime Survey for England and Wales estimated that between April 2024 and March 2025, 9.1% of women aged 16 and over experienced domestic abuse nationally.⁸⁷

When applied to the 2021 census, this represents almost 36,000 women over the age of 16 in Norfolk who may be at increased risk of mental illness because of experiencing domestic abuse.⁸⁸

Domestic abuse related incidents and crimes

Crude rate per 1,000



Source: OHID Fingertips

Figure 5: Trends of crude rates of domestic abuse related incidents and crimes recorded by the police in Norfolk, East of England and England between 2015/16 and 2024/25. Shaded areas show 95% confidence intervals (not available for Norfolk).

Paternal mental health and wellbeing

While maternal mental health is often the primary focus of perinatal care, co-parent mental health also plays a critical role in family wellbeing and child development.⁸⁹ A meta-analysis of 43 studies involving over 28,000 fathers estimated that 10.4% of men experience depression between the first trimester and one year after birth, rising to 25.6% in the 3–6 months postpartum period.^{90 91} These rates are approximately double the baseline 12-month prevalence of depression in the general male population.^{92 93} The same study found a moderate correlation between paternal and maternal depression, indicating that both parents may experience difficulties concurrently.⁹⁴

Co-parent mental health remains under-recognised, under-diagnosed and under-researched.^{95 96} Risk factors for paternal mental illness include younger age, low social support, financial insecurity and maternal mental illness. In England and Wales, the mean average age of fathers increased to 33.8 years in 2023 compared with 2022, while the mean average age of mothers remained at 30.9 years.⁹⁷ Protective factors for mental wellbeing of fathers include a supportive partner relationship, emotional and practical preparation for parenthood,

access to timely information on services, inclusion in perinatal care and mental health screening.⁹⁸

Social support and connectedness

Support from family and community networks is a key protective factor for perinatal mental wellbeing.^{99 100} A systematic review found that women with strong social connections are less likely to experience postpartum depression and anxiety.¹⁰¹ Family support can provide a buffer against stress and can help reduce perinatal depressive symptoms.¹⁰² For more information on social connectedness in Norfolk, please read the Social Isolation Needs Assessment.¹⁰³

Wider social and environmental factors

Socioeconomic circumstances

Socioeconomic deprivation is associated with poorer perinatal mental health and wellbeing.¹⁰⁴ Women living in more deprived areas have a higher risk of perinatal anxiety, which is linked to adverse outcomes for infants.^{105 106} Mothers in low-income households were found to be 1.69 times more likely to experience perinatal depression.¹⁰⁷

The Index of Multiple Deprivation (IMD) is a way to measure how deprived an area is relative to other areas.¹⁰⁸ It combines information on income, employment, education, housing, crime and the local environment to give each neighbourhood a score.¹⁰⁹ Areas can then be grouped into deciles from 1 (most deprived) to 10 (least deprived). The levels of deprivation vary across each district in Norfolk.¹¹⁰ According to the IMD 2025, 34% of the population in Great Yarmouth and almost 32% of the population in Norwich live in areas that are among the two nationally most deprived deciles (Core20 areas).¹¹¹ This is significantly higher than the national average of 20% and regional average of around 11% (Figure 6).¹¹²

Index of Multiple Deprivation (IMD)

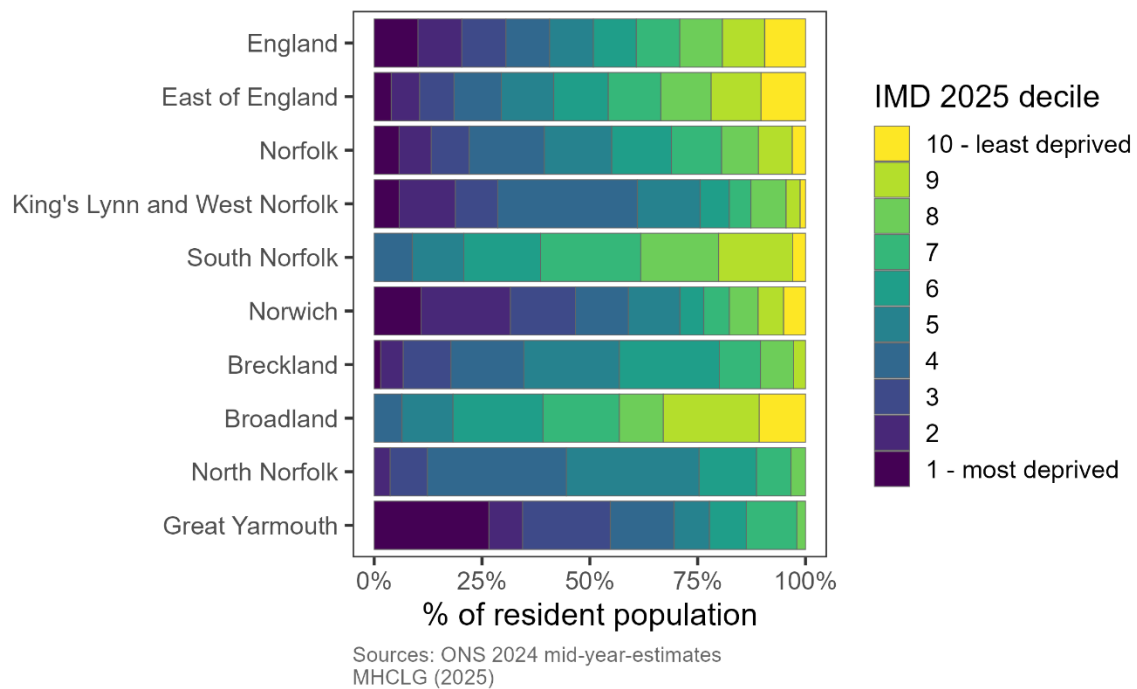


Figure 6: Distribution of the resident population by Index of Multiple Deprivation deciles across Norfolk districts, Norfolk, East of England and England in 2025.

Housing

Stable and secure housing plays an important role in supporting perinatal mental wellbeing. Stable living conditions can reduce stress, support emotional stability and enable better engagement with perinatal services.¹¹³ Conversely, unstable or insecure housing is associated with an increased risk of perinatal depression.^{114 115 116 117} For vulnerable or low-income families, housing stability may play a preventative role in reducing perinatal mental illness.

3.5 Approaches to Mental Health and Wellbeing in the Perinatal Period

Support for perinatal mental health is shaped by national frameworks such as the Healthy Child Programme, Best Start in Life, and All Our Health, which emphasise prevention, early identification and integrated delivery across maternity, primary care and early years settings. Within Norfolk, local delivery sits across the Integrated Care System's perinatal pathways, including maternity services, health visiting, primary care and specialist perinatal mental health provision. Community-based support, such as breastfeeding and infant relationship services also contribute to promoting wellbeing and strengthening early relationships.

3.6 Summary

Perinatal mental health and wellbeing in Norfolk are influenced by a range of individual, family and wider social factors. While overall birth rates have declined nationally and locally, the complexity of perinatal need is changing due to demographic factors such as maternal age and socioeconomic inequality. Younger mothers remain at higher risk of perinatal mental illness, with national estimates indicating that around 40% of mothers aged under 25 are affected. Norfolk generally aligns with national patterns across key indicators, though

higher levels of early pregnancy obesity and high levels of deprivation in Norwich and Great Yarmouth highlight local differences in risk.

A range of factors are associated with increased vulnerability to perinatal mental illness, including a history of mental illness, younger maternal age, obesity in early pregnancy and experience of domestic abuse. Protective factors include strong social support networks and early parent-infant interaction, such as breastfeeding and skin-to-skin contact, which may support maternal wellbeing and bonding.

There are gaps in routinely collected local data that limit detailed assessment of unmet need. In particular, data on the prevalence of maternal and paternal mental illness at local level, and information on key social determinants such as housing insecurity, are not consistently available. The absence of granular data by age, sex, ethnicity or deprivation makes it difficult to identify specific population groups who may be at greater risk.

4 Children and Young People's Mental Health and Wellbeing in Norfolk

This chapter explores the mental health needs of children and young people in Norfolk. For the purposes of this assessment, children and young people are defined as those aged up to 18, with young adults aged 18–25 also considered where relevant, reflecting the importance of this transition period for mental health and wellbeing. Much of the available data relates to children aged 8–16, with more limited routine data available for young adults aged 18–25. As a result, the primary focus of this chapter is on children and young people aged up to 18, with 18–25 year olds highlighted where evidence allows.

This chapter examines patterns of mental health and wellbeing, alongside risk and protective factors across individual, family, school, and community settings.

Alongside the perinatal period, children and young people have been selected as a starting point for the needs assessment due to strong evidence that early experiences are important in shaping long-term mental health.^{118 119}

4.1 Key findings

- National data indicate that around one in five children and young people aged 8–16 had a probable mental illness in 2023. This equates to approximately 18,400 children in Norfolk.
- Local Flourish survey findings show that around four in ten pupils report low wellbeing. The proportion of year 8 pupils reporting low wellbeing rose from 26.2% in 2017 to 45.8% in 2024.
- Modelled estimates indicate that more than 1,000 children aged 8–16 in Norfolk with a probable mental illness self-harmed in the previous four weeks. The hospital admission rate for self-harm among 10–24-year-olds in Norfolk is higher than the national rate.
- Girls aged 17–19 show a significantly higher risk of probable mental illness than boys.

- Looked after children, those with special educational needs and children living in low-income households experience greater mental health need.
- School absence and exclusion rates are key concerns. Nationally, close to one in three children with a probable mental illness missed more than 6 days of school, and school exclusion rates in Norfolk are higher than both regional and national averages. Locally, the Flourish survey indicated that one in six sampled pupils' mental health sometimes stopped them from going to school.
- Wider social conditions, including housing instability, poverty, and weak support networks, increase mental health and wellbeing needs among children and young people.

Alongside the areas of need highlighted above, several protective factors also contribute to positive mental health and wellbeing among children and young people in Norfolk. Physical activity is one such factor, with 49% of children and young people in Norfolk reported to be physically active. Findings from the Flourish survey show that pupils who report not having a trusted adult to talk to have lower wellbeing than those who do, highlighting the importance of supportive relationships. Social connectedness is also protective, with the Active Lives Survey finding that 57% of children aged 3–11 in Norfolk said they could trust people of a similar age “a bit”, while around 1 in 4 said they could trust them “a lot”.

Why this matters in Norfolk

Children and young people's mental health is a growing national concern, with significant long-term implications for education, employment, health and overall quality of life. Evidence suggests that the majority of mental health conditions begin early in life, with evidence suggesting that around half of lifetime mental health disorders begin by the age of 14, and three quarters by the age of 24.¹²⁰ This highlights the importance of early life experiences in shaping long-term mental wellbeing.

Without timely intervention and support, mental health difficulties in childhood and adolescence can persist into adulthood, widening inequalities and limiting life opportunities. In response to these concerns, the Children's Commissioner for England has emphasised the importance of early preventative action that addresses the underlying drivers of poor mental health.¹²¹

4.2 National Context

The Mental Health of Children and Young People in England 2023 survey estimates that around one in five (20.3%) children and young people aged 8–16 had a probable mental illness.¹²²

The Strengths and Difficulties Questionnaire (SDQ) was used in this survey to identify children who may have had problems with aspects of their mental health to such an extent that it impacted their daily lives.¹²³ Based on responses from parents and children and young people, each child or young person was grouped into one of three categories that reflected the likelihood that they might have a mental disorder. These were ‘unlikely’, ‘possible’ and ‘probable’.¹²⁴ Those in the probable category are more likely to meet the criteria for a mental health disorder.¹²⁵

The prevalence of probable mental illness has increased since 2017, when 12.5% of children were estimated to have a probable mental illness.¹²⁶ In 2023, prevalence rates were

similar for boys and girls aged 8–16. However, marked differences emerge in later adolescence, with significantly higher rates among girls aged 17–19 (31.6%) compared with boys of the same age (15.4%).¹²⁷

Teenage girls are more likely to experience mood disorders, and eating disorders appear to be more prevalent in this group.¹²⁸ In 2023, 77.5% of girls aged 17–19 screened positive for a possible eating disorder, an increase from 60.5% in 2017. Although prevalence remains higher among girls, rates have also increased among boys over the same period, from 29.6% to 42.3% of survey respondents.¹²⁹

Children living in the most deprived areas, particularly those with parents in receipt of disability benefits showed higher rates of probable mental illness, highlighting the influence of socioeconomic circumstances on children's mental health.¹³⁰

Children and young people's wellbeing also continues to be a concern. In 2023, around 5% of children aged 10–15 in the UK reported low life satisfaction or low feelings that life is worthwhile, indicating broader challenges to wellbeing beyond mental illness.¹³¹

4.3 Local Data on Mental Health and Wellbeing

As of mid-2023, an estimated 179,509 children and young people aged 0–18 were living in Norfolk.¹³² National survey data from 2023 were modelled by applying mid-year population estimates based on the specific year to Norfolk.¹³³ Modelled estimates suggest that around 18,380 children (20.2%) in Norfolk aged 8–16 would screen positive for a probable mental illness (Figure 7).¹³⁴

Local survey data indicate higher levels of reported need. The 2024 Norfolk Flourish survey, based on responses from 9,347 pupils in 28 primary schools and 17 secondary schools, found that 4 in 10 children reported low mental wellbeing. This is higher than the prevalence suggested by national estimates (20.2%) and reflects differences in the concepts being measured, with Flourish capturing self-reported wellbeing rather than probable mental illness.

The Flourish survey also shows a worsening pattern over time. Although average wellbeing scores have not changed dramatically between 2017 and 2024, the overall distribution has shifted closer to the threshold for 'low' wellbeing. As a result, in 2017 there were many pupils who were just above the threshold whereas in 2024 more fell just below it. The largest rise was among year 8 pupils, where the share classified as having low wellbeing increased from 26.2% in 2017 to 45.8% in 2024. This pattern occurs at a time of major brain development which leads to hormonal changes as well as the emotional, cognitive and behavioural characteristics of the teenage years and may heighten sensitivity to stress during early secondary school.¹³⁵ A national study of over 100,000 pupils found a sharp and sustained decline in school enjoyment during the transition from primary to secondary school.¹³⁶ The study is cross-sectional and does not capture comparable data to show the views of pupils over time. Average enjoyment scores fall markedly between year 6 and year 7, decline further in year 8 and do not recover in later years. This decline occurs alongside reduction in pupils' reported trust, sense of agency, feelings of safety and perceptions of inclusion, with the first year of secondary school identified as a critical point at which engagement deteriorates, particularly for girls and pupils from disadvantaged backgrounds. The study found little evidence of gender differences in responses among primary school pupils, but

among those in secondary school, girls were more likely to express worry about school than boys and less likely to feel safe and to trust their peers and teachers. However, boys and girls reported similar levels of enjoyment of secondary school.

Figure 7: Norfolk modelled estimates of number of children aged 8–16 with possible and probable mental illness over time based on national survey for mental health in children and young people (2017–2023).¹³⁷

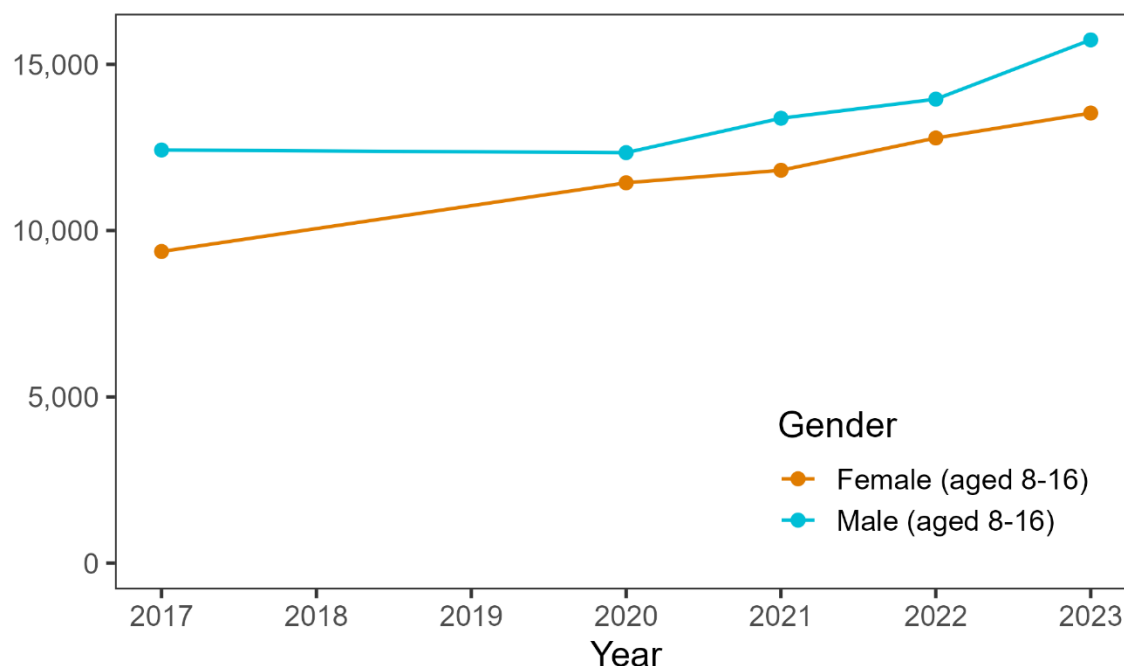
Self-Harm in children and young people

Self-harm refers to intentional self-injury or self-poisoning.¹³⁸ While distinct from suicide, self-harm is associated with increased risk of subsequent suicide, and repetition of self-harm further increases this risk.¹³⁹ The risk is particularly elevated by between 30- to 100-fold in the year following hospital admission for self-harm, compared with the general population.¹⁴⁰ Among coroner's inquest files reviewed for the 2024 Norfolk suicide audit, self-harm and/or suicide attempt was a risk factor present in 54% of suicides.¹⁴¹

Although self-harm data is subject to underreporting and presentation bias, self-harm remains a widely used indicator of the burden of mental illness in children and young people. People with mental illness are more likely to self-harm, die younger and on average lose

CYP mental health

Estimated number of children in Norfolk with a possible or probable mental health disorder



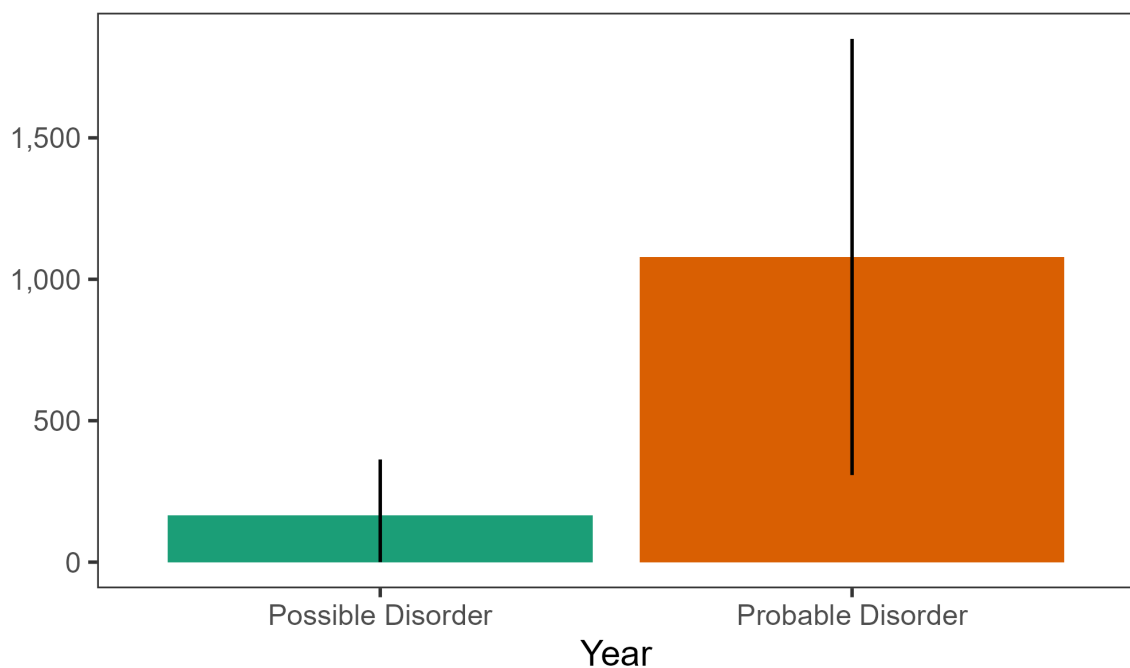
Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

around eight years of life.¹⁴²

Figure 8: Modelled estimates showing the number of children with possible or probable mental disorder in Norfolk who have tried to harm themselves (2023).¹⁴³

CYP mental health and self-harm

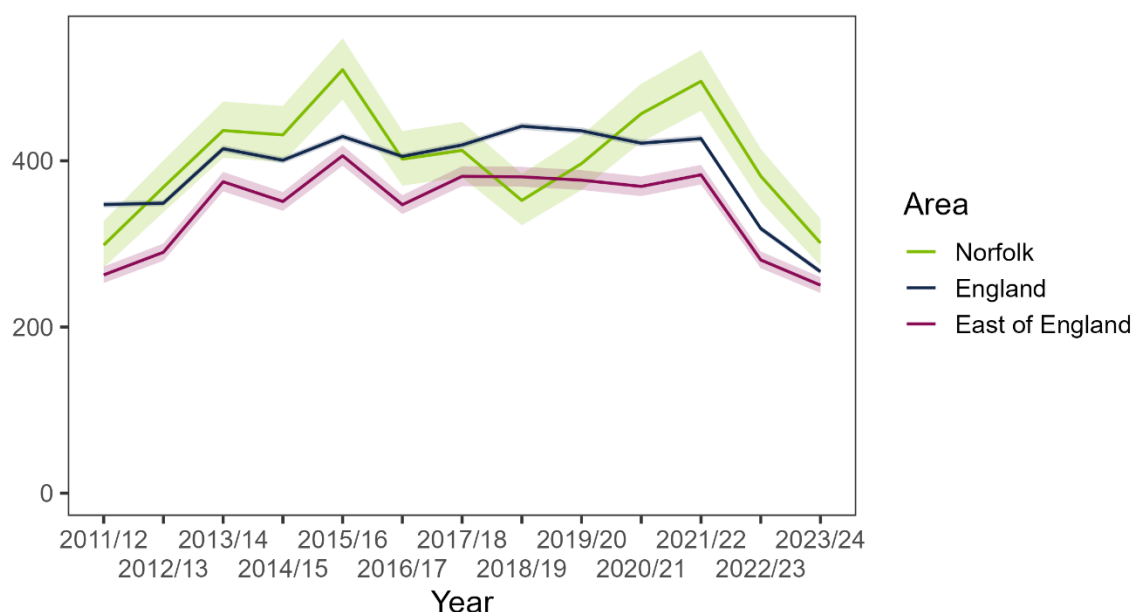
Estimated number of children in Norfolk aged 8–16 with a possible or probable mental health disorder who have tried to harm themselves



Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

Hospital admissions as a result of self-harm

DSR per 100,000 population (10–24 yrs)



Source: OHID Fingertips

Figure 9: Rates of hospital admissions as a result of self-harm for 10–24-year-olds in Norfolk, East of England and England (2011/12–2023/24). The shaded areas show 95% confidence intervals.

Modelled estimates for 2023 suggest that more than 1,000 children aged 8–16 who had a probable mental disorder had tried to harm themselves in the four weeks prior (Figure 8).¹⁴⁴ Hospital admission data also indicate elevated levels of self-harm locally. In 2023/24, the rate of hospital admission for self-harm among 10 to 24-year-olds in Norfolk was 301.1 per 100,000 people, which was statistically significantly higher than the national average of 266.6 per 100,000 (Figure 9).¹⁴⁵ Decreasing rates nationally and locally are related to a reporting change. Since 2020/21 acute hospitals are transitioning from recording Same Day Emergency Care activity within Admitted Patient Care data to the Emergency Care Data Set. The Norfolk and Norwich University Hospital was among early adopters, whereas the two other acutes in Norfolk transitioned later.

Although emergency hospital attendances and admissions are a selective subset of all self-harm, these healthcare interactions can provide insight into risk factors for self-harm (Norfolk and Waveney Self-Harm Report). In a pilot study which looked at A&E attendances for self-harm at Norfolk and Norwich University Hospital, the most commonly reported antecedents of self-harm were poor mental health, relationship and family difficulties, and substance use issues. Teenage girls had the highest rates of self-harm-related A&E attendances, and self-poisoning was by far the most common method for self-harm. Around 30% were repeat attendances by the same patient within a given year. Of all individuals who attended A&E for self-harm, around 20% attended multiple times in the same A&E department within a given year.

4.4 Risk and Protective Factors

Children and young people's mental health is shaped by interacting biological, psychological, social and environmental factors. Some increase vulnerability whereas others buffer risk and build resilience.

Individual factors, health and development

Each child brings a unique set of characteristics such as biological predisposition, temperament and personal experiences that may affect their risk of mental illness.¹⁴⁶ Those living with chronic physical health conditions, disabilities or special educational needs (SEN) are at increased risk of anxiety, depression and behavioural difficulties.

Children with chronic health conditions

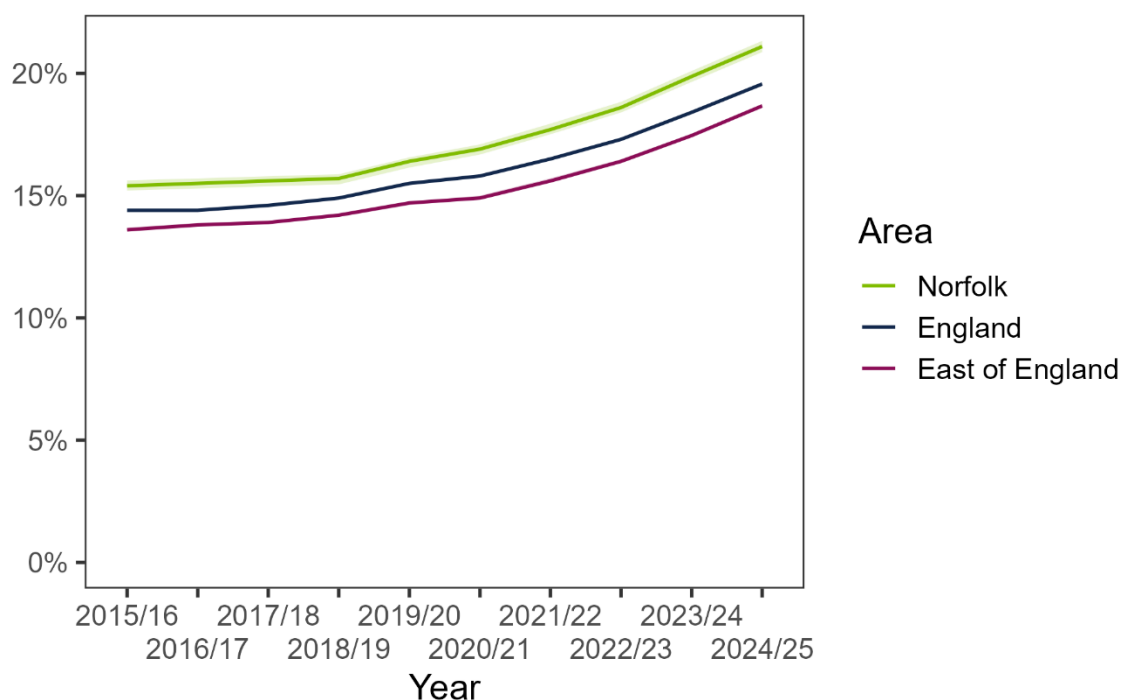
Children with chronic health conditions may be more likely to experience anxiety, depression and behavioural difficulties due to the emotional and physical strain of managing long-term illness.¹⁴⁷ Approximately 15% of children aged 0 to 18 who are registered and resident in Norfolk and Waveney have a chronic health condition, equivalent to 30,700 children. This group may therefore represent a substantial population with increased vulnerability to poor mental health.

Children with special educational needs (SEN) and learning disabilities

Children with special educational needs (SEN) and learning disabilities are also at increased risk of experiencing poor mental health (Figure 10).^{148 149 150 151}

Special educational needs

Percentage of school pupils



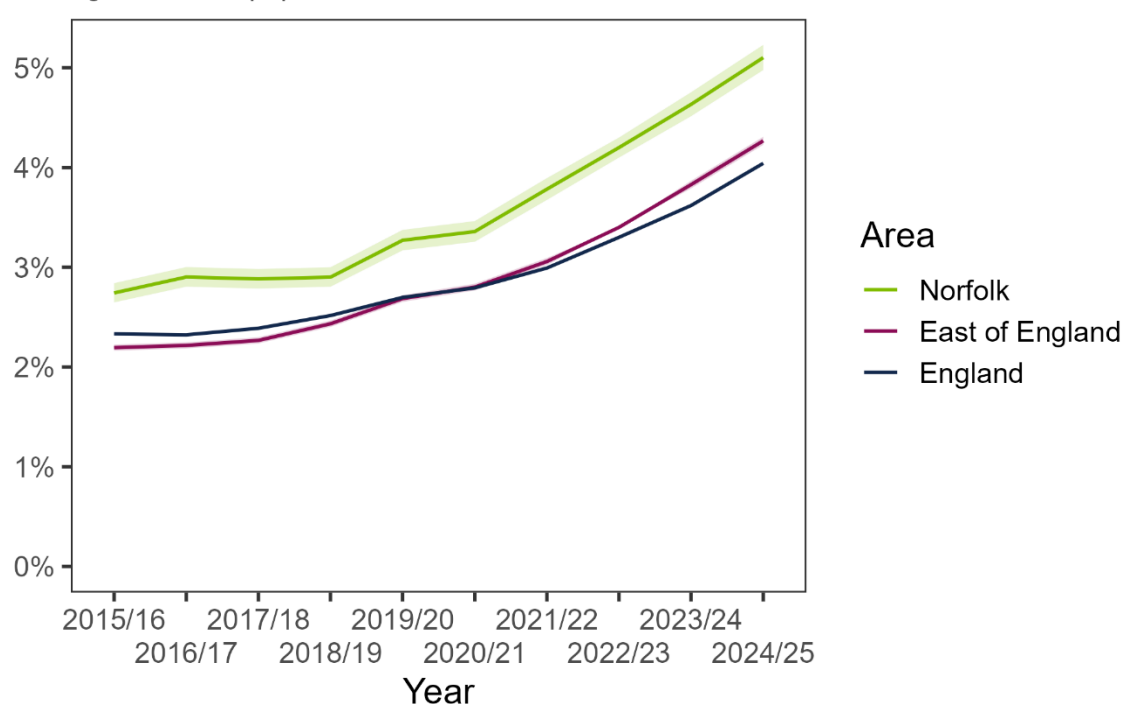
Source: OHID Fingertips

Figure 10: Percentage of pupils with special educational needs in Norfolk, East of England and England (2015/16–2024/25).¹⁵² The shaded areas show 95% confidence intervals.

In Norfolk, there has been a rising trend in social, emotional and mental health (SEMH) needs over time, relative to both England and the East of England (Figure 11).¹⁵³ 21.1% of school pupils had an Education, Health and Care (EHC) plan or were receiving special educational needs (SEN) support in 2024/25.¹⁵⁴ This is significantly higher than the national average and appears to be increasing.¹⁵⁵ In the same year, 5.1% of school pupils were recorded as having SEMH needs, compared with a national average of 4.0% (Figure 11).¹⁵⁶ This elevated rate is not fully explained by levels of deprivation, which are broadly average in Norfolk, suggesting other contributing factors. These may include the smaller size of schools, structure of schools and/or recording practices, which may limit capacity to support diverse needs, as well as longer times to diagnosis that may delay access to appropriate interventions.¹⁵⁷ Additionally, not all pupils with Education, Health and Care (EHC) plans meet formal SEN criteria, indicating a broader issue linked to educational and emotional need.

Social, emotional and mental health needs

Percentage of school pupils



Source: OHID Fingertips

Figure 11: Percentage of male school-age pupils with social, emotional and mental health needs (2015/16–2024/25).¹⁵⁸ The shaded areas show the 95% confidence intervals.

A dedicated Joint Strategic Needs Assessment for children and young people with Special Educational Needs and/or Disabilities (SEND) in Norfolk was published in 2025 and provides a comprehensive overview of prevalence and need for children and young people aged 0–25. The SEND JSNA highlights that children and young people with SEND in Norfolk experience additional barriers and challenges, particularly with their mental health, compared to those without SEND. It also highlights the intersection between SEND, socioeconomic disadvantage and educational attainment. Further detail is available in the Norfolk SEND JSNA.¹⁵⁹

Language and communication challenges also co-occur with mental health problems though the mechanisms behind this relationship remain unclear¹⁶⁰. Poor language skills are common in children with emotional behavioural disorders. Developmental language disorders are associated with anxiety and depressive symptoms in young adulthood. Evidence also shows an association between past early language challenges and anxiety or social phobia disorders among adults¹⁶¹.

Neurodiversity

While neurodevelopmental conditions such as autism and ADHD are not mental illnesses, neurodivergent children and young people may face additional challenges that increase vulnerability to poor mental health, such as difficulties accessing appropriate adjustments in school. National evidence suggests inequalities in identification and support; for example, children from less advantaged backgrounds may be less likely to have caregivers report that ADHD symptoms impact their daily life, and those from economically inactive households may be less likely to receive medication following diagnosis.¹⁶² Emerging research also highlights that families sometimes pursue diagnosis primarily to access school-based support or adjustments that could be provided on a needs-led basis.¹⁶³ Proposed SEND reform policy, including the introduction of the Inclusive Mainstream Fund for schools from 2026/27, aims to strengthen inclusive mainstream provision so that earlier support can be delivered without reliance on diagnosis or statutory process.¹⁶⁴ Some parents also feel that teachers lack training in recognising and supporting neurodiversity, which may contribute to unmet emotional and educational needs. This suggests that some neurodivergent children who do not have, or do not pursue, a formal diagnosis may not receive the support they need. A national independent review launched in 2025 is expected to provide further clarity on prevalence, inequalities and pathways. Given these uncertainties, and limitations in the availability of population-level data, this needs assessment focuses on mental health outcomes, with neurodiversity noted as a related area where future consideration may be required to understand local needs and inequalities more fully.

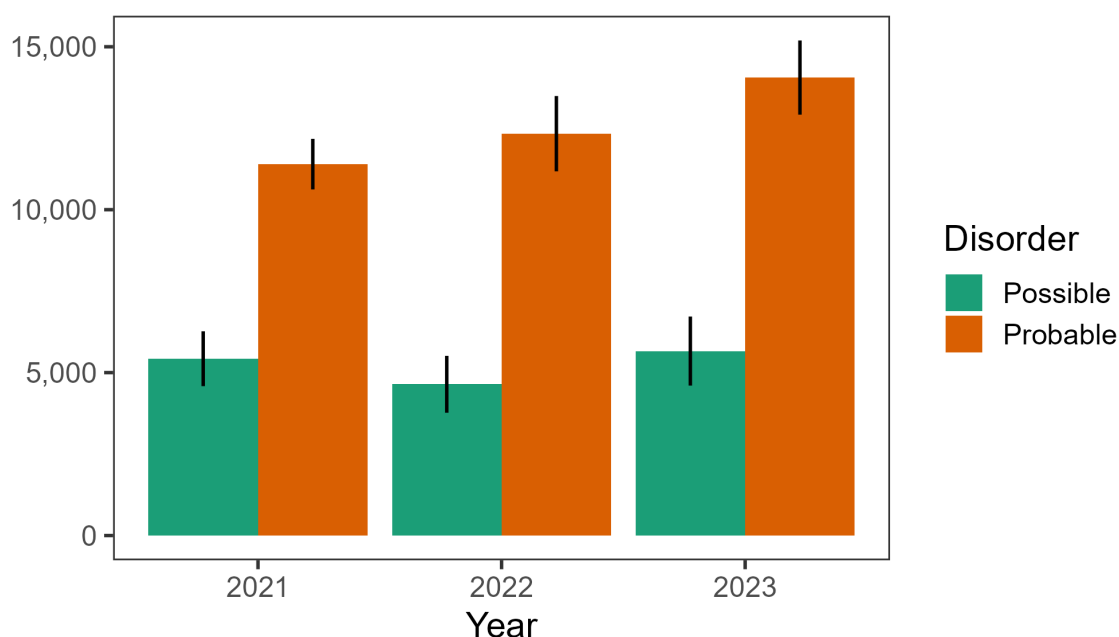
Sleep

Sleep is a key factor in children and young people's mental health. Research shows that poor sleep is associated with increased risk of depression, anxiety, low self-esteem, and emotional regulation difficulties, especially in adolescents.¹⁶⁵

Sleep disturbance can be influenced by factors such as overuse of mobile phones, social media stress, and cyber-victimisation.¹⁶⁶ In some studies, changes in sleep behaviour explained up to 73% of the impact of night-time mobile phone use on low mood.¹⁶⁷

CYP mental health and sleep

Estimated number of children in Norfolk aged 8–16 with a possible or probable mental health disorder experiencing 3+ nights of sleep problems



Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

Figure 12: Modelled estimates of the number of children in Norfolk who have a possible or probable mental disorder experiencing 3+ nights of sleep problems (2021–2023). (77)

Children aged 6–12 are recommended to have 9–12 hours of sleep and those aged 13–18 years are recommended to have 8–10 hours of sleep.¹⁶⁸ The Flourish survey found that in Norfolk almost 1 in 4 reported that they never sleep well.¹⁶⁹ Modelled estimates for Norfolk indicate that from 2021 to 2023, there was an increase in the number of children experiencing three or more nights of sleep problems and who had a possible or probable mental disorder (Figure 12).¹⁷⁰

Resilience

Alongside these risks, individual protective factors play an important role in supporting children and young people's mental wellbeing. Resilience is a dynamic process that emerges from the interaction of biological, psychological, social and environmental influences.¹⁷¹ It supports recovery from adversity and helps young people to maintain wellbeing.^{172 173} Key factors that support resilience such as optimism, problem-solving and self-efficacy can enhance the ability to manage stress and adapt to challenges.¹⁷⁴

Diet, nutrition and physical activity

Health promoting behaviours are also important protective factors for mental health.^{175 176} Nutrition supports emotional resilience, mood regulation, wellbeing and energy levels.^{177 178} Improved physical activity is associated with better cognitive health, performance and reduced risk of depression.^{179 180} In England, an estimated 47% of children aged 5–16 took part in sports and/or physical activity for more than 60 minutes a day in 2023/24.¹⁸¹

In Norfolk, 49.4% of children and young people were reported as physically active, which was similar to national trends.¹⁸² However, inactivity remains a concern: 30.3% of children were active for an average of less than 30 minutes a day during the academic year 2023/24, and 35% of those children were not active at all on a typical day.¹⁸³ Among less active children, the proportion who were not active at all has increased since 2017/18 from 24.6% in Norfolk.¹⁸⁴

Levels of overweight and obesity are also relevant to both physical and mental wellbeing. Higher levels of overweight and obesity affect children's wellbeing because they can increase vulnerability to low self-esteem, body-image dissatisfaction, and experiences of stigma and bullying which may lead to social isolation and feelings of worthlessness, which increases the risk of developing depression.¹⁸⁵ Evidence also suggests the relationship is bidirectional; emotional distress can lead to unhealthy coping behaviours such as emotional eating, poor sleep and inactivity, which may contribute to further weight gain, creating a self-reinforcing cycle of worsening mental and physical health. In Norfolk, 35.1% of children aged 10–11 were classified as overweight or obese in 2023/24, similar to the national average.¹⁸⁶ Among reception age children, 22.1% were overweight or obese, again consistent with national levels¹⁸⁷

Oral Health as a Protective Factor of Children and Young People's Mental Wellbeing

Oral health is an important component of children and young people's overall wellbeing. Maintaining good oral hygiene reduces the risk of dental decay, gum disease, and associated pain or infection, which can affect eating, sleeping, concentration, and daily functioning. Evidence also links poor oral health with lower self-esteem, especially during adolescence, as well as unhappiness, shyness, and feelings of worthlessness.¹⁸⁸ In 2023, it was estimated that 12.2% of children aged 10–15 would rate their happiness with their appearance as low.¹⁸⁹

In Norfolk, 21.3% of children aged 5 were identified with visually obvious dental decay in 2023/24.¹⁹⁰ This figure is similar to the national average and represents an increase from 15.4% in 2016/17.¹⁹¹

Vulnerable groups of children and young people

Certain population groups face a higher risk of mental illness due to greater exposure to adversity and structural disadvantage.

Looked after children

'Looked after' is the legal term for any child who comes into the care of their local authority. Looked after children have higher rates of mental illness than their peers due to experiences both before and during care.¹⁹² Nationally, around 70 per 10,000 children are looked after, and abuse or neglect remains the most common reason for entering care.^{193 194}

Experiencing abuse or neglect increases the risk of a child experiencing symptoms of trauma with long term impacts on mental and physical health. Increased levels of uncertainty and insecurity due to moving into care can also be a traumatic experience, and changes in placements can impact relationships.¹⁹⁵

In Norfolk, 68 per 10,000 children were classed as looked after in 2024, equivalent to 1,152 children and similar to the national average.^{196 197} Local data indicates substantial mental

health need within this group. Data on looked after children's wellbeing measures the proportion of looked after children aged 5–16 who have been in care for at least 12 months and have a Strengths and Difficulties Questionnaire (SDQ) score of 17 or over, suggesting emotional wellbeing concerns. In 2023/24, 48% of looked after children in Norfolk had emotional wellbeing concerns based on SDQ scores, significantly higher than the national average of 41%.¹⁹⁸ There has been an upward trend over the past five years, with the proportion increasing from 44% in 2021 and 2022 to 48% in 2023 and 2024, reaching 49% in 2025.¹⁹⁹

Most looked after children are cared for in foster placements.²⁰⁰ A systematic review of research on children in foster care aged 0–18 in Western countries (not including the UK) found that foster children had higher rates of mental illness than the general population.²⁰¹ The most common diagnoses were oppositional defiant disorder/conduct disorder, major depressive disorder and post-traumatic stress disorder.²⁰² One of the studies reviewed found that children in foster care who were in a group home were seven times more likely to have symptoms of depression compared with those who were living with a relative.²⁰³

Stability, safety and trusted relationships with carers are important for the emotional wellbeing of children in care. National evidence indicates that shortages of foster placements are increasing demand for children's homes and supported accommodation.²⁰⁴ In residential settings, stability is shaped not only by placement continuity but also factors such as staff turnover and co-resident dynamics. Unplanned moves and placement breakdowns are consistently associated with poorer outcomes.²⁰⁵ Placement instability is associated with double the risk of mental health problems.²⁰⁶

Children of parents with health conditions

Children of parents with chronic health conditions or with mental illness also may experience poorer mental health and wellbeing.^{207 208} The most recent data showing the number of children in need due to parent disability or illness was from 2018 and found that in Norfolk 55 children were in need.²⁰⁹ This local rate of 3.2 per 10,000 in 2018 was significantly lower than the national average 8.8 per 10,000 children in 2018.²¹⁰

Children living with parents who experience poor mental health are at an increased risk of emotional and behavioural challenges. A longitudinal study in Scotland found a statistically significant relationship between maternal mental health and children's social, emotional and behavioural development.²¹¹ Prolonged exposure to poor maternal mental health increased the likelihood of poorer outcomes around emotional wellbeing, cognitive development, behaviour and social relationships. Poor paternal mental health is also associated with increased risk of mental health difficulties in children. Evidence suggests that children exposed to paternal depression in both prenatal and postnatal periods have higher risks of early behavioural problems, independent of maternal depression.²¹²

Young carers

Although research on young carers is limited, an international systematic review published in 2022 found that, on average, young carers have poorer mental and physical health than their peers, particularly those providing more intense levels of care. This includes more symptoms of anxiety and depression, lower self-esteem, poorer health-related quality of life,

and greater likelihood of reporting chronic mental health conditions compared with their peers.²¹³

Local evidence also suggests that young carers in Norfolk face particular challenges. Flourish survey findings showed that participants who identified as young carers were more likely to report low mental wellbeing than pupils who are not carers.

A Healthwatch Norfolk report on carers of adults with serious mental illness also found that young carers are often not recognised by adult services, may lack appropriate support and do not receive sufficient information to help them understand the mental health needs of the person they care for.²¹⁴ These factors may contribute to increased stress and emotional burden among young carers.

Asylum-seeking children

Asylum-seeking children often face additional risks related to trauma, displacement, or family separation and uncertainty around immigration status.²¹⁵ An international systematic review and meta-analysis published in 2020, pooling data from 26 studies involving over 5,000 refugees and asylum-seeking children, found an 11% prevalence of anxiety disorders and a 1.5% prevalence of psychotic disorders.²¹⁶ Rates of PTSD and depression in this group have been reported at 31.5%, significantly higher than in the general population. In 2024, there were 1,152 supported accompanied and unaccompanied asylum-seeking children in Norfolk.²¹⁷ This does not include those in short-term accommodation nor those supported by the local authority.

Young people who are Not in Education, Employment or Training (NEET)

Mental ill-health is a recognised risk factor for young people becoming NEET. In Norfolk, 5.2% of 16–17-year-olds are NEET, similar to the England average of 5.4%.²¹⁸ Although local authority data is not available for 16–24-year-olds, modelled estimates suggest that around 11,800 (13.3%; based on 2024 mid-year population estimates) young people aged 16–24 in Norfolk are NEET.²¹⁹ Evidence from European systematic reviews show that prior or existing mental health and neurodevelopmental conditions are strongly associated with becoming NEET and with dropping out of secondary education.²²⁰ The National Centre for Social Research's analysis similarly identifies poor mental health as one of the five strongest predictors of NEET status in England.²²¹ The Health Foundation reports that in 2025, mental health conditions and autism accounted for over two thirds of NEET young people who said poor health was a barrier to working.²²² These findings highlight the importance of early support and identification to prevent disengagement from education and to promote a smoother transition into work.

Family relationships and early experiences

Family environments play a central role in shaping children and young people's mental health. Parental separation and divorce have been associated with increased risk of mental illness in children and young people.²²³ A meta-analysis of over 500,000 participants found that parental divorce was associated with a 29% higher risk of depression, a 12% higher risk of anxiety, and a 35% higher risk of suicide attempts compared with those whose parents did not divorce before their child was 18.²²⁴ These increases in risk were statistically significant.²²⁵ According to the 2021 census, there were 22,961 lone parent households with dependent children in Norfolk.²²⁶

While family changes such as parental separation can increase emotional vulnerability, the quality and consistency of relationships within the family are more important than structure alone. Stable, positive and affectionate parenting, consistent discipline, and support for learning are protective for children's emotional wellbeing.²²⁷ Shared family routines such as regular meals are also associated with better mental health outcomes.²²⁸ Evidence suggests that children who eat more frequently with their families report fewer depressive symptoms, reduced emotional difficulties and improved wellbeing.^{229 230}

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) refer to potentially harmful events occurring before the age of 18. ACEs include experiencing abuse, neglect and household dysfunction. They include five forms of direct harm:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Emotional neglect
- Physical neglect

ACEs also include growing up in a household where:

- There are adults with drug and alcohol problems
- There are adults with mental health problems
- There is domestic violence
- There are adults who have spent time in prison
- Parents have separated

It is recognised that many other traumatic experiences could impact health and wellbeing, such as experiencing homelessness, not having enough to eat, or unstable housing.

Exposure to ACEs is strongly associated with poor mental health across the life course.²³¹ ACEs have been linked with increased risk of depression, substance use, behavioural disorders and antisocial behaviour.^{232 233} One study found that children who experience trauma have higher rates of conduct disorders, as well as increased risk of self-harm and suicide attempts during childhood.²³⁴ Evidence also indicates that individuals who grew up in a household affected by mental illness or who experienced childhood sexual abuse were significantly more likely to report low mental wellbeing in adulthood, including reduced optimism, difficulty managing emotions, and lower life satisfaction.²³⁵

Although ACEs occur during childhood, their impacts can persist into adulthood, and there is evidence that certain ACEs, such as physical abuse and mental health problems, are linked across generations within families.²³⁶

There is strong evidence that people who experience four or more ACEs have poorer health outcomes. One systematic review and meta-analysis found individuals with at least four ACEs were at increased risk of several health outcomes, with strong associations for mental ill-health and problematic alcohol use, and the strongest associations for problematic drug use and interpersonal and self-directed violence.²³⁷

The whole family context is therefore considered throughout this needs assessment to acknowledge the intergenerational nature of adversity and the ways in which parental experiences, family functioning and household circumstances may impact mental health and wellbeing from the perinatal period through to adulthood.

Several indicators in this assessment relate to ACE-associated risk factors, including domestic abuse, parental separation, substance use, child protection interventions, and findings from the Flourish survey on exposure to shouting, arguing or violence between adults at home. These indicators provide partial insight into the distribution of adversity within the population.

A child protection plan is developed by a local authority to outline how a child identified as being at risk of abuse or neglect can be kept safe.²³⁸ It also highlights what improvements are needed for the family and the support required.²³⁹ In Norfolk, 25.4 per 10,000 children were on child protection plans in 2020/21.²⁴⁰ This is statistically significantly lower than the national average of 41.4 per 10,000.²⁴¹

Local Flourish survey data provides further insight into children's experiences within the home.²⁴² The 2024 survey found that 12.4% of pupils in years 4 to 13 reported that shouting or arguing between adults at home had upset them at least once a week in the month prior to the survey, including 5% who reported witnessing this daily or almost daily. 6% of pupils also reported witnessing violence between adults at home at least once in the previous month, with 1.9% reporting this occurred weekly or more often. These findings indicate that some children in Norfolk are regularly exposed to household conflict or violence, both of which are associated with increased risk of poor mental health outcomes.

The effects of ACEs often intersect with other forms of vulnerability, reinforcing the importance of early help and prevention.

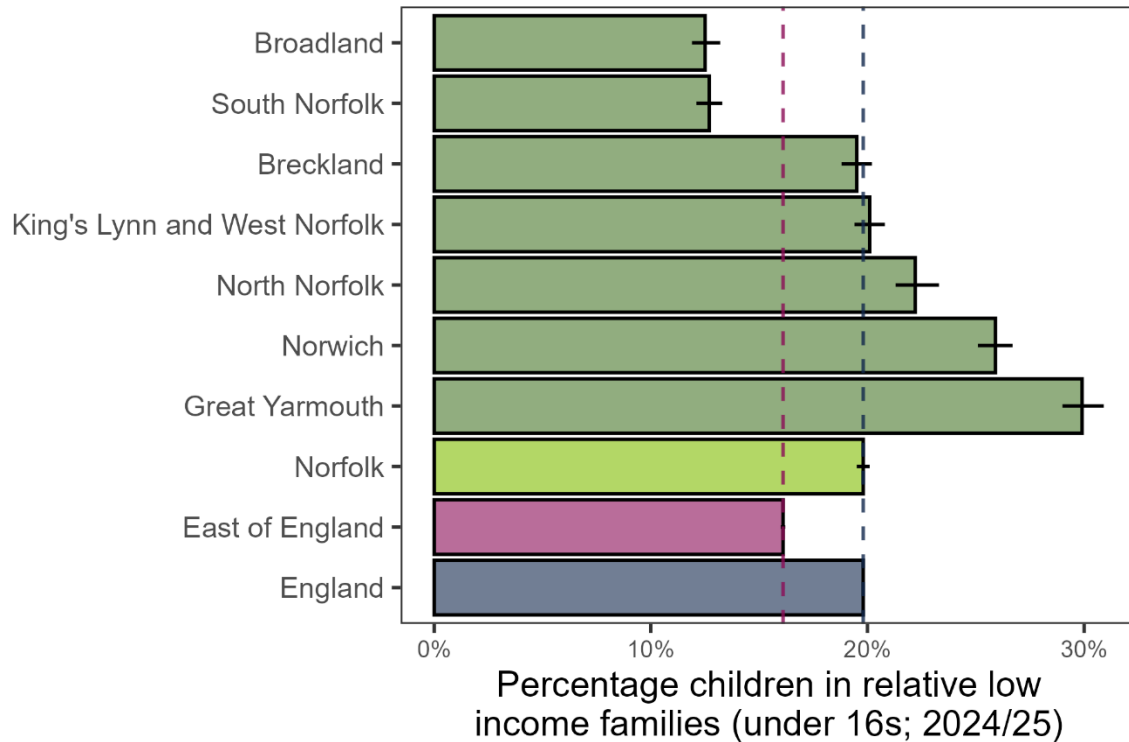
Emotional regulation

Emotional regulation, a key component of resilience, refers to how individuals manage and respond to emotions.^{243 244} Difficulties in emotional regulation, particularly maladaptive strategies such as rumination or suppression, are more common in those exposed to early adversity and are linked to poorer mental health outcomes.²⁴⁵ In contrast, adaptive strategies like cognitive reappraisal appear less commonly in those with adversity but are linked to more positive psychological outcomes.²⁴⁶

Socioeconomic circumstances

Economic stress within families further compounds risk to mental health and wellbeing. Lower socioeconomic status is associated with poorer mental health in children.²⁴⁷ In Norfolk, 22.3% of children live in relative low-income households (below the threshold of 60% of the UK median income), with higher rates reported in Great Yarmouth and Norwich (Figure 13).²⁴⁸

Children in relative low income families



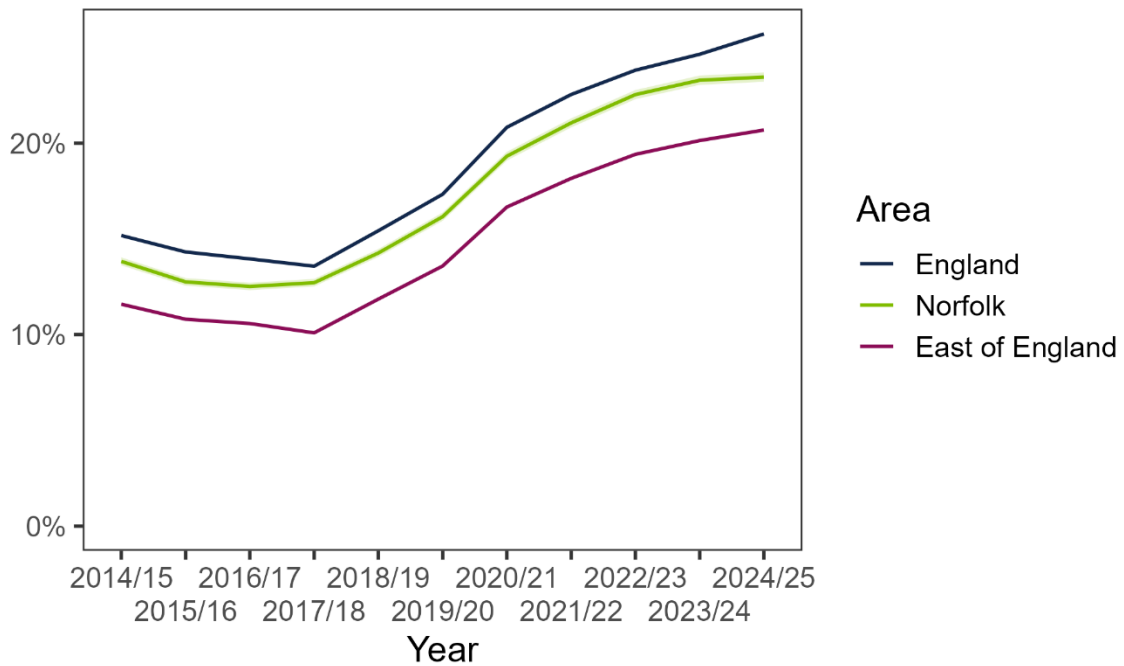
Source: OHID Fingertips

Figure 13: Percentage of children in relative low-income families in England, East of England, Norfolk and its district areas in 2023/24.²⁴⁹ Error bars show 95% confidence intervals.

Families who experience financial strain, including difficulty keeping up with bills, are more likely to experience chronic stress and have increased vulnerability to poor emotional wellbeing.²⁵⁰ These socioeconomic pressures can compound other risk factors, contributing to persistent inequalities in mental health across childhood and adolescence. In Norfolk, 23.4% of children were eligible for free school meals in 2024/25 (Figure 14).²⁵¹ This is statistically significantly lower than the national average.²⁵² However, the percentage of children eligible for free school meals is increasing both nationally and locally.²⁵³ Additionally, over 15% of children whose parents have fallen behind on bill payments have a probable mental disorder.²⁵⁴

Free school meals

Percentage of pupils eligible for free school meals



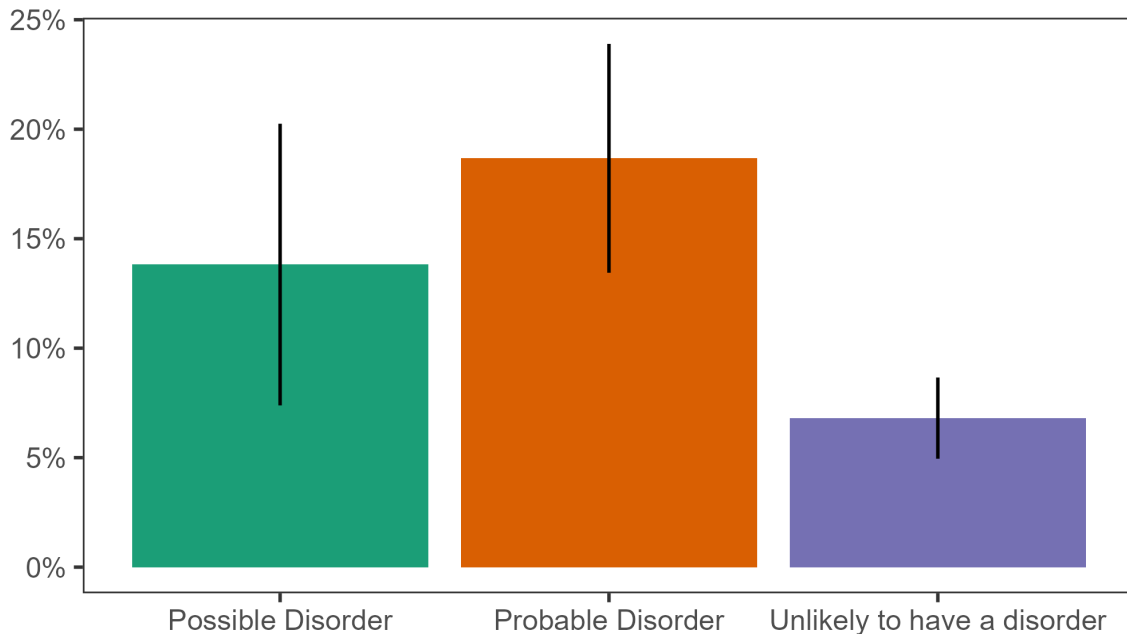
Source: OHID Fingertips

Figure 14: Trend in the percentage of children eligible for free school meals in Norfolk, East of England and England (2014/15–2024/25). The shaded area shows the 95% confidence interval for Norfolk.

In 2023, young people in England reporting probable mental disorders were more likely to have parents that have fallen behind on bill, rent or mortgage payments, highlighting the broader mental health implications of material deprivation (Figure 15).²⁵⁵

CYP mental health and parental debt

Percentage of young people with different likelihoods of mental disorder who have parents that have fallen behind with bills, rent or mortgage



Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

Figure 15: Percentage of young people with different likelihoods of mental disorder who have parents that have fallen behind with bills, rent or mortgage (2023).²⁵⁶

School environments and educational experiences

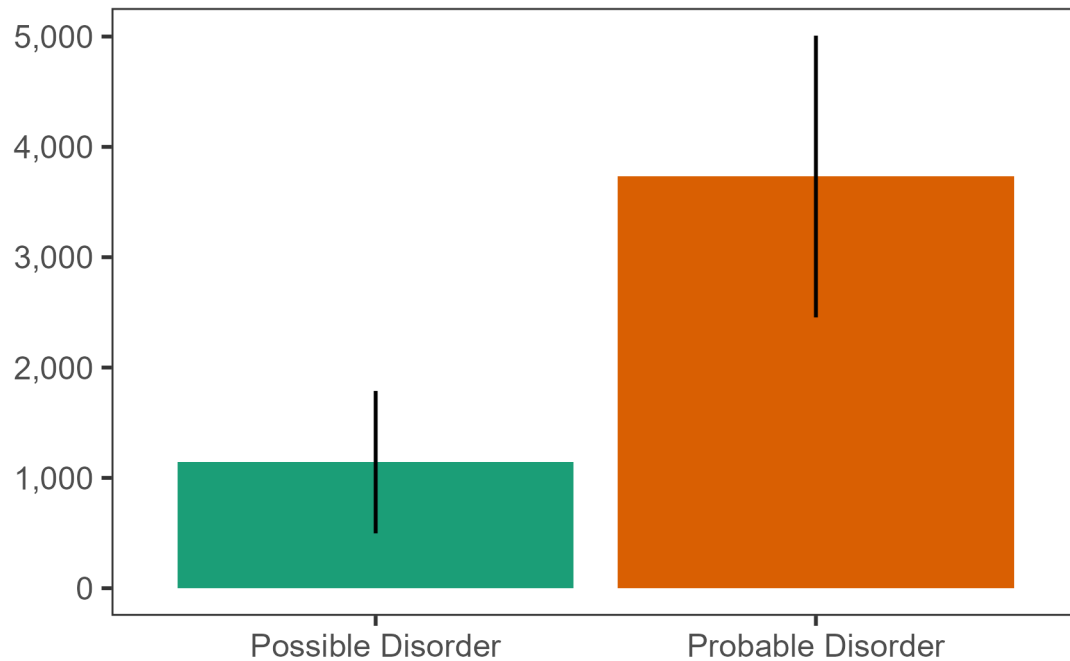
Schools are a central context for children and young people's social, emotional and cognitive development. Academic pressure in particular can contribute to emotional distress. Between ages 10–15, the average time spent on homework increases from 1.3 to 1.9 hours per day, which may negatively impact time for rest, recreation, and social connection.²⁵⁷

Experiences of bullying are linked to anxiety, depression, low self-esteem and suicidal ideation. Children who are bullied are 2.5 times more likely to use mental health services in childhood and adolescence.²⁵⁸ It was estimated that 12.9% of children aged 10–15 in the UK experienced bullying "quite a lot" or "a lot" physically, in other ways, or both within the last 6 months between January 2021 to May 2023.²⁵⁹ Modelled estimates suggest over 3,000 children in Norfolk who had a probable mental health disorder did not feel safe at school (Figure 16).²⁶⁰

Those who feel connected to their school are less likely to experience depression and social anxiety.²⁶¹ Schools can play a central role in supporting the mental health and wellbeing of children and young people by providing structured routines, social interaction and opportunities to identify emerging emotional or behavioural needs.^{262 263}

CYP mental health and safety

Estimated number of children in Norfolk aged 11–16 with a possible or probable mental health disorder who disagree with feeling safe at school



Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

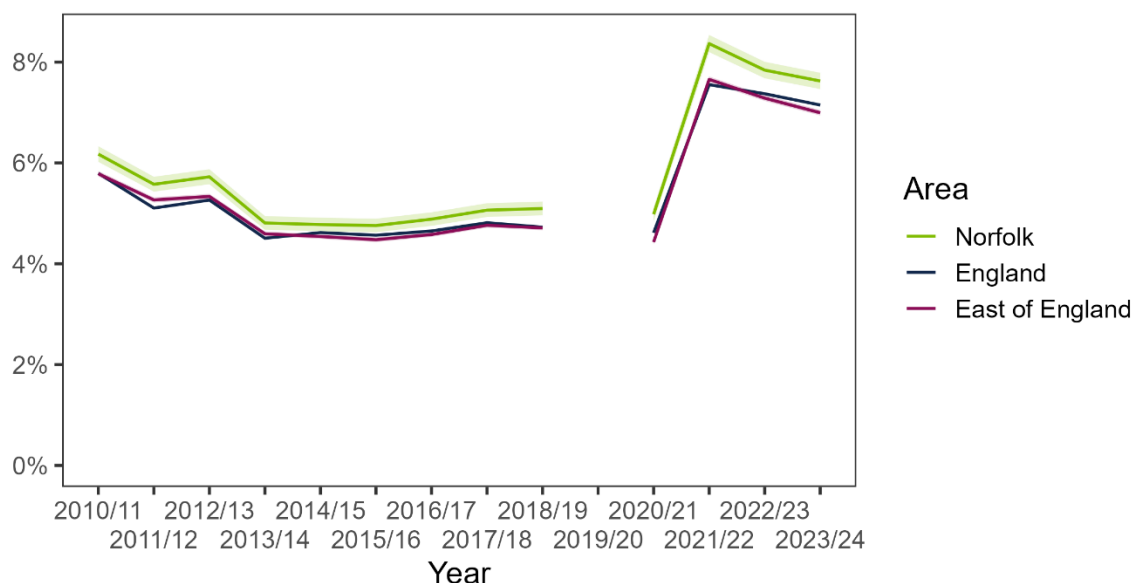
Figure 16: Estimated number of children in Norfolk who disagree with feeling safe at school and their likelihood of having a disorder (2023).²⁶⁴

School exclusion and chronic absence are also associated with increased psychological distress. Research shows that boys in socioeconomically disadvantaged areas and pupils with learning difficulties are at higher risk of exclusion.²⁶⁵

Post-pandemic data indicates an increase in school absence across Norfolk.²⁶⁶ Norfolk's pupil absence rate now exceeds both regional and national averages (Figure 17).²⁶⁷ However, rates vary across the county: in 2023/24, Great Yarmouth recorded the highest absence rate at 8.5%, significantly higher than the overall Norfolk average of 7.6%.²⁶⁸

School absence

Percentage of half days missed by pupils (5–15 yrs) due to overall absence in the academic year



Source: OHID Fingertips

Figure 17: Proportion of half days missed for children aged 5 to 15 years old in Norfolk, East of England and England from 2010/2011 to 2023/2024.

Mental illness is linked to a higher likelihood of being absent from school.²⁶⁹ In the UK, between September 2022 and July 2023, 21% of children in state, primary, secondary and special schools in England were estimated to be persistent absentees (missing 10% or more of school).²⁷⁰ Over 15% of children with a probable mental disorder missed 6–15 days of school in 2023 and more than 10% missed more than 15 days (Figure 18).²⁷¹

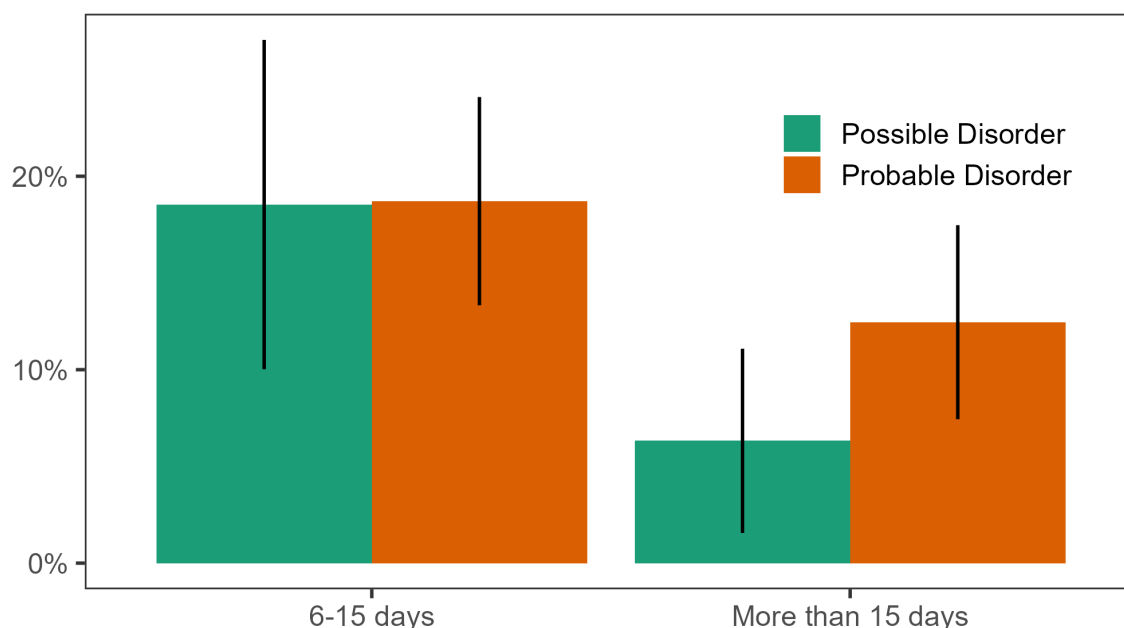
Norfolk's permanent exclusion rate was 2.1 per 1,000 pupils in 2023/24. This is higher than the national rate of 1.3 per 1,000 pupils and regional rate of 1.2 per 1,000.²⁷² Males tended to have higher exclusion rates locally, regionally and nationally. In Norfolk, there were 1.4 per 1,000 female exclusions compared with the 2.7 per 1,000 male exclusions in 2023/24.²⁷³

School exclusions risk marginalising children and young people, removing them from structured educational settings and social support systems.²⁷⁴ Additionally, children and young people facing emotional distress at home or in school can exhibit disruptive behaviour leading to exclusion and exacerbating feelings of isolation and rejection.²⁷⁵

In the Norfolk Flourish survey 2024, 16.9% of Year 4 to Year 13 pupils reported that their mental health had stopped them from going to school at some point in the previous 12 months.²⁷⁶ The proportion reporting this rose sharply with age, from 5.5% in Year 5 to 19.8% in Year 8, reaching 29.2% among Year 12/13 pupils. Pupils identifying as young carers, as having SEND and/or reporting low mental wellbeing were more likely to report missing school due to their mental health than pupils not in these groups.

CYP mental health and school absence

Percentage of 11–16-year-olds who have missed 6–15 or more than 15 days of schooling among those with a possible or probable mental disorder (2023)



Source: Mental Health of Children and Young People in England 2023 (NHS Digital)

Figure 18: Percentage of 11–16-year-olds who have missed 6–15 or more than 15 days of schooling among pupils with a possible or probable mental disorder (2023).²⁷⁷

Early years development and school readiness

School readiness refers to the extent to which children are prepared to succeed in a formal educational environment, both academically and socially.²⁷⁸ Children who are school-ready are more likely to experience school as a positive environment, which supports their emotional wellbeing, confidence, and sense of belonging.

In Norfolk, 67.3% of children met a good level of development by the end of Reception, similar to national figures in 2023/24.²⁷⁹ Conversely, 32.7% did not meet a good level of development in Norfolk and this reflects a continuing concern both locally and nationally. However, only 46.7% (significantly lower than the national average of 51.5%) of children eligible for free school meals reached a good level, highlighting a gap in school readiness linked to disadvantage.²⁸⁰

Community and wider environmental influences

Wider community and environmental conditions also influence children and young people's mental health.

Housing instability

Homelessness is associated with increased risk of childhood mental illness and housing instability is often a precursor to homelessness.^{281 282} Families experiencing insecure housing may also have additional financial pressures or domestic conflict, further compounding risks to mental wellbeing. Moreover, evidence shows that frequent moves,

particularly in early childhood, can disrupt developmental stability.²⁸³ One study found that children who moved house more than twice before age two had significantly higher levels of internalising behaviours later in childhood.²⁸⁴

Neighbourhood Safety

Children's perception of safety within their local neighbourhood is associated with emotional wellbeing. A study of 11–16-year-olds found that feeling unsafe in their community was linked to increased risk of emotional disorders.²⁸⁵ In the 2024 Flourish survey, those who reported low mental wellbeing were more likely to rate safety at home as okay, poor or very poor.²⁸⁶

Supportive relationships beyond the family

Supportive relationships in the family and at the community level are important protective factors for the mental health of children and young people. Relationships with trusted adults can provide emotional support, promote a sense of safety and help young people feel valued and connected. In the Norfolk Flourish survey, those sampled from school years 8 to 13 who reported low mental wellbeing were more likely to report not having a trusted adult to talk to when upset.²⁸⁷

Secure, stable relationships outside the home can strengthen protective factors developed in families and schools.²⁸⁸ Positive peer relationships, opportunities for social engagement and inclusive community environments are associated with better emotional wellbeing and lower risk of mental illness.²⁸⁹ In 2023, 8.3% of UK children aged 10–15 rated their happiness with friends as low.²⁹⁰ In Norfolk, the 2023–24 Active Lives Survey found that 56.7% of children in school years 3–11 said they could trust people of a similar age “a bit”, while 23.0% said they could trust them “a lot”.²⁹¹

Loneliness and social isolation

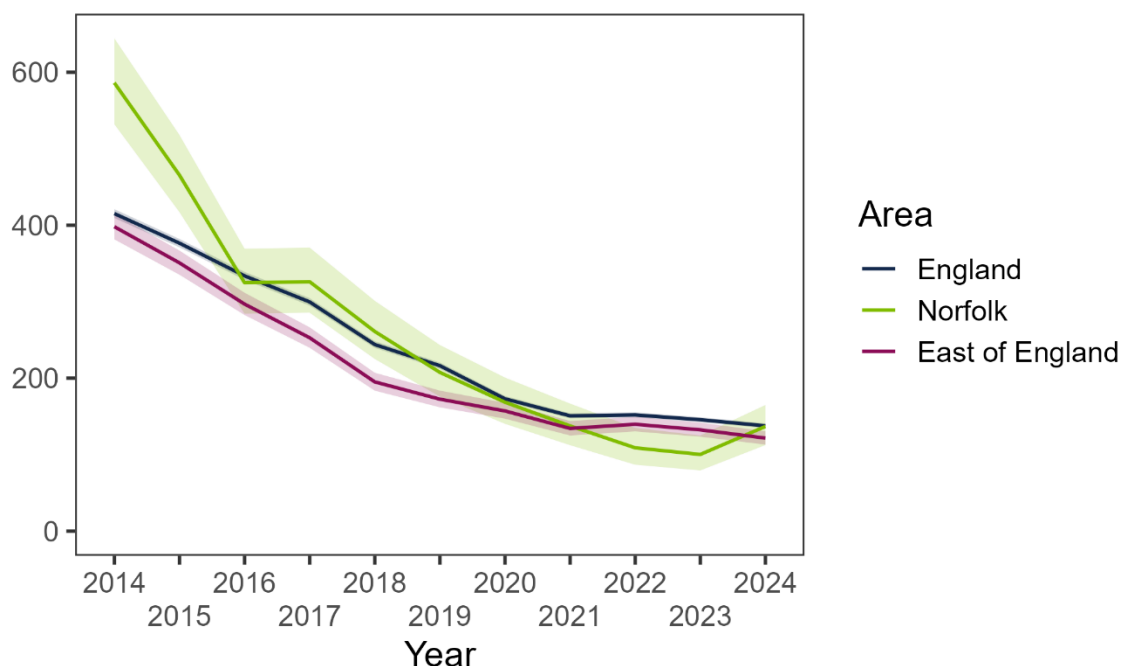
Where supportive relationships are lacking, loneliness can emerge as a significant risk factor for mental health and wellbeing. Loneliness arises from a lack of meaningful social connections which are important for mental health and wellbeing.²⁹² Nationally, 10.3% of children aged 11–16 said they felt lonely often or always between September 2022 and July 2023.²⁹³ In the UK, 31% of young people aged 16–29 reported feeling lonely often, always, or some of the time, compared with 25% of those aged 30–49.²⁹⁴ In Norfolk, the 2023/24 Active Lives Survey found that 21.9% of children in school years 7 to 11 experienced loneliness some of the time, while 10.3% felt lonely often or always.²⁹⁵ For more information, please read the Social Isolation and Loneliness Needs Assessment.²⁹⁶

Youth Justice System Involvement

Mental illness can increase vulnerability to behaviours that bring children and young people into contact with the youth justice system. In Norfolk, the rate of first-time entrants into the youth justice system has declined significantly over the past decade, mirroring regional and national trends (Figure 19).²⁹⁷

Youth Justice System

First time entrants to the youth justice system (10–17 yrs;
crude rate per 100,000 population)



Source: OHID Fingertips

Figure 19: Rate of first-time entrants to the youth justice system in Norfolk, East of England and England (2014–2024).²⁹⁸ The shaded areas show the 95% confidence intervals.

Climate Anxiety

Climate anxiety is an emerging mental health issue affecting many young people.²⁹⁹ It describes chronic fear of environmental doom and can impact the wellbeing of children and young people.³⁰⁰ Children and young people have reported feeling helpless, angry or overwhelmed about climate change and its implications for their future.³⁰¹ Global surveys have indicated that more than 45% said that their feelings about climate change impacted their daily life.³⁰² For more information, please see the 2025 Norfolk Director of Public Health Annual Report.³⁰³

4.5 Approaches to Mental Health and Wellbeing in Children and Young People

Support for children and young people is typically structured using the nationally established THRIVE framework, while Flourish reflects Norfolk's local principles for children's wellbeing. Both are underpinned by a whole-system, needs-led approach that promotes wellbeing, provides timely support and responds effectively to increasing levels of complexity and risk.

4.6 Summary

Mental health and wellbeing in childhood and adolescence are shaped by a complex interplay of individual, family, school, community and wider socioeconomic factors. Risks include individual vulnerabilities such as chronic physical health conditions and special educational needs; family circumstances including parental separation, exposure to adversity, low income and housing instability; school-related factors such as academic

pressure, bullying, absence and exclusion; and wider community influences including perceived safety, youth justice involvement and emerging concerns such as climate anxiety. Rates of special educational needs, particularly social, emotional and mental health needs, are higher in Norfolk than national averages, indicating increased levels of vulnerability within the school age population.

Self-harm is a concern, with hospital admissions for self-harm among 10–24-year-olds in Norfolk statistically significantly higher than national rates.

Protective factors operate across the same areas. These include individual skills and emotional regulation; stable and positive family relationships; school connectedness; and supportive community networks, trusted adults and opportunities for social participation. Behaviours and conditions that support wellbeing, such as adequate sleep, physical activity, healthy diet, good oral health and a sense of safety and belonging, also play an important role in emotional wellbeing. Inequalities in these protective factors are evident, particularly among children living in socioeconomic disadvantage. For example, local school readiness rates are similar to national levels overall, but lower among children eligible for free school meals.

Important data gaps include limited data for young adults aged 18–25, a key transition period when vulnerability to mental ill-health remains high. Improving the completeness and granularity of local data could enhance understanding of need and inform targeted prevention and early intervention approaches.

5 Working-Age Adults' Mental Health and Wellbeing in Norfolk

This chapter explores the mental health of working-age adults in Norfolk, defined as those aged 16 to 64. One in five adults in England experience a mental health challenge.³⁰⁴ Mental health problems are the second leading cause of morbidity in England and 75% of mental ill-health is established by the age of 24.³⁰⁵

5.1 Key findings

- Around 15.8% of adults aged 16+ in Norfolk were estimated to have a common mental disorder in 2017, slightly below the England average (16.9%). This is the most recent local estimate.
- Depression prevalence among GP-registered patients in Norfolk has more than doubled over the past decade, rising from 5.6% in 2012/13 to 13.9% in 2024/25. This mirrors national trends.
- Severe mental illness (SMI) prevalence in Norfolk is around 1%, in line with England.
- Self-reported wellbeing indicators (life satisfaction, happiness, anxiety) in Norfolk are broadly similar to national averages, with slightly better life satisfaction and worthwhile scores.

5.2 National Context

The mental health of working-age adults in England appears to be worsening, with over 10% of this group reporting signs of poor mental health across different data sources, including survey measures, screening tools and clinical diagnoses.³⁰⁶ The most significant increase has been among those aged 16–34, with rates at least doubling since 2010.³⁰⁷

There are many possible reasons for rising reports of poor mental health. According to The Health Foundation these include increased living costs, lasting impacts of the Covid-19 pandemic, work and living conditions, the influence of social media and social attitudes, evolving definitions of mental health, and increased awareness leading to reduced stigma which may have led to higher rates of reporting.³⁰⁸

A recent report written by Mind and the Centre for Mental Health, drawing from a range of data sources, echoes some of these findings. It notes how risk factors have increased, especially for young adults, whereas protections to keep people mentally well have diminished. The report highlights financial insecurity as a major pressure on mental health, with rising cost of living and falling benefit levels weakening the safety net that protects against poverty.³⁰⁹ Cuts to public services such as local spending on libraries, parks and community programmes were also linked to worsening mental health, with the most deprived areas experiencing the most reductions. The report also emphasises the impact of the Covid-19 pandemic, with nearly 2 in 5 adults in England reporting anxiety or depression during its first year. People with pre-existing mental health conditions, racialised communities and those in poverty were disproportionately impacted. Emerging evidence suggests pandemic-related stress accelerated brain ageing, regardless of whether someone had contracted the virus, with older adults and disadvantaged groups most affected. Overall, the report argues that declining mental health is not so much the result of reduced resilience, particularly among younger generations, but instead driven by a reduction in the social infrastructure that helps people be resilient.

The interim report from the Department of Health and Social Care's Independent Review into Mental Health Conditions, ADHD and Autism further clarifies that the observed deterioration in mental health reflects a real increase in reports of psychological distress, including both rising population prevalence of symptoms and functional impairment among those affected, particularly young people.³¹⁰ The review finds that these trends cannot be explained by reduced stigma and lower reporting thresholds alone and were evident prior to the Covid-19 pandemic. The review also highlights challenges in the current system response to distress. It notes that a wide range of difficulties arising from social, educational and environmental pressures are often interpreted through a medical lens within current systems of response, leading to responses that are not always well matched to the underlying causes of need. In some cases, this may result in inappropriate treatment, for example, experiences such as loneliness are unlikely to respond to antidepressant medication alone. The report concludes that a more effective approach is one in which people are directed to the form of support that best meets their needs. While this may include clinical responses for some, in other cases community-based, social or educational support may be more appropriate.

The Adult Psychiatric Morbidity Survey (2023/24) found that 1 in 5 adults in England have symptoms of a common mental health condition (CMHC) at a level likely to benefit from acknowledgement and possible intervention.³¹¹ Within the survey sample, women were more likely to report symptoms than men. These estimates are derived from structured interviews and clinical screening by trained professionals rather than formal clinical diagnosis.

When socioeconomic factors were considered, the survey showed that associations between unemployment, economic activity and CMHCs were stronger for men than women. Those who were unemployed (40%) and economically inactive (38.8%), were more likely to have a CMHC than those in employment (18.3%).

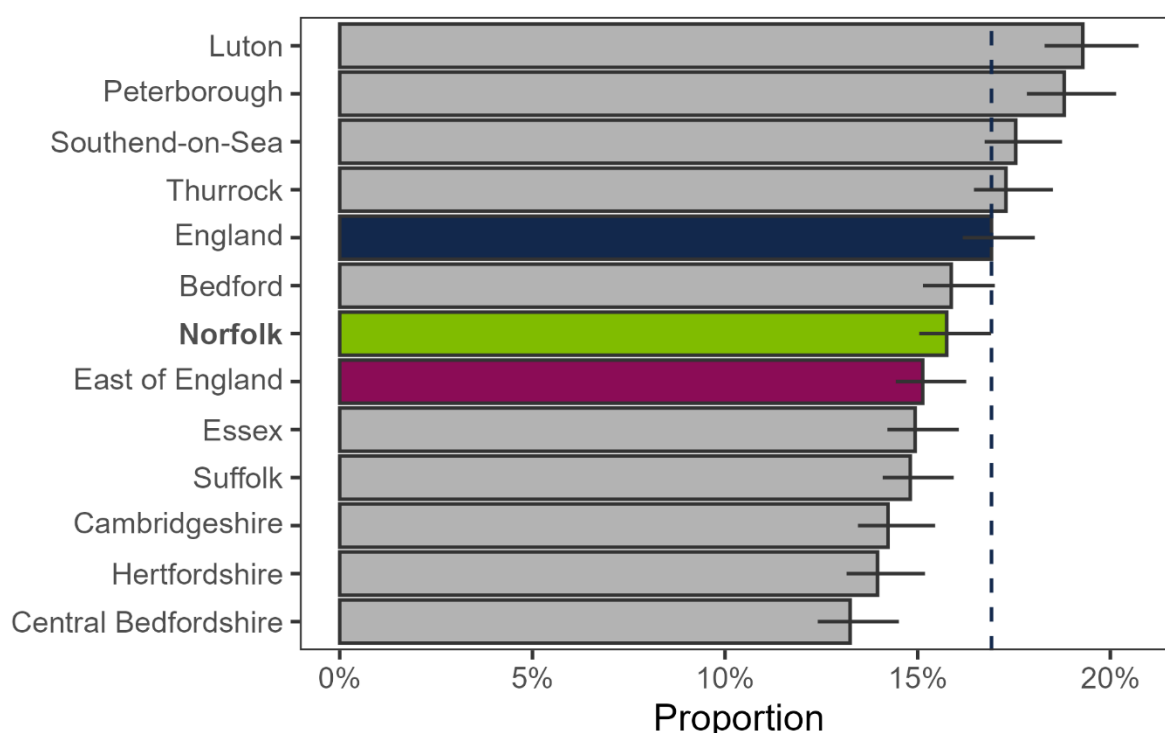
Similarly, the link between limiting physical health conditions and CMHCs was stronger for men than women. Overall, 39.2% of those with limiting physical health conditions had a CMHC compared with 12.6% without.

The relationship between problem debt and CMHCs was similar for both genders: adults with problem debt were twice as likely to have a CMHC (39%) compared with those without (18.4%). Adults living in the most deprived fifth of areas (26.2%) were also more likely to report symptoms than those in the least deprived fifth (16%).³¹²

5.3 Local Data on Mental Health and Wellbeing

The latest available data from the Office of Health Improvement and Disparities estimated that, in Norfolk, 15.8% of the population aged 16 and over had a common mental disorder in 2017, slightly below the England average of 16.9% (Figure 20).³¹³ This data is not available at Lower Tier Local Authority (LTLA) level. In 2024/25, around 1% of patients in Norfolk were recorded as having a Severe Mental Illness (SMI) on practice disease registers, which is in line with the national average.³¹⁴ In the Annual Population Survey in 2022–23, 22% of adults in Norfolk self-reported high anxiety, which was similar to the England average of 23%.³¹⁵ This represents a slight but not statistically significant decrease from 24% in 2019.

Estimated prevalence of common mental disorders: % of population aged 16 & over (2017)



Source: OHID fingertips & NHS Digital

Figure 20: Estimated prevalence of common mental disorders in people aged 16+ in 2017 in counties in the East of England, compared with the East of England and England averages.

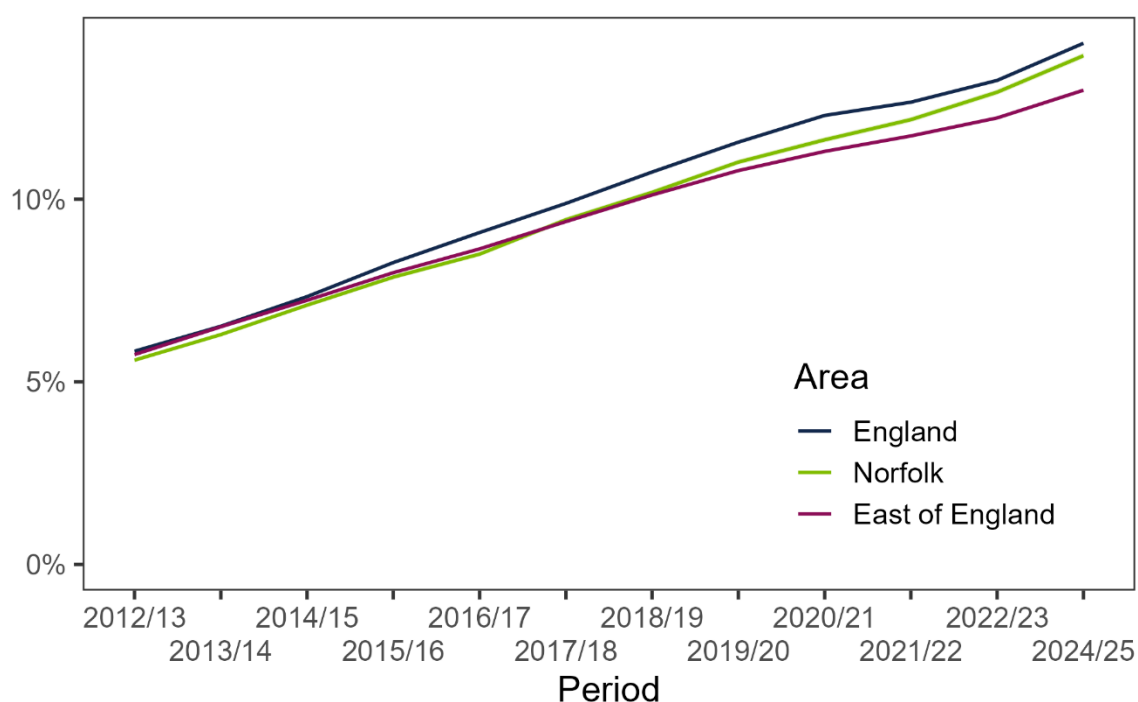
In 2024/25 the prevalence of depression in Norfolk among those registered with a GP practice was 13.9%, significantly higher than 2012/13 at 5.6% but in line with national trends (Figure 21).³¹⁶ The incidence of new diagnoses of depression in adults aged over 18 has remained stable, ranging between 1.4% and 1.5% annually for England from 2019/20 to

2023/24. However, there has been a slight decreasing trend for Norfolk, from 1.3% in 2019/20 to 1% in 2023/24 (Figure 22).³¹⁷

According to the Adult Psychiatry Morbidity Survey, an estimated 6.9% of adults aged 16+ in the East of England had symptoms of Generalised Anxiety Disorder (GAD) in the past week, compared with 7.5% nationally. Data is only available at regional level and is based on survey interviews and screening tools used by clinically trained interviewers rather than clinical diagnosis.³¹⁸

Depression

QOF prevalence

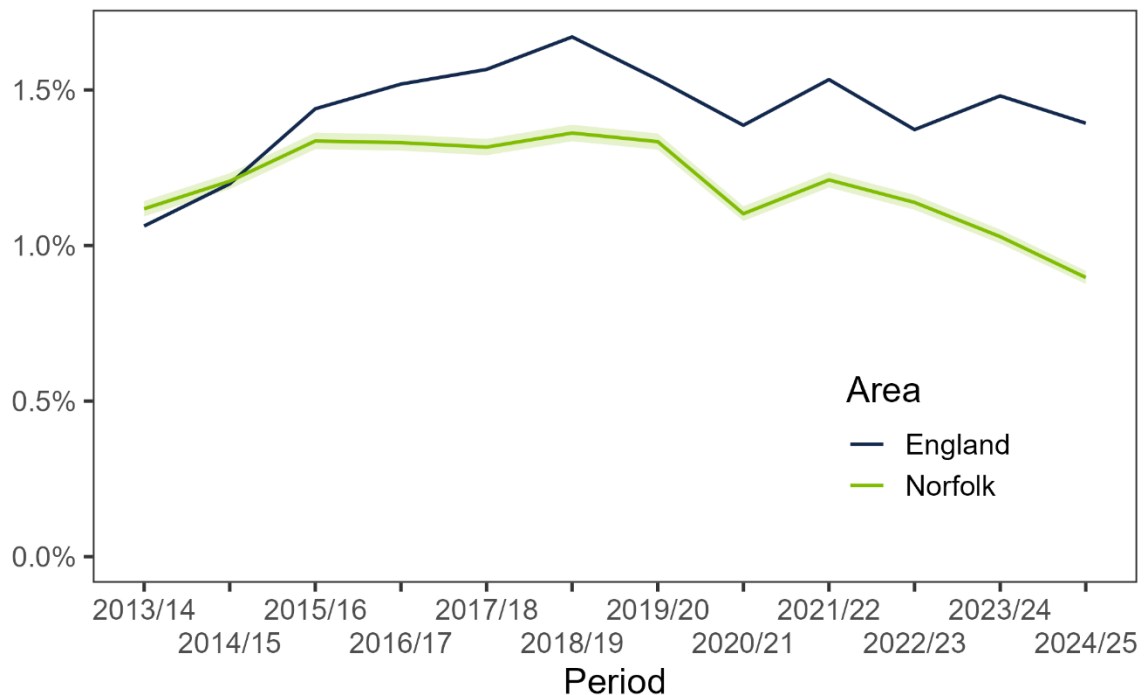


Source: OHID Fingertips

Figure 21: Prevalence of depression in Norfolk compared with East of England and England from 2012/2013–2024/2025 (OHID).

Depression

QOF incidence - new diagnosis



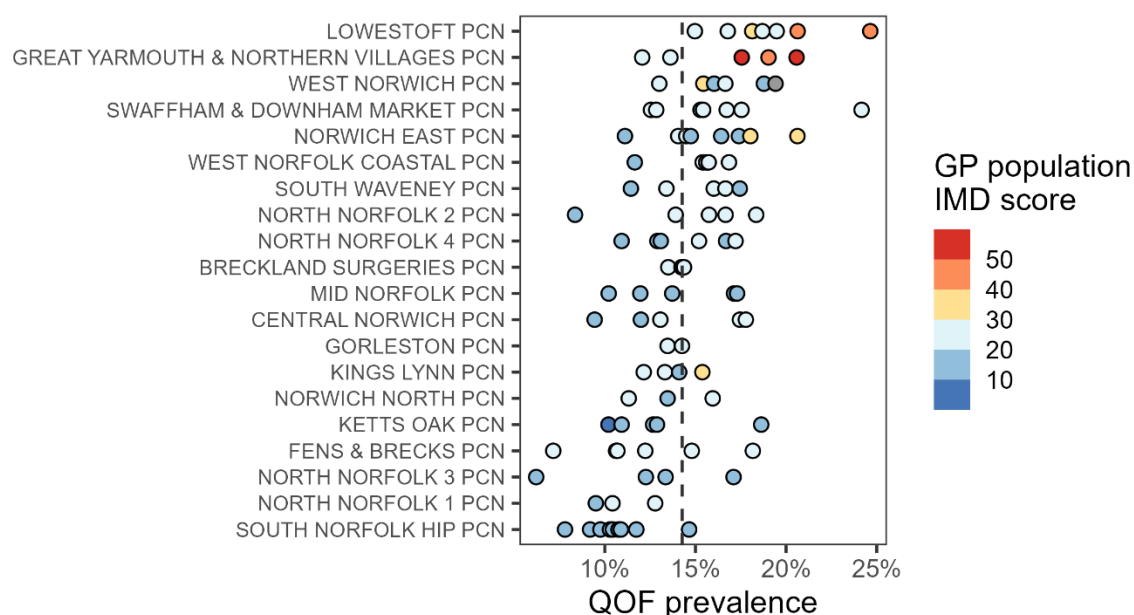
Source: OHID Fingertips

Figure 22: Incidence rate of depression in adults over the age of 18 in Norfolk compared with England from 2013/2014 to 2023/2024 (OHID).

Within Norfolk and Waveney, there is considerable variation in depression prevalence between different GP practices. GP practices with patients living in more deprived areas tend to have higher recorded depression prevalences than those with patients living in less deprived areas. There is substantial variation between GP practices within the same Primary Care Network (PCN) illustrating small area variation.

Depression

PCN



Sources: OHID Fingertips, NHS England (2024/25), MHCLG (2025)

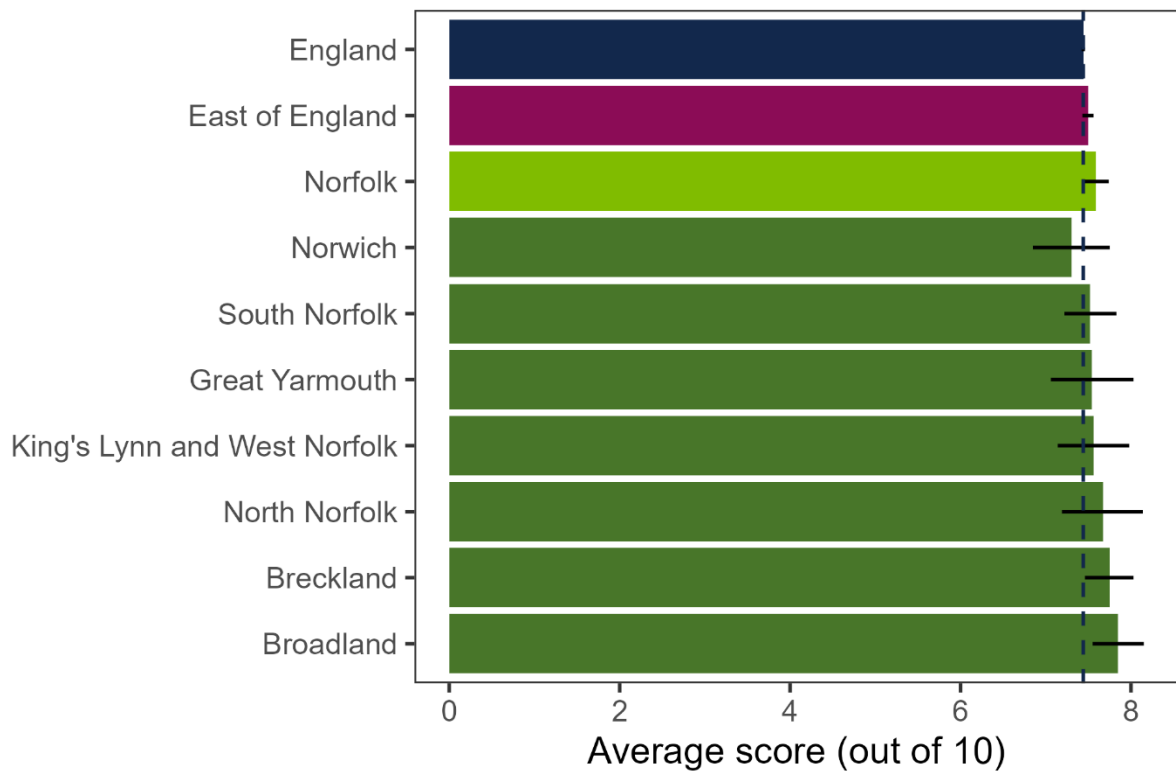
Figure 23: Prevalence of depression in Norfolk and Waveney GP practices in 2024/25 grouped by Primary Care Networks. Individual points represent GP practices, with the estimated Index of Multiple Deprivation (IMD 2025) score based on the patient population residence (higher = more deprived). The England average prevalence is indicated by the vertical dashed line.

High levels of life satisfaction and happiness, and low levels of anxiety indicate higher levels of emotional and mental wellbeing. Nationally, average ratings for life satisfaction have decreased over the past 10 years. There was a gradual improvement between 2011 and 2019, but this trend was reversed, likely due to the Covid-19 pandemic, and life satisfaction has not fully recovered.³¹⁹

Overall, wellbeing measures in Norfolk are broadly in line with national averages, though some indicators show Norfolk performing slightly better. In 2022/23, the percentage of people with a low life satisfaction score was 3.9% in Norfolk compared with 5.6% in England.³²⁰ Similarly, low worthwhile scores were 3% in Norfolk versus 4.4% nationally in 2022/23.³²¹ The percentage of people with a low happiness score in Norfolk in 2022/23 was 9.1%, similar to the England average at 8.9%.³²²

The average score for life satisfaction in Norfolk in 2022/23 for those aged 16+ in Norfolk was 7.59 (where 0 is 'not satisfied at all' and 10 is 'completely satisfied'), similar to the average national score at 7.44 (Figure 24).

Life satisfaction (2022/23)



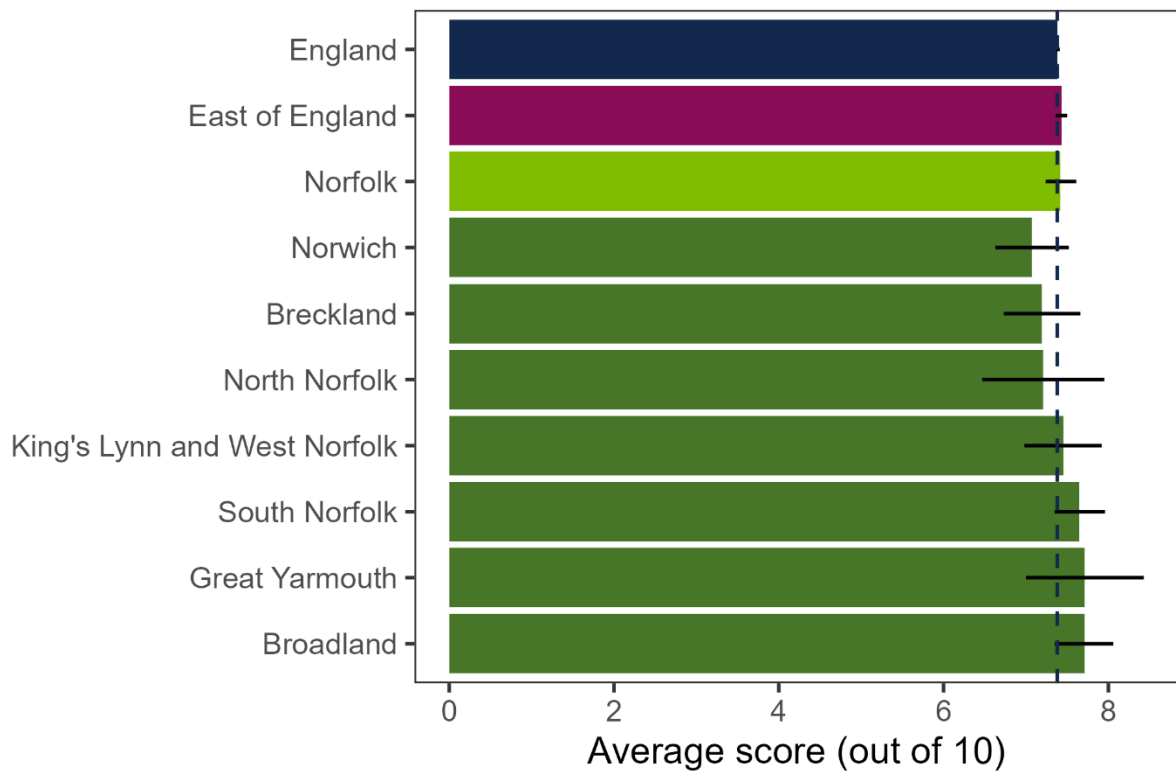
Source: ONS

Figure 24: Average score for self-reported life satisfaction in 2022/2023 for people aged 16+ in Norfolk, Norfolk districts, East of England and England. 0 is 'not at all satisfied' and 10 is 'completely satisfied' (ONS).

The average score for happiness in Norfolk was 7.42 in 2022/23 (where 0 is 'not happy at all' and 10 is 'completely happy') similar to the national average at 7.38 (Figure 25).³²³

On average, Norfolk followed national trends and scored 3 out of 10 for anxiety (where 0 was 'not anxious at all' and 10 was feeling 'completely anxious'; Figure 26).³²⁴

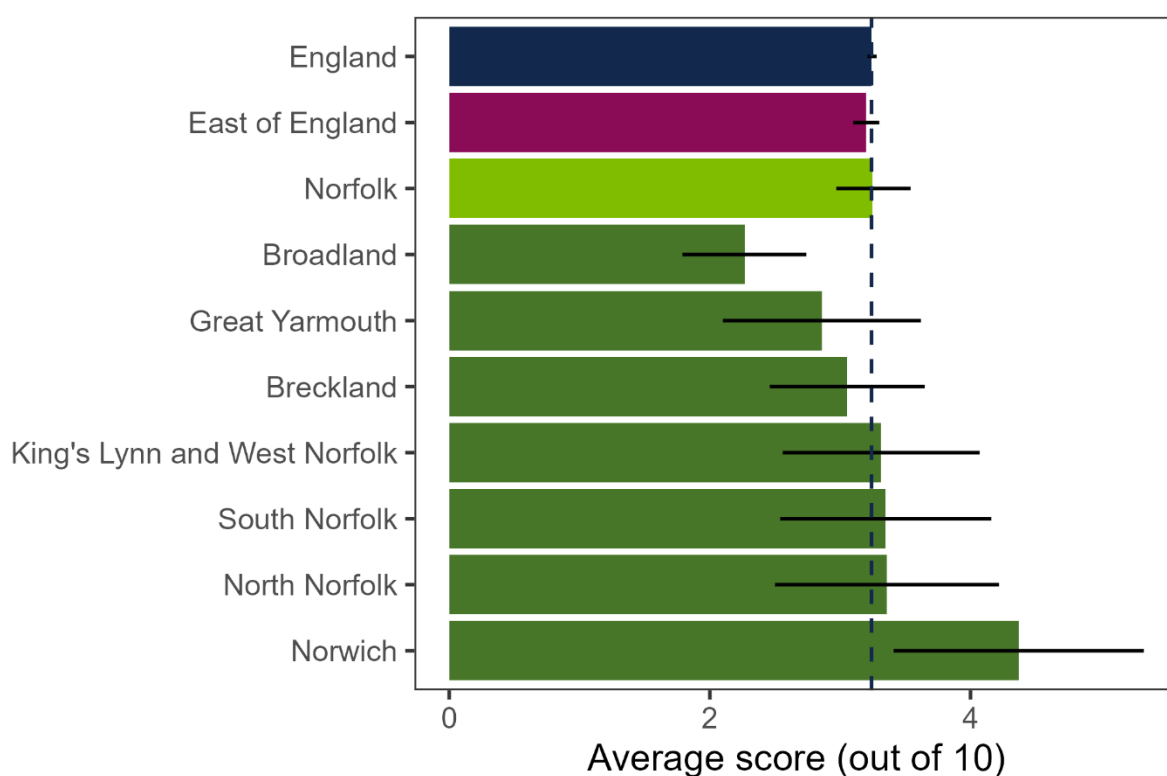
Happiness (2022/23)



Source: ONS

Figure 25: Average score for self-reported happiness in 2022/2023 for those aged 16+ in Norfolk, districts in Norfolk, East of England and England. 0 is 'not at all happy' and 10 is 'completely happy'.

Anxiety (2022/23)



Source: ONS

Figure 26: Average score for self-reported anxiety in Norfolk, districts in Norfolk, East of England and England in 2022/23. 0 is 'not at all anxious' and 10 is 'completely anxious' (ONS).

An estimate of mental health at a small-scale local level is provided by the Small Area Mental Health Index (SAMHI). The SAMHI is a composite annual measure of population mental health for each Lower Super Output Area (LSOA) in England. It combines data on mental health related hospital attendances, antidepressant prescribing, GP register-based depression prevalence, and disability as well as personal independence claims for mental health reasons and learning difficulties into a single index. Many areas of Norfolk are in high SAMHI deciles, especially in relatively more deprived areas in cities and towns (Figure 27), suggesting higher mental health needs in these areas compared with other areas in England. This is mainly driven by high scores for the antidepressant prescribing component of the index, for which the Norfolk average is significantly higher than the national average. Nationally, antidepressant prescribing increased between 2015 and 2019³²⁵ a trend which appears to have continued in recent years.³²⁶

Small Area Mental Health Index (SAMHI)

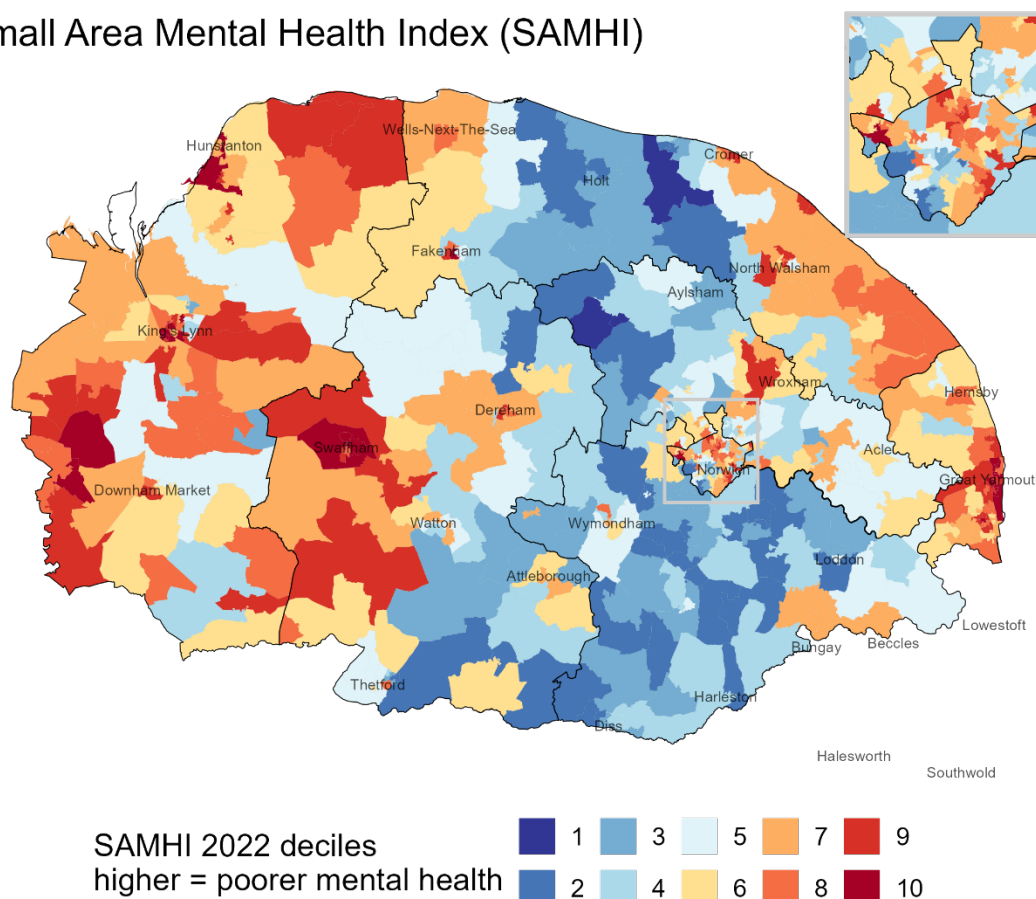


Figure 27: Mental health (Small Area Mental Health Index 2022) in small areas in Norfolk. Higher national deciles (red) show small areas with a worse estimated mental health.

Source: Daras K, Barr B (2021), Small Area Mental Health Index (SAMHI) 5.00 [Open Dataset], Place-based Longitudinal Data Resource, DOI: 10.17638/datacat.liverpool.ac.uk/1188

5.4 Risk and Protective Factors

This section explores the risk factors, including biological, psychological, social and environmental influences, that can increase the likelihood of developing mental health conditions and hinder recovery from mental ill-health, alongside the protective factors that mitigate these risks and promote resilience.

Obesity and Diet

Obesity is strongly associated with an increased likelihood of depressive symptoms, particularly low mood, feelings of inadequacy and low energy.³²⁷ Cultural misperceptions that disregard the social and environmental factors that contribute to obesity and focus instead on personal responsibility can lead to stigma and worsen the mental health of those with obesity.³²⁸

In Norfolk, 65.4% of adults are classified as overweight or obese, slightly above the national average of 64%.³²⁹

When considering obesity alone, prevalences in King's Lynn and West Norfolk, Breckland and Great Yarmouth are significantly higher than the England average (26.5%; Figure 28).

Obesity

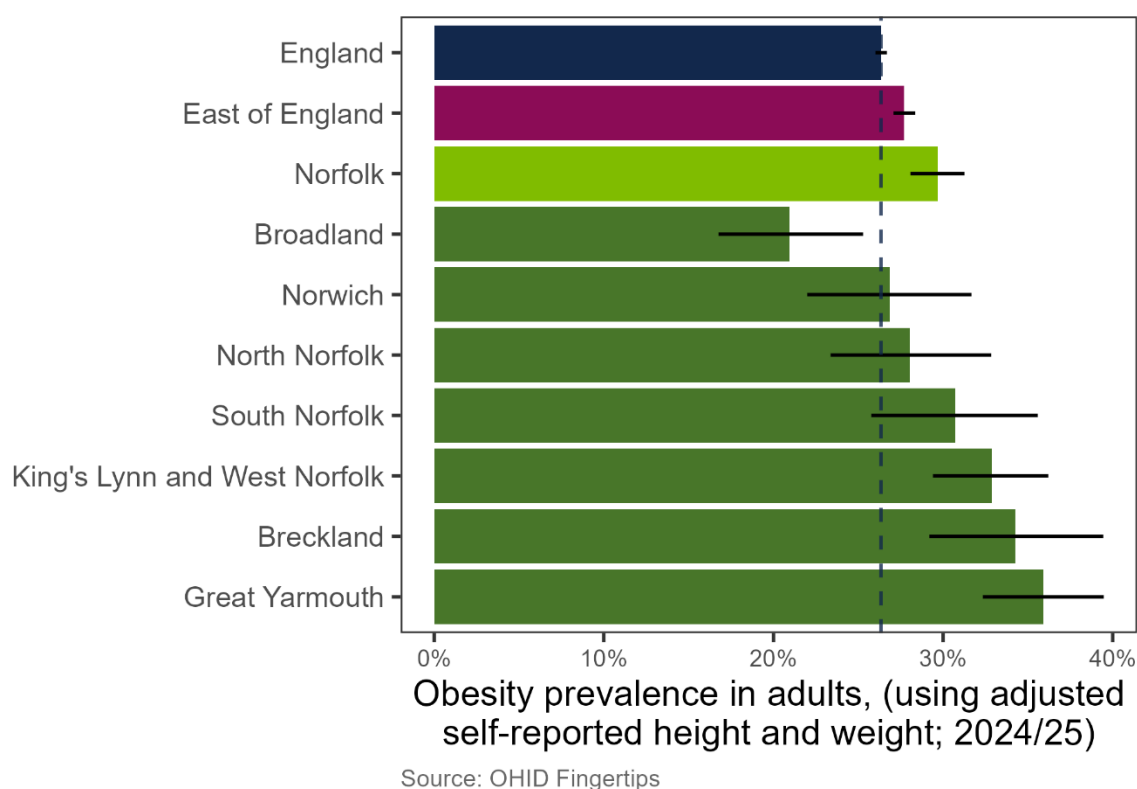


Figure 28: Prevalence of Obesity in adults over the age of 18 in Norfolk and its districts compared with the East of England and England averages in 2024/25.

A healthy diet that incorporates fruits and vegetables and avoids pro-inflammatory foods such as fast food and high meat intake is important for tackling obesity and may also reduce the risk of developing depression.³³⁰ In particular, the Mediterranean diet has been found to have a positive effect on mood.³³¹ In Norfolk, it is estimated that 36% of adults meet the recommended five portions of fruit and vegetables per day.³³² Norfolk is estimated to have had the second highest consumption of fruit and vegetables in the region during 2022/23, significantly higher than the national average.

Physical Activity

There is strong evidence that physical activity improves symptoms of anxiety, depression and psychological distress, with some studies suggesting that physical activity may have effects similar to psychotherapy and antidepressants.³³³ Even relatively low levels of physical activity have been found to reduce the risk of depression.³³⁴ Evidence suggests this could be due to the positive impacts on mood, self-esteem, self-worth and body image.³³⁵

In 2023/24, 67.8% of adults were physically active in Norfolk — a stable trend since 2015/16.³³⁶ Physical activity levels were highest in Norwich and lowest in Great Yarmouth.

Physical activity indicators are published as crude rates and are not age-standardised. Norwich has a comparatively younger adult population, and young adults tend to be more physically active. This may partly explain why Norwich shows higher physical activity levels despite also reporting higher anxiety (Figure 29). Without age-standardised data, we cannot fully account for demographic differences, so these figures should be treated with caution.

Physical activity

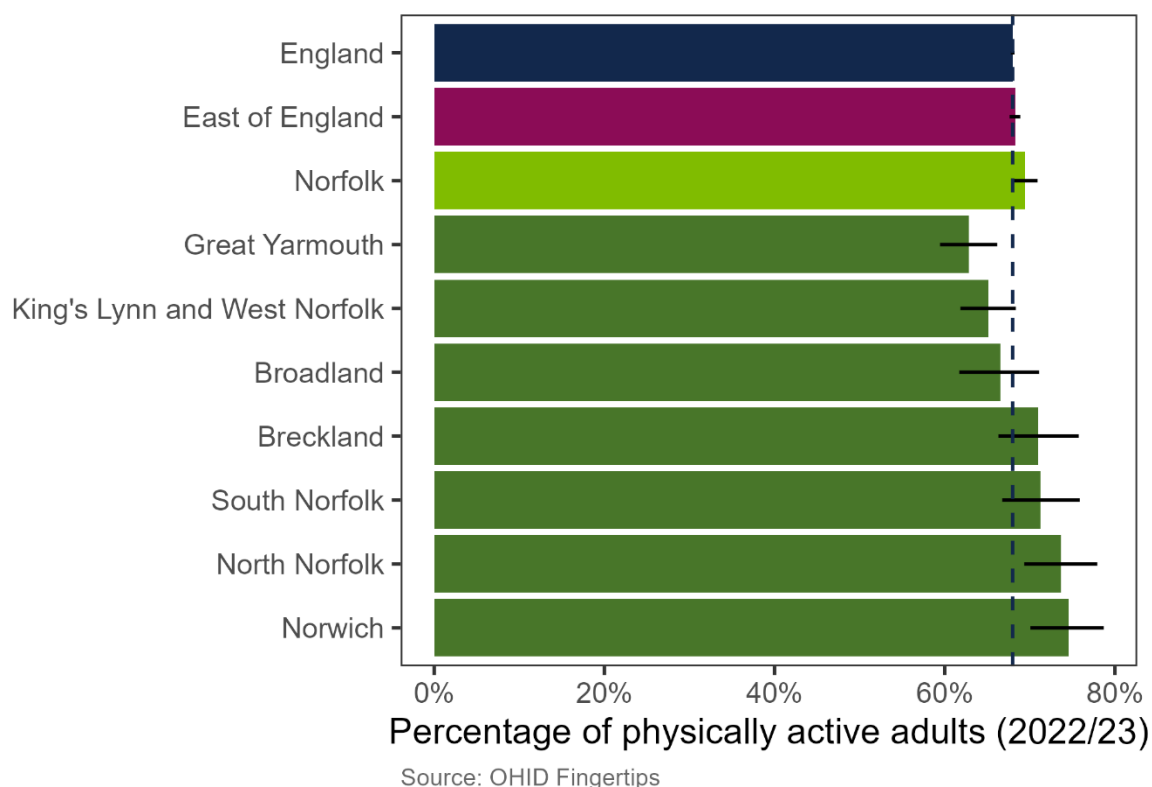


Figure 29: Percentage of physically active adults in Norfolk, districts in Norfolk, East of England and England in 2022/23.

Access to Green Spaces

There is some evidence to suggest access to open spaces is a protective factor for mental wellbeing. A study analysing data on more than 2 million people in Wales over 10 years found that living in greener areas, or close to green and blue spaces (e.g. beaches, parks, lakes), reduced the risk of developing a common mental disorder, with the positive effects on mental health being particularly significant for those who live in more deprived communities.³³⁷ Another study found that open space usage is associated with feeling close to other people and feeling optimistic about the future among those living in deprived areas.³³⁸

Problematic Substance Use and Integrated Support

Evidence indicates a relationship between problematic substance use, including alcohol, illicit drugs and prescription medication misuse, and poor wellbeing across all age groups.³³⁹ Generally, people with substance use disorders are likely to also have comorbid mental illness.³⁴⁰

Data from the Adult Psychiatric Morbidity Survey (APMS) shows strong links between problematic alcohol use and both physical and mental ill-health. The Alcohol Use Disorders Identification Test (AUDIT) classifies alcohol-related risk, with scores of 0–7 indicating low risk, 8–15 as hazardous drinking requiring brief intervention, 16–19 as harmful drinking or mild dependence, and 20+ suggesting probable dependence requiring specialist support.

In 2023/24, adults with common mental health conditions were more likely to have issues with problematic alcohol use; 20.7% drank at hazardous levels or above (scored 8+) compared with 17.1% of adults without mental health conditions. Harmful drinking was also more common, with 5.3% of adults with a common mental health condition scoring 16 or above compared with 2% of those without.³⁴¹

Between 2020/21 and 2023/24, the proportion of clients in Norfolk entering drug treatment who were also receiving mental health treatment consistently exceeded the England average. In 2023/24 this was 80.9% of clients in Norfolk compared with 74.5% in England. Similarly, 85.5% of clients entering alcohol treatment were also identified as having a mental health treatment need, similar to the national average of 83.4%.³⁴²

Individuals with mental health conditions are twice as likely to use tobacco and tobacco use itself can increase vulnerability to mental health issues. It has been shown to negatively affect quality of life and may reduce the effectiveness of certain medications used to treat mental health conditions.³⁴³ Nationally, smoking prevalence among adults aged 18 and over has decreased from 19.8% to 11.6% from 2011 to 2023.³⁴⁴ In 2023, smoking prevalence was 12.2% in Norfolk, similar to the national average of 11.6%.³⁴⁵

Among adults with a long-term mental health condition, smoking prevalence in Norfolk was 21.4% in 2022/23, lower than the national average of 25.1%.³⁴⁶

Interpersonal trauma, including emotional, physical and sexual abuse, as well as physical and emotional neglect, has been linked to an increased risk of severe mental health problems and a higher prevalence of addictive behaviours including alcohol, tobacco and drug use.³⁴⁷ Trauma-informed services and care that recognises and responds to substance use issues can improve engagement and outcomes.

Protective factors against problematic substance use include adopting a life course and whole-system approach that prioritises prevention, early identification, harm reduction and treatment-based approaches.³⁴⁸ Prevention efforts should recognise the social drivers of substance use including deprivation, trauma and ACEs, and equip professionals across health, education and criminal justice to identify and reduce harm. Interventions that focus on prevention include alcohol brief interventions, screening and advice in primary care, and access to holistic, recovery-oriented treatment services including psychosocial support and prescribing support interventions.³⁴⁹ These services should be tailored to individuals and cater for mental health, physical health and housing needs to reduce health inequalities.³⁵⁰

Adverse Childhood Experiences (ACEs) and Resilience

ACEs are strongly linked to anxiety and depression in adulthood. One study estimated that ACEs increase the risk of mental health problems by 66%.³⁵¹ ACEs are also widespread; the National household survey of ACEs found that 47% of individuals had experienced at least one ACE, and 9% had four or more.³⁵² Risks associated with ACEs intersect with other vulnerabilities such as socioeconomic disadvantage and housing instability.

Despite being common, some argue that ACEs are rarely enquired about in routine clinical practice and that thorough training for staff on how to ask about ACEs and respond, as well as role-appropriate training on 'therapeutic' skills and concepts is lacking.³⁵³ This should include being trauma-informed, and education on early warning signs and the importance of self-care, rest and resilience.

There is extensive guidance on implementing trauma-informed services. Services can ensure they respond appropriately to trauma and promote protective factors, particularly for those with ACEs, such as supportive relationships and good quality sleep, to build resilience and counter toxic stress associated with ACEs.^{354 355}

The Welsh ACE and Resilience Study by Public Health Wales and Bangor University found that higher adult resilience significantly reduces the likelihood of current mental illness, even in individuals with multiple ACEs. Other resilience resources in adulthood, such as perceived financial security and community engagement, more than halved the risk of current mental illness in those with 4 or more ACEs.³⁵⁶

Caregiving Responsibilities and Support

Caregiving, particularly for individuals with dementia, is associated with poor wellbeing, chronic stress and depression.³⁵⁷ In the latest State of Caring report (2025), 35% of carers who completed the survey said they had bad or very bad mental health, compared with 27% the previous year, with carers who are struggling financially more likely to report poor mental health.³⁵⁸ In Norfolk, 26.8% of adult carers reported that they have as much social contact as they would like, similar to the England average at 30%.³⁵⁹ Strong social support networks, resilience and a sense of purpose can reduce the risk of depression and loneliness among caregivers.³⁶⁰ Promoting social participation through things like volunteering and activities outside the home, is found to be just as crucial for protecting caregivers' mental health as more traditional interventions, such as educational workshops, physical activity initiatives, CBT, mindfulness and coping skills training.³⁶¹

Mental and Physical Health: A Bidirectional Relationship

Physical and mental health are closely linked. Individuals with physical health conditions are at an increased risk of developing poor mental health, while psychological distress and poor emotional health can increase the risk of developing physical conditions.³⁶² For example, those with a tendency to report distress, discomfort, dissatisfaction and feelings of hopelessness may be at increased risk of heart disease.³⁶³

Long-Term Conditions

This relationship is particularly strong for those with long-term conditions. Mental health conditions often precede long-term physical illness, for example, emotional distress has been found to predict the onset and recovery from heart disease and stroke, and severe mental illness has been linked to increased risk of long-term physical conditions such as coronary heart disease, COPD, cancer, musculoskeletal disorders and psychosomatic problems like irritable bowel.³⁶⁴ Around 30% of people with a long-term physical condition also experience a mental health problem, particularly depression and anxiety. This bidirectional relationship increases mortality, reduces treatment adherence for those with long-term physical conditions and increases healthcare costs by an estimated 45%.

Evidence suggests that physical activity may help reduce depression, anxiety and distress among those with chronic disease.³⁶⁵ Similarly, internet-based CBT and other digital health interventions appear to support mental wellbeing in this group. Teleconsultation and web-based interventions are identified as the more effective delivery modes for adults with chronic conditions.³⁶⁶

Menopause and Perimenopause

The menopause and perimenopause are increasingly recognised as important phases of vulnerability for women's mental health. Hormonal changes can significantly impact wellbeing and in some cases trigger new psychological symptoms, such as low mood, anxiety and cognitive changes, as well as worsen pre-existing mental health conditions or trigger new mental illness.³⁶⁷ A large UK study found that perimenopause is associated with increased risk of first-onset major depressive disorder and mania, although it did not identify an association with first-onset schizophrenia spectrum disorders.³⁶⁸ Research also suggests in addition to a risk window in adolescence and early adulthood, women approaching the menopause transition experience a second window of risk for new onset psychosis.³⁶⁹

Loneliness and Social Isolation

In Norfolk, the proportion of adults feeling lonely is greatest in Norwich where levels exceed the England average.³⁷⁰ Higher reporting of loneliness in the younger age groups may explain this in part, as Norwich has a younger-than-average population, and deprivation may also be a contributory factor. Among younger adults (16–24), reported feelings of loneliness increased from 2019/20 but were not sustained, with levels slightly declining in the most recent 2022/23 survey.

Higher social connectedness is a protective factor against depression and for better cognitive health.³⁷¹ Interventions and activities that foster social support, community connection and friendship are among the most effective to reducing loneliness. Group-based formats that encourage active participation, interaction with facilitators and peers, and the formation of shared interest groups are found to be particularly beneficial, especially when delivered over a sustained period.³⁷²

Housing and homelessness

Housing instability, affordability issues, overcrowding, poor quality housing and homelessness are risk factors for poor mental health among adults. For example, those on housing benefit are more than twice as likely to have a common mental health problem than those not receiving it (35.1% vs 14.9%).³⁷³

In Norfolk, the rate of those owed a prevention or relief duty under the Homelessness Reduction Act has consistently been below the national average. However, the rate doubled from 5.5 per 1,000 in 2022/23 to 10.5 in 2023/24.³⁷⁴

Research from Homes England found that those who lived in temporary accommodation for long periods (over three years) reported lower levels of happiness and life satisfaction compared with those who moved into social housing.³⁷⁵ Rates of households in temporary accommodation remain lower in Norfolk than the England and East of England averages, although Great Yarmouth shows the highest local rate (Figure 30).

According to the latest Ministry of Housing, Communities and Local Government statutory homelessness returns, 65 households in Norfolk were assessed as homeless and not in priority need during April–June 2025.³⁷⁶ This figure represents a quarterly snapshot rather than an annual total. Most of this cohort tend to be single homeless people who have a high prevalence of mental and physical health issues.

Half of rough sleepers report mental health problems and rates of psychosis are estimated to be 50–100 times higher than in the general population.³⁷⁷ Studies show that ACEs are also highly prevalent among people experiencing homelessness, with lifetime prevalence estimated at 90% for one or more ACEs and 54% for four or more ACEs.³⁷⁸ Trauma-informed care is essential when supporting those experiencing homelessness, shifting the focus from “What is wrong with you?” to “What has happened to you?”, and complemented by integrated services and flexible care models to meet complex needs.³⁷⁹

Homelessness

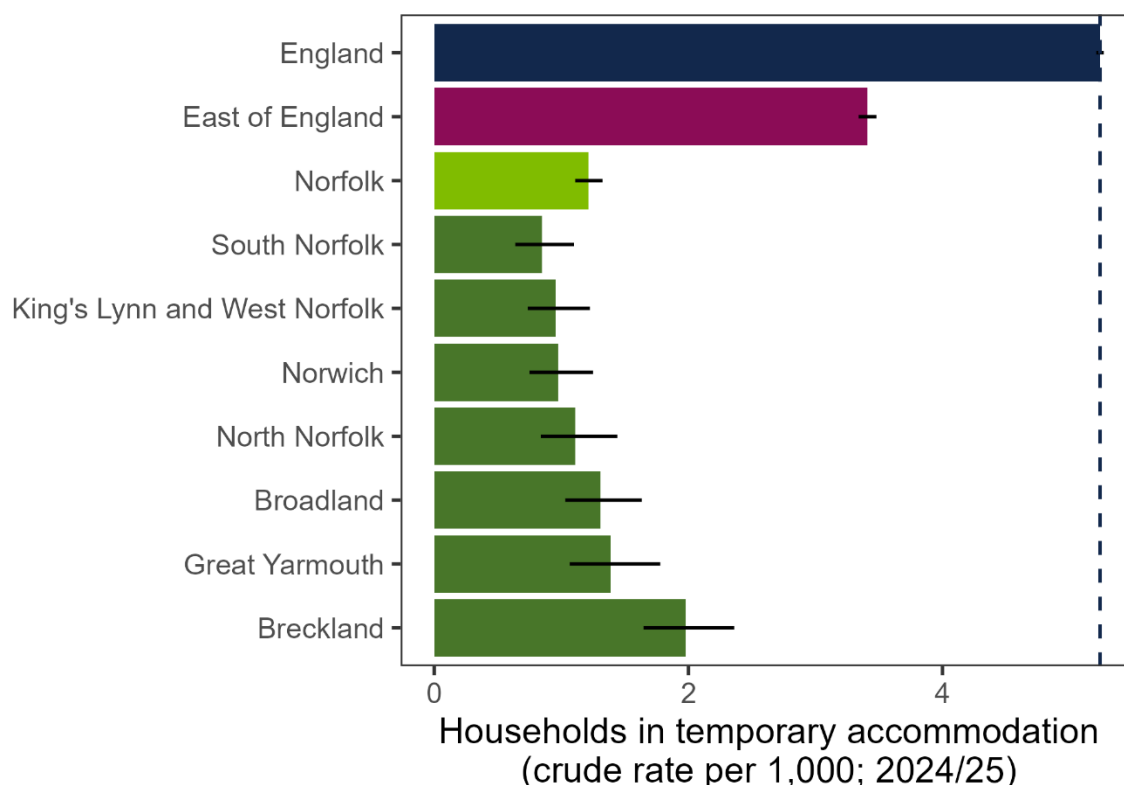


Figure 30: Rate of homeless households in temporary accommodation in Norfolk, Norfolk districts, East of England and England in 2024/2025 (OHID).

Hoarding and self-neglect

Hoarding disorder is recognised as a mental health condition, characterised by persistent difficulty discarding possessions leading to accumulation that significantly compromises living spaces and daily functioning. Self-neglect is a broader pattern of maladaptive behaviours that may include hoarding, poor diet and nutrition, refusal of treatment and mismanagement of finances.³⁸⁰ Hoarding is associated with physical, psychological and social morbidity and contributes to reduced quality of life. Challenges with hoarding may only become apparent when people seek support for other mental health or physical conditions.³⁸¹ These behaviours highlight the importance of multi-agency awareness, as hoarding may intersect with wider determinants such as poverty and social isolation.³⁸²

Employment

Good quality employment is a protective factor for mental health. Work that is stable, pays fairly and has a supportive environment can contribute to purpose, routine and social connection, while also offering financial security. In contrast, unemployment and poor-quality work increase the risk of poor wellbeing and mental ill-health.³⁸³

The Health Foundation also note that people with lower-level qualifications and those outside the labour market are more likely to report mental health conditions, however the greatest increase over the past two decades has been in non-work-limiting mental health conditions.³⁸⁴ This refers to mental health conditions that do not prevent someone from doing the type or amount of work they can do.

In Norfolk, the percentage of working-age people in employment in 2023/24 was 73.8%, similar to the national average. The percentage of the working population in Norfolk claiming out of work benefit was 2.9% in 2024/25, lower than the England average at 4.1% (Figure 31).³⁸⁵ Further, the number of people in long-term unemployment and claiming out of work benefit for over 12 months was lower than the national average in 2024/25.³⁸⁶ Employment and Support Allowance (ESA) provides financial and personalised support to individuals who are unable to work due to a health condition or disability. In May 2025, mental and behavioural disorders accounted for 47% of all ESA claims in Norfolk (7,660 out of 16,239).³⁸⁷

Unemployment

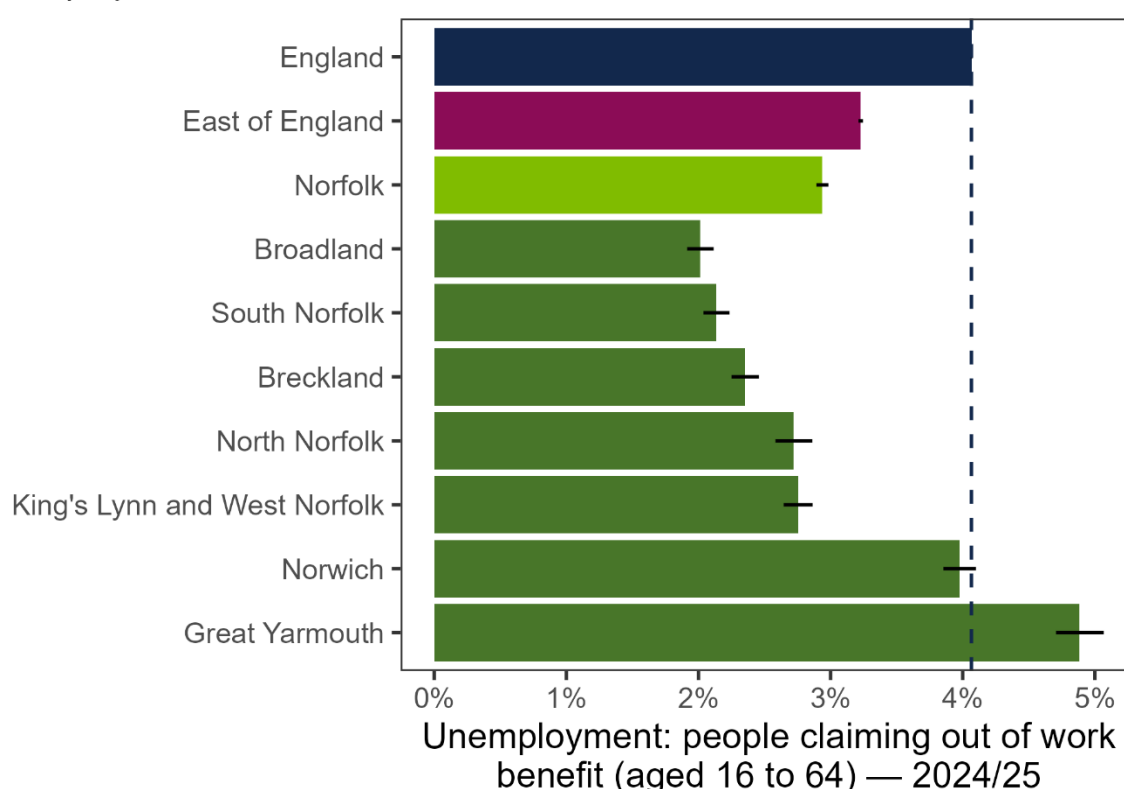


Figure 31: Percentage of working-age population claiming out of work benefits in Norfolk and its districts, East of England and England (OHID).

A national occupation and mental health survey in 2011 found that managers, administrators, clerical and secretarial, and personal service occupations (e.g. care

assistants) had a higher prevalence of common mental disorders.³⁸⁸ According to the 2021 Census, national trends in occupation are similar regionally and locally. In Norfolk, over 10% of the population were in Level 7 intermediate NS-SEC occupations which include jobs in clerical, service and intermediate technical occupations.³⁸⁹

Socio-economic classifications

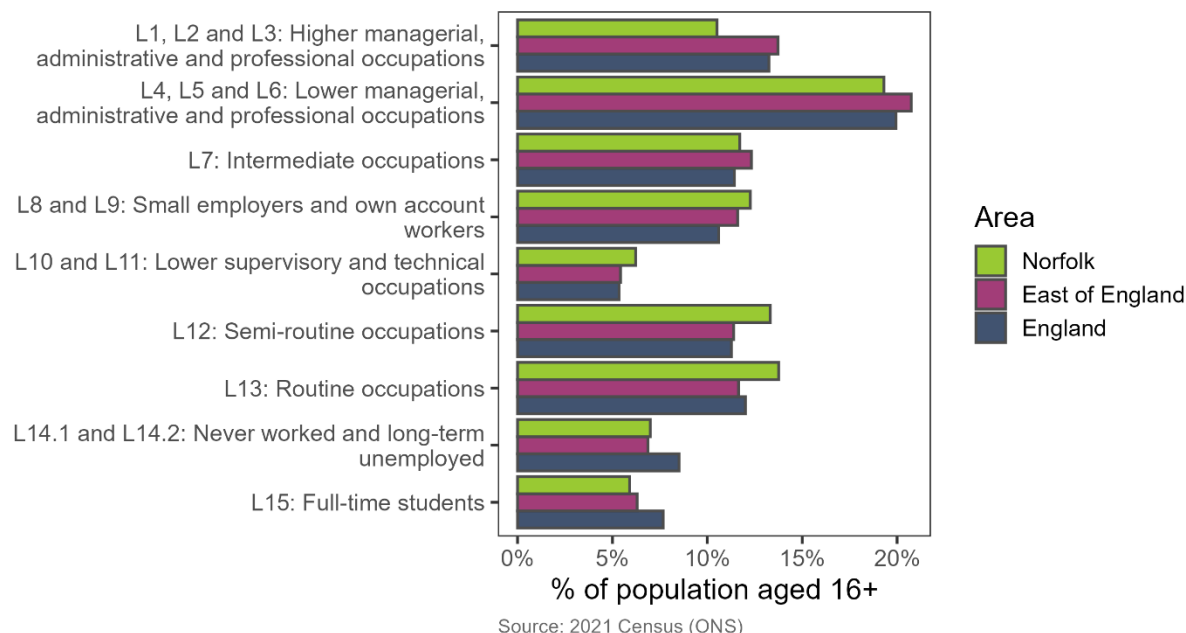


Figure 32: Percentage of population aged 16+ working in different occupations (2021 census, ONS)

According to the latest Annual Population Survey, Norfolk has a lower proportion of people working in professional occupations (20.2% compared with 27.2% in England) and a higher proportion in 'elementary occupations', which are typically associated with lower socio-economic circumstances (12.9% compared with 8.9% in England).³⁹⁰

Median annual earnings for those in full-time employment in Norfolk remain below the England median for both men and women. In 2025, the median annual gross pay for men was £38,575 in Norfolk compared with £42,157 in England. For women in Norfolk, the median annual gross pay was £33,077 compared with £35,674 for England.

Promoting access to good quality employment and improving working conditions could help reduce mental health inequalities locally. This is reflected in the Adult Psychiatric Morbidity Survey, which found that, nationally, those who were unemployed (40%) and economically inactive (38.8%) were more likely to have a common mental health condition than those in employment (18.3%).

Crime, Safety and Violence

Being a victim of violence and abuse is a known risk factor for poor mental health outcomes. While Norfolk experiences lower rates of domestic abuse and violent crime compared with the national averages, reoffending rates are slightly elevated:

- Domestic abuse related incidents and crime rates in Norfolk were 22.6 per 1,000 in 2023/24 compared with 27.1 per 1,000 nationally.³⁹¹

- Norfolk had a violent crime rate of 27.9 offences per 1,000 in 2023/24 compared with the national average of 32.7.³⁹²
- 27.5% of offenders reoffended in Norfolk in 2022/23, slightly higher than the national average of 26.2%.³⁹³

Poverty

Poverty is both a cause and a consequence of poor mental health. The stress, stigma and trauma associated with poverty can increase the risk of developing mental health conditions and equally, mental health conditions can lead to job loss, reduced income or underemployment, further deepening financial insecurity.³⁹⁴ Evidence from a systematic review indicates that income inequality is associated with poorer mental health.³⁹⁵

According to the 2025 Index of Multiple Deprivation (IMD) dataset for England, Norfolk ranks 86th out of 153 local authorities based on average deprivation score.³⁹⁶

In 2023, 11.7% of households in Norfolk experienced fuel poverty compared to 11.4% in England.³⁹⁷ Within Norfolk, North Norfolk (13.5%) and Great Yarmouth (13.1%) had the highest proportions, followed by King's Lynn and West Norfolk (12.6%) and Norwich (12.1%).³⁹⁸

Data from Citizen's Advice Bureau Norfolk shows that the cost-of-living crisis is applying sustained pressure on Norfolk residents. The number of clients asking for advice around charitable support and food banks has increased year-on-year since 2022. The pressures are felt most acutely by more vulnerable members of society, with many being single parents or living in single-person households and a high proportion (63%) having a disability and/or a long-term health condition.

Climate Change

Climate change is increasingly recognised as a risk factor for mental health. A recent review of existing literature and studies by the UK Health Security Agency found that there is an increased risk of PTSD, depression and anxiety following exposure to flooding.³⁹⁹ Mental health morbidity is also negatively impacted following exposure to high temperatures, and psychological distress, stress and anxiety are some of the mental health impacts of drought. Norfolk's long, low-lying terrain coastline and relatively warm, dry climate increase the risk of flooding, coastal erosion, drought and heatwaves.⁴⁰⁰

Gambling

There is emerging evidence of an association between gambling, mental ill-health and suicide. One study found that a diagnosis of gambling harm is a predictor of suicide and that those with a gambling diagnosis who died by suicide had more recent contact with mental health services, particularly hospital admissions.⁴⁰¹

National data from the Adult Psychiatric Morbidity Survey (APMS) using the Problem Gambling Severity Index (PGSI) shows a clear link between gambling harms and poor mental and physical health. While most adults either do not gamble or do so without harm, moderate to high-risk gambling is more common among people with a CMHC. Among adults, 2.6% of those with a CMHC score in the moderate to high-risk gambling range, compared with 1.3% of those without.⁴⁰²

These differences are particularly more pronounced among men; men with a CMHC are more than twice as likely to be moderate to high-risk gamblers (4.4% compared with 1.7%) and higher-risk gambling is also more frequent in this group. Although gambling is lower among women overall, the same pattern is seen, with women with a CMHC around twice as likely to report moderate to high-risk gambling compared with those without, albeit absolute prevalence remains low among women.

Across all groups, adults with CMHCs are less likely to gamble without harm and more likely to report negative consequences linked to gambling. This reinforces that gambling harm is both a mental health inequality and a potential contributor to deteriorating mental health.

Data on gambling harm is limited, however we know that Norfolk has a higher density of gambling premises than the national average, with 19.2 premises per 100,000 residents compared with 12.9 per 100,000 across England.⁴⁰³ Great Yarmouth has the highest rate (91.9 per 100,000) among the Norfolk districts. Some studies suggest that greater availability of gambling outlets is linked to increased gambling participation and problem gambling rates, and harms are often concentrated among socioeconomically disadvantaged groups.

Neurodiversity

Data on neurodiverse conditions in adults is limited, and service-level data is not included in this assessment. However, ADHD in adults has been associated with health inequalities, including reduced life expectancy, with one study estimating 7–9 years lower than the general population, largely due to modifiable factors such as smoking, unmet mental and physical health needs and lack of treatment.⁴⁰⁴ This indicates increased vulnerability to poor health outcomes among some neurodiverse adults. Autistic adults are also more likely to report mental ill-health, chronic health conditions and poorer healthcare quality than non-autistic adults.⁴⁰⁵ These disparities have been linked to increased anxiety during healthcare interactions.

5.5 Summary

Mental health and wellbeing among working-age adults in Norfolk are shaped by social, economic and environmental factors, alongside individual circumstances. Overall self-reported wellbeing in Norfolk is broadly similar to England, with slightly better life satisfaction and worthwhile scores, while anxiety and happiness are comparable. The estimated prevalence of common mental disorders in Norfolk is slightly below the national average, however this data has not been updated since 2017. Severe mental illness is also in line with England averages. Depression prevalence among those registered with a GP practice has more than doubled over the past decade, mirroring national trends. Self-reported anxiety levels also mirror national averages.

Certain groups face higher risk of poor mental health in Norfolk, including those experiencing poverty, unemployment, low-paid work, housing insecurity and long-term physical conditions. Other at-risk groups include people with substance use issues, caregivers and those exposed to ACEs or trauma.

Protective factors such as physical activity, access to green spaces, a healthy diet, resilience, financial security and good quality employment are important for promoting wellbeing.

Interventions should focus on prevention and resilience-building across the life course, particularly for high-risk groups, such as those who have experienced trauma. Approaches that address social determinants, including poverty, housing and employment, and that integrate trauma-informed care are also essential.

6 Older Adults' Mental Health and Wellbeing in Norfolk

This chapter explores the mental health needs of older adults in Norfolk. Those aged 65 and over are generally considered to be older adults, however it is important to recognise that people in this group can biologically age at different rates and therefore wide variations exist in terms of health status.⁴⁰⁶ These differences are further shaped by health inequalities, with factors such as access to services, socioeconomic status and housing influencing both physical and mental health outcomes in later life.

For the purposes of this chapter, older adults are defined as those aged 65 and over, in line with age thresholds commonly used by national organisations such as NHS England, the Office for National Statistics and the Association of Directors of Public Health.

6.1 Key findings

- In 2017, an estimated 10.1% of people aged 65 and over in Norfolk had a common mental disorder, similar to the England average (10.2%). This is the latest available data.
- Dementia prevalence recorded in Norfolk is higher than the England average, reflecting Norfolk's older demographic profile. However, dementia diagnosis rates are below national averages, suggesting potential underdiagnosis locally.
- It is estimated that all Norfolk districts will have an increase in older adults feeling lonely in the next fifteen years. Breckland and South Norfolk are projected to have the largest increase in older adults feeling lonely, both above 40% by 2040.

6.2 National Context

The UK population is ageing, with the number of people aged 65 and over having increased by 19% between 2011 and 2021, from 9.2 million in 2011 to 11 million in 2021.⁴⁰⁷ By 2041, one in four people living in the UK will be aged 65 and over.⁴⁰⁸ In Norfolk, the proportion will be even higher. This demographic shift has raised growing concerns about the rising prevalence of mental health conditions in later life. In 2017, it was estimated that 10.2% of people aged 65 and over in England were living with a common mental health condition such as depression or anxiety.⁴⁰⁹ However, broader estimates suggest that as many as one in four older people experience symptoms of depression that require treatment.⁴¹⁰

Mental health conditions in older adults are often undetected and undertreated. Research shows that common mental health conditions such as depression and anxiety may present differently in older adults, often masked by other physical symptoms or cognitive decline and therefore could be overlooked by both patients and GPs, potentially leading to significant unmet mental health needs in this population.⁴¹¹

Although older adults are more likely to experience adverse life events such as bereavement, chronic physical conditions and caring responsibilities without support, the associated mental health impacts of these experiences should not be normalised. For example, older adults typically take the same amount of time as other age groups to return to their baseline level of personal functioning following bereavement.⁴¹² With appropriate

support and treatment, particularly psychological therapy, older adults' mental health does improve.

Population profile

Norfolk already has an older population compared with the national average (Figure 33), and this demographic is projected to grow at a faster rate than in the rest of England.

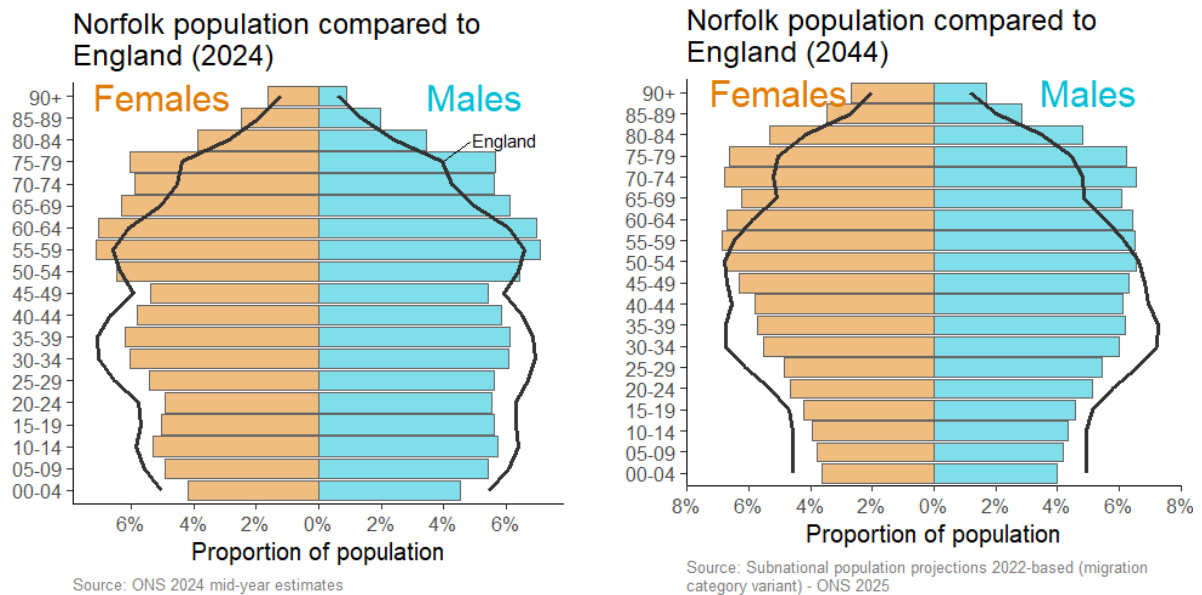
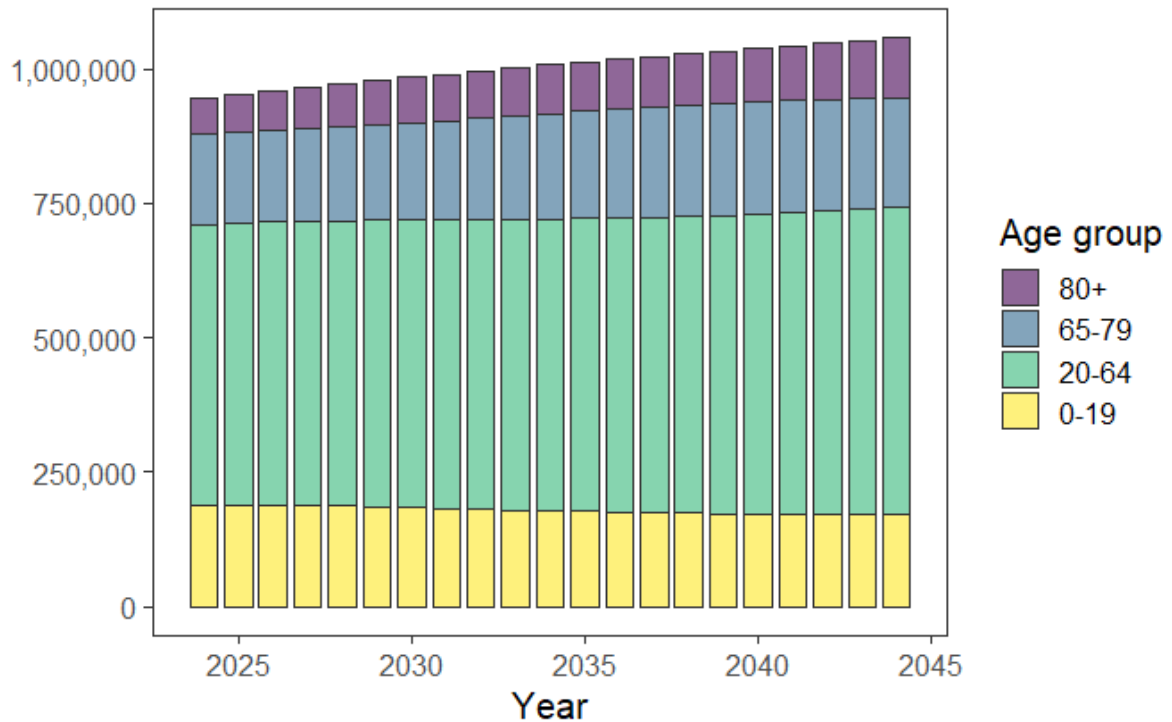


Figure 33: Age distribution of Norfolk compared with England (left: 2024, right: 2044).

Over the next decade in Norfolk, the most significant population increases are expected in the 65 and over age bands, and by 2044, the number of people aged 80 and over is projected to increase by 64%, such that one in 10 residents will be aged 80 years or more (Figure 34).⁴¹³

Norfolk Residents



Source: ONS population projections (2025)

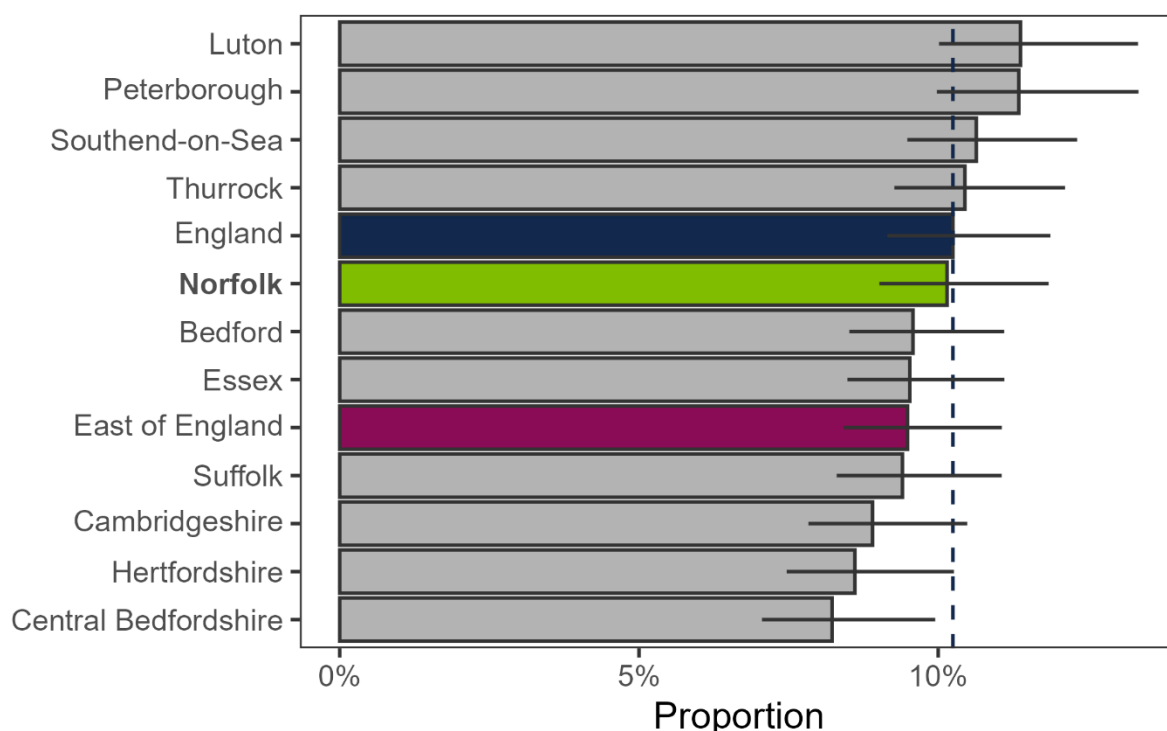
Figure 34: Projected population growth in Norfolk by age group (2024 to 2044).

Understanding the mental health needs of those aged 65 and over is therefore crucial to both ensure services are responsive to the current population and prepare for the increasing demand and complexity of needs that will accompany an ageing population. This includes planning for age-appropriate mental health services, addressing inequalities and any barriers to access, and ensuring that older adults are supported to maintain wellbeing as they age.

6.3 Local Data on Mental Health and Wellbeing

In 2017, an estimated 10.1% of people aged 65 and over in Norfolk had a common mental disorder, which was comparable to the England average of 10.2% (Figure 35).⁴¹⁴ This data is no longer available at Lower Tier Local Authority (LTLA) level.

Estimated prevalence of common mental disorders: % of population aged 65 & over (2017)



Source: OHID fingertips & NHS Digital

Figure 35: Estimated prevalence of common mental disorders in people aged 65 & over in 2017 in Norfolk and other upper tier local authorities in the region, the East of England and England.

6.4 Risk and Protective Factors

This section explores the risk factors, including biological, psychological, social and environmental influences, that can increase the likelihood of developing mental health conditions and hinder recovery from mental ill-health, alongside the protective factors that mitigate these risks and promote resilience.

Promoting healthy ageing requires a focus on mental health promotion and prevention measures to reduce the risk of mental ill-health. Evidence shows that such measures can enhance mental health and wellbeing, improve quality of life, and help alleviate depressive symptoms:⁴¹⁵

- Reducing financial insecurity and income inequality.
- Safe and accessible housing, public buildings and transport.
- Enhancing social connection to reduce social isolation and loneliness, including social support for older adults and their carers.
- Supporting healthy behaviours including eating a balanced diet, being physically active, and refraining from tobacco and alcohol use.
- Health and social programmes targeted at vulnerable groups such as those who live alone or in remote areas and those living with chronic health conditions.
- Protection from ageism and abuse.

The Centre for Mental Health also notes the following factors to prevent mental health problems in older adults:⁴¹⁶

- Psychological resilience
- Positive relationships and networks
- Person-centred care and holistic care
- Therapies to address physical and mental health problems, including:
 - CBT and other talking therapies
 - Acupuncture
- Retaining and having access to meaningful roles and purpose e.g. volunteering; having a choice as to whether to work past retirement age.

The following section outlines the factors that may increase the risk of developing mental health conditions in older age, as well as ways to mitigate their impact and relevant local data.

Chronic Health Conditions and Frailty

The relationship between chronic illness and depression is bidirectional: illness can lead to depression, and depression can worsen outcomes for physical health conditions. Individuals with one or more chronic health conditions are significantly more likely to experience depression.⁴¹⁷ A growing number of older adults live with multiple long-term conditions. This can lead to chronic pain, impaired functioning, reduced independence and social isolation, all of which are associated with poorer mental health outcomes. In 2015, 54% of people in England aged 65 and over had two or more chronic health conditions, projected to rise to 67.8% in 2035.⁴¹⁸

Frailty refers to a person's "mental and physical resilience or their ability to bounce back and recover from events like illness and injury".⁴¹⁹ Frailty is often but not always experienced by older people. A systematic review found a bidirectional relationship between frailty and depression; participants with frailty were around 2.6 times more likely to have depression when adjusted for other factors.⁴²⁰

Frailty can complicate mental health assessment. On one hand, mental health needs may be overlooked as health professionals prioritise physical health.⁴²¹ On the other hand, physiological changes linked to frailty can sometimes be misinterpreted as depressive symptoms, leading to misclassification.⁴²²

Enhancing social support, both formal (e.g. given by organisations) and informal (e.g. given by colleagues and family), can help reduce frailty in older adults by improving physical and mental health, and even postpone the onset of frailty.⁴²³

Supporting a sense of control in older adults living with frailty can also help protect against poor mental health. Engaging in self-care activities such as exercise, managing medication, maintaining a good diet, and adopting a good oral hygiene routine, can help support the management of existing conditions, reinforce a sense of control, and maintain wellbeing.⁴²⁴

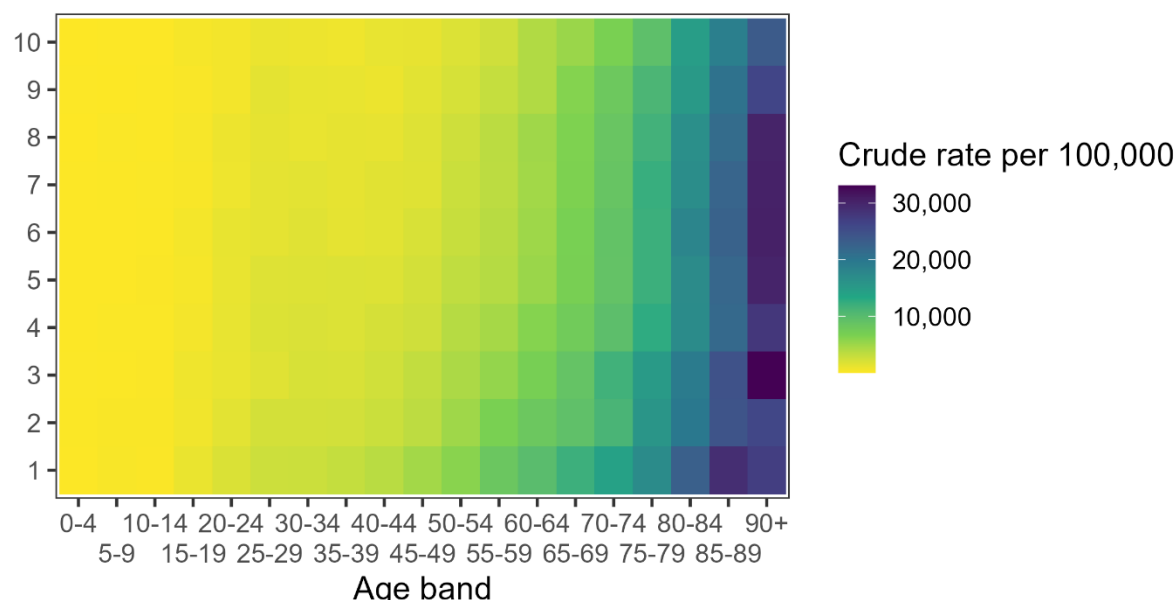
Psychological factors such as a perceived sense of control, optimism and self-esteem have also been found to protect wellbeing among older adults with chronic health conditions.⁴²⁵

In Norfolk, the discrepancy in the rate of long-term conditions between the most and least deprived areas is most notable in people in their 40s to 60s (Figures 36 and 37). This

indicates that health inequalities begin well before old age and may compound over time, increasing the risk of poor mental health in later life. Proactive management of long-term conditions, especially in more deprived communities, may therefore play a vital role in protecting mental health as people age.

Admissions of patients with 2+ long-term conditions between Apr 2022 - Mar 2025

IMD 2025 decile



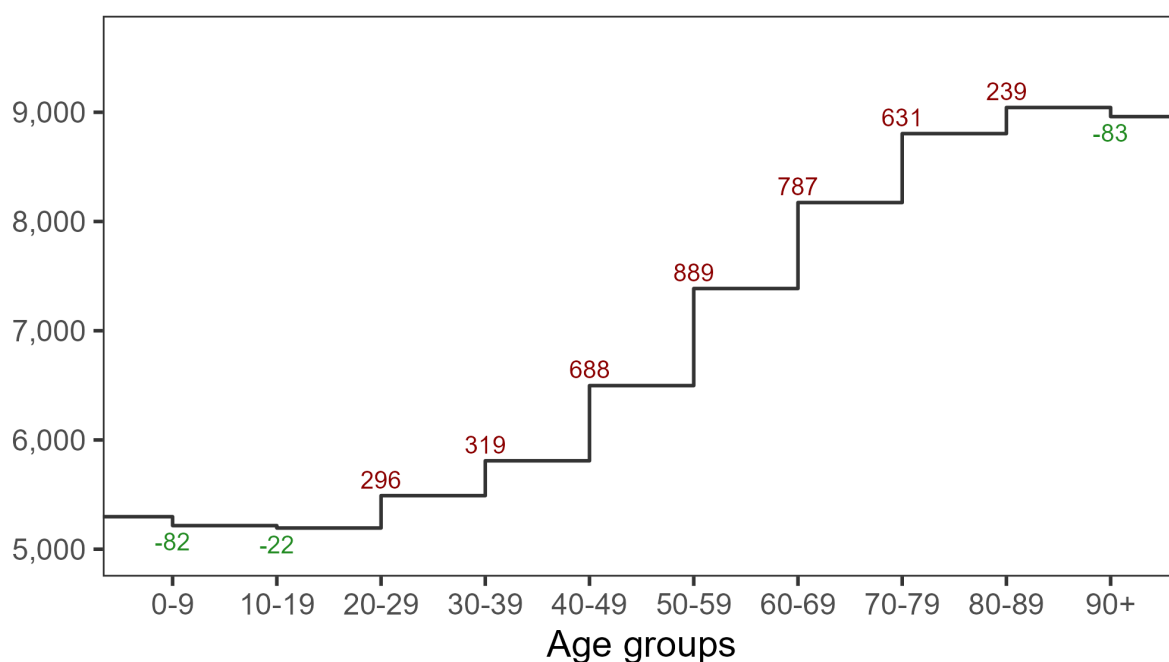
Sources: HES (NHS Digital); ONS

Figure 36: Hospital admissions for patients with two or more long-term conditions by age band and deprivation decile (1 is most deprived) in Norfolk (April 2022–March 2025).

The greatest inequalities in rates of long-term conditions between the most and least deprived areas occur in the 50–59 and 60–69 age groups (Figure 37). These groups contribute most to the overall deprivation gap. For example, if inequalities in long-term conditions were eliminated for people in their 50s, there would be 889 fewer people with long-term conditions per 100,000 in the most deprived areas than there are now. In the oldest age groups, the gap narrows and even slightly reverses. This pattern highlights the need for intervention and equitable management of long-term conditions in working-age adults to protect mental health and wellbeing in later life.

Contribution of age groups to the gap in rates of long-term conditions between the least and most deprived areas (IMD deciles)

DSR per 100,000



Sources: HES (NHS Digital) and ONS mid-year estimates
NB: Small area deprivation scores based on IMD 2025

Figure 37: Contribution of age decades to the difference in rates of long-term conditions between the least and most deprived areas in Norfolk (DSR per 100,000, April 2022–March 2025).

Dementia

Dementia can both trigger mental health problems and make treatment of mental health conditions more challenging. It is estimated that 40% of people with dementia also have depression.⁴²⁶ Antidepressants are not found to be effective in supporting this cohort.⁴²⁷

The behavioural and psychological symptoms of dementia can be distressing for individuals and families and often lead to residential care. Non-pharmacological interventions such as cognitive and sensory stimulation, music therapy, animal therapy and psychotherapeutic approaches such as CBT show promise in reducing symptoms of anxiety and depression, as well as enhancing mood and improving quality of life. These approaches may be more effective and have fewer adverse effects than pharmacological treatments.⁴²⁸

Home-delivered psychotherapy such as Problem Adaptation Therapy (PATH) has been shown to reduce depressive symptoms in older adults with cognitive impairment.⁴²⁹ Therapists work with individuals and caregivers to identify activities that elicit positive emotions such as scheduling pleasurable activities, and to develop compensatory strategies like using calendars and checklists to support daily functioning and emotional wellbeing.

Caregiving plays a significant role in the wellbeing of people with dementia. High levels of caregiver-expressed emotion, such as criticism or emotional overinvolvement (e.g. exaggerated emotional response or being over-intrusive), are linked to increased depression

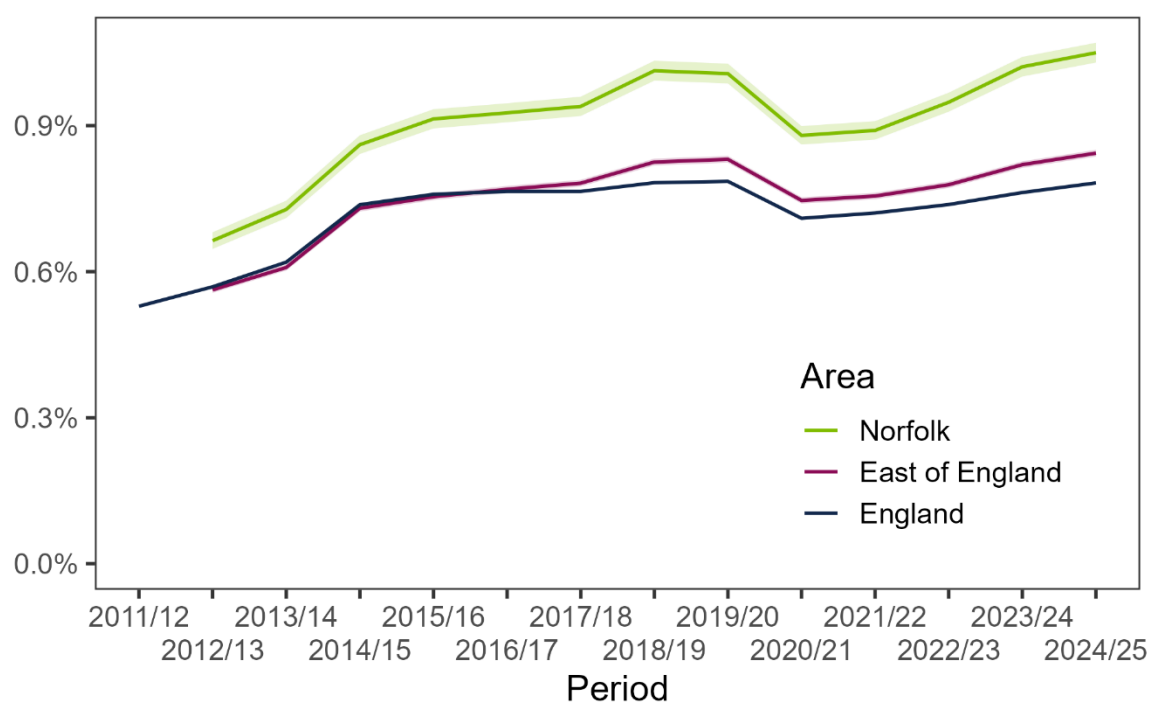
and anxiety in those with dementia. CBT-informed family-based interventions that address caregiver emotional and behavioural responses and foster low expressed emotion can support better wellbeing of those with dementia.⁴³⁰

The recorded prevalence of dementia in Norfolk is higher than the national average, however this indicator is not age-adjusted (Figure 38). Areas with older populations will typically show higher rates of dementia, and Norfolk's older demographic profile may explain its higher prevalence compared with England.

The estimated dementia diagnosis rate compares the number of people diagnosed with dementia to the number expected based on population characteristics, particularly age. Norfolk has a relatively older population who are at risk of dementia. Despite this, diagnosis rates in Norfolk remain consistently below the national average, suggesting that dementia may be underdiagnosed locally (Figure 39).

Dementia

QOF prevalence

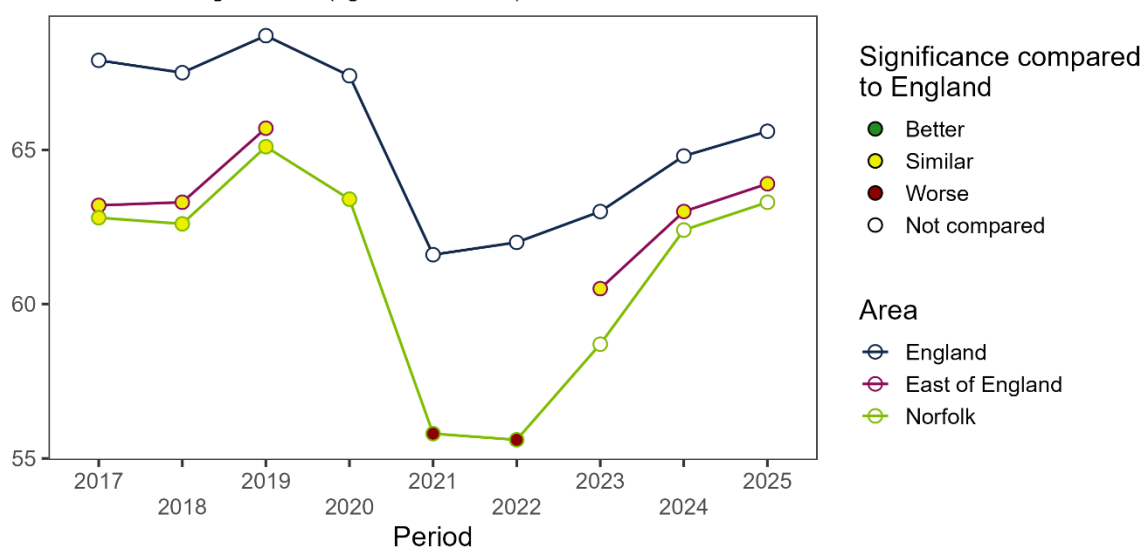


Source: OHID Fingertips

Figure 38: Recorded prevalence of dementia in Norfolk and England (2011/12–2024/25).

Dementia diagnoses

Estimated dementia diagnosis rate (aged 65 and older)



Source: OHID Fingertips

Figure 39: Estimated dementia diagnosis rate for adults aged 65 and over in Norfolk, East of England and England (2017–2025).

Wernicke-Korsakoff syndrome is a condition similar to dementia but is caused by drinking too much alcohol. Further details will therefore be included in the drug and alcohol needs assessment.

Loneliness and Social Isolation

Loneliness and social isolation are related but distinct concepts. Loneliness refers to the subjective, negative feeling of being alone, while social isolation is an objective lack of social contact or interaction. Both are significant risk factors for poor mental health, particularly in later life.

In England, 25% of adults report feeling lonely “often or always” (7%) or “some of the time” (18%).⁴³¹ Although loneliness tends to decline with age, it rises again among those aged 85 and over. Transitions such as bereavement, retirement or the onset of disability and illness can increase vulnerability to loneliness.^{432 433} Additional risk factors include caring responsibilities, digital exclusion, reduced mobility and limited access to transport.⁴³⁴

Health-related challenges (e.g. hearing loss or mobility issues) and changes in social networks also contribute to social isolation, especially following the loss of a spouse or close friend.

Meaningful social activities can improve mental health, quality of life and life satisfaction, and can reduce depressive symptoms. Example interventions to prevent social isolation and loneliness in old age include befriending initiatives, community and support groups, social skills training, creative arts groups, leisure and education services and volunteering.⁴³⁵

Data on reported feelings of loneliness are only available at district level for 2019/20. Norwich has the largest proportion of people aged 16 and over experiencing loneliness, higher than the England average.⁴³⁶

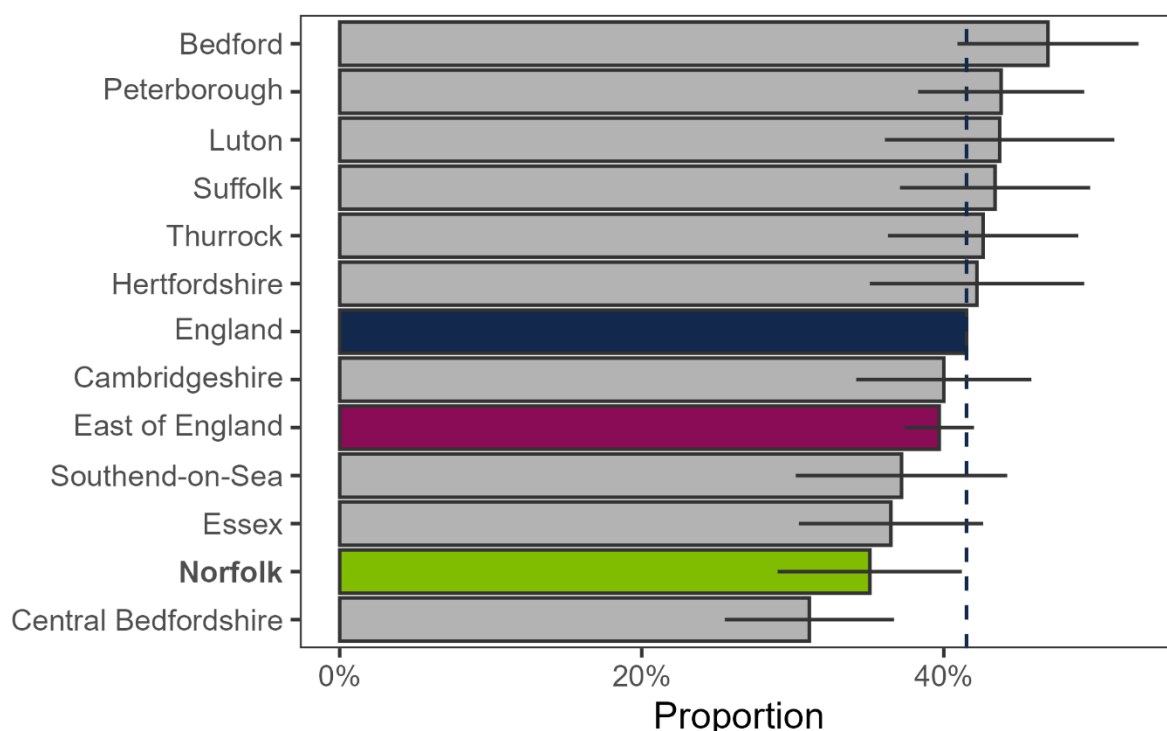
It is estimated that all districts will have an increase in older adults feeling lonely in the next fifteen years because of an ageing demographic. Breckland and South Norfolk are projected to have the largest increase in older adults feeling lonely, both increasing by almost 40% by 2040 (Table 1).

Area	2025	2030	2035	2040
Breckland	1,510	1,730 (+14.6%)	1,970 (+30.5%)	2,110 (+39.9%)
Broadland	1,440	1,610 (+11.5%)	1,800 (+24.9%)	1,900 (+31.9%)
Great Yarmouth	970	1,070 (+10.3%)	1,190 (+22.1%)	1,250 (+28.3%)
King's Lynn and West Norfolk	1,660	1,840 (+10.6%)	2,040 (+22.6%)	2,150 (+29.1%)
North Norfolk	1,440	1,590 (+10.5%)	1,770 (+23.4%)	1,870 (+30.1%)
Norwich	870	950 (+8.5%)	1,040 (+18.9%)	1,090 (+24.9%)
South Norfolk	1,490	1,700 (+14.5%)	1,930 (+30.0%)	2,080 (+39.7%)

Table 1: Projected number of older adults aged 65+ in Norfolk districts feeling lonely often or always in 2025 to 2040 using 2023/24 national age prevalence and 2025 sub-national population projections; change from 2025 in brackets.

Data on social isolation is limited, however adult social care users aged 65 and over in Norfolk report lower levels of satisfaction with their social contact compared with the England average. In 2023/24, Norfolk had one of the lowest proportions of older adult social care users who felt they had as much social contact as they would like, falling below both the national average and most neighbouring regions in the East of England (Figure 40). While this does not reflect all older adults, it suggests that social isolation may be an issue among those with care needs, with potential indications for mental health and wellbeing.

Social Isolation: percentage of adult social care users who have as much social contact as they would like (2022/23)



Source: OHID fingertips

Figure 40: Percentage of adult social care users aged 65 and over who report having as much social contact as they would like in Norfolk, other upper tier local authorities in the region, the East of England and England (2023/24).

Demography

Older adults may face age-related discrimination in mental health care. There is evidence to suggest that symptoms of poor mental health such as low mood or anxiety are often dismissed as an inevitable part of ageing or attributed to physical illness or dementia by both patients and GPs.⁴³⁷ This can result in limited or inappropriate treatment options being offered.⁴³⁸

Research also shows that GPs are much less likely to refer older people to Talking Therapy services, despite higher levels of engagement and being more likely to benefit from treatment than younger age groups, with recovery rates in those 65 and over exceeding those of younger patients.⁴³⁹

Older adults themselves are also reluctant to seek help for their mental health due to stigma surrounding these conditions.⁴⁴⁰

As a result of this complex interplay of ageism and stigma, only one in six older people with depression discuss their symptoms with their GP and fewer than half of these receive appropriate treatment.⁴⁴¹

The number of referrals to Norfolk and Suffolk NHS Foundation Trust Talking Therapies for adults aged 65 and over in Norfolk and Waveney has increased steadily since 2017/18, with consistently higher counts for females than males (Figure 41). Self-referrals are the most

common referral route for both males and females, and the most recent years (2023/24 and 2024/25) show the highest referral volumes (Figure 41). A higher proportion of residents in urban areas have talking therapy referrals recorded than those in rural areas (Figure 42).

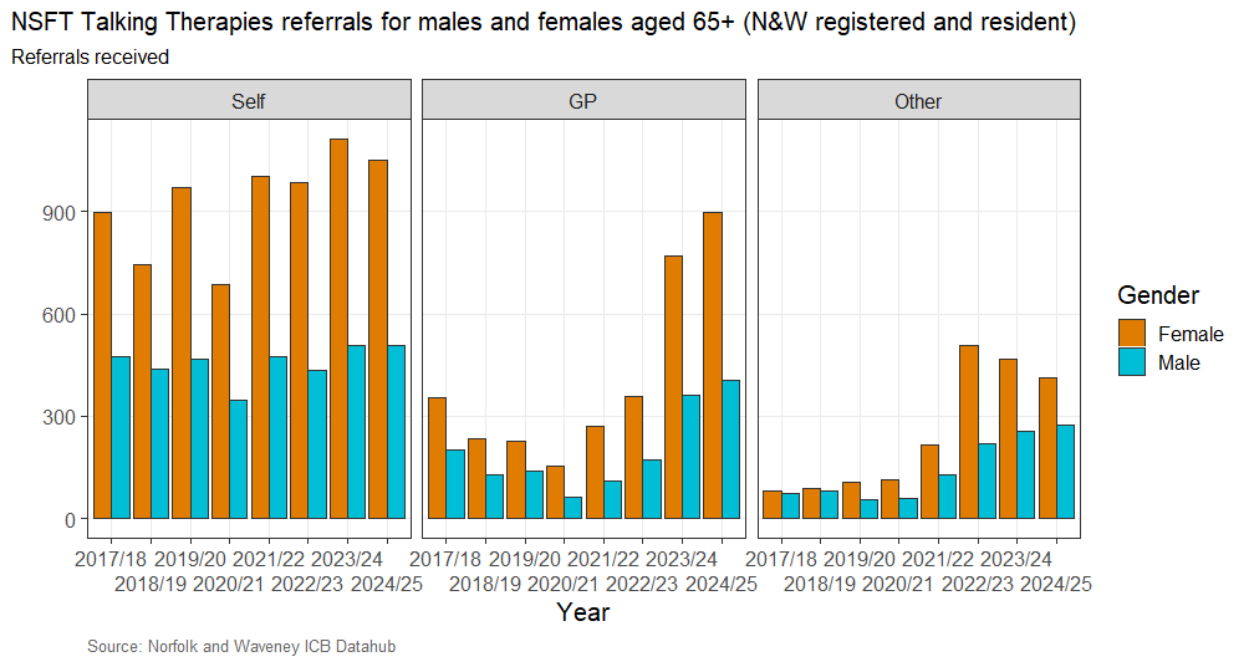
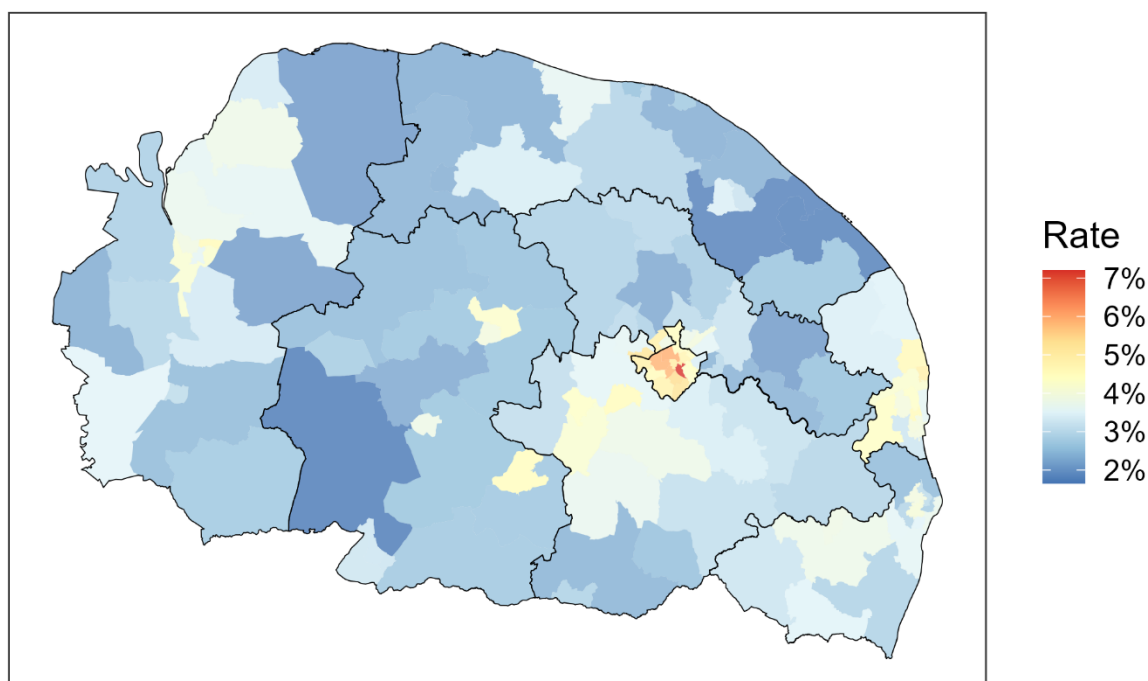


Figure 41: Number of referrals to talking therapies made by patients themselves (self), by primary care (GP) or any other for male and female patients (Norfolk and Waveney registered and resident) aged 65+ in 2017/18 to 2024/25.

Proportion of 65+ residents who had any Talking Therapy referral in 2020/21-2024/25



Source: Norfolk and Waveney ICB Datahub

Figure 42: Proportion of individuals aged 65+ (Norfolk and Waveney registered and resident) who had a referral to talking therapies in 2020/21 to 2024/25 by small area (MSOA).

Caregiving Responsibilities

The number of hours spent caring increases with age. An estimated 28% of informal carers in the UK are aged 65 and over, with recipients likely to be partners or older relatives.⁴⁴² Caregiving is associated with higher levels of common mental disorders, with Carers UK finding that 30% of carers report bad or very bad mental health, and 29% reporting feelings of loneliness.^{443 444}

A range of approaches can help mitigate the mental health impacts of caregiving. These include caregiver education and workshops to reduce stress and improve coping and resilience; physical activity, CBT, psychoeducation, coping skills and mindfulness to manage stress and reduce depression; and promoting social participation through community groups, volunteering and online networks to maintain wellbeing over time.⁴⁴⁵

Among those aged between 65 and 84 in Norfolk, the proportion providing unpaid care is overall higher than other age bands. Females are significantly more likely than males to take on caring responsibilities below the age of 65, but that pattern reverses over the age of 85, when a higher proportion of males provide unpaid care (Figure 43). The decrease in female unpaid carers in the 85 and over group may reflect demographic realities, such as women living longer and therefore being more likely to outlive the person they were caring for. The data highlights the hidden burden of care carried by older adults and the need for targeted support for this group, as unpaid care can increase the risk of loneliness and poor mental health.

Unpaid care in Norfolk

Age group

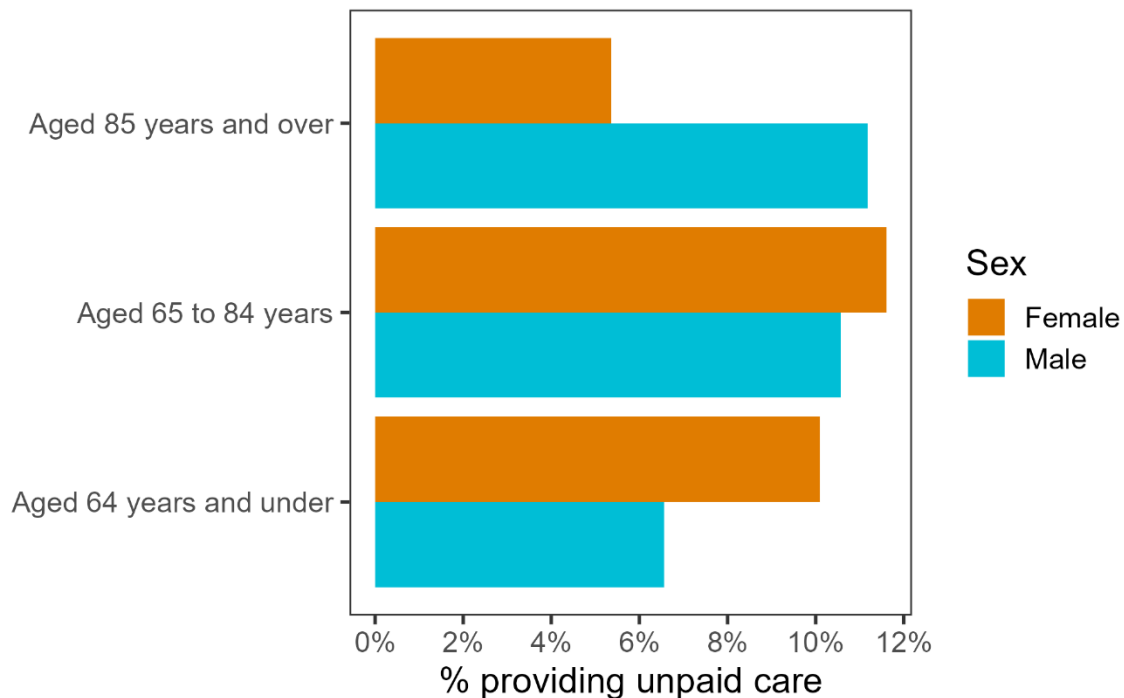


Figure 43: Percentage of female and male Norfolk residents who provide unpaid care according to the 2021 census.

Receipt of Care

The prevalence of depression in care home residents is estimated to be around 4 in 10.⁴⁴⁶ Further, 1 in 10 nursing home residents have symptoms of psychosis such as delusions and hallucinations.⁴⁴⁷

International studies suggest that frequent family visits may help reduce depression among care home residents, but other factors such as cultural values, comorbidities and functional impairment, and opportunities for socialisation, including social involvement, also influence depression among this cohort.⁴⁴⁸ These findings highlight the important role of healthcare staff in facilitating socialisation and promoting mental wellbeing, especially for residents who are not visited by family.⁴⁴⁹

Abuse

Abuse affects a significant proportion of adults aged 60 and over globally, with a prevalence rate of 15.7%.⁴⁵⁰ Psychological abuse is the most common form, affecting around 11.6%, followed by financial abuse (6.8%), neglect (4.2%), physical abuse (2.6%), and sexual abuse (0.9%).⁴⁵¹ Abuse of older adults can have significant mental health impacts including depression and cognitive decline, as well as physical injuries, premature mortality, financial impacts and placement in nursing homes.⁴⁵²

Although domestic abuse among older adults is often overlooked and lacks sufficient research, a review of existing literature on domestic violence and mental health in older adults indicates that between 20% and 30% of individuals aged 65 and over, most of whom

are women, experience, or have in their lifetime experienced, some form of domestic violence.⁴⁵³ While physical abuse appears less common in later life, psychological, non-physical abuse remains consistently prevalent. These experiences are linked to increased risk of poor mental and physical health.

The ONS note that there is limited data on the prevalence of victimisation and abuse in care home settings due to the high proportion of residents who do not have capacity for consent or participation in surveys.⁴⁵⁴ However, neglect is the most frequent form of abuse reported anonymously by care home staff.⁴⁵⁵ Experiencing neglect can potentially have negative consequences on older adults' mental wellbeing and quality of life, increasing the risk of developing mental health conditions such as depression.

Interventions that protect older adults from ageism include anti-discrimination policies, educational interventions and intergenerational activities.⁴⁵⁶ The World Health Organization also highlight the importance of carer interventions including respite care, advice, education, financial support and psychological interventions to support carers to maintain a healthy caring relationship that avoids abuse of older people.⁴⁵⁷

Problematic Substance Use

There has been an increase nationally in the number of people aged 65 and over with substance use and dependency problems involving prescription and over-the-counter medications. Deaths related to this type of drug use are more likely to be found in older people than younger age groups, with both intentional and unintentional misuse of prescription and over-the-counter drugs.⁴⁵⁸

Housing

Poor quality housing is a well-recognised risk factor for poor physical health, particularly among older adults who may be more vulnerable due to age-related frailty or chronic conditions. Recent research highlights that poor quality homes can also have a negative impact on mental health. Homes that are excessively damp, cold or hazardous, or classified as “non-decent” under housing standards, can contribute to stress, anxiety and a decline in overall wellbeing. According to the State of Ageing 2025 report, 2.3 million people aged 55 and over live in non-decent homes and more than a third of homeowners aged 55 and over living in non-decent homes report high or very high levels of anxiety.⁴⁵⁹

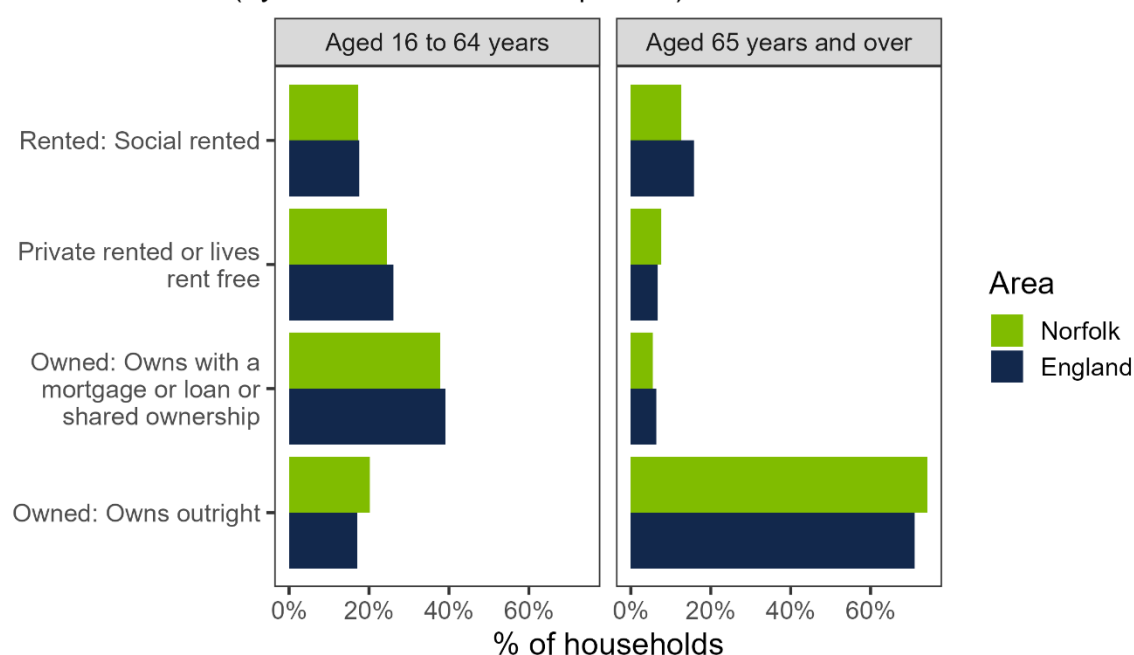
In addition to poor quality housing, many older adults live in homes that do not meet their accessibility needs, increasing the risk of falls and injuries, which may contribute to social isolation and loneliness. The impact of poor housing is not evenly distributed; adults from ethnic minority backgrounds or living with long-term health conditions or disabilities are more likely to be affected by inadequate housing and its consequences.⁴⁶⁰ Older people in privately rented accommodation are at the greatest risk of living in inadequate housing.⁴⁶¹ Draughty, damp or hard-to-heat housing also contributes to older people becoming isolated due to reluctance to invite friends or relatives to their homes.⁴⁶²

Older people may remain in family-sized homes that are expensive to heat, leading to prolonged exposure to cold and potentially worsening physical health conditions such as respiratory problems which can in turn impact on wellbeing. Older people's homes may also lack necessary adaptations. Research shows that adaptations can be transformative for

older people and improve their safety, independence and overall mental health and wellbeing.⁴⁶³

Housing tenure differs by age. Among households where the reference person is aged 65 and over, the majority own their homes outright (Figure 44). Older homeowners may face challenges maintaining or adapting their homes to meet accessibility needs, which could impact their wellbeing. The Centre for Ageing Better highlight that although the rate of non-decent homes is highest in the private rented sector, the absolute number of non-decent homes is highest in the owner-occupied sector; nationally, 1.3 million homes owned by someone aged 55 and over are non-decent.⁴⁶⁴

Household tenure (by household reference person)



Source: ONS 2021 Census

Figure 44: Tenure of households in Norfolk and England by age of the household reference person (2021 census).

Poverty

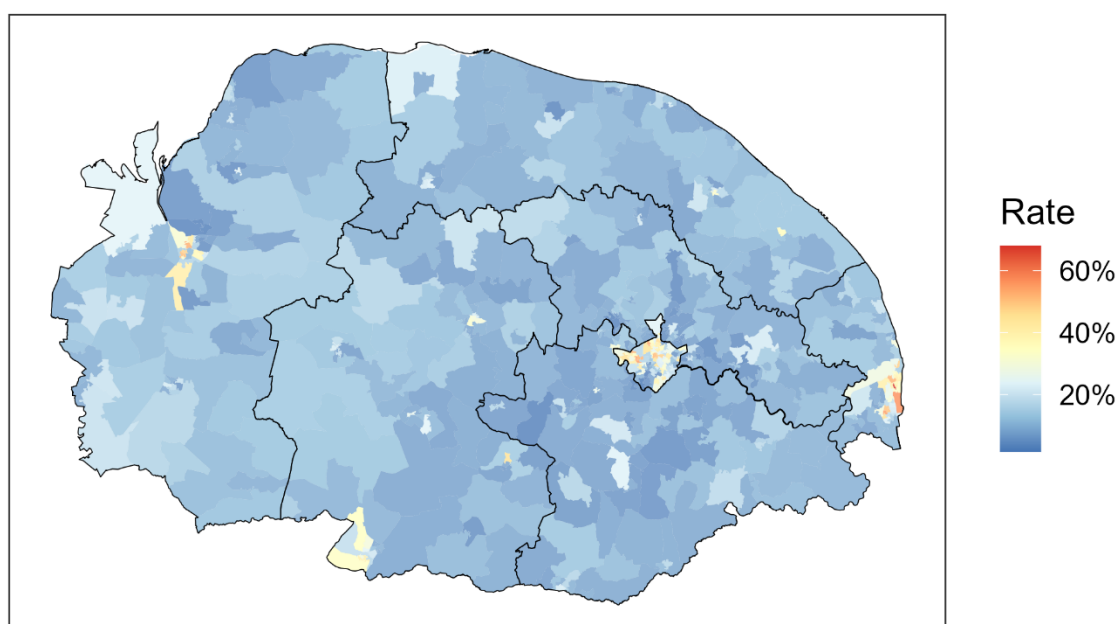
Poverty is both a cause and a consequence of poor mental health. The stress, stigma and trauma associated with poverty can increase the risk of developing mental health conditions and equally, mental health conditions can lead to job loss, reduced income or underemployment, further deepening financial insecurity.⁴⁶⁵ The mental health impacts on older adults can be significant, with constant worrying, fear, sadness, anxiety, depressive symptoms and social isolation being reported.⁴⁶⁶

Nationally, the number of pensioners aged 65 and over in material deprivation grew by 2 percentage points between 2021 and 2022, meaning 300,000 people in this age group are unable to afford essential items necessary for a decent standard of living, including being able to afford three meals a day and pay for bills.⁴⁶⁷ Older adults are typically on fixed incomes, such as pensions, which may limit their ability to manage rising living costs, making them particularly vulnerable to material deprivation when prices increase. Older adults living

in poverty are also more likely to experience digital exclusion which has also been linked to poorer mental health. A recent international study found that older adults without internet access were significantly more likely to experience depressive symptoms, particularly those with lower incomes or social contact.⁴⁶⁸

In Norfolk, 12.1% of older adults are living in poverty, which is lower than the England average of 14.2%. However, rates are significantly higher in certain areas, with 20.2% in Norwich and 17% in Great Yarmouth.⁴⁶⁹ In some small areas of Norwich, Great Yarmouth, Lowestoft and King's Lynn, more than 50% of older people are income deprived (Figure 45).

IoD 2025 Income Deprivation Affecting Older People (IDAOP) Score (rate)

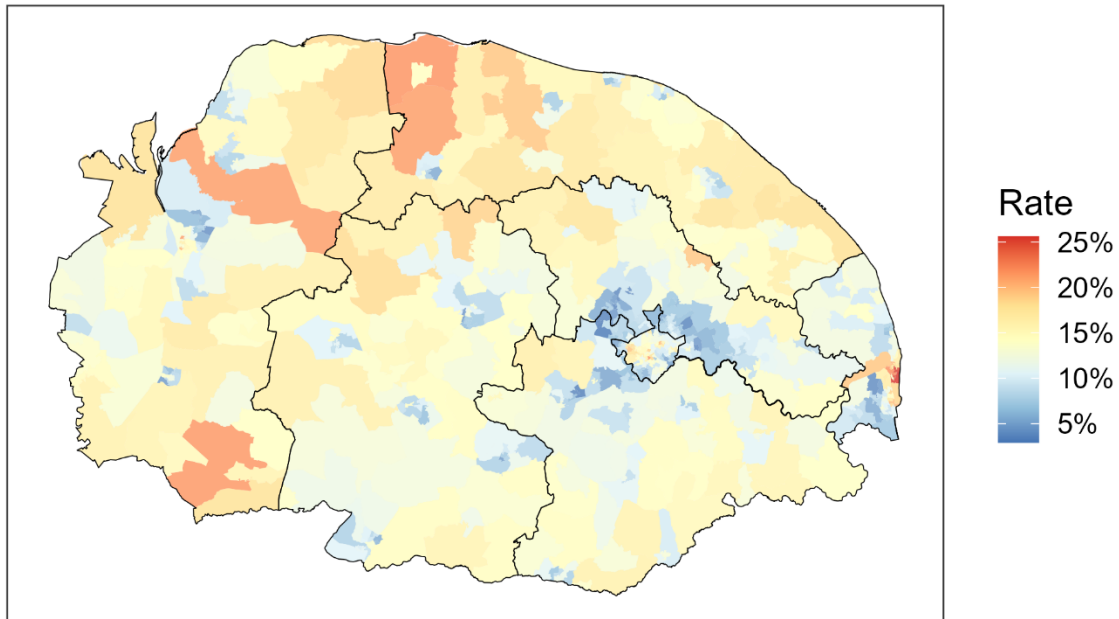


Source: Ministry of Housing, Communities & Local Government (2025)

Figure 45: Map of the rate of Income Deprivation Affecting Older People (IDAOP). Darker red indicates areas with the highest rates, while darker blue indicates areas with the lowest rates. Ministry of Housing, Communities & Local Government (2025).

A similar pattern is seen in fuel poverty, which is estimated based on energy efficiency ratings and disposable income after housing costs. In 2022, 12.1% of people in Norfolk were experiencing fuel poverty, below the England average of 13.1%. However, levels were notably higher in Great Yarmouth (14.7%), and slightly higher in North Norfolk (13.5%) and King's Lynn and West Norfolk (13.2%).⁴⁷⁰

% of households in fuel poverty 2023



Source: Department for Business, Energy & Industrial Strategy (BEIS)

Figure 46: Map of the proportions of households living in fuel poverty. Darker red indicates areas with the highest proportions, while darker blue indicates areas with the lowest proportions. Source: Department for Business, Energy & Industrial Strategy (BEIS).

Sleep

Across all ages, poor quality sleep is associated with poorer mental health. Sleep efficiency has been found to decline with age, and older adults are more likely than younger adults to experience inefficient sleep, spending extended periods in bed without sleeping.⁴⁷¹

6.5 Summary

Mental health and wellbeing among older adults in Norfolk are shaped by a combination of age-related changes, social determinants, and individual circumstances. While the most recent estimated prevalence of common mental disorders in Norfolk was similar to the national average, this figure has not been updated since 2017. Dementia prevalence is higher than England, reflecting Norfolk's older population, yet diagnosis rates remain below national averages, suggesting underdiagnosis locally.

Health inequalities persist into later life. Although poverty and fuel poverty rates among older adults in Norfolk are lower than England overall, rates remain high in Norwich and Great Yarmouth.

Protective factors, including strong social connections, access to meaningful roles, physical activity, financial security and age-appropriate housing are important in promoting wellbeing in older age.

7 Conclusion

The findings of this MHNA demonstrate that mental health in Norfolk is not determined solely by individual characteristics, but by the broader social, economic and environmental context in which people live. The assessment highlights cumulative and interacting pressures, where risk factors such as early adversity, material deprivation and lack of social connection intersect across the life course to create unequal opportunities for mental wellbeing.

There is a consistent pattern across the life course showing that mental health and wellbeing are closely linked to material conditions. National evidence shows that worsening mental health among working-age adults has coincided with financial insecurity, higher living costs and reductions in public spending. Norfolk's context mirrors this; the county has a lower median annual salary than England and pockets of significant deprivation in Norwich and Great Yarmouth meaning that many residents face pressures that heighten vulnerability to mental ill-health.

Across all chapters, evidence points to accumulation; early experiences of adversity, poverty, housing instability, chronic illness or family stress can compound over time.

At place level, the Small Area Mental Health Index highlights how mental health need clusters, often in communities already experiencing socioeconomic disadvantage.

The findings highlight key strategic considerations:

- Prevention must begin early. The perinatal period and early childhood represent key leverage points for improving long-term outcomes and breaking cycles of adversity.
- Transition periods, including the move from childhood to adolescence and again into young adulthood, are moments when risk increases and support structures change.
- Physical and mental health cannot be separated, particularly in relation to chronic illness, obesity, frailty and disability.
- Places shape mental health.
- Protective factors must be strengthened. Social connection, opportunities for physical activity, financial security, secure housing and supportive relationships emerge as buffers across the life course.

The MHNA highlights that protecting good mental health and wellbeing in Norfolk requires tackling socioeconomic drivers, building supportive environments, strengthening early relationships, reducing inequalities, and ensuring that hidden need becomes visible.

8 Recommendations

The recommendations are informed by the available data, stakeholder engagement and the evidence included in this document at the time of publication. They do not represent agreed priorities, approved policy, or a commitment to funding, commissioning, or implementation by any organisation. Recommendations highlighted in bold are aligned with those produced in the Suffolk Mental Health Needs Assessment.

For Families:

- Adopt a 'Think Family' approach, embedded in practitioner response to need.
- Practitioners who are in contact with children, young people and families access comprehensive training to address and reduce the impact of adverse childhood experiences (ACEs).
- **Strengthen early intervention and crisis prevention for children and young people** emphasising prevention, resilience-building and earlier support within community and education setting, alongside targeted support for vulnerable cohorts.
- **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, young carers and families experiencing intergenerational mental health challenges, recognising the impact of adverse childhood experiences (ACEs) on mental health and wellbeing.
- Greater emphasis on multi-agency partnership working during transition periods for children to adults aged 18–25-year-olds, particularly in relation to loneliness and securing a job.
- Strengthen access to self-harm interventions such as the RUSH Rapid Response Pathway to provide timely, community-based support.

For working age adults:

- **Reduce inequalities in mental health outcomes through targeted, place-based approaches** including action on wider determinants of mental health — such as poverty, housing, social relationships and access to trusted support.
- A system approach to tackling the impact of economic adversity.
- Local organisations across sectors work together to increase access to good work, including work which offers a living wage, alongside secure and supportive working conditions.
- Responsible organisations reduce reliance on prescribing anti-depressants, and increase referrals to complementary, evidence-based interventions such as talking therapies, physical exercise and creative health approaches, shifting from a solely medical model toward a community-based approach.

For older adults:

- **Plan for the mental health needs of an ageing population** by improving recognition of poor and deteriorating mental health in older people and support through evidence-based interventions.

- Improve the way organisations approach the management of physical pain and mental health to increase wellbeing and reduce barriers between services.
- Identify approaches that increase dementia diagnoses and importantly, adequate ways to prevent and manage the disease.

For system partners:

Improve mental health intelligence, data integration and pathway transparency.

Strengthen mental health intelligence across Norfolk and Suffolk by improving the use of population health management 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.

Glossary

Adverse Childhood Experiences (ACEs): Adverse childhood experiences (ACEs) refer to potentially harmful events occurring before the age of 18. Further detail is included in section 4.4.

Common Mental Health Condition (CMHC)/Common Mental Disorder (CMD): Terms used in national datasets to describe different types of depression and anxiety disorders that cause emotional distress but are usually less disabling than major psychiatric disorders.⁴⁷² Both terms refer to the same conditions and are used in this MHNA as they appear in data sources.

Confidence intervals: A confidence interval is a range of values that shows how certain we are about an estimate and where the true value is likely to lie. Wider intervals indicate greater uncertainty and less precise estimates.

Bradshaw's Taxonomy: A framework used to understand different types of need, including needs identified by professionals, experienced by individuals, expressed through service use, and inferred through inequalities between groups. Further detail is provided in section 2.1.

Functional Impairment: Limitations in a person's ability to carry out everyday activities or fulfil usual roles such as work, education or social activities due to physical or mental health problems.

Index of Multiple Deprivation (IMD): The official measure of relative deprivation for small areas in England, based on factors such as income, employment, health, and housing.

Looked after child: A legal term for a child under the age of 18 who is in the care of their local authority for more than 24 hours.

Mental wellbeing: A positive state of emotional, psychological and social functioning, including the ability to manage stress, build relationships and engage in daily life. A fuller definition, including its place on the mental health continuum, is provided in chapter 2.

Mental ill-health: A broad term used in this report to describe the full range of diagnosed and undiagnosed mental health conditions. Further detail is provided in chapter 2.

Modelled estimates: Estimates of need derived from applying national data to local population characteristics where local data is unavailable.

Perinatal period: The time from the start of pregnancy up to one year after birth.

Prevalence: The proportion of a population with a condition at a given time.

Severe Mental Illness (SMI): Diagnosed psychiatric conditions including schizophrenia-spectrum disorders, severe bipolar disorder and severe major depression.

Small Area Mental Health Index (SAMHI): A measure of mental health need for small areas, based on a range of indicators, such as depression diagnoses and antidepressant prescribing. Further detail is provided in section 5.3.

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