# Adult Mental Health

**Nottingham and Nottinghamshire Joint Strategic Needs Assessment (JSNA) Profile**

**November 2024**

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Nottinghamshire Health & Wellbeing Board

Nottingham City Council

# Scope and local strategic context

**Scope**

This Mental Health JSNA Profile is focused on people aged 16 and older living in Nottingham or Nottinghamshire experiencing:

- **Common Mental Health Disorders** (CMDs) comprising types of depression and anxiety, including generalised anxiety disorder, panic disorder, phobias, and obsessive compulsive disorder [1]; and/or
- **Low mental wellbeing**. Mental wellbeing can be defined as feeling good and functioning well [2]. Mental wellbeing helps people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community.

This JSNA Profile also explores how to help people to stay mentally well in their communities. This can include promoting mental wellbeing and mental health, preventing future mental health problems, and supporting recovery. This is sometimes referred to as a public mental health approach.

Although the focus of this JSNA Profile is not on secondary mental health care or mental health crisis services, people experiencing CMDs or low mental wellbeing may access these types of services. The Profile therefore includes some information about these services, including data on service access.

Serious Mental Illness (SMI), which includes diagnoses such as schizophrenia, bipolar disorder or other psychotic illnesses that cause severe functional impairment, is not in scope of this JSNA. You can find out about the terms and definitions used in this JSNA in the Glossary from page 29.

**Local strategic context**

The ambition for Nottingham and Nottinghamshire residents to have good mental health features across the local strategic context. Prevention is a common theme across local strategies, whether in the context of reducing mental or physical ill health. The locally endorsed Nottingham and Nottinghamshire Integrated Mental Health Pathway: Strategic Plan 2024/25-2026/2027 in particular is a driver for delivering an integrated mental health pathway that supports people to live well in their local community. For more details of the local strategic context including links to relevant local strategies and plans, click here. Common local strategic themes include:

- A focus on and investment in prevention of mental health problems occurring and prevention of existing mental health problems escalating.
- Ensuring there is parity of esteem between physical health and mental health. This includes reducing inequalities in life expectancy and healthy life expectancy experienced by people living with mental health problems.
- Ensuring people have mental health awareness and know how to, and can, access the right support, in the right place, at the right time. This includes providing information and signposting to help people look after their own mental wellbeing and to reduce stigma.
- Supporting the workforce to be trained in mental health awareness.
- Ensuring the building blocks of mental health are in place, through community-based support, early intervention, and support for financial wellbeing.

# Why is this topic important?

## Living well and thriving

Mental health and mental wellbeing are important resources for our health, wellbeing, and participation in society.

Good mental health and mental wellbeing support physical health and social relationships, enable people to manage illness and adversity, make it easier to adopt a healthy lifestyle, and support people to work, study and contribute to their communities[2].

Covid-19 exacerbated mental health inequalities and led to a worsening of population mental health[59, 60].

## Societal costs

Mental illness is an important societal problem, responsible for the largest burden of disease in England (23% of the total burden, compared to 16% for cancer and 16% for heart disease)[3].

An estimated one in four people has a mental health problem at any one time. This costs the English economy around £105b every year[4] and presents a large and increasingly common barrier to work. Nearly 5% of people of working age have a work-limiting mental health problem, with disproportionate impact among young people, women and people with lower education levels[5].

## Planning for the future

It is important to better understand this topic because mental health need has increased in recent years. Nationally, the proportion of people who do not have access to the building blocks of mental wellbeing and mental health, such as financial wellbeing, continues to increase[6,7]. Similarly, the proportion of people experiencing mental ill health continues to grow - and at a faster rate than increases in physical ill health[8]. For example, prevalence of depression increased from 5.8% in 2012 to 13.2% in 2022[1]. In 2023, 54% of adults in Britain identified mental health as the biggest health problem facing people today [9].

## Health inequalities

The burden of mental ill health is not shared equally. Some groups of people - including people with low incomes, disabled people, and people from some minority ethnic groups - are at higher risk of experiencing mental health problems[10]. In addition, mental health problems are both a cause and consequence of disadvantage. Disadvantage, discrimination, and exclusion increase the risk of experiencing mental health problems and low mental wellbeing. Conversely, mental health problems and low mental wellbeing increase the risk of experiencing disadvantage[11].

Alongside this inequality in need, access to support is unequal. People from disadvantaged groups are more likely than others to experience barriers to access to mental health support and services, and, when they access services, to have poorer experiences and outcomes[12].

# Health and wellbeing - overview

Everyone has mental health. Mental health encompasses a person's emotional, psychological, and social wellbeing and affects how we think, feel and act. The World Health Organisation defines mental health as "…a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" [13].

The impacts of poor mental health can be seen on social relationships, educational attainment, physical health, crime, homelessness and employment prospects[14]. Most people who experience mental health problems face stigma and discrimination, which cause further harm and make it harder to talk about mental health and to seek and access support[15]. Mental health is influenced by the social, physical and economic conditions that we are born, grow, live, work and age in[15] (shown in figure 1 below). These factors can be thought of as the building blocks of health. Risk factors interact and affect how resilient we are in coping with challenges. Some important protective and risk factors are shown below.

## Protective factors[16]

- Maternal and infant mental health
- Early years support
- Family and parenting support
- Connecting with others and forming good relationships
- Good education
- Stable secure, good quality and affordable housing
- Good quality work
- A healthy standard of living
- Accessible safe and green outdoor space
- Arts and cultural activities
- Community cohesion

## Risk factors[16]

- Poverty
- Discrimination
- Socio-economic inequalities
- Child neglect and abuse
- Unemployment
- Poor quality work
- Debt
- Drug and alcohol use
- Homelessness
- Loneliness
- Violence
- Poor physical health[15]
- Unstable relationships[15]
- Caring responsibilities[15]

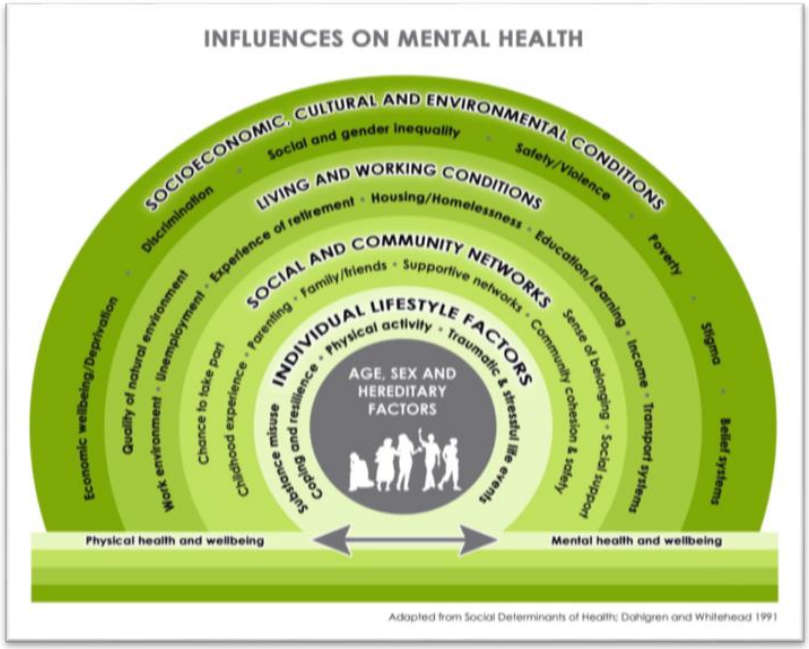



Figure 1. Influences on mental health[61]

# Health inequalities (1)

This section provides an overview of mental health inequalities in relation to common mental health disorders and low mental wellbeing taken from **national** reports and evidence. Additional information, including links to sources, is provided in supplementary documents about health inequalities here and women's mental health here. Inequalities in mental health can include inequalities in the prevalence of mental health problems, inequalities in accessing and outcomes from mental health support, and inequalities experienced by people with mental health problems.

The interplay between the determinants of mental health problems and inequalities is complex and many factors involved can be both a cause for mental health problems and be a result of experiencing mental health problems. The experience of inequalities and risk factors can have a cumulative effect. Inequalities in mental health often reflect social disadvantage[17, 18]: practical problems and wider social factors can impact on mental health[19], including social inequality and disadvantage; discrimination and social exclusion or isolation; and traumatic experiences[20].

## Inequalities in the prevalence of mental health problems

**Mental health problems are more prevalent in some groups or populations, including:**

Black and Black British people[18, 20], and people from other ethnic minority groups[21]
Women, who have a higher rate of depression[17]
Younger people, who have a higher rate of depression[17]
Young women, among whom self-reporting of CMDs has been increasing
People living in more deprived communities[19]
People in lower socio-economic groups or experiencing debt[22, 23, 24, 25]
People in Gypsy Roma and Traveller communities[26]
People who are living alone[17]
People who are unemployed[19, 27]
People with poor physical health[17]
Disabled people, who have a higher rate of depression[17, 18, 24]
People with communication impairments[49]
Autistic people[18]
People who identify as LGBTQIA+[18, 20, 28]
People experiencing severe multiple disadvantage[20], including homelessness[19, 29], substance use[30], and contact with the criminal justice system[19]
People who are unpaid carers[24]
Deaf people[62]

## Inequalities experienced by people with mental health problems

**People with mental health problems are more likely to experience[19]:**

Financial vulnerability unemployment and lower pay[25]
Homelessness
Social isolation
Poor physical health[24, 31]
Contact with the criminal justice system and prison

# Health inequalities (2)

### Inequalities in access, experience and outcomes from mental health support

Groups that experience higher prevalence of mental health problems often have poorer access to mental health support[18] and worse experiences[32], satisfaction[17] and outcomes[33]. For example, people from minority ethnic groups in the UK have poorer mental health, worse access to mental health support and treatment[18], and more negative experiences of and outcomes from services when compared to people in White British groups[12, 21, 33].

Groups underrepresented in Talking Therapies include people from minority ethnic groups[18], older people[17, 18, 34], and disabled people[17]. People with lower recovery rates after Talking Therapies include those from minority ethnic groups [12, 21, 33], disabled people [17], lesbian, gay or bisexual people [17], people experiencing financial difficulty [25] and those living in deprived areas [17].

### Common barriers to accessing mental health support

Language and literacy needs [26, 32]

Perceptions and expectations about the support people are likely to receive[21, 26, 28]

Previous experiences of discrimination and stigma

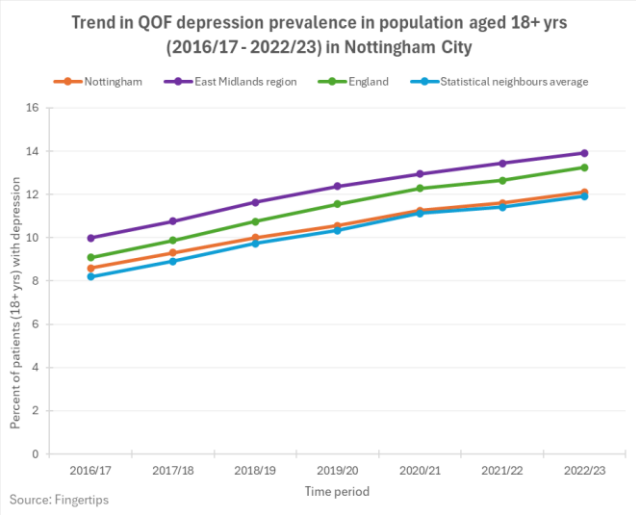
Trauma[21, 26, 28, 35, 36]

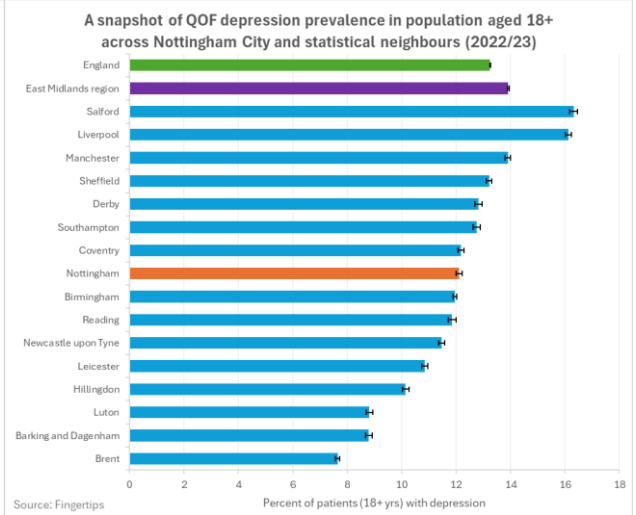
Difficulties associated with recognising mental health problems[35, 37]

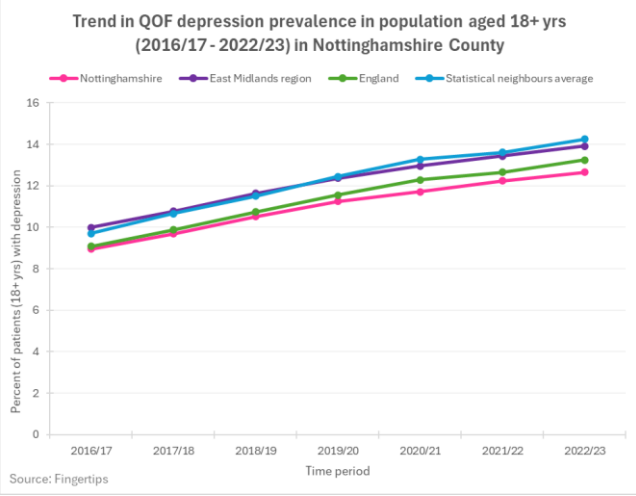
### Recommendations from national reports to reduce mental health inequalities

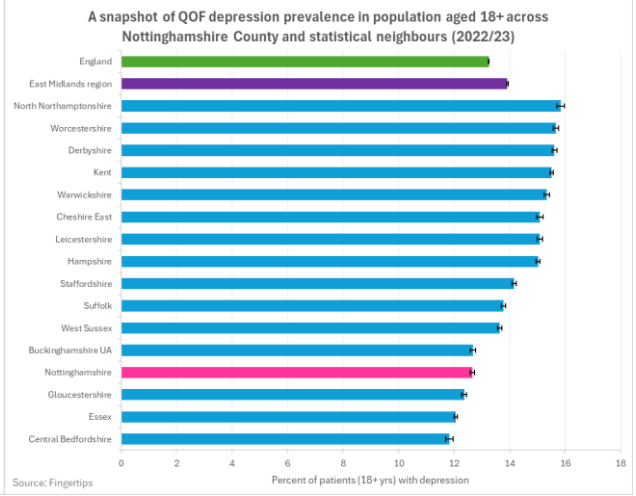
- A workforce that is representative of the community and trained in cultural understanding and competency[12, 32].
- Provide targeted mental health awareness and education campaigns that also reduce stigma and increase trust[26, 37, 38].
- Use community centred approaches and reduce social isolation and loneliness[19].
- Work collaboratively with the community and voluntary sector[26, 34, 35].
- Provide person centred care[28, 38, 39].
- Provide trauma-informed care[32, 36].
- Provide information and resources in appropriate languages and accessible formats[26, 35, 39].
- Ensure provision of good quality green space[19].
- Ensure the physical environment is appropriate and visibly inclusive[28, 34, 36, 39, 40]
- Provide choice of different ways to engage including community outreach and consider digital exclusion[26, 28, 34, 35].
- Provide routine screening for financial difficulties, drug and alcohol use, domestic and sexual violence and abuse within mental health services [25, 30, 36].
- Provide very brief advice for alcohol use and ensure an open-door approach for people with co-occurring mental health problems and drug and alcohol use[30].
- Screen for mental health problems in physical health services and have effective referral pathways and integrated services/care in place[41].
- Adapt Talking Therapies provision for people with learning disabilities, older people, autistic people, and women[34, 36, 39, 40].
- Do not refuse registration in primary care to people of no fixed abode or people who are nomadic[26].

# Nottingham and Nottinghamshire picture and how we compare: depression




In England, the prevalence of depression (based on recorded diagnoses of depression[1]) among adults aged 18+ has steadily increased in recent years, rising from **8.3%** in 2016/17 to **13.2%** in 2022/23.

For Nottingham City, the rate has risen from **8.6%** in 2016/17 to **12.1%** in 2022/23. This figure was statistically significantly lower than the national average and the East Midlands regional average throughout this period.

Nottingham consistently showed a higher prevalence than the average of its statistical neighbours throughout the same period and ranks 8th highest for depression prevalence among its statistical neighbours.

For Nottinghamshire, the rate has risen from **8.9%** in 2016/17 to **12.7%** in 2022/23. This figure remained statistically significantly lower than the national average and the East Midlands regional average throughout this period.

Among its statistical neighbours, Nottinghamshire ranks 4th lowest in depression prevalence. Data on depression at District and Borough level is not available.

# Nottingham/Nottinghamshire picture and how we compare: mental wellbeing (1)

This section examines mental wellbeing based on widely used self-report measures of aspects of wellbeing: anxiety, happiness, satisfaction and feeling the things you do are worthwhile[50]. Each measure has a threshold of low wellbeing in that domain (e.g. low satisfaction). This section includes analysis of data on high anxiety and low happiness. Supplementary analysis is available here, covering satisfaction and worthwhile measures of wellbeing, and further analysis of mental wellbeing of men and women in Nottingham and Nottinghamshire, and mental wellbeing of the population of each Nottinghamshire district and borough.

## High anxiety - England

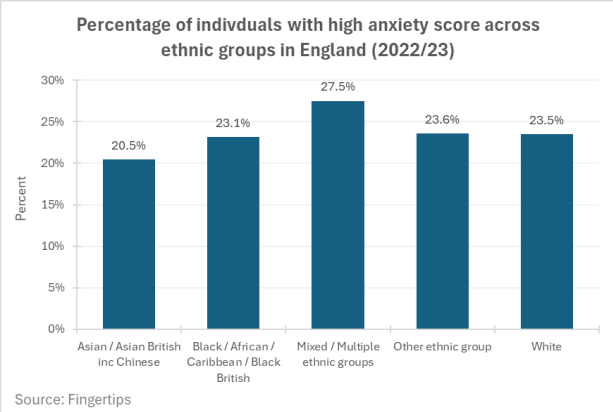
Between 2016/17 and 2022/23, the percentage of people in England aged 16+ with high anxiety increased from **19.9%** in 2016/17 to **23.3%** in 2022/23, with a peak of **24.1%** in 2020/21 during the COVID-19 pandemic (see page 9).

In 2022/23, the prevalence of high anxiety in England was statistically significantly lower among people who were employed (**21.2%**) than among people who were unemployed (**26.3%**) or economically inactive (**25.6%**).

**35.6%** of disabled individuals had high anxiety scores in 2022/23, compared to **18.2%** of those who were not disabled.

## Ethnicity - England

In 2022/23, prevalence of high anxiety varied between ethnic groups, with highest prevalence among mixed/multiple ethnic groups (**27.5%**).



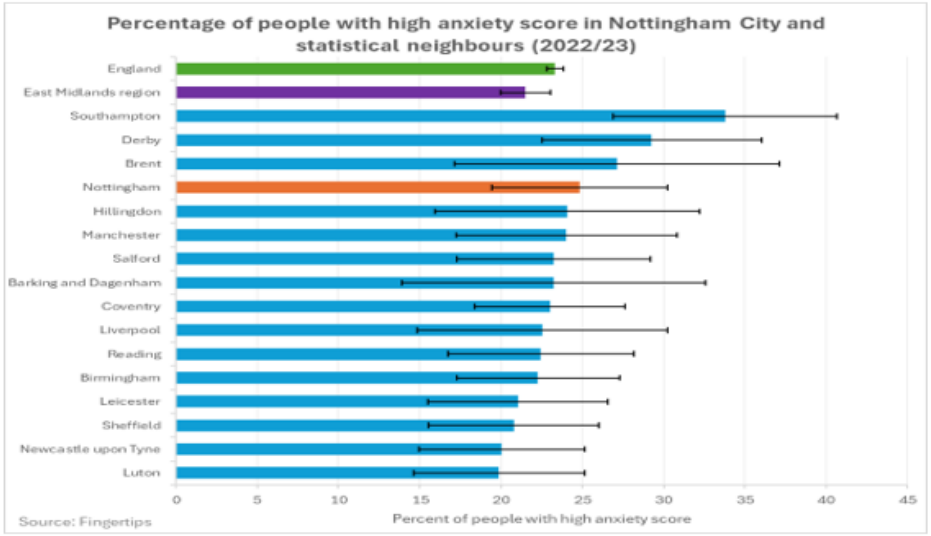

## High anxiety – Nottingham and Nottinghamshire

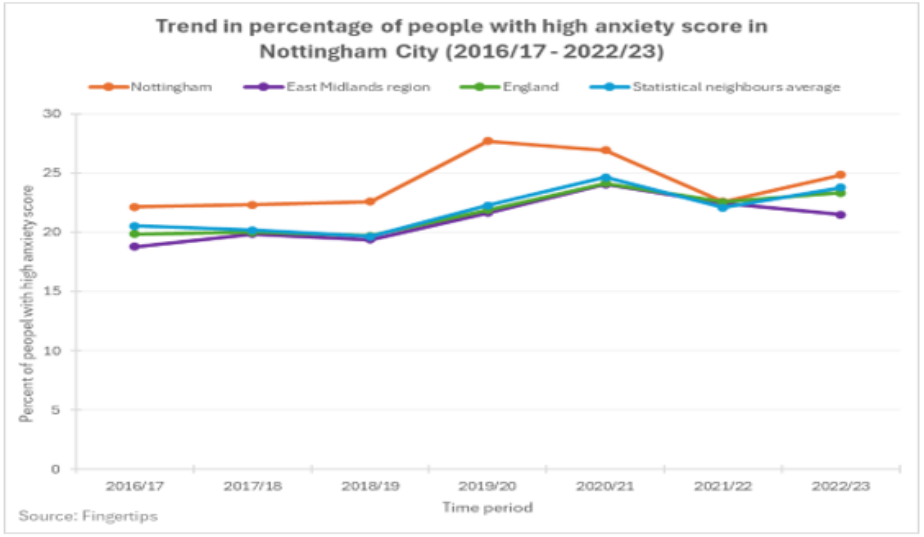
Overall, this national trend of increasing prevalence of high anxiety is seen in the local trends for Nottingham and Nottinghamshire (as shown in figures on page 9).

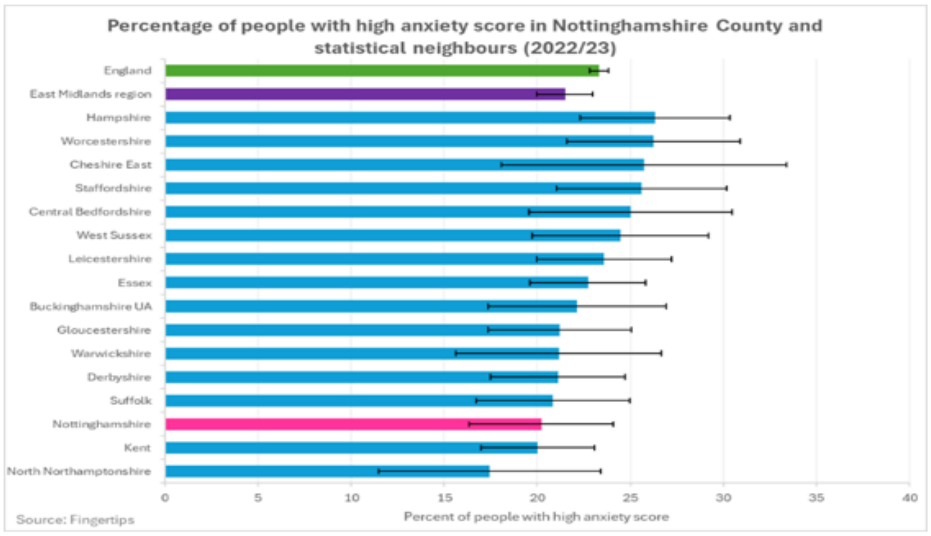
Between 2016/17 and 2022/23, Nottingham recorded a higher percentage of individuals with high anxiety compared to national, regional and statistical neighbours' averages. This difference was statistically significantly higher than national and regional averages only in 2019/20. Throughout the comparison period, there was no statistically significant difference between Nottingham and the combined average of its statistical neighbours. In 2022/23, the prevalence of high anxiety was **24.8%** in Nottingham. This was not statistically significantly different to the England average of **23.3%** or the regional average of **21.5%.** Among its statistical neighbours, Nottingham's prevalence ranks 4th highest.

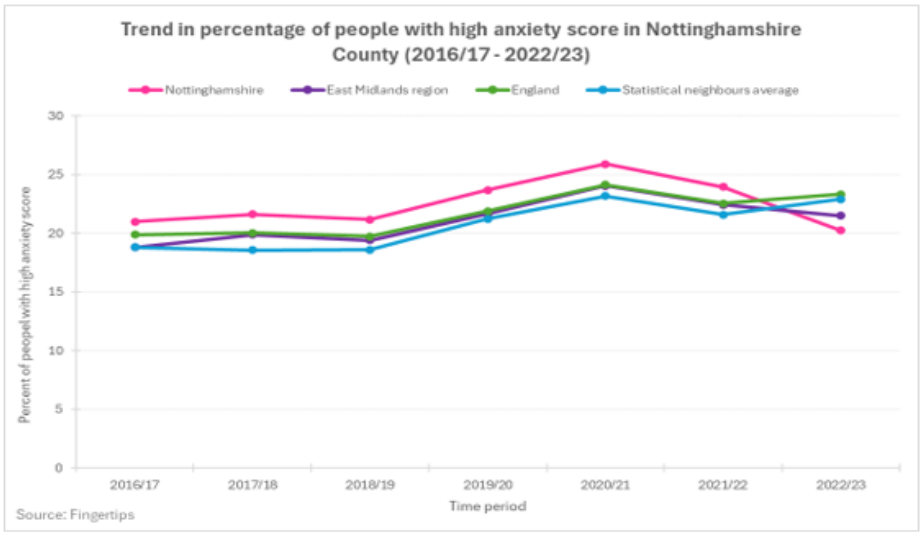
Between 2016/17 and 2021/22, Nottinghamshire consistently recorded a higher percentage of individuals with high anxiety compared to national, regional and statistical neighbours' averages, but the difference was not statistically significant. In 2022/23, the prevalence of high anxiety was **20.2%** in Nottinghamshire. This was not statistically significantly different to the England average of **23.3%** or the regional average of **21.5%.** Among its statistical neighbours, Nottinghamshire ranks 3rd lowest.

# Nottingham/Nottinghamshire picture and how we compare: mental wellbeing (2)



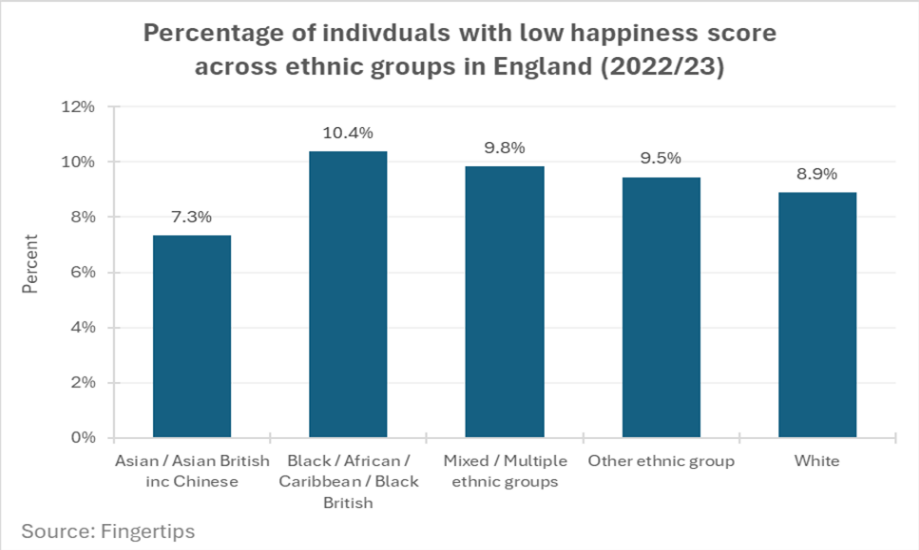
# Nottingham/Nottinghamshire picture and how we compare: mental wellbeing (3)

**Low happiness – England**

Between 2016/17 and 2022/23, the percentage of people in England aged 16+ with low happiness fluctuated, peaking at **9.2%** in 2020/21 and slightly declining to **8.9%** in 2022/23 (as shown on page 11).

In 2022/23, the prevalence of low happiness in England

- was statistically significantly lower among people who were employed (**7.4%**) than among people who were unemployed (**12.1%**) or economically inactive (**11.1%**).
- varied between ethnic groups. Prevalence was highest among people from Black ethnic groups (**10.4%**)
- was higher among disabled people **(17.4%)** than among people who were not disabled **(5.5%)**




**Low happiness – Nottingham and Nottinghamshire**

Overall, this national trend of fluctuating prevalence of low happiness is seen in the local trends for Nottingham and Nottinghamshire during this period (as shown in figures on page 11).

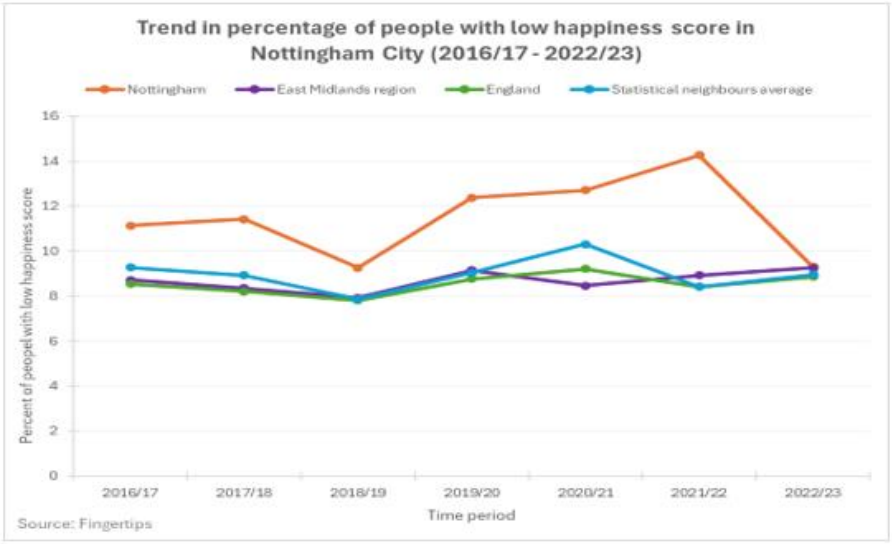
Between 2016/17 and 2021/22, Nottingham recorded a higher percentage of individuals with low happiness compared to national and regional averages. Nottingham was significantly different from England in several years: 2016/17, 2017/18, 2019/20, and 2021/22. The largest gap occurred in 2021/22, with Nottingham (**14.3%**) notably exceeding the averages for England (**8.9%**) and the East Midlands (**9.3%**).

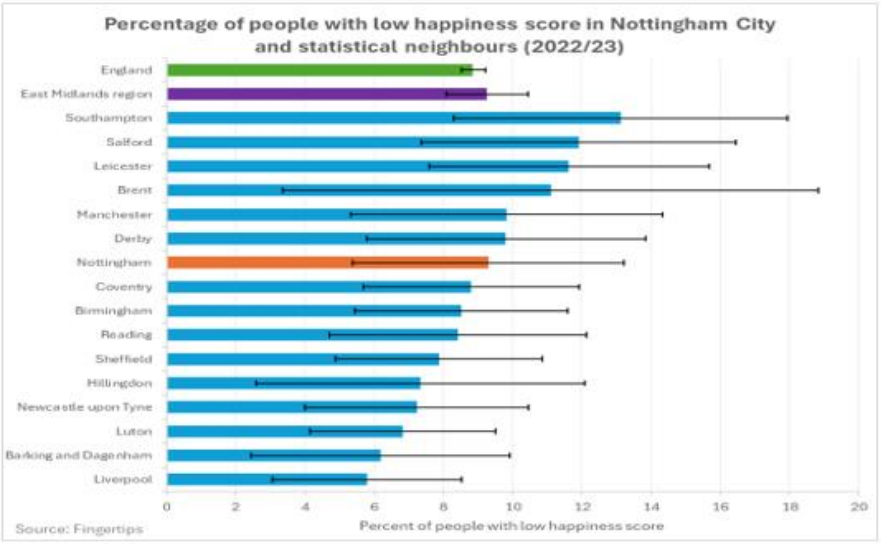
In 2022/23, the percentage of individuals with a low happiness score in Nottingham (**9.3%)** and Nottinghamshire **(8.8%)** was not statistically significantly different to the England average (**8.9%)** or East Midlands average (**9.3%).** There was no statistically significant difference between Nottinghamshire and England throughout the reporting period (2016/17 – 2022/23) in the percentage of individuals with low happiness.

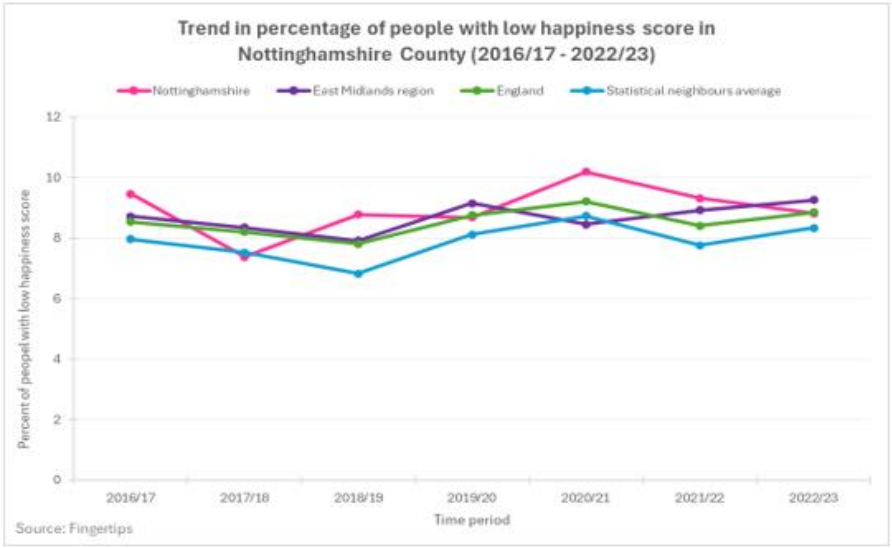
Among its statistical neighbours, Nottingham ranks 7th highest for prevalence of low happiness.

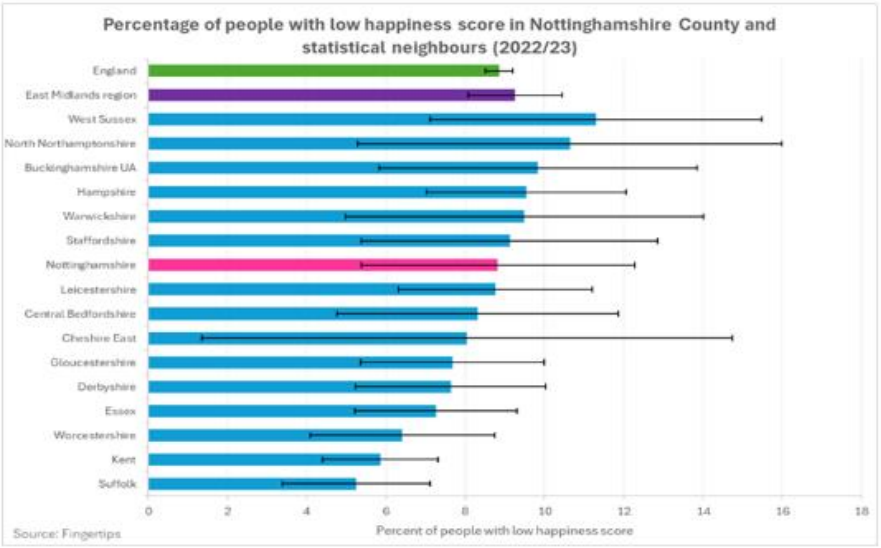
Among its statistical neighbours, Nottinghamshire ranks 7th highest for prevalence of low happiness.

# Nottingham/Nottinghamshire picture and how we compare: mental wellbeing (4)



# Policy and guidance: common mental health disorders

## Common mental health disorders: clinical guidance

National clinical guidelines[51, 52, 53, 54] on the treatment and management of common mental health disorders (CMDs) highlight key principles of care:

**Take action to reduce barriers to access, stigma, and discrimination**. Possible actions include: promoting parity of esteem (see the Glossary for a definition) between mental and physical illness, demonstrating compassion, and addressing and combating judgmental attitudes.

**Enable access to treatment.** This may include providing services in community settings (e.g. homes, community centres), or out of working hours.

**Provide person-centred care**. For example, by responding to individual's preferences, ideas and hopes for treatment; supporting people to make informed decisions about their care; and providing continuity of care (including care with the same healthcare professional when possible).

**Provide stepped care** by providing the least intrusive, most effective intervention first.

**Communicate in ways that people understand.** Possible measures include working with interpreters (for spoken and signed languages); using augmentative/ alternative communication; and including family/carers in communication, when appropriate.

**Consider how to support lifestyle factors which contribute to mental wellbeing.** These include diet, sleep, and physical activity. Services should understand and respond to the structural barriers some individuals experience to being able to access these supportive factors (such as lack of access to safe outdoor spaces).

Clinical guidelines[51, 52, 53, 54] identify **groups who may face stigma, discrimination, or barriers to accessing mental health services,** including:

Members of LGBTQ+ communities.
People from ethnic minority communities.
People of an older age.
Men.
People experiencing homelessness.
Refugees and people seeking asylum.
People with learning disabilities.
People with acquired cognitive impairments.
People with physical or sensory disabilities.
People with conditions which impact their ability to communicate.

# Policy and guidance: mental wellbeing

## Mental wellbeing

National guidance[3, 5, 10, 11] on promoting good mental health and prevention of mental health problems advises a focus on support for assets that create mental wellbeing and support good mental health: the building blocks of health, such as housing, employment, and education; and individual and social influences, such as diet, physical activity, and social connection.

While high quality mental health services are an important support for people with mental health conditions, they are only one component of the assets, systems and resources which support mental health and mental wellbeing of all people, including people with common mental health disorders and those with low mental wellbeing. Promotion of mental wellbeing is therefore an important public health priority for all people, including those who need mental health services.

A widely promoted framework[56] to promote wellbeing is the Five Ways to Wellbeing. Local systems should consider how they create opportunities, motivation and abilities for individuals – including those with CMDs or low mental wellbeing – to take the actions identified in the framework to promote their mental wellbeing.

### Five Ways to Wellbeing

1. Connect with other people.
2. Be physically active.
3. Take notice of the present moment/be mindful.
4. Keep learning.
5. Give to others/acts of kindness.

## Mental health and wellbeing at work

Working environments contribute to mental health and wellbeing. To prevent mental health problems and promote good mental health and wellbeing, national guidance[55] directs workplaces to:

Ensure the workplace is a compassionate, positive, and inclusive environment. Actions to ensure this include active leadership support, effective engagement and communication with employees, peer support (e.g. a buddy system) and increasing mental health literacy across the workforce.

Recognise that mental wellbeing of employees at work is impacted by structural factors, including discrimination; and individual factors outside of work (e.g. home and financial circumstances, physical health).

Provide mental wellbeing training for managers.

Assess workforce mental wellbeing needs and risks.

# Evidence of what works: public mental health interventions

## Types of public mental health interventions

Public mental health interventions aim to promote mental wellbeing and resilience, prevent mental health problems, prevent their associated impacts and inequalities, or support the delivery of effective interventions for mental health problems. A 2024 evidence review [57] by the UK Health Security Agency Knowledge and Library Services identified a range of types of public mental health intervention that can improve adult mental health and / or mental wellbeing:

- **Physical activity**, such as physical activity programmes for people with, or at risk of, CMDs, including tailored programmes for specific population groups.
- **Environment**, such as community-wide strategies to promote the use of green spaces and blue spaces (outdoor spaces dominated by water) for mental wellbeing, and nature-based social prescribing interventions to complement mental health interventions for people with CMDs.
- **Mindfulness**, such as mindfulness-based therapeutic programmes for people with CMDs, and mindfulness-based resilience training for clinical and non-clinical groups.
- **Digital interventions**, such as apps delivering cognitive-behavioural or mindfulness activities to promote mental wellbeing in the general population.
- **Community support / connectedness**, such as community engagement strategies to promote mental wellbeing in at-risk groups, and community interventions to prevent and reduce social isolation in at-risk groups.
- **Support groups**, such as tailored community initiatives or peer spaces to promote mental wellbeing for at-risk or under-served groups.
- **Peer support,** such as peer support or peer-led group interventions for people with CMDs.
- **Cognitive behavioural therapy** to promote mental wellbeing, resilience, or to reduce the impacts of CMDs.
- **Arts therapy**, such as creative arts, music or singing groups for people with CMDs or to promote mental wellbeing in the general population.
- **Meditation**, such as meditation interventions for people with CMDs.
- **Workplace interventions** to promote mental wellbeing for the entire workforce, reduce stigma and / or improve workplace support and access to wider support for people with mental health problems including CMDs.
- **Family interventions**, such as parenting programmes for at-risk populations to improve parent / carer mental health and mental wellbeing, and to prevent child mental health problem (also therefore mitigating a risk factor for mental health problems in the next generation of adults).
- **Healthy lifestyle interventions,** such as smoking cessation or healthy eating interventions, including interventions available to the general population, and those targeted for people with low mental wellbeing or people with CMDs.

# Community and service user views

The key findings below are taken from a range of recent engagement projects in Nottingham and Nottinghamshire[42, 43, 44, 45, 46, 47, 48]. More detailed information on these engagement projects, including links to reports and outputs from them, is available here.

- Mental health is a high priority for local people. People are concerned about access to mental health services and access can be difficult.
- Primary care is a key point of first contact for people concerned about their own or a loved one's mental health. Primary care staff need knowledge about mental health problems and services and 'expert' support should be available in primary care.
- All professionals need mental health awareness.
- Lengthy waiting times can be a barrier to accessing support. People want to receive communication on waiting times and advice on 'waiting well'. People want rapid access to services.
- People report being told their needs are too complex for one service and not complex enough for another and are left with no support. This includes people finding their needs do not meet criteria for accessing either primary or secondary mental health services.
- Communities and community support are key to addressing social isolation and providing support. People want more community services.
- Signposting and coordinating access are important to prevent people falling through gaps, including appropriate information sharing between services.
- Holistic and personalised care that 'treats the person not the diagnosis' and allows choice about support are important.
- Stigma is a barrier to accessing support, although some people feel mental health stigma has declined in recent years. Poor past experience of support and not knowing where to go for help are other barriers.
- Accident and Emergency departments could be adapted to better meet the needs of people experiencing a mental health crisis needs, such as having a separate physical area within A&E, or supporting access to appropriate safe places as an alternative to A&E.
- Physical barriers to accessing support include transport, finances and lack of IT infrastructure.
- People want family, friends and significant others involved in their care where appropriate.
- The cost of living impacts health and wellbeing negatively and is a barrier to community activities that provide social connection. Financial crisis, stigma and stress can exacerbate mental health problems.
- Gambling harm is felt to be a growing problem. Locally, harms to mental health - both to people with a gambling problem and their loved ones - are the most commonly reported harms from gambling problems.
- Privacy, confidentiality and anonymity are important. People want safe, non-judgemental spaces to have conversations about mental health.
- Peer support models are valued, as is employing people with similar lived experience.
- People want support after discharge, including advocacy, support in the community and peer support options.

# What we are doing, including assets and services (1)

**NottAlone: information and mental health support for people of all ages in Nottingham and Nottinghamshire**

In October 2024, the NottAlone website was relaunched by Nottinghamshire County Council, Nottingham City Council and the NHS Nottingham and Nottinghamshire Integrated Care Board. NottAlone is intended to be the key source of mental health information, advice and signposting to support and services for all citizens. Click here to visit NottAlone.

**Mental health pathway**

As part of the Nottingham and Nottinghamshire Integrated Mental Health Pathway Strategic Plan, available mental health services for adults were mapped in September 2024. The pathway identifies services of different types: Early Intervention and Prevention, Primary Care, Enhanced Support, Crisis Services, In-patient Services, Rehabilitation, and Community Support (Post Discharge). Click here to see the September 2024 pathway, developed by the Integrated Mental Health Pathway Programme.

**Mental health services accessible by self-referral**

Information on local mental health services which can be accessed by self-referral can be found here

**Social prescribing services** provide personalised support for physical, social and mental wellbeing. In October 2024, 82.5 Social Prescribing link workers were part of the local primary care workforce. For more on social prescribing services, including Green Social Prescribing, click here or click here for the local social prescribing website.

**Mental health support available within primary care**

20 x Primary Care Network (PCN) Mental Health Practitioners: Provide assessment, brief intervention, and signposting, and liaise between primary and secondary care.

3 x Mental Health Pharmacists: Provide support with the initiation, optimisation, and management of mental health medication.

6 x Mental Health, Health Coaches: Provide brief interventions and signposting for patients with mild to moderate mental health conditions.

6 x Mental Health First Contact Occupational Therapists: Provide assessment, triage, intervention, and onward referral for people presenting in primary care with a mental health need.

11x Health Improvement Workers: Provide annual physical health checks for the patients with severe mental illness, including home visits.

# What we are doing, including assets and services (2)

**NHS Talking Therapies**

During 2023/24, Talking Therapies received 37,315 referrals locally. 26,810 of these (71.8%) accessed services. Of people who finished a course of treatment, 70.1% were recorded as having an improvement, 50.4% as having a recovery, and 47.2% reliable recovery. This is similar to England rates.

In Nottingham and Nottinghamshire, some groups of people have lower rates of improvement and recovery outcomes from Talking Therapies when compared to the overall rates of improvement and recovery: people aged 18-25, people from black and minority ethnic groups, people who are lesbian, gay and bisexual, people who have a disability, and people who have a long-term condition.

Talking Therapies provide a treatment offer and personalised employment support to help people stay in work and resolve work issues, and to help people with mental health problems to gain employment. In Nottingham and Nottinghamshire, 1,255 service users who were open to Talking Therapies during July 24, had an employment support appointment at some point, and 400 service users had an employment support appointment during the month[58].

**University of Nottingham counselling service, mental health advisory services, and support and wellbeing teams**

- In 2023/24, 6548 students accessing the counselling service, an 18% increase compared to the previous year.
- Demand for the mental health advisory service has increased steadily since 2018/19. Demand in 2022/23 increased by 3% compared to 2021/22. Partial data available for 2023/24 suggests a likely further year-on-year increase in demand by the end of 2023/24. 1346 students accessed the service between 01/09/23 and 30/6/24.
- In 2022/23 and 2023/24, the most common presenting needs at the counselling service were anxiety and depression/low mood. Around 1 in 3 students who accessed the service had one of these presenting needs.

**Service access for people aged 16 to 25 years**

- Between January and June 2024, 1,516 people aged under 25 were referred to Be U Notts (early mental health and emotional wellbeing support for CYP aged 0-25 in Nottingham and Nottinghamshire (excluding Bassetlaw)). 67.4% were aged 11 to 17, and 10% 18 to 25 years.
- Between January and July 2024, 5,208 people aged 16 to 25 were referred to, and 3,527 accessed, the local NHS Talking Therapies service.

Click here for further service information and data about NHS Talking Therapies, University of Nottingham support services, service access for people aged 16 to 25, Nottingham Counselling Centre, and Nottinghamshire Mind mental health and wellbeing services

# What we are doing, including assets and services (3)

**Nottingham Counselling Centre** (from service data for the period 30/9/23 to 30/9/24)

- 614 adults from Nottingham accessed counselling services. Another 250 people (28.9% of those referred) were signposted elsewhere as the services available were not suitable for them.
- The two most common presenting needs were anxiety/stress, reported by 40.1% of service users, and depression, reported by 35.5% (NB service users may report more than one presenting need).
- 60.1% of people who accessed services were female; 37.6% male; 2.1% other, and 0.1% not specified.
- 76.3% were aged 20 to 39 years, meaning people of this age were over-represented among service users given the size of this population.
- 75.7% were from White ethnic groups (including 60.7% of White British ethnicity); 8.5% from Asian ethnic groups; 8.1% from Black ethnic groups; 6.7% from Mixed/Multiple ethnic groups.
- Females, people aged 20 to 39 years and people from White ethnic groups were over-represented and people from Asian ethnic groups under-represented among service users, given the size of these population groups in Nottingham.

**Nottinghamshire Mind mental health and wellbeing services** (from service data for the period 1/4/2023 to 27/9/2024)

- 4282 individuals accessed Nottinghamshire Mind services (equating to an estimated 2868 service users per year).
- A mental health diagnosis was recorded for 42% of service users. 44.6% of people with a recorded diagnosis had a CMD.
- The largest group of service users was aged 25 to 34 years old (31.2% of service users), followed by 18 to 24 year olds (20.1%).
- 94.5% of service users with ethnicity recorded were from White ethnic groups; 3.1% Mixed ethnic groups; 0.9% Asian; and 0.9% Black.
- 79.8% of service users who reported their sexuality were heterosexual.
- Adults aged 18 to 34 years were over-represented and heterosexual people under-represented among service users, given the size of these population groups in Nottingham and Nottinghamshire. From service data included in this JSNA Profile, it is not possible to assess the ethnic representativeness of people who used Mind services as the ethnicity of service users is not linked to individual services in city and county.

**Local Authorities** commission and provide a range of services that support the good mental health of adults. Examples include, **Community Friendly Nottinghamshire** community organising approach, **Community Health and Wellbeing Champion** networks in Nottingham and Nottinghamshire, and the **Moving Forward Service** in Nottinghamshire providing support to people with mental health conditions to help reduce likelihood of admission to hospital and to help people live well in their communities. Along with the Integrated Care Board, the Local Authorities also commission mental health awareness training for frontline staff and volunteers. For more information on some of the provision from Local Authorities click here.

# What we are doing, including assets and services (4)

**Integrated wellbeing services** (Your Health Notts in Nottinghamshire and Thriving Nottingham in Nottingham) provide health behaviour change support such as weight management, stop smoking and physical activity programmes. For further information, click here.

- **Nottinghamshire**: Between April 2023 and August 2024, 2,866 people who were referred to Your Health Notts reported having a CMD. 56% reported a diagnosis of anxiety and depression combined, 23% depression and 17% anxiety.
- **Nottingham**: Between April 2024 and September 2024, 276 people (20.9% of service users) who accessed Thriving Nottingham reported a CMD.

## Crisis services (for more information on crisis services and further data, click here)

**Crisis Sanctuaries**

- The numbers of service users and interventions provided by Crisis Sanctuaries shows an upward trend since 2021/22.
- In 2023/24, 1,008 people accessed Crisis Sanctuaries (514 new users and 494 repeat users).
- 48.7% were female including trans women; 42.1% male including trans men. The largest age group was 25 to 34 years (23.0% of service users).
- 30% of people present with a primary reason of negative thoughts / low mood, 26% with a long-term mental health problem, and 19% due to anxiety.
- The most common intervention was talking / listening support (43.6% of interventions).

**Crisis Line**

- In 2023/24, 128,809 crisis line calls were received from 71,353 callers. The busiest time for answered calls was between 12pm and 4pm.
- On average, 5,946 unique callers contacted the service each month. On average, 1,533 people called more than once in each month.

**Text SHOUT** (data below relates to self-reported Nottingham/Nottinghamshire users of the national SHOUT service, March 2023 to February 2024. As this data relates to people who self-reported being from Nottingham and Nottinghamshire, it likely underestimates service use by local people).

- 7,596 individuals took part in 13,797 text conversations. 68% of texters were aged between 14 and 34, with 24% aged 14 to 17.
- The most commonly reported needs were suicidality (reported in 42% of conversations), stress/worry (33%) and low mood/sadness (31%).
- 74% of users were female, 20% male, 4% non-binary and 2% transgender male. 86% were White, 5% Asian, 5% mixed ethnicity, and 3% Black.

**Haven House**

- In 2023/24, 223 stays at Haven House were recorded. Total occupancy in days was 1,430. For this JSNA Profile, no demographic data on service users or on the number of people who stayed on more than one occasion during this period was available.

# Stakeholder views: community assets

In September 2024, stakeholders were surveyed about their views of local community assets (places, groups, people and things) that support good mental wellbeing. 51 people who work or volunteer in the local area responded. 12 worked or volunteered in Nottingham, 25 in one or more Nottinghamshire districts, and 14 in both city and county.

Respondents highlighted important community assets for mental wellbeing:

- **Outdoor spaces** such as green spaces, parks, community gardens and allotments.
- **Community settings** such as community centres, coffee mornings, places of worship, libraries, and community hubs.
- **Assets for physical activity**, such as gyms, outdoor spaces for exercise, and sports clubs and teams.
- **Adult education**, such as adult learning programmes and educational skills-based wellbeing programmes.
- **Mental health and wider services that support wellbeing**, including Talking Therapies, SHOUT, Nottinghamshire Mind services, Nottingham Wellbeing Hub and Citizen's Advice.
- **Community assets for specific population groups**, such as women's centres, men's support groups, and centres for refugees and people seeking asylum.

Respondents reported that community assets work well when they are:

- **Accessible**: free, easy to travel to, multiple services available in one place, accessible to all.
- **Inclusive and empowering** by providing mutual support within communities, creating volunteering opportunities, and by tackling social isolation.
- **Integrated** with of a range of services and support available together.

Respondents named many types of community assets and examples that are working well to support mental wellbeing, including self-help groups, community groups, Places of Welcome in Inspire libraries, food banks, Men in Sheds, Improving Lives, Chestnut Community Centre in Bingham, Newark Food and Wellbeing Hub, Framework Training Centre in Bulwell, St Ann's Community Orchard, Nottingham Women's Centre, Vibrant Warsop, the Core Centre in Calverton, and Oasis - Men at the Edge in Bassetlaw.

## Identified challenges and gaps

Respondents highlighted:

**Lack of funding and resources** for services and support, resulting in some closing or reducing their offer or eligibility.

**Lack of services**, including evening services, one-to-one support, staff to co-ordinate support for individuals, and support for specific population groups (such as men who have experienced abuse, and people from LGBTQ+ communities).

**Lack of clarity**, including not knowing what is available or the best programme, group, or service for an individual.

**Barriers to access**, such as problems with transport, language barriers, long waiting lists, limited opening hours, lack of affordable spaces, financial vulnerability, and some services being accessible only via a GP.

**Stigma** is a barrier to accessing mental health support for some people.

# Opportunities and recommendations for improvement and future development

**The following themes and findings have been summarised from this JSNA Profile and recommendations for improvement and future development are provided for consideration by the local system:**

| Theme | Findings | Recommendations |
|---|---|---|
| **Reach and equity of access to support**  | People do not always know how and where to access mental health support, and some people report they cannot find a service to meet their needs.<br><br>Access to support is inequitable, and some groups have poorer experiences of, and outcomes from, mental health services.<br><br>People with additional needs as well as mental health needs report finding services hard to access.<br><br>Some people find they have to wait for the right support, and this can be a barrier to engaging with services.<br><br>Some groups with greater need for mental health support are at-risk of their needs becoming more acute or not being met because they experience barriers to accessing early support. | All partners should promote the NottAlone website as the main source of mental health information, advice, and signposting.<br><br>The NottAlone mobilisation group and mental health strategic communication group should identify how to remove barriers to this information (such as digital exclusion, cultural differences and communication and language barriers), and co-produce alternative messages and materials for identified demographic groups who need them.<br><br>Commissioners and providers of mental health services should identify how they can use the insight from this JSNA Profile to increase access for underrepresented groups. This may include:<br>• increase capacity to deliver services in local community-based venues, and in environments which meet the needs of different groups (such as men, older people, autistic people, or in women-only spaces).<br><br>• remove and reduce practical barriers to accessing support, such as those related to travel and transport, information technology, and the time and location of service delivery.<br><br>• increase understanding of the needs, preferences and barriers experienced by these groups and identify ways |

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|---|---|---|
| | | to better meet their needs by coproducing solutions with people with lived experience, particularly people from groups experiencing inequalities and including people experiencing SMD.<br><br>• explore ways to improve access for those with additional needs and ensure pathways do not allow people to fall through gaps in eligibility criteria.<br><br>• include family and friends, as appropriate, in service users' care, and support family and friends to access information and support for their own mental wellbeing.<br><br>• identify and share learning from mental health services with established 'waiting well' initiatives.<br><br>• review crisis provision for people with or without CMDs experiencing significant emotional distress. |
| **Building blocks of health**  | Primary care is a key point of first contact for people concerned about their own or a loved one's mental health.<br><br>Local people value community assets (such as parks and community groups and spaces) to help them stay mentally well, especially when assets and services are accessible, inclusive and integrated at the same location.<br><br>People find that gaps and problems with funding, resources and accessibility limit the availability and impact of community assets. | The Integrated Care Board should ensure staff across primary care have the information and resources they need to inform and support people making first contact for mental health support, and the resources to help people access community resources and practical support for mental wellbeing.<br><br>All partner organisations should identify how they can expand how they promote ways to stay mentally well, recognising the role of communities and community assets. This may include mental health services building links or co-locating with community groups or organisations, or supporting people to access community assets in their communities before, during and after contact with services, such as Green Social Prescribing services. Public health teams should consider how they provide information and support for partners to help them do this. |

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|---|---|---|
| | People who lack access to the building blocks of health – such as decent housing and financial wellbeing - are at higher risk of experiencing common mental health disorders and low mental wellbeing. People who experience CMDs and low mental wellbeing are more likely need support to access good quality housing, jobs, education and safe spaces to exercise and socialise. | All health and care organisations should increase routine enquiries to identify mental health risks and needs. This includes physical health care and money help services enquiring about mental health, and mental health care services enquiring about risk and protective factors, such as financial vulnerability, drug and alcohol use, gambling related harm, and domestic abuse or violence. All health and care organisations should ensure that the workforce have information about where to signpost and refer on to.<br><br>There should be strong partnership working between professionals in mental health and housing to support people with poor mental health or poor mental wellbeing to have and maintain stable, affordable and decent housing. Identifying this as a strategic priority in key forums such as the Nottinghamshire Housing Group will enable a shared focus on mental health and housing. |
| **Supporting the workforce**<br> | The proportion of people experiencing common mental health disorders and low mental wellbeing has increased in recent years.<br><br>Many people who need mental health services have additional needs that impact on their ability to access and benefit from services.<br><br>People value services which take account of their individual and cultural needs.<br><br>Many people experiencing common mental health disorders and low mental wellbeing access other types of services and groups in the community to seek help for their mental health and wellbeing, including many people who are not currently accessing mental health support. | The Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board should receive regular information about mental health workforce training in equality and diversity; cultural competence; trauma-informed care; neurodiversity awareness; drug and alcohol use; and person-centred care.<br><br>Partner organisations should identify how to increase access to mental health awareness training for the whole health and care workforce, including physical health care and primary care staff and the community and voluntary sector.<br><br>Health and care organisations should review their policies and offers for staff mental wellbeing to identify any improvements or successes they could share with partners. |

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|---|---|---|
| **Understanding and insight**  | Local insight, data and wider evidence show the need to improve how the mental health needs of some groups of people are met. This includes people from minority ethnic groups, people who are lesbian, gay and bisexual, disabled people, and people who have a long-term condition.<br><br>Among people experiencing common mental health disorders, local data shows different patterns of service use for different demographic groups, such as men and women and people in different age groups. | The Integrated Care Board should support NHS Talking Therapies to continue to apply and to share learning from their current work to increase access for under-served groups.<br><br>Mental health services should improve data recording to increase understanding of service user needs, and the needs of those who require services and do not access them. This may include recording socio-demographic and behaviour data, such as ethnicity, deprivation, employment status, disability status, sexuality, drug and alcohol use, and homelessness. Services should ensure their data contributes to the SAIU mental health system dashboard to improve understanding of local need. This data should be used to improve access and adapt delivery to better meet service user need. |
| **Strategic approach**  | People seek and benefit from a wider range of community assets and services to support their mental health and wellbeing.<br><br>Stigma is a barrier to accessing mental health support for some people.<br><br>Citizens and stakeholders report they would like more and clearer information about community assets and mental health services, greater integration of and pathways between different kinds of services, and more community assets which support mental wellbeing and prevent mental health problems. | Health and care partner organisations should consider how they can adopt a Mental Health in All Policies approach to prevent mental health problems, promote mental health equity and create environments that support good mental health.<br><br>Places, districts, and boroughs should identify or strengthen their place-based collective approaches to promoting mental health and preventing mental health problems. This may be achieved through a place-based adoption of the Prevention Concordat for Better Mental Health. |

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# Glossary

**Anxiety** is a feeling of unease, such as worry or fear, that can be mild or severe. Anxiety can be a common reaction to stress and can be a feature of some mental health conditions when it interferes with daily activities. Anxiety can be a main symptom of some mental health conditions including panic disorder, phobias and post-traumatic stress disorder[i].

The **building blocks of health** refer to the aspects of our lives that impact our health. They are often referred to as the 'wider determinants of health'. The building blocks of health include our jobs and homes, our access to education, public transport and safe green spaces with clean air, and whether we experience poverty or discrimination[ii].

**Common mental health disorders** (CMDs) include conditions such as depression, anxiety disorders, Obsessive Compulsive Disorder, Panic Disorder, phobias and stress-related disorders[iii]. Common mental health disorders can cause emotional distress, and affect mood, thinking and behaviour.

**Community assets** are resources within a community that can improve the quality of life for its members. Community assets can be thought about as the people, places, groups and things that support community and individual wellbeing. This could include things like parks and community centres, local groups, connected communities and individual skills.

**Coproduction** is a way of working that includes people who use health and care services, carers and communities in equal partnership; and which does this at the earliest (and all) stages of service design, development and evaluation.

A **crisis** in mental health is where a person needs urgent help, and they may feel 'at breaking point'. It might include feelings of extreme anxiety or panic, having thoughts of suicide or self-harm, or having an episode of mania or psychosis. A mental health crisis can be triggered by significant or distressing life events (such as bereavement, relationship breakdown or financial worries) or experienced as part of managing an ongoing mental health problem[iv].

**Depression** is a Common Mental Health Disorder (CMD) characterised by low mood, persistent sadness, loss of interest and enjoyment in ordinary activities and things, and a range of emotional, physical and behavioural symptoms[v].

**Emotional distress** is not typically a clearly defined term. It can be thought of as an emotional and/or stressful reaction to external life challenges or events. It might include feelings of being overwhelmed or burdened, stressed, anxious or worried about things that are happening in a person's life. Emotional distress exists on a continuum and some people who experience emotional distress may experience crisis (as defined above) and may or may not also have a diagnosed mental health condition.

**Ethnic minorities** refers to all ethnic groups except the White British group[vi]. Views differ on the most appropriate language to write or talk about more than one ethnic group collectively. Although ethnic minorities is the most commonly preferred collective term for describing groups except the White British group or except White groups[vii] , other terms are used including racialised minorities; global majority; Black, Asian, and minority ethnic (BAME); and marginalised ethnic groups.

**Health equity** is about providing services, interventions, or the allocation of resources in a way that addresses health inequalities. It means making sure that everyone has access to the resources they need to achieve good health outcomes and recognises that some individuals or groups may require adaptations or additional support or resources to have equity of access to services or interventions and to achieve equity of health outcomes.

**Health inequalities** are avoidable, unfair and systematic differences in health status between different groups of people. Health inequalities also refer to unfair and systematic differences in access to healthcare between population groups[viii].

**Low mental wellbeing** means experiencing feelings may include sadness, anxiety, and low self-esteem, which can affect how people function in life. Low mental wellbeing can make it difficult to manage emotions, cope with stress, and maintain a positive outlook on life[ix].

**Mental health** means being able to cope with the typical stresses of life, work productively and contribute to communities. Mental health is an important part of overall health and well-being. Having mental health (or 'good mental health') is not just the absence of mental health disorders[x].

**Mental health and wellbeing literacy** means having the knowledge and skills to understand, manage, and improve your own mental health and wellbeing. This can include knowing about mental health conditions and available help and support. It also means having the knowledge and skills to look after and protect your mental health and wellbeing.

**Mental Health in All Policies (MHiAP)** is an approach that integrates mental health considerations into all public policies to improve population mental health and wellbeing. This approach recognises that policies across all sectors can have significant impact on mental health and wellbeing. The goal of Mental Health in All Policies is to promote mental health equity, prevent mental health problems, and create environments that support good mental health. An effective Mental Health in All Policies approach requires collaborative partnership work[xi].

A **mental health problem** is a condition that affects a person's thinking, feeling, behaviour, or mood [xii]. A mental health problem encompasses all kinds of mental health issues and disorders and can include Common Mental Health Disorders (CMDs) and Severe Mental Illness (SMI). Mental health problems can be short term or longer lasting and can vary in severity.

**Mental health promotion** involves strategies and actions to enhance the mental health and wellbeing of individuals and communities. This can be through awareness and communication campaigns, supporting mental resilience, and providing information and support to identify and support mental health problems early[xiii].

**Mental wellbeing** includes emotional, psychological and social wellbeing. A person who experiences mental wellbeing lives their life in the way the want to and has a sense of purpose and feelings of contentment and happiness[ix].

**Neurodivergence** means processing information and experiencing the world in a way that is different to neurotypical people. Examples of neurodivergent conditions including autism, Attention Deficit Hyperactivity Disorder, dyslexia, Developmental Language Disorder and others[xiv].

**Neurodiversity** describes the full range of different ways in which people process information and experience the world. It includes the whole population, including neurotypical people and people with neurodivergent conditions, and discourages viewing neurodivergence as a deficit[xv].

**Neurotypical** means processing information and experiencing the world in a way that is generally considered typical or as the societal "norm"[xiii].

**Parity of esteem** means valuing mental health equally with physical health and ensuring equal access to care and treatment for both mental and physical health issues. This can include providing holistic care and support, where people's physical and mental health are supported together[xiii].

**Prevention** in mental health involves approaches and activities to reduce the risk of mental health problems before they begin, as well as preventing existing mental health problems from becoming worse. It is focused on reducing the incidence, prevalence, and recurrence of mental health problems, and to promote mental wellbeing. This can include primary prevention (aimed at promoting protective factors and reducing risk factors in the general population), secondary prevention (providing targeted activities or support to people at higher risk of developing mental health problems and identifying and responding early to mental health problems), and tertiary prevention (aiming to support those people who are already experiencing mental health problems) [xiii].

The **Prevention Concordat for Better Mental Health** is a framework for local and national action to prevent mental health problems and promote good mental health[xvi].

**Proportionate universalism** is the principle that actions to reduce health inequalities should be universal (for all) but offering more help, or targeting more resources, to those who need it the most. It recognises that some people or groups face greater challenges and need more resources or support to achieve the same outcomes[xvii]. It has a similar meaning to **equity**.

A **public mental health approach** focuses on improving mental health and wellbeing at a population level through prevention, early intervention, and the promotion of mental health[xiii]. A public mental health approach does not generally include providing individual help, support or treatment.

The term **Severe Mental Illness** (SMI) refers to specific types of mental health problems that severely impact people's ability to function in daily life[xviii]. Examples of Severe Mental Illness include schizophrenia, schizotypal and delusional disorders, psychosis and bipolar disorder

**Severe multiple disadvantage** is a way of describing the lived experience of people whose current circumstances have been strongly shaped by deprivation, trauma, and abuse – often leading to experiences of a combination of homelessness, mental ill-health, domestic abuse and sexual violence, harmful use of drugs and alcohol, and contact with the criminal justice system[xix].

**Stigma** in relation to mental health means the negative attitudes and beliefs that continue to exist around mental health problems. Stigma can lead to feelings of shame and mean people are less likely to seek help when they need it. Stigma can occur at an individual, community or population level.

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