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Foreword

This report looks at the current profile of mental ill health for adults in Lincolnshire, as part of the process which allows us to reflect on and improve services delivered to those who need them. Conversations about mental health are becoming more and more widespread, raising awareness and setting the stage for positive action.

The analyses not only look at the mental health profile in the county, but also study the demographic profile and all of the associated needs that this may indicate for the mental health of our residents, now and in the years to come. In Lincolnshire we have a high population of armed forces personnel, current serving and veterans, as well as other specific groups, and as such have a responsibility to ensure that their needs, emotional and physical, are met.

Individuals in Lincolnshire face a number of barriers in everyday life which, whilst not necessarily relating to a mental illness they may have, can prevent them responding to treatment and delay their recovery. Issues with access to high standards of housing and support into education or employment continue to be challenged across the county, and progress will continue to be made.

Parity of Esteem, No Health Without Mental Health, and Closing the Gap are all government publications which are taken into consideration here. All outline the responsibility of Local Authorities, Public Health, NHS, and other services to enforce the recommendations given in them, reducing the stigma of mental ill health and promoting parity of esteem. The ongoing work and activities being carried out by these parties is so successful because the passion the individuals hold for this cause falls outside of statutory duties; we all work towards these aims because it is the right thing to do, for the residents of Lincolnshire and for society as a whole.

In Lincolnshire, we are proud to be actively reducing stigma and promoting equality of provision across our health services, communities, and work places; helping residents to lead fulfilling lives and be part of a community that cares. It is hoped that this assessment can help us to understand the health needs of the Lincolnshire population experiencing mental ill health, and to work together to better commission and deliver services that address their specific health needs.

Allan Kitt
Chief Officer, South West Lincolnshire Clinical Commissioning Group

Lead Commissioner CCG for Mental Health and Learning Disability services
Chair of the Lincolnshire Specialist Adult Services Joint Delivery Board
Executive Summary

Introduction

Whilst great improvements have been made in mental health provision and follow-up care, there still exists wide variation in the quality of care, and inequalities persist in access to services. The impact and cost of mental ill health includes lost productivity at work, reduced quality of life and direct costs to services.

The aim of this Health Needs Assessment is to systematically assess the health needs of working age adults with a mental illness or mental disorder who live within the geographical boundary of Lincolnshire, with a view to improving health outcomes.

Methods

A number of different approaches were utilised in the production of this Health Needs Assessment, including epidemiological methods, published literature reviews, engagement with, and contributions from, stakeholders and service providers, and consultation with service users. Work took place from late 2013 to July 2014.

Epidemiological methods included the use of national estimates for specific mental health conditions to estimate the potential local prevalence. Prescribing practices, registered prevalence of specific mental conditions, hospital admissions data and mortality data were used to consider geographical inequalities. As the main provider of mental health services in the county, data from Lincolnshire Partnership Foundation Trust (LPFT) was used as a proxy to understand service user demographics over a three-year period.

Service-user and provider feedback was encouraged through two questionnaires sent out in March 2014. A questionnaire concerning people’s experiences of health services was used to gather information from users of mental health services. A second questionnaire was used to elicit feedback from mental health service providers and commissioners on their views and experiences of the provision and commissioning of services.

The steering group obtained advice from a range of people and organisations throughout the project. The draft assessment was commented on by stakeholders, who also helped to shape suitable recommendations before release of the final assessment.

Background

In 2010-2011, over 1.25 million adults accessed NHS services for severe or enduring mental health problems. In England, the wider economic cost of mental health has been estimated at £105.2 billion each year.

Mental health problems range from common mental health disorders to psychotic disorders, and are described in a number of sources. There are 10 main groups
each with several subcategories. The categories of mental illness included in this assessment are:

- common mental disorders, such as depression, anxiety, bi-polar disorder;
- post-traumatic stress disorder;
- suicidal thoughts, suicide attempts and self-harm;
- psychosis;
- anti-social and borderline personality disorders;
- attention deficit hyperactivity disorder;
- eating disorders;
- mental health illnesses due to psychoactive substance abuse (alcohol misuse and dependence, drug use and dependence);
- gambling behaviour; and
- psychiatric co-morbidity.

The most common of the 10 classified types of mental health illness are anti-social and borderline personality disorders. A number of factors increase the risk of mental ill health, including being female, Black African and Caribbean, a carer, or a refugee; having low levels of social support, or financial problems; and having a long-term condition. Relationships have been found between mental health illness and smoking, alcohol use and obesity. Mental ill health can also impact on relationships, employment and housing for individuals, which can, in turn, impact on their conditions. Suicide also has a strong association with mental illness, and contributes to the excess mortality of persons who are mentally ill.

**Policy context**

There are various laws, policies and strategies that are relevant to mental health.

The NHS Outcomes Framework 2014/15 sets the high-level national outcomes that the NHS should be aiming to improve. The Public Health Outcomes Framework for England aims to improve life expectancy generally, and reduce differences in life expectancy and healthy life expectancy between communities. These two frameworks contain indicators relevant to mental health. More specifically, the National Institute for Health and Care Excellence (NICE) has a variety of guidance related to mental ill health, and the Joint Commissioning Panel for Mental Health provides guidance for commissioners.

The Health and Social Care Act 2012 enshrined in law the principle of parity of esteem, whereby mental health must be given equal priority with physical health. It also requires Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy. The Lincolnshire JSNA addresses some core themes, such as adult health and wellbeing, and ill health and inequalities, and a number of related topics that are relevant to mental health. Also, locally, Lincolnshire County Council developed a Lincolnshire Dual Diagnosis Strategy with NHS Lincolnshire to bridge the requirements of individuals with complex needs, and is now developing a Mental Health Promotion Strategy (2013-2016) with partners.
Service configuration

As a result of the Health and Social Care Act 2012, commissioning arrangements for mental health services have changed. In Lincolnshire, mental health services are commissioned in various ways. The main providers of NHS care for the county’s population are United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services and the East Midlands Ambulance Service. The clinical commissioning groups (CCGs) are responsible for ensuring that these mainstream health services address the needs of people with a mental illness.

South West Lincolnshire CCG ensures that specialist mental health services are commissioned and provided on behalf of all Lincolnshire CCGs. South West Lincolnshire CCG also leads on the procurement of specialist, non-commissioned and out-of-area healthcare for service users with mental health problems. In addition, NHS England is responsible for the specialised commissioning of some mental health services.

Lincolnshire County Council is responsible for the commissioning of accommodation and housing-related support, and a range of public health commissioned services relevant to people with mental ill health (for example, smoking cessation, crisis housing, and drug and alcohol services).

Lincolnshire mental health services

People in Lincolnshire with mental ill health may access a wide range of services in primary, community and secondary care to address their health needs. For example, in primary care, the Quality and Outcomes Framework (QOF) rewards GPs financially for care provided to people with a serious mental illness.

Lincolnshire Partnership NHS Foundation Trust (LPFT) provides specialist health and care services for people with mental health problems, learning disabilities, or drug or alcohol problems. LPFT Adult Mental Health Services care for people of working age (18 to 65 years old) who are experiencing severe episodes of mental illness, or who need longer-term recovery plans put in place in order to return to independent living.

These services include:

- a community mental health service;
- a crisis resolution and home treatment team;
- acute inpatient care;
- veterans’ mental health services;
- a drug and alcohol recovery team;
- a forensic mental health service;
- prison services; and
- an anorexia nervosa service.

LPFT also provides other psychological therapies and primary care programmes relating to mental ill health. NHS England is responsible for the specialised
commissioning of the national mental health programme of care. Under the programme, Clinical Reference Groups (CRGs) have been established to develop services.

Lincolnshire’s Managed Care Network for mental health is intended to help both those who have already experienced mental health problems and those who are having their first experience of mental illness. Members of the network have close links with each other, in order to help people prevent, manage and recover from mental illness.

The Mental Health Promotion Fund finances activities for people who are not eligible for social care support, but who, without additional help, would be likely to become eligible as their needs intensified. It funds a range of countywide and locality specific projects.

**Mental ill health in Lincolnshire**

The scale, or potential scale, of mental ill health in Lincolnshire has been analysed. Where accurate data is limited, proxy data has been used to quantify issues in the county.

The 2007 national adult psychiatric morbidity survey showed 16.2% of all adults aged 16 and above had a common mental disorder. Mixed anxiety and depressive disorder was the most common form of mental disorder. Women were more likely than men to suffer from common mental disorders, across all age groups.

Using age specific rates of common mental disorder alongside the Lincolnshire GP registered population (18 to 64 years old) for 2012, it can be estimated 78,500 people (17.5%) suffer from common mental disorders.

**Depression:** There were 2,394 females and 1,521 males referred for depression in 2012/13. Overall, the number of depression referrals increased in comparison to 2011/12 and 2010/11 for both genders, but for males the increase was more pronounced.

**Anxiety:** During 2012/13, over 3,700 individuals were referred to LPFT’s primary and community services because of anxiety; 63% of the patients were females. The number of patients referred due to anxiety increased by 20% between 2010/11 and 2011/12, and by a further 18% between 2011/12 and 2012/13. Anxiolytics prescribing rates were lowest in South West Lincolnshire CCG. This is consistent with an Office for National Statistics (ONS) 2012/13 survey, which saw evidence of lower levels of anxiety in South Lincolnshire than in the rest of the county and nationally.

**Post-traumatic stress disorder (PTSD):** England’s age specific rates of PTSD (1.9 – 5.1%) were applied to Lincolnshire population figures, producing an estimated prevalence in the county of 15,000 people aged 18-64 suffering with PTSD (equating to 3.4% of the working-age population). Given the large number of armed forces
personnel in the county, it is possible that the figures for PTSD in Lincolnshire could be much higher than the average estimated.

**Suicidal thoughts, suicide attempts and self-harm:** Rates of suicidal thoughts and suicide attempts vary by age, ethnicity, marital status and income. According to national mortality statistics for 2012, in Lincolnshire, 45 people died as a result of suicide and a further 33 died from undetermined causes. Mortality rates for Lincolnshire are above the national level, and are higher than those for other counties in the East Midlands.

National data suggests that the prevalence of self-harm is highest amongst women, young people, those with the lowest income, people of white ethnicity and people not in a relationship. Data from LPFT showed that, in the 2013 calendar year, there were 1,439 self-harm referrals in Lincolnshire, an increase of nearly 44% compared to 2011. Local data suggests that the likelihood of engaging in self-harm increases significantly with the level of deprivation, those in the most deprived areas being 3.5 times more likely to self-harm than those in the least deprived areas.

**Psychoses:** According to the 2007 adult psychiatry morbidity survey, the estimated national prevalence of psychosis in the past year was 0.4% of the adult general population. Applying the national rates to the Lincolnshire population, it is estimated that there are 2,150 adults aged 18-64 with psychotic disorders in the county. Quality Outcome Framework (QOF) data 2012/13 showed that there were 4,779 patients on the mental health register with schizophrenia, bipolar affective disorder and other psychoses. Emergency hospital admissions for schizophrenia have declined in the last four years. Despite this, anti-psychotic drug prescriptions increased by 13.7% between 2011/12 and 2012/13. The lowest rates of anti-psychotic drug prescribing were in South West Lincolnshire CCG.

**Anti-social and borderline personality disorders:** Nationally, anti-social personality disorder (ASPD) is present in 0.3% of adults aged 18 or over. The overall prevalence of borderline personality disorder (BPD) is about 0.4% in adults aged 16 or over. Applying the national rates to the Lincolnshire population suggests that approximately 1,800 working-age people in the county could suffer from ASPD and 2,200 could suffer from BPD. The prevalence of both disorders is expected to be higher in the Lincolnshire West CCG area, because this CCG serves a generally younger population.

**Attention deficit hyperactivity disorder (ADHD):** At the 2007 adult psychiatric morbidity survey, for the last six months the proportion of people who screened positive for ADHD by ASRS score (%) was 8.2%. Applying the national rates to the Lincolnshire population, it is suggested that approximately 2,900 working-age people in the county suffer from ADHD. The volume of stimulants and other drugs prescribed for ADHD in Lincolnshire increased by 22% between 2010/11 and 2012/13.

**Eating disorders:** Epidemiological data regarding the prevalence of eating disorders amongst the adult population is limited. The adult psychiatric morbidity survey used
the ‘SCOFF’ assessment tool, which indicated the prevalence of eating disorders ranged from 0.1 in the ‘male 55-64 year old’ age group to 5.4% in the ‘female 16-24 year old’ age group. In the period from 2009 to 2012, there were 261 hospital admissions in Lincolnshire relating to eating disorders in working-age adults, the majority of whom were women (76%). For women, anorexia nervosa was the most common eating disorder requiring hospitalisation; for men, it was bulimia nervosa.

**Alcohol misuse and dependence:** Excess use of alcohol can lead to mental and behavioural disorders. According to 2010 NICE guidance, higher risk (harmful) drinking is defined as regularly drinking more than 50 units per week for men, or more than 35 units per week for women. Nationally, in 2007, nearly a quarter (24.2%) of adults were considered ‘hazardous drinkers’. Men were twice as likely as women to be hazardous drinkers, and younger people were more likely to be hazardous drinkers than older adults.

By applying national, age specific rates to the Lincolnshire population, it is estimated that 18,700 adults in Lincolnshire could be drinking harmful amounts of alcohol on a regular basis. In the three-year period from 2010 to 2012, there were over 5,200 hospital admissions in Lincolnshire due to mental disorders caused by alcohol. Lincolnshire West CCG had the greatest number of admissions. This is probably due to its lower age profile. Further analysis showed a statistically significant association between admissions for mental disorder caused by alcohol and local conditions of multiple deprivation.

**Drug misuse and dependence:** According to the adult psychiatric morbidity survey, 12.0% of men and 6.7% of women admitted to having taken an illicit drug in the previous year. Overall, 3.4% of adults showed signs of dependency on drugs in the previous year. Drug use was most common in young people, the greatest rates of dependence being in young men.

Between 2010 and 2012, over 1,600 hospital admissions of Lincolnshire-registered patients were due to mental or behavioural disorders caused by the use of psychoactive substances (excluding alcohol and tobacco). Lincolnshire West CCG had the highest rate of admissions. Between April 2013 and March 2014, 31% of new drug-dependent clients in Lincolnshire were classified as ‘dual diagnosis’ (i.e. also receiving care from mental health providers).

**Gambling:** The prevalence of pathological gambling is estimated to range from zero in some specific age groups and genders to 1.4% in 24-35-year-old men. On applying age specific rates to Lincolnshire population figures, it can be estimated that around 1,500 working-age people may have pathological gambling issues. Across Lincolnshire, 1,102 gambling licences were held in 2012/13, the number having almost doubled since 2009/10.

**Mental health and those in prison and on probation:** Prevalence of mental health issues in prisons is higher than in the general population. According to research, about 4% of male and female prisoners have psychotic illnesses, 10% of men and 12% of women have major depression, and 65% of men and 42% of women have a personality disorder. Furthermore, between 2004 and 2009, 5-6% of male prisoners and 20-24% of female inmates self-harmed every year.
In 2012, Lincoln University undertook research into the prevalence of mental health conditions within the caseload of the Lincolnshire Probation Trust. This revealed:

- 60% of cases had a current mood disorder;
- 59% of cases had a current anxiety disorder;
- 50% of cases had a current psychotic disorder;
- 75% of cases had a current eating disorder; and
- 55% of cases had a probable personality disorder.

Significantly, none of these individuals reported having a mental health intervention. The Youth Offending Service Health Needs Assessment (March 2014) highlighted the fact that 45% of young offenders had, or have, contact with Child and Adolescent Mental Health Services (CAMHS), but only a small number have had a formal diagnosis of a mental health problem.

**Life expectancy and mortality of people with mental illness:** The life expectancy gap between people with mental health issues and the rest of the population is evident in peer-reviewed literature. People with mental disorders have a higher risk of poor physical health and premature mortality than the general population. The causes of mortality are multiple, and influenced by both increased health-risk behaviours, such as smoking, and increased risk of obesity. In Lincolnshire, between 2009/10 and 2011/12, premature mortality decreased in both the general population and those with mental health issues. The gap between these two rates has also decreased.

**Service users**

**Characteristics:** The characteristics of service users have been summarised using LPFT data. In the financial year 2012/13, over 18,000 Lincolnshire-registered patients aged 18-64 accessed mental health services provided by LPFT. The majority of service users accessed primary care services. Although usage of these services has remained relatively stable over the past three years, usage of community and outpatients services has increased. Only inpatient services saw a decrease in usage.

The lowest proportion of the adult population using services was in the south of the county, particularly the South Holland area. However, cross-border service use was not known. The '55-64 years old' age group saw the greatest increase in usage across all services during the last three years. As might be expected, areas of higher deprivation had a higher proportion of the population using mental health services. Of those for whom employment data was available, 41.1% of primary care patients and 61% of outpatient service users were unemployed.

The majority of referrals in LPFT services were from GPs, with the adult mental health team being the second most common source of referrals. In the past three years, the number of self-referrals has doubled. The number of referrals from A&E has also increased.
LPFT does not provide secure mental health services. However, NHS England data indicated that 64 Lincolnshire patients were in secure units, either in the county or elsewhere in the country. The majority of these were men. Individuals are also referred to services which are not commissioned through the standard commissioning processes, but this number remains low, with 100 complex cases in Lincolnshire.

**Experiences:** In total, 25 service providers and 75 service users responded to the questionnaire. These represented users of a variety of services and with a range of mental health needs. There was no obvious difference in experience because of a client’s gender or age.

Several key themes were identified by service users:

- Waiting times were longer in South Kesteven; whereas in East Lindsey, the majority of respondents only waited two weeks or less to access a service.
- Satisfaction with services was greatest in East Lindsey. Across districts, satisfaction was lower for those who had to wait longer than six months. Having an accessible service was seen as important.
- People who self-referred were often the most satisfied with the services that they received.
- Outside of the City of Lincoln, 70% of people were able to access a local (within five miles) service, but 12% of respondents had to travel 10 miles or more to access their service.

**Suggestions for improvement:** A number of suggestions for service improvement were identified by service users and providers. The role played by staff attitude, empathy and understanding in tackling the stigma associated with mental ill health was noted as an important factor in engaging patients, as was continued contact for those with chronic mental health issues.

Service users identified other more specific suggestions for improvement:

- increasing the number of support groups;
- extending services to support wider family members and carers;
- more investment to increase the total scale of service;
- longer GP appointments for consultations about mental health issues;
- better communication between health professionals;
- having mental health drop-in centres and access to out-of-hours support;
- more support workers to accompany clients out of inpatient care;
- daytime activity centres;
- help and signposting for vulnerable groups;
- further training for those already working in mental health services;
- further training and awareness for all staff working in health; and
- provision of alternative services.
Service providers identified a wide range of health and emotional support programmes that they delivered, the breadth of which highlighted the need to consider the scale, promotion, signposting and accessibility of these services for users. Providers also saw opportunities for closer working between different commissioning and delivery organisations, and improved levels of training and specialist knowledge for those making initial assessments. They agreed with service users that a lack of resources may at times impact on the quality/effectiveness of service delivery. Finally, providers acknowledged the importance of service evaluation, although, at present, this was being carried out inconsistently.
Recommendations

Recommendation 1 – Identification and Recording: Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental illness.

Recommendation 2 – Data Sharing: Improvements in data sharing are needed between local providers, national data controllers and local intelligence teams. Better sharing and transfer between child and adult service provision is also recommended.

Recommendation 3 – Awareness of Services and Support: Collation of information on mental health services and support networks is needed to ensure both the public and professionals are clear on availability and accessibility of services.

Recommendation 4 – Service User Consultation: Feedback should be sought from those who contact or use any mental health services or support networks. Service evaluation processes, reporting and monitoring should form a standard requirement of contracts, with a commitment from providers and commissioners to act upon findings.

Recommendation 5 – Service Provision and Best Practice: Specific consideration should be given to the potential improvements suggested. Examples of good practice should be shared throughout the sector. A picture of what excellence could look like in Lincolnshire should be developed, alongside an understanding of what this would require.

Recommendation 6 – Professional Skills: Front-line staff in mental health services should have consistent skills, including listening, empathy, respect and trust building. They should also be aware of the need to address other areas of health improvement.

Recommendation 7 – Strategic Linkages: There is a need to improve governance structures around mental health service provision. An action plan should be created to address the recommendations in this HNA, and there should be an ongoing review and evaluation of progress.

Recommendation 8 – Further Work Areas: Case studies should be conducted on a range of service users to provide true insight into their needs and experiences. A series of specific workstreams should be set up, and this HNA should be used as a building block for further work.

Acknowledgements

Lincolnshire County Council would like to thank all those who contributed and advised on this health needs assessment, including various departments of the county council, commissioners, providers and service users themselves.
1 Introduction

The Government's mental health strategy of 2011, *No Health without Mental Health*, describes some of the changes that need to occur in relation to mental health service provision.

In January 2014, through the Department of Health, the Government also launched a policy document, *Closing the Gap: Priorities for Essential Change in Mental Health*. The document identifies 25 aspects of mental health provision where the Government, health and social care commissioners and providers, and a range of representative organisations can work together to improve outcomes for persons living with mental health, and reduce stigma and discrimination.

Whilst great improvements have been made in mental health provision and follow-up care, there still exists wide variation in the quality of care, and inequalities persist in access to services. The impact and cost of mental health problems includes lost productivity at work, reduced quality of life and direct costs of services.

This Health Needs Assessment is intended to systematically assess the health needs of working-age adults living in Lincolnshire, who have mental ill health or mental disorder, with a view to improving health outcomes.
2 Aims, Objectives and Scope

2.1 Aim

The aim of this Health Needs Assessment is to systematically assess the health needs of working-age adults with mental ill health or mental disorder, who live within the geographical boundary of Lincolnshire, with a view to improving health outcomes.

2.2 Objectives

The objectives of the assessment are:

- to review the published literature on the health needs of adults with specific mental ill health (described in section 2.3), including an overview of the policy context, local, regional and national priorities;
- to describe the local epidemiology of these mental illnesses and compare this data to that from other areas;
- to describe current service provision;
- to explore views on the quality, availability and accessibility of current services; and
- to make recommendations based on the findings from a synthesis of the preceding four objectives.

2.3 Scope of the work

Mental health problems range from common mental health disorders to psychotic disorders, and are described in a number of sources. The International Classification of Diseases (ICD-10) divides mental health disorders into 10 main groups, each with several subcategories, and these can be fitted to those used by the Adult Psychiatric Morbidity Survey (APMS)\(^1\) as shown in Appendix A. These are the categories upon which the scope of this health needs assessment is based, as shown below.

Categories of mental ill health described by the APMS and included in this assessment:

- Common mental disorders, such as depression, anxiety and bipolar disorder
- Post-traumatic stress disorder
- Suicidal thoughts, suicide attempts and self-harm
- Psychosis
- Anti-social and borderline personality disorders
- Attention deficit hyperactivity disorder
- Eating disorders
- Mental health illnesses due to psychoactive substance abuse (alcohol misuse and dependence, drug use and dependence)
- Gambling behaviour
- Psychiatric co-morbidity
In addition, the assessment is focussed on working-age adults (aged 18 to 65 years), and is intended to cover only the health needs of this population, and not the wider care or societal needs of individuals. As such it is intended that this report forms part of the wider set of evidence and strategy documents available nationally and locally.
3 Methodology

A number of different approaches were utilised in the production of this Health Needs Assessment, including epidemiological methods, published literature reviews, engagement with, and contribution from, stakeholders and service providers, and consultation with service users. Work took place from late 2013 to July 2014.

The project was managed by staff from the Public Health Directorate of Lincolnshire County Council, and a small steering group oversaw the work, in which a range of stakeholders, including commissioners, providers and service users, were consulted.

3.1 Epidemiology

National estimates for specific mental health conditions by age group have been applied to the Lincolnshire GP registered population to estimate the potential scale of those in the county affected by these conditions.

Specific medication group prescribing has been analysed over a three-financial-year period, for prescribing in relation to the conditions in the scope of the assessment, including total volume of prescriptions, costs and rate per registered patient.

Where possible, the registered prevalence of specific mental health conditions (for example, registered prevalence of depression based on Quality and Outcome Framework data) has been provided, and geographical inequalities have been compared.

Hospital admissions data has been used as a proxy for the prevalence of some conditions and behaviours, such as eating disorders and self-harm.

Mortality data has been analysed in order to gain an understanding of patterns in suicide and deaths from undetermined causes.

Links between mental health issues and a number of demographic characteristics, such as age, gender, employment, deprivation and geographical location, have been investigated through stratification and through statistical analysis.

Where necessary, data has been categorised from ICD10 codes. (International Classification of Disease codes are the standard diagnostic codes used within the health system as defined by the World Health Organisation.) Mapping of ICD10 codes to mental ill health categories for the purpose of this assessment is shown in Appendix A.

3.2 Service User Demographics

As the main provider of mental health services in the county, service user demographic data from Lincolnshire Partnership Foundation Trust (LPFT) was analysed to provide an understanding of patient characteristics, which would not be possible across the full range of providers and services. Although there are some limitations in generalisation across all services, the data has been used as a proxy
for understanding the demographics and characteristics of Lincolnshire GP registered service users.

Data for Lincolnshire-registered patients, aged 18 to 64 years, who had accessed mental health services provided by LPFT, was analysed for a three-year period covering the financial years 2010/11 to 2012/13.

For analysis, LPFT services have been grouped into four general categories: inpatients, outpatients, community and primary.

The four service categories are defined as follows:

- **Inpatients** – activity on inpatient wards providing acute care to patients experiencing severe short term episodes of mental health issues. There are four inpatient wards in the county, located at sites in Lincoln, Boston and Grantham\(^2\).

- **Outpatients** – activity at consultant outpatient clinics\(^1\).

- **Community** – activity in a community setting undertaken by a range of services; the main categories being psychology, Community Mental Health Teams (CMHT), crisis, assertive outreach and early intervention\(^4\).

- **Primary** – activity at IAPT (Improving Access to Psychological Therapies) services. The service provides non-urgent help and support to adults suffering from mild to moderate depression, anxiety, post-traumatic stress, panic, phobia and obsessive compulsive disorder\(^3\).

In the case of prison services, most activity is within the ’primary’ category. However, some elements are delivered through community services.

### 3.3 Service User and Provider Feedback

Service user and provider feedback was encouraged through two questionnaires.

A questionnaire concerning people’s experiences of health services was used to gather information from users of mental health services. The questionnaire was made available in paper format and electronically, and was intended to generate qualitative information to add value and background to analysis included in the assessment.

A second questionnaire was used to elicit feedback from mental health service providers and commissioners on their views and experiences of the provision and commissioning of services. Again, this was available in paper format and electronically, and was intended to generate qualitative information to add value to analysis in the assessment.

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\(^1\) Information provided by Lincolnshire Partnership NHS Foundation Trust (LPFT)

\(^2\) Ibid.

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Views were gathered during March 2014, and promotion took place through the Lincolnshire County Council communication team and website, Public Health staff, the GP gateway, LPFT communications team, key managers and newsletters, Shine Network and the Managed Care Network.

In total, 100 responses were received, 25 from service providers and 75 from service users. Service user respondents, with conditions of various types and levels of severity, represented users of a range of adult mental health services in Lincolnshire. Responses from service providers were submitted by professionals from both inpatient services (2 responses) and community services (23 responses).

3.4 Stakeholder Involvement

Throughout the project, the steering group obtained advice from a range of people and organisations (referenced in this assessment). In addition, a stakeholder meeting took place to gain feedback and input on the work being carried out. Key contacts were also consulted to complement desk research carried out on the policy context and service configuration sections of the assessment.

The draft assessment was commented on by stakeholders, who also helped to shape suitable recommendations before release of the final assessment in July 2014.

3.5 Desk Research and Literature Reviews

The main national policy documents relating to mental ill health service provision were identified and reviewed through desk research, and a range of relevant local strategies were also identified and have been detailed in the assessment.

The various commissioning approaches for configuration of mental ill health services were also investigated through desk research. This identified a wide range of service provision for people with mental ill health, the most relevant of which have been described. (It is not the intention of the assessment to describe in depth all the services that are available.)

National guidelines and high-level research (such as Cochrane Reviews) were identified through evidence reviews by Lincolnshire Knowledge and Resource Service, and a number of literature searches were carried out to inform parts of the assessment, particularly in relation to the policy context.
4 Background to Mental Health Issues

4.1 Aspects of Mental Ill Health

Mental health issues range from the everyday worries we all experience to more serious long-term conditions\(^4\).

In 2010-2011, over 1.25 million adults accessed NHS services for severe or enduring mental health problems\(^5\). According to the Mental Health Minimum Data Set (September 2013) report, 925,157 people in England were in contact with secondary mental health services, and of these 22,555 were inpatients in a psychiatric hospital (2.4%). The report also revealed that 15,837 people were subject to the Mental Health Act, and of these 11,467 were detained in hospital (72.4%) and 4,182 were subject to a community treatment order (CTO).

4.2 General Risk Factors

There are many factors that can increase the risk of developing mental ill health. These risks factors are presented in table 1\(^6\).

Table 1: Risk factors for mental ill health

| Individual factors                          | Grief and bereavement                      |
|                                           | Loneliness and isolation                   |
|                                           | Anxiety and stress                         |
|                                           | Relationship difficulties                  |
|                                           | Single parenthood                          |
|                                           | Unemployment and financial difficulties    |
|                                           | Drug and alcohol consumption               |
| Social factors                            | Low socio-economic status                  |
|                                           | Lack of support networks                   |
|                                           | Homelessness                               |
|                                           | Stigma and discrimination                  |
| Community and cultural factors            | Membership of certain ethnic groups        |
|                                           | Language barriers                          |
|                                           | Refugee status                             |

Women are more likely than men to be treated for mental health problems (29% compared to 17\%\(^7\)).

Rates of mental health problems in the UK are thought to be higher in minority groups than in the White population, and research suggests that Black African and Caribbean people are three times as likely to be admitted to hospital, and up to 44% more likely to be detained under the Mental Health Act than White people\(^8\).
Compared to the general population, persons who provide a substantial amount of care to relatives are also more likely to have a mental health problem. Indeed, people who spend 20 or more hours a week caring are twice as likely to suffer from anxiety and depression than those spending less time providing care\(^9\).

Two-thirds of refugees have experienced anxiety and depression, which may be linked to social isolation, language difficulties and discrimination in their new country\(^10\).

30-50% of homeless rough sleepers experience mental health problems, and about 70% misuse drugs\(^11\).

Social isolation is a major risk factor for mental health problems; 20% of people with mental health problems live alone compared with 16% of the overall population\(^12\).

Low levels of social support can reduce the likelihood of recovery. In one study of people with mental health problems, 54% of women and 51% of men who had good social support recovered over an 18-month period. During the same period, the recovery rate for people with a severe lack of social support was only 35% for women and 36% for men\(^13\).

Financial problems can be both a cause and a consequence of mental health problems. People with mental health problems are three times more likely than the general population to be in debt, and more than twice as likely to have problems managing money\(^14\).

There is evidence that people with a long-term condition are two to three times more likely than the general population to experience mental health problems, such as depression or anxiety. These can lead to significantly poorer health outcomes and reduced quality of life. There is particularly strong evidence for a close association with cardiovascular disease, diabetes, chronic obstructive pulmonary disease and musculoskeletal disorders. There is also evidence for higher levels of mental health issues associated with other long-term conditions, such as asthma and cancer\(^15\).

### 4.3 Features of the Categories of Mental Disorder

Mental disorders (such as mixed anxiety and depressive disorder, generalised anxiety disorder and panic disorder, obsessive compulsive disorder, post-traumatic stress disorder and social anxiety disorder) can affect 15% of the population at any one time\(^16\). The most common method of treatment is psychotropic medication. There is also limited availability of alternative psychological interventions, although patient preference may be for the latter. Common features of these main categories of mental disorder are detailed below.

#### 4.3.1 Mixed Anxiety and Depressive Disorder (MADD)

Mixed anxiety and depressive disorder (MADD) is diagnosed when symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that would justify a diagnosis if considered separately\(^17\). Patients often present with symptoms of
both anxiety and depression, and although none of the individual symptoms are sufficient to warrant a diagnosis, in combination they result in a disability.

Clinical features include a combination of typical depressive symptoms, such as low mood, lassitude and pessimism about the future, and symptoms of anxiety such as tension, insomnia and irritability. Other symptoms include disturbed sleep, fatigue, dizziness and loss of libido. Persons with mixed anxiety-depressive symptoms may also represent a population who are at risk of more severe major affective and anxiety disorders, when exposed to significant life stresses.

Persons with MADD generally have poorer mental-health-related quality of life compared to those without a psychiatric diagnosis, but a better quality of life than persons with other ICD-10 diagnoses.

Persons with MADD are likely to be women with a history of mental health problems, a history of mental health disorders in the family (including substance addictions), low socio-economic status, and a lack of social or family support. They may also be affected by a serious or chronic illness, low self-esteem, childhood trauma and stress.

Symptoms usually improve over time, but, in a small number of cases, active monitoring (discussion of problems/concerns, psychoeducation and active follow-up within two weeks) is recommended by the National Institute of Health and Care Excellence (NICE).

4.3.2 Generalised Anxiety Disorder

Generalised anxiety disorder (GAD) is a persistent and common disorder, in which the patient has unfocussed worry and anxiety that is not connected to recent stressful events, although it can be aggravated by certain situations. It is typically regarded as a chronic illness.

The symptoms include generalised and persistent excessive anxiety and a combination of various psychological and somatic complaints, such as palpitations, sweating, trembling, dry mouth, hot flushes, cold chills, and an inability to relax. To be diagnosed as suffering from GAD, symptoms should have been present for at least six months and cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Female gender, childhood trauma, illness, stress, genetics and substance misuse are all known risk factors for GAD.

NICE recommends a ‘Stepped Care Approach’ for people with GAD. Step one is identification and assessment, education about GAD and treatment options. Step two involves the use of low intensity psychological interventions, which might include non-facilitated self-help and psychoeducational groups. Step three is reserved for patients who do not respond to step two interventions, and includes the use of cognitive behavioural therapy or drug treatment.
four entails highly specialised treatment, which may require involvement from multi-agency teams\textsuperscript{25}.

**4.3.3 Panic Disorder**

The ICD-10 describes panic disorder as the occurrence of recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances, and are therefore unpredictable\textsuperscript{17}. Panic disorder is often associated with other psychiatric conditions, such as depression and other anxiety disorders. A third of patients with depression present with panic disorder\textsuperscript{26}. It is characterised by recurrent, unexpected panic attacks, at least one of which leads to suffering for a month or longer from one or more of the following:

- persistent concern about having additional attacks;
- worry about the implications of the attack or its consequences; and
- a significant change in behaviour related to the attacks.

These panic attacks are not due to drug misuse, prescribed drugs, or a medical condition, and are not better accounted for by another disorder\textsuperscript{26}.

During an attack, sufferers may experience one or more of the following symptoms: chest pain or discomfort, dizziness, fear of dying, fear of losing control, nausea and palpitations\textsuperscript{27}.

The cause of panic disorder is unknown. It is twice as common in women as in men, and genetic influences have been implicated. Other family members may have the disorder, but in many cases there is no clear family history\textsuperscript{28}.

The goal of management is to improve daily functioning. Treatment may include a combination of psychoeducation, psychotherapy (particularly cognitive behaviour therapy), lifestyle changes, and drugs. NICE guidelines suggest that psychotherapy, drugs and self-help are usually effective\textsuperscript{27}.

**4.3.4 Obsessive Compulsive Disorder**

Obsessive Compulsive Disorder (OCD) is described as a severe and disabling clinical condition that usually arises in adolescence or early adulthood, and is characterised by the occurrence of obsessions or compulsive rituals, or indeed, most commonly, the occurrence of both symptoms\textsuperscript{29}.

This disorder is characterised by obsessions: recurrent and persistent thoughts, impulses or images that are experienced as intrusive and cause great anxiety. Examples include persistent doubts about whether doors have been locked or electrical appliances switched off, and morally or sexually repugnant thoughts.

These kinds of obsession are often combined with compulsions: repetitive behaviours (including hand washing, checking and sorting) or mental acts (such as praying or counting), which the affected person feels compelled to do.
in response to the obsession, in order to prevent or reduce distress, or avoid
an imagined adverse event\textsuperscript{30}.

A genetic predisposition to OCD has been described in persons with
obsessive-compulsive disorder\textsuperscript{31}. They are also less likely to be married,
more likely to be unemployed, and more likely to report impaired social and
occupational functioning.

Randomised controlled trials\textsuperscript{29} have indicated that efficacious
pharmacotherapies for obsessive-compulsive disorder include serotonin
reuptake inhibitors, such as clomipramine, and some selective serotonin
reuptake inhibitors. These are often recommended alongside cognitive
behavioural therapy.

4.3.5 Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is an anxiety disorder in which an
individual's ability to function is impaired by emotional responses to memories
of a traumatic event\textsuperscript{32}. In order to be diagnosed as having the disorder, an
individual has to be exposed to a traumatic event that involves actual or
threatened death or serious injury, or a threat to the physical integrity of self or
others. It is also essential that the individual experience a response at the
time that involves intense fear, helplessness or horror.

Features of this disorder include recurrent and intrusive distressing
recollections, recurrent distressing dreams, acting or feeling as if events are
recurring, avoidance of reminders, detachment or estrangement feelings,
sleep difficulty, difficulty concentrating and hypervigilance\textsuperscript{33}.

Risk factors can be described as pre-traumatic, peri-traumatic or post-
traumatic\textsuperscript{33}.

- Pre-traumatic risk factors include: previous psychiatric disorder, gender
  (females at greater risk than males), personality, lower socio-economic
  status, lack of education, race (minority status), previous trauma and
  family psychiatric history.

- Peri-traumatic factors include: trauma severity, perceived life threat,
  peri-traumatic emotions and peri-traumatic dissociation.

- Post-traumatic factors include: perceived lack of social support and
  subsequent life stress.

Management includes psychological interventions and early pharmacological
interventions. NICE recommends the use of trauma-focussed cognitive
behavioural therapy, stress management and other types of management
(including non-directive counselling, psychodynamic therapies and
hypnotherapy)\textsuperscript{34}.

There is a particular risk of PTSD in Lincolnshire due to the large numbers of
service and ex-service personnel, whose occupations carry a high likelihood of
exposure to traumatic events which may cause actual or threatened death, or
serious injury, to themselves or others.
4.3.6 Social Anxiety Disorder (SAD)

Social Anxiety Disorder (SAD) is also known as social phobia, and is characterised by a notable and persistent fear of one or more social or performance situations, requiring exposure to unfamiliar people or possible scrutiny by others. This, in turn, leads to marked distress or avoidance. Typical situations that might provoke anxiety include:

- meeting people, including strangers;
- talking in meetings or in groups;
- starting conversations;
- talking to authority figures;
- working, eating or drinking while being observed;
- going to school, going shopping;
- being seen in public;
- using public toilets; and
- public performances, such as public speaking.

Two subtypes of social anxiety disorder are recognised: generalised SAD and non-generalised SAD. The generalised subtype is characterised by a fear of most social and performance situations, whilst the non-generalised type is limited to one or two performance situations. Onset is usually in childhood or adolescence.

Female gender, family history, temperament and the environment are all known risk factors for the disorder.

NICE recommends individual cognitive behavioural therapy, pharmacological interventions and supported self-help.

4.3.7 Suicidal Thoughts, Suicide Attempts and Self-harm

Suicide is the deliberate taking of one’s own life. It has a strong association with mental ill health, and contributes to the excess mortality of persons who are mentally ill.

The Royal College of Psychiatrists recommends that suicide prevention should remain a priority of public health policy in the UK. There should be structures at national, regional and local level, and mechanisms for the flow of information, evaluation and best practice to ensure effective implementation. The Royal College also recommends that a partnership approach to implementation should be adopted, wherever feasible.

Certain groups have been identified as being more prone to attempting suicide, so the needs of such groups need to be actively addressed. Risk groups include:
• asylum seekers;
• minority ethnic groups;
• people in institutional care or custody, such as prisoners;
• people of sexual minorities,
• veterans; and
• those bereaved by suicide.

Self-harm is poorly understood in society, and people who self-harm are often subject to stigma and hostility. An act of self-harm is not necessarily an attempt, or even an indicator of intent, to commit suicide, and can sometimes be a form of self-preservation.

Early trauma, especially childhood sexual abuse, has been identified as a crucial factor in the development of self-harm. Other risk factors include childhood trauma, neglect and insecure attachment.

NICE provides specific guidelines for the management of self-harm in primary care and in the emergency department. Guidance is available on assessment and support, psychosocial interventions and discharge following self-harm.

4.3.8 Psychosis

Psychosis is a medical word used to describe a series of mental health problems that cause hallucinations and delusions. The term is used to describe a group of psychotic disorders, including schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder.

The disorder is characterised by a ‘prodromal’ period, which is often accompanied by some deterioration in personal functioning. Difficulties may include memory and attention problems, social withdrawal, unusual and uncharacteristic behaviour, disturbed communication and affect, unusual perceptual experiences (accompanied by bizarre ideas), poor personal hygiene, and reduced interest in day-to-day activities.

During this prodromal period, people with psychosis often feel that their world has changed, but their interpretation of this change may not be shared by others. This is typically followed by an ‘acute’ phase, which is marked by positive symptoms, such as hallucinations (hearing, seeing or feeling things that others do not), delusions (markedly unusual or bizarre ideas), behavioural disturbances (such as agitation and distress), and disorders of thinking, so that speech becomes muddled and hard to understand.

People with psychosis experience disabilities that are not just the result of the recurrent bouts of illness; side effects of treatment, social isolation, poverty and homelessness often combine to exacerbate these disabilities.

Genetic predisposition, infectious agents, toxins and allergies have all been posited as risk factors for psychosis. It has been suggested that environmental risk factors interact with genetic factors, before and shortly after
birth, during the crucial formation of the nervous system, to cause subtle abnormalities and leave the individual vulnerable to psychosis in later life. In utero exposure to non-infectious agents has been studied. Maternal stress, maternal malnutrition, maternal diabetes and maternal smoking have all been suggested as possible risk factors\textsuperscript{42}. For example, the risk of schizophrenia in the offspring has been found to be increased sevenfold for women exposed to influenza during the first trimester of pregnancy\textsuperscript{43}.

Diagnosis is based on clinical features, and management of psychosis is best carried out by a mental health service. This includes, but is not limited to, identification of environmental factors that perpetuate symptoms, antipsychotic medication, psychosocial intervention and social support\textsuperscript{44}.

### 4.3.9 Anti-social and Borderline Personality Disorders

Of the 10 classified types of personality disorder, anti-social and borderline disorders are the most common, and often co-exist. These are the types included in the Adult Psychiatric Morbidity Survey (APMS), upon which this report is based. Persons with either disorder often report a history of serious family problems, domestic violence and abuse. They often engage in criminal behaviour and have a strong tendency to be irresponsible and reckless\textsuperscript{45}.

NICE guidelines for the management of these disorders recommend psychological treatment, inclusion, routine assessment by community mental health services and multi-agency networking.

### 4.3.10 Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) is a heterogeneous behavioural syndrome, characterised by the core symptoms of hyperactivity, impulsivity and inattention. Historically, the disorder has been considered as, principally, a disorder of childhood. However, follow-up studies of people diagnosed with ADHD as children have found the disorder to persist into adulthood in as many as 30\%-50\% of the cases diagnosed\textsuperscript{46}.

Clinical features may include excessive problems with organisation, difficulties with activities requiring cognitive involvement, hyperactivity, restlessness and impulsiveness to an extent that causes significant distress and/or significantly interferes with everyday functioning\textsuperscript{47}.

The risk is often higher in men than in women, and adults with ADHD often have a history of educational under-achievement, school disciplinary measures and social interaction problems. Moreover, a family history of ADHD is usually present.

Drug treatment is the first line of treatment for adults with ADHD (whether levels of impairment are moderate or severe). However, psychological interventions without medication may be effective for some adults with moderate impairment\textsuperscript{48}.
4.3.11 Eating Disorders

The two main types of eating disorder that have been described in the literature are anorexia nervosa (AN) and bulimia nervosa (BN). Both are common in late adolescent and young adult women in developed countries.

The diagnostic criteria for AN are maintaining a body weight at a level less than 85% of normal weight for age and height, an intense fear of weight gain, disturbed experience of one’s body weight or shape, and amenorrhea for at least three consecutive menstrual cycles. The DSM-IV criteria for BN include recurrent episodes of both binge eating (i.e. eating a larger amount of food than most people would eat in a similar time and circumstances, and a feeling of lack of control of one’s eating during the episode) and compensatory behaviours (such as purging, exercising, or fasting) to prevent weight gain from the overeating. For a diagnosis of BN, these behaviours must occur at least twice a week for a minimum of three months.

Risk factors include socio-economic status, female gender, race/ethnicity (higher prevalence observed in young White women) and familial influences.

NICE recommends that management should include assessment and coordination of care and the provision of good information and support, alongside the management of physical aspects of the disorder and the use of psychological interventions.

4.3.12 Mental Health Illnesses due to Psychoactive Substance Abuse (alcohol misuse and dependence, drug use and dependence)

Individuals with psychiatric disorders who also practise substance misuse are likely to have significantly poorer outcomes than individuals with a single disorder. These outcomes include:

- worsening psychiatric symptoms;
- poorer physical health;
- increased use of institutional services;
- poor medication adherence;
- homelessness;
- increased risk of HIV infection;
- greater dropout from services;
- and higher overall treatment costs.

Social outcomes are also significantly worse, and include greater homelessness, a greater impact on families and carers, and increased contact with the criminal justice system.

The risk factors for drug use are similar to those for criminal behaviour, including social and economic deprivation and family breakdown.
Management recommended by NICE includes assessment of dependency, biological and physical testing, treatment of the specific mental illness using the relevant guideline, and treatment of the substance misuse\textsuperscript{53}.

### 4.3.13 Gambling Behaviour

Gambling is a common recreational activity and not typically a reflection of disordered behaviour, but can sometimes escalate to problematic levels characterised by impaired control and adverse personal and social consequences\textsuperscript{54}.

Clinical features include preoccupation with gambling, repeated unsuccessful attempts to cut back or stop gambling, restlessness or irritability when attempting to stop or cut back on gambling, lying to conceal the extent of or involvement with gambling, and committing illegal acts to finance gambling\textsuperscript{47}.

Risk factors include younger age, male gender, low educational and academic attainment, unemployment and low socio-economic status\textsuperscript{55}. Individuals who struggle with pathological gambling also tend to suffer from substantial comorbidity.

The main psychological therapies for pathological and problem gambling are based on cognitive and behavioural models. Cognitive therapies focus on correcting erroneous beliefs about gambling and biased information processing. By contrast, behavioural therapies are based on assumptions that gambling is a maladaptive learned behaviour\textsuperscript{54}.

### 4.4 Comorbidity and Associations

Psychiatric comorbidity (meeting the diagnostic criteria for two or more psychiatric disorders) is known to be associated with increased severity of symptoms, longer duration of disorders, greater functional disability and increased use of health services.

Comorbidity has practical implications for both the diagnosis and the treatment of each disorder: not only might the symptoms of one condition mask those of another, but they might also interfere with its treatment.

Some comorbid relationships are well established, such as the coexistence of depression and anxiety, and the coexistence of post-traumatic stress disorder with other psychiatric disorders. Others are complex and difficult to diagnose\textsuperscript{56}.

Clinical features include the occurrence of signs and symptoms of the individual disorders that make up the comorbid state. Management principles are based on managing the separate mental health disorders.

A long-term longitudinal study of the association between mental ill health and morbidity and mortality found that there was a strong association between mental illnesses, such as anxiety and depression, and functional gastrointestinal disorders\textsuperscript{57}.
Jonas et al. found that, even after adjustment for potential confounders, high anxiety and depression remained independent predictors of incident hypertension.

People in contact with specialist mental health services had a higher death rate for most causes of death, especially mental and behavioural disorders and diseases of the nervous system, such as Alzheimer’s disease. They also had nearly four times the general population’s rate of deaths from respiratory diseases and diseases of the digestive system, and 2.5 times the general population’s rate of death from diseases of the circulatory system.

4.4.1 Tobacco and Alcohol Use

A study that examined the relationship between tobacco use and mental health found that current smokers were more likely to screen positively for psychosis, and that they reported greater psychological distress and disability than non-smokers or former smokers.

Depression and anxiety are most commonly associated with alcohol and tobacco use, and there is evidence that active psychiatric disorder predicts a significantly increased risk of the subsequent first onset of daily smoking. In a large community sample of Australian adults, a significant association between tobacco use and both anxiety and depression was found. Persons who have a mental disorder are also likely to smoke more heavily than smokers in the general population.

4.4.2 Obesity

There is now documentary evidence of the complex and multifactorial relationship between obesity and mental health, especially amongst adults and teenagers. Some researchers suggest that obesity can lead to common mental health disorders, whilst others have found that people with such disorders are more prone to obesity. Other studies have found no association between the two. In studies that have found an association, it appears to be bidirectional, so that obese persons have a 55% increased risk of mental health disorders, and persons with mental health problems have a 58% increased risk of becoming obese. Another recent systematic review and meta-analysis found a weak, but positive, association between obesity and anxiety disorders.

Behavioural, social and psychological aspects act as mediating factors in the relationship between obesity and mental health disorders. They include dieting and binge eating, weight-related stigma and weight bias, reduced physical activity, low self-esteem and body image concerns. Weight stigma in itself increases vulnerability to depression, low self-esteem, poor body image, maladaptive eating behaviours and exercise avoidance.

4.4.3 Attitudes

People with mental health problems are challenged by the stereotypes and prejudice that result from misconceptions about mental ill health. In addition, professionals can sometimes see mental health as the predominant issue. Consequently, other aspects of health, or the person’s wider needs, are not
addressed in the same way as they would be for those without mental health issues. As a result, the opportunities that define good quality of life can be reduced. These include good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people.\(^{67}\)

Studies suggest that many people are inclined to stigmatise those suffering from mental ill health. Such attitudes are not confined to uninformed members of the public; even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental ill health.\(^ {68}\). Persons with mental ill health also experience self-stigma, as well as fear of discrimination and rejection, which translates into a lack of motivation to pursue life opportunities for themselves.\(^ {69}\)

The principles of parity of esteem are intended to ensure not only that mental health is given equal priority with physical health, but also that there is equality in the meeting of other needs and outcomes between those who have, and those who do not have, mental health issues.

### 4.4.4 Relationships

Whilst social isolation is an established trigger for mental ill health, persons with mental ill health tend to become more isolated because of their illness.

Mental disorders impact not only on the individuals affected, but also on those around them (including immediate family and other relatives), and may be both a cause and a consequence of family and relationship difficulties.

Children in these circumstances may be affected directly in terms of their own care, or indirectly through the effect on their social and emotional health and wellbeing. Core attachment needs, such as love, physical and emotional nurturing, and security, may be at risk. For example, depressed mothers may provide less stimulation, support and responsiveness for children, which can affect their physical and psychological health, and cause attachment and social problems.\(^ {70}\).

People with common mental health problems are twice as likely to be separated or divorced as their mentally healthy counterparts (14% compared to 7%), and are more than twice as likely to be single parents as those without a mental health problem (9% compared to 4%).\(^ {12}\).

Carers of persons with mental ill health often have physical and mental health needs that may go unnoticed and unidentified by families and professionals, and which may have long-term implications for both their wellbeing and the wellbeing of the care recipient.\(^ {71}\).

### 4.4.5 Employment

According to the independent report produced by the Department for Work and Pensions (DWP) on the relationship between mental health and work, mental ill health affects the productivity of those in work by impairing their ability to function at full capacity, and causes about 40% of all days lost
through sickness absence. It also accounts for 40% of those claiming Incapacity Benefit and 23% of new claimants of Disability Living Allowance.

Mental ill health can contribute to people falling out of work, and, in many cases, having difficulty securing suitable employment. The stigma associated with mental ill health has the greatest impact on work, and evidence suggests that many employers request additional information from people with mental ill health who apply for a job.

People with mental health problems are likely to secure jobs that are not commensurate with their skills and qualifications. They are also more likely to report being denied opportunities for training, promotion and transfer.

Work colleagues may view mental ill health as a personal failure, and may be uncomfortable working with people suffering from mental ill health. A number of people with mental health problems have been dismissed, and one study revealed that 6.3% out of 222 employees with a serious mental illness reported that they had been sacked, laid off or told to resign.

4.4.6 Housing

People with mental health problems are less likely to be homeowners, and far more likely to live in unstable environments. In many cases, severe mental ill health can lead to homelessness. Mental ill health is frequently cited as a reason for tenancy breakdown, and housing problems are often given as a reason for a person being admitted, or readmitted, to inpatient care.

Few landlords and social housing officers have received mental health awareness training, and many may be unaware of the simple adjustments and flexibilities that can prevent housing breakdown. This is exacerbated by limited collaborative working between agencies, together with limited sharing of knowledge across health, housing and related services and sectors.

Lack of housing can impede access to treatment, recovery and social inclusion; accessing mental health services and employment is more difficult for people who do not have settled accommodation.

4.4.7 Costs of Mental Ill Health

Much of the economic burden of mental ill health is not the cost of care, but the loss of income due to unemployment, expenses for social support, and a range of indirect costs due to a chronic disability that begins early in life.

In England, the wider economic cost of mental ill health has been estimated at £105.2 billion each year. This includes lost productivity at work, reduced quality of life and direct costs of services.

The cost to businesses of poor mental health is just over £1,000 per employee per year, or almost £26 billion across the UK economy.
In 2008/09, the NHS spent 10.8% of its annual secondary healthcare budget on mental health services, which amounted to £10.4 billion. In 2007, service costs in England, including NHS, social, and informal care costs, amounted to £22.5 billion\textsuperscript{82}.

Indirect costs of mental ill health have also been described. These costs fall to social care, education, housing and the criminal justice system and are often felt by individuals with mental health problems and their families\textsuperscript{83}.
5 The Lincolnshire Context

5.1 Location

Lincolnshire is one of the largest counties in England, with a land area of over 5,921 square kilometres and an estimated population of 718,800 in 2012. The county has a diverse geography with large rural and agricultural areas, urban areas and market towns, and a long eastern coastline. The population density in the county is just 121 persons per square kilometre (less than a third of the average for England and Wales). 

Figure 1: Location of Lincolnshire districts (on the left) and Clinical Commissioning Groups (on the right)

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5.2 Population

As noted above, the population mid-year estimates for the area covered by Lincolnshire County Council in June 2012 was 718,800. The rate of increase in Lincolnshire’s population has slowed in recent years, with latest figures showing that it is below the national rate of growth. The annual percentage change between 2011 and 2012 shows the increase in the population of Lincolnshire (0.6%) was lower than the national figure (0.7%). However, Lincolnshire’s population is projected to increase by approximately 82,000 people by 2021, a growth rate of 11% compared to 9% nationally.
The proportion of young people in Lincolnshire (aged 0-19 years) fell from approximately 24% of the total population in 2002 to 22% in 2012. In contrast to this, and during the same period, the population of those in the county aged 65 and over increased by 3% to approximately 22%. However, nationally, the proportion of people aged 65+ increased by only 1%, to 17%, during this period.

All local authority districts of Lincolnshire are projected to experience a decrease in the working-age population by 2021. Although the decrease is relatively small in percentage terms, when considered alongside the increasingly ageing population, it will present a challenge in respect of a declining tax-paying population at a time when the need for services for an ageing population will be rising.

**Figure 2: Age structure of the Lincolnshire population in 2011 and 2021**

![Age structure graph](image)

*Source: ONS, 2011 Population Census; ONS Population Projections*

### 5.3 Deprivation

Across the county, 12% of Lincolnshire residents live within areas classified in the 20% most deprived in England. This 'average' deprivation is lower than nationally, but there are differences across the county. In Lincoln City, 28.4% of people live within this national quintile of deprivation, followed by 22.3% in East Lindsey and 19.5% in Boston Borough. 85, 86

Nationally, deprivation tends to be associated with pockets of urban areas (in Lincolnshire, being such areas as Lincoln, Gainsborough and Boston) and with the many seasonal coastal areas (in Lincolnshire, being along the east coast). However, with relatively poor transport and broadband infrastructure, the county also suffers from wide areas of rural deprivation.
5.4 Employment and Skills

Although average unemployment is slightly lower than nationally, there are pockets of long-term unemployment as well as seasonal employment and unemployment in the major industries of agriculture and tourism. Unemployment among the younger population (aged 24 years and below) is higher than the national average\(^7\).

The predominantly low-wage and low-skilled economy encourages the outflow of more highly educated residents, and general levels of education among adults are below the national and regional levels, according to the ONS\(^8\).

In Lincolnshire, in August 2013, there were over 4,100 people aged 18-64 years claiming Disability Living Allowance (DLA) because of mental health conditions (including psychosis, psychoneurosis, personality disorder, behavioural disorder, alcohol and drug abuse, severe mental impairment)\(^3\). This accounted for around 18% of all DLA claims in Lincolnshire for working-age people. Whilst many of the people who receive DLA may be in employment, mental health issues can affect or limit the employment opportunities available to them.
The number of mental-health-related claims in the county increased by around 5% between August 2011 and August 2012, and remained stable between August 2012 and 2013. Over the same period, total DLA claims saw a slight decline. It is important to note that, from April 2013, Personal Independence Payment (PIP) started to replace DLA for people aged 16-64 years. Over half of the mental-health-related claims were due to psychosis, with psychoneurosis being the second most common condition recorded (at around a third of claimants).

In August 2013, across all types of DLA, there were slightly more male claimants (52%) than female claimants of working age in Lincolnshire, which is in line with the gender profile of DLA in England. Of all DLA claimants, 89% were in receipt of the benefit for two years or longer, compared to 88% nationally; and for claimants with a mental health condition, the rate was 83% compared to 85% nationally.

5.5 Ethnicity and Country of Birth

At the 2011 census, the non-White population made up 2.4% of Lincolnshire residents, compared to 1.4% in 2001. Despite the increase, the rate remained lower than the national rate for the non-White population, which was 14%.

Between 2001 and 2011, the number of Lincolnshire residents who were born outside the UK more than doubled. According to the ONS 2011 population census, the proportion of foreign-born residents in Lincolnshire stood at 7.1% (compared to 13.8% nationally). The majority of recently arrived international migrants came from Eastern and Central Europe, and tended to be younger and more economically active than the UK-born residents of Lincolnshire.

Figure 4: People born outside the UK as a percentage of the whole population

Source: ONS, 2001 and 2011 Population Census
5.6 General Health

There is a mixed picture of health for the people of Lincolnshire. Life expectancy is 7.3 years lower for men, and 4.9 years lower for women, in the most deprived areas of Lincolnshire compared to the least deprived areas. However, average life expectancy for both men and women at the county level is similar to the England average.

Based on the 2011 census, the proportion of people who reported having bad, or very bad, health was slightly higher in Lincolnshire than in England (5.9% compared to 5.5%). The data from the census shows a link between poor health and an ageing population, and also suggests a link between poor health and deprivation (although IMD scores themselves do include aspects of health).

Of the Lincolnshire districts, East Lindsey had the highest proportion of self-reported poor health across the entire adult population. The proportion of people of all ages whose day-to-day activities were limited was also greater in Lincolnshire than in England as a whole (20.4% compared to 17.6%).

5.7 Alcohol (Adults)

The populations with higher levels of risk can be broken down into:

- dependant drinkers (it is estimated that 17,160 people in Lincolnshire fall into this group);
- higher risk drinkers (estimates indicate that 24,949 people in the county are in this category); and
- increasing risk drinkers (over 106,000 people in Lincolnshire are thought to be drinking at a level indicating an increased risk to their health).

Although alcohol treatment data is reliable, the minimum data set is small, so insight into population trends is limited. In 2010/11, the numbers of people entering specialist alcohol treatment services dropped by 19% (a total of 892 people were in treatment at the end of March 2011) after having increased by 71% between 2008/09 and 2009/10.

Within Lincolnshire there is a clear divide between male and female alcohol specific mortality, as seen in table 2. In 2010-2012, across all districts, male mortality rates were higher than female mortality rates. The highest rate for males was in Lincoln, which was higher than the East Midlands and England rates. Mortality rates in North Kesteven and South Holland were significantly below England's rate. In comparison to 2009-2011, mortality rates improved in East Lindsey, but increased in Lincoln, Boston and South Kesteven. For females, mortality rates from causes specifically related to alcohol remained highest in East Lindsey.
Table 2: Alcohol specific mortality by Lincolnshire district, directly standardised rate per 100,000 population (2010-12)

<table>
<thead>
<tr>
<th>Area name</th>
<th>Males</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
<th>Females</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>14.57</td>
<td>7.69</td>
<td>24.86</td>
<td>5.31</td>
<td>1.68</td>
<td>12.16</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>10.62</td>
<td>6.66</td>
<td>15.84</td>
<td>8.66</td>
<td>5.15</td>
<td>13.34</td>
</tr>
<tr>
<td>Lincoln</td>
<td>22.37</td>
<td>14.49</td>
<td>32.73</td>
<td>4.75</td>
<td>1.71</td>
<td>10.33</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>6.20</td>
<td>2.93</td>
<td>11.38</td>
<td>3.04</td>
<td>0.94</td>
<td>7.05</td>
</tr>
<tr>
<td>South Holland</td>
<td>6.76</td>
<td>3.06</td>
<td>12.81</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>12.98</td>
<td>8.42</td>
<td>18.97</td>
<td>3.76</td>
<td>1.60</td>
<td>7.36</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>9.50</td>
<td>4.76</td>
<td>16.66</td>
<td>6.91</td>
<td>3.25</td>
<td>12.76</td>
</tr>
<tr>
<td>East Midlands (GOR)</td>
<td>14.40</td>
<td>13.49</td>
<td>15.36</td>
<td>6.42</td>
<td>5.83</td>
<td>7.06</td>
</tr>
</tbody>
</table>

*Data counts below 3 have been suppressed to prevent disclosure

Source: PHE, Local Authority Alcohol Indicators

5.8 Drug Use

Between 2006/07 and 2010/11, the estimated number (crude rate per 1,000 people aged 15-64 years) of problem drug users of crack and/or opiates in Lincolnshire has been consistently lower than the figures for the East Midlands and England. As demonstrated in figure 5, there are differences between the districts of Lincolnshire, with the more urban areas of Lincoln and Boston having higher crude rates than more rural districts\(^92\).

The most recent problematic drug user (PDU) prevalence estimate for Lincolnshire is 2,676 people. Figures are only available at partnership level, and the estimate is updated annually by the National Drug Treatment Monitoring System (NDTMS) regional teams (normally at Quarter 2). The lower 95% confidence interval (CI) is 2,243, whilst the upper 95% CI is 3,143\(^92\).

At Quarter 3 of 2010/11, 1,654 PDUs were engaged in effective drug treatment, with a further 187 non-PDU adults in services. This is indicative of a penetration rate of 62% into the PDU estimate for the county (above wider averages)\(^93\).
Figure 5: Drug misuse, estimated problem drug users (crack and/or opiates), crude rate per 1,000: ages 15 to 64 (health profiles), 2010-2011

5.9 Homelessness and Intervening Organisations

Recent increases in unemployment over the global downturn and a rise in personal debt has resulted in more people becoming at risk of losing their home. Successful implementation and development of the prevention approach taken by homelessness teams across the county has greatly affected the potential number of households that could have become homeless.

Table 3: Homelessness presentation rates by district

<table>
<thead>
<tr>
<th>Year</th>
<th>Homelessness applications in Lincolnshire</th>
<th>BBC</th>
<th>EL</th>
<th>CoL</th>
<th>NK</th>
<th>SH</th>
<th>SK</th>
<th>WL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>814</td>
<td>146</td>
<td>191</td>
<td>163</td>
<td>49</td>
<td>65</td>
<td>132</td>
<td>68</td>
</tr>
<tr>
<td>2009/10</td>
<td>632</td>
<td>93</td>
<td>152</td>
<td>100</td>
<td>31</td>
<td>62</td>
<td>144</td>
<td>50</td>
</tr>
<tr>
<td>2010/11</td>
<td>692</td>
<td>80</td>
<td>153</td>
<td>97</td>
<td>34</td>
<td>60</td>
<td>201</td>
<td>67</td>
</tr>
<tr>
<td>2011/12</td>
<td>795</td>
<td>84</td>
<td>159</td>
<td>157</td>
<td>51</td>
<td>63</td>
<td>245</td>
<td>36</td>
</tr>
<tr>
<td>2012/13</td>
<td>847</td>
<td>70</td>
<td>202</td>
<td>240</td>
<td>42</td>
<td>46</td>
<td>216</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: DCLG, P1E Homelessness returns & live tables on homelessness
Table 3 shows homelessness presentation rates, and number of homelessness applications accepted, across all seven Lincolnshire districts from 2008/09 to 2012/13. Levels of presentation for both fell across the county following 2008/09. However, figures since that time have continued to rise, year on year, with the highest levels of both presentation and acceptance rates recorded during 2012/13.}

5.10 Travellers

According to the 2011 population census, there were just over 600 people in Lincolnshire stating their ethnicity as Gypsy or Irish Traveller, making up less than 0.1% of the population. West Lindsey district had the highest proportion of their population from this ethnic background (0.18%).

Broadly speaking, the age profile of Gypsies and Travellers is younger than that for the general population, both in Lincolnshire and nationally. In Lincolnshire, nearly 30% of the population from this ethnic background was made up of children and young people aged below 18, compared to 22% in the general Lincolnshire population. Only 8.4% of Gypsies and Travellers were aged over 65, compared to 20.7% in the general Lincolnshire population.

There are four Local Authority Gypsy and Traveller sites in Lincolnshire, which are located in Lincoln, Boston, Gainsborough and Grantham. There are also 25 private sites (some very small, accommodating just one family) and six showmen's sites. According to the Department for Communities and Local Government, there were 352 Gypsy and Traveller caravans in Lincolnshire in January 2012, an increase of 37% since January 2010.

According to the Commission for Racial Equality (CRE), experience of discrimination can undermine Gypsies and Travellers’ access to key services, and engender feelings of mistrust. Gypsies and Irish Travellers are less likely than other sections of the population to engage with vital statutory services, such as healthcare. Lower levels of literacy amongst Gypsies and Travellers can prevent them from accessing support.

5.11 Adults in Prisons and Detention Centres

There are two prisons in Lincolnshire: HMP North Sea Camp (NSC) and HMP Lincoln. Prisons have different security categories, which range from category A (prisoners who are highly dangerous) to category D (prisoners who can be reasonably trusted in open conditions).

HMP Lincoln is a category B male prison, located in Lincoln City. It has a certified normal accommodation for 408, and an operational capacity of 729 prisoners. At the time of the latest inspection, in May 2012, 632 prisoners were held at the institution. HMP NSC is an adult male category D prison (open) located in Freiston, a rural area near Boston. It has certified normal accommodation of 378, and an operational capacity of 420 prisoners. At the time of latest inspection, 362 prisoners were held.

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iii Information provided by Lincolnshire County Council Corporate Property Department
Lincolnshire also has an immigration removal centre a few miles to the south-west of Lincoln, at Morton Hall, near Swinderby. It has 392 places for male detainees. At the time of the last inspection, in March 2013, 362 detainees were held at the centre.\textsuperscript{100}

5.12 Armed Forces

According to Defence Statistics, in January 2014, the UK forces population in Lincolnshire was 7,390, including both military personnel and civilians. The majority of these were RAF personnel, based across nine RAF bases in Lincolnshire (Barkston Heath, Coningsby, Cranwell, Digby, Donna Nook, Holbeach, Kirton in Lindsey, Scampton and Waddington).

Table 4: UK forces population in Lincolnshire by service type and Clinical Commissioning Group, January 2014

<table>
<thead>
<tr>
<th>CCG</th>
<th>RAF</th>
<th>Naval Services</th>
<th>Army</th>
<th>Civilians</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincolnshire East</td>
<td>2060</td>
<td>0</td>
<td>20</td>
<td>110</td>
<td>2190</td>
</tr>
<tr>
<td>Lincolnshire West</td>
<td>2630</td>
<td>50</td>
<td>120</td>
<td>10</td>
<td>2810</td>
</tr>
<tr>
<td>South West Lincolnshire</td>
<td>1280</td>
<td>90</td>
<td>260</td>
<td>760</td>
<td>2390</td>
</tr>
<tr>
<td>South Lincolnshire</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>5970</td>
<td>140</td>
<td>400</td>
<td>880</td>
<td>7390</td>
</tr>
</tbody>
</table>

Source: MoD - Defence Analytical Services and Advice (DASA)

Females account for just over 13% of military personnel. Unsurprisingly, people aged 25-34 years are the largest age group within Lincolnshire's forces population. According to NHS registration data, there are also around 500 children aged under 15 living on service bases, and registered to Lincolnshire CCG practices.\textsuperscript{101}

Lincolnshire also has a large number of ex-armed forces personnel. However, data on this cohort is currently very limited, so it is difficult to provide accurate estimates.
6 The Policy Context

6.1 The National Policy Context

There are various laws that apply to mental health and mental illness.

- The Mental Health Act (1983) is the law under which someone can be admitted to hospital, detained there, and treated against their wishes.

- The Mental Capacity Act (2005) provides a framework to protect vulnerable people over the age of 16 years, who are not able to make their own decisions.

- The Equality Act 2010 protects disabled people from being treated unfairly in their everyday lives.

- The Care Act is a new piece of legislation designed to reform the law relating to care and support for adults and for carers.

Similarly, there is a wide range of policies and strategies that are specifically relevant to mental health and mental illness.

The National Service Framework for Mental Health\textsuperscript{102} raised the profile of mental health and mental illness. This Framework identified seven standards, which contained aims, interventions, evidence base, service models and examples of good practice.

The five broad areas within the seven standards are:

- mental health promotion;
- primary care and access to services;
- effective services for people with severe mental illness;
- caring about carers; and
- preventing suicide.

More recently, mental health was a key feature in the Public Health Strategy for England \textit{Healthy Lives: Healthy People}\textsuperscript{103}, which was published in 2010.

In 2011, \textit{No Health Without Mental Health}\textsuperscript{82}, was published. This is the Government’s mental health outcomes strategy, which aims to improve the mental health and wellbeing of the population and keep people well. It is also intended to improve outcomes for people with mental health problems through high quality services that are equally accessible for all. The strategy has six objectives, which are set out in table 5.
Table 5: No Health Without Mental Health, objectives and outcomes

<table>
<thead>
<tr>
<th>Objective</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| More people will have good mental health | • People will have better wellbeing and good mental health  
• Fewer people will develop mental health problems |
| More people with mental health problems will recover | • More people who develop mental health problems will have a good quality of life |
| More people with mental health problems will have good physical health | • Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health |
| More people will have a positive experience of care and support | • Access to timely, evidence-based interventions and approaches should be offered |
| Fewer people will suffer avoidable harm | • Services users should have the confidence that the services they use are of the highest quality |
| Fewer people will experience stigma and discrimination | • Public understanding of mental health will improve, and negative attitudes and behaviours towards people with mental health problems will cease |

In December 2013, a mental health dashboard\textsuperscript{104} was launched, which brings together information about the progress that has been made on the objectives in the No Health Without Mental Health strategy. This dashboard includes data and information on a range of indicators that support the objectives in the strategy, such as prevalence of mental health, employment of people with a serious mental illness, and excessive mortality in people with a serious mental illness.

One of the core objectives in The Mandate. A mandate from the Government to NHS England: April 2014 to March 2015\textsuperscript{105}, produced by the Department of Health, is to give mental health the same importance as physical health. The Department wishes to improve the management of ongoing mental health conditions such as depression, and, in particular, to reduce premature mortality in people with a serious mental illness. At the same time, it is hoped that the experience of healthcare for people with mental ill health will be improved. Under the Mandate, it is intended that the NHS should provide a good example by promoting the mental health of its workforce.
The Department of Health’s, *Closing the Gap: Priorities for Essential Change in Mental Health*\(^\text{106}\), explains how changes in local service planning and delivery will make a difference to the lives of people with mental health problems. It sets out 25 areas requiring change, within four broad themes:

- increasing access to mental health services;
- integrating physical and mental health care;
- starting early to promote mental wellbeing, and prevent mental health problems; and
- improving the quality of life of people with mental health problems.

Although not specific to people with mental ill health, the Public Inquiry into Mid Staffordshire NHS Foundation Trust has significant implications for all providers of healthcare. The Francis Inquiry\(^\text{107}\) identified a wide range of recommendations.

Mental health is a key area in the National Outcomes Frameworks for Health and Social Care.

The NHS Outcomes Framework 2014/15\(^\text{108}\) includes indicators grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there is a small number of ‘overarching indicators’, which are linked to several ‘improvement areas’. Some of the domains and improvement areas that are relevant to mental ill health are shown in table 6.

**Table 6:** The NHS Outcomes Framework 2014/15. Domains and improvement areas relevant to mental health

<table>
<thead>
<tr>
<th>Domain</th>
<th>Improvement areas in relation to mental ill health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Reducing premature death in people with serious mental illness</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>Enhancing quality of life for people with mental ill health</td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care</td>
<td>Improving experience of healthcare for people with mental ill health</td>
</tr>
</tbody>
</table>

The *Public Health Outcomes Framework for England*\(^\text{109}\) is intended to protect the nation’s health and wellbeing, and to improve the health of the poorest members of society. Its success will be measured in terms of both increased life expectancy generally, and reduced differences in life expectancy and healthy life expectancy between communities. These outcomes are to be delivered through four domains, which again are linked to a range of indictors. Table 7 shows the domains and indicators specifically relevant to mental health.
Table 7: Public Health Outcomes Framework. Domains and indicators relevant to mental ill health

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the wider determinants of health</td>
<td>• People with mental ill health or disability living in settled accommodation</td>
</tr>
<tr>
<td></td>
<td>• Employment for those with a long-term condition, including those with a learning disability or mental illness</td>
</tr>
<tr>
<td></td>
<td>• Utilisation of green space for exercise/health reasons</td>
</tr>
<tr>
<td>Health improvement</td>
<td>• Hospital admissions as a result of self-harm</td>
</tr>
<tr>
<td>Healthcare public health and preventing premature mortality</td>
<td>• Excessive under-75 mortality in adults with serious mental illness</td>
</tr>
<tr>
<td></td>
<td>• Suicide</td>
</tr>
<tr>
<td></td>
<td>• Dementia and its effects</td>
</tr>
</tbody>
</table>

The Adult Social Care Framework 2014/15\textsuperscript{110} has four domains and a wide range of measures, many of which are relevant to mental health. Table 8 outlines the domains and some of the measures that are relevant to this HNA.

Table 8: Adult Social Care Framework 2014/15. Domains and measures relevant to mental ill health

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancing quality of life for people with care and support needs</td>
<td>• Proportion of adults in contact with secondary care mental health services who are in paid employment</td>
</tr>
<tr>
<td></td>
<td>• Proportion of adults in contact with secondary care mental health services who are in paid employment and living independently, with or without support</td>
</tr>
<tr>
<td>Delaying and reducing the need for care and support</td>
<td>• Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs</td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care</td>
<td>• People who use social care, and their carers, are satisfied with their experience of care and support services</td>
</tr>
<tr>
<td>Safeguarding adults whose circumstances make them vulnerable, and protecting them from avoidable harm</td>
<td>• Everyone enjoys physical safety and feels secure</td>
</tr>
</tbody>
</table>
The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care\textsuperscript{111} sets out the principles and processes for people requiring NHS continuing healthcare and NHS-funded nursing care.

A number of national strategies have particular relevance to mental ill health, including the Government’s Alcohol Strategy\textsuperscript{112} and the Preventing Suicide in England Strategy\textsuperscript{113}.

The Joint Commissioning Panel for Mental Health (JCPMH) is a collaboration between leading organisations, with the aim of inspiring commissioners to improve mental health and wellbeing. The JCPMH has produced guidance for commissioners on a range of services. Examples include eating disorder services, forensic mental health services and primary healthcare services.

NICE guidance sets the standards for high-quality healthcare, and encourages healthy living. The guidance can be used by the NHS, local authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.

With regard to mental health, NICE has published a wide range of clinical guidelines and public health guidance, including the following:

- Clinical Guideline 123\textsuperscript{16} offers evidence-based advice on the care and treatment of adults who have common mental health disorders, with a particular focus on primary care.
- Clinical Guideline 82\textsuperscript{114} covers the care, treatment and support that adults with schizophrenia should be offered.
- Clinical Guideline 38\textsuperscript{115} makes recommendations for the identification, treatment and management of bipolar disorder for children, adolescents, and adults in primary and secondary care, including those covered by prison medical services.
- Clinical Guideline 90\textsuperscript{21} makes recommendations about the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care.
- Public Heath Guidance 16\textsuperscript{116} is for all those involved in promoting older people's mental wellbeing. It focuses on practical support for everyday activities, based on occupational therapy principles and methods.
- Public Heath Guidance 22\textsuperscript{117} is for those who have a direct or indirect role in, and responsibility for, promoting mental wellbeing at work.

The Improving Access to Psychological Therapies (IAPT) programme\textsuperscript{118}, which began in 2006, supports the front-line NHS in implementing NICE guidelines for people suffering from depression and anxiety. Under the programme, it is intended that, by 2015, psychological therapy services for adults will have been established, a programme for children and young people will have been initiated, and models of care for people with severe mental illness will have been developed.

The Health and Social Care Act 2012 enshrined in law the principle of parity of esteem, whereby mental health must be given equal priority with physical health. NHS England must work for parity of esteem for mental and physical health through
the NHS mandate, and it is intended that the principles are embraced by all involved in the provision of health and care services. However, according to the Centre for Mental Health, an independent mental health charity, there are many areas where parity of esteem has not yet been realised\(^{19}\).

### 6.2 The Local Policy Context

As part of the Health and Social Care Act 2012, Health and Wellbeing Boards are required to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy.

The Lincolnshire JSNA addresses some core themes (such as adult health and wellbeing, and ill health and inequalities) and a number of related topics (including suicide) that are specifically relevant to mental health. Within the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018\(^ {120}\), the subject of mental health cuts across all five of the Strategy's themes. Table 9 provides information on the five themes, and on some of the associated measures that are specifically relevant to mental ill health.

**Table 9: JHWS themes and some measures for mental health**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples of Measures</th>
</tr>
</thead>
</table>
| Promoting healthier lifestyles | • Alcohol-related admissions to hospital  
• Self-reported wellbeing  
• People who use services who have control over their daily lives |
| Improving the health and wellbeing of older people | • Health-related quality of life for older people  
• Enhancing quality of life for people with dementia  
• Social connectedness |
| Delivering high-quality systematic care for major causes of ill health and disability | • Take up of the NHS Health Check Programme  
• Cancer screening coverage |
| Improving health and social outcomes for children and reducing inequalities | • Hospital admissions caused by unintentional or deliberate injuries in under 18s |
| Tackling the social determinants of health | • Employment of people with mental ill health  
• People with mental ill health or disability living in settled accommodation  
• Proportion of adults in contact with secondary mental health services who are living independently, with or without support |
A number of local strategies and plans have been developed.

Lincolnshire County Council is currently developing a Mental Health Promotion Strategy (2013-2016) with partners. This has a number of themes, including starting early, improving access to services and engaging the community. A Suicide Action Plan is also being developed following the Public Health 'Suicide and Self-Harm 2014 Annual Report'.

Together with NHS Lincolnshire, Lincolnshire County Council developed a Lincolnshire Dual Diagnosis Strategy to bridge the requirements of individuals with complex needs, who have co-existing mental health and substance use problems.

The Lincolnshire Alcohol and Drug Strategy established the strategic vision and key objectives for the next five years. This strategy comprises three main themes:

- promoting responsible drinking, and preventing alcohol- and drug-related harm;
- tackling alcohol- and drug-related crime and anti-social behaviour; and
- delivering high-quality alcohol and drug treatment systems.

Lincolnshire Health and Care (LHAC) is currently being reviewed in Lincolnshire. The review is looking at the services provided in hospitals, primary, community and social care as a result of rising costs and demands. Four key areas are being looked at: urgent care, planned care, women's and children's services, and prevention and long-term care. A high level blueprint has been created and approved by the Lincolnshire Health and Wellbeing Board. The needs of people with mental ill health will be explored as part of the four key areas.
7 Service Configuration

7.1 Healthcare Commissioning Arrangements

Health and social care organisations are going through a period of significant organisational change. In April 2013, large-scale organisational changes took place as a result of the Health and Social Care Act 2012, which changed the commissioning arrangements for mental ill health services. Clinical Commissioning Groups (CCGs) have become responsible for the majority of the NHS budget, and many public health budgets have been transferred to local authorities. NHS England oversees the work of CCGs, and also has its own specific commissioning role, being responsible for primary care commissioning and specialised commissioning. Public Health England has been established to protect and improve the nation's health and to address inequalities. Health and Wellbeing Boards have become a statutory requirement in every upper-tier local authority.

The four Lincolnshire Clinical Commissioning Groups (CCGs) are responsible for commissioning the majority of healthcare for the Lincolnshire population, but mental ill health services are commissioned in various ways.

People with a mental ill health may access a wide range of mainstream services that are provided for the general population, including primary, community and hospital care. Although some people will access such services outside the county, the main providers of NHS care for the Lincolnshire population are United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services and the East Midlands Ambulance Service. The CCGs are responsible for ensuring that these mainstream health services address the needs of people with mental ill health.

They must also ensure that specialist mental health services are commissioned and provided for people who require this level of healthcare. South West Lincolnshire CCG commissions these services on behalf of the four Lincolnshire CCGs, predominantly through Lincolnshire Partnership NHS Foundation Trust (LPFT).

South West Lincolnshire CCG also leads on the procurement of specialist, non-commissioned and out-of-area healthcare for service users with mental health problems. This process is delivered by the complex case team. The team works with the out-of-area treatments (OATs) panel if a service cannot be delivered by locally commissioned providers. A wide range of providers is used to meet these needs.

In addition to the mainstream and specialist mental health services that are commissioned by the CCGs, NHS England is responsible for the specialised commissioning of some mental health services. Mental health is the subject of one of the five national programmes of care (PoCs) designed by NHS England in order to bring together individual, but related, service areas. (The other groups are internal medicine, cancer and blood, trauma, and women and children.) Each PoC may include specialised and highly-specialised prescribed services, and surgical and medical services. 

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A section 75 (s75) agreement for ‘Adult social care for people with mental health needs aged between 18 and 64 years’ is in place between Lincolnshire County Council and LPFT. The aim of this agreement is ‘to provide an effective, personalised social care service to meet the mental health needs of the people of Lincolnshire’. Service delivery under the agreement is provided by LPFT, and by others whom they have commissioned, such as the Managed Care Network (including some Shine activities). Broadly, this includes the assessment of individuals to determine eligibility, the management of eligible care needs, and managing the discharge of service users.

Lincolnshire County Council is responsible for the commissioning of accommodation and housing-related support for individuals who are experiencing a severe psychiatric emergency crisis (funded through the NHS via a s256 agreement). The County Council also commissions a range of public health programmes, in relation to such matters as obesity, physical activity, smoking, prevention and treatment of drug- and alcohol-abuse, and a Wellbeing Service.

7.2 Health and Care Service Provision

People in Lincolnshire with mental ill health may access a wide range of services to address their health needs, as described below. General health needs are met through primary, community and secondary care.

Primary care services are central to addressing the health needs of people with mental ill health, and also provide for the needs of families and other carers. The range of services provided includes the work of GP practices, dental practices, opticians and pharmacies.

The Quality and Outcomes Framework (QOF)\textsuperscript{124} is part of a voluntary incentive scheme, the General Medical Services Contract, which rewards GPs financially for implementing good practice across a number of areas. It includes a set of indicators for care provided to people with a serious mental illness (such as schizophrenia, bipolar affective disorder and other psychoses) or those undergoing such treatment as lithium therapy.

QOF indicators address record-keeping (including registration of patients) and the ongoing management of patients (such as developing and tracking comprehensive care plans, and recording blood pressure and BMI).

A separate set of indicators focusses on depression, and includes measures and standards for the initial diagnosis and clinical management of depression.

Primary care provides a range of public health programmes, such as smoking cessation, which are discussed in more detail elsewhere in this report.

Lincolnshire Community Health Services (LCHS) provide a range of services, such as district nursing, health visitors, speech and language therapy, and smoking cessation. The Trust is also responsible for services provided from a walk-in centre in Lincoln, an out-of-hours service, and the work of four GP practices. In addition, LCHS provide care from four community hospitals: John Coupland Hospital in
Gainsborough, Skegness and District General Hospital, Spalding's Johnson
Community Hospital, and Louth County Hospital.

A special care dentistry service is also provided by LCHS, and is delivered at a range
of health clinics in Lincolnshire. The aim of this service is to improve the oral health
of individuals and groups in society with a physical, sensory, intellectual, mental,
medical, emotional or social impairment or disability, or, more often, those affected
by a combination of such factors. Consequently, the care provided to these patients
is beyond the skill set and facilities of a general dental practitioner.

Secondary care is provided by United Lincolnshire Hospitals NHS Trust, which
provides healthcare from three main hospitals: Pilgrim Hospital in Boston, Grantham
and District Hospital, and Lincoln County Hospital. The Trust also provides some
services at the four community hospitals, identified above.

Lincolnshire is serviced by the East Midlands Ambulance Service (EMAS).

7.3 Specialist Mental Health Services

7.3.1 Lincolnshire Partnership NHS Foundation Trust (LPFT)

Lincolnshire Partnership NHS Foundation Trust (LPFT) provides specialist
health and care services for people with mental health problems, learning
disabilities, or drug or alcohol problems.

LPFT Adult Mental Health Services care for people of working age (18 to 65
years old) who are experiencing severe episodes of mental ill health, or who
need longer-term recovery plans put in place in order to return to independent
living. In relation to this HNA, relevant services include:

- Community mental health service
  LPFT community mental health teams provide care for people who are
  recovering from an ongoing mental health problem. People may be
  referred to this service if they have, or may have, a severe or long-term
  mental illness. Support is provided in people's own homes and in the
  community.

- Crisis resolution and home treatment
  The crisis resolution and home treatment team is for people who are
  experiencing a mental health crisis, and who, as a result, are at risk of
  being admitted to hospital. The service will generally become involved
to try and prevent the situation from escalating to this point. This team
provides appropriate services to people with severe and enduring
mental ill health, the main categories being psychosis, bipolar disorder
and severe depression.

- Acute inpatient care
  LPFT acute care is for people who are experiencing a severe,
short-term episode of mental ill health, which cannot be dealt with by the Trust’s community service. Treatment, usually for a short time, is provided on an inpatient ward at Lincoln, Grantham or Boston.

- Veterans' Mental Health Services
NHS mental health services in the East Midlands, in partnership with Combat Stress, are committed to improving both access to, and the quality of, mental health services for armed forces’ veterans, their carers and their families. The region’s five mental health trusts and Combat Stress are working together to ensure there is a proactive approach to care and treatment, and a clear point of contact for servicemen and women, as well as veterans, whenever they need help, support or advice.

LPFT Specialist Services provide a range of assessment, treatment and rehabilitation interventions on an inpatient, outpatient, and community basis to patients who have mental and/or physical health needs. In relation to this HNA relevant services include:

- Drug and Alcohol Recovery Team
  Lincolnshire’s Drug and Alcohol Recovery Team (DART) provides support and treatment for anyone aged 18 or over who is experiencing problems with drugs and/or alcohol use. Addaction also provide drug and alcohol services, and are commissioned by Lincolnshire County Council (see section 7.4)

- Forensic mental health service
  The community forensic service provides care and treatment for individuals experiencing mental health problems, who also pose a risk to the public. This service also provides care co-ordination for people suffering from mental ill health, who are placed out of the county in low-, medium- or high-security hospitals.

The Francis Willis Unit is a 15-bed, low-security, inpatient unit, which provides assessment and treatment for males aged 18 to 65 years who have a primary diagnosis of mental illness, and who may exhibit challenging or high-risk behaviours. The aim of the unit is to promote recovery and rehabilitation, to reduce the risks posed, and, ultimately, to enable the individual to leave that secure environment for a less restrictive one.

- Prison Services
  The LPFT prison mental health service has provided fully integrated mental health care, from initial assessment to the provision of care under the Care Programme Approach (CPA). Responsibility for providing this service passed to Nottinghamshire Healthcare NHS Trust from 1st October 2014.
• Rehabilitation services
  Rehabilitation teams provide tailored therapeutic programmes to empower individuals to take decisions about their future needs, maximise their independence, and increase their overall participation in community life.

• Anorexia Nervosa Service
  This team provides a gradual exploration of feelings and attitudes towards food, in order to develop a tailor-made plan for the individual. Inpatient treatment is an option at the Bennion Centre in Leicester.

LPFT also provides psychological therapies and primary care, including the following services and programmes:

• Improving Access to Psychological Therapies Programme (IAPT)
  The Improving Access to Psychological Therapies Programme (IAPT) aims to improve access to evidence-based talking therapies in the NHS, through an expansion of the psychological therapy workforce and services. In Lincolnshire, the IAPT service is for anyone, over the age of 16, who is feeling stressed, anxious, low in mood or depressed.

• Adult Psychology
  The adult psychology service works alongside the primary mental health teams throughout Lincolnshire, but also receives referrals from other services within LPFT. Service users may be referred because of the complex and enduring nature of their mental health difficulties, or because of a lack of response to other accessible therapeutic interventions, such as counselling and cognitive behavioural therapy.

• Bulimia Nervosa Treatment
  Outpatient treatment for bulimia nervosa, based on NICE guidance, is provided.

• Employment Advisory Service
  This service meets the needs of people with common mental health problems, such as anxiety and depression, who are having difficulties at work.

• Dynamic Psychotherapy
  Dynamic psychotherapy is a form of psychotherapy deriving from psychoanalysis, and provides an opportunity for patients to explore how traumatic experiences and conflicts have shaped their emotional development.
Neuropsychology Service
The neuropsychology service provides assessment, support and advice for people with various aetiologies, including brain injury, neurological problems and multiple sclerosis. It also provides this service for people experiencing difficulties with memory and concentration, for which there is no known cause.

7.3.2 Out-of-County Providers
A wide range of providers (for example, Cygnet Health Care and the Priory Group) is used to meet the needs of patients commissioned through the OATs process.

In addition, Lincolnshire prison services offer fully integrated mental health care for inmates, from initial assessment to the provision of care under the Care Programme Approach (CPA). This service was previously provided by LPFT, but is now under the auspices of Nottinghamshire Healthcare NHS Trust.

7.3.3 Specialised Commissioning
NHS England is responsible for the specialised commissioning of the national mental health programme of care. Under the programme, Clinical Reference Groups (CRGs) have been established to develop services. The CRGs that are relevant to this HNA are:

- specialised services for eating disorders;
- high and medium secure mental health services;
- low secure mental health services;
- specialised mental health services for the deaf;
- gender identity services;
- perinatal mental health services;
- tier 4 severe personality disorder services (adults); and
- mental health specialised services (such as the severe obsessive compulsive disorder and body dysmorphic disorder service; and veterans' post-traumatic stress disorder (PTSD) programme).

7.4 Public Health Services
Local providers deliver a range of public health commissioned services relevant to people with mental ill health, including smoking cessation, crisis housing and drug and alcohol services. Many different providers support the delivery of public health commissioned programmes. For example:

- Various providers deliver physical activity programmes (such as exercise on referral and walking programmes).
A tier 2 weight management service for adults is provided by Weight Watchers.

Addaction provides therapeutic and pharmacological interventions to support problematic and dependent drug and alcohol users to become drug free.

Community pharmacists provide a supervised administration scheme for methadone.

A Wellbeing Service supports people to feel confident within their own homes. The Health Support Service assists offenders released on probation (with such matters as health assessments, accessing health and care services, and making healthy lifestyle changes).

7.5 Social Care Provision

Social Care fulfils an essential role in meeting the needs of people with mental health problems. By using a structural approach, influenced by values such as 'human rights' and 'social justice', Social Care workers seek to help people understand and deal with the factors that might have affected their mental health. These include debt, employment and substance misuse.

Services that support people at times of crisis, and help them to move forward towards recovery, include the following:

- **Residential**
  LPFT provides a range of integrated health and social care services designed to meet the needs of people with poor mental health. The type of service(s) provided will be determined by the severity and complexity of an individual's mental health condition, and also the level of risk this might present, either to themselves or to others. Where necessary, residential care is provided.

- **Community Supported Living**
  Where possible, and subject to a risk assessment, social care support is provided in the community setting to enable the service user to remain at home. Services under the broader heading of 'Community Supported Living' are designed to provide the support people need to help them overcome barriers that prevent them from living in their own homes, and also help to improve the public’s understanding of mental health issues.

- **Direct Payments**
  A service user who has been assessed as eligible for Social Care support is offered a 'personal budget'. This is to cover the cost of service provision, and can be used either by the Local Authority (to deliver services directly) or by the individual, with the help and support of the Local Authority (to purchase services of their own choosing). In either case, the intention is to help the individual meet their particular need(s), as set down in a support plan.

- **Best Interest Assessors**
  The Deprivation of Liberty Safeguards (DOLS) cover patients in hospitals and
people in care homes who are registered under the Care Standards Act 2000. The safeguards apply where the individual has been placed under public or private arrangements.

Recently, a test case resulted in these safeguards being extended to cover people who may be confined to their own homes, but not of their own choice. As a result, both the NHS and Local Authority commissioners and providers are under a statutory duty to take account of the need to safeguard vulnerable adults who are, or may become, deprived of their liberty.

Under the flexibilities permitted by Section 75 (s75) of the Health Act 2007, LPFT, acting on behalf of the Local Authority, implements and monitors the systems and processes designed to safeguard vulnerable adults by determining 'lawful deprivation of liberty'.

Where a mental health assessor considers that an individual is being, or is likely to be, deprived of their liberty, she or he must inform the Best Interest Assessor, who will carry out a further assessment and consider the following:

- whether or not deprivation of liberty is occurring, likely to occur or needs to occur;
- the views of the individual being assessed, as well as those of anyone else who has an interest in the individual's welfare (such as a family member or friend, carer, advocate or someone with lasting power of attorney);
- the effect that deprivation of liberty may have on the individual's mental health; and
- the individual's needs, including cultural, religious, spiritual and faith, and family contact.

- Management of Adult Mental Health Professionals
Under s75, LPFT manages and co-ordinates a service of approved mental health professionals (AMHPs) for undertaking independent assessments of any person who may have a mental disorder requiring either urgent admission to hospital or guardianship.

This service operates during normal working hours, after which callers are referred to the Council's Emergency Duty Team.

- Crisis Houses (Section 256)
Crisis houses are designed to provide short-term respite and sanctuary for those experiencing a mental health crisis. Haven House in Lincoln and Collyhurst in Spalding, which are staffed 24 hours a day and are run by a charitable organisation called 'Making Space', provide this service, in partnership with LPFT's Crisis Resolution Home Treatment (CRHT) team.

- Section 136 of the Mental Health Act 1983 (revised 2007)
From time to time, people with a mental illness come into contact with the
police. If a police officer considers an individual to have mental ill health and be in need of care, she or he can arrange for this to be provided by a hospital, at a police station or at the special Section 136 suite located at the Peter Hodgkinson's Centre in Lincoln. The police can detain someone for up to 72 hours, during which time the individual may be assessed by a mental health professional.

Individuals detained under Section 136 have rights, such as for:

- access to legal advice;
- assessment and treatment by a healthcare professional; and
- someone to be informed of their whereabouts.

As detention under Section 136 is only short-term, access to legal advice is likely to be through a duty solicitor.

Once an assessment has been carried out, individuals who require care may either remain of their own free will, or be sectioned under the Mental Health Act. Those who are assessed as 'not requiring further care' are free to leave.

7.6 Community Health Support Networks

Lincolnshire's Managed Care Network (MCN)\textsuperscript{126} for mental health was created to strengthen what is available to people once they are well enough to be discharged from LPFT services, and to prevent the need for specialist mental health services in the first place. It helps both those who have already experienced mental health problems, and those who are having their first experience of mental illness.

Lincolnshire County Council commissions LPFT to provide:

- a range of support and services (through partner providers) for adults of all ages, through the Mental Health Promotion Fund; and
- projects that promote good mental health across all ages, with the aim of influencing people's knowledge and attitudes about mental health, encouraging them both to help others and to learn about how they can look after their own mental health.

The Managed Care Network is a federation of organisations providing a range of services (for example, wellbeing services or activities) to give people support and structure in their lives. These organisations have close operational and developmental links with each other, with the aim of helping people to prevent, manage and recover from mental illness in order to enjoy the best quality of life possible. The MCN supports those with all types of mental ill health, and is the only commissioned support for those with ADHD. Currently, the network consists of 67 groups and organisations across 83 sites, and has an estimated 3,000 beneficiaries.

The Mental Health Promotion Fund finances activities for people who are not eligible for social care support, but who, without additional help, would be likely to become eligible as their needs intensified. This is managed as part of the s75 agreement (as
described in section 7.1). A wide range of countywide and locality specific projects are provided with financial resources from this Fund. Some examples of these are:

- Shine Network – Prompt;
- Lincolnshire Rural Support Network;
- Trinity Centre, Louth;
- Rasen Hub – Inspire;
- LPPG Outreach;
- Home-Start South West Lincolnshire – Feel Good Mums;
- Grantham Green Fingers; and
- United Together.

The Shine mental health support network\textsuperscript{126} has been established in Lincolnshire for individuals, groups and organisations with an interest in mental health. The mission of the network is to enable people with mental health problems to achieve the best possible quality of life by connecting people with services and support that will address their needs.

Shine is not a single organisation; it is a network of people, groups, organisations and businesses with a common interest.

Their aim is for the members of the network to work together in order to:

- connect services so as to improve efficiency and effectiveness;
- support the best use of resources;
- connect people with the services that will best meet their needs; and
- add value to the work of each member.

Further information on all of the above projects may be found on the Managed Care Network pages of the LPFT website\textsuperscript{125}.
8 Mental Ill Health in Lincolnshire

This chapter focusses on the scale, or potential scale, of mental ill health issues in Lincolnshire. In some cases, accurate data is sparse, so estimates, prescribing rates and acute admissions have been used in an attempt to quantify issues affecting the county.

For many conditions, estimated rates have been based on the Adult Psychiatric Morbidity Survey (APMS) 2007. The survey was commissioned by the NHS Information Centre for Health and Social Care (now the Health and Social Care Information Centre), and was the third survey of its type in England. The main aim of the 2007 survey was to collect data on the mental health of adults, aged 16 and over, living in private households in England. It is the primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations.

For some issues, data from the APMS for the 16-24-year age group has been used as an indicator of prevalence in the 18-24-year age group for this HNA.

As there is a lack of accurate data at the local level about the number of people who suffer from mental health problems, supplementary data on prescribing for relevant pharmaceutical treatment, and on appropriate acute admissions, has been used to help determine population estimates. This is intended as an indicator of scale, but it should be borne in mind that prescribing, for example, does not always form part of a treatment plan, and, where it does, it may not be the first, or only, course of action.

8.1 Common Mental Disorders (CMD) in General

The 2007 national psychiatric morbidity survey showed 16.2% of all adults aged 16 and above had a common mental disorder (CMD). Table 10 shows age-specific rates for various categories of CMD.

Table 10: Age-specific rates of common mental disorders in England (percentages)

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>10.2</td>
<td>10.8</td>
<td>8.5</td>
<td>11.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>3.6</td>
<td>4.2</td>
<td>5.3</td>
<td>6.1</td>
<td>4.1</td>
</tr>
<tr>
<td>All phobias</td>
<td>2.2</td>
<td>2.2</td>
<td>2.9</td>
<td>3.7</td>
<td>1.9</td>
</tr>
<tr>
<td>OCD</td>
<td>1.5</td>
<td>1.9</td>
<td>2.1</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>2.3</td>
<td>1.5</td>
<td>1.1</td>
<td>1.1</td>
<td>0.5</td>
</tr>
<tr>
<td>Any CMD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17.5</td>
<td>18.8</td>
<td>17.3</td>
<td>19.9</td>
<td>14.1</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

The rates above have been applied to the Lincolnshire-GP registered population
aged 18-64, for 2012\textsuperscript{127}. The results suggest that approximately 78,500 people in this age group (17.5\%) suffer from common mental disorders.

Mixed anxiety and depressive disorder is the most common form of mental disorder, and peaks amongst people aged 45-54 (11.2\% of this age group). Moreover, nearly one in five people in this age group are expected to suffer from one of the common mental disorders.

Across all age groups, females are more likely than males to suffer from common mental disorders.

8.2 Depression

General Practices in the UK keep a record of all patients diagnosed with depression. Figure 6 shows the proportion of patients, aged 18 and over, on the depression register. From the chart, Lincolnshire West CCG appears to have the highest rate of patients on the depression register. This figure is also higher than the England average, although it is difficult to know whether this has been influenced by diagnostic or recording behaviour within the CCG\textsuperscript{128}.

**Figure 6**: Percentage of patients aged 18 and over with depression, as recorded on GP practice depression registers (all patients diagnosed since April 2006).

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lincolnshire East CCG</td>
<td>5.77%</td>
</tr>
<tr>
<td>NHS Lincolnshire West CCG</td>
<td>7.34%</td>
</tr>
<tr>
<td>NHS South Lincolnshire CCG</td>
<td>6.87%</td>
</tr>
<tr>
<td>NHS South West Lincolnshire CCG</td>
<td>6.28%</td>
</tr>
<tr>
<td>England</td>
<td>5.80%</td>
</tr>
</tbody>
</table>

*Source: Quality and Outcomes Framework 2012/13*

During the 2012/13 financial year, over 3,900 Lincolnshire GP registered patients, aged 18-64 years, were referred to LPFT primary and community services because of depression. The vast majority of these cases were referred for primary care.
In 2012/13, 2,394 females and 1,521 males were referred for depression. Overall, the number of depression referrals increased in comparison to 2011/12 and 2010/11 for both genders, but for males the increase was more pronounced. There were nearly 300 more male patients referred for depression in 2012/13 than in 2010/11, a 23% increase over the three years. The proportion of males among all patients referred for depression increased from 36% in 2010/11 to 39% in 2012/13\textsuperscript{iv}.

Of the patients referred to LPFT in 2012/13, 53 were admitted with a primary diagnosis of depressive episode (ICD10 – F32), and were provided with acute services. Two-thirds of these were male. Although the numbers are small, this could suggest that higher rates of engagement with primary care treatment services by female patients provided them with an opportunity to receive assistance, before their illness progressed to a degree requiring acute care. Between 2011/12 and 2012/13, the number of female patients decreased by nearly a third, whilst the number of male patients increased slightly\textsuperscript{v}.

During the 2012/13 financial year, over 912,500 antidepressant items were prescribed, across all four Lincolnshire CCGs, to a total value of over £3.8 million. The number of antidepressants prescribed in Lincolnshire increased by 19% between 2010/11 and 2012/13, which was greater than the increase observed nationally (16%). Figure 7 shows the number of prescribed antidepressants per person in Lincolnshire’s CCGs and nationally\textsuperscript{vi}.

**Figure 7:** Prescribed antidepressants per person (registered population all ages)

\begin{center}
\includegraphics[width=\textwidth]{prescribed_antidepressants_per_person.png}
\end{center}

*Source: NHS Business Services Authority; Public Health England*

\textsuperscript{iv} Information provided by Lincolnshire Partnership NHS Foundation Trust (LPFT)
\textsuperscript{v} Ibid
\textsuperscript{vi} NHS Business Services Authority data, provided by the Prescribing and Medicines Optimisation Service for GEMCSU
The number of prescribed antidepressants per registered patient was 30% higher for Lincolnshire than for England in 2012/13. Lincolnshire East CCG had the highest rate, with 1.3 items per person per year, compared to 1.05 items in South West Lincolnshire CCG (Lincolnshire’s lowest rate) and 0.93 nationally.

The high number of antidepressants prescribed in Lincolnshire East CCG is not consistent with the lower rates of depression observed in the same population (figure 6), but it must be remembered that prescribing rates do not take age and gender profiles into account. Antidepressant drugs could be prescribed for older people to treat other illnesses, such as dementia.

Moreover, cases of older people receiving prescriptions to treat depression or anxiety may be under-reported in mental health registers. Consequently, it is difficult to make direct comparisons between the various populations.\(^7\)\(^\text{vii}\)

### 8.3 Anxiety

During 2012/13, over 3,700 individuals were referred to LPFT’s primary and community services because of anxiety. This figure includes working-age adults (aged 18-64 years), who were registered with Lincolnshire GPs. Of these patients, 63% were females.

The vast majority (96.6%) were referred to primary care services. Between 2010/11 and 2011/12, the number of patients referred as a result of anxiety increased by 20% (526 additional patients), and then increased by a further 18% (568 additional patients) between 2011/12 and 2012/13. The increases among males and females were similar over the three-year period.\(^\text{viii}\)

Anxiolytics (drugs used in the treatment of anxiety) are prescribed less frequently than antidepressants. In 2012/13, over 117,300 anxiolytics (with a value of around £270,000) were prescribed in Lincolnshire. Between 2010/11 and 2012/13, prescribing in Lincolnshire increased slightly, by 5.8%. However, national prescribing levels increased by nearly a half (48.6%) over the same period.

Despite the slight increase in the prescribing of anxiolytics, for Lincolnshire, the total cost of these drugs decreased by nearly a third between 2010/11 and 2012/13.\(^\text{ix}\)

(Total costs may decline, despite a growth in the volume of prescriptions, because they are affected by the expiry of drug patents, and the emergence of low-cost generic drugs.)

The findings for Lincolnshire suggest that anxiolytics prescribing rates were lowest in South West Lincolnshire CCG, for which figures were also lower than national levels across the full three-year period. South Lincolnshire CCG had the second lowest rates out of Lincolnshire’s CCGs, which could suggest that people living in the south of the county are less likely to suffer from anxiety than those in other areas.

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\(^\text{vii}\) NHS Business Services Authority, op. cit.

\(^\text{viii}\) Information provided by LPFT

\(^\text{ix}\) NHS Business Services Authority, op.cit.
Indeed, a national wellbeing survey conducted by the Office for National Statistics (ONS) in 2012/13 reported that districts in the south of Lincolnshire (South Holland, Boston and South Kesteven) had levels of anxiety that were not only lower than those in the rest of the county, but also lower than national levels\(^{129}\).

### 8.4 Post-traumatic Stress Disorder (PTSD)

The 2007 APMS showed that a third of adults reported experiencing trauma in adulthood, with 3% of adults screening positive for PTSD. Trauma, in this case, was described as a major experience: a severe natural disaster, a serious automobile accident, being raped, seeing someone killed or seriously injured, having a loved one die as a result of murder or suicide, or any other experience that puts the individual, or someone close to them, at risk of grave injury or death\(^1\).

#### Table 11: Estimated prevalence rates in England of post-traumatic stress disorder by age and gender (percentages)

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>5.1</td>
<td>3.6</td>
<td>3.0</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Women</td>
<td>4.2</td>
<td>3.7</td>
<td>3.5</td>
<td>5.8</td>
<td>1.9</td>
</tr>
<tr>
<td>All adults</td>
<td>4.7</td>
<td>3.7</td>
<td>3.2</td>
<td>3.9</td>
<td>1.9</td>
</tr>
</tbody>
</table>

*Source: 2007 Adult Psychiatric Morbidity Survey*
Table 1 shows the estimated prevalence of PTSD in England, by age and gender. These rates were applied to Lincolnshire (for the GP registered population in 2012) in order to estimate the potential scale of the disorder in the county. This indicated that there may be more than 15,000 people, aged 18-64 years, in Lincolnshire, who are suffering with PTSD (equating to 3.4% of the working-age population).

However, as the county has a large number of armed forces personnel, it is possible that more people have experienced some of the types of trauma mentioned. Therefore, the figures for PTSD in Lincolnshire could also be higher than the average.

In 2012/13 there were 171 individual patients referred to LPFT primary and community services for PTSD. This number only includes working age adults registered with Lincolnshire GPs and accessing services provided by LPFT. Numbers were similar for both genders. The number of individuals referred due to PTSD increased by 31.5% between 2011/12 and 2012/13.

8.5 Suicidal Thoughts, Suicide Attempts and Self-harm

According to the 2007 psychiatric morbidity survey, 16.7% of people said that they had had suicidal thoughts at some point in their life, 5.6% said that they had attempted suicide and 4.9% said that they had engaged in self-harm (other than attempted suicide).

Rates of suicidal thoughts and suicide attempts vary by age, ethnicity, marital status and income. Risk of self-harm is generally higher among females, and decreases with age for both genders. Single people of both genders are more likely to self-harm than those of other marital statuses. The prevalence of self-harm is highest amongst those with the lowest income, and people of White ethnicity are more likely to self-harm than those from other ethnic backgrounds.

The pattern of association with household income was especially pronounced for suicide attempts: 9% of men and 12.2% of women from the lowest income quintile reported having attempted suicide, compared with 1.8% of men and 3.8% of women from the highest quintile.

According to national mortality statistics, in 2012, 45 people in Lincolnshire died as a result of suicide (ICD10 X60-X84), and a further 33 died from undetermined causes.

Taking into account mortality from intentional self-harm and undetermined injury, whether accidental or inflicted on purpose, (ICD-10 X60-X84, Y10-Y34) the rates for Lincolnshire are above the national level. They are also higher than those for some of the county’s statistical neighbours, such as Derbyshire, Leicestershire and Nottinghamshire.

* Information from HSCIC Primary Care Mortality Database
Figure 9: Mortality from suicide and injury undetermined (ICD-10 X60-X84, Y10-Y34): directly standardised rate per 100,000, 15-74 years, 2010-2012 pooled data

Source: HSCIC, Primary Care Mortality Database

The mortality rates from suicide and undetermined causes for working-age people in Lincolnshire’s CCGs suggest that Lincolnshire West CCG has the highest rate. However, the difference between the CCGs is not statistically significant\(^\text{**}\). National comparators for this indicator are not available for the corresponding period. From further statistical analysis, no evidence was found of a relationship between suicide and multiple deprivation, although, as the numbers are low, associations are difficult to identify.

Figure 10: Mortality from suicide and injury undetermined (ICD-10 X60-X84, Y10-Y34) directly standardised rate per 100,000, aged under 65, 2010-2012 pooled data

Source: HSCIC, Primary Care Mortality Database

\(^\text{**}\) Information from HSCIC Primary Care Mortality Database
Although there was an increase in the number of suicides in Lincolnshire, from 57 to 78 per year, between 2010 and 2012, it should be borne in mind that small numbers are very volatile, making it difficult to monitor a trend (for example, 2009 had an unusually high figure of 90).

Investigation of the trend in directly standardised rates of suicide, using a three-year rolling average, showed no change in rate over the period from 1995 to 2012. In the most recent three-year period, three-quarters of suicides were committed by males, and the highest rates were amongst people in their early forties\textsuperscript{xii}.

In 2011, 56 individual cases of suicide were reviewed, including patients' medical records. Over 40\% of males and 60\% of females had some previous contact with mental health services. History of depression was evident in 33\% of males' records and in 56\% of females' records. A history of alcohol problems was evident in 20\% of records, and 11\% showed a history of drug misuse. However, the percentage of cases with a record of drug and alcohol issues was lower in 2011 than in the previous year. Although the number of cases is small, detailed reviews of individual cases provide important evidence to inform local interventions and action plans\textsuperscript{[xiii]}

Data from LPFT showed that, in the 2013 calendar year, there were 1,439 self-harm referrals for patients aged 18 to 64 years, registered with Lincolnshire GPs. The number of referrals had increased by nearly 13\% compared to the previous year, and by 44\% compared to 2011. Across the whole three-year period, nearly 60\% of all referred patients were females\textsuperscript{xiv}.

\textbf{Table 12:} Self-harm referrals to LPFT by year of referral and patient's registration CCG, aged 18-64

<table>
<thead>
<tr>
<th>CCG name</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lincolnshire East CCG</td>
<td>375</td>
<td>478</td>
<td>447</td>
</tr>
<tr>
<td>NHS Lincolnshire West CCG</td>
<td>408</td>
<td>533</td>
<td>670</td>
</tr>
<tr>
<td>NHS South Lincolnshire CCG</td>
<td>99</td>
<td>120</td>
<td>141</td>
</tr>
<tr>
<td>NHS South West Lincolnshire CCG</td>
<td>119</td>
<td>145</td>
<td>181</td>
</tr>
<tr>
<td>Total</td>
<td>1,001</td>
<td>1,276</td>
<td>1,439</td>
</tr>
</tbody>
</table>

\textit{Source: Lincolnshire Partnership NHS Foundation Trust}

\textsuperscript{xii} Information from HSCIC Primary Care Mortality Database  
\textsuperscript{xiii} Information provided by LCC Public Health Department, Vulnerable People's Team  
\textsuperscript{xiv} Information provided by LPFT
Referral rates have been calculated from self-harm referral numbers for 2013, and numbers for GP-registered patients (aged 18 to 64 years)\textsuperscript{127}.

The highest referrals rate was in Lincolnshire West CCG (4.8 per 1,000 population) and the lowest was in South Lincolnshire CCG (1.52 per 1,000 population). However, it should be remembered that, in some cases, patients may access services outside of the county.

**Figure 11:** Self-harm referrals to LPFT in 2013 per 100,000 registered patients, aged 18-64

![Bar chart showing self-harm referrals in different areas of Lincolnshire]

*Source: Lincolnshire Partnership NHS Foundation Trust*

In contrast to national trends in suicide rates, incidence of self-harm has continued to rise in the UK over the past 20 years, and is said to be among the highest in Europe\textsuperscript{130}. Levels of self-harm can be difficult to estimate, so events severe enough to lead to hospital admission are used as a proxy of the prevalence of self-harm in society.

In 2011/12, there were 1,445 hospital admissions in Lincolnshire due to self-harm\textsuperscript{131}. Figure 12 shows rates of hospital admission for self-harm, for Lincolnshire and the county’s closest statistical comparators\textsuperscript{132}.

There are clear and significant differences between Lincolnshire's rate and that for some of its statistical neighbours. Rates in Lincolnshire increased slightly between 2010/2011 and 2011/12, whereas national rates showed a slight decline.
**Figure 12:** Emergency hospital admissions for intentional self-harm, all ages, directly standardised rate per 100,000, 2011/12


There are differences across Lincolnshire in the level of hospital admissions for self-harm, as shown in figure 13.

**Figure 13:** Hospital admission rate for intentional self-harm, 2010-2012, directly age standardised rate per 100,000 population

Source: Hospital Episodes Statistics (Secondary Uses Service), HSCIC GP registration data
Directly standardised rates of hospital admissions for 2010-12 show that Lincolnshire East CCG had a significantly higher rate than either South Lincolnshire CCG or South West Lincolnshire CCG.

The rate for Lincolnshire West CCG was significantly higher than any of the other CCGs, and, indeed, was twice the South West Lincolnshire rate. Further analysis confirmed that the level of self-harm is of particular concern for the City of Lincoln, within Lincolnshire West CCG.

The association between deprivation and self-harm has been investigated, using hospital admissions data for small geographical areas, and deprivation scores (IMD 2010). A higher IMD score indicates a higher level of deprivation, based on various factors, including employment, education, health and crime within an area.

Findings suggest that the likelihood of engaging in self-harm increases significantly with the level of deprivation. A person who lives in one of the 20% most deprived areas in Lincolnshire is 3.5 times more likely to engage in self-harm than someone who lives in one of the 20% least deprived. It is important to note that, using residential postcode is a proxy measure of deprivation, and may not reflect an individual patient’s circumstances. Furthermore, it should be borne in mind that this association is based on crude rates, and so has not been corrected for age structure. This could affect the findings for some areas, whose population includes a significant proportion of age groups known to be at higher risk of self-harm.

**Figure 14:** Hospital admissions for self-harm, 2010-2012, crude rates per 1,000 population by quintiles of deprivation, based on residential address of the patient.

Source: Hospital Episodes Statistics (SUS), Department for Communities and Local Government, IMD 2010
Figure 14 shows the crude rates of hospital admission in Lincolnshire, by quintile of deprivation\textsuperscript{86, xv}.

Further analysis of the correlation suggested a moderate positive association, both between hospital admissions for self-harm and level of multiple deprivation (R= 0.53), and between hospital admissions for self-harm and level of income deprivation (R=0.49). In both cases, there was a statistically significant level (p<0.01). Again, further analysis would need to be conducted in order to understand the association after adjustment for other factors, which may be playing a role.

8.6 Psychoses

According to the 2007 adult psychiatry morbidity survey, the estimated national prevalence of psychosis in the past year was 0.4% of the adult general population, (0.3% of men and 0.5% of women). As shown in table 13, for both men and women, the highest prevalence was observed amongst those aged 35-44 years (0.7% and 1.1% of this age group, respectively).

The survey found that the prevalence of psychotic disorders was significantly higher among Black men (3.1%) than among men from other ethnic groups. Prevalence also varied according to income, with the age-standardised rates ranging from 0.1% of adults in the highest income quintile to 0.9% of adults in the lowest income quintile\textsuperscript{1}.

<table>
<thead>
<tr>
<th></th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>-</td>
<td>0.6</td>
<td>0.7</td>
<td>0.1</td>
<td>-</td>
</tr>
<tr>
<td>Women</td>
<td>0.4</td>
<td>0.2</td>
<td>1.1</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>All adults</td>
<td>0.2</td>
<td>0.4</td>
<td>0.9</td>
<td>0.5</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

Applying these rates to the population of Lincolnshire\textsuperscript{127}, it can be estimated that 2,150 adults, aged 18-64 years, with psychotic disorders are living in the county.

In the financial year 2012/13, 138 working-age adults registered with Lincolnshire GPs were referred to LPFT community services because of psychosis. Of these, 36% were female and 64% male. The number referred had decreased slightly compared to previous years\textsuperscript{xvi}.

Data from the 2012/13 Quality Outcome Framework (QOF) showed that there were 4,779 patients on the mental health register, suffering from schizophrenia, bipolar

\textsuperscript{xv} Hospital Episodes Statistics, extracted by LCC Public Health Intelligence Team

\textsuperscript{xvi} Information provided by LPFT
affective disorder and other psychoses. This equates to 0.64% of the Lincolnshire GP registered population, for all ages. Figure 15 shows the QOF prevalence of psychoses for Lincolnshire CCGs and for England.

**Figure 15:** Prevalence of psychoses, 2012/13, all ages

![Bar chart showing prevalence of psychoses](chart_image)

Source: *Quality and Outcomes Framework, QMAS database*

Emergency hospital admissions for schizophrenia (ICD10 codes: F20., F21., F23.2 and F25.) peaked in Lincolnshire in 2008/09, but are currently showing a declining trend. In 2011/12, the county's hospital admissions for schizophrenia were at a similar level to national figures.

**Figure 16:** Emergency hospital admissions for schizophrenia; indirectly standardised rates per 100,000 population, aged 15-74

![Line chart showing hospital admissions](chart_image)

Source: *HSCIC; Hospital Episodes Statistics (admissions), Office for National Statistics (population estimates)*
Figure 16 shows indirectly standardised rates of hospital admissions for Lincolnshire, the East Midlands and England, where rates have been standardised to the 2007/08 population. In terms of numbers, for the age group 15-74 years, there were approximately 200 admissions per year in Lincolnshire from 2009 to 2011.

In 2012/13, more than 140,296 items of anti-psychotic drugs were prescribed in Lincolnshire. The number had increased by 13.7% compared to the previous year, a greater increase than was observed nationally (7%). Total spend on anti-psychotic drugs in Lincolnshire in 2012/13 was £2,291,991\(^{xvii}\), or approximately £3 for each registered patient\(^{127}\).

As shown in figure 17, the lowest rates of prescribing for anti-psychotic drugs were in South West Lincolnshire CCG, which was consistent with the CCG’s lower percentage of people with psychosis, as recorded on mental health registers. A similar correlation was found for the highest rates of prescribing, Lincolnshire West CCG having the highest rate, as well as the highest prevalence of psychoses, of all four Lincolnshire CCGs.

**Figure 17: Anti-psychotic drugs prescribed per person, registered population, all ages**

![Bar chart showing anti-psychotic drug prescription rates for different CCGs.](chart.png)

*Source: NHS Business Services Authority*

### 8.7 Anti-social and Borderline Personality Disorders

It is estimated that, nationally, anti-social personality disorder (ASPD) is present in 0.3% of adults aged 18 or over. Prevalence is higher amongst men than amongst women, and is highest in the age group ‘18-35 years’.

\(^{xvii}\) NHS Business Services Authority, op.cit.
The overall prevalence of borderline personality disorder (BPD) is about 0.4% in adults aged 16 or over. Females are more likely than males to be diagnosed with this condition, although, possibly due to the small numbers, the association with gender is not significant. Younger women are more likely to have BPD than older women, but no association with age was observed in men\(^1\).

**Table 14:** Estimated national prevalence of anti-social and borderline personality disorders (percentages)

<table>
<thead>
<tr>
<th></th>
<th>16-34</th>
<th>35-54</th>
<th>55-74</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASPD</td>
<td>1.1</td>
<td>0.1</td>
<td>-</td>
</tr>
<tr>
<td>BPD</td>
<td>0.8</td>
<td>0.4</td>
<td>0.2</td>
</tr>
</tbody>
</table>

*Source: 2007 Adult Psychiatric Morbidity Survey*

Applying the national rates, as shown in table 14, to the Lincolnshire population (based on GP registration\(^{127}\)) suggests that approximately 1,800 working-age people in Lincolnshire could be suffering from ASPD, and 2,200 could be suffering from BPD. The prevalence of both disorders is expected to be higher in the Lincolnshire West CCG area, as this CCG generally serves a younger population than do the other Lincolnshire CCGs.

According to data provided by LPFT, in 2012/13, 70 people aged 18-64 years, and registered with Lincolnshire GPs, were admitted to acute inpatient services with a primary diagnosis of personality disorder (ICD10 F60-61). The majority of these patients were female (68%).

In recent years, the number of admissions relating to personality disorder for both genders has been decreasing.

**8.8 Attention Deficit Hyperactivity Disorder (ADHD)**

There is currently a lack of epidemiological data on the prevalence of ADHD in the adult population nationally. In order to estimate the prevalence of the condition amongst adults for the psychiatric morbidity survey, an ADHD Self-report Scale (ASRS) was developed, in collaboration with the World Health Organisation (WHO)\(^{133}\).

The overall proportion of adults scoring four or more on the ASRS scale (the threshold at which clinical assessment for ADHD is granted) was 8.2%. A much smaller proportion of adults (0.6%) reported all six characteristics on the ASRS screen. There was no significant association between sex or ethnicity and a positive screening for ADHD\(^1\).
Table 15: Proportion of people who screened positive for ADHD in the past six months, by ASRS score (percentages), at the 2007 APMS

<table>
<thead>
<tr>
<th>ASRS score</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or more</td>
<td>13.8</td>
<td>8.7</td>
<td>9.7</td>
<td>8.8</td>
<td>4.9</td>
</tr>
<tr>
<td>6</td>
<td>1.1</td>
<td>0.6</td>
<td>0.9</td>
<td>0.6</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

In order to estimate the potential scale of ADHD in Lincolnshire, the rates in table 15 were applied to the Lincolnshire GP registered population. The results suggested that approximately 2,900 working-age people in the county suffering from ADHD have a score of six points on the ASRS.

Between 2010/11 and 2012/13, the volume of stimulants and other drugs prescribed for ADHD in Lincolnshire increased by 22%. In 2012/13, the county spent £700,000 on this group of drugs.

8.9 Eating Disorders

Epidemiological data regarding the prevalence of eating disorders amongst the adult population is limited. The APMS used the ‘SCOFF’ assessment tool to screen for eating disorders. The acronym relates to key words in the five questions used in the tool. Table 16 shows the estimated prevalence of eating disorders, based on a score of two or more with significant impact.

There was a strong association between gender and screening positive for an eating disorder: 3.5% of men and 9.2% of women scored two or more on the assessment tool, and 0.6% of men and 2.5% of women also reported significant negative impact on their life. The prevalence of screening positive decreased with age.

Table 16: Estimated prevalence of eating disorder by age and gender (score of two or more on SCOFF toolkit with significant impact, percentages)

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>1.7</td>
<td>0.7</td>
<td>0.3</td>
<td>0.8</td>
<td>0.1</td>
</tr>
<tr>
<td>Women</td>
<td>5.4</td>
<td>3.6</td>
<td>2.5</td>
<td>3.1</td>
<td>0.9</td>
</tr>
<tr>
<td>All adults</td>
<td>3.5</td>
<td>2.1</td>
<td>1.4</td>
<td>1.9</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

From 2009 to 2012, there were 261 hospital admissions in Lincolnshire relating to working-age adults suffering from eating disorders. This is an average of 65 per
year. Over three-quarters of these cases (76%) involved females. Of these, the highest proportion were from the age group '18-24 years'. For males, the vast majority of admissions were for the '25-34 years' age group.

Anorexia nervosa (ICD10 F50.0) was the most common eating disorder requiring hospital admission for females (54.3% of cases). In males, 67.2% of eating disorder admissions were due to bulimia nervosa (ICD10 F50.2). There were no recorded cases of hospitalisation due to overeating associated with other psychological disturbances (F50.4).

8.10 Mental Health Illnesses due to Psychoactive Substance Abuse

8.10.1 Alcohol Misuse and Dependence

According to the 2007 Adult Psychiatric Morbidity survey, nationally, nearly a quarter (24.2%) of adults were hazardous drinkers.

Men were twice as likely as women to be hazardous drinkers (33.2% of men, 15.7% of women), and younger people were more likely to be hazardous drinkers than older adults, though the pattern by age varied with gender. In men, hazardous drinking was most common between the ages of 25 and 34 (46.0%), whereas in women it was most common between the ages of 16 and 24 (32.0%).

It is estimated that 3.8% of the population drink at a level considered to be harmful. 'Harmful alcohol users' are those who drink alcohol to such a degree that damage to health is likely. The damage may be physical (such as liver damage or alcohol-induced falls) or mental (such as depressive episodes after heavy consumption of alcohol).

According to 2010 NICE guidance, higher risk (harmful) drinking is defined as 'regularly drinking more than 50 units per week' for men, or 'regularly drinking more than 35 units per week' for women.

Table 17 shows the estimated prevalence of harmful drinking.

Table 17: Estimated prevalence of hazardous drinking, by age and gender (percentage)

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>8.8</td>
<td>11.6</td>
<td>6.6</td>
<td>3.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Women</td>
<td>4.8</td>
<td>1.6</td>
<td>2.9</td>
<td>2.0</td>
<td>0.3</td>
</tr>
<tr>
<td>All adults</td>
<td>6.8</td>
<td>6.6</td>
<td>4.8</td>
<td>2.6</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

---

xviii Hospital Episodes Statistics, op.cit.
xix Ibid.
These rates have been applied to Lincolnshire GP registered population figures for 18-64 year olds. The results suggest that approximately 18,700 adults in Lincolnshire could be drinking harmful amounts of alcohol on a regular basis. Lincolnshire West CCG is likely to have higher proportion of hazardous and harmful drinkers due to its lower age profile compared to the other CCGs in Lincolnshire.

Excess use of alcohol can lead to mental and behavioural disorders (including acute drunkenness, chronic alcohol dependence, alcohol withdrawal syndrome, hallucinations, memory loss and other conditions). In the three-year period from 2010 to 2012, there were over 5,200 hospital admissions in Lincolnshire due to mental disorders caused by alcohol (ICD10 F10).

The number of admissions because of 'mental or behavioural disorders due to use of alcohol' in each five-year age band has been compared to the corresponding number of Lincolnshire GP registered patients, in order to calculate age specific rates, as shown in figure 18. Significantly more males than females were admitted for such disorders, and the age group with the highest admission rate was '40-44 year olds'.

**Figure 18:** Hospital admissions in Lincolnshire because of mental and behavioural disorders due to use of alcohol (ICD10 F10), age specific rates (percentages), by gender, 2010-12 pooled data

---

**Source:** Hospital Episodes Statistics (SUS)
Age-standardised rates of hospital admissions because of mental and behavioural disorders due to excess alcohol consumption are shown in figure 19. This indicates that Lincolnshire West CCG’s rate is the highest in the county, that it is significantly higher than the rates for the other CCGs, and that it is twice as high as the rate for South Lincolnshire CCG\textsuperscript{xxi}.

**Figure 19:** Hospital admissions because of mental and behavioural disorders due to use of alcohol (ICD10 F10), directly standardised rates per 100,000 population, 2010-12 pooled data, all ages

Source: Hospital Episodes Statistics (SUS)

Further analysis showed a statistically significant association between admissions because of ‘mental disorders caused by alcohol’ and multiple deprivation, although it should be noted that some health factors are included in the multiple deprivation classification\textsuperscript{86}.

In Lincolnshire, people admitted to hospital as a result of mental disorders related to the consumption of alcohol were nearly five times more likely to come from one of the county’s 20% most deprived areas than from one of the 20% least deprived areas.

\textsuperscript{xxi} Hospital Episodes Statistics, op.cit.
Figure 20: Hospital admissions because of mental and behavioural disorders due to use of alcohol (ICD10 F10), by quintile of deprivation, based on patient’s home address, crude rate per 1,000 population

Source: Hospital Episodes Statistics (SUS); IMD 2010, Department for Communities and Local Government

8.10.2 Drug Misuse and Dependence

According to the APMS, 29.9% of men and 21.8% of women in England admitted to having taken an illicit drug at least once in their life. A smaller proportion (12.0% of men and 6.7% of women) had taken illicit drugs in the previous year. Incidence of illicit drug use in the previous year was most common in young people, specifically in men aged 16 to 34 years (27.8%) and in women aged 16 to 24 years (21.9%). In other age groups, the proportion who had taken illicit drugs in the previous year was smaller.

Overall, 3.4% of adults showed signs of dependency on drugs in the previous year, including 2.5% who were dependent on cannabis only, and 0.9% who were dependent on other drugs. Rates of dependence varied with age and gender, and were greatest for men and for the 'youngest adult' age group. Table 18 shows the estimated prevalence of drug dependency.

Table 18: Estimated prevalence of drug dependence, by age and gender (percentages)

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>13.3</td>
<td>9.0</td>
<td>2.9</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Women</td>
<td>7.0</td>
<td>3.6</td>
<td>2.0</td>
<td>0.6</td>
<td>1.3</td>
</tr>
<tr>
<td>All adults</td>
<td>10.2</td>
<td>6.3</td>
<td>2.5</td>
<td>0.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey
In the three-year period from 2010 to 2012, there were over 1,600 hospital admissions of Lincolnshire GP registered patients due to mental or behavioural disorders caused by the use of psychoactive substances (excluding alcohol and tobacco). There were twice as many admissions of men than of women. People aged between 30 and 35 years old were most likely to be admitted for disorders triggered by substance abuse\textsuperscript{xxii}.

People living in areas classified amongst the '20% most deprived in England' were more likely to be admitted to hospital because of mental disorders due to substance abuse than those from other areas\textsuperscript{86, xxiii}. Figure 21 shows the breakdown of admissions by psychoactive substance type.

**Figure 21:** Hospital admissions because of mental or behavioural disorders due to psychoactive substance use, by type of substance (ICD10 F11-16, and F18-19) 2010-12, all ages

![Hospital admissions by psychoactive substance type](image)

*Source: Hospital Episodes Statistics*

Directly age standardised hospital admission rates because of 'mental or behavioural disorders due to psychoactive substance use' are shown in figure 22, broken down by CCG. Similar to the disorders caused by alcohol, Lincolnshire West CCG had the highest rate and South Lincolnshire CCG the lowest rate in Lincolnshire\textsuperscript{xxiv}.

\textsuperscript{xxii} Hospital Episodes Statistics, op.cit.

\textsuperscript{xxiii} Ibid.

\textsuperscript{xxiv} Ibid.
Figure 22: Hospital admissions because of mental or behavioural disorders due to psychoactive substance use, by the type of substance (ICD10 F11-16, and F18-19), directly standardised rate per 100,000, 2010-2012 pooled data

Source: Hospital Episodes Statistics

Over 300 admissions during the period examined were for patients who used psychoactive substances combined with alcohol.

According to the APMS, 14% of alcohol-dependent adults in England were receiving treatment for a mental health problem, and 36% of those dependent on other drugs were receiving treatment for a mental or emotional problem\(^1\).

Latest local treatment figures show that, in the period between April 2013 and March 2014, 412 people in Lincolnshire, who were being treated for alcohol dependency, were classified as 'dual diagnosis' (i.e. they were concurrently receiving care in relation to both mental health and substance misuse). Clients with 'dual diagnosis' made up 45% of all clients in alcohol treatment\(^{xxv}\). In the same period, 234 drug-dependent clients in Lincolnshire were classified as 'dual diagnosis', equating to 31% of new drug treatments in the financial year\(^{xxvi}\).

For both drug- and alcohol-dependent clients, there has been a year-on-year increase in the number of people classified as being 'dual diagnosis'. It is thought that this is due to improved recording and data capture, which now better reflects the situation, rather than to any dramatic increase in dual diagnosis. Anecdotally, it has been suggested that there may still be a degree of under-reporting on dual diagnosis.


\(^{xxvi}\) Public Health England, NDTMS, Adult Partnership Drug Treatment Performance Report for Lincolnshire – Quarter 3, 2013/14
8.11 Gambling Behaviour

According to the APMS, two-thirds of adults spend money on gambling activities at least once a year. It appears that more men than women participate in gambling\(^1\).

‘Problem gambling’ is gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits. ‘Pathological gambling’ is a term used to describe a greater degree of harmful impact on gamblers and on the people around them\(^135\).

The DSM-IV\(^49\) lists ten diagnostic criteria relating to problem gambling:

- preoccupied with gambling;
- needs to gamble with increasing amounts of money;
- repeated unsuccessful efforts to cut back or stop gambling;
- restless or irritable when attempting to cut down or stop gambling;
- gambles as a way of escaping from problems or relieving a dysphoric mood;
- after losing money from gambling, often returns to gamble another day in order to ‘get even’;
- lies to conceal the extent of involvement with gambling;
- commits illegal acts to finance gambling;
- jeopardises a significant relationship, job, or opportunity because of gambling; and
- relies on others to provide money to relieve a desperate financial situation caused by gambling.

A diagnosis of ‘pathological gambling’ is made if a person meets at least five of the above criteria. Table 19 shows the estimated prevalence of pathological gambling, by age and gender, in England.

<table>
<thead>
<tr>
<th>Table 19: Estimated prevalence of pathological gambling, by age and gender, in England (percentages)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>All Adults</td>
</tr>
</tbody>
</table>

Source: 2007 Adult Psychiatric Morbidity Survey

By applying these survey rates to the Lincolnshire GP registered population of 18-64 year olds, it is estimated that there may be in the region of 1,500 working-age people in the county who could be diagnosed with ‘pathological gambling’ disorder.
In 2012/13, 1,102 gambling licences were held across Lincolnshire. The number of licences had nearly doubled since 2009/10.

The majority of gambling licences issued by authorities in Lincolnshire (69%) were for machines placed in alcohol-licenced premises. East Lindsey District Council issued the highest number of licences at 345, equating to 2.5 per 1,000 of the usual resident population. Businesses across North Kesteven held the smallest number of gambling licences per resident (0.73 per 1,000 population).

8.12 Psychiatric Comorbidity

Psychiatric comorbidity (meeting the criteria for two or more psychiatric disorders) is associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services.

According to the APMS, 7.2% of the population in England suffer from two or more mental health conditions. As with individual conditions, prevalence of comorbidity decreases with age. Amongst younger adults, aged below 35, more than a third of those affected by mental health issues are likely to suffer from two or more conditions, whereas for the age group ‘50-64 years’ the rate is about one in five.

The authors of the APMS conducted correlation analyses to investigate associations between pairs of individual conditions. There was a very strong correlation between anti-social personality disorder and drug dependency (R=0.81). Other strong correlations included the coexistence of obsessive compulsive disorder (OCD) and borderline personality disorder (BPD), and the coexistence of OCD and depressive episodes. Correlation findings can be seen in table 2.

8.13 Mental Health and Those in Prison and on Probation

Imprisonment is a distinct situation with its own particular requirements in terms of diagnosis and treatment.

The prevalence of mental health issues in prisons is higher than in the general population. When people with mental disorders are arrested and imprisoned, the mental disorders are ‘imported’. In other cases, people without mental disorders develop problems during imprisonment, due to the isolation and deprivation that they encounter.

According to research on prisoners, about 4% of both males and females have psychotic illnesses, 10% of the men and 12% of the women have major depression, and 65% of the men and 42% of the women have a personality disorder (including 47% of men and 21% of women who have an anti-social personality disorder). In addition, other research has shown that 89% of all prisoners have depressive symptoms, and 74% have stress-related somatic symptoms.
Table 20: Correlation between conditions

<table>
<thead>
<tr>
<th></th>
<th>GAD</th>
<th>Mixed A &amp; D</th>
<th>OCD</th>
<th>Depressive episodes</th>
<th>Panic disorder or phobia</th>
<th>Alcohol dependent</th>
<th>Drug dependent</th>
<th>Psychotic disorder</th>
<th>BPD</th>
<th>ASPD</th>
<th>PTSD</th>
<th>ADHD</th>
<th>Eating disorder</th>
<th>Problem gambling</th>
<th>Suicide attempt</th>
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<tr>
<td>GAD</td>
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<td>S</td>
<td>S</td>
<td>S</td>
<td>N</td>
<td>W</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>W</td>
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<td>S</td>
</tr>
<tr>
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<td>ASPD</td>
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<td>PTSD</td>
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<td>ADHD</td>
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<tr>
<td>Eating disorder</td>
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<td>N</td>
</tr>
<tr>
<td>Problem gambling</td>
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<td>W</td>
<td>W</td>
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<td>W</td>
<td>W</td>
<td>S</td>
<td>N</td>
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<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Suicide attempt</td>
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<td>S</td>
<td>S</td>
<td>S</td>
<td>W</td>
<td>W</td>
<td>S</td>
<td>S</td>
<td>W</td>
<td>S</td>
<td>W</td>
<td>W</td>
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</tr>
<tr>
<td>Number of conditions with strong correlation:</td>
<td>6</td>
<td>0</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

S - Strong association (correlation coefficient >= 0.5)  
W - Weak association (0.3-0.49)  
N - Little or no association (<0.3)

Source: 2007 Adult Psychiatric Morbidity Survey
A study conducted between 2004 and 2009 in England and Wales revealed a significant burden of self-harm in prisoners; 5-6% of male prisoners and 20-24% of female inmates self-harmed every year. Rates of self-harm incidents were more than ten times higher amongst female prisoners than amongst males, because repetition of self-harm is more common in females. In both sexes, self-harm was associated with younger ages, White ethnic origin, prison type, and either a life sentence or being unsentenced. It was determined that the risk of suicide was greater for those who self-harmed than for the general prison population. During the study period, more than half of suicides occurred within a month of self-harm. For male prisoners, risk factors for suicide after self-harm were older ages and a previous self-harm incident of high or moderate lethality\textsuperscript{141}.

In 2012, Lincoln University undertook research into the prevalence of mental health conditions within the caseload of the Lincolnshire Probation Trust. The research revealed that:

- 60% of cases had a current mood disorder;
- 59% of cases had a current anxiety disorder;
- 50% of cases had a current psychotic disorder;
- 75% of cases had a current eating disorder; and
- 55% of cases had a probable personality disorder (defined according to the Standardised Assessment of Personality: Abbreviated Scale, and including probable cases of anti-social, borderline and other personality disorders).

Significantly, none of these individuals reported having a mental health intervention\textsuperscript{142}.

The Youth Offending Service Health Needs Assessment (March 2014)\textsuperscript{143} examined the health needs of children who came into contact with the Lincolnshire Youth Offending Service (YOS). Although this Mental Illness HNA focusses on working-age groups, it is worth noting some of the findings of the YOS assessment which overlap with adult provision.

The YOS HNA found that 45% of young offenders had, or have, contact with Child and Adolescent Mental Health Services (CAMHS), but only a small number have had a formal diagnosis of a mental health problem. One in ten offenders had an emotional or mental health problem that was strongly linked to the risk of re-offending, and 8.1% of offenders had been formally diagnosed as having a mental health condition.

It was apparent from the assessment that:

- transition from adolescent to adult mental health services could be improved;
- there were variations in referral to services; and
- there was a lack of communication with external organisations.

Initial assessment, using the ASSET tool and additional mental health screening questionnaire for adolescents, could also be improved, in order to ensure that the
physical and emotional health needs and circumstances of individuals were consistently identified and acted upon.

8.14 Life Expectancy and Mortality of People with Mental Health Issues

The national publication, 'Parity of Esteem', revealed that current average life expectancy in England and Wales for people with serious mental health issues is at the level seen in the general population in the 1950s\textsuperscript{144}.

The life expectancy gap between people with mental health issues and the rest of the population has been examined in a number of studies, with one suggesting that life expectancy at birth for those with a personality disorder was 63.3 years for women and 59.1 years for men\textsuperscript{145}. Another study, carried out using a secondary mental healthcare case register in London, examined differences in life expectancy between people with serious mental ill health and rest of the population. The results suggested a reduction of between 8.0 and 14.6 life years for men and between 9.8 and 17.5 life years for women. The greatest reductions in life years were for men with schizophrenia\textsuperscript{146}.

People with mental disorders have a greater risk of poor physical health and premature mortality than the general population. This reflects increased health-risk behaviours, such as smoking, and a greater prevalence of obesity. The causes of increased mortality are multiple. According to one study, depression was associated with increased mortality from cardiovascular disease (1.67 mortality rate increase compared to the general population), cancer (1.50), respiratory disease (2.06), metabolic disease (3.03), nervous system diseases (4.66) and accidental death (2.09)\textsuperscript{147}. However, cause and effect, and also confounding variables, should be considered.

Schizophrenia is associated with increased death rates from cardiovascular disease (2.0), respiratory disease (3.0) and infectious disease (4.0)\textsuperscript{148}. For people with schizophrenia, those aged 25 to 44 years were found to be over six times more likely than the age-matched general population to die from cardiovascular disease\textsuperscript{149}. Similarly, schizophrenia sufferers were more likely to die prematurely from treatable cardiovascular, pulmonary and infectious diseases (1.66) than from suicide or injury (1.33)\textsuperscript{150}.

The Health and Social Care Information Centre (HSCIC) collaborated with Connecting for Health and the ONS, on behalf of the Department of Health, to link the Mental Health Minimum Data Set (MHMDS) to ONS mortality data. This comprehensive analysis included the deaths of people aged 19 years and over in England\textsuperscript{151}. The premature mortality rate for 2011/12 in the MHMDS was 1,275 deaths per 100,000 service users, compared to 382 deaths per 100,000 in the general population in England. Thus, the MHMDS mortality rate was 3.3 times higher than the rate in the general population.

In Lincolnshire, people with serious mental health issues were 2.3 times more likely to die prematurely than the general population of the county. The difference in mortality rates in the county was smaller than the difference nationally, partly due to
higher mortality rates in the general population of Lincolnshire, and partly because of lower mortality rates amongst local people with serious mental health issues\textsuperscript{152}.

**Table 21**: Excess under-75 mortality rate in adults with serious mental illness 2011/12 financial year

<table>
<thead>
<tr>
<th>Level description</th>
<th>General population DSR (1)</th>
<th>Mental health DSR (2)</th>
<th>Standardised mortality ratio (2/1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>382.3</td>
<td>1274.8</td>
<td>337.4</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>442.7</td>
<td>1043.1</td>
<td>231.5</td>
</tr>
</tbody>
</table>

*Source: HSCIC, NHS Outcome Framework*

In Lincolnshire, between 2009/10 and 2011/12, the premature mortality rate declined, both for people with mental health issues and for the general population. However, there was a greater reduction in the rate for those with mental health issues, so the mortality ratio between them and the general population also decreased, as shown in figure 23.

**Figure 23**: Standardised mortality ratio (SMR) for premature mortality in those with mental health issues compared to the general population, 2009/10-2011/12 financial years

*Source: HSCIC, NHS Outcome Framework*
9 Service Use

9.1 Characteristics of Those Accessing Services

Lincolnshire Partnership NHS Foundation Trust (LPFT) is the main provider of mental health services in the county. Therefore, analysis of LPFT data allows an understanding of patient characteristics which would not be possible across the full range of providers and services. Thus, LPFT data has provided a proxy by which to understand the demographics and characteristics of Lincolnshire GP registered service users.

In the financial year 2012/13, more than 18,000 Lincolnshire GP registered patients, aged 18-64 years, accessed mental health services provided by LPFT.

For analysis, the services have been grouped into four general categories, which are described in more detail in chapter 3:

- inpatients;
- outpatients;
- community; and
- primary.

The majority of service users accessed primary care services. Over the three-year period from 2010/11 to 2012/13, the level of primary service usage remained relatively stable (a 3% increase in patients). However, the number of working-age people accessing community services increased by 16%, and the number accessing outpatient services increased by 22%. Inpatient services were the only category where usage decreased, with a fall of 16%, although it is possible that this may have been partly due to a closure of some wards during the period.

<table>
<thead>
<tr>
<th>Service type</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>641</td>
<td>602</td>
<td>534</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,467</td>
<td>1,777</td>
<td>1,797</td>
</tr>
<tr>
<td>Primary</td>
<td>13,691</td>
<td>13,738</td>
<td>14,216</td>
</tr>
<tr>
<td>Community</td>
<td>3,540</td>
<td>3,578</td>
<td>4,111</td>
</tr>
<tr>
<td>Total</td>
<td>19,339</td>
<td>19,695</td>
<td>20,658</td>
</tr>
</tbody>
</table>

Source: Lincolnshire Partnership NHS Foundation Trust, January 2014

Slightly more males than females accessed inpatient and outpatient services during the study period. Primary services had the widest gender gap of all service types, being mainly utilised by females.
Table 23: Percentage of male and female Lincolnshire GP registered patients, aged 18-64 years, who accessed the LPFT mental health services, by financial year

<table>
<thead>
<tr>
<th>Service type</th>
<th>Sex</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>F</td>
<td>49.5</td>
<td>43.2</td>
<td>44.4</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>50.5</td>
<td>56.8</td>
<td>55.6</td>
</tr>
<tr>
<td>Outpatients</td>
<td>F</td>
<td>48.9</td>
<td>48.8</td>
<td>46.0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>51.1</td>
<td>51.2</td>
<td>54.0</td>
</tr>
<tr>
<td>Primary</td>
<td>F</td>
<td>62.8</td>
<td>63.0</td>
<td>62.0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>37.2</td>
<td>37.0</td>
<td>38.0</td>
</tr>
<tr>
<td>Community</td>
<td>F</td>
<td>52.3</td>
<td>52.2</td>
<td>49.4</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>47.7</td>
<td>47.8</td>
<td>50.6</td>
</tr>
</tbody>
</table>

Source: Lincolnshire Partnership NHS Foundation Trust, Jan 2014

Figure 24 shows usage of LPFT services by age, as a percentage of the Lincolnshire GP registered population, in the financial year 2012/13. The youngest adults (aged 18-24 years) made the greatest use of LPFT services.

Figure 24: LPFT service users as a percentage of the Lincolnshire GP registered population by age, 2012/13

Source: Lincolnshire Partnership NHS Foundation Trust; HSCIC, 2012 GP registered population
From 2010/11 to 2012/13, the number of service users aged 55-64 years increased by nearly 17% (over 400 additional patients). This was a greater rate of increase than that experienced by any other age group. The number of patients in the age group ‘45-54 years’ increased by 11% (also more than 400 patients), whilst the number of patients in the remaining age groups increased only slightly, or remained the same.

Service usage across Lincolnshire’s CCGs has been analysed and calculated as rates per registered population. This allowed a comparison of rates which was not affected by total population numbers for each of the CCGs. The highest rates of access to the inpatient, primary and community services were by patients registered with Lincolnshire West CCG. Patients from South Lincolnshire CCG were least likely to access outpatient, primary and community services. Other differences in service usage proved not to be statistically significant. It is important to note that crude rates have been used, and have not been adjusted for age structure.

Figure 25: 2012/13 number of patients accessing the main types of LPFT services per 1,000 registered patients, aged 18-64 years

![Figure 25: 2012/13 number of patients accessing the main types of LPFT services per 1,000 registered patients, aged 18-64 years](source)

Source: Lincolnshire Partnership NHS Foundation Trust; HSCIC, GP registered population 2012

Figure 26 shows LPFT service users (aged 18-64 years) for the calendar year 2013, as a proportion of the resident population of the same age. The areas of dark green show the highest rate of use of LPFT mental health services. The lowest rates were in the south of the county, particularly the South Holland area. However, it is important to remember that the analysis only includes patients attending Lincolnshire services. More analysis would be required to understand the levels of cross-border service use.
Figure 26: Lincolnshire GP registered patients using LPFT mental health services in 2013 as a proportion of the resident population, aged 18-64 years, by LSOA

High rates of service use along the East Lindsey coast, and in areas of Lincoln, Grantham and Gainsborough, could indicate a link between mental health issues and deprivation.

Figure 27 shows service use as a proportion of the resident population, split by deprivation quintile, where the most deprived quintile corresponds to areas classified
amongst the 20% most deprived in England. Whilst there are clear similarities between the level of deprivation and the rate of use of mental health services, it is not possible to identify a causal link between the two.

**Figure 27**: LPFT service users in 2013 as a proportion of Lincolnshire residents, aged 18-64 years, by quintile of deprivation

![Bar chart showing the proportion of LPFT service users by quintile of deprivation in 2013.](source: Lincolnshire Partnership NHS Foundation Trust, January 2014; IMD 2010, Department for Communities and Local Government; ONS 2012 mid-year population estimates)

Employment status was recorded for just over half of patients accessing the LPFT services. Of these, the proportion recorded as unemployed in 2012/13 varied from 41.1% for primary care patients to 61% for outpatient service users. This included those in voluntary, unpaid, employment who were actively seeking paid work.

**Table 24**: Proportion of unemployed service users as a percentage of patients with employment status recorded, 2012/13

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Unemployed</th>
<th>Employment status not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>41.1%</td>
<td>39.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>61.0%</td>
<td>49.2%</td>
</tr>
<tr>
<td>Community</td>
<td>59.8%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>59.9%</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

*Source: Lincolnshire Partnership NHS Foundation Trust, January 2014*

In the middle of 2013, LPFT services started to record whether a patient was either a veteran or a current member of the armed forces. In the five-month period from July to November 2013, 238 Lincolnshire-registered patients, aged 18-64 years, who
were veterans or current service personnel, were referred to LPFT. Of these, 77% were male and 23% were female, and the majority (88%) were ex-service personnel.

As such recording has only recently started, the amount of data currently available is low. However, once more data has been gathered, it may be possible to establish whether veterans and military personnel are a specific group of great need in Lincolnshire.

As shown in table 25, the majority of referrals to LPFT services in 2012/13 were from GPs. The Adult Mental Health Team was the second most common source of referrals, and mainly referred people to community services. Self-referrals more than doubled in the period 2010/11 to 2012/13, and referrals from carers increased by over 50% in the same period. Referrals from A&E and the police also increased from the previous year, by 65% and 30% respectively. Information about the referral source is not available for inpatient services.

**Table 25:** 2012/13 Lincolnshire GP registered LPFT service users by source of referral and service type.

<table>
<thead>
<tr>
<th>Referral by</th>
<th>Service type</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Outpatients</td>
</tr>
<tr>
<td>General practitioner (GP)</td>
<td>16,328</td>
<td>2,130</td>
</tr>
<tr>
<td>Adult mental health team</td>
<td>3,562</td>
<td>1,296</td>
</tr>
<tr>
<td>Self-referral</td>
<td>2,319</td>
<td>52</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Other provider</td>
<td>837</td>
<td>75</td>
</tr>
<tr>
<td>Other medical</td>
<td>500</td>
<td>80</td>
</tr>
<tr>
<td>Other mental health specialist</td>
<td>426</td>
<td>103</td>
</tr>
<tr>
<td>Inpatient – adult mental health</td>
<td>22</td>
<td>945</td>
</tr>
<tr>
<td>ULHT</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td>641</td>
</tr>
<tr>
<td>Carer</td>
<td>9</td>
<td>623</td>
</tr>
<tr>
<td>Prison</td>
<td>118</td>
<td>377</td>
</tr>
<tr>
<td>Local Authority</td>
<td>5</td>
<td>443</td>
</tr>
<tr>
<td>Other</td>
<td>316</td>
<td>536</td>
</tr>
</tbody>
</table>

*Source: Lincolnshire Partnership NHS Foundation Trust, January 2014*

Secure mental health services are provided for those who are deemed to be a risk to themselves or to others, or who are subject to custody. People are detained in secure units under mental health legislation. As LPFT does not provide secure
mental health services, information from NHS England has been used. In April 2013, there were 64 Lincolnshire GP registered patients in secure units, either in the county (at the Francis Willis Unit) or elsewhere across the country. The majority of these patients were male. Table 26 shows the number of patients in secure mental health services by gender and security level.

Table 26: Number of Lincolnshire GP registered patients in secure mental health services, April 2014

<table>
<thead>
<tr>
<th>Security level</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>9</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>Medium</td>
<td>2</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>High</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Grand total</td>
<td>14</td>
<td>50</td>
<td>64</td>
</tr>
</tbody>
</table>

*Source: NHS England*

Individuals are also referred to services which are not commissioned through the standard commissioning processes, as described in section 7. A relatively small number of people require this level of service, which includes, for example, out-of-county psychiatric intensive care and acute mental health services.

Some people have a range of mental health needs (usually in the context of severe and enduring mental health problems) that are part-funded in conjunction with continuing healthcare, social services and via s117 aftercare. At the time of compiling this report, there were fewer than 100 complex cases.

The number of people referred for specialist assessment, and sometimes for subsequent out-patient treatment, fluctuates. Such assessments are very wide-ranging in nature and are often provided by national centres. The assessments may include specialist OCD, psychosis, deaf interpretation and sexual dysfunction.

9.2 Experiences of Those Accessing Services

Feedback was gathered from users of any Lincolnshire mental health services, and showed a range of experiences, both positive and negative, but with no obvious difference related to gender or age. Although numbers were small, the largest number of respondents lived in Lincoln, East Lindsey and North Kesteven. For all three districts, the number of positive responses outweighed the number of negative ones. This was not the case in the other four Lincolnshire districts, but, as noted, there were fewer responses from these areas.

More than half of respondents in East Lindsey reported waiting two weeks or less to access a service, whereas in South Kesteven, more patients than the average reported longer waiting times. Although there was no clear association between waiting time and service satisfaction (potentially due to the small numbers) East
Lindsey did see the best average satisfaction score, alongside relatively short waiting times for its respondents.

In general, those who waited for longer than six months to be seen expressed significant dissatisfaction with the service (an average score of 5.5 where 6 was defined as ‘very poor’). Patients referred by a GP appeared to wait slightly longer than those who self-referred, or those who were referred by another professional. However, the length of waiting time may have been affected by the type of service to which the patient was being referred, or by whether this was a first-time or a repeat referral, rather than being due to a more lengthy procedure being followed by GPs.

People who self-referred were frequently the most satisfied with the services that they received.

Respondents felt that accessibility was one of the most important factors for services designed to address mental health needs. All respondents from Lincoln were able to access services locally (within five miles of their home address). Outside the City of Lincoln, 70% of people were able to access a local (within five miles) service, but 12% of respondents had to travel 10 miles or more to access the service they had used.

9.3 Suggestions for Improving Commissioning and Delivery

A number of possibilities for service improvement were identified by service users and providers. Many comments from service users concerned the scale of the service and extensions to the current provision. These comments should be taken into account when considering future commissioning, to help identify ways of increasing service provision using the resources available.

For all services, important factors in ensuring that patients engaged with services, and were happy with the service provided, included the following:

- positive staff attitudes and understanding in their contact with patients (both within mental health services and in the wider health sector);
- continued engagement with patients who had chronic mental health issues, rather than simply discharging them; and
- short waiting times.

Cancelled appointments for people feeling on the verge of crisis were deemed to be unacceptable. Similarly, some respondents felt that waiting times for mental health services were unacceptably long, and, indeed, comments on waiting times were a running theme across all mental health services.

It has not been possible to directly measure waiting times for mental health services, and so further work would be required to compare these to waiting times for other health and care services.

Some of the negative comments specifically mentioned ‘Crisis’. However, some respondents suggested that the negative aspects they noted could reflect pressures
on service provision, rather than being due to the performance of individual staff. It is also possible that some clients may expect something of the service that it is not designed to provide, which could indicate a 'gap' in provision, or that 'signposting' to appropriate services needs to be improved. Further investigation would be required to fully understand the issues raised in the context of the whole service, and to address these concerns accordingly.

The stigma of mental ill health was raised as an important issue when engaging with the most vulnerable.

The need for empathy, understanding and non-judgemental listening from staff, at 'first point of contact' was highlighted. So, too, was the need to raise awareness about, and provide suitable training on:

- spotting the signs that someone is suffering from mental ill health; and
- how to treat people diagnosed with mental ill health.

Although good service may be provided in most cases, one instance of poor or rushed service, or a lack of empathy, could result in the client feeling stigmatised, or thinking they are wasting the time of the professionals, and becoming 'disengaged'.

In order to gain a clearer understanding of the extent to which mental health service provision is affected by such attitudes, it would be useful to identify further sources of client feedback, and to assess the processes that are in place for gathering, analysing and acting on the findings of this feedback.

Suggestions from service users for improving mental health services in Lincolnshire included the following:

- Increase the number of support groups, led by service users and service providers, across the county, improve awareness of those that already exist, and improve 'signposting to these services' by professionals. This would provide help within the community and reduce the number of people who require services again in the future. (This was a dominant theme amongst respondents.)

- Extend services to support wider family members and carers. Such support could prevent the breakdown of communication, relationships and family life, which affects all involved. The assistance offered could include
  - support groups;
  - information designed specifically for family members, carers or employers to help them understand the effect of a condition; and
  - courses for carers and family members, designed to help them provide support and, at the same time, feel supported themselves.
  (This was another dominant theme, and will be addressed by the 'Carers strategy' that is currently being developed.)

- More investment to:
- Increase the scale of service provision (including making beds available in the county for those who need to remain in care);
- Reduce waiting times; and
- Enable clients to remain with one professional in order to build trust.

- Longer GP appointments for consultations regarding mental health issues.
- Better communication between health professionals, so that client history does not have to be repeated on multiple occasions. This is an area which will benefit from the Lincolnshire Health and Care programme (LHAC) through the introduction of neighbourhood teams and improved operating protocols.
- Mental health drop-in centres should be established to provide both access to support outside of normal opening hours, and telephone listening services, for people in crisis.
- More support workers to accompany clients out of inpatient care.
- Daytime activity centres should be set up.
- Help and signposting should be provided for vulnerable groups, such as released offenders with mental health problems, who may not be registered with a GP. For example, they could be signposted to the Health Support Service (HSS), described in section 7.4.
- Further training should be provided for those already working in mental health services to ensure consistency of communication skills, including listening skills, empathy, respect and building of trust. There could be opportunities for joint local training to address this, particularly as the Lincolnshire Health and Care programme moves forward.
- Further training should be provided for all staff working in health environments, including staff in GP practices and hospital A&E departments, to raise awareness and understanding of how to deal with patients suffering from mental ill health.
- Alternative services, such as relaxation therapy, should be provided.

Service providers identified a wide range of health and emotional support programmes that they delivered, including:
- Physical health checks;
- Referral to other service providers;
- Cognitive behavioural therapy;
- Psychotherapy;
- Guided self-help;
- Peer mentoring,
• listening; and
• accompanying people when attending appointments or participating in day-to-day activities, in order to boost confidence.

They also confirmed that they provided support plans and advice in relation to such 'housing' matters as:
• personal care;
• nutrition;
• managing a tenancy;
• benefits;
• and budgeting.

In light of this, questions about the scale, promotion and signposting of these services, and their accessibility, may need to be addressed in order to improve clients' awareness, and their perception, of the services.

Providers suggested that the different commissioning and delivery organisations in the county should work more closely together, in order to improve the quality and consistency of service provision. It was noted that services could be more effective if the professional was able to 'see the whole picture'. This would include the client's history, and information about any other support they were receiving, or services they had accessed.

In order to build confidence and trust with clients, and encourage them to remain fully engaged with mental health services, it was thought that those making initial assessments should receive further training to improve their specialist knowledge. This should ensure that professionals make accurate diagnoses, and correctly identify the particular needs of their clients.

Both service users and providers agreed that a reduction in resources could increase pressures on staff, to such an extent that their ability to provide an effective service was compromised. For example, providers noted that the quality of service they were able to offer could be affected by such administrative matters as their need to balance the requirements of paperwork with the management of waiting times.

This was particularly important for an area of healthcare where a perceived 'lack of care or time' could result in the client feeling undervalued. Moreover, the difficulty of providing a high quality service could cause staff to become demoralised. Indeed, sickness rates and problems with retaining staff were identified as matters of concern for service providers.

The development of a 'working model' of service delivery could be helpful in determining an appropriate balance of conflicting demands and requirements, whilst taking into account the constraints of limited resources.

Although the importance of both service evaluation, and gathering feedback from clients, was recognised, there were inconsistencies in the way these processes were conducted, which prevented proper review and hampered subsequent improvement.
Whilst it can be difficult to obtain feedback from all service users, it would still be possible for commissioners to develop and manage simple processes, which could be applied consistently, in order to gather sufficient responses to inform the future development of services. As providers may lack some of the requisite data-handling skills and experience, again, the development of a standard model for gathering and analysing such feedback may be beneficial.

Some professionals identified areas of good practice in service delivery, including the day service provided by the Pelican Trust, Lincoln, and the support provided by the Volunteer and Contact Association. Through such organisations, people suffering from mental ill health are provided with opportunities to socialise, and engage in purposeful activities.

Specifically, service providers made the following suggestions for improving mental health services in Lincolnshire in the future:

- The various commissioning and delivery organisations should work more closely together, through regular meetings (including case management meetings) and improved information sharing.

- Staff who are involved in making assessments and managing complex needs should receive appropriate training to ensure consistency of skills and knowledge. This is necessary for the voluntary sector as well as for the statutory sectors.

- Resources need to be increased in order to:
  - ensure that the service delivered to clients is of good quality;
  - reduce waiting times for clients; and
  - ensure that all those who require services are able to access them.

- Methods of evaluating services and gathering feedback from clients need to be improved, and applied consistently, to enable appropriate action (based on the results) to be taken for the development of the county's services.

- Communication between the voluntary and statutory sectors should be improved, in order to raise awareness of available services, and enable signposting to these services to be both effective and appropriate.
10 Recommendations

10.1 Understanding Needs

There is a lack of comprehensive information on the mental health needs of key ‘at risk’ groups. Consequently, for some groups, it has not been possible to understand the scale or nature of their needs, to determine whether or not they are accessing services in Lincolnshire, nor to discover whether or not services are being accessed equitably.

Thus, in order to ascertain the mental health needs of these key groups, and whether or not they differ from those of the rest of the population, further work is required. The initial requirement would be to put in place robust processes for recording and sharing data between a range of organisations, including the following groups:

- pregnant and post-natal women;
- service personnel and ex-service personnel, and their families*;
- Black and minority ethnic (BME) groups, migrants, refugees and asylum seekers;
- lesbian, gay, bisexual and transgender groups; and
- offenders and ex-offenders.

(*A new mental health service for veterans has been commissioned by NHS England, and is being delivered via Combat Stress. However, the service is in the early days of operation, so comprehensive service activity is not yet available.)

In order to improve service provision, it was recognised that the different commissioning and delivery organisations would need to work more closely together, and, in particular, share information more effectively. This could be addressed, at least in part, by the development of the Lincolnshire Health and Care programme.

Following an assessment of the current situation, processes should be developed to tackle any deficiencies in information sharing that may be identified. The first priority would be to ensure that data is collected effectively, and in a consistent manner, across all services. At present, for example, some services only record partial information (on such topics as demographics), so that it can be difficult to determine the characteristics of those who do, or do not, access services.

The number of people living with a dual diagnosis for mental health problems (such as being treated for both alcohol and drug dependence at the same time) appears to have increased. Further work could help to determine whether this is an actual increase in numbers, or one brought about by better recording. It may also be beneficial to investigate, and assess, the pathways of care that exist for people with dual diagnosis, in order to identify potential areas for improvement.

Similarly, during the last three years, there appears to have been an increase in the volume of prescriptions for antidepressants, anxiolytics, and antipsychotic and
stimulant drugs. Again, further work could provide intelligence on the reasons for this, and on the implications of this trend.

It is intended that the findings of this HNA are used as a building block in order to extend understanding to wider demographics and illnesses than were included in the scope of this particular assessment.

10.2 Identifying Mental Ill Health

It is important that the signs and symptoms of all forms of mental ill health are identified correctly, and that the mental health register is fully and accurately completed, and updated.

In order to achieve this, it is necessary not only to raise the awareness, and improve the knowledge, of professionals, but also to educate the general public, so that they are able to recognise any need for help and can seek early intervention.

The Quality and Outcomes Framework (QOF) collects information on some mental illnesses (schizophrenia, bipolar affective disorder and other psychoses). There is a need for clear processes to be in place to effectively identify those suffering from other mental illness, not only to ensure that record-keeping is as complete and accurate as possible, but also so that those in need are able access appropriate treatment, services and support, including health checks.

In addition, the Youth Offenders Service HNA identified inconsistencies in the use of assessment tools. It also highlighted the need for clear protocols and standards for the transition of offenders between children's and adult services, so that the needs of those moving into adult services are appropriately met.

10.3 Understanding Patient Experience

Research carried out for HNAs such as this can be enriched with information from case studies about the 'journey, experience and outcomes' of individual clients. Therefore, commissioners may find it helpful to draw upon Healthwatch case studies, or to conduct similar research for themselves. Indeed, the anonymised comments from service users obtained for this HNA will be shared with commissioners in order to inform the ongoing commissioning process.

The attitude of providers towards collecting, and acting on, feedback from service users varies a great deal. Some service providers do not seek or encourage any feedback from service users. Others do gather feedback, but the findings are not necessarily passed on to commissioners, so cannot be effectively monitored. Thus, it is difficult to identify trends in the experience of service users, or to determine whether improvements are being made in the light of this information.

Commissioners should consider making evaluation of customer feedback a standard requirement of provider contracts, alongside other monitoring and review requirements. It is also important that both commissioners and providers are committed to taking appropriate action, upon due consideration of the findings.
However, effective customer engagement requires specific skills and experience that may not exist within provider organisations, especially some of the smaller or third sector providers. Therefore, commissioners should also consider supporting providers by developing standard procedures and models for obtaining feedback from service users, as well as offering appropriate advice about methods of engagement, and interpretation of data.

10.4 Improving Commissioning and Provision

Analysis of mental health provision suggests that there appears to be a comprehensive structure of services available in Lincolnshire. There is also a mental health promotion and well-being strategy which re-enforces an integrated lifestyle approach to the management of mental health.

There is an opportunity to do more in bringing together information on mental health services in one place so that both users and provider organisations are clear what services and support networks are available and how to access them. This could also help to manage customer expectation of services and signpost to the most appropriate service for their needs. Consideration would need to be given to the sources of information that are already available but which are not comprehensive, and also to the LPFT Single Point of Access (SPA) service, which provides a first point of contact for people wishing to access mental health, learning disability, and drug and alcohol recovery services in Lincolnshire.

As noted in section 9.3, service users made various suggestions for improving services. These included:

- increasing the number of support groups;
- expanding the scale of services;
- extending services to include family members and carers;
- providing additional drop-in centres and day centres; and
- making use of alternative therapies.

Many of these services already exist, and some are in the process of being further developed.

Service providers have supplied details of the wide range of health and emotional support programmes they deliver. Some of the concerns raised by service users could be addressed through better information and signposting to services which are already available.

There are opportunities to further develop some provision of services and support networks to fill gaps. One example of this is in the case of support for families and carers of those who suffer with mental ill health, where impacts and needs are recognised both by specialists (section 4.4.4) and services users (section 9.3). Agencies could work together to identify and develop support mechanisms and to ensure that these are promoted to service users and their families.

There remains the need to improve, and make more consistent, the training provided for those working in mental health services, both to improve their communication
skills, and to ensure that there is consistency in their attitudes towards clients. The training should cover such topics as listening skills, empathy, respect and building of trust.

There are certainly many positive experiences and highly skilled staff, and the ultimate aim is to ensure that all staff are highly skilled, and to provide high standards of service, consistently, across all health and social care sectors. Adopting a holistic approach for those suffering from mental ill health, rather than attempting to treat the mental illness in isolation, could contribute to achieving this aim.

Opportunities for joint local training should be considered, which could be linked to the Lincolnshire Health and Care programme as this moves forward. Organisations could develop in-house awareness training, with champions in this area of skills providing advice and consistency across training programmes, either from with commissioning organisations or from other organisations cited as having particularly good practice. In addition, existing mental health awareness training could be extended to include wider aspects of attitudes and communication styles.

Furthermore, the possibility of becoming involved in the 'Time to Change' campaign should be investigated. Through this anti-stigma campaign, which is led by Mind and Rethink Mental Illness, grants may be made available for local projects that address mental health issues.

Service providers noted that it was essential for those making initial assessments in respect of mental health to be highly trained, and to have detailed specialist knowledge in this field. It is possible that LHAC may be able to provide support for such training and professional development.

Taking into account the importance of relevant knowledge and expertise, provider organisations should make use of appropriate supervision and appraisal processes. Indeed, participation in such processes could be made mandatory for all front-line professionals in health and social care, and not just for those directly involved in delivering mental health services. This could be made a compulsory aspect of commissioned contracts.

Many services users commented that they had to repeat their history several times, because they were being treated by a number of different professionals. This highlighted the need for providers to share information more efficiently and effectively.

It has proved difficult at times for providers to share information, whether because of technological or legislative restrictions, or because of inherent or perceived problems in sharing information appropriately. However, the introduction of neighbourhood teams under LHAC, together with pertinent operating protocols, should assist in overcoming these obstacles.

The situation in respect of information sharing should be reviewed in due course, in order to determine whether additional improvements might be made.
Further work is required to understand how waiting times for mental health and care services, and the needs and perceptions of the patients of these services, compare or differ to those of other services. Where different needs are identified, innovative solutions to assessment, signposting and referral will be required in order to address needs effectively within the limitations of commissioned services. It has also been suggested that longer GP appointments for consultations regarding mental health issues would benefit, and again, further work would be required to understand how this could operate in practice.

Analysis of the data indicates that, although the rate of suicide in Lincolnshire appears to be stable, it is higher than the national average. In order that the long-term, national downward trend may be mirrored in the county, agency commitment to the Public Health Suicide Prevention Action Plan for Lincolnshire needs to be re-energised, and relevant partner organisations should continue to work together towards this goal.

Findings from local research, such as the Youth Offending Service HNA, and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, should also be taken into account in planning future strategies.

Governance structures in respect of mental health service provision need to be improved. Equally, it is important that any action taken in the light of findings from this HNA is compatible with the county’s Mental Health Promotion Strategy, and with national recommendations on parity of esteem.

It would also be beneficial to develop a framework for sharing examples of good practice in service delivery, of which there are many in the county. Furthermore, studying national and international examples of best practice could help to identify opportunities for providing excellent service and achieving favourable outcomes in Lincolnshire.

10.5 Combined Recommendations

Recommendation 1 – Identification and Recording

Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental ill health. Consistent data collection across services is required in order to gain common understanding of issues and characteristics, and therefore this also includes the recording of common demographic and characteristic data. Work should also be carried out to ensure that the mental health register is fully populated in a consistent manner, and recording should not be limited to the specific illnesses referred to in the Quality and Outcomes Framework (QOF).

Recommendation 2 – Data Sharing

In order to provide a better experience for patients, particularly if they need to access a variety of services, or consult a number of professionals, the sharing of data between different organisations needs to be improved. This should also ensure that essential data is available for analysis of risks and associations, understanding
various need, service review purposes and investigating health equity. This includes improved data sharing between local providers but also between national data controllers and local intelligence teams of data such as the Mental Health Minimum Dataset, Hospital Episodes Data, GP patient demographic data and, eventually, data from the Care.Data programme. The effective sharing of information is vital during the transition of patients between children’s and adult services, and this is also an area of concern.

**Recommendation 3 – Awareness of Services and Support**

More should be done to comprehensively bring together information on mental health services and support networks in one place, so that both the public and professionals are clear on what is available and how it can be accessed. This should then be promoted as the primary source on information to, and by, all agencies. This would help to raise awareness, signpost to the most appropriate services and manage expectation. There were similar findings in the Youth Offender Service HNA in regard to knowledge and awareness of the remits of the CAMHS, Addaction and YOS services.

**Recommendation 4 – Service User Consultation**

Providers should seek feedback from those who contact or use all mental health services and support networks. Although the nature and scale of this may vary, for example between commissioned services and community support networks, feedback is essential in order to review and improve. Service evaluation processes, reporting and monitoring should form a standard requirement of contracts with a commitment from providers and commissioners to act upon findings. Standard frameworks should be developed to aid organisations in engaging service users and collecting feedback, along with provision of appropriate advice.

**Recommendation 5 – Service Provision and Best Practice**

In the light of the suggestions for improvement made by services users (as discussed in section 9.3), potential changes to commissioning, delivery or processes should be considered, whilst bearing in mind the financial constraints of funding bodies. Examples of good practice exist locally, nationally and internationally. Mechanisms should be developed to share these throughout the sector, including with commissioners, to build a picture of what excellence would look like in Lincolnshire and to understand what this would require.

**Recommendation 6 – Professional Skills**

There remains a need to improve, and make more consistent, the training provided for front-line staff working in mental health services. Training should cover such topics as listening skills, empathy, respect and building of trust. It is important that staff adopt a holistic approach in their treatment of those suffering from mental ill health, rather than attempting to treat the mental illness in isolation. Opportunities for joint local training should be considered (potentially linked to the LHAC programme) alongside in-house awareness training, with advice from commissioning and exemplar organisations and extension of existing mental health awareness training.
to include wider aspects of attitudes and communication styles. The opportunity to become involved in the ‘Time to Change’ campaign should also be investigated.

Supervision and appraisal for front-line staff should be mandatory, to include performance and development in this area of skills, with consideration made to how this could be extended to all front-line professionals rather than just those directly delivering mental health services. Services providers should ensure that relevant clinical guidance (for example, from NICE) has been adopted.

**Recommendation 7 – Strategic Linkages**

Mental health service governance structures need to be improved. Commissioners should work together to create an action plan to address the recommendations of this HNA, and to review and evaluate progress. This should link to related recommendations and policies, including:

- the Suicide Prevention Action Plan for Lincolnshire;
- the local Mental Health Promotion Strategy;
- the Carer's Strategy, which is being developed in Lincolnshire;
- the national recommendations on parity of esteem; and
- the findings of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness\(^{153}\).

Joint agency commitment to the Suicide Prevention Action Plan should be re-energised. Furthermore, commissioners should ensure that the findings of this HNA inform the development of future strategies relating to mental health but also those relating to other appropriate topics, for example smoking and alcohol.

**Recommendation 8 – Further Work Areas**

Case studies of service users should be carried out to provide true insight into their needs and experiences, building on evidence from Healthwatch, where that data can be shared.

Specific workstreams should be established to examine: increases in dual diagnosis; waiting times; the possibility of extending mental health-related GP appointments; prescribing patterns; and treatment effectiveness.

Finally, it is recommended that this HNA is used as a building block in future work to extend understanding to wider demographics and illnesses than were included in the scope of this particular assessment.
11 Acknowledgements

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would like to thank all of those who contributed and advised on this health needs
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providers and service users themselves.
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Appendix A: Conditions described in the Adult Psychiatric Morbidity Survey, mapped to ICD10 codes for analysis

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD10 code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common mental disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>F41.2</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>F41.1</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>F32</td>
</tr>
<tr>
<td>Phobias</td>
<td>F40</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>F41.0</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>F42</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>F43.1</td>
</tr>
<tr>
<td>Self-harm</td>
<td>X60-F84</td>
</tr>
<tr>
<td>Psychosis</td>
<td>F20-F21</td>
</tr>
<tr>
<td><strong>Personality disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Anti-social</td>
<td>F60.2</td>
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<tr>
<td>Borderline</td>
<td>F60.31</td>
</tr>
<tr>
<td>Attention deficit hyperactivity disorder</td>
<td>F90</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>F50-F59</td>
</tr>
<tr>
<td>Mental illness due to psychoactive substance abuse</td>
<td>F10-F19</td>
</tr>
</tbody>
</table>

Source: WHO, International Classification of Diseases (ICD)