# A Mental Illness Health Needs Assessment for Lincolnshire

## August 2016

## Table of Contents

## Acronyms

ADHD – Attention Deficit Hyperactivity Disorder
AIDS – Autoimmune Deficiency Syndrome
APMS – Adult Psychiatric Morbidity Survey
ASD – Autism Spectrum Disorders
CAMHS – Child and Adolescent Mental Health Services
CCG – Clinical Commissioning Group
CMD – Common Mental Disorders
CPA – Care Programme Approach
DART – Drug and Alcohol Recovery Team
DCLG – Department for Communities and Local Government
EMDR – Eye movement desensitization and reprocessing
GP – General Practitioners
HES – Hospital Episode Statistics
HMP – Her Majesty's Prison
HSCIC – Health and Social Care Information Centre
IAPT – Care Programme Approach
ICD-10 – International Classification of Diseases Version 10
IMD – Indices of Multiple Deprivation
JHWS – Joint Health and Wellbeing Strategy
LAC – Looked After Children
LD – Learning Disabilities
LGBT – Lesbian, Gay, Bi and Trans
LHAC – Lincolnshire Health and Care
LPFT – Lincolnshire Partnerships Foundation Trust
MCN – Managed Care Network
MiHNA – Mental Illness Health Needs Assessment
NHS – National Health Service
ONS – Office for National Statistics
PTSD – Post Traumatic Stress Disorder
QOF – Quality and Outcomes Framework
SCOFF – Sick, Control, One Stone, Fat, Food dominates
SEN – Special Educational Needs
SPR – Single Point of Referral
TAC – Team Around the Child
UK – United Kingdom
YOS – Young Offenders Service

# 1. Executive Summary

## 1.1. Introduction

At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time [1].

The aim of this health needs assessment is to systematically identify the mental ill health needs of children, adolescents, and adults living in Lincolnshire, in order to inform the development of the suicide prevention plan and assist commissioners to establish needs based mental health services. It will also feed into the Joint Strategic Needs Assessment and help to inform the priority setting for the next Joint Health and Wellbeing Strategy.

The scope of the adult needs assessment is based upon conditions reported in the Adult Psychiatric Morbidity Survey (APMS) [1]. The children and adolescents needs assessment is based Green et al.'s [2] *Mental health of children and young people in Great Britain*.

## 1.2. Methods

Three approaches were used to collate evidence for this Mental Illness Health Needs Assessment (MiHNA):

- Literature reviews and desk based research, used to develop an overview of current policy and mental health services, the prevalence of mental ill health, and service provider and user experiences of mental health services in Lincolnshire.
- Epidemiological, using a range of data to build a picture of the scale of those people in Lincolnshire who are affected by mental ill health.
- Service user and provider perspectives, including both children's and adults service user evaluations.

Work was carried out by staff from the Public Health Directorate of Lincolnshire County Council between August and November 2015.

## 1.3. Epidemiology

### Adults

The prevalence of a range of mental health conditions in Lincolnshire have been estimated in this health needs assessment. This includes:

- 98,328 people who are estimated to have suffered from a Common Mental Disorder (CMD) in the past week, equal to 16.2% of the population aged 16+ years.
- 7.3% of adults aged 18 years and older (n=45,007) on the depression register in 2013/14.
- 18,209 adults currently living with Post traumatic stress disorder (PTSD).
- 2,448 emergency admissions for intentional self-harm and 184 deaths from suicide and injury undetermined in people aged 15+ years between 2011-13.
- 2,428 people estimated to be living with a psychotic disorder in the past year.
- 1,821 people with an antisocial personality disorder and 2,428 with a borderline personality disorder.
- 9,711 adults estimated to have an eating disorder and, in 2013, 2,448 hospital admissions for eating disorders in Lincolnshire.

As the main provider of mental health services, data from Lincolnshire Partnership Foundation Trust (LPFT) was used as a proxy to understand service use and service user demographics. In 2014-15, a total of 39,514 patient contacts were recorded. The gender distribution of clients is approximately 58% women and 42% men.

Certain population subgroups are more likely to experience mental ill health or attempt to complete suicide. Risk factors or vulnerabilities may operate in isolation or interact (e.g. unemployment and deprivation) within individuals to further increase risk. Key risk factors for mental ill health include deprivation, homelessness, financial exclusion, unemployment, substance misuse, and loneliness and social isolation. Key risk factors for suicide include minority ethnic groups, people in institutional care or custody, people with post-natal depression, people of sexual minorities, veterans, people bereaved by suicide, and people who have self-harmed.

**Children and Adolescents**

In Lincolnshire in 2014-15 it is estimated that:

- 2,210 children aged 5-10 years and 3,075 children aged 11-16 years have a conduct disorder.
- 1,050 children aged 5-10 years and 2,360 children aged 11-16 years have an emotional disorder.
- 750 children aged 5-10 years and 670 children aged 11-16 years have a hyperkinetic disorder.
- 565 children aged 5-10 years and 575 children aged 11-16 years have a less common disorder.

A large proportion of children and young people with mental health needs will be seen in universal services provided by practitioners who are not mental health specialists (e.g. GPs, health visitors, or school nurses). For more specialist support, children may be referred to CAMHS (Child and Adolescent Mental Health Services). The total number of referrals to Lincolnshire CAMHS between April 2014 and March 2015 was 4,569. This number is unlikely to represent single individual cases but includes some individuals with more than one condition requiring CAMHS intervention or repeat referrals during the year.

Key risk groups include children and young people with learning disabilities, looked after children, homeless children and those sleeping rough, and children who are being bullied.

## 1.4. Local Services

Across Lincolnshire, both CAMHS and adults mental health services are provided by Lincolnshire Partnership Foundation Trust.

In addition to specialist services, there are a range of voluntary and community sector organisations across Lincolnshire that support people with mental ill health.

**Adults**

Adults with mental ill health in Lincolnshire may access a wide range of primary, community and secondary care services to address their health needs.

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 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. LPFT also provides a dementia & specialist older adult mental health service for people of any age experiencing needs associated with suspected or diagnosed dementia and for older adults presenting with complex mental health problems. The range of services provided across Lincolnshire is described in Chapter 6.

**Children and Adolescents**
CAMHS provide services across Lincolnshire with clinic bases in Lincoln, Gainsborough, Louth, Boston, Spalding, and Grantham. Based across these locations, multi-disciplinary CAMHS teams can help with a range of complex mental and emotional health issues, including anxiety, depression, trauma, eating disorders and self-harm.

Following a consultation process in 2015, a new CAMHS model will be launched in 2016. Chapter 6 details the structure of this new service.

In addition to CAMHS provision there are a number of initiatives, both in Lincolnshire and nationally that offer mental health support for young people, for example The Beacon Project, which supports the development of emotional resilience in pupils who are identified as needing support with confidence building and emotional resilience and Lost Luggage, which is a young person led lobbying/awareness raising/campaigning group.

**Service User Perspectives**
Both adult services and CAMHS have undertaken service user consultations in recent years.

Key areas in which adult service users perceive the service could be improved include waiting times, timely access to services, service quality (including rushed service that can lead to feelings of stigma and disengagement with services) and longer GP consultations for mental health issues. Service users would like to see developments that include more support groups and improved awareness of those that already exist, and an extension of services to support wider family members and carers.

Consultation for the new CAMHS included stakeholder engagement to identify factors identified as important to consider during service redevelopment. External stakeholders (e.g. schools, the voluntary and community sector, and parents and children) shared a range of issues that were categorised into themes of access, intervention, discharge and integration.

## 1.5. Recommendations
The main recommendations arising out of this work are: better identification and recording of mental ill health; data sharing between organisations to improve patient experience; timely access to mental health services based on need; raised awareness of and access to support networks that signpost services; frequent service user consultation; and consistent training of front line staff working across a range of services that may come into contact with people with mental health needs.

## 2. Introduction

At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time [1].

In 2011, the Government released its mental health strategy *No Health without Mental Health* [3], a cross-government mental health outcomes strategy for people of all ages. The strategy sets out clear, shared objectives for mental health. Further, in January 2014, the Government launched *Closing the Gap: Priorities for Essential Change in Mental Health* [4], which identified 25 aspects of mental health provision where the Government, health and social care commissioners and providers, and other organisations can work together to improve outcomes for people living with mental ill health. Parity of Esteem between mental and physical health – equality in how we think and value mental and physical health care – has been a priority for Government since 2013. Whilst improvements have been made in mental health provision and follow-up, inequalities persist in access to good quality services.

A number of risk factors for the development of mental ill health have been identified for different age groups. In childhood and adolescence key risk factors are having a learning disability, being a looked after child, being homeless or sleeping rough, and parental unemployment and lone parenthood [2]. The risk factors in adulthood are numerous and many are summarised in Table 2.1, including individual factors (such as loneliness, relationship difficulties and unemployment), social factors (such as low socio-economic status and homelessness) and community and cultural factors (such as ethnic minority group membership) [5]. Research has also identified that people with long-term conditions (e.g. cardiovascular disease and diabetes) are two to three times more likely than the general population to experience mental health problems such as depression or anxiety [6]. Finally, women are more likely than men to be treated for mental health problems (29% vs 17%) [7].

Examining risk factors for suicide separately, risk of suicide increased with history of suicide or self-harm among close friends or family [8] [9] [10], alcohol or substance misuse [11], unemployment [12], male gender [13] and schizophrenia spectrum disorders [10].

Identifying the key risk factors can assist with estimating the prevalence of specific mental health conditions in Lincolnshire and in targeting services to those in greatest need.

Table 2.1: Risk factors for mental ill health

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

## 2.1. Purpose

The aim of this health needs assessment is to systematically identify the mental ill health needs of children, adolescents, and adults living in Lincolnshire, in order to inform the development of the suicide prevention plan and assist commissioners to establish needs based mental health services.

Specific objectives are to:

- summarise national guidance for CAMHS and adults' mental health services;
- review published literature on the health needs of children and adults with mental ill health, including key risk factors;
- describe the local epidemiology of mental ill health in Lincolnshire and compare with the wider East Midlands region and national epidemiology;
- describe current CAMHS and adult service provision in Lincolnshire;
- make recommendations for CAMHS and adults mental ill health services based on needs

This work will support the development of the suicide action plan for Lincolnshire. It will also feed into the Joint Strategic Needs Assessment and help to inform the priority setting for the next Joint Health and Wellbeing Strategy.

Many people who complete suicide are not in contact with mental health services. As such, it is important to consider this needs assessment alongside other evidence on suicide (e.g. the Suicide and Self-harm Audit 2014 [14]), to ensure an understanding of the range of risk factors for suicide in Lincolnshire.

## 2.2. Scope of this MiHNA

**In scope**

The adult needs assessment is based upon conditions reported in the Adult Psychiatric Morbidity Survey (APMS) [1] (see Appendix A for a brief description of each condition):

- Common mental disorders (mixed anxiety and depressive disorder, generalised anxiety disorder, depression, phobias, panic disorder, obsessive compulsive disorder);
- Post-traumatic stress disorder;
- Self-harm (including suicidal thoughts and suicide attempts);
- Psychosis;
- Personality disorders (anti-social and borderline);
- Attention deficit hyperactivity disorder;
- Eating disorders;
- Mental health illnesses due to psychoactive substance abuse (alcohol misuse and dependence, drug use and dependence).

The children and adolescents needs assessment is based Green et al.'s [2] *Mental health of children and young people in Great Britain* and includes:

- Emotional disorders (e.g. anxiety and depression);
- Conduct disorders (awkward, troublesome, aggressive and antisocial behaviours);
- Hyperkinetic disorders (involving inattention and over activity);
- Less common disorders (e.g. Autistic Spectrum Disorder and multiple disorders).

Combining these two frameworks together, this work assesses the mental illness health needs of all people living in Lincolnshire.

**Out of scope**

Areas that were outside of the scope of this health needs assessment are:

- Dementia: a dementia strategy was developed in 2014 [15].
- Carers: a Joint Carers Strategy 2014-2018 has been developed for Lincolnshire [16].

Summary data on mental illness due to psychoactive substance use and gambling is included in the report. However, a more comprehensive understanding of substance misuse in Lincolnshire is available in the form of a substance misuse health needs assessment that was conducted in early 2015 [17].

## 3. Methods

Three approaches were used to collate evidence for this Mental Illness Health Needs Assessment (MiHNA):

- Literature reviews and desk based research
- Epidemiology
- Service user and provider perspectives

Work was carried out by staff from the Public Health Directorate of Lincolnshire County Council between August and November 2015.

### 3.1. Literature Reviews and Desk Based Research

Key national and local policy and strategy documents, commissioning approaches for configuration of mental ill health services, previous mental health needs assessments for Lincolnshire and commissioner and voluntary sector led service user exercises were identified through desk-based research. Together, these documents helped to develop an overview of current policy and mental health services, the prevalence of mental ill health, and service provider and user experiences of mental health services in Lincolnshire.

### 3.2. Epidemiology

A range of data has been used to build a picture of the scale of those in Lincolnshire affected by the specific mental health conditions within the scope of this review (see Section 2.2 Scope, page 8). For adults:

- National estimates by age group (for adults aged 16+ years) measured in the 2007 Adult Psychiatric Morbidity Survey (APMS) applied to the ONS 2014 mid-year population estimates for Lincolnshire to estimate the number of people in Lincolnshire affected by mental ill health. APMS is the primary source of information on both treated and untreated psychiatric disorders in England.
- The registered prevalence of specific mental health conditions (e.g. registered prevalence of depression based on Quality and Outcome Framework data).
- Hospital admissions data, used as a proxy for the prevalence of some conditions and behaviours, such as eating disorders and self-harm.
- Mortality data, to examine patterns in suicide and deaths from undetermined causes.
- Lincolnshire Partnership Foundation Trust (LPFT) service user demographic data, analysed to provide an understanding of patient characteristics in Lincolnshire. Data for Lincolnshire-registered patients who had accessed mental health services provided by LPFT was analysed for a 5-year period from 2010/11 to 2014/15.

For children, national prevalence estimates drawn from Green et al. [2] were used to estimate the number of children and young people with mental ill health in Lincolnshire. Referrals to Lincolnshire CAMHS at tier 2[1] and above were examined to develop an understanding of the service user demographics of children and adolescents.

[1] Tiered services enable people with different treatment needs to be signposted to appropriate forms of treatment. Tier 1 is for people with low support needs, tier 2 for people with medium support needs and tier 3 and 4 for people with high and complex support needs.

Where necessary, data has been categorised from ICD10 codes (International Classification of Disease codes are standard diagnostic codes defined by the World Health Organisation). Mapping of ICD10 codes to mental health conditions for the purpose of this assessment is shown in Appendix B. Geographical variations in mental ill health are compared to develop an understanding of the distribution of mental ill health across different parts of Lincolnshire.

### 3.3. Service User and Provider Perspectives

Service user and provider feedback for adult mental health services was drawn from a previous MiHNA for Lincolnshire carried out in 2014. In 2014, two questionnaires were used to gather feedback on current services: one from *users* of mental health services and the other from mental health service *providers and commissioners* on their views and experiences of the provision and commissioning of services.

During March 2014 the questionnaire was promoted through a range of channels: 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. Participants could complete the questionnaire either electronically or on paper. 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).

Further adult service user views were generated through a HealthWatch Lincolnshire survey carried out between September and November 2014 [18]. This survey examined a range of issues around waiting times, service experience ratings, self-harm episodes and healthcare contacts. In total, 126 people completed the questionnaire.

Service user and provider feedback for child and adolescent mental health services were generated from a review of CAMHS in Lincolnshire that included a broad stakeholder consultation. Between August and November 2013 stakeholders from Lincolnshire County Council, Clinical Commissioning Groups, the voluntary community sector, LPFT, health providers, schools, and parents, children and young people were consulted to explore aspects of CAMHS including access, intervention, discharge and integration.

Further insight was drawn from a HealthWatch Lincolnshire survey of more than 1,200 children and young people, which examined a range of issues important to young people such as smoking, drinking, drugs, bullying and self-harm [19]. Included in this research were some service user reflections on support services available.

## 4. Policy Context

### 4.1. Adults

A wide range of policies and strategies to improve mental health in the UK have been implemented in recent decades. Some are specific to mental health, for example:

- No health without mental health: A cross-government mental health outcomes strategy for people of all ages;
- Closing the Gap: Priorities for essential change in mental health;
- The National Service Framework for Mental Health.

Others are broader health policies and strategies that include objectives specific to improving mental health within, for example:

- The Mandate. A mandate from the government to NHS England: April 2014 to March 2015;
- Public Health Outcomes Framework for England;
- Healthy Lives, Health People.

Together, these documents provide a 'way-forward' for improving the nation's mental health and wellbeing, identifying good practice and key indicators that can be used to measure progress. An overarching aim is to ensure Parity of Esteem - giving mental health the same importance as physical health and improving the health care experience of people with mental ill health [20] [21]. Through mental health promotion (starting early to promote mental wellbeing and prevent problems from developing) and ensuring access to effective services for people with mild and severe mental illness, the Government's strategy aims to ensure fewer people will suffer avoidable harm, stigma and discrimination, and more people will recover from mental health problems [3]. These policies aim to reduce premature mortality in people with serious mental illness and improve the quality of life of people with mental health problems [4] [22].

Additionally, the Government has developed a separate policy specific to preventing suicide. Suicide is a leading cause of years of life lost and the 2012 *Suicide Prevention Strategy for England* [23] aims to reduce the suicide rate in the general population in England and better support those who are bereaved or affected by suicide. The strategy identified six key areas for action:

1. Reduce the risk of suicide in key high-risk groups;
2. Tailor approaches to improve mental health in specific groups;
3. Reduce access to the means of suicide;
4. Provide better information and support to those bereaved or affected by suicide;
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour; and,
6. Support research, data collection and monitoring.

The implementation framework for *No health without mental health* explicitly covers suicide prevention and supports implementation of the *Suicide Prevention Strategy for England*.

In Lincolnshire, improving mental health and reducing mortality from suicide have been identified as public health priorities. Mental health is embedded as a cross-cutting theme in the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018 (see Table 4.1).

Table 4.1: mental health outcomes in the Joint Health and Wellbeing Strategy for Lincolnshire

| Theme | Mental Health Outcomes |
|---|---|
| Promoting healthier lifestyles | • Alcohol-related admissions to hospital<br>• Self-reported wellbeing<br>• People who use services who have control over their daily lives |
| Improving the health & wellbeing of older people | • Health-related quality of life for older people<br>• Enhancing quality of life for people with dementia<br>• Social connectedness |
| Delivering high-quality systematic care for major causes of ill health & disability | • Take up of the NHS Health Check Programme<br>• Cancer screening coverage |
| Improving health & 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<br>• People with mental ill health or disability living in settled accommodation<br>• Proportion of adults in contact with secondary mental health services who are living independently, with or without support |

Lincolnshire County Council has developed a draft Mental Health Promotion Strategy (2013-2016) with themes that include starting early, improving access to services and engaging the community. It has also 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. Treatment pathways and local services are described in Chapter 6.

The 2014 Annual Director of Public Health Report for Lincolnshire [24] identified that death from suicide or undetermined causes is the third biggest cause of years of life lost in Lincolnshire. Recommendations arising from the report include:

- Continued monitoring of suicide and death by undetermined causes to enable the identification of causes and delivery interventions that could save lives. Develop a suicide surveillance system, with appropriate information sharing and reporting.
- More people trained through SafeTALK and ASIST, working with commissioned providers to raise awareness of how to talk to someone who may be at risk of suicide.
- Create an action plan for suicide prevention, working together to help people and making sure frontline staff have the skills and information to help people at risk.

## 4.2. Children and Adolescents

The Government's Mental Health Strategy *No Health without Mental Health,* is an all-ages strategy to improve the mental health and wellbeing of the population [3]. For children and young people, the specific aims are to:

- Improve the mental health and wellbeing of all children and young people and keep them well; and
- Improve outcomes for children and young people with mental health problems through high quality services that are equally accessible to all.

The Children and Young People's Health Outcomes Forum - Mental Health Subgroup has drawn on this strategy and other sources, (e.g. [22] [25] [26] [13]) to develop a set of proposed outcome indicators to support the delivery of *No Health without Mental Health to* improve mental health among children and adolescents. The full range of indicators can be viewed in the *Report of the Children and Young People's Health Outcomes Forum – Mental Health Sub-Group* [27] but include parental mental health, poor parental relationships, adversity in early life and suggestions to develop measures around school readiness and transition between primary and secondary school. The report also presents opportunities for monitoring and, where appropriate intervening, to improve mental health outcomes, for example in school and college settings.

An independent review of tier 4 CAMHS commissioned by NHS England [28] and evidence presented at the House of Commons Health Committee's inquiry (2014) into children and young people's mental health [29] have shown that many children and young people with mental health and emotional difficulties do not receive timely, high quality, accessible or evidence-based support. The Children and Young People's Mental Health and Wellbeing Taskforce was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. The Taskforce published its report *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing* in March 2015, and the report made key recommendations to schools, commissioners, and early years' staff. It emphasised the need to improve services for children and young people from vulnerable backgrounds, to improve access to services and to improve data and standards [30].

Young people are vulnerable to suicidal feelings. The *Suicide Prevention Strategy for England* identifies that a tailored approach to mental health is required among children and young people in order to reduce their risk of suicide [23]. This is especially true for those who are vulnerable such as looked after children, care leavers, young carers and children and young people in the youth justice system. Services to reduce suicide among children and young people can operate in a range of settings, including school, healthcare and custodial or secure settings. An effective school-based suicide prevention strategy would include [23]:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems & risk;
- clear referral routes to specialist mental health services.

In Lincolnshire, the mental health of children and adolescents is embedded within the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018 (see Table 4.1).

Mental health services are commissioned locally for children and adolescents (separate to adults services), which are tailored to the needs of younger people with mental health problems. These services can be accessed through both GPs and school health teams (e.g. nurse or pastoral care). CAMHS also provides services for vulnerable groups, for example looked after children and youth offenders. Treatment pathways and current and future CAMHS provision is detailed in Chapter 6.

# 5. Epidemiology

## 5.1. Adults

### 5.1.1. National Overview

Mental health issues range from the everyday worries we all experience to more serious long-term conditions [31]. Mental health problems can affect 15% of the adult population at any one time [32]. In 2013-2014 over 1.7 million adults accessed NHS services for severe or enduring mental health problems [33]. In England during the same period, 922,025 adults were in contact with secondary mental health services, and of these 23,394 were inpatients in a psychiatric hospital (2.5%). 16,837 people were subject to the Mental Health Act 1983 and of these 12,403 were detained in hospital (73.7%) and 4,270 were subject to a community treatment order (25.4%) [34].

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. 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. The prevalence of psychiatric comorbidity is estimated to be 31.3% of adults with at least one mental health condition, and 7.2% of the general population [35].

### 5.1.2. Lincolnshire

The scale of mental ill health in Lincolnshire is described using the range of sources described in Chapter 3 (page 10). Where estimates are drawn from APMS data, national prevalence estimates are applied to the ONS 2014 mid-year population figures for Lincolnshire (see Table 5.1) to estimate the number of cases of each mental ill health condition in the county. Tables of prevalence estimates for the range of mental health conditions recorded in APMS for England are presented in Appendix C.

Table 5.1: estimated mid-year population figures for Lincolnshire (unrounded): 2014

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Male | 39,320 | 40,100 | 40,800 | 51,500 | 45,800 | 45,100 | 31,400 | 294,020 |
| Female | 38,140 | 40,900 | 43,400 | 54,300 | 48,800 | 46,500 | 40,900 | 312,940 |
| **All** | **77,380** | **81,100** | **84,200** | **105,800** | **94,600** | **91,700** | **72,300** | **607,080** |

*Source: Office of National Statistics*

#### 5.1.2.1. Common Mental Disorders (CMD)

APMS measured past-week symptoms of common mental disorders[2] using the revised Clinical Interview Schedule. It is estimated that in the past week 98,328 adults in Lincolnshire have suffered from a CMD, equal to 16.2% of the population aged 16+ years

[2] Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety.

(Table 5.2). Past week prevalence of CMD is higher in younger age groups and is highest in the 45-54 year age group at 19.9%. Prevalence is lowest in adults aged 65 years and older: 10.6% for adults aged 65-74 years and 9.9% for adults aged 75 years and older.

Table 5.2: estimated population in Lincolnshire with common mental disorders (numbers)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| National prevalence - Any CMD | 17.5% | 18.8% | 17.3% | 19.9% | 14.1% | 10.6% | 9.9% | 16.2% |
| Estimated CMD prevalence - Lincolnshire | 13,556 | 15,228 | 14,567 | 21,054 | 13,339 | 9,720 | 7,148 | 98,328 |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

#### 5.1.2.2. Depression

General Practices in the UK keep a record of all patients diagnosed with depression. In 2013/14, 7.3% of adults aged 18 years and older (n=45,007) in Lincolnshire were on the depression register. This was an increase of 0.8% from 2012/13 and is slightly higher than the England average. There is variation in prevalence rate by CCG: prevalence is lowest in Lincolnshire East at 6.6% and highest in Lincolnshire West at 8.1% (Appendix D, Figure 1).

#### 5.1.2.3. Post-traumatic stress disorder (PTSD)

The prevalence of current PTSD estimated from APMS is 3% (see Appendix C, Table 2). Men and women aged 55 years and older have a lower prevalence of PTSD than men aged 16-44 years and women aged 16-54 years. The highest male prevalence of PTSD is aged 16-24 years at 5.1% and the highest female prevalence is aged 45-44 years at 5.8%. In Lincolnshire, it is estimated that 18,209 adults in are currently living with PTSD (Table 5.3).

Table 5.3: estimated population in Lincolnshire with post-traumatic stress disorder (numbers)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 2,005 | 1,444 | 1,224 | 979 | 870 | 316 | 63 | 7,645 |
| Women | 1,602 | 1,513 | 1,519 | 3,149 | 927 | 698 | 327 | 10,327 |
| **All adults** | **3,637** | **3,001** | **2,694** | **4,126** | **1,797** | **1,009** | **434** | **18,212** |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

#### 5.1.2.4. Suicide

Between 2011 and 2013, 184 people aged 15 years and older died from suicide and injury undetermined in Lincolnshire. The age-standardised suicide and undetermined injury mortality rate (per 100,000) in Lincolnshire is 7.0, comparable to the East Midlands rate of 6.8 and lower than the England rate of 7.9 [36]. The mortality rate is lowest in Lincolnshire East and South Lincolnshire at 7.5 and 7.6 respectively and highest in Lincolnshire West at 10.4 (see Appendix D, Figure 2).

Certain groups have been identified as being more prone to attempting suicide [37], including:

- minority ethnic groups;
- people in institutional care or custody, such as prisoners;
- people of sexual minorities,
- veterans; and
- those bereaved by suicide.

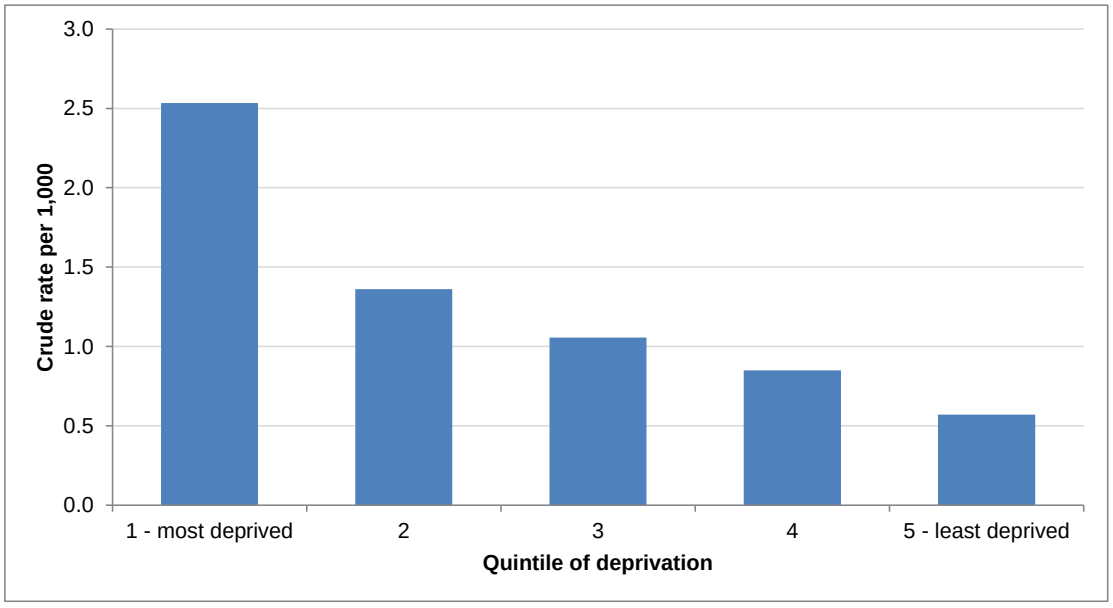
See Section 5.1.3 to understand more about these at risk populations in Lincolnshire.

#### 5.1.2.5. Self-harm

Between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm in Lincolnshire, a directly age standardised rate of 117.6/100,000 population. The rate of emergency admissions was highest in Lincolnshire West CCG at 145.0/100,000 and lowest in South West Lincolnshire CCG at 83.9/100,000 population (see Appendix D, Figure 3).

There is a clear deprivation gradient in the rate of emergency admissions for self-harm (Figure 5.1). People living in the most deprived areas are five times more likely to have an emergency admission to hospital for self-harm than people in the least deprived areas.

Figure 5.1: emergency hospital admissions for intentional self-harm, directly age standardised rate per 100,000, all ages, by quintiles of deprivation: 2011 - 2013




*Source: HSCIC, Hospital Episode Statistics (HES), Department for Communities and Local Government (DCLG)*

#### 5.1.2.6. Psychoses

The Adult Psychiatric Morbidity Survey (APMS) estimates that 0.4% of the population aged 16+ years have experienced a psychotic episode in the past year. In Lincolnshire, this is equivalent to 2,428 people (see Table 5.4). Prevalence is highest in men aged 25-44 years

and women aged 35-54 years, although for some age groups an age-specific prevalence rate is not available (see Appendix C, Table 3).

Table 5.4: estimated no. of people in Lincolnshire with reported psychotic disorders in past year

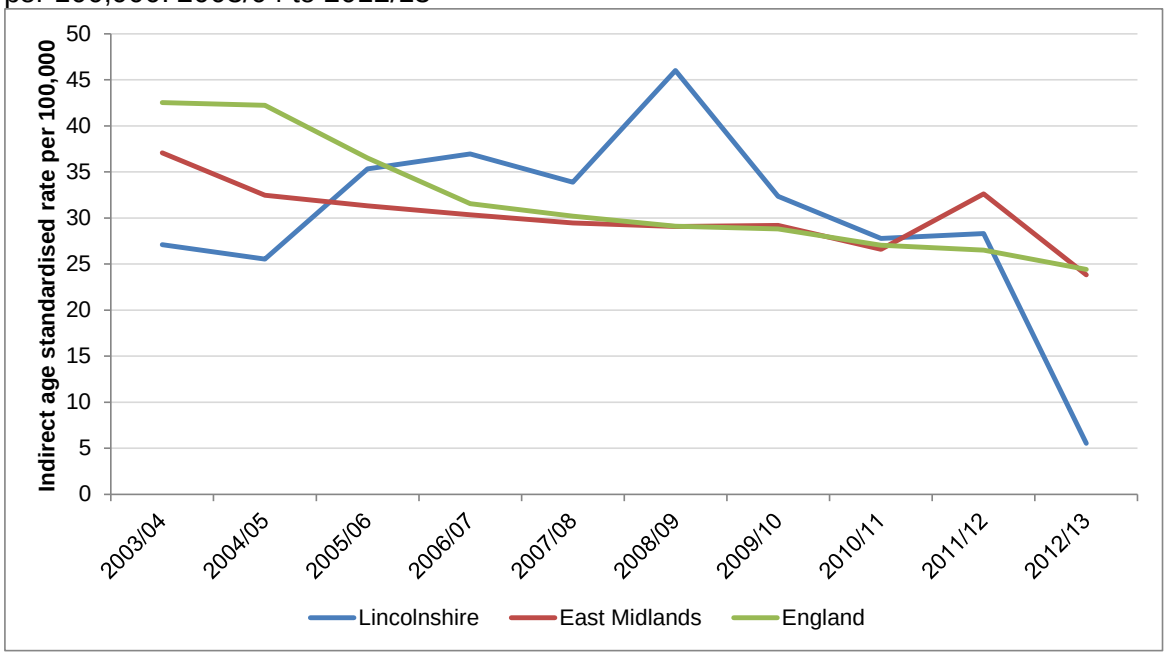
| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 0 | 241 | 286 | 52 | 0 | 0 | 0 | 882 |
| Women | 153 | 82 | 477 | 434 | 293 | 0 | 0 | 1,565 |
| **All adults** | **155** | **324** | **758** | **529** | **284** | **0** | **0** | **2,428** |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

GP mental health registers record the number of patients with schizophrenia, bipolar affective disorder and other psychoses. Overall, the prevalence of psychoses recorded on GP mental health registers is lower in Lincolnshire (0.74%) than in England (0.86%). Within the county, prevalence is lowest in South West Lincolnshire CCG at 0.60% and highest in Lincolnshire West CCG at 0.88%. There was an increase in the prevalence of psychoses recorded on GP mental health registers between 2012/13 and 2013/14: this increase was observed across all four Lincolnshire CCGs (see Appendix D, Figure 4).

Emergency hospital admissions for schizophrenia in Lincolnshire have fluctuated over time (see Figure 5.2). In 2012/13, emergency hospital admissions in Lincolnshire (5.54) were lower than in the East Midlands (23.82) and England (24.41). Monitoring this trend over time will be important to see if the large decrease in emergency admissions in Lincolnshire between 2011/12 and 2013/14 is maintained over time.

Figure 5.2: emergency hospital admissions for schizophrenia, indirectly standardised rates per 100,000: 2003/04 to 2012/13




*Source: HSCIC, Hospital Episode Statistics (HES)*

### 5.1.2.7. Antisocial and Borderline Personality Disorders

APMS estimates the one-year prevalence of antisocial and personality disorders in England at 0.3% and 0.4% respectively (see Appendix C, Table 4). Prevalence decreases with increasing age. Applying these national prevalence rates to the ONS 2014 mid-year population estimates for Lincolnshire, 1,821 people have antisocial personality disorder and 2,428 have borderline personality disorder.

### 5.1.2.8. Attention Deficit Hyperactivity Disorder (ADHD) among adults

The Adult Psychiatric Morbidity Survey (APMS) measured prevalence of ADHD using the Adult ADHD Self-Report Scale Symptom Checklist, an 18-item checklist measuring how often the individual experiences a range of symptoms such as remembering appointments and feeling overly active or compelled to do things. An adult score of 4 or more suggests the individual has symptoms highly consistent with ADHD. Table 5.5 shows the estimated population in Lincolnshire that would screen positive for ADHD based on prevalence rates identified in APMS (see Appendix C, Table 5). In total, 50,378 adults aged 16 years and older are estimated to have an ADHD score of 4 or more. Prevalence is highest in adults and 16-24 years of age, and decreases with increasing age, stabilising at just over 4% for adults aged 65 years and older.

Table 5.5: estimated no. people in Lincolnshire screening positive for ADHD in past six months

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| National ADHD prevalence - score of 4 or more | 13.9% | 8.6% | 9.7% | 8.7% | 4.9% | 4.3% | 4.2% | 8.3% |
| National ADHD prevalence - score of 6 | 1.1% | 0.6% | 0.9% | 0.6% | 0.2% | 0.0% | 0.1% | 0.6% |
| Estimated ADHD prevalence - score of 4 or more | 10,767 | 6,966 | 8,167 | 9,205 | 4,635 | 3,943 | 3,032 | 50,378 |
| Estimated ADHD prevalence - score of 6 | 852 | 486 | 758 | 635 | 189 | 0 | 72 | 3,642 |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

### 5.1.2.9. Eating Disorders among adults

APMS measured the prevalence of eating disorders using SCOFF, a five-item questionnaire addressing core features of anorexia nervosa and bulimia nervosa. The age-specific prevalence of eating disorders in England was measured in APMS at 1.6%: 0.6% in men and 2.5% in women. Prevalence decreases with increasing age, from 3.5% in adults aged 16-24 years, to 0.1% in adults aged 75 years and older (see Appendix C, Table 6). Table 5.6 presents the age-specific estimates of adults in Lincolnshire who have an eating disorder, with a total of 9,711.

Table 5.6: estimated population in Lincolnshire with eating disorders (score 2+ on SCOFF toolkit with significant impact) (numbers)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 668 | 281 | 122 | 412 | 46 | 135 | 0 | 1,764 |
| Women | 2,060 | 1,472 | 1,085 | 1,683 | 439 | 279 | 41 | 7,824 |
| **All persons** | **2,708** | **1,703** | **1,179** | **2,010** | **473** | **367** | **72** | **9,713** |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

In 2013, there were 2,448 hospital admissions for eating disorders in Lincolnshire. The rate was highest in Lincolnshire West CCG at 145.0/100,000 and lowest in South West Lincolnshire CCG at 83.9/100,000 (see Appendix D, Figure 5).

### 5.1.2.10. Mental health illnesses due to psychoactive substance abuse

**Alcohol consumption**

Hazardous drinking is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. Harmful drinking denotes the most hazardous use of alcohol, at which damage to health is likely. One possible outcome of harmful drinking is alcohol dependence, a cluster of behavioural, cognitive, and physiological phenomena that typically include a strong desire to consume alcohol, and difficulties in controlling drinking.

APMS measured the prevalence of hazardous and harmful drinking in England. It is greater among men (5.8%) than women (1.8%), and decreases with increasing age, from 6.8% in adults aged 16-24 years to 0.4% in adults aged 75 years and older (see Appendix C, Table 7). Applying these prevalence rates to the 2014 population of Lincolnshire, an estimated 23,064 people aged 16 years and older are hazardous or harmful drinkers (see Table 5.7).

Figure 5.3 compares of the age-standardised rates of hospital admissions for alcohol related mental and behavioural disorders due to use of alcohol in Lincolnshire and our statistical neighbours[3]. The rate in Lincolnshire is lower than most of our statistical neighbours, as well as the East Midlands and England average.

Table 5.7: estimated population in Lincolnshire with reported hazardous or harmful drinking behaviour in the past year (numbers)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 3,460 | 4,652 | 2,693 | 1,648 | 1,328 | 767 | 314 | 17,053 |
| Women | 1,831 | 654 | 1,259 | 1,086 | 146 | 233 | 0 | 5,946 |
| **All persons** | **5,262** | **5,353** | **4,042** | **2,751** | **1,514** | **1,009** | **289** | **23,069** |

*Source: 2007 Adult Psychiatric Morbidity Survey, ONS 2014 mid-year population estimates*

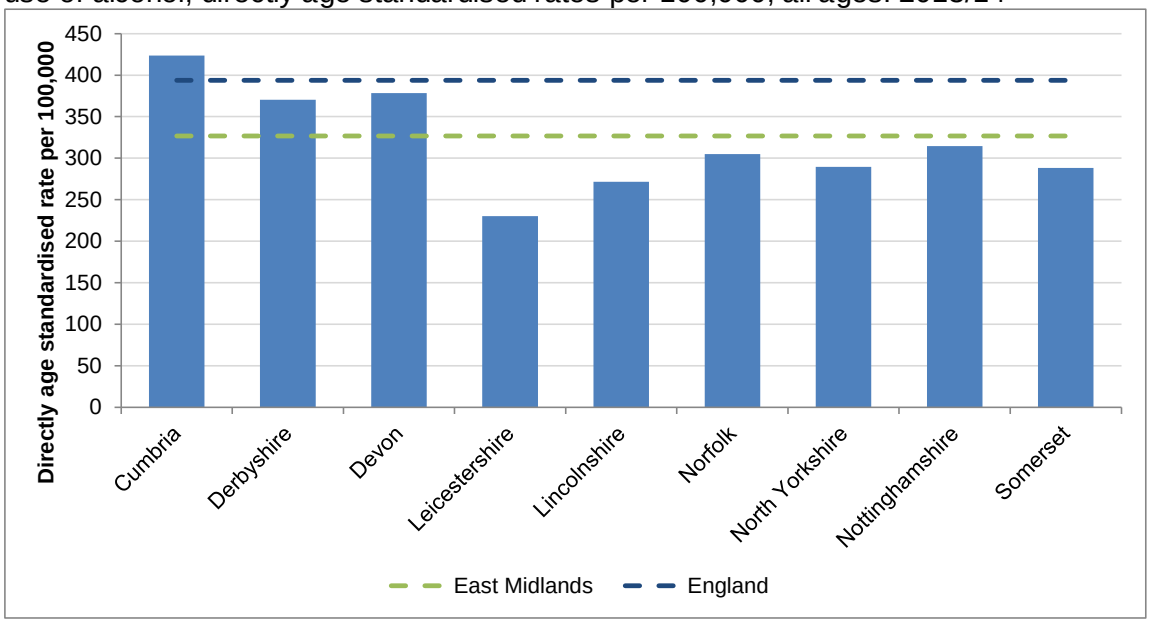
Within the county, Lincolnshire West CCG has the highest rate of hospital admissions for mental and behavioural disorders due to the use of alcohol (76.8/100,000) and South Lincolnshire has the lowest rate (47.7) (see Appendix D, Figure 6).

[3] A term used to describe local authorities with similar characteristics (e.g. age profile, rurality or deprivation).

There is a gradient in the crude rate of hospital admissions for mental and behavioural disorders due to use of alcohol. In 2011-2013 the crude rate of hospital admissions was highest in the most deprived quintile (1.35/1,000) and lowest in the least deprived quintile (0.56/1,000).

More information on alcohol consumption in Lincolnshire can be found in the Lincolnshire substance misuse health needs assessment 2015, which can be accessed from the following website: http://www.research-lincs.org.uk/Home.aspx [17].

Figure 5.3: hospital admissions for alcohol related mental and behavioural disorders due to use of alcohol, directly age standardised rates per 100,000, all ages: 2013/14




*Source: Public Health England, Public Health Outcomes Framework*

**Psychoactive substance use (excluding alcohol)**

Psychoactive substances are those which, when taken in or administered into one's system, affect mental processes such as cognition. Psychoactive substance abuse is a maladaptive pattern of use indicated by continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use or recurrent use of a substance [38]. Psychoactive substance abuse encompasses states such as acute intoxication, dependence syndrome, and withdrawal. When talking about psychoactive substances we often use the term interchangeably with the word drugs. Accurate measures of the prevalence of certain forms of psychoactive substance use are not available; however, data is available on the more serious drug dependence and hospital admissions for mental and behavioural disorders due to psychoactive substance use. More information can be found in the Lincolnshire substance misuse health needs assessment 2015, which can be accessed from the following website: http://www.research-lincs.org.uk/Home.aspx [17].

The estimated prevalence of past year drug dependence (cannabis, amphetamines, cocaine, crack, ecstasy, heroin and methadone, tranquillisers and volatile substances) in England is 4.5% in men and 2.3% in women in England (see Appendix C, Table 8). Prevalence decreases with increasing age, from 13.3% among men aged 16-24 years to 0.3% among men aged 75 years and older, and from 7% among women aged 16-24 years to 0.6% among women aged 75 years and older. For most age groups, dependence was most likely to be related to cannabis only [1]. In Lincolnshire, the number of people who are estimated to be drug dependent is 20,637.

In 2011-2013 there were 168 hospital admissions in Lincolnshire for mental and behavioural disorders due to psychoactive substance use. The directly age standardised rate is 8.26/100,000 population. Within the county, the rate of hospital admissions is highest in Lincolnshire West and South West Lincolnshire CCGs at 10.2/100,000 and lowest in South Lincolnshire at 6.2/100,000 (see Appendix D, Figure 7). Hospital admissions are most often related to multiple drug use (40.8%), stimulants (21.4%), cannabinoids (16.4%), opioids (13.9%) and sedatives/hypnotics (4.5%).

**Pathological Gambling**

Pathological gambling disorder occurs when a person gambles compulsively to such an extent that it has a severe negative effect on their life, continuing even after the individual has developed social, economic, interpersonal, or legal problems as a result of the gambling. The estimated prevalence of pathological gambling is 0.6% among men and 0.1% among women in England (see Appendix C, Table 9. Applied to the 2014 ONS mid-year population estimate for Lincolnshire, these prevalence rates suggest that 1,821 people in the county may suffer from pathological gambling.

### 5.1.3. Risk factors for mental ill health and suicide

Certain population subgroups are more likely to experience mental ill health or attempt to complete suicide. Risk factors or vulnerabilities may operate in isolation or interact within individuals to further increase risk (e.g. unemployment and deprivation). Key risk factors for mental ill health include:

#### 5.1.3.1 Deprivation

People from the most deprived areas are at higher risk poor mental health and of developing mental health problems, as are their children [39].

The Index of Multiple Deprivation (IMD) is a composite measure of deprivation that looks at outcomes across a range of domains such as housing, employment, education and health to rank small geographical areas in terms of overall deprivation. England is split into 32,844 small geographical areas, or lower-level super output areas, across 152 upper tier local authorities. Lincolnshire ranks 90$^{th}$ out of 152 upper tier local authorities in England in 2015, where 1$^{st}$ is the most deprived. 6.9% of lower-level super output areas in Lincolnshire are ranked within the most deprived 10% of the 32,844 areas used in 2015 to measure overall deprivation in England (ranking 79$^{th}$ out of 152). This equates to approximately 50,000 people living in the most deprived 10%.

#### 5.1.3.2 Homelessness

The prevalence of common mental health problems among people who are homeless is more than twice that in the general population, and the prevalence of psychosis is 4-15 times higher. Serious mental illness is often accompanied by alcohol and/or substance misuse problems, with most studies suggesting that around 10-20% of the homeless population fulfil the criteria for dual diagnosis [40].

In Lincolnshire in Autumn 2014 the district councils estimated there to be 22 rough sleepers. Rough sleepers are people who are sleeping, about to bed down or are actually bedded down in the open air, as well as people in buildings or other places not designed for habitation (such as stairwells, barns, sheds, or car parks). In addition, there are many people who self-identify as homeless who can apply for acceptance for housing support from the local authority. In 2014-15 across Lincolnshire there were 646 homeless acceptances. Over a third of these were in Lincoln and almost a further third in South Kesteven. Finally, homelessness prevention and relief is where the household becoming homeless was avoided and can be through a number of routes. In 2014-15, Lincolnshire managed 3,320 such cases [41].

#### 5.1.3.3 Financial exclusion

Financial exclusion is a process whereby people encounter difficulties accessing and/or using financial services and products in the mainstream market that are appropriate to their needs and enable them to lead a normal social life in the society in which they belong. Financial exclusion can lead to social exclusion, debt and poverty. People with five or more separate debts have a 6-fold increased risk of mental ill health and difficulty repaying debt is a risk factor for suicide [42].

Measuring financial exclusion is challenging because it has so many dimensions and is not always easily identifiable. However, one indication of the number of people who are experiencing financial exclusion is the number of people who are accessing funds through the Lincolnshire Community Assistance Scheme, which helps people going through unexpected difficulties and who need urgent assistance to meet their basin needs (e.g. food and drinking water, clothes and shoes, support for household heating or lighting payments and one-off payments of rent or lodging costs if your local housing department cannot help). In 2013-14 there were 5,283 claims, in 2014-15 there were 6,302 claims, and in the first 5 months of 2015-16 there have been 2,576 claims.

LCAS has provided support to people experiencing a range of types of financial exclusion, for example people with chaotic lives and people experiencing shorter term problems such as bereavement, redundancy and serious illness. Each person receiving LCAS funds has a follow-up with the Citizen's Advice Bureau (CAB) to try to identify the root cause of their problems and to prevent recurrence. CAB provides support around a range of issues including debt and income maximisation – making sure people are claiming the benefits to which they are entitled.

#### 5.1.3.4 Unemployment

Unemployment is associated with social exclusion and isolation, which has a number of adverse effects, including reduced psychological wellbeing and a greater incidence of self-harm, depression and anxiety.

Unemployment in Lincolnshire is lower than the national average. Between April 2014 and March 2015, 4.9% of the population of Lincolnshire was unemployed, compared with 5.3% in the East Midlands and 6.0% in England. However, across the county there are pockets of long-term unemployment and seasonal employment. Unemployment among younger adults (aged 18-24 years) is higher than the national average (12-month job seekers allowance 0.5% in Lincolnshire, 0.3% in the East Midlands and England). Further, a higher proportion of those people who are economically inactive in Lincolnshire, are inactive due to long-term sick leave (25.7%) compared with the East Midlands (23.0%) and England (21.6%) [43].

#### 5.1.3.5 Substance misuse

Substance use and mental health problems often co-occur, with a complex relationship existing between substance misuse and mental health.

Substance use is a risk factor for the onset of mental health problems. A range of mental and behavioural disorders caused by alcohol or other substance use have been identified, for example delirium and perceptual distortions. Conversely, people with mental health problems may use substances to manage their symptoms, for example to self-medicate the symptoms of depression or anxiety. Substance use can exacerbate the symptoms of mental ill health and may interact with medications used to treat conditions such as mood stabilisers and anti-depressants.

The number of people in Lincolnshire estimated to misuse alcohol and/or drugs is described above on pages 20 and 21.

#### 5.1.3.6 Loneliness and social isolation

It is estimated that between 5% and 16% of over 65 year olds nationally have reported loneliness, while 12% report social isolation. Both loneliness and social isolation can negatively impact on health and wellbeing, with high blood pressure and depression being closely associated amongst those who are lonely or who feel isolated.

Whilst there is no current data to identify loneliness or social isolation in Lincolnshire, we can provide a rough estimate using given national rates. Of the 159,953 over 65 year old residents living in Lincolnshire, we can estimate that between 8,000 (5%) and 25,500 (16%) are lonely, with a further 19,200 who feel isolated.

Mental ill health is a risk factor for suicide. In addition, a number of population subgroups that are at increased risk of completing suicide have been identified:

#### 5.1.3.7 Minority ethnic groups

Risk of suicide in minority ethnic groups is difficult to measure as place of birth rather than ethnicity is recorded on death certificates. However, research has used data on place of birth to compare suicide ratios of foreign-born and UK-born nationals. Ratios vary by country and age group, for example being low in Pakistani and Bangladeshi women overall, but elevated in the 15- to 25-year-old group [44].

At the 2011 census, 2.4% of the population of Lincolnshire was non-White, an increase from 1.4% at the 2001 census. This is much lower than the proportion of the population of England that is non-White (14%). Between 2001 and 2011, the number of Lincolnshire residents who were born outside the UK more than doubled. According to the 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.

More information on migrants' health needs in Lincolnshire can be obtained from the document, "Ensuring inclusive health care in Lincolnshire 2013", which can be downloaded from the following website: http://www.research-lincs.org.uk/Home.aspx [45].

#### 5.1.3.8 People in institutional care or custody

The rate of self-inflicted deaths in prisoners in the period ending September 2014 was 1.0/1,000 prisoners (n=87). This was a 38% increase on the same period in 2013 and is the highest annual number of deaths since 2007 [46]. The rate of suicide and self-harm is much greater in the prison population that the general population (7.9/100,000 people).

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 [47]. 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 [48].

A more detailed examination of the mental health needs of prisoners in Lincolnshire is available through the Health Needs Assessments for HMP Lincoln [49] and HMP North Sea Camp [50], which looked at the health and wellbeing of prisoners in the county and how this information can be used to improve partnership working and the commissioning of healthcare in prisons.

Data on rates of suicide and self-harm among asylum seekers in the UK is scant. However, using data that is available from Immigration Removal Centres, coroner's records and the Prison Ombudsman's reports, there are high levels of self-harm and suicide among detained asylum seekers compared with the UK prison population [51]. Lincolnshire has an immigration removal centre a few miles to the southwest of Lincoln, 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 [52].

#### 5.1.3.9 People with post-natal depression

Suicide is the leading cause of maternal death in England. Key risk factors for maternal suicide included severe onset of mental illness soon after childbirth, older age and being free from social adversity [53].

#### 5.1.3.10 People of sexual minorities

Lesbian, gay, bisexual and trans-gender (LGBT) people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. This may be linked to experiences of homophobic discrimination and bullying, especially during vulnerable adolescent years [54]. It is estimated that 5-7% of the

population are LGBT, although the exact proportion of the population who identify as LGBT is difficult to estimate given the absence of a measurement across some national surveys and the possible reluctance to disclose sexual orientation. If estimates of 5-7% are accurate for Lincolnshire, this suggests that between 36,575 and 51,205 people self-identify as LGBT.

#### 5.1.3.11 Veterans

The overall rate of suicide among ex-Armed Forces personnel does not significantly differ from the general population. However, young men who leave the armed forces (particularly those with a short length or services and of lower rank) are 2-3 times more likely to complete suicide than members of the general population. For men aged 30-49 years the risk of suicide is lower than in the general population [55].

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.

#### 5.1.3.12 Students at University and College

Students make up approximately 3% of the Lincolnshire population (n=23,000). In the past 12-months there have been three suicides across the student population in Lincolnshire (12.8/100,000). Further, in recent years the University of Lincoln has reported an increasing number of students seeking support for mental health and complex mental health needs through the University's Student Wellbeing and Mental Health Service.

#### 5.1.3.13 People bereaved by suicide

Research supports an increased risk of suicide in mothers bereaved by the suicide of an adult child and partner's bereaved by suicide, as well as an increased risk of a range of other mental health outcomes for people bereaved by suicide [56]. In Lincolnshire, between 2011 and 2013 there were 184 deaths due to suicide. Ensuring mental health services are able to support those people who are bereaved by suicide may help to reduce future burden of mental ill health and suicide mortality.

#### 5.1.3.14 People who have self-harmed

Self-harm is a highly stigmatised behaviour. There is an increased in risk of suicide following self-harm episodes. Among a cohort of almost 8,000 emergency department self-harm attendees followed up over a four-year period, there was a 30-fold increased risk of suicide compared with the general population [57]. Suicide rates were especially high in the 6 months after the index self-harm episode suggesting that early intervention after an episode of self-harm may be important to reduce suicide risk.

In Lincolnshire, between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm. This is a population in which timely intervention might reduce future suicide risk.

## 5.2. Children and young people

### 5.2.1. National Overview

Children and young people with mental health problems represent some of the country's most vulnerable people. Their mental health and wellbeing is important to the future health, wellbeing and prosperity of our society. Emotional and behavioural problems in early life are predictors of poor outcomes in later years.

The best available estimates of the prevalence of mental disorders amongst children and young people are those from the Office for National Statistics surveys in 1999 [58] and 2004 [2]. These reports found one in ten children aged between 5 and 16 years has a mental disorder. About half (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression), 1–2% have severe Attention Deficit Hyperactivity Disorder (ADHD) and 1% have neurodevelopmental disorders. The rates of disorder rise steeply in middle to late adolescence and the profile of disorder changes with increasing presentation of the types of mental illness seen in adults. However, as noted in the Chief Medical Officer's 2012 report [59] these prevalence estimates may be out of date.

The Prince's Trust Macquarie Youth Index 2014 identified that 26% of young people in the UK experience suicidal thoughts [60]. ChildLine (UK) held 34,517 counselling sessions in 2013/14 with children who talked about suicide – a 116% increase since 2010/11 [61]. From 2003-13, 658 suicides were of people aged under 18 years, an average of 60 per year [62].

### 5.2.2. Lincolnshire

To estimate the need for child and adolescent mental health services in Lincolnshire, data was drawn from the National Child and Maternal Health Intelligence Network [63] and provided by LPFT via the Children's Commissioners in Lincolnshire County Council.

#### 5.2.2.1 Prevalence of mental health disorders in pre-school children

There is relatively limited data on the prevalence of mental health disorders in pre-school age children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% [64]. Applying this average prevalence rate to the population of Lincolnshire, there are an estimated 6,320 children aged 2 to 5 years inclusive who have mental ill health. This figure includes all mild, moderate and severe cases of a broad range of conditions (ADHD, oppositional defiant and conduct disorders, anxiety disorders, and depressive disorders).

#### 5.2.2.2 Prevalence of mental health disorders in school-age children

Using ICD-10 Classification of Mental and Behavioural Disorders, Green et al. [2] estimated the prevalence of mental health disorders in children aged 5 to 16 years. Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, Table 5.9 estimates the number of children with mental health disorders by age group and sex in Lincolnshire.

Table 5.8: estimated no. of children with mental health disorders by age group and sex, 2014

| | **All children** | | | **Boys** | | | **Girls** | | |
|---|---|---|---|---|---|---|---|---|---|
| | Aged 5-10 years | Aged 11-16 years | Aged 5-16 years | Aged 5-10 years | Aged 11-16 years | Aged 5-16 years | Aged 5-10 years | Aged 11-16 years | Aged 5-16 years |
| **Lincolnshire** | 3,410 | 5,325 | 8,735 | 2,265 | 2,965 | 5,230 | 1,150 | 2,360 | 3,505 |

*Source: ONS mid-year population estimates for Lincolnshire for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).National prevalence from Green, H. et al (2004).*

These prevalence rates can be subdivided by prevalence of conduct, emotional, hyperkinetic and less common disorders [2]. Table 5.10 shows the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in Lincolnshire, by applying these prevalence rates. Please note the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder.

Table 5.9: estimated no. of children in Lincolnshire with specific mental health disorders by age group and sex, 2014

| | All children | | Boys | | Girls | |
|---|---|---|---|---|---|---|
| | Aged 5-10 years | Aged 11-16 years | Aged 5-10 years | Aged 11-16 years | Aged 5-10 years | Aged 11-16 years |
| **Conduct disorders** | 2,210 | 3,075 | 1,580 | 1,910 | 630 | 1,165 |
| **Emotional disorders** | 1,050 | 2,360 | 475 | 950 | 575 | 1,415 |
| **Hyperkinetic disorders** | 750 | 670 | 650 | 565 | 100 | 105 |
| **Less common disorders** | 565 | 575 | 450 | 375 | 115 | 200 |

*Source: ONS mid-year population estimates for Lincolnshire for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).National prevalence from Green, H. et al (2004).*

#### 5.2.2.3 Prevalence of Autistic Spectrum Disorder (ASD) in children and young people

A study of 56,946 children in London estimated the prevalence of autism in children aged 9 to 10 years at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000 [65]. A separate study of autism-spectrum conditions using the Special Educational Needs (SEN) register and a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively [66]. The ratio of known to unknown cases is about 3:2. Taken together, these data suggest an estimated prevalence of 157 per 10,000, including previously undiagnosed cases.

Establishing prevalence rates for Autistic Spectrum Disorders is challenging for reasons that include the absence of long-term studies of psychiatric case registers and inconsistencies of definition over time and between locations. However, using the prevalence rates established by Baird et al. [65] and Baron-Cohen et al. [66], estimates of the number of children with ASD in Lincolnshire were generated and are presented in Table 5.11.

Table 5.10: estimated number of children with autistic spectrum disorders in 2014

| | Baird et al. (2009) | | | Baron-Cohen et al. (2009) |
|---|---|---|---|---|
| | Autism in children aged 9-10 years | Other ASDs in children aged 9-10 years | Total of all ASDs in children aged 9-10 years | Autism-spectrum conditions in children aged 5-9 years |
| **Lincolnshire** | 60 | 115 | 170 | 605 |

*Source: ONS mid-year population estimates for Lincolnshire for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).*

#### 5.2.2.4 Suicide and self-harm

Suicide is the leading cause of death in young people. Risk factors include male gender (up to three times as many men than women complete suicide) and mental health problems [67]. Young people who complete suicide are less likely to be in contact with mental health services compared with adults (14% vs 26%). Young men, who are more likely to complete suicide, are less likely to be in contact with mental health services than young women.

In Lincolnshire between September 2011 and January 2014 there were 4 confirmed cases of suicide and 2 suspected cases of suicide among young people aged under 18 years of age.

Self-harm is a key risk factor for suicide. In the UK, a 30-fold increase in risk of suicide, compared with the general population, was observed for a cohort of people aged 10-92 years of age who had attended an emergency department following deliberate self-harm. Suicide rates were highest in the first 6 months after presentation for the self-harm episode [68]. In Lincolnshire, hospital admissions as a result of self-harm in people ages 10-24 years in 2013/14 were significantly higher than the national average [69].

A HealthWatch survey of 1,251 young people in Lincolnshire identified that 20.5% (n=257) have ever self-harmed [19]. Reasons for self-harm included being bullied (40.2%), anxiety/hopelessness (46.7%), difficulties at school/college (52.1%), family problems (58.7%), depression (61.8%) and loneliness/isolation (38.2%). Almost two-fifths of young carers stated that they self-harm.

A key challenge supporting young people who self-harm is to be able to unpick self-harm behaviour and identify those young people whose self-harm is most likely to lead on to something else (e.g. attempted suicide).

### 5.2.3. Risk factors for mental ill health among children and young people

The reasons why a child or young person experiences mental health problems are likely to be complex. However, certain factors are known to influence the likelihood of someone experiencing problems. Key risk groups include:

- Children and young people with learning disabilities
- Looked after children
- Homeless children and those sleeping rough
- Children who are being or have been bullied

People with learning disabilities are more likely to experience mental health problems [70], although estimation of the population prevalence of learning disability is problematic and should be treated with caution. Emerson et al. [71] have calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years - 0.97%; 10 to 14 years - 2.26%; and 15 to 19 years - 2.67%. Table 5.13 applies these prevalence rates to estimate the number of children in Lincolnshire with learning disabilities.

Thus, as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with learning disability, with higher rates

for those with severe learning disabilities. Table 5.13 estimates the number of children with learning disabilities who also experience mental health problems in Lincolnshire.

Table 5.11: estimated number of children with a learning disability, and with a learning disability and mental health problems combined, in Lincolnshire in 2014

| | Children aged 5-9 years | Children aged 10-14 years | Children aged 15-19 years |
|---|---|---|---|
| **Learning disability** | 375 | 850 | 1,155 |
| **Learning disability and mental health problems** | 150 | 340 | 465 |

*Source: ONS mid-year population estimates for Lincolnshire for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Emerson E. at al (2004). The Foundation for People with Learning Disabilities (2002).*

Looked-after children are more likely to experience mental health problems [72]. Among children aged 5 to 17 years who are looked after by local authorities in England, 45% have a mental health disorder, 37% have clinically significant conduct disorders, 12% have emotional disorders (e.g. anxiety or depression), and 7% are hyperkinetic [73]. Prevalence varies by placement type; two-thirds of children in residential care have a mental health disorder compared with two-fifths of those placed with foster-carers or their birth parents.

Homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS) [74]. The estimated number of young people aged 16 to 24 sleeping rough in England in 2008/9 was 3200 [75], giving a rate of 51.3 per 100,000. Among 16 to 25 year olds sleeping rough in London, 67% had mental health problems [76]. Applying these rates to the population in Lincolnshire provides an estimate of 30 young people with mental health problems who are sleeping rough.

Bullying is a key concern for children and young people, with many children and young people affected by bullying at some time in their childhood. Helping children and young people to feel good about themselves, to enjoy relationships and to promote confidence and self-esteem has a positive impact on their development. Bullying affects children and young people in different ways, but particular groups of children and young people are more vulnerable than others. Where incidents of bullying are allowed to become persistent and continuous, the outcomes for those involved can be damaging educationally, physically, socially and emotionally.

There is an increased risk of suicidal ideation and suicide attempts associated with bullying behaviour and cyberbullying, with both bullying and peer victimization leading to suicidality, although this association varies by sex [77]. Cyberbullying can be difficult to escape given that many young people use technology frequently – whilst the home used to be a place of relative safety from bullying, through technology bullies can continue to harass their victims inside the home, increasing persistent and continuous bullying.

In addition, there is a growing use of the Internet as a source of information sharing around self-harm and suicide.

## 6. Local Services

Across Lincolnshire, both tier 2 (for mild to moderate mental ill health) and tier 3 (moderate to severe mental ill health) CAMHS and adults mental health services are provided by Lincolnshire Partnership Foundation Trust. Tier 4 services are commissioned by NHS England and provided by a range of providers across the country. The following chapter provides an overview of current services and service user and provider perspectives for adult and then child and adolescent mental health services. CAMHS is about to be restructured, so this report describes both the old and new CAMHS services (that will operate from 2016).

### 6.1. Adult Mental Health Services

People in Lincolnshire with mental ill health may access a wide range of primary, community and secondary care services to address their health needs.

Primary care services (e.g. GPs, dentists, opticians and pharmacies) 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 Quality and Outcomes Framework (QOF) is part of a voluntary incentive scheme, 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 on-going management of patients (such as developing and tracking comprehensive care plans, and recording blood pressure and body mass index). A separate set of indicators focuses on depression, and includes measures and standards for the initial diagnosis and clinical management of depression.

#### 6.1.1 Specialist mental health services in Lincolnshire

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 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. LPFT also provides a dementia & specialist older adult mental health service for people of any age experiencing needs associated with suspected or diagnosed dementia and for older adults presenting with complex mental health problems.

Services include:

- Community mental health service – providing care for people who are recovering from an on-going 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 – 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 – for people who are experiencing a severe, short-term episode of mental ill health that cannot be managed by the 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 a proactive approach to care and treatment, and a clear point of contact for servicemen and women, and veterans, whenever they need help, support or advice.

LPFT Specialist Services also 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, for example:

- Drug and Alcohol Recovery Team (DART) – provides support and treatment for anyone aged 18+ years who is experiencing problems with drugs and/or alcohol use. Addaction, commissioned by Lincolnshire County Council, also provide drug and alcohol services.
- Forensic mental health 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 – 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 unit aims 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.

To identify people in custody who may have mental health needs, Lincolnshire Police conduct a risk assessment on all individuals taken into custody. This includes risk assessment around suicide and self-harm. The risk assessment determines whether the individual can be held in a cell, or a detention room. There are also some 136 beds in Lincolnshire (health-based place of safety). If required, a medical professional will attend to look at the individual's immediate needs.

When an individual is released from custody (i.e. with no action) they undergo another risk assessment, and are given a care plan and a leaflet with contact details for key organisations that they might be able to access for support if required. If the individual is proceeding to court and/or prison, the police risk assessment conducted by the desk sergeant when they were taken into custody remains with them through the transfer process.

The Prison Service has fully integrated mental health care, from initial assessment to the provision of care under the Care Programme Approach (CPA). Since 1st October 2014 this service has been provided by Nottinghamshire Healthcare NHS Trust. There are challenges in providing mental health services to the prison population, for example where mental health services are provided off-site, appointments may be missed because there is limited resource to escort prisoners out of prison to their appointment. The prison service uses ACCT – Assessment, Care in Custody, Teamwork – to help the prison to monitor individuals who are self-harming and at risk of suicide more closely.

Continuity of treatment for prisoners on release can be disjointed. The referral to mental health services on release is a desk based exercise and there is no relationship with the Community Mental Health Team. The Prison Chaplaincy in HMP Lincoln highlighted the following key issues:

- On release, medication is not always available and/or picked up by offenders. There is a high risk of deterioration in mental health if people are not taking their medication.
- Prisoners can choose to have a volunteer mentor on release to support them with starting the benefit process, identifying accommodation, etc. Not all prisoners choose to have a mentor, therefore have to navigate the systems alone. Those that 'drop through the net' are usually the most vulnerable.
- Access into mainstream mental health services can be a lengthy and problematic process. Access to notes and records for those with mental health issues is often difficult, particularly for out of area offenders. There seems to be a revolving door around acceptance of referrals by mental health services particularly for complex cases, involving substance misuse, particularly from the crisis teams.

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.

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

- Improving Access to Psychological Therapies Programme (IAPT) – 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 – this service works alongside the primary mental health teams throughout Lincolnshire and 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.
- Eating Disorders Service – services to support people with an eating disorder, e.g. one-to-one sessions, nutritional advice, self-help materials, body image workshops community support and peer-led groups for sufferers and their families and friends.
- Employment Advisory Service – to support the needs of people with common mental health problems, such as anxiety and depression, who are having difficulties at work.

In addition to services provided by LPFT, Lincolnshire residents can also access some out-of-county services (e.g. Cygnet Health Care and the Priory Group).

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 here 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' PTSD programme).

A range of public health services are also available that may contribute towards improving mental health, for example:

- Therapeutic and pharmacological interventions to support problematic and dependent drug and alcohol users to become drug free provided by Addaction.
- A supervised administration scheme for methadone provided by community pharmacists.
- A Wellbeing Service that supports people to feel confident within their own homes.
- A service that assists offenders released on probation (e.g. with health assessments and accessing health and care services) provided by The Health Support Service.
- The Health Trainer Programme. Health Trainers help people to improve their physical health and mental wellbeing, including cutting down or stopping drinking alcohol or taking drugs, and supporting people who feel anxious, stressed or lacking in confidence.

In additional to LPFT mental health services across Lincolnshire, 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 to understand and deal with the factors that might have impacted on their mental health, e.g. debt, employment and substance misuse. The following outlines the services that support people at times of crisis and also help them to move forward towards recovery.

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 and individual's mental health condition and also the level of risk this might present to either 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 living in their own home and also help to provide a public understanding of mental health issues.

Direct payments: a service user that 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 to help meet their individual need(s) as set down in a support plan.

Best Interest Assessors: the Deprivation of Liberty Safeguards (DOLS) cover patients in hospitals and people on care homes registered under the Care Standards Act 2000; these apply where the individual has been placed under public or private arrangements. A test case recently also resulted in these Safeguards being extended to cover people that may be confined to their own homes against their own preference. 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 of the Health Act 2007 LPFT, acting on behalf of the Local Authority, implement and monitor the systems and processes designed to safeguard vulnerable adults in determining a lawful deprivation of liberty.

Where a mental Health assessor considers that an individual is being or likely to be deprived of their liberty, s/he must inform the Best Interest Assessor, who will carry out a further assessment to 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 and also those of anyone else that has an interest in the individual's welfare; for example, this could be 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
- The individual's needs including cultural, religious, spiritual and faith, family contact

Management of Adult Mental Health Professionals: under the Mental Health Section 75, LPFT manage and co-ordinate a service of Approved Mental Health professionals (AMPHs) for undertaking independent assessments of any person that may have a mental disorder that requires 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, sanctuary for those experiencing a mental health crisis and are staffed 24 hours per day. This service is provided in Lincoln and Boston under contract by the Richmond Fellowship.

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. Where a Police Officer considers an individual to have mental ill health and be in need of care, s/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 an individual for up to 72 hours, during which time the individual can be assessed by a mental health professional. This service is provided for children and young people as well as for adults.

Individuals detained under Section 136 have rights, such as access to legal advice, assessment and treatment by a health care professional and also for someone to be informed of their whereabouts. Owing to the short term duration of detainment under Section 136, access to legal advice is likely to be through a duty solicitor.

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

Finally, in additional to specialist mental health services and social care services, in Lincolnshire there is a range of voluntary and community sector organisations that support people with mental ill health. Many of these organisations are linked into a Managed Care Network (MCN) for mental health that was created to strengthen the support available to people once they are well enough to be discharged from LPFT services, as well as 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 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 MCN 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, aiming to help people to prevent, manage and recover from mental illness and to enjoy a good quality of life. 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.

In addition to services specifically for people with mental ill health, there is a broad range of more generic community and voluntary services that are available to support people with mental ill health. For example, the Citizens Advice Bureau (CAB), financial and benefits advice services (such as the East Lindsey Advice Project), physical activity organisations (such as Hill Holt Health and Lincolnshire Sport) and a number of faith based organisations (such as the Samaritans). These organisations work to support people who may have or are at risk of mental ill health, for example Lincolnshire CAB provided specialist debt advice to 1,202 clients between April and June 2015 (equating to over £5 million of debt) and 1,196 clients from July to September (equating to £2.6 million of debt). This advice supports people at risk of financial exclusion, who are at risk of mental ill health and suicide.

### 6.1.2 Accessing mental health services

#### 6.1.2.1 Non-emergency services

The majority of non-emergency referrals into the mental health service are through the patient's GP via the Single Point of Access. Once referred, patients will undergo an initial assessment of needs to help decide which services and treatment will best suit their problems.

Exceptions to this include access to Talking Therapies and the Drug and Alcohol Recovery Team, which can be through self-referral. Further, anyone can contact the Eating Disorder Service for a chat, with referrals to the service required to go through GPs.

For more specialist services, such as Adult Psychology, referrals are made either through the primary care service, or from other teams within the Trust such as psychiatric and recovery services. Direct referrals from GPs or service users are redirected into the primary care tams in the first instance, to determine whether needs can be met within the IAPT service.

For specialist older adult mental health services, whilst direct referrals are made through GPs via the Single Point of Access, referrals can also be made between professionals working in certain specialities.

From January 16th 2016, it will be possible for adults to self-refer into mental health services through the Single Point of Access.

#### 6.1.2.2 Emergency services

Emergency services are available for people who are experiencing a crisis and/or feel suicidal, as well as carers who feel threatened by the person that they are caring for.

For people in an emergency situation who are already accessing LPFT adult services, assessment and assistance may be available from the Crisis Resolution and Home Treatment team. A crisis is considered to be when normal methods of coping are not working, which can result in a rapid deterioration in mental health.

During the day (9am-5pm), people who have a care co-ordinator or key worker should contact them, and they may be referred into the crisis resolution service. Out of hours (5pm-9am) patients will have a crisis contingency plan to follow. Patients who have been discharged from mental health services in the past 12-months should have a discharge plan that explains what to do in an emergency.

For people experiencing a mental health crisis, two crisis houses, which are designed to provide short-term respite and sanctuary, are available in Lincoln and Spalding. These houses are staffed 24 hours a day and are run by a charitable organisation called 'Making Space' in partnership with LPFTs Crisis Resolution and Home Treatment team.

Anecdotal evidence from a range of sources (e.g. Lincolnshire's Rural Support Network and Rethink) suggests that this crisis referral process does not always work for patients. For example, the crisis team is unable to refer back into main stream mental health services and their expectations of what families can deal with, in supporting an individual with mental health, are often unrealistic. Developing an evidence base for how well this referral process works will enable the service to better meet patients' needs for crisis care.

For people who are not currently in contact with mental health services there are a range of services that can provide support in a crisis:

- The Samaritans, who offer a 24-hour helpline.
- SANE Line, a national out-of-hours telephone helpline offering emotional support and information for people affected by mental health problems (6pm-11pm every day).
- NHS 111, where trained nurses can give help and support 24 hours a day.

Lincolnshire has also trained over 2000 ASIST (Applied Suicide Intervention Skills Training) 'care-givers' who are in our communities to support people who are going through a crisis and to provide suicide first aid.

If the emergency has an immediate life threatening danger, the individual or carer should call 999. If there is no immediate risk of harm, help should be sought from a GP or in an emergency the local Accident and Emergency department, which will provide immediate advice and refer on to specialist mental health services if required.

If a police officer comes into contact with an individual he or she considers to have a mental illness, it is possible to arrange for care to be provided at a police station or at the Section 136 suite at the Peter Hodgkinson's Centre in Lincoln. The individual may be detained for up to 72 hours, during which time they may be assessed by a mental health professional.

## 6.2. LPFT Service Use

Mental health services are provided by a number of organisations in Lincolnshire. However, as the main provider of mental health services, data from Lincolnshire Partnership Foundation Trust (LPFT) was used as a proxy to understand service user demographics over a five-year period. The number of patients, split by age group and gender, who attended an LPFT contact between 2010 and 2015 is presented in Table 5.8.

Of total patients attending an LPFT contact between 2010 and 2015, the proportion of adults aged 66 years and older increased (from 20.4% in 2010 to 27.5% in 2015) and the proportion of adults aged 36-45 decreased (from 16.6% in 2010 to 12.1% in 2015). Most other age groups remained the same. Between 2010 and 2015 the gender distribution of clients remained stable at around 58% women and 42% men.

LPFT mental health services are available to all residents of and visitors to Lincolnshire based on need. No distinction in access to services is made between patients who are registered with GP practices in neighbouring counties (for example Lincolnshire residents who live in border areas of the county) and those who are registered with a GP in Lincolnshire. Visitors to the county are also eligible to access mental health services as needed, with payment for LPFT services recouped from their place of residence. In practice, this protocol may need consolidation among healthcare professionals.

Table 6.1: patients, split by age group and gender, who attended an LPFT contact 2010-15

| | Female | Male | Not known/ specified | Total | % of Total |
|---|---|---|---|---|---|
| **2010 to 2011** | **22310** | **16079** | **17** | **38406** | |
| 0-16 | 2211 | 2823 | 2 | 5036 | 13.1% |
| 17-25 | 3470 | 2147 | 2 | 5619 | 14.6% |
| 26-35 | 3228 | 2241 | 1 | 5470 | 14.2% |
| 36-45 | 3753 | 2611 | 3 | 6367 | 16.6% |
| 46-55 | 2921 | 2038 | 1 | 4960 | 12.9% |
| 56-65 | 1774 | 1337 | 1 | 3112 | 8.1% |
| 66 & Over | 4953 | 2882 | 7 | 7842 | 20.4% |
| **2011 to 2012** | **26272** | **18416** | **21** | **44709** | |
| 0-16 | 2350 | 2852 | 1 | 5203 | 11.6% |
| 17-25 | 4258 | 2744 | 9 | 7011 | 15.7% |
| 26-35 | 4030 | 2655 | 1 | 6686 | 15.0% |
| 36-45 | 4578 | 3022 | 2 | 7602 | 17.0% |
| 46-55 | 3500 | 2413 | 4 | 5917 | 13.2% |
| 56-65 | 2051 | 1516 | | 3567 | 8.0% |
| 66 & Over | 5505 | 3214 | 4 | 8723 | 19.5% |
| **2012 to 2013** | **27666** | **19786** | **24** | **47476** | |
| 0-16 | 2575 | 2809 | 2 | 5386 | 11.3% |
| 17-25 | 4297 | 2837 | 8 | 7142 | 15.0% |
| 26-35 | 4046 | 2865 | 1 | 6912 | 14.6% |
| 36-45 | 4480 | 3097 | 4 | 7581 | 16.0% |
| 46-55 | 3745 | 2685 | | 6430 | 13.5% |
| 56-65 | 2177 | 1726 | 2 | 3905 | 8.2% |
| 66 & Over | 6346 | 3767 | 7 | 10120 | 21.3% |
| **2013 to 2014** | **25158** | **17949** | **7** | **43114** | |
| 0-16 | 2608 | 2363 | 1 | 4972 | 11.5% |
| 17-25 | 3895 | 2627 | | 6522 | 15.1% |
| 26-35 | 3574 | 2514 | 2 | 6090 | 14.1% |
| 36-45 | 3794 | 2704 | 1 | 6499 | 15.1% |
| 46-55 | 3336 | 2408 | | 5744 | 13.3% |
| 56-65 | 2011 | 1627 | 2 | 3640 | 8.4% |
| 66 & Over | 5940 | 3706 | 1 | 9647 | 22.4% |
| **2014 to 2015** | **22632** | **16877** | **5** | **39514** | |
| 0-16 | 3197 | 2701 | 2 | 5900 | 14.9% |
| 17-25 | 3158 | 2285 | | 5443 | 13.8% |
| 26-35 | 2705 | 2171 | | 4876 | 12.3% |
| 36-45 | 2667 | 2102 | 3 | 4772 | 12.1% |
| 46-55 | 2559 | 2041 | | 4600 | 11.64% |
| 56-65 | 1670 | 1370 | | 3040 | 7.69% |
| 66 & Over | 6676 | 4207 | | 10883 | 27.54% |

*Source: Lincolnshire Partnership Foundation Trust*

### 6.2.1 LPFT waiting times

The current target is for 95% of outpatients to wait no longer than 18 weeks for an appointment. In 2014-15, 98.5% of adult outpatients on the waiting list for mental health services were seen within the 18 week limit.

Between 2011 and 2014, around 95% of patients were seen within 18 weeks (2011-12, 95.8%; 2012-13, 94.4%; 2013-14, 95.6%). Thus, the proportion of patients receiving an outpatient appointment within the 18 week target has increased over time.

Waiting times for access to specific mental health services with the LPFT portfolio are varied and the target of 95% access within 18 weeks is often missed. For example, in 2014-15, just over half (54.4%) of patients had access to dynamic psychotherapy services within the 18 week waiting time target. In the same time period, less than a quarter (23.7%) of outpatients had access to psychological therapies within the 18 week target waiting time.

The 'did not attend' (DNA) rate for appointments is higher than the target for both first and follow-up appointments. In 2014-15, 16.9% of first appointments were DNA (target 10%) and 16.3% of follow-up appointments were DNA (target 15%). The DNA rate for 1st appointments has increased slightly over time, from 14.4% in 2011-12. The DNA rate for follow-up appointments has also increased slightly over time, from 14.7%. Decreasing the DNA rate should improve waiting times for LPFT services.

### 6.3. Adult User Perspectives

Service user perspectives were collated from two sources:

- views generated through questionnaires circulated to users of Lincolnshire mental health services in March 2014 (n=75) [78]; and
- a HealthWatch Lincolnshire survey of mental health services from the perspectives of current users and those waiting to enter the assessment and treatment pathways conducted in September to November 2014 (n=126) [18].

Respondents shared a range of positive and negative experiences of mental health services.

The key themes that emerged from these two surveys are summarised below.

**Waiting times** – waiting times varied across the county [78]. In East Lindsey more than half reported waiting two weeks or less to access a service, but elsewhere more patients reported long waiting times. Many (36.5%) reported waiting over 6 months for an assessment, which lead to high level of dissatisfaction [18].

**Cancelled appointments** – cancelled appointments for people feeling on the verge of crisis were deemed to be unacceptable.

**Accessibility of services** - accessibility is important to patients. 70% of patients are able to access a service within 5 miles of home, and 12% have to travel more than 10 miles [78].

**Service satisfaction** – many current service users reported poor service experience ratings (50% of users of certain services) [18]. Self-referrals were frequently the most satisfied with their service experience [78]. Participants described the importance of service quality, as one instance of poor or rushed service can lead to feelings of stigma and disengagement with services.

**GPs** - respondents report frequently visiting their GP in the past 12 months (35% more than 6 times). Service users would like to see longer GP appointments for mental health consultations. There were mixed views on GP listening skills - some respondents felt that their GP was not good at listening whilst others reported that their GP was excellent [18].

Service users would like to see:

- more support groups and improved awareness of those that already exist;
- an extension of services to support wider family members and carers (e.g. support groups, tailored information, courses);
- drop-in centres, a telephone listening service and daytime activity centres;
- better training for all healthcare staff to raise awareness and understanding of how to deal with patients suffering with mental ill health; and
- better communication between health professionals.

In a separate survey of service providers [78] strategies identified to improve mental health services included commissioning and delivery services working more closely together (e.g. to improve communication and signposting) and improved resources to ensure quality of service, reduced waiting times and improved accessibility.

Adult user perspectives have also been shared through case studies collated by case workers in the community (e.g. through Rethink). Such case studies highlight challenges in accessing appropriate support for complex cases (e.g. people with comorbidities or complex housing or other needs). Clients report being passed around different services and failing to access timely preventive mental health support. Such cases also often present challenges for carers, who may be able to recognise when someone is one the verge of a mental health crisis but not know what to do about it.

### 6.4. CAMHS

CAMHS provide services across Lincolnshire with clinic bases in Lincoln, Gainsborough, Louth, Boston, Spalding, and Grantham. There are also satellite clinics provided in Sleaford, Bourne, Mablethorpe and Skegness. Based across these locations, multi-disciplinary CAMHS teams can help with a range of complex mental and emotional health issues, including anxiety, depression, trauma, eating disorders and self-harm.

The current CAMHS service is a tier based service, operating across 4 tiers of provision.

A large proportion of children and young people with mental health needs will be seen within tier 1 services, which are provided by practitioners who are not mental health specialists working in universal services (e.g. GPs and teachers). A range of education and training sessions for tier 1 practitioners are provided by specialists working within the CAMHS team.

Tier 2 or 'Primary Mental Health Services' are provided by a team of specialised clinicians. They work with children, young people and their families, where the young person is experiencing mild to moderate mental health difficulties. They are part of the Mental Health and Emotional Well-being Service along with KOOTH online counselling (https://www.kooth.com/ - an on-line counselling and message board service available to young people in Lincolnshire). Their focus is early intervention and mental health awareness which in addition to work with the child/young person includes advice, consultation and training to other professionals on mental health issues. They offer a wide range of interventions to children and young people including individual therapies, group work and family therapy/support. Currently, the Primary Mental Health Team will consider direct referrals from a range of agencies including social services, school nurses and Lincolnshire

Schools via the ‘schools pathway’, and educational psychologists. In addition, tier 2 services, as with tier 3 CAMHS, can be accessed via GP referral.

Tier 3 or 'Specialist Services' are provided across the county by multi-disciplinary teams who offer services to children and young people with moderate or severe mental health conditions, usually within a clinic setting. Referrals to tier 3 teams are generally made by GPs or other doctors (such as paediatricians) following their initial assessment; they may also be made by social workers where appropriate. Following our assessment the service may offer a variety of individual, family, carer and group interventions tailored to individual needs, or recommend alternative services. Tier 3 services also work in partnership with other agencies, such as health, schools and other children’s services, where appropriate. Sometimes this is achieved through a 'Team Around the Child' process (known as TAC) or through Child In Need processes and at times, Safeguarding.

CAMHS also provides specific services for some vulnerable groups including:

- A specialist service for 'Looked After Children' and to young people leaving care. These services provide training for foster carers and therapeutic interventions for the children/young people.
- Specialist CAMHS nursing input to Youth Offending Services
- Self-harm practitioners assess children and young people who are admitted on to Paediatric wards following an incident of self-harm.
- Specialist learning disabilities practitioners. This team provides mental health services for children, families and the schools of young people diagnosed with moderate to severe learning disabilities.
- Input for emotional and well-being support to the Diabetic Services for young people within Lincolnshire.
- Forensic assessments and consultation to other agencies.

The types of help that can be provided may include family therapy, individual therapy, cognitive behavioural therapy, solution focused brief therapy, group work, psychiatric intervention, psychotherapeutic intervention, trauma interventions (e.g. EMDR), counselling, and where necessary, medication.

Tier 4 inpatient services (e.g. inpatient eating disorder treatment) are commissioned separately by NHS England, providing tertiary level care and treatment to young people with severe and/or complex mental disorders.

Following a year-long stakeholder consultation that involved a wide range of organisations and groups with an interest in CAMHS, the current CAMHS service is currently being redesigned and it is anticipated that the new service will be implemented in 2016.

In addition to CAMHS provision there are a number of initiatives, both in Lincolnshire and nationally that offer mental health support for young people, for example:

- The Beacon Project, which supports the development of emotional resilience in pupils who are identified as needing support with confidence building and emotional resilience.
- Lost Luggage, which is a young person led lobbying/awareness raising/campaigning group, comprised of young people who are or have been, using the services of LPFT. Funding for activities is secured through fundraising by the young people themselves,

whilst staff support and venues are provided by LPFT. Although there is an element of peer support within this group, the main role is directed at helping remove the stigma around mental health.

- Mental Health Prevention. Mental Health First Aid Training is a national programme of low level mental ill health support, and preventative strategies. In Lincolnshire the programme is self-funded. Whilst this is not specifically aimed at young people, there are a number of Lincolnshire organisations who use this preventative programme, including Lincoln University [79].
- Online training to educate professionals about suicide and self-harm in young people. This online training has been developed with Safeguarding Boards to educate professionals about the warning signs, risk factors and actions to take should they suspect a child or young person is self-harming or having suicidal thoughts.

### 6.4.1 Crisis care

The routes to accessing support during a crisis depend on whether the child or young person is already in contact with CAMHS.

Currently, for children and young people who are already in contact with CAMHS, if it is during working hours (Monday-Friday, 9am-5pm) then they should contact the person they are working with (e.g. their key worker). Outside of these hours (Monday-Friday, 5pm-9am and at weekends) they should either contact their GP or the Crisis Intervention Team. If it is an emergency then they should attend their local Accident and Emergency department.

For children and young people who are not already in contact with CAMHS, in the first instance their GP or social worker should be contacted to discuss a referral. However, in an emergency or out of hours it may be necessary to attend the local Accident and Emergency department, if appropriate.

There are also a number of other services who might be able to provide some support during a crisis, for example:

- The Samaritans, who offer a 24-hour helpline.
- ChildLine, who offer telephone and online chat support.

Within the new CAMH service described below (Section 6.7) and to be launched in Spring 2016, children and young people who experience severe mental health difficulties will be able to access an emergency assessment through a Single Point of Referral (SPR). This will include a 24/7 on-call service, urgent assessment (within 4 hours by telephone and 13 hours face-to-face), and coordinate with colleagues working in a range of settings (e.g. A&E and paediatrics) to provide consultations and advice.

## 6.5. CAMHS Use

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at tiers 1-4 have been provided by Kurtz [80]. Table 5.12 shows these estimates for the population aged 17 and under in Lincolnshire.

Table 6.2: estimated number of children/young people who may experience mental health problems appropriate for a response from CAMHS in 2014

| | Tier 1 (2014) | Tier 2 (2014) | Tier 3 (2014) | Tier 4 (2014) |
|---|---|---|---|---|
| **Lincolnshire** | 21,210 | 9,900 | 2,620 | 110 |

*Source: ONS mid-year population estimates for Lincolnshire for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Kurtz, Z. (1996).*

The total number of referrals to Lincolnshire CAMHS at tier 2 and above between April 2014 and March 2015 was 4,569. This number is unlikely to represent single individual cases but includes some individuals with more than one condition requiring CAMHS intervention or repeat referrals during the year.

The majority were GP referrals (65.5%), with the second commonest referral through 'Other Medical' services (21.3%) and third commonest through schools (4.9%). The average number of open cases held by the whole service each month is 1912. 66% of the cases are held within tier 3, 22.5% are within Primary Mental Health with the remaining 11.5% of cases held within the smaller teams for specific vulnerable groups (LAC, YOS, LD, Community Forensic, Diabetes). In 2014 there were 5 referrals to tier 4 services.

Data on the reasons for presenting to Lincolnshire CAMHS at tier 2 and tier 3 in 2013-14 show that the three most common presenting conditions were anxiety, depression and low mood (33%), behavioural problems (22%) and self-harm (17%). This does not consider those young people who may have been supported in tier 1 services or whose mental health problems having not been identified. In addition, during this period, the Lincolnshire service did not receive any referrals for children with Autistic Spectrum Disorders, however during this time, Children with Autistic Spectrum Disorders were seen by another service and so the data was is not included in these figure.

Comparing the actual number of referrals to CAMHS with the estimates provided by Kurtz on children and young people who may experience mental health problems appropriate to a response by CAMHS, there is a large gap between the number accessing services and estimated need. This could mean either that there is a large unmet need for CAMHS services in Lincolnshire, or that the prevalence of mental ill health among children and young people in Lincolnshire is lower than national prevalence estimates suggest.

### 6.5.1 Waiting times

Lincolnshire has ambitious and stretching targets in place for CAMHS. The tier 2 aim is to see 95% of referrals within 6 weeks and the tier 3 aim is to see 95% of patients within 12 weeks. For vulnerable groups such as Looked After Children and Youth Offenders these waiting time are lower at 4 weeks and 3 weeks respectively.

The average waiting time for tier 2 services between April 2014 and March 2015 was 7 weeks, and the average wait for tier 3 services was 3 weeks. Between April 2013 and March 2014, the average wait was 5 weeks for tier 2 services and 2 weeks for tier 3 services. Between April 2012 and March 2013, the average wait for tier 2 services was 4 weeks, with no comparable tier 3 data for this period. Thus average waiting times have increased over

time; however, demand on the service has also increased considerably from 870 referrals in 2012 to 4,569 referrals in 2014.

## 6.6. CAMHS User Perspectives

A HealthWatch Lincolnshire survey of children and young people identified a range of positive and negative experiences of mental health services, including CAMHS. Overall, there was a 25% dissatisfaction rate with more recognised services (such as CAMHS, ChildLine and NHS111) [19], although many young people also described positive experiences of services.

Consultation for the new CAMHs included stakeholder engagement to identify factors identified as important to consider during service redevelopment. External stakeholders (e.g. schools, the voluntary and community sector, and parents, children and young people) shared a range of key themes including:

- Access
  - A single point of access that allows open referrals
  - Out-of-hours access
  - Clear reasons for referral being declined, with signposting to other support
  - Reduced waiting times at Tier 3
- Intervention
  - A single services that address emotional well-being issues
  - Family therapy and more creative therapies (alternative to talking therapies)
  - Up-skill CAMHS staff to work with children with a learning disability at all Tiers.
  - Plan for transition earlier; all young people open to CAMHS at age 17 should have an assessment by adult mental health services.
- Discharge
  - Don't discharge cases so quickly because children do not attend. These are often the children that need to be seen most.
  - Inform other professionals involved with the child of a planned discharge.
  - Reduce in-eligible discharges by improving the quality of the initial triage.
- Integration
  - Improve information sharing between CAMHS and Social Care, Schools, Education Psychology, School Nurses, Paediatrics and GPs.
  - Improve communication in general between CAMHS and other professionals. CAMHS to be more accessible and staff seen more in the community e.g. running clinics from GP surgeries and children's centres.

This is not an exhaustive list of issues raised by key stakeholders, but rather some of the key themes highlighted during the engagement process. This feedback was used to develop a new CAMHS service for Lincolnshire.

## 6.7. New Child and Adolescent Mental Health Service

Following a service review and successful funding application process, a new Child and Adolescent Mental Health Service (CAMHS) is going to commence in spring 2016. Changes to the CAMHS model reflect new legislation, best practice guidance, such as "Future In

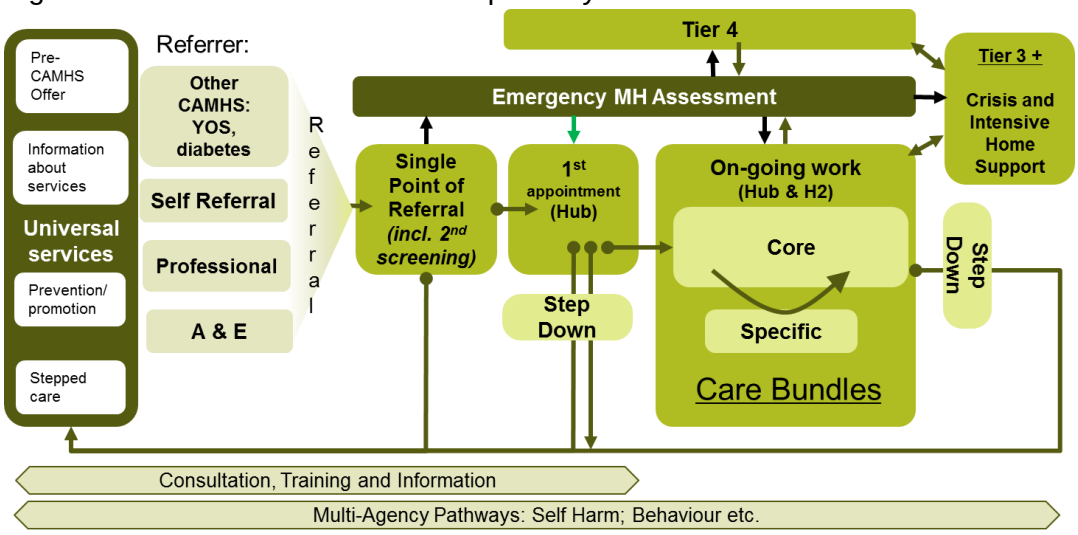
Mind" and the views of the 55 stakeholder groups engaged as part of the review, including GP's, Schools, Young People, Social Workers, Health Providers and the third sector.

Lincolnshire County Council and Lincolnshire Clinical Commissioning Groups collectively put forward a successful bid for Local Transformation money, that would improve the offer of mental health and emotional wellbeing services for Lincolnshire children. Upon achievement of this funding, a new and improved model has been designed, which includes elements such as extended opening hours, reduced emergency and routine wait times, accessible locations, a tierless, step up-step down model and the establishment of an emergency, out of hours, community based service (Tier 3+).

The core CAMH Service is funded by the Local Authority and the four Lincolnshire Clinical Commissioning Groups, through a Section 75 Agreement.

Detailed below is more information on the new CAMH service (and see Figure 6.1). The procurement, letting and contract management of Lincolnshire CAMHS is held within the remit of the Children's Commissioning Team. Any queries should be directed to Catherine.southcott@lincolnshire.gov.uk.

Figure 6.1: illustration of the CAMHS pathway in Lincolnshire




### 6.7.1 Universal Services (formerly Tier 1)

CAMHS works in partnership, support of, and with wider universal and emotional well-being services to provide a coordinated and holistic approach to supporting children and young people's mental health. In particular, the new service will engage with GPs, Community Paediatricians, A&E professionals, Health Visitors, schools, school nurses, colleges, further education, third sector agencies and Lincolnshire County Council's commissioned and provider services.

Universal Services will deliver a range of mental health prevention and promotion activities, an anti-stigma programme, self-help materials and some direct support through counselling or individual brief interventions, either online, telephone or face to face. CAMHS will support the development of accessible, quality information on mental health for professionals,

children, young people and their families that is up-to-date and available in a range of mediums, both digital and written as well as comprehensive information about CAMH services. Universal Services will also include a directory of local and national emotional well-being and mental health services that all children, young people and their families can access.

### 6.7.2 Single Point of Referral (SPR)

All referrals to the CAMH Service will be made through a dedicated Customer Service Centre (the SPR). Any professional or agency working with a child or young person can make referrals via the SPR, and in addition children, young people and parents/carers can refer via the SPR. The Customer Service Centre will be available 365 days per year, 24 hours per day. Initial contact for referrals can be made by telephone. All children and young people will be screened on referral through the SPR, and directed to the appropriate services based on the outcome of that screening process (e.g. CAMH service or alternative, more appropriate support).

For children and young people who experience severe mental health difficulties that require emergency assessment, the new CAMHS has a set of pathways to enable assessment of needs and immediate determination of appropriate care arrangements. CAMHS will provide a 24/7 on-call service, urgent assessment (within 4 hours by telephone and 13 hours face-to-face), and coordinate with colleagues working in a range of settings (e.g. A&E and paediatrics) to provide consultations and advice.

### 6.7.3 The Integrated CAMH Service (formerly Tier 2 - 3)

The service will be facilitated through a single CAMHS management centre that will have an overview of all incoming referrals from the SPR, and a role in monitoring and managing the flow of children and young people through the service. Children and young people referred to the Integrated CAMH Service through the SPR will have access to a range of evidence-based services, as appropriate to their needs, for example cognitive behavioural therapy, psychotherapy and neuropsychological assessment.

The integrated CAMH Service will also provide extended work interventions that will typically be of a higher intensity or duration and may require a specific skill set or a multi-disciplinary team to provide support as necessary. Extended work targets specific symptoms or problems and complements the core range of evidence-based services. Regular reviews will be conducted with the child, young person and their family, and with the relevant multi-disciplinary team members, to assess the effect of interventions and ensure the timely execution of a move back to a lower level of intervention or an agreed and appropriate discharge or transition from care protocol.

CAMH Services will be available for needs including;

- Anxiety
- Self-Harm or Suicidal Thinking
- Depression
- Bipolar Affective Disorder
- Obsessive Compulsive Disorder
- Psychosis
- Eating Problems and Disorders

- Mental Health impact on physical health or Psychological impact of physical health Behaviour Problems (including in relation to ASD or ADHD)
- Stress or response to trauma (including Post Sexual Abuse with or without presenting Mental Health Issues)
- Bereavement (prolonged grief response)
- Severe ADHD with or without other associated mental health concerns
- Neuro-psychiatric disorders
- Attachment Disorder

### 6.7.4 CAMHS Tier 3 Plus Service

Tier 3 plus services will provide specialist CAMHS intensive community based outreach for children, young people and families whose high levels of complex needs cannot be met by the existing integrated CAMHS (Tier 2 and 3) provision (e.g. due to risk or severity of mental illness). The service aims to reduce the need for in-patient admissions and length of stay in cases where admission is necessary, as well as managing discharge back to the community.

The service will be integrated within the CAMHS service model to ensure continuity of care and enabling delivery of step-up and step-down care. This will also provides opportunities for CAMHS team members to identify the need for intensive outreach pro-actively.

Tier 3 plus services will offer a high intensity, time limited programme of intervention, linked to existing care plans, without duplication of services. The service will be available for extended hours and will work with children, young people and their families, to ensure responsive, appropriate and flexible care based on need. The service will have strong links with other agencies that work with children (e.g. Local Authorities and the voluntary/community sector) to create a support network around the young person and prevent future crisis episodes.

The CAMH service is monitored through quarterly contract management meetings and in addition, receives strategic steer from the Women and Children's Board and Health and Wellbeing Board. At an operational level, the contract receives a monthly risk and performance rating, which reflect any interim issues.

The changes to the new service should improve outcomes for young people, reduce the use of high-cost, short-term out of county placements, emphasise participation and engagement with young people, reduce inappropriate referrals, provide an improved and transparent offer for young people and increase the consistency of experience for service users.

# 7. Discussion and Recommendations

## 7.1. Discussion

This health needs assessment has estimated the prevalence of a range of mental health conditions in the population of Lincolnshire, identified key risk factors for mental ill health and suicide, and presented an overview of local mental health services to support people with mental ill health.

Key findings on the prevalence of mental ill health include:

- 7.3% of adults aged 18 years and older are on the depression register, an estimated 18,209 adults in are currently living with PTSD and in the past week 98,328 adults in Lincolnshire have suffered from a CMD.
- Between 2011 and 2013, 184 people aged 15 years and older died from suicide and injury undetermined in Lincolnshire.
- Between September 2011 and January 2014, there were 4 confirmed and 2 suspected cases of suicide among people aged less than 18 years of age.
- Between 2011 and 2013, there were 2,448 adult emergency admissions to hospital for intentional self-harm.

There are a number of risk factors for mental ill health in adults and children. It is important to recognise that risk factors often do not act in isolation, but instead interact within individuals to generate complex individual cases. This necessitates a holistic approach to mental health support that considers the range of factors that may be impacting on individual mental 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. 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.

Data on the mental ill health needs of certain groups at elevated risk of mental ill health and suicide is limited (e.g. minority ethnic groups). Better identification and recording process in these population subgroups would support a more nuanced understanding of mental health needs moving forward.

Mental health service provision is commissioned separately for children and adults:

- In 2014-2015 there were 39,514 LPFT adult mental health service contacts.
- In 2014-2015 there were 4,569 referrals to CAMHS tier 2 and above. The three most common presenting conditions were anxiety, depression and low mood (33%), behavioural problems (22%) and self-harm (17%)

Both services support or provide a range of interventions across three tiers, from a universal service delivered by non-mental health specialists at tier 1, through tier 2 services for mild to moderate mental ill health, and tier 3 specialist services for severe mental ill health. Tier 4 inpatient services are commissioned separately by NHS England.

In addition to CAMHS and Adult Services, a wide range of community and voluntary sector organisations operate to support people with mental health needs. Information about these services is not always easy to access, for the general public, general practitioners or other stakeholders. As such, bringing together information on mental health services into one place so that both users and provider organisations are clear what services and support networks are available and how to access them could be a valuable innovation. This could also help to manage client expectation of services and signpost to the most appropriate service for their needs.

KOOTH has been identified as an excellent resource for young people with mental ill health and providing a similar resource for adults could help to increase access to timely support at an early stage of mental ill health.

This mental illness health needs assessment has been developed to inform the development of a suicide action plan for Lincolnshire. However, it is important to remember that not all people who complete suicide are in contact with mental health services; indeed on average it is estimated that fewer than half of adults and a quarter of children and young people who complete suicide had previous contact with mental health services. As such, it is important to consider this needs assessment alongside other key evidence on suicide and risk factors for suicide in Lincolnshire. The 2014 suicide audit presents the most recently available information on suicide in Lincolnshire, reporting on the key factors perceived to have contributed to suicides completed in 2011 [14].

## 7.2. Recommendations

Six broad recommendations for Lincolnshire have been identified from this work.

### 1. Identification and recording of mental ill health

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).

### 2. Timely access to mental health services based on needs

People in Lincolnshire should have timely access to mental health services based on their needs. Whilst most adult outpatients are initially seen within the 18 week target, timely access to specific services such as IAPT and dynamic psychotherapy could be improved.

Further, the strengths and challenges of the current crisis care management process should be examined to develop an evidence base for how well this referral process works. Such an evidence base will support the service to meet patient needs for crisis care.

### 3. Data Sharing between different organisations

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.

**4. 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 of information to, and by, all agencies. This would help to raise awareness, signpost to the most appropriate services and manage expectations for children and adults services.

Further, whilst a number of crisis care services are currently available (e.g. specialist mental health crisis resolution and home treatment services), developing a clear, comprehensive network of information on the support available for people in crisis will enable the better signposting of people in crisis to the appropriate support.

**5. Service User Consultation**

Service user feedback is important for understanding and improving the experience of service users. 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.

**6. Professional Skills**

It is important that all staff have a basic understanding of how to promote mental wellbeing among themselves and the general public. Training provided for front line staff working across a range of specialist services (e.g. mental health) and universal services (e.g. GPs, health visitors, the police, teachers, customer service centre operatives etc.) that may come into contact with people with wellbeing or mental health needs should be improved and made more consistent. It should cover topics such as listening skills, empathy, respect and building of trust, and should adopt a holistic approach to the treatment of those with wellbeing and mental ill health needs. The community and voluntary sector should also be supported to upskill volunteers, empowering them to have conversations to support mental health and wellbeing with people using their services. 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.

## 8. Bibliography


[1] Health and Social Care Information Centre, “Adult Psychiatric Morbidity in England, 2007. Results of a household survey.,” The NHS Information Centre for health and social care, Leeds, 2009.

[2] H. Green, A. McGinnity, H. Meltzer, T. Ford and R. Goodman, “Mental Health of Children and Young People in Great Britain 2004,” Office for National Statistics, London, 2005.

[3] Department of Health, “No health without mental health: a cross-government mental health outcomes strategy for people of all ages,” Stationary Office, London, 2011.

[4] Department of Health, “Closing the Gap: Priorities for essential change in mental health,” Stationary Office, London, 2014.

[5] C. Willinsky and A. Anderson, “Analysis of Best Practices in Mental Health Promotion across the Lifespan. Final Report,” CAMH, Toronto, 2003.

[6] C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea, “Long-term conditions and mental health: The cost of co-morbidities,” The Kings Fund, London, 2012.

[7] Office for National Statistics, “Better Or Worse: A Follow-Up Study Of The Mental Health Of Adults In Great Britain,” The Stationary Office, London, 2003.

[8] J. Randall, N. Nickel and I. Colman, “Contagion from Peer Suicidal Behavior in a Representative Sample of American Adolescents,” *Journal of Affective Disorders,* vol. 186, pp. 219-225, 2015.

[9] P. Qin, E. Agerbo and P. Mortensen, “Suicide Risk in Relation to Family History of Completed Suicide and Psychiatric Disorders: A Nested Case-control Study Based on Longitudinal Registers,” *The Lancet,* vol. 170, pp. 1126-1130, 2002.

[10] K. Hor and M. Taylor, “Suicide and Schizophrenia: A Systematic Review of Rates and Risk Factors,” vol. 24.4S, 2010.

[11] S. Nilsson, C. Feodor, R. Hjorthoj, A. Erlangsen and M. Nordentoft, “Suicide and Unintentional Injury Mortality among Homeless People: A Danish Nationwide Register-based Cohort Study,” *European Journal of Public Health,* vol. 24, pp. 50-56, 2013.

[12] A. Milner, A. Page and A. Lamontagne, “Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis,” *PLOS One,* vol. 8, 2014.

[13] Department of Health, “Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives.,” The Stationary Office, London, 2015.

[14] Lincolnshire County Council, “Suicide and Self-Harm 2014 Annual Report,” Lincolnshire County Council, Lincoln, 2014.

[15] Lincolnshire County Council, “Lincolnshire Joint Strategy for Dementia 2014-2017,” Lincolnshire County Council, Lincoln, 2014.

[16] Lincolnshire County Council, “Joint Carers Strategy 2014-2018,” Lincolnshire County Council, Lincoln, 2014.

[17] Lincolnshire County Council, “Substance Misuse Health Needs Assessment for Lincolnshire,” Lincolnshire County Council, Lincoln, 2015.

[18] Healthwatch Lincolnshire, “Service Users, Patients and Carers views on Mental Health

Services: Interim Report," Healthwatch Lincolnshire, Boston, 2014.

[19] Healthwatch Lincolnshire, ""Hear our voice": children and young people of Lincolnshire," Healthwatch Lincolnshire, Boston, 2014.

[20] Department of Health, "A mandate from the Government to NHS England: April 2014 to March 2015," Department of Health, London, 2014.

[21] HM Government, "Health and Social Care Act 2012," Crown Copyright, London, 2012.

[22] Department of Health, "NHS Outcomes Framework 2014 to 2015," Department of Health, London, 2013.

[23] Department of Health, "Suicide prevention strategy for England," The Stationary Office, London, 2012.

[24] Lincolnshire County Council, "Annual Report of the Director of Public Health on the health of the people of Lincolnshire," Lincolnshire County Council, Lincoln, 2015.

[25] Public Health England, "Public Health Outcomes Framework," Public Health England, London, 2015.

[26] Department of Health/Department for Children, Families and Schools, "Healthy Child Programme: Pregnancy and the First Five Years of Life," Department of Health, London, 2009.

[27] Children and Young People's Health Outcomes Forum, "Report of the children and young people's health outcomes forum - mental health sub-group," Children and Young People's Health Outcomes Forum, London, 2012.

[28] NHS England, "Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report," NHS England, London, 2014.

[29] House of Commons Health Select Committee, "Children's and adolescent mental health and CAMHS," 2014. [Online]. Available: http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/. [Accessed 17 September 2015].

[30] NHS England, "Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing," NHS England, London, 2014.

[31] Mental Health Foundation, "What are mental health problems?," [Online]. Available: http://www.mentalhealth.org.uk/help-information/an-introduction-to-mental-health/what-are-mental-health-problems/. [Accessed 30 September 2015].

[32] National Institute for Health and Care Excellence, "Common Mental Health Disorders - Identification and Pathways to Care - CG123," NICE, London, 2011.

[33] Health and Social Care Information Centre, "Mental Health," [Online]. Available: http://www.hscic.gov.uk/mental heatlh. [Accessed 27 August 2015].

[34] Health and Social Care Information Centre, "Monthly Mental Health Minimum Data Set (MHMDS) Reports, England - August 2014 summary statistics and related information," 2014. [Online]. Available: http://www.hscic.gov.uk/article/2021/Website-Search?productid=16444&q=Title%3a+%22Monthly+Mental+Health+Minimum+Data+Set+(MHMDS)+Reports%22&sort=Most+recent&size=10&page=1&area=both#top. [Accessed 27 August 2015].

[35] The Health and Social Care Information Centre, "Adult psychiatric morbidity in England, 2007 Results of a household survey," HSCIC, Leeds, 2009.

[36] Health and Social Care Information Centre, "Mortality from Suicide 2011-2013 pooled," Crown Copyright, London, 2014.

[37] Royal College of Psychiatrists, “Self-harm, suicide and risk: a summary.,” Royal College of Psychiatrists, London, 2010.

[38] World Health Organisation, “Abuse (drug, alcohol, chemical, substance or psychoactive substance),” WHO, Geneva, 2015.

[39] M. Stafford and M. Marmot, “Neighbourhood deprivation and health: does it affect us all equally?,” *International Journal of Epidemiology,* vol. 32, pp. 357-66, 2003.

[40] B. Gill, H. Meltzer and K. Hinds, “The prevalence of psychiatric morbidity among homeless adults,” *International Review of Psychiatry,* vol. 15, pp. 134-40, 2003.

[41] Office for National Statistics, “Statutory homelessness in England,” Department for Communities and Local Government, London, 2015.

[42] H. Meltzer, P. Bebbington, T. Brugha, R. Jenkins, S. McManus and M. Dennis, “Personal debt and suicidal ideation.,” *Psychological Medicine,* vol. 41, pp. 771-778, 2011.

[43] NOMIS, “Labour Market Profile - Lincolnshire,” Office for National Statistics, Newport, 2015.

[44] V. Soni Raleigh, “Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales.,” *Ethnicity and Disease,* vol. 1, pp. 55-65, 1996.

[45] Lincolnshire County Council, “Ensuring Inclusive Healthcare in Lincolnshire,” Lincolnshire County Council, Lincoln, 2013.

[46] Ministry of Justice, “Safety in Custody Statistics England and Wales Deaths in Custody to September 2014 Assaults and Self-harm to June 2014,” Office for National Statistics, London, 2014.

[47] HM Chief Inspector of Prisons, “Report on a full unannounced inspection of HMP Lincoln 20-24 August 2012.,” HM Inspectorate of Prisons, London, 2012.

[48] HM Chief Inspector of Prisons, “Report on an unannounced short follow-up inspection of HMP North Sea Camp 16-18 April 2012,” HM Inspectorate of Prisons, London, 2012.

[49] NHS Lincolnshire, “Health Needs Assessment for HMP Lincoln,” Lincolnshire Public Health Directorate, Lincoln, 2011.

[50] NHS Lincolnshire, “Health Needs Assessment for HMP North Sea Camp,” Lincolnshire Public Health Directorate, Lincoln, 2011.

[51] J. Cohen, “Safe in our hands? A study of suicide and self harm in asylum seekers,” *Journal of Forensic and Legal Medicine,* vol. 15, pp. 235-244, 2008.

[52] HM Chief Inspector of Prisons, “Report on an announced inspection of Morton Hall Immigration Removal Centre 4-8 March 2013.,” HM Inspectorate of Prisons, London, 2013.

[53] M. Oates, “Suicide: the leading cause of maternal death,” *The British Journal of Psychiatry,* vol. 183, pp. 279-81, 2003.

[54] Public Health England/Royal College of Nursing, “Preventing suicide among lesbian, gay and bisexual young people,” Public Health England, London, 2015.

[55] N. Kapur, D. While, N. Blatchley, I. Bray and K. Harrison, “Suicide after leaving the UK Armed Forces,” *PLOS Medicine,* 2009.

[56] A. Pitman, D. Osborn, M. King and A. Erlangsen, “Effects of suicide bereavement on mental health and suicide risk,” *The Lancet Psychiatry,* vol. 1, pp. 86-94, 2014.

[57] J. Cooper, N. Kapur, R. Webb, M. Lawlor, E. Guthrie, K. Mackway-Jones and L.

Appleby, “Suicide after deliberatre self-harm: a 4-year cohort study,” *American Journal of Psychiatry,* vol. 162, pp. 297-303, 2005.

[58] Office for National Statistics, “The mental health of children and adolescents in Great Britain.,” Office for National Statistics, Newport, 2000.

[59] Department of Health, “Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays.,” CMO, London, 2013.

[60] The Prince's Trust, “The Prince's Trust MacQuarie Youth Index 2014,” [Online]. Available: https://www.princes-trust.org.uk/about_the_trust/what_we_do/research/youth_index_2014.aspx. [Accessed 17 September 2015].

[61] NSPCC, “On the Edge: ChildLine Spotlight: suicide,” NSPCC, London, 2014.

[62] The University of Manchester, “The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2015,” The University of Manchester, Manchester, 2015.

[63] National Child and Maternal Health Intelligence Network, “CAMHS Needs Assessments Dynamic Reports,” [Online]. Available: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34&geoTypeId=. [Accessed 2015 September 17].

[64] H. L. Egger and A. Angold, “Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology,” *Journal of Child Psychology and Psychiatry,* vol. 47, p. 313–37, 2006.

[65] G. Baird, E. Simonoff, A. C. S. Pickles, T. Loucas, D. Meldrum and T. Charman, “Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP).,” *The Lancet,* vol. 368, pp. 210-215, 2006.

[66] S. Baron-Cohen, F. Scott, C. Allison, J. Williams, P. Bolton, F. Matthews and C. Brayne, “Prevalence of autism-spectrum conditions: UK school-based population study,” *The British Journal of Psychiatry ,* vol. 194, pp. 500-509, 2009.

[67] K. Windfuhr, “Suicide in juveniles and adolescents in the United Kingdom,” *Journal of Child Psychology and Psychiatry,* vol. 49, pp. 1157-67, 2008.

[68] J. Cooper, N. Kapur, R. L. M. Webb, E. Guthrie, K. Mackway-Jones and L. Appleby, “Suicide after deliberate self-harm: a 4-year cohort study,” *American Journal of Psychiatry,* vol. 162, pp. 297-303.

[69] Public Health England, “Child Health Profiles - local authorities,” [Online]. Available: www.altas.chimat.ork.uk/dataviews/report/fullpage?viewId=493&reportId=535&geoId=4&geoReportIs=4618. [Accessed 17 September 2015].

[70] E. Emerson and C. Hatton, “Estimating Future Needs for Adult Social Care for People with Learning Disabilities in England,” Centre for Disability research, Lancaster University, Lancaster, 2008.

[71] E. Emerson and C. Hatton, “Estimating current need/demand for supports for people with learning disabilities in England,” Institute for Health Research, Lancaster University, Lancaster, 2004.

[72] T. Ford, P. Vostanis, H. Meltzer and R. Goodman, “Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households,” *British Journal of Psychiatry,* vol. 190, pp. 319-325, 2007.

[73] H. Meltzer, R. Gatward, T. Corbin, R. Goodman and T. Ford, “The mental health of young people looked after by local authorities in England,” Office for National Statistics, London, 2003.

[74] P. Vostanis, “Mental health of homeless children and their families,” *Advances in Psychiatric Treatment,* vol. 8, pp. 463-469, 2002.

[75] D. Quilgars, S. Fitzpatrick and N. Pleace, “Ending youth homelessness: Possibilities, challenges and practical solutions.,” Universities of York and Heriot-Watt, for Centrepoint, York, 2011.

[76] C. Vasiliou, “Making the link between mental health and youth homelessness. a pan-London study,” Mental Health Foundation, London, 2006.

[77] A. Sourander, “The association of suicide and bullying in childhood to young adulthood: a review of cross-sectional and longitudinal research findings.,” *Canadian Journal of Psychiatry,* vol. 55, p. 282, 2010.

[78] Lincolnshire County Council, “A Mental Illness Health Needs Assessment for Lincolnshire,” Lincolnshire County Council, Lincoln, 2014.

[79] MHFA, “Mental Health First Aid England,” 2015. [Online]. Available: http://mhfaengland.org/. [Accessed 29 October 2015].

[80] Z. Kurtz, “Treating People Well.,” Mental Health Foundation, London, 1996.

## 9. Appendices

### 9.1. Appendix A – brief description of conditions examined in APMS

| Condition | | Brief Description |
|---|---|---|
| **Common mental disorders** | **Mixed anxiety and depressive disorder** | 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.<br><br>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, disturbed sleep, fatigue, dizziness and loss of libido. |
| | **Generalised anxiety disorder** | A persistent and common disorder, in which the patient has unfocussed worry and anxiety that is not connected to recent stressful events, but can be aggravated by certain situations.<br><br>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. For diagnosis 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. |
| | **Panic disorder** | Recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances, and so are unpredictable. Often associated with other psychiatric conditions, such as depression and other anxiety disorders.<br><br>Characterised by recurrent, unexpected panic attacks, at least one of which leads to suffering for a month or longer from one or more of: 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.<br><br>Attacks are not due to drug misuse, medication or a medical condition, and cannot be better accounted for. During an attack, sufferers may experience one or more of: chest pain, dizziness, fear of dying, fear of losing control, nausea and palpitations. |

| Condition | | Brief Description |
|---|---|---|
| | **Obsessive compulsive disorder** | A severe and disabling clinical condition that usually arises in adolescence or early adulthood, characterised by the occurrence of obsessions or compulsive rituals, or most commonly both.<br><br>Obsessions are recurrent and persistent thoughts, impulses or images that are experienced as intrusive and cause anxiety. E.g. persistent doubts about whether doors have been locked or appliances switched off. Obsessions are often combined with compulsions: repetitive behaviours (e.g. hand washing, checking and sorting) or mental acts (such as praying or counting), which the person feels compelled to do in response to the obsession to prevent or reduce distress, or avoid an imagined adverse event. |
| **Post-traumatic stress disorder** | | An anxiety disorder in which an individual's ability to function is impaired by emotional responses to memories of a traumatic event (that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others).<br><br>Features 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. |
| **Self-harm (including suicidal thoughts and suicide attempts)** | | 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.<br><br>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 complete suicide, and can sometimes be a form of self-preservation. |
| **Psychosis** | | Describes 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.<br><br>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.<br><br>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. |

| Condition | Brief Description |
|---|---|
| **Personality disorders (anti-social borderline)** | Of the 10 classified types of personality disorder, anti-social and borderline disorders are the most common, and often co-exist. 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. |
| **Attention deficit hyperactivity disorder** | 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 cases diagnosed.<br><br>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. |
| **Eating disorders** | The two main types of eating disorder are anorexia nervosa (AN) and bulimia nervosa (BN).<br><br>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.<br><br>The DSM-IV49 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. |
| **Mental health illnesses due to psychoactive substance abuse (alcohol misuse & 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. |

**9.2. Appendix B -** mapping of ICD10 codes to mental health conditions in APMS

| Condition | | ICD10 Codes |
|---|---|---|
| **Common mental disorders** | Mixed anxiety and depressive disorder | F41.2 |
| | Generalised anxiety disorder | F41.1 |
| | Depressive episodes | F32 |
| | Phobias | F40 |
| | Panic disorder | F41.0 |
| | Obsessive compulsive disorder | F42 |
| **Post-traumatic stress disorder** | | F43.1 |
| **Self-harm** | | X60-F84 |
| **Psychosis** | | F20-F21 |
| **Personality disorders** | Anti-social | F60.2 |
| | Borderline | F60.31 |
| **Attention deficit hyperactivity disorder** | | F90 |
| **Eating disorders** | | F50-F59 |
| **Mental illness due to psychoactive substance abuse** | | F10-F19 |

## 9.3. Appendix C – national prevalence of common mental disorders in England

Table 1: estimated national prevalence of common mental disorders in England (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Mixed anxiety and depressive disorder | 10.2 | 10.8 | 8.5 | 11.2 | 8 | 6.4 | 5.9 | 9 |
| Generalised anxiety disorder | 3.6 | 4.2 | 5.3 | 6.1 | 4.1 | 3.3 | 2.6 | 4.4 |
| Depressive episode | 2.2 | 2.2 | 2.9 | 3.7 | 1.9 | 1 | 1.5 | 2.3 |
| All phobias | 1.5 | 1.9 | 2.1 | 1.5 | 1.4 | 0.3 | 0.1 | 1.4 |
| Obsessive compulsive disorder | 2.3 | 1.5 | 1.1 | 1.1 | 0.5 | 0.3 | 0.4 | 1.1 |
| Panic disorder | 1.1 | 1.6 | 1.3 | 0.9 | 1 | 0.5 | 0.5 | 1.1 |
| **Any CMD** | **17.5** | **18.8** | **17.3** | **19.9** | **14.1** | **10.6** | **9.9** | **16.2** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 2: estimated national percentage of adults that have screened positive for post-traumatic stress disorder (PTSD), by age and gender (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 5.1 | 3.6 | 3 | 1.9 | 1.9 | 0.7 | 0.2 | 2.6 |
| Women | 4.2 | 3.7 | 3.5 | 5.8 | 1.9 | 1.5 | 0.8 | 3.3 |
| **All adults** | **4.7** | **3.7** | **3.2** | **3.9** | **1.9** | **1.1** | **0.6** | **3** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 3: estimated national prevalence of psychotic disorder in past year, by age and gender (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | - | 0.6 | 0.7 | 0.1 | - | - | - | 0.3 |
| Women | 0.4 | 0.2 | 1.1 | 0.8 | 0.6 | - | - | 0.5 |
| **All adults** | **0.2** | **0.4** | **0.9** | **0.5** | **0.3** | **-** | **-** | **0.4** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 4: estimated national prevalence of antisocial and borderline personality disorders (percentages)

| | 16-34 | 35-54 | 55-74 | 75+ | All |
|---|---|---|---|---|---|
| Antisocial | 1.1 | 0.1 | - | - | 0.3 |
| Borderline | 0.8 | 0.4 | 0.2 | - | 0.4 |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 5: proportion of people who screened positive for ADHD in the past six months, by ASCR score (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| 4 or more | 13.9 | 8.6 | 9.7 | 8.7 | 4.9 | 4.3 | 4.2 | 8.3 |
| 6 | 1.1 | 0.6 | 0.9 | 0.6 | 0.2 | - | 0.1 | 0.6 |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 6: estimated national prevalence of eating disorders by age and gender (score of two or more on SCOFF toolkit with significant impact) (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 1.7 | 0.7 | 0.3 | 0.8 | 0.1 | 0.3 | - | 0.6 |
| Women | 5.4 | 3.6 | 2.5 | 3.1 | 0.9 | 0.6 | 0.1 | 2.5 |
| **All persons** | **3.5** | **2.1** | **1.4** | **1.9** | **0.5** | **0.4** | **0.1** | **1.6** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 7: estimated national prevalence of hazardous or harmful drinking in the past year by age and gender (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 8.8 | 11.6 | 6.6 | 3.2 | 2.9 | 1.7 | 1.0 | 5.8 |
| Women | 4.8 | 1.6 | 2.9 | 2.0 | 0.3 | 0.5 | - | 1.9 |
| **All persons** | **6.8** | **6.6** | **4.8** | **2.6** | **1.6** | **1.1** | **0.4** | **3.8** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

Table 8: estimated national prevalence of drug dependence by age and gender (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 13.3 | 9 | 2.9 | 1.3 | 1.7 | - | 0.3 | 4.5 |
| Women | 7 | 3.6 | 2 | 0.6 | 1.3 | 0.6 | 0.6 | 2.3 |
| **All persons** | **10.2** | **6.3** | **2.5** | **0.9** | **1.5** | **0.3** | **0.5** | **3.4** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

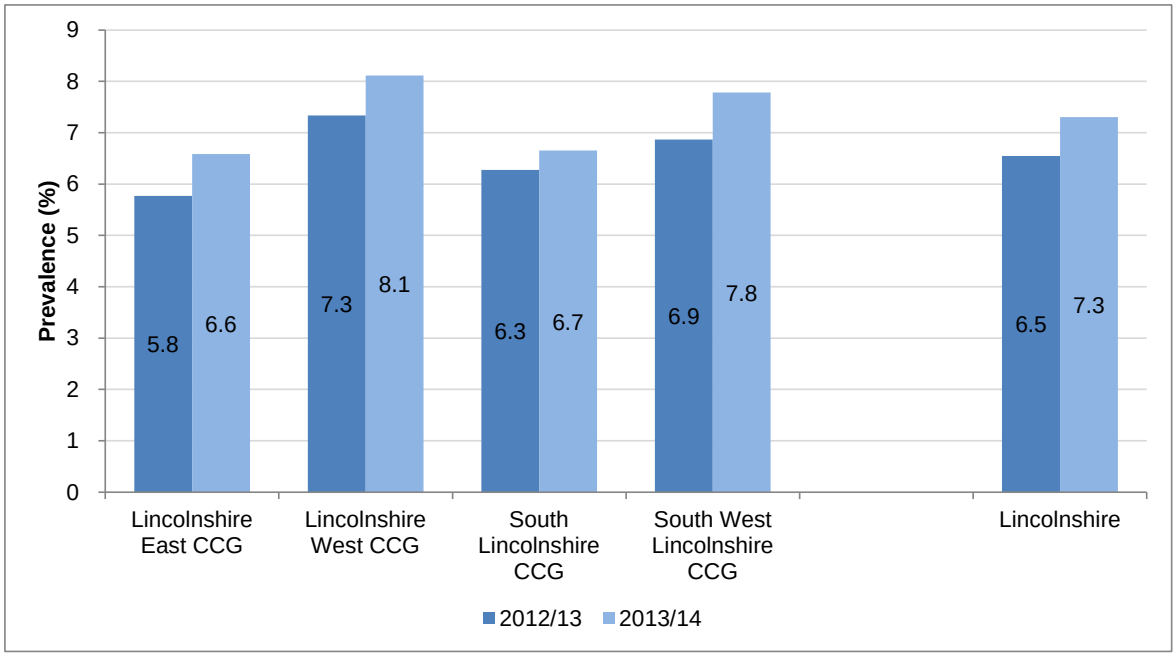
Table 9: estimated national prevalence of pathological gambling by age and gender (percentages)

| | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75+ | All |
|---|---|---|---|---|---|---|---|---|
| Men | 0.9 | 1.4 | - | 0.9 | 0.1 | 0.4 | 0.2 | 0.6 |
| Women | - | - | 0.1 | 0.2 | - | - | 0.3 | 0.1 |
| **All persons** | **0.5** | **0.7** | **0.1** | **0.5** | **0** | **0.2** | **0.2** | **0.3** |

*Source: 2007 Adult Psychiatric Morbidity Survey*

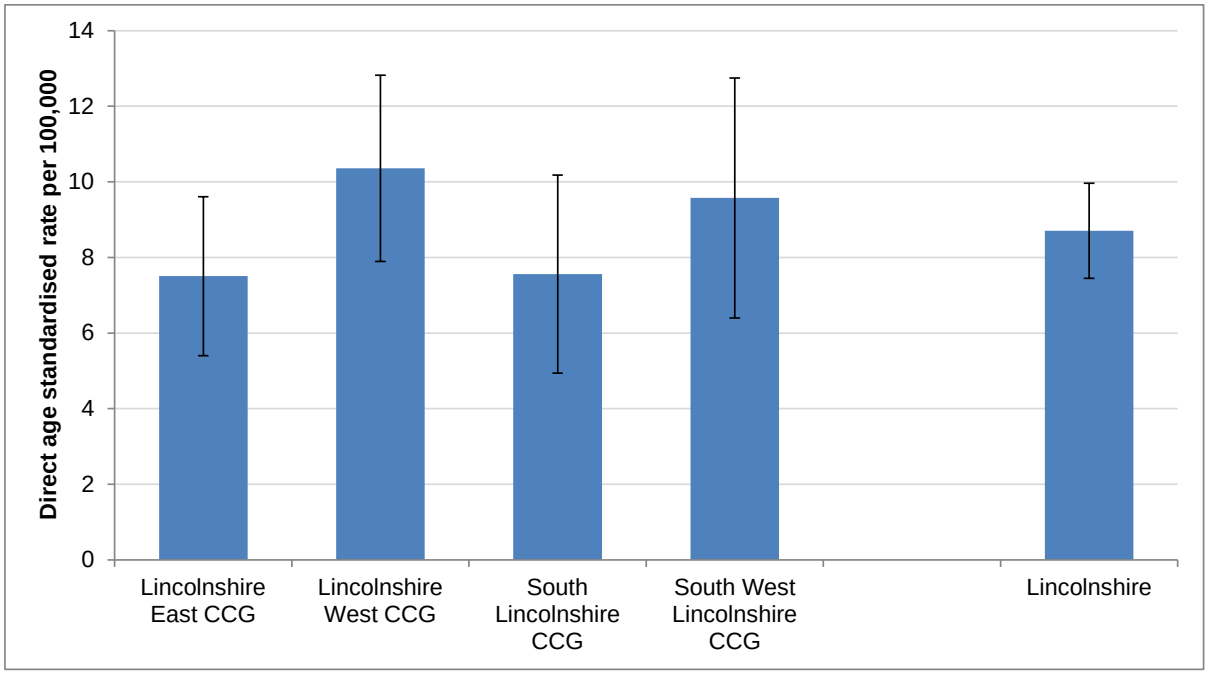
## 9.4. Appendix D – CCG variation in the prevalence of mental ill health

Figure 1: Percentage of patients aged 18 and over with depression, as recorded on GP practice depression registers: 2012/13 to 2013/14



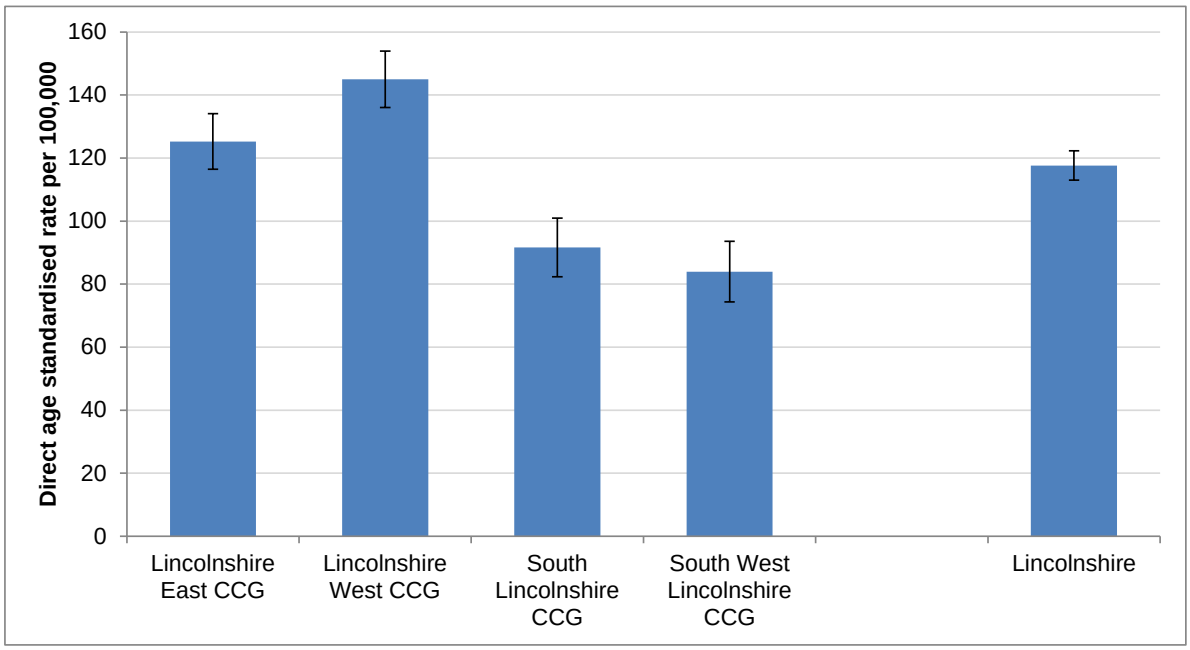

*Source: Quality and Outcomes Framework 2013/14*

Figure 2: mortality from suicide and injury undetermined (ICD-10 X60-X84, Y10-Y34), directly age standardised rate per 100,000, 15 years and over, by CCG: 2011 – 2013



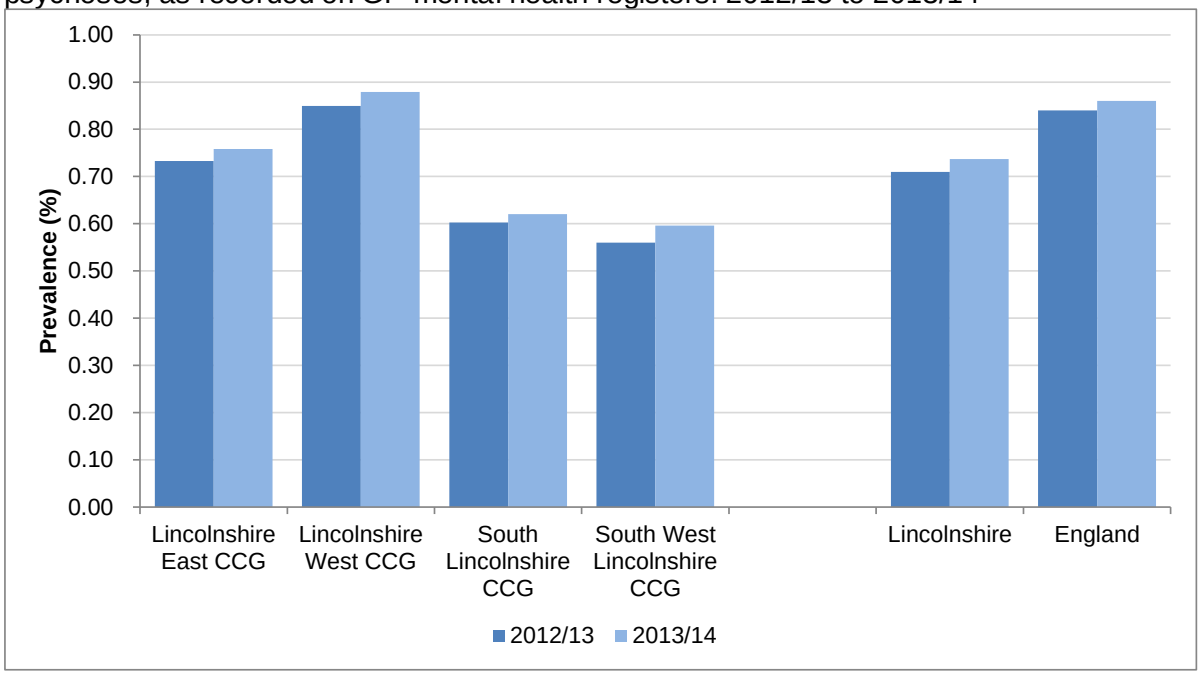

*Source: HSCIC, Primary Care Mortality Database*

Figure 3: emergency hospital admissions for intentional self-harm, directly age standardised rate per 100,000, all ages, by CCG: 2011 - 2013



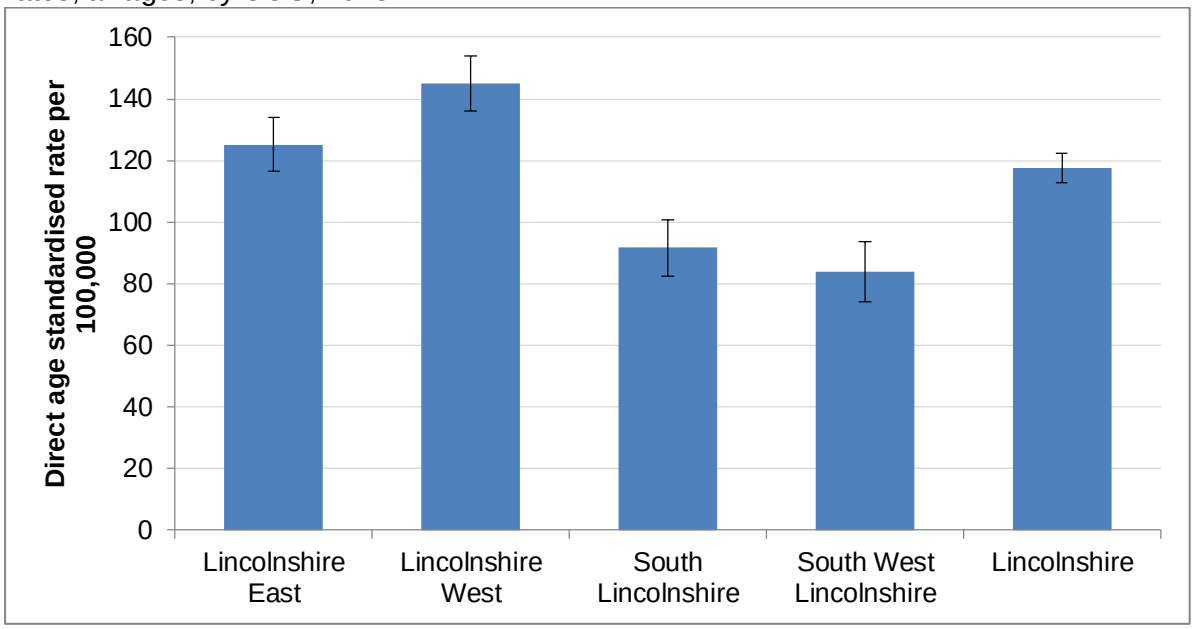

*Source: HSCIC, Hospital Episode Statistics (HES)*

Figure 4: percentage of patients with schizophrenia, bipolar affective disorder and other psychoses, as recorded on GP mental health registers: 2012/13 to 2013/14



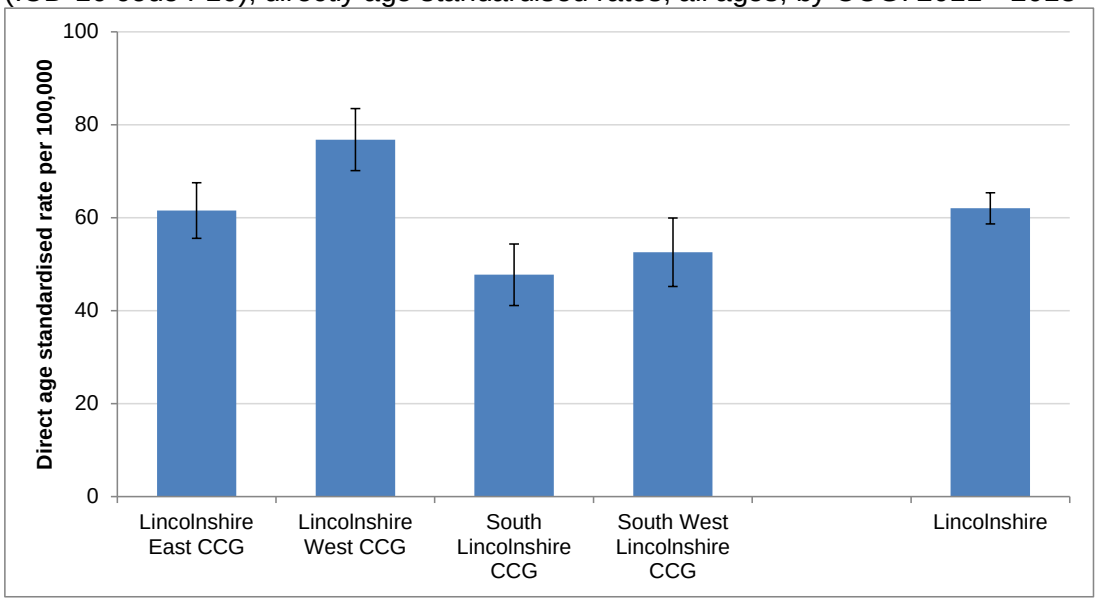

*Source: Quality and Outcomes Framework 2013/14*

Figure 5: hospital admissions for eating disorders in Lincolnshire, directly age standardised rates, all ages, by CCG, 2013



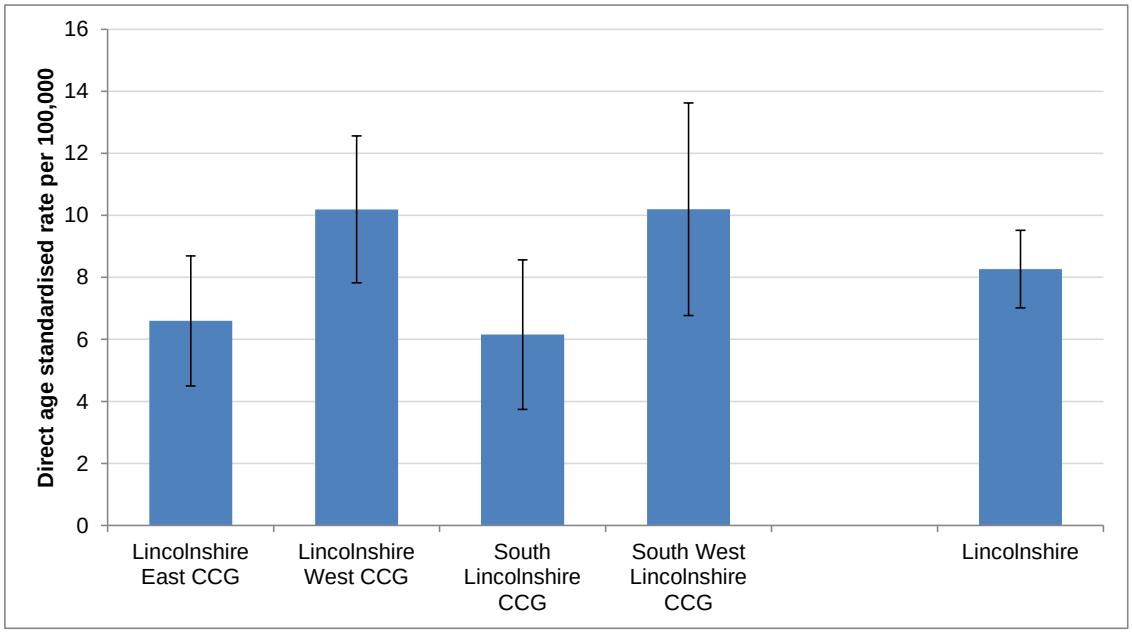

*Source: HSCIC, Hospital Episode Statistics (HES)*

Figure 6: hospital admissions for mental and behavioural disorders due to the use of alcohol (ICD-10 code F10), directly age standardised rates, all ages, by CCG: 2011 - 2013




*Source: HSCIC, Hospital Episode Statistics (HES)*

Figure 7: hospital admissions for mental and behavioural disorders due to psychoactive substance use (ICD-10 code F11-16, F18-19), directly age standardised rates, all ages, by CCG: 2011 - 2013




*Source: HSCIC, Hospital Episode Statistics (HES)*