NHS
Greater Glasgow and Clyde

Keeping health in mind

Report of the Director of Public Health into the health of the Population of Greater Glasgow and Clyde and Recommendations for Action

2011 - 2013

Content Page

The Director of Public Health says …..

This is my third report on the health of the population of NHS Greater Glasgow and Clyde. As Director of Public Health, my role is to help improve the health and wellbeing of people across the area. I look to advocate for policies and actions which I think can make a positive difference to health and to encourage a wide debate about health. In particular, I have a strong focus on the need to tackle inequalities in health across our area.

Part of my role is to report publicly and independently on what I see as the main health issues and to make recommendations for addressing them. For this report, I have decided to focus on mental health because it is key to improving health and wellbeing and reducing health inequalities.

Before focusing on mental health this report will describe the substantial progress that has been made on the priorities for action in my previous report "An Unequal Struggle for Health".[1] The report will then go on to define what we mean by mental health and wellbeing and illustrate how this encompasses being able to cope with life, realise your potential, have high self-esteem and have positive emotions and relationships. It shows how mental health is about more than the absence of mental illness. The chapters, which follow it, cover the stages of our lives from pre-conception through youth and adulthood and into old age. All of the chapters recommend priorities for action around individual level and community level actions as well as structural changes required.

In 1948, the World Health Organisation defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[2] Public health professionals welcomed this definition because it had breadth beyond a medical model. There is, however, a growing concern that the definition is now inadequate, particularly given the increasing older population coping with chronic disease. Huber et al recently suggested we should adopt "the ability to adapt and self manage" in the face

of social, physical and emotional challenges as a definition.[3] This would fit well with the aspirations in this report.

In an area with the health challenges of Greater Glasgow and Clyde, many of which have their roots in poor mental health, it is easy to feel overwhelmed by the difficulty of achieving change. However, I have been encouraged by the results that have been achieved by motivated colleagues who have made use of the best evidence of what works and by the actions of communities and individuals who have taken control of their own health.

The key things, which are good for mental health, can be summed up by the expression 'activity'. They are about:

- Physical activity – keeping our weight down and keeping active by getting out and about and doing a bit of exercise
- Labour market activity – having meaningful work and a daily routine
- Social activity – being connected to our families and communities and making a contribution. Meaningful activity that improves mental health also includes volunteering and involvement in clubs, choirs, churches and other group activities

These activities are good for mental health throughout our life and discussion of them occurs in each chapter of this report. Recommendations are made which look to encourage partners to support these activities and to think more about how they can contribute to good mental health.

I want to emphasise two other things, which come up again and again in my reports. The first is alcohol and its adverse effects on mental health. The unhealthy relationship that Scotland has with alcohol needs to be challenged. In his recent book about Scotland, *Alcohol Nation,* Sigman highlighted the issue of teenage drinking.[4] He points out that, although Scotland has much to be proud of, when it comes to alcohol, we should be ashamed of ourselves. Parents must be better role models. Restoring the stigma of drunkenness and recognising the role of parents would help create a healthier

nation. It would prevent a generation of young people from being harmed by the substance their parents adore.

The second is the value and vital importance of a good start in life. Good parenting makes an important contribution to the mental health of the child and the adult they will become. One of the most important public mental health interventions is the strengthening of the parent-child bond and supporting good parenting. Having a safe, stable, nurturing child-parent relationship is a vital protective factor against stresses throughout life. It is one of the best public health investments a society can make. However, it is more difficult to develop a safe, stable and nurturing relationship between parent and child when the parent is highly stressed, socially isolated, living in poverty or suffering abuse. Mental wellbeing of everyone including parents is highly dependent on the distribution of social, economic and environmental resources, with high levels of inequality being damaging to communities and society as a whole as discussed in my previous report "An Unequal Struggle for Health".[1]

Alain Gregoire recently wrote in the BMJ that "Far from breaking intergenerational cycles of disadvantage we have low and falling levels of social mobility coupled with inequitable education and health. Our poorest most vulnerable and most disadvantaged children are the first to become parents themselves".[5] Gregoire also quotes work from Action for Children showing that the lowest rates of child maltreatment are found not in countries with the strongest emphasis on child protection services but in those countries that invest in families and prevention. We must therefore invest in cost effective early and pre-birth interventions and support that is targeted at the most vulnerable families.

Recent research has studied the associations between common mental disorders and obesity as part of the Whitehall II study of Civil Servants.[6] These findings suggest that the direction of association between common mental disorders and obesity is from common mental disorder to increased future risk of obesity. Although my report does not focus on mental health services for people with severe and enduring mental illness,

the need to improve the quality of life and improve physical health of people with mental illness is discussed.

As well as working with partners in government and local authorities to address the determinants of poor mental health, NHS Greater Glasgow and Clyde has undertaken a great deal of work to promote individual mental health and wellbeing. Examples of these individual actions are given within each chapter.

The content of the report is based on the best available evidence and, in many cases, on good practice developed within the Greater Glasgow and Clyde area. Interested readers can follow up on the references if they want to look further at this evidence. On the whole, however, I have tried to present this report in an accessible manner for the general reader as well as for fellow professionals and partner agencies so that it can inform a wide debate about what we can all do to support mental health in challenging times.

I look forward to discussing the recommendations which follow with our partners in local government, housing and economic development. The key message of this report for those partners is simple: if we work together, we can do better. In that light, I decided to ask a range of influential people working in Greater Glasgow and Clyde what was their vision of a mentally healthy Greater Glasgow and Clyde. Excerpts of these views are shown below.

"The perspective of primary care should shift away from the traditional paternalistic view of people living in deprivation to one in which patients were encouraged to value their own lives and develop their potential." **Georgina Brown, Glasgow GP with lead role for deprivation**

"My vision for a mentally healthy Greater Glasgow and Clyde would be one in which the relationship with alcohol had been transformed and a healthier culture of drinking brought about." **Stephen House, Chief Constable, Strathclyde Police**

"To improve the quality of people's lives and to make a positive impact on the health and wellbeing of the community as a whole, we believe the community controlled governance model should be extended to include further fiscal responsibility for health and employment as well as housing. **Anne Lear, Director, Govanhill Housing Association**

"My vision for a mentally flourishing Greater Glasgow and Clyde is one where people spend less time watching television and more on activities which support them socially and emotionally." **Carol Craig, Director, Centre for Confidence and Wellbeing**

"Our education system is relatively successful in supporting children and young people in difficult circumstances but we need to be more successful in including the parents in this process". **Robert Naylor, Director of Education, Renfrewshire Council**

"My vision for a healthy Glasgow is one where people have a common sense of hope and purpose in their lives" **Neil Hunter, Chief Reporter to the Children's Panel**

"All of the resources of this council will be brought to bear on mitigating the harmful effects of the current financial crisis and ensuring the financial success of this city. In doing so we hope to contribute not only to protecting jobs locally but also to encourage growth and economic opportunities for our citizens and will be a key partner in promoting good mental health and wellbeing in Glasgow." **Gordon Matheson, Leader of Glasgow City Council**

"We have to speak, act and reflect on our actions as men. Develop a language, which breaks the silences, and omissions, which characterise so much of our society. We can take steps as individuals, but we need to come together as men and say that disrespect and hurting women, children, other men and ourselves is wrong. We have to navigate a way in which in our public and private lives we learn to respect ourselves and others". **Gerry Hassan, political commentator**

From the varied visions and aspirations I have collected, some themes can be distilled:

- The importance of supporting parents in their vital role of bringing up healthy, confident children
- Inspiring hope, respect and aspiration in our population
- Releasing and fostering a person's capacity to heal and care for him or herself
- Radical and effective action on alcohol and drug misuse in our population
- Developing and nurturing integrated service provision
- Giving more control to communities to create healthier environments in which to live

This report emphasises the importance of a range of partners working together on those themes, which we know can help to create and sustain good mental health. Equally, we all need to be aware of the things that can have adverse effects on mental health. The current difficult economic climate is likely to impact disproportionately on the mental health of the population compared to other causes of poor health. Previous recessions indicate that it is the most vulnerable who suffer the most and who bear the longest lasting effects. We will need a strong resolve to ensure this does not happen over the next 5 years. I urge all public agencies and community planning partners to reflect carefully about the impact on mental health when they make decisions about services and priorities in a time of reducing public sector budgets.

I hope that the report provides useful information and generates discussion on how to take forward the aspirations for a mentally healthy Greater Glasgow and Clyde. I commend this report to you and look forward to telling you about our successes in my next report.

Chapter 1: Progress against priorities for action in the DPH report 2009-2011

This chapter presents progress on the implementation of priorities for action described in 'An Unequal Struggle for Health: Report of the Director of Public Health into the health of the Population of Greater Glasgow and Clyde and Priorities for Action 2009 – 2011. '[1]

Progress is summarised under each of the chapter headings in the previous report:

1. Alcohol: the burden of harm
2. The population of NHSGGC needs to get more active
3. Implications of the financial crisis for health
4. The early years: the foundation for future health and wellbeing
5. The potential of preventative health programmes in improving wellbeing and preventing disease

Section 1: Alcohol: the burden of harm

1.1 **Action point**: Scotland is consuming far more alcohol than is safe. The most effective means of decreasing alcohol consumption is to increase the price of alcohol relative to income.

Update: The Scottish Parliament is expected to introduce a minimum price per unit of alcohol within this parliamentary term. NHSGGC and its partners will continue to support this, as well as other potential regulations e.g. separate checkouts.

1.2 **Action point:** Alcohol related violence is associated with the number of licensed premises in the area. Public Health will offer Licensing Boards guidance on analysis of alcohol related violence and licensed premises.

Update: We provided information on outlet density and alcohol related crime to all Licensing Boards. Combined with Health Board data, this gave a comprehensive picture of acute and chronic alcohol related issues. In most cases where there was a problem with alcohol related crime, there was also a high rate of alcohol-related chronic health problems. West Dunbartonshire Council is to be commended on its overprovision policy.

1.3 **Action point:** Each CH(C)P should engage with local communities and their community planning partners in drawing up and implementing an action plan, which provides communities with the support they need to tackle alcohol misuse based on good evidence. Communities and individuals who have experienced the adverse health effects of alcohol misuse should be supported in raising objections to any application for further alcohol licences in their area.

Update:

The statutory consultation period for the application for a new licence is 21 days. This is insufficient time for a Community Council to be able to consider this. Further work needs to be undertaken in this area. Some of it can be achieved at local level, but other aspects would be more appropriately addressed at national level and through legislation.

	Communities are involved in licence applications	Health data is used in defining assessment of overprovision	Health impact of licensing policies is assessed
East Dunbartonshire	✓	X	X
East Renfrewshire	✓	X	X
Glasgow	✓	Limited	✓
Inverclyde	✓	In progress	X
Renfrewshire	✓	Limited	X
West Dunbartonshire	✓	✓	In progress

1.4 **Action point:** Screening and brief interventions allow people who drink at hazardous levels to think about and curtail their drinking habits. Screening and referral for brief intervention should be expanded to include community planning partners.

Update: HEAT targets for screening and brief interventions have been extended to facilitate the expansion and embedding of this process. The targets for screening and brief interventions were met by NHSGGC last year. Training of community planning partners has been extended.

Section 2: The population of NHSGGC needs to get more active

2.1 **Action point**: Support and develop a sustainable transport infrastructure which promotes active travel, including cycling and walking.

Update: These examples demonstrate progress and good practice in promoting active communities throughout the Health Board and local authority areas:

- Go Barrhead is a three-year project led by East Renfrewshire Council. It is funded by the Scottish Government through the Smarter Choices, Smarter Places Initiative. The project aims to create more opportunities for residents in Barrhead to walk, cycle and use public transport, in order to encourage people to lead more active and environmentally friendly lifestyles.
- Walk Glasgow is the city's community walking programme, delivering over 60 led walks each week. The programme commenced in January 2009, recording over 13,000 attendances by December 2010.
- Active Environments: Glasgow City Council has started work on the segregated Copenhagen-style cycle track on James Street and London Road in Bridgeton. The track will link from Glasgow Green to the Commonwealth Games site at Parkhead as part of the Smarter Choices Smarter Places project.

Section 3: Implications of the financial crisis for health

3.1 **Action point**: In order to understand the impact of the recession, we need to monitor not only economic indicators but also changes in health service use and potential adverse health outcomes over the period of the crisis and beyond. We should therefore be monitoring use of primary care, mental health and hospital services, trends in suicide, prevalence of mental distress, health behaviours and overall mortality, and potential secondary effects such as levels of violence and child abuse.

Update:

- A small group has been meeting to develop a set of indicators which can be used to monitor the impact of the recession to ensure that decision makers in NHSGGC are forewarned of any risks. The group has selected the most useful indicators to form a baseline which can be measured annually as part of the planning cycle. This will enable local areas to take any concerning trends into account in their development plans combined with their local knowledge of the impact on their patients.

- Understanding Glasgow is a new web-based resource, which covers a range of issues, including poverty related indicators for the city and surrounding local authorities. Poverty indicators specific to children will be added later this year.

- Reports published by the Scottish Observatory for Work and Health detail population level trends and patterning relating to health-related worklessness benefit claims.

- A project to describe patterns and trends in mental health led by GCPH and the Mental Health Partnership in Greater Glasgow and Clyde is nearing completion. A detailed report describing mental health and wellbeing within Greater Glasgow and Clyde will be published by GCPH in autumn 2011.

- The Scottish Government implemented the Scottish Living Wage across the NHS in April 2011. Other employers will be encouraged to adopt the living wage and to provide support for their direct and indirect employees to help mitigate the effects of the economic downturn.

- We are working with our partners on employment and financial inclusion for groups particularly affected by the current financial crisis. An example of this work is the Healthier, Wealthier Children pilot, which aims to reduce child poverty by helping families with money worries.

Section 4:   The early years: the foundation for future health and wellbeing

4.1 **Action point:** The evidence for parenting interventions is overwhelming. We can support parents much more effectively by widespread implementation of the agreed parenting programme for NHSGGC, Triple P. Core to the programme should be a strategy to engage parents fully in the process of delivery. There are opportunities to work with academic partners to establish a world-leading research group on parenting programmes and their effectiveness in a Scottish context.

Update:
- Triple P is designed to improve the quality of parenting advice. Implemented as a joint programme in Glasgow City, it is now being rolled out to Renfrewshire Community Health Partnership.
- A Triple P for baby trial will be launched in autumn 2011. Forty practitioners have been trained to deliver an antenatal and postnatal parenting support programme to 160 couples with a control group of 160 receiving standard support. This is being led by the Department of Psychology at Caledonian University and Triple P international.
- Five groups have been delivered in HMP Barlinnie since November 2009. In total 25 fathers have taken part (21 completed the programme). From the 25 fathers who took part in the Triple P groups, 19 partners also took part.
- Since November 2009, 700 staff trained in different levels of Triple P and over 10,000 parents (including grandparents and other caregivers) have taken part in the programme. Most of these have been parents of children starting primary school in 2010 and 2011 attending Triple P seminars as part of school induction but there have also been hundreds of parents who have completed group Triple P or four session one-to-one interventions in primary care Triple P. Early

indications from the evaluation show positive outcomes for parents, e.g., reduced anxiety, depression and stress after taking part in a group. We are continuing with our robust monitoring and evaluation process to make sure we provide the most effective, appropriate and timely parenting support across NHSGGC.

Section 5: The potential of preventative health programmes in improving wellbeing and preventing disease

5.1 **Action point:** NHSGGC must start planning now for board-wide anticipatory care after the end of the Keep Well pilots. This planning must incorporate evidence from the project to identify and deliver the most appropriate practical actions for providing anticipatory care services to those who remain unengaged with health services and are likely to be most in need.

Update:

- Now in its sixth year, the [Keep Well Programme](#) has expanded to 89 practices across five CH(C)Ps. The focus of Keep Well has been broadened from cardiovascular disease (CVD) to the wider range of modifiable risk factors that can contribute to health inequalities in later adult life. The lower age limit has been reduced from 45 to 40. By March 2011, over 37,000 individuals had attended a Keep Well health check. The Keep Well secondary prevention programme in NHSGGC ended on 31st March 2010 and has now been replaced by the standard Coronary Heart Disease Local Enhanced Service. Since 1st April 2010, Keep Well in Inverclyde and West Dunbartonshire has focussed exclusively on people without established CVD in order to reduce the likelihood of the condition developing.
- The Scottish Government has asked us to mainstream Keep Well health checks from April 2012. To do this, we have established a new NHSGGC Anticipatory Care Planning Group, chaired by the Director of Public Health. The group's work was informed by a stakeholders' event in October 2010 to disseminate learning and evidence from the national and local evaluations of Keep Well.

5.2   **Action point**: An evidence-based debate is required on the appropriate balance between individual level cardiovascular risk reduction delivered through health checks and intensifying our current actions to create health promoting communities and environments.

Update: The NSGGC Anticipatory Care Planning Group is developing a framework to guide the planning and prioritisation of the different elements of preventive healthcare. The framework is based on three principles:

- Focus on the factors that make the biggest contribution to our total burden of disease and to inequalities in health.
- Promote an integrated spectrum of prevention activities woven throughout all clinical care.
- Encourage prioritisation of activities, which offer the strongest evidence of effectiveness.

5.3   **Action point:** We must continue the process of learning from and continuously improving successful prevention programmes, including screening and vaccination, ensuring that their equity dimensions are actively monitored and appropriate action taken to deliver the programme in ways that reach those who are less likely to take part.

Update: These reports detail our commitment to improving uptake and access to screening programmes: NHSGGC Public Health Screening Annual Report 2010, ISD Cancer screening, and ISD Immunisation by health board.

5.4   **Miscellaneous updates on preventative health programmes**:
NHSGGC Falls and Fracture Liaison Service: the number of admissions for hip fractures was reduced by 3.6% between 1998 and 2008. This compares with a 5.1% increase across Scotland as a whole. Over the same period, there has been a 32% decrease in hospital admissions due to falls at home, a 27% reduction in falls in residential institutions, and almost a 40% reduction in falls in public spaces.

The strategy has several strands: direct GP referrals for bone scans; clinical nurse specialist assessment and treatment advice for all fracture patients; a community falls prevention programme, which undertakes home assessment of falls risk factors and arranges home adaptations; and referral to other services as appropriate e.g. physiotherapy led exercise classes.

Smoking Cessation Services: for HEAT 6, the board's three-year target (1/4/08-31/3/11) was that 21,240 smokers should have stopped smoking, four weeks after their quit date. By the end of year two, there was a projected short fall of 15% in meeting the target. Service development measures were put in place to address this:

- Dual NRT therapy for four weeks made available to smokers fitting criteria
- Structured follow up: clients attending any stop smoking service who have relapsed, are invited by telephone to re-enter
- Communication with GPs to try to ensure all patients prescribed therapy for smoking cessation were linked into our services
- By the end of year 3, 25,455 smokers had stopped smoking four weeks from their quit date, a variance of 19.8% from the target

People living on low incomes have a lower success rate than those on higher ones. We introduced a dual therapy initiative for some patient groups to help reduce the inequalities in tobacco related mortality and morbidity. Evidence demonstrates that withdrawal is better managed with two products, compared with nicotine patches alone. There is variability in success rates across different CH(C)Ps, ranging from almost 23% below the 4 week quit target in the North Sector, Glasgow City CHP, compared with East Dunbartonshire, which superseded its target by 70% in 2010. The Tobacco Planning and Implementation Group are sharing good practice and the implementation of evidence based initiatives in order to address this variation.

Chapter 2:   Mental Health is Important

This chapter provides an overview of the report's main themes. It considers how mental health should be defined, highlighting important differences between positive and negative aspects of mental health. It goes on to explain why mental health is important at many levels - to individuals, to whole communities and to wider society. As well as noting the continuing challenges to mental health in NHS Greater Glasgow and Clyde (NHSGGC), it points to promising activities to improve mental health and wellbeing, which are further developed in each of the chapters that follow.

Evidence within this chapter highlights clear social inequalities in mental health, which suggests a need for more focused debate on how services should respond. UK Foresight's *Mental Capital and Wellbeing Project* (2008) emphasised the importance of considering mental health and wellbeing across the entire lifecourse, because human experience and interventions at one stage of life so powerfully affect an individual's mental capital and wellbeing for decades to come.[7] For very similar reasons, we have adopted a lifecourse perspective in considering mental health within the NHSGGC context.

Section 1:   The people of the NHSGGC area

1.1   NHSGGC serves a population of approximately 1.2 million people. The age and sex distribution of the population is described in Figure 2.1.

1.2   The estimated mid-2010 NHSGGC total population was 1,203,870. Of those, 194,562 (16%) were children and young people, aged under 20 years, with just over one third of these being under five. Adults (aged 20-64 years) represented the majority of the population (823,087; 62%) and a further 186,221 older adults accounted for the remaining 16%. Just over half of the total NHSGGC population is female (624,390; 52%).

Figure 2.1:   Population pyramid for residents of NHSGGC
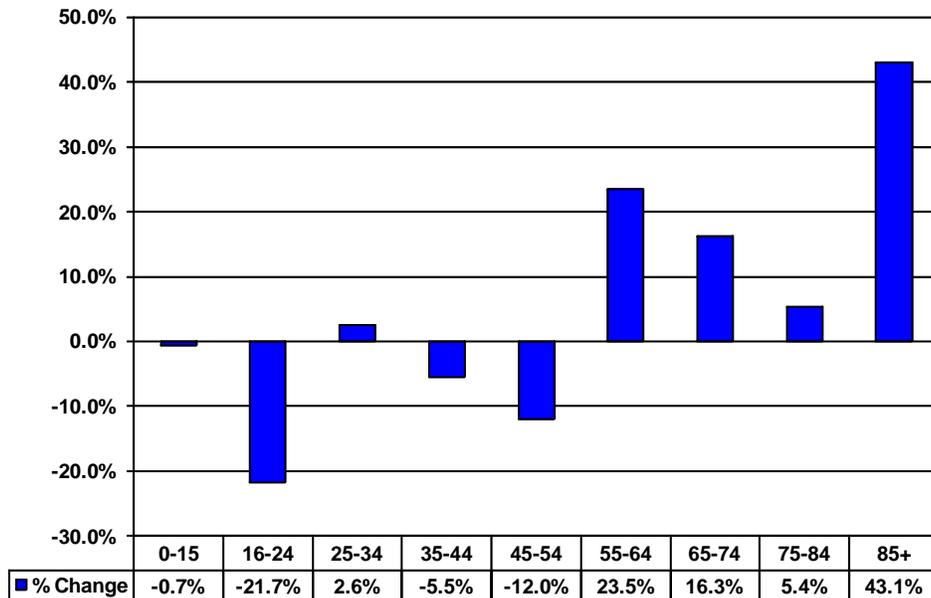**Source: 2010 MYE (NRS (formerly GRO(S))**
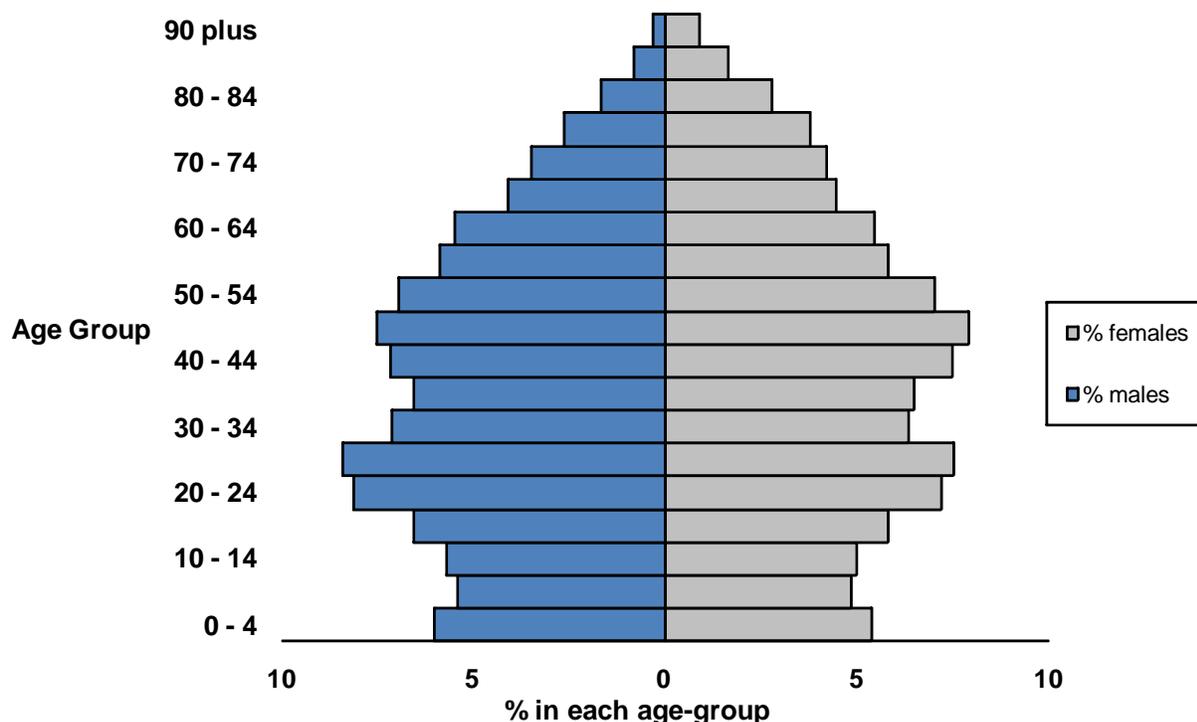
1.3   Population health status varies enormously between different geographical locations. For example, average life expectancy at birth in NHSGGC overall is 73.1 and 78.9 years for men and women respectively, well below the Scottish average (Table 2.1). However, this overall picture masks considerable internal variation within NHSGGC; the difference in average male life expectancy between the areas with the most and least favourable health status (East Dunbartonshire and Glasgow City respectively) amounts to 7.2 years, with average male life expectancy at birth in East Dunbartonshire exceeding the Scottish average by three years, whereas men in Glasgow City can, on average, expect to live four years less than the Scottish average.

Table 2.1: **Life expectancy at birth by gender, 2007 to 2009**
Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

1.4   Over the next ten years, our population demographics are predicted to change significantly (see Figure 2.2). By 2021, it is expected that the number of adults will fall overall, most notably in the 16-24 age group, followed by the 45-54 year olds. The most dramatic change will be in the ageing population, with the proportion of those over 85 years old expected to rise by over 40%.

Figure 2.2: **Population projections for NHSGGC population: %Change 2008- 2021**
Source: NRS (formerly GRO(S))

	0-15	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
% Change	-0.7%	-21.7%	2.6%	-5.5%	-12.0%	23.5%	16.3%	5.4%	43.1%

## Section 2:   Mental health: its nature and consequences

2.1   Mental health is defined by the World Health Organisation as:

"a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[8]

2.2   Mental, physical and social wellbeing are virtually inseparable. Good mental health is a vital asset for individuals, families and society. It enhances healthy lifestyles, physical health and functional abilities and promotes recovery from illness. It also has important social benefits on educational attainment, economic productivity, social and family relationships, social cohesion and overall quality of life across the entire population.

2.3   Poor mental health is both a consequence and cause of inequalities and social exclusion; people with mental health issues experience many barriers to full participation in society, including overt stigma and discrimination.

2.4   Mental health problems are one of our most pervasive public health challenges, estimated to contribute to a third of all illness and disability in Scotland. In Europe as a whole, the World Health Organization has calculated that neuropsychiatric conditions are the second largest cause of all poor health, accounting for one fifth of our total disease burden, exceeded only by heart disease. Depression and anxiety are the most common causes of mental ill-health and are important contributors to sickness absence from employment. Nine per cent of the Scottish population (age 15 and over) is estimated to take antidepressant drugs on a daily basis.[9]

2.5   Substance misuse and addiction problems are integrally linked with mental health. They embrace a broad spectrum across prescribed, legal and illegal substances, from people who use legal substances such as alcohol, tobacco or prescribed drugs at levels which impair their health; to those who use illegal drugs only once or rarely; to regular recreational drug users; and finally to people who are highly dependent on illegal drugs or alcohol. Problem drug and alcohol use exert a ripple effect across the population. In addition to their direct effects on the brain in those who consume substances, in whom it affects neural networks responsible for thinking, learning, attention, memory and behaviour, it has multiple secondary effects on the mental wellbeing of others, damaging social relationships, families and the lives of dependant children, who are critically dependent on nurturing relationships for a mentally healthy start in life.

Section 3:   The social determinants of mental health

3.1   The NHSGGC Health and Wellbeing Survey 2008 recorded the proportion of people with a positive perception of mental and emotional wellbeing across a range of profiles (Figure 2.3). Overall, 85% had a positive perception of mental health and wellbeing. The subgroup most likely to report a positive perception were those aged 16 to 24 years old (92%); in contrast, those least likely to do so were those who felt isolated from family and friends (65%) and those with long-term limiting illness (56%).

**Figure 2.3: Positive Perception of Mental and Emotional Wellbeing - % of Respondents by Selected Indicators, adults aged 16+
Source: NHSGGC Health & Wellbeing Survey 2008**
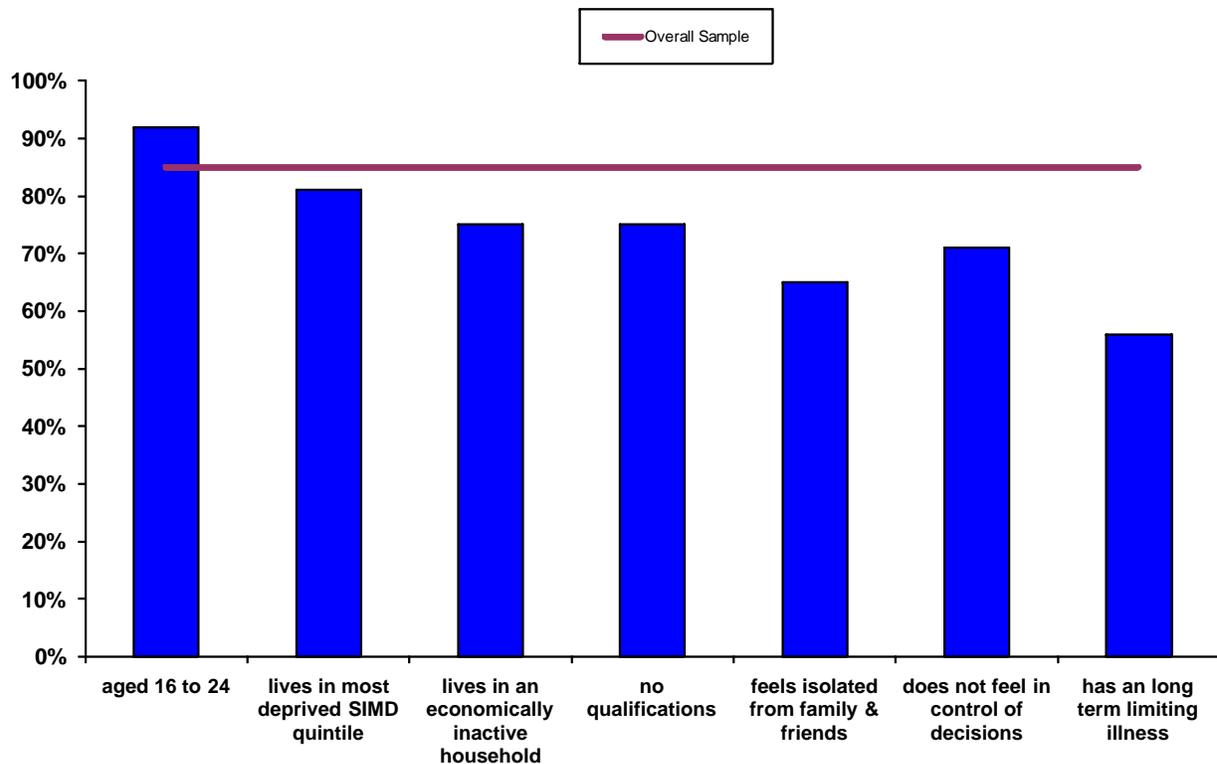
3.2   Growing social and economic inequalities contribute to levels of anxiety, depression and stress. It is therefore unsurprising that mental health patterns in NHSGGC are very closely aligned with other social inequalities. Societies with greater inequality have a greater prevalence of a range of mental health problems and even relatively small levels of inequality can have significant effects on health. Several reports have described patterns and trends in mental health across NHSGGC and in smaller neighbourhoods, further described below.

3.3   Until recently, there was no systematic assessment of the mental health profile of the Scottish population, making it difficult to measure improvement or to track progress. However, NHS Health Scotland has now developed indicators to address this at a national level and work by Glasgow Centre for Population

Health (GCPH) has developed this further at a local level.[10] These data are discussed further in Chapter 5.

3.4   GCPH's 'Turning the tap off', report described trends in incapacity benefit claimants in Glasgow between 2000 and 2005 recent years.[11] One of its main findings is that over 50% of claimants in Glasgow had a mental health diagnosis.

3.5   GCHP's The Shape of Primary Care report predicted that patients attending practices serving predominantly deprived areas were more than twice as likely to present with mental health problems as those from one of the least deprived areas.[12] Depression was also documented more frequently as a co-morbid condition among patients with coronary heart disease in more deprived practices. There are profound socioeconomic and geographic variations in mental health problems across NHSGGC, for example, in rates of suicide (Figure 2.4) and psychiatric admissions to hospital (Figure 2.5).

Figure 2.4:   NHSGGC Suicides 2006–2009 Rates per 100,000 population aged 16+ Source: GCPH Mental Health Profiles
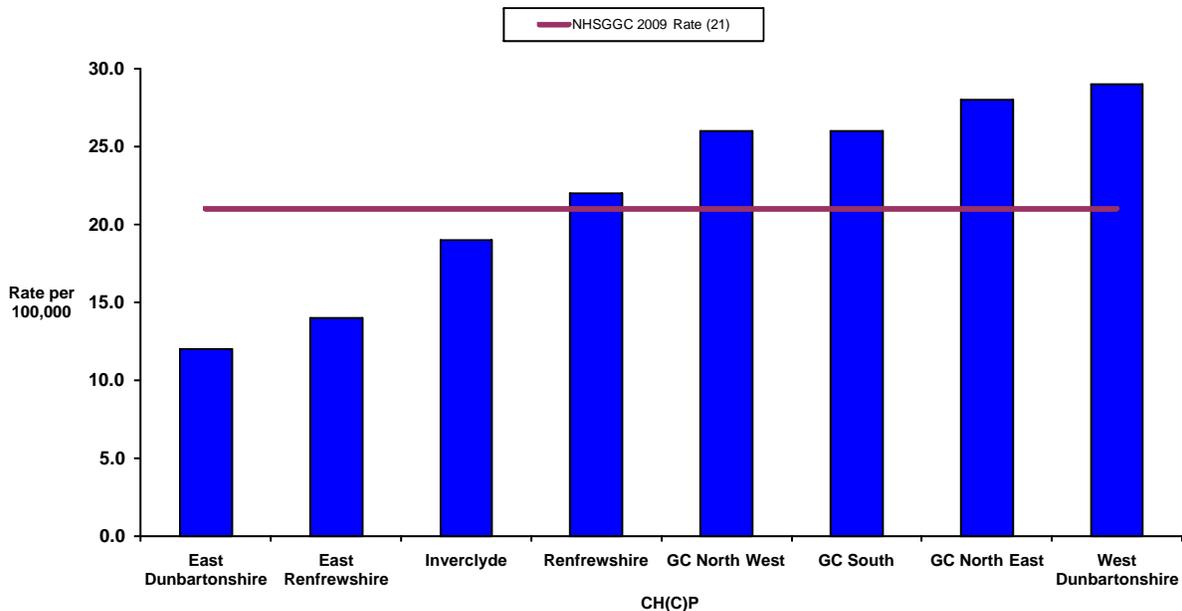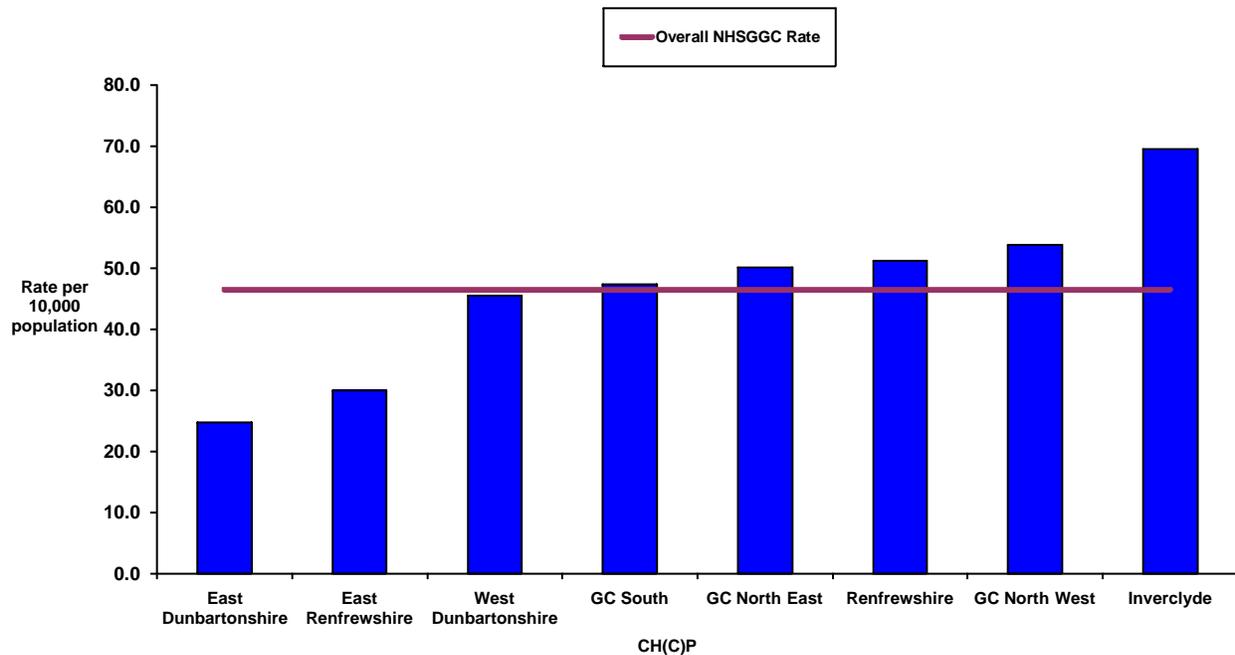
Figure 2.5: NHSGGC Psychiatric inpatient admissions April 2008 to March 2011

3.6 East Dunbartonshire and East Renfrewshire have the lowest rates of suicide and psychiatric admissions in NHSGGC. These are well below the average of 46.4 per 10,000 population for NHSGGC as a whole. In contrast, Inverclyde have significantly higher than average rates of admission for psychiatric inpatients 69.5 per 10,000 population.

Section 4: Influences on positive and negative mental health

4.1 Several inter-related factors influence and determine our mental health status (Table 2.2).[13] Many of these influences start before birth and continue throughout the life course.

Table 2.2: The social determinants of mental health

Society	Community	Family	Individual
Equality of opportunity	Safety and social order	Family structures and networks	Lifestyle (e.g. food, exercise, alcohol intake)
Employment opportunities	Housing and amenities	Family dynamics (e.g. high/low expressed emotion)	Attributional style (i.e. how events are understood) and self efficacy
Social cohesion	Quality of physical environment and green space	Genetic characteristics	Financial security
Educational opportunities	Social connections and networks	Intergenerational relationships	Physical health
Health care provision	External influence and control	Parenting skills and resources	Individual relationships

4.2   The physical and social environment in which people live and work exert powerful effects on their wellbeing, mediated through the houses they inhabit; the neighbourhood's cultural and social patterns; the quality of its local facilities; and how easy it is to move from one place to another. People feel better and more positive in places that provide comfort, stimulation, as well as opportunities to learn, share experiences and form connections.

4.3   There is a very strong body of evidence demonstrating that certain fundamental human needs, particularly the ability to undertake personally meaningful activity and to sustain reciprocity in relationships with others, are vital for sustaining good mental health.

Section 5: The natural environment as a determinant of mental health

5.1 The importance of natural environment in preserving and promoting human health is now being increasingly recognised. Research indicates that green spaces improve mental health and overall quality of life. Opportunities to be outdoors, in fresh air and to be in contact with plants and animals have a profound impact on wellbeing. Green spaces provide a place to exercise. The more time people spend in outdoor green spaces, the less stressed they feel. This is true regardless of their age, gender, and socio-economic status.

5.2 There is growing evidence that the positive effects of high quality green space and the natural environment may be further enhanced by outdoor physical activity, which also exerts an independent effect on mental health in its own right, as discussed in the next section.

Section 6: Impact of physical activity on mental health

6.1 Physical activity benefits mental as well as physical health. The new UK physical activity guidelines recommend a renewed focus on being active every day. Minimum levels of activity for adults are as follows[14]:

Adults (19-64 years old) and older people (65 plus): should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more. Muscle strengthening activity should also be included twice a week.

6.2 Most people are aware of the physical and mental benefits of physical activity and recent surveys show that population attitudes towards physical activity are generally positive.[15] An understanding of the benefits, however, does not necessarily lead to increased levels of physical activity among the population. Elderly people often find environmental barriers particularly problematic.

6.3   Younger people and those in less deprived areas are more likely to report higher levels of physical activity. However, those in more disadvantaged areas are less likely to exercise and are less convinced of its benefits, citing barriers such as lack of motivation and accessibility, availability and quality of facilities. Overall, those in most disadvantaged situations due to poor life circumstances or poor health, are less likely to undertake physical activity and hold stronger views that external factors, such as social and environmental, inhibit them.

6.4   Research suggests that levels of physical activity may be linked to perceived degree of control over issues such as body size and metabolism; those who feel less in control are less likely to be active. Thus, better transport links and improved facilities may not be enough to encourage more people to undertake more physical activity.

Section 7:   Arts, culture and mental health

7.1   Art, dance, and music therapy are well established in mental healthcare. They are also widely advocated for promotion of positive mental health. However, the evidence base for any measurable benefits on health status *per se* is currently inadequate and needs to be improved. There is some limited observational research conducted in Sweden over 15 years ago which suggests that, after controlling for all other variables, involvement in cultural events, reading and music is related positively to longevity and health.[16] There is also a plethora of descriptive reports of wide-ranging positive health and social outcomes attributed to participation in creative arts. However, these contrast with a dearth of well designed controlled interventional studies. Cited benefits for arts participation suggest that they may:

- Contribute to effective health education
- Contribute to a more relaxed atmosphere in health centres
- Help improve the quality of life of people with poor health
- Provide a unique and deep source of enjoyment

- Help people develop their creativity
- Satisfy needs relating to health, education, community development and happiness
- Encourage people to accept risk positively
- Help community groups to raise their vision beyond the immediate
- Raise expectations about what is possible and desirable.[17]

7.2   In summary, the anecdotal health and wellbeing benefits so consistently attributed to involvement in artistic and cultural activities suggest that there may be a plausible link to mental health outcomes, but this requires to be tested much more rigorously in order to generate the critical mass of evidence needed before investment in this area should be extended.

Three extensive systematic reviews in this topic area provide further detail of the current evidence.[18-20]

Section 8:   Mental health improvement work in Glasgow

8.1   NHSGGC has made real progress in developing its strategic approach to the promotion of population mental health at Health Board, CH(C)P and Community Planning Partnership levels. A locally developed strategic framework for mental health improvement, 'No Health Without Mental Health', provides an overarching guiding approach for this work.

8.2   'No Health Without Mental Health' is a framework to guide strategic planning and actions at local level, with a particular focus on Community Health (and Care) Partnerships and Community Planning Partnerships. It connects closely with wider government policy, including Towards a Mentally Flourishing Scotland, Choose Life suicide prevention policy and wider mental health policy. It is also in tune with the preventative approaches recommended in the Christie report.[21] This strategic framework is being actively used as a guide to inform planning and delivery across the Health Board area. Local mental health improvement

development work is also actively drawing on other development resources, such as the work of the Anti-Stigma Partnership and Choose Life Programmes.

8.3   Each chapter in this report showcases real world examples of mental health improvement initiatives that are appropriate to each period across the lifecourse. However, there are some unifying actions that are relevant to all. The UK Foresight Project proposed five actions for individuals that can be used to promote public understanding and engagement with mental health improvement. These are:

- **Connect** with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

- **Be active**... Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

- **Take notice**... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

- **Keep learning**…Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.

- **Give**… Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself and your happiness linked to the wider community can be incredibly rewarding and creates connections with the people around you.

8.3   Case studies

Case study 1: 'Branching Out' is a collaboration involving NHSGGC, the Glasgow Centre for Population Health, Forestry Commission Scotland and others. It promotes the health of people who use mental health services through structured environmental and conservation programmes using Forestry Commission woodlands. People develop new skills, which can lead to new interests or vocational training. Some participants have obtained the internationally recognised John Muir Conservation Award. Results from the Branching Out programme evaluation are promising. There are low dropout rates (75% completion); significant increases in physical activity levels; self reported improvements in confidence and self-esteem; and a strong appeal across age ranges and genders.

Case study 2: The Alec Finlay Home for a King/waiting room in the park project has opened up a new entrance at Springburn Park for Stobhill Hospital patients, staff and visitors. Boulders engraved with poetry, a bird box walk and benches seek to encourage people to use the green space, to walk and to wait in a natural environment.

Case study 3: The Scottish Mental Health Arts and Film Festival includes writing workshops, community theatre, exhibitions, concerts and a short film competition. International figures in music and literature feature. Local communities and service users also contribute. The festival has been successful in involving people who are less likely to attend arts events: those from areas of multiple deprivation; BME communities; and those who experience poor mental health. Those who attend events report being motivated to reconsider their conceptions of mental health and wellbeing, feel a keener understanding of the impact of stigma and heightened empathy for people who experience mental health problems.

Section 9: Recommendations

9.1   Good mental health and wellbeing is a positive resource for individuals, communities and society. The promotion of good mental health must be a priority area for action by all public sector agencies. We need to widen awareness of mental health issues and to understand better what helps and undermines good mental health and promotes resilience in coping with life's difficulties, as well as to enable access to quality services for those that need them.

9.2   The determinants of mental health problems are wide-ranging and include influences at all stages and aspects of life such as early life experiences, environment, employability, income, relationships and lifestyle. Mental health improvement needs to be included in all plans, strategies, policies and service designs, to understand and account for the needs of all age groups within the population, and to recognise the influence of inequalities.

9.3   We need to ensure that public policies, spending decisions and service design promote good mental health in the population and address inequalities in mental health.

9.4   We need to promote the value of positive environments and of activities and experiences that can promote good mental health and wellbeing, particularly physical activity. Promising interventions should be submitted to rigorous evaluation.

9.5   We need a much stronger focus and leadership to get our population more physically active. This will involve some high profile campaigns as well as an understanding in all services on the importance of physical activity to promote good mental health and access to services to support and motivate behaviour change. Even in times of austerity, we must continue to advocate active transport, cycle lanes, walking groups, good signage, cycle lane schemes and cycling proficiency in schools.

Chapter 3: Early years

A mentally healthy childhood is crucial in promoting positive social, emotional and behavioural development in children. The national strategy 'Getting it Right for Every Child' defines wellbeing in terms of eight indicators: nurtured, active, respected, responsible, included, safe, healthy and achieving. The strategy states these are the basic ingredients necessary for all children to reach their full potential. It places the child and family at the centre of all care and services. Children exposed to poor parental mental health and lifestyles are more likely to experience poor birth outcomes and poorer mental and physical health as they grow. Early intervention and preventative investment is more effective than trying to improve outcomes through interventions at a later stage of development.[22]

The early years in the context of this report includes the time from conception to nursery school age. There are just over 68,000 children aged 0-4 years living within the NHSGGC Board's boundaries. This chapter includes a description of the issues related to mental health and wellbeing in the early years, an overview of local practice and recommendations for action.

Section 1: Determinants of mental health in early years

1.1   Influences on the likelihood of developing mental ill-health are called protective and risk factors and impacts on all stages of the life course. Protective factors for wellbeing include resilience, self-esteem and the ability to cope with stress. Diet and physical activity help improve mental and physical health and are important pre-pregnancy, during pregnancy and after birth for mothers and children. Secure attachment, good parenting and a supportive environment are foundations for wellbeing.

1.2   Risk factors for this stage include parental mental ill-health, substance misuse, physical and emotional abuse. Family conflict, isolation, poverty and stressful life events including bereavement and loss also contribute to an increased risk of poor mental health. Risk factors for children include genetic factors, low birth weight and prematurity. Many of these risk factors are associated with social disadvantage, adding to the risk of mental ill-health.

Section 2:   Challenges to wellbeing in pregnancy

2.1   Poor mental health and wellbeing from preconception have health and social costs to mothers, babies, families and the wider community. Early experiences set the course for the rest of our lives.

2.2   Inequalities have a bearing on maternal health and the development of the child and his or her happiness and productivity in society. This is the start of a recurring cycle of social disadvantage for generations, which can lead to huge costs for the wider society.[23]

2.3   The greatest health inequalities are both a direct and indirect result of poverty. Low income and poverty are associated with worse physical, mental and social outcomes starting pre-birth, into childhood and throughout adult life. This is compounded by other forms of inequality such as race, gender and disability. Poorer children are three times more likely to have mental ill-heath, with higher rates of suicide or self-harm compared to children with positive mental wellbeing during childhood.[24] Of the 14,020 live births in 2009/10 in NHSGGC, 42.5% were to mothers living in the most deprived communities.[25] There were just under 750 babies born with low birth weight (excluding multiple births) in NHSGGC in 2009/10 (see Figure 3.1). The overall rate of these low birth weight babies was 66.9 per 1,000 live births in the most deprived compared to 34.2 per 1,000 live births in the least deprived. The rate of premature low birth weight babies was almost three times higher in the most deprived than in the least deprived

communities. Across Scotland, there are more deaths in the first year of life in the most deprived compared to the remaining population. Infant mortality rates in Scotland fluctuate between years but are about double those of some Scandinavian countries.

Figure 3.1:   NHSGGC Low birth weight babies (singleton); rate per 1000 live births by gestational age at delivery and deprivation Source: SMR02, extracted August 2011
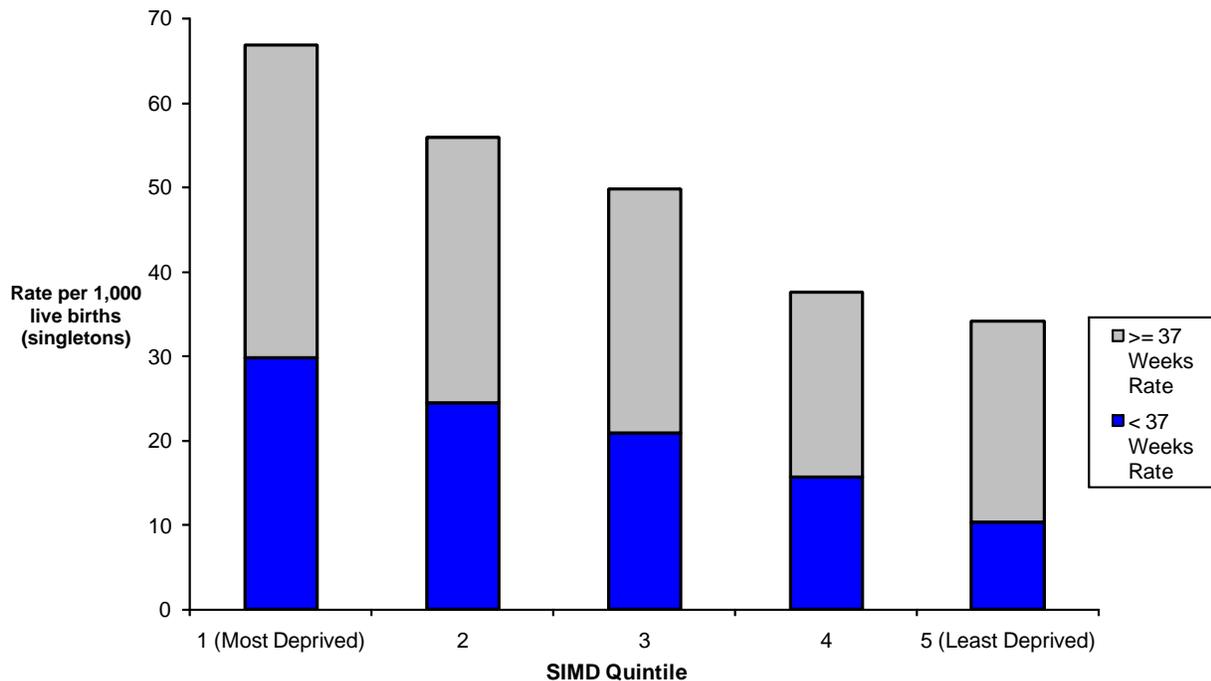
2.4   Socially disadvantaged women frequently have unplanned but not unintended or unwanted pregnancies and are least likely to have a termination of pregnancy. It is particularly important for these women to receive advice and services to enable them to have pregnancies if and when they want to, with appropriate timing to promote optimal medical and social outcomes. Many of these women are known to or are in contact with health and social service agencies that address many aspects of their life but seldom discuss their reproductive plans. These opportunistic contacts with services provide opportunities to enable women to protect and control fertility and have pregnancies when they choose to do so. In

addition, offering women who have had babies, long acting and reversible contraception before they leave hospital after giving birth is a way we can give women back some control and help them have children at a better time in their life.

2.5   Almost half the children in NHSGGC live in low-income households – defined as the proportion of children that are dependent on out of work benefits OR Child Tax Credit more than the family element (see Table 3.2). For the year 2009/10, the estimate of children living in low-income households ranges from 32% in East Dunbartonshire to 62% in Glasgow City. The national average for that year was 48%.

Table 3.2:   Percentage of Children in Low Income Households by Local Authority area across NHSGGC, Source: Scottish Government, 2010a

	2005/06	2006/07	2007/08	2008/09	2009/10
East Dunbartonshire	28%	29%	29%	31%	32%
East Renfrewshire	28%	29%	29%	31%	32%
Glasgow City	58%	58%	59%	62%	62%
Inverclyde	52%	53%	53%	55%	56%
Renfrewshire	45%	46%	46%	48%	49%
West Dunbartonshire	53%	54%	55%	57%	58%
SCOTLAND	44%	45%	45%	47%	48%

2.6   Financial security is an important social determinant of mental health and
        wellbeing. Many families with children living in low-income households across
        NHSGGC may feel this is out of their reach. Tackling child poverty is a priority for
        local partners and cannot be separated from the circumstances of parents or
        carers.[26] This work is supported by the national policy agenda, e.g. *Equally Well,
        Achieving Our Potential, and The Early Years Framework.*

Section 3:   Risk factors

Child and family poverty

3.1   Poverty can transfer from generation to generation. Poor outcomes for babies
        and mothers associated with deprivation include higher maternal illness,
        premature labour, foetal growth restriction, low birth weight and above average
        birth complications.[27] Adverse life circumstances, maternal lifestyle and poor
        maternal mental health, are linked to income inequalities and social
        disadvantage.

        Women with complex social problems e.g. substance misuse, homelessness,
        and mental health problems, are considered to be high-risk groups. High-risk
        women require the support of all our services pre pregnancy, during pregnancy
   and beyond.

3.2   In his report for the End Child Poverty Campaign, Nick Spencer writes;
        "The health of the mother has a profound effect on the health of her children. This
        effect is most noticeable during pregnancy but persists throughout the child's
        life."[27]

3.3   Stress and prenatal depression have an effect on physical health and brain
        development of the foetus. Women experiencing high levels of anxiety in
        pregnancy at 32 weeks may be twice as likely to have children with behavioural
        or emotional problems even after allowing for postnatal factors.[28] Risk factors for

stress and depression in pregnancy include a prior history of depression, women living with domestic abuse, complications in pregnancy, poor social support and low income.

3.4   Mothers under 20 years are also a high-risk group. There were fewer than 2,000 pregnancies to women in NHSGGC under 20 years old in 2009, of which 58% were in the most deprived communities.[29] There were 143 pregnancies to mothers under 16 years. Women under 20 years old living in the most deprived areas are ten times more likely to continue with their pregnancy and deliver than those in the least deprived areas. There is a higher risk of depression and anxiety in teenage mothers. Risk factors for teenage pregnancy include exposure to parental separation and divorce and there is a strong association with social disadvantage. Over the past 15 years, the rates of teenage pregnancies in women under 20 and women under 16 have fluctuated (See Figure 3.3). The current rates for pregnancies in women under 20 are higher in NHSGGC compared with Scotland, 53.6 and 52.8 per 1,000 women under 20 respectively. Within NHSGGC, the highest rates for pregnancy for women under 20 years are in Glasgow City and West Dunbartonshire (63.3 and 62.1 per 1,000 relevant female populations respectively). The highest rates of pregnancy for women under 16 years in Glasgow City and Inverclyde are 9.5 and 9.1 per 1,000 relevant female populations respectively. In comparison, the figures in both age categories for East Renfrewshire and East Dunbartonshire are well below the Health Board average (24.0 and 31.9 per 1,000 relevant population respectively for Under 20's and 2.6 and 2.9 per 1,000 relevant populations respectively for Under 16's).
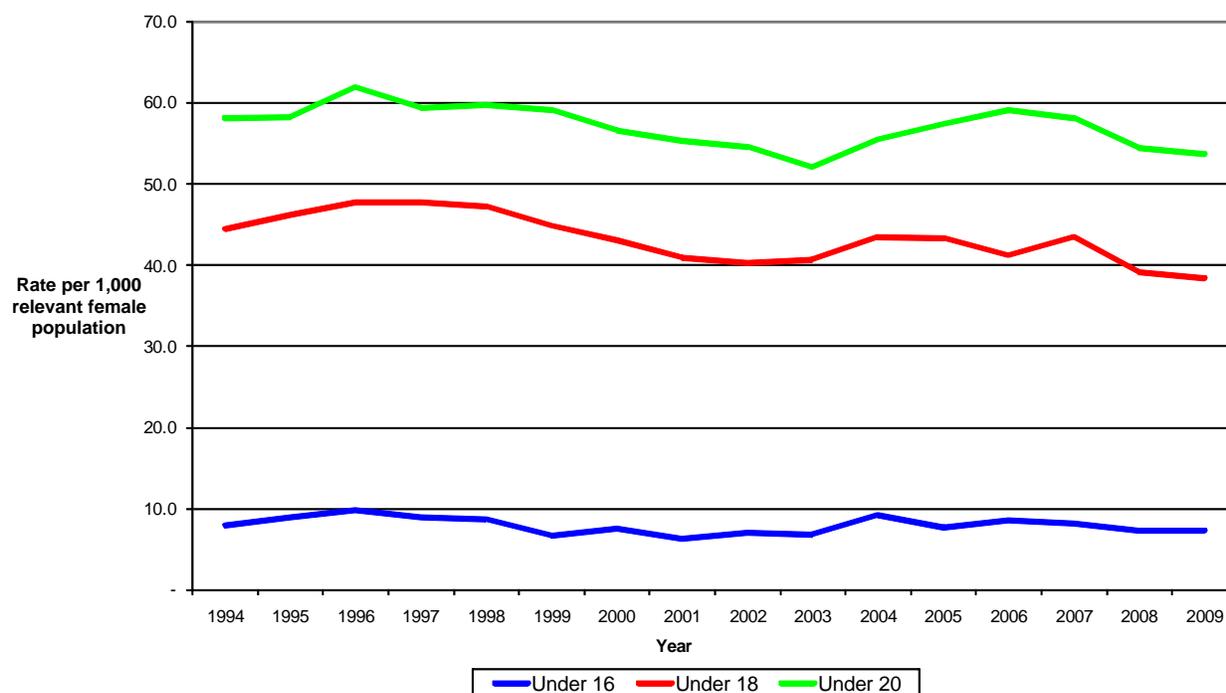
3.5   Child sexual abuse survivors are at higher than average risk of mental health problems, substance misuse and homelessness, risky sexual activities and sexual exploitation. For example, over 50% of young homeless people disclosed they had experienced childhood sexual abuse when asked during the assessment process.[30]

3.6   There is a relationship between stress, poverty and impact on family wellbeing e.g. social isolation and little family support, unemployment, mental health (anxiety and depression), money and housing matters all contribute to poor mental wellbeing. These effects are linked to poor attachment with the infant after birth and increased risk of suicide in the postnatal period. Maternal suicide is now the leading cause of indirect deaths after a pregnancy, leaving bereaved families

to cope and increasing their risk of mental ill-health among other family members. Fortunately, these events are rare, but their effects are severe.

Smoking

3.7 Women who smoke in pregnancy are more likely to be young, single, lack support, have higher levels of stress and be living in more deprived areas with complex social needs. It is both a cause and effect of health inequalities.

3.8 Figures for Glasgow suggest that 17.5% of women booking in NHSGGC maternity units are current smokers. This means that of the 13,876 maternities in NHSGGC in 2009/10, we estimate that at least 2,475 pregnant women were smokers. This is only an estimate because in approximately 10% of women, smoking status is unknown, usually because they are not asked. Recent data suggests the proportion of unknown smokers has fallen. Pregnant smoking rates range from 5.5% to 25.9%, between women in the least and most deprived areas respectively.

Figure 3.4   NHSGGC Maternities, smoking during pregnancy by deprivation Source: SMR02, extracted August 2011
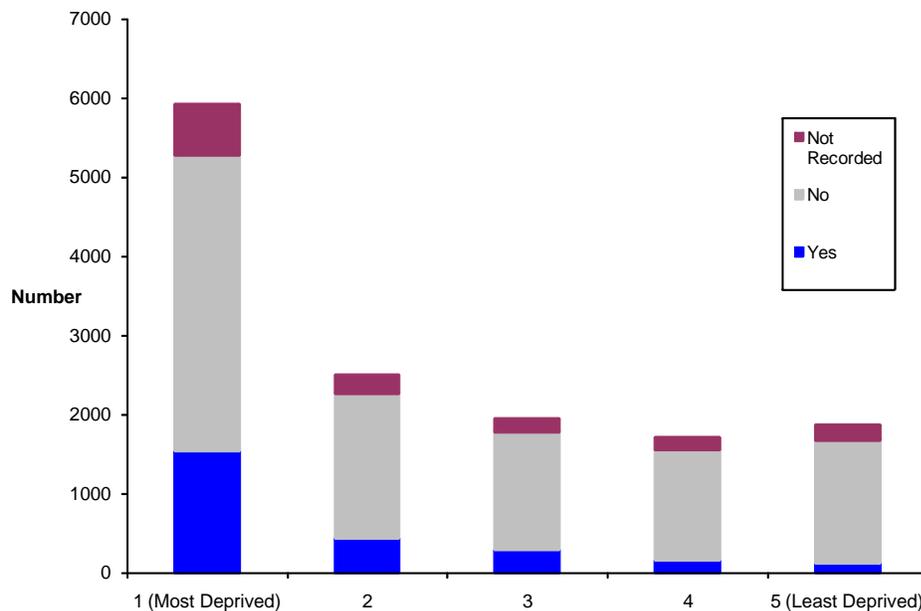
3.9   Reducing smoking in pregnancy would have immediate benefits in birth outcomes. To illustrate this point, if we use a delivery rate of 13,860 per year and assume we can reduce the smoking rate to precisely 10%, we would expect to see about 13 fewer stillbirths per year (74 in 2009), 38 fewer miscarriages, fewer hospital admissions in pregnancy and fewer sudden infant deaths. Our nurses, midwives, general practitioners and health visitors play a vital role in reducing the number of mothers who smoke. Their intervention may be the most important single influence on a woman's health. NICE guidance stated that early results around using incentives to stop smoking were promising but that more UK research is needed about effectiveness in pregnancy. We will be hosting a randomised controlled trial in NHSGGC to look at this in the near future.

Alcohol and substance misuse

3.10   Drinking too much alcohol in pregnancy affects foetal development and is associated with adverse pregnancy outcomes. Women who abuse alcohol are more likely to suffer from poor mental health and wellbeing. Foetal alcohol harm (FAH) is the term used to describe the range of outcomes resulting from exposure to alcohol during pregnancy and incorporates foetal alcohol syndrome (FAS) and foetal alcohol spectrum disorder (FASD). Foetal alcohol harm is estimated to effect over 10,000 children and young people (0-18yrs) in Scotland and is thought to be the most common environmental cause of learning difficulties. Foetal alcohol syndrome, the more severe form of the condition, affects between one and seven per 1,000 live-born infants, equating to an estimated 137-964 children in NHSGGC per year based on the current birth rate. FASD affects a much larger number of children and is associated with learning disability and behavioural problems including the inability to plan, learn from experience or control impulses. FAH has large economic and social costs. It is preventable but because many pregnancies are unplanned, much of the harm is done before a women herself is aware that she is pregnant.

3.11   We do not know if there is a safe level of alcohol consumption during pregnancy. The UK Chief Medical Officers advise that pregnant women and women trying to conceive should avoid drinking any alcohol and, if they choose to drink, this should be limited to one or two units once or twice per week. The Glasgow Health Commission has recommended clear messages in bars and off-licences to advise pregnant women against drinking alcohol.

3.12   Alcohol and drug intake is poorly recorded in pregnancy and health care professionals report barriers to asking about sensitive issues. Pregnant women abusing alcohol often hide or deny their addiction. Health workers are less likely to question women who are more affluent. NHSGGC is training midwives to give alcohol brief interventions to women at their booking visit as part of the HEAT targets.

Gender based violence

3.13   Women and children who experience some form of gender-based violence are at significantly higher risk of experiencing other risk factors associated with maternal and child health. Research from 2008 by Family Action and Gingerbread, revealed how domestic violence can push women into severe debt and hardship.[31] A recent UK wide NHSPCC report highlighted that 1 in 20 secondary school pupils has been sexually abused and far more likely to self-harm, abuse drugs and alcohol, suffer from depression and experience post-traumatic stress disorder.[32] This abuse may have happened or began before secondary school. Furthermore, pregnancy itself is a risk factor for domestic abuse.[33]

Services to address these factors

3.14   NHSGGC provides a number of services aimed at addressing the determinants of ill-health in pregnant women. The redesign of Special Needs in Pregnancy (SNIPs) service will provide additional support for women with complex social

needs in an equitable way across the whole board area. SNIPs midwives work with addiction, mental health staff, social and support workers. We will also implement the programme for Vulnerable Children and Families and align it with current primary care and maternity services. One of the greatest challenges facing these services is providing referral to the support needed in a time sensitive way. This is to allow for every additional day a pregnancy or new baby is exposed to adverse vulnerable circumstances, there is a significant impact on the future of that individual and their family.

3.15   We promote sensitive antenatal enquiry to identify women already accessing specialist services such as substance misuse, social work and mental health services. Comprehensive antenatal care takes into account a woman's personal social context and identifies those with additional stress and social care needs who may need further support relating to emotional and psychological wellbeing. Stresses may include a history of domestic abuse, financial worries or anxiety and depression. Findings from this enquiry are documented in the maternal handheld record which can be used as a tool to support access to other services e.g. financial inclusion (benefit maximisation, debt and potential debt support, budgeting skills), and housing services. Women with socially disadvantaged high-risk pregnancies should be considered just as vulnerable as those with medically high-risk pregnancies and have their care delivered through a consultant led obstetric service.

3.16   Maximising families' income is one element of addressing the effects of poverty on the health of women and their children. The Healthier, Wealthier Children (HWC) project aims to improve financial security for families with children living in low-income households. Health staff enquire sensitively if their patients have any money worries and can then refer them to financial advisers. Between February and May 2011, there were 1,585 HWC referrals to advice services, of which 72% (n=1,137) were from Midwives and Health Visitors. The Glasgow Centre for Population Health evaluation report for HWC will be available in March 2012.

HWC Family Case Study: Mum is in low paid work and dad is caring for three young children. Despite thinking she had received all her benefit entitlements, mum spoke to a health worker about her money worries. A HWC referral resulted in a Council Tax saving of just under £1,000. The family stress levels were significantly reduced. The family can now save for emergencies, e.g. a new washing machine. They can buy the children toys they previously couldn't afford. Mum feels more confident about looking for a better paid job.

Section 4:   Children and early experiences

4.1   The relationship between secure attachment, good parenting and a supportive environment are protective factors for mental wellbeing in the early years and predictors of future health and wellbeing. Likewise parental ill-health, family conflict and poor parenting are risk factors for mental ill-health.

4.2   Young children experience short-term stress in normal circumstances such as fear, hunger, or pain, for example, falling over and hurting their knee. Usually parents provide the support required to sooth and reassure a child. The child feels secure through this relationship. It affects how they grow and develop new relationships with others. Parents' own stress can affect their ability to support their child. It is not always easy to know the best thing to do to support your child.

4.3   Children suffering from severe neglect experience negative effects on brain development. Severe neglect includes failing to provide for basic needs or emotional support, or with inappropriate care. Neglect accounts for two-thirds of all abuse and can go unrecognised for long periods. Early neglect has been

shown to predict high levels of aggression in older children and, in the long-term, can lead to attention deficits, social deficits and abnormal stress responses. This means children will find it difficult to sit still and concentrate at school, will struggle to maintain friendships, and could over or under-react to stressful situations such as getting into a disagreement. There is an association between erratic, coercive or negative parenting and problems with aggression, such as conduct disorder. In extreme circumstances, children suffering prolonged stress such as physical abuse, neglect, parental substance misuse or a mother with severe postnatal depression or mental ill-health, are more likely to develop depression, anxiety and substance misuse in later life. This is where parenting support can be an effective way to reduce the burden of mental illness in the long-term.

4.4   Support for parenting skills can bring positive outcomes for parents and children, increasing parental wellbeing and experience and enhancing long-term protective factors for children. Better Health, Better Care[34] and Towards a Mentally Flourishing Scotland[35] stress the importance of providing parenting support in order to achieve the desired goal of providing children with the best possible start.

4.5   It is possible to see some early warning signs of poor outcomes in physical and psychological domains, including language delay and disruptive behaviours. A new universal contact between health visitors and children aged 30 months is being planned. Using tools to assess aspects of social, emotional and language development, the families of children identified with language delay, emotional, conduct, attention or peer-relationship problems at 30 months will be offered further help. This work will help us to develop care pathways and preventative programmes using interventions that are based on good evidence to improve outcomes for children and families. However, as brain development is largely complete by three years of age, and change thereafter slower and harder to achieve, even earlier intervention should be prioritised.

Section 5:   Parenting

5.1   NHSGGC has adopted Triple P (Positive Parenting Programme), an evidence-based parenting programme, in partnership with a number of local authorities.

5.2   Early indications from the evaluation show positive outcomes for parents e.g. reduced anxiety, depression and stress after taking part in a group. We are continuing with our robust monitoring and evaluation process to make sure we provide the most effective, appropriate and timely parenting support across NHSGGC. The roll out of Triple P takes in other areas such as Inverclyde and West Dunbartonshire.

5.3   We will also be carrying out a trial of Triple P for Baby and Mellow Bumps programmes. These group-based programmes for prospective parents aim to improve relationships between parents and children by intervening at the antenatal period. They differ in their approach, time commitment and costs. Both programmes are appropriate for vulnerable mothers, but we do not yet know how effective they are. Trained staff in community settings will run the programmes. We aim to assess whether either programme can save money for the NHS in the long-term. The programmes will be compared in terms of (a) the quality of the mother-child relationship and (b) mothers' mental health when the baby is 6 months: both related to risk of maltreatment and child development.

5.4   It is important to provide high quality universal services to engage all parents, ensuring the majority of resources meet the needs of the most vulnerable groups.

Section 6:   Parental mental health

6.1   There is a sub optimal understanding of mental ill-health affecting parents. Parents with poor mental health cope less well with parenting and as identified earlier, this can lead to poor attachment as well as long-term emotional, physical and behavioural problems in children.

6.2 The Scottish Health Survey 2008/9 showed that 15.4% of pregnant women scored poorly, indicating possible psychiatric disorder. When we apply these results to the 13,823 NHSGGC maternities of 2009, we estimate that 2,129 of the NHSGGC maternity cohort would have been expected to score poorly on this measure, indicating poor mental wellbeing. However, not all of these women would be expected to qualify for a psychiatric diagnosis.

6.3 The Growing up in Scotland report suggests about a third of mothers experience poor mental health at some point in the first four years of life. This equates to over 4,500 women each year in NHSGGC.

6.4 Children exposed to maternal mental ill-health are more likely to have poor outcomes. Children whose mothers are emotionally well have better social behavioural and emotional development. Mothers' vulnerability e.g. those who have suffered domestic violence and/or mental ill-health, makes it more likely that the child will develop poorly and be maltreated.[36-38]

6.5 Midwives, General Practitioners and Health Visitors have an important role in identifying women who are depressed before and after their babies are born and supporting them in recovery and identifying neglect in young children.

6.6 Health Visitors use the Edinburgh Postnatal Depression scale, a self-reporting tool to assess new mothers for depression in the postnatal period. Postnatal depression is relatively common, affecting 10-15% of women having a baby. Symptoms include low mood, irritability, tiredness, sleeplessness, changes in appetite, difficulty in enjoying anything, loss of interest in sex, negative and guilty thoughts, anxiety, avoiding other people, and feelings of hopelessness or suicidal thoughts. A small number of women with very severe depression develop psychotic symptoms: they may hear voices and have unusual beliefs. This equates to between 1,367 and 2,050 women per year in NHSGGC, suffering from postnatal depression and between 136 and 273 women experiencing

psychosis. Research suggests 1 in 4 mothers will still be depressed by the time their child is one year old.

Section 7: Recommendations

7.1   We must recognise the importance of preconceptual and maternal health in public health and maternity planning to ensure that every child is born in the best health possible and nurtured in early life. Integrated planning should include preconception counselling, contraception advice and provision for high-risk, vulnerable groups. This includes strengthening the role of health visitors and midwives working together to detect and support those with mental health problems in the early years. Preconception care also includes youth services that promote mental health and self-esteem as discussed in the next chapter. Staff must be aware of the implications of poverty on health and what support can be provided. We will continue to support women at risk of poverty, gender based violence or who could benefit from employability advice, by recommending sensitive enquiry in services.

7.2   The evidence base should be used to target services to need. We can do this with a blend of universal and targeted services for pregnant women and young children continuing the population approach to Triple P but identifying and supporting more vulnerable families to access more intensive parenting interventions. Plans are in place to strengthen routine child health surveillance with the introduction of a new universal contact at around 30 months of age. We must ensure that there are effective ways to engage families identified as requiring more support in evidence based parenting programmes and early language development.

7.3   We will continue to prioritise the implementation of the Triple P positive parenting programme. We will use early lessons and evaluation to make seminars as attractive and useful to parents as possible and utilise parent discussion groups

on specific topics. We will work with existing parents groups and organisations to support engagement with the Triple P programme.

7.4   We need to raise awareness amongst all staff in contact with pregnant women of the harms caused by smoking and alcohol in pregnancy and the effectiveness of cessation support to encourage women to access smoking cessation services as early in pregnancy as possible. We endorse the national approach to giving clear messages of no alcohol in pregnancy. We will implement alcohol brief interventions in pregnancy but it will be vital to evaluate the effectiveness of this intervention, as this is unclear. We would also like to work with licensing boards to encourage clear warnings of the harms of drinking in pregnancy in licensed premises.

7.5   We should ensure that primary mental health services prioritise pregnant women and women with very young children in need. We must aim for fast track access to support with psychological therapies before or soon after their child is born to reduce any effect on attachment or bonding.

7.6   In March 2011, the Scottish Government published their Child Poverty Strategy for Scotland, which sets out how the 2020 targets laid down by the Child Poverty Act 2010 will be met.[39] We will take action to reduce child poverty by developing local partnership strategies, which will help families, reduce their outgoings, increase their incomes and reduce the negative effects of poverty. These partnership strategies should describe clearly each agency's role in addressing child poverty.

Chapter 4:   Children and young people

The term 'children and young people' in this report relates to the phase of life which starts with a child's entry into formal education at around age 3 and ends at age 19, when the majority of young people have left secondary education and occupy the role of an adult in society.

Children and young people need health, education, equality and protection in order to thrive. Children are growing and developing. This makes them vulnerable. They require the support of adults to help them articulate their needs and protect their rights. Adult problems with mental health or low wellbeing often have their origins in childhood. If issues are not identified and addressed in childhood, they set the course for prolonged mental health problems and poorer outcomes across the adult phase of a person's life. This results in increased risk of suicide, lower educational and employment outcomes and increased risk of substance misuse. Similarly, mental health needs or problems with low wellbeing in adults who are parents or carers can in turn, have a negative affect on the health and wellbeing of their children.

Socioeconomic deprivation is a major cause of mental health needs and low levels of wellbeing. Tackling the consequences of socioeconomic deprivation will require action by everyone: the welfare of children must become everyone's business.

Section 1:   Determinants of mental health

1.1   The population of children aged 5-19 is falling. In 2010, there were 199,414 children and young people in the board area, making up 16.6% of the population. It is estimated that the number of 5-19 year olds will fall by 4.2% to 190,993 in 2020 (15.9% of the population).[40]

1.2   The Scottish Public Health Observatory's Children and Young People's health
        Profiles from 2010 provide a detailed snapshot of the health, wellbeing and life
        circumstances of children and young people.[41]

1.3   For the entire Health Board population, the proportion of children living in
        households reliant on out of work benefits was significantly higher than the
        Scottish average. A significantly higher number of children were living in areas
        classified as income deprived (33% versus 16.5% nationally), although levels in
        East Dunbartonshire and East Renfrewshire were below the Scottish average.

1.4   Children and young people in NHSGGC were significantly more likely to be
        admitted to hospital as the result of being assaulted than their Scottish
        counterparts. More children were living in areas with the highest levels of crime in
        Scotland. Children and young people in NHSGGC were also more likely to be
        referred to the Scottish Children's Reporter Administration on suspicion of having
        committed violent offences.

1.5   We have a higher rate of looked after and accommodated children than the
        Scottish average. Child protection concerns are known to be higher in areas of
        socioeconomic deprivation, although it is not understood why this is the case.

1.6   The rate of children referred by professionals or members of the public to social
        work services because of concerns around their general care was significantly
        lower than the Scottish average – 10.9 per thousand compared to 13.9 per 1000
        for Scotland as a whole. This referral rate varied greatly by area; from a high of
        22.9 per 1000 children aged 0-15 in Inverclyde, to a low of 9.7 and 9.6 per 1000
        in Glasgow City and West Dunbartonshire respectively. Some of the variation
        may be due to different definitions used across different council areas.

1.7   For our population overall, children and young people's health behaviours were
        not significantly worse than the Scottish average. The indicators used included

active travel to school (physical activity); young people admitted to hospital through alcohol use; and smoking, alcohol and drug use at age 15.

1.8   Active travel to school varied from a high of 54% in East Dunbartonshire to a low of 45% in West Dunbartonshire.

1.9   Admissions of young people associated with alcohol were significantly above the Scottish level in North East and South Glasgow and in Inverclyde, and significantly below the Scottish average in East Renfrewshire, East Dunbartonshire and Renfrewshire. The highest prevalence of alcohol use in 15 year olds was 33.3% in West Dunbartonshire, with the lowest being 23.8% in East Renfrewshire.

1.10   Admissions of young people associated with drug misuse varied from a high of 68 per 100,000 persons aged 0-24 per year in Inverclyde, through to a low of 15.3 in East Dunbartonshire. The percentage of 15 year olds who admitted using drugs varied from a high of 10.7% in West Dunbartonshire to a low of 5.0% Glasgow City.

1.11   Local teenage pregnancy rates were not statistically different from the Scottish average, although the Scottish teenage pregnancy rate is relatively high. The highest rate was 59.3 per 1000 females aged 15-17 per year in North East Glasgow, with the lowest level being in East Renfrewshire where the rate was 17.4 per 1000.

1.12   Scores from the Strengths and Difficulties Questionnaire, which is used to identify behavioural problems in children, were s better in NHSGGC than the Scottish average, although this difference was small. Within our area, the highest problem score (worse) was in West Dunbartonshire (12.3) and the lowest (best) was in East Dunbartonshire (11.3).

1.13 Educational indicators were significantly worse than for Scotland as a whole in terms of school attendance rates for primary and secondary school pupils. Similarly, young people were more likely than the Scottish average to not be in education, employment or training (aged 16-19), although school leavers overall had a similar proportion entering further or higher education, or employment or training.

1.14 The influence of socioeconomic disadvantage is seen across all indices, characterising health and wellbeing challenges for this age group. Tackling the social determinants of children's health therefore requires action with partners to reduce child poverty, the leading cause of lower levels of health and wellbeing in NHSGGC.

Section 2: What determines the wellbeing of children and young people?

2.1 The recent national consultation with children[42] has identified their priorities as:
- safety and security at home, on public transport and on the streets
- alcohol and drug misuse
- gang fighting
- the state of the environment, e.g. litter and graffiti
- a desire for equal life chances, and
- respect and inclusion

2.2 The United Nations Children's Fund (UNICEF) Report Card 7: an overview of child wellbeing in rich countries demonstrated that the challenge to improve the wellbeing of children in the UK is not limited to addressing those who are living in disadvantage.[43] The UK as a whole was in the bottom third of rankings for five out of six dimensions used to assess health and wellbeing. The lowest rankings were for children's behaviours and risks; family and peer relationships; subjective wellbeing; material wellbeing; and educational wellbeing.

2.3   Recent work sponsored by UNICEF attempts to understand the reasons for low child wellbeing.[44] This research has identified that UK parents struggle to provide children with the time they need in comparison with other European families. UK parents and children were also more likely than their international counterparts to be influenced by a culture of materialism. Parents felt pressure to give children things when in fact children wanted more family time with their parents.

2.4   A strong, stable and nurturing relationship with a parent or main carer is an important precondition for mental health and wellbeing in children. This is true in the early years and it is equally important for older children and young people.

2.5   There is evidence that parenting support can help parents to become more effective. The National Institute for Public Health and Clinical Excellence (NICE) has recommended parenting support for the treatment of conduct problems and conduct disorder in children.[45] There is some evidence to suggest that parenting support aimed at whole communities may reduce the numbers of children involved in the child protection system.[46]

2.6   As described in the previous chapter on early years, the NHSGGC and Glasgow City Parenting Support Framework provides a basis for helping children through improving parenting. The framework has been designed to ensure all the agencies around children and families can provide appropriate parenting support wherever necessary. An evaluation of the framework will seek to understand how best to engage with families and support them with parenting.

Section 3:   A vision of positive mental health and wellbeing in children and young people

3.1   All public services need to work together across the whole population of children and families in order to address the factors associated with low levels of mental health and wellbeing. We also need to provide additional support for children and

families identified as having mental health problems, or for those at high risk of such problems because of risk factors such as socioeconomic disadvantage.

3.2   The elements needed to bring about this change are set out in Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care.[47] These include:

- Developing universal services in the early years in order to provide supports for all children, and tailored support for those at greatest risk in order to improve social, cognitive and emotional development and act to support self-esteem, and promote confidence and independence

- Promoting a positive view of mental health and wellbeing in schools and provide supports by working in partnership with children, parents and other agencies

- Actions with the community: work with groups to support self-esteem of children and young people in their community

- Actions for specific groups or for agencies including the needs of looked after children and young people, and work around addictions in order to provide accessible, quality services which make mental health and wellbeing a priority

- Building capacity within the entire workforce who work with children and young people to build on their strengths in order to support mental health and wellbeing

Section 4:   Improving mental health and wellbeing in children and young people

4.1   The WHO's report Promoting Mental Health recognises the central importance of socioeconomic disadvantage in its widest sense as a determinant of mental health and wellbeing.[48] It cites low standard housing, low educational opportunity, substance misuse and violence as specific risk factors.

4.2   School is a central setting to influence the mental health and wellbeing of children and young people. Health Scotland has worked in partnership with Her Majesty's

Inspectorate of Education (HMIE) and with Education Scotland in order to develop resources for schools. The principles for effective action: promoting children and young people's social and emotional wellbeing in educational establishments for both primary[49] and secondary schools[50] reports build on the work of NICE and set out in a Scottish planning and policy context the ways in which schools should promote wellbeing.

4.3   The central task is to develop a whole-school approach to wellbeing, building on the work of health promoting schools. This approach will use the Curriculum for Excellence's Health and Wellbeing Theme to see wellbeing embedded across learning, so that children achieve learning outcomes against social, emotional, mental and physical wellbeing (Figure 4.1).

4.4   The Health and Wellbeing strand in the Curriculum for Excellence (CfE) seeks to ensure that children[51]:

- make informed decisions in order to improve their mental, emotional, social and physical wellbeing

- experience challenge and enjoyment

- experience positive aspects of healthy living and activity for themselves

- apply their mental, emotional, social and physical skills to pursue a healthy lifestyle

- make a successful move to the next stage of education or work

- establish a pattern of health and wellbeing which will be sustained into adult life, and which will help to promote the health and wellbeing of the next generation of Scottish children

Figure 4.1: **The outcomes for health and wellbeing within the curriculum for excellence. From Education Scotland's Curriculum for Excellence Health and Wellbeing: principles and practice**
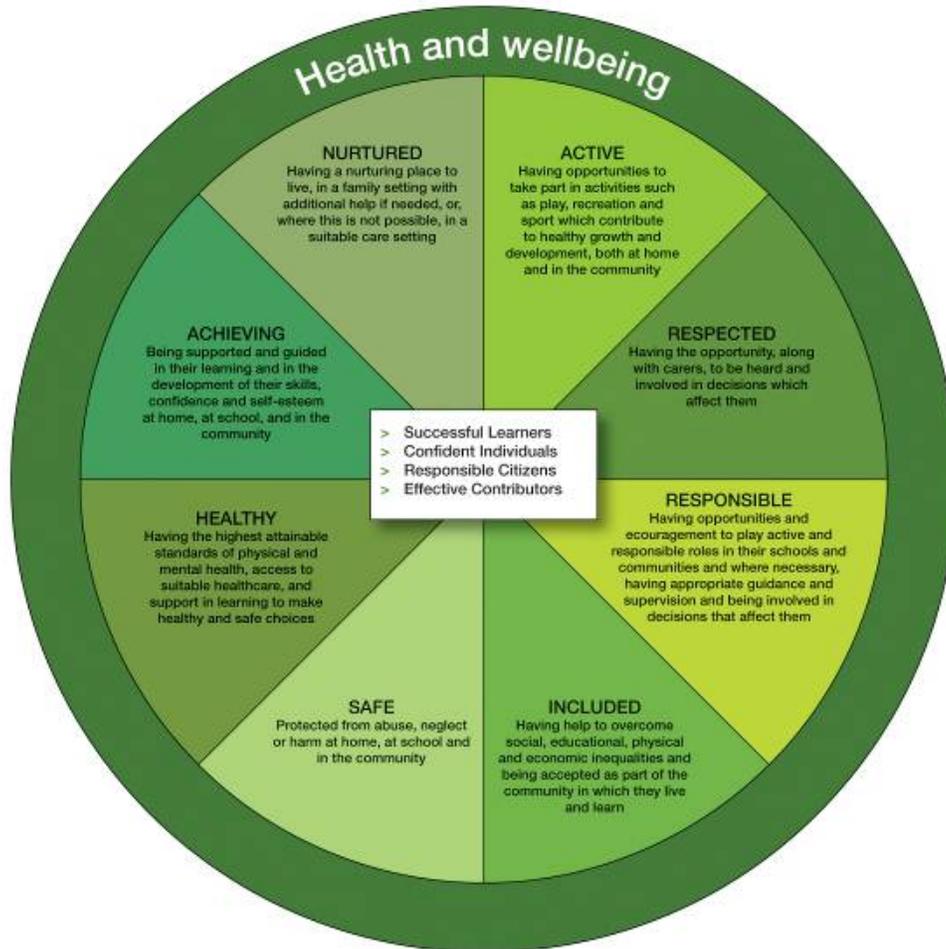
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4.5   The current financial challenges have given an impetus to cross agency working, which is focused on outcomes rather than structures. The WHO guidance, CfE and the Framework for Promotion, Prevention and Care, all rely upon partnership working as a central element of their action. The importance of preventative work and better outcomes has also been emphasised for the Scottish public sector by the recent Christie report.[21]

4.6   The UNICEF Child-Friendly City Initiative framework for place-based services helps agencies to articulate a rights-based approach through their decision making and planning for services.[52] It places the needs of children and their views at the centre of decision-making.

Section 5:   Specific action to support mental health and wellbeing

5.1   Recent guidance has clarified the role for school-based work around alcohol.[53] Health improvement approaches across NHSGGC include the development of training for people who work with young people, in schools or in community settings. The aim is to raise awareness and knowledge about alcohol and the most popular drugs in current youth culture. The CfE will need to make use of this training as part of the whole school approach to health and wellbeing.

5.2   Further population work involves ensuring that parenting programmes equip parents of teenage children to address issues around drinking and drug use. Work across police, education, social work and health is underway to ensure that young people with harmful drinking are referred on for further interventions. The GCPH research on young people and alcohol provides important insights that can inform health improvement strategies.[54]

5.3   Scottish Government estimate there are between 12,000 and 100,000 young carers in Scotland.[55] Young carers are children who look after someone in their family who has an illness, a disability, a mental health problem or a substance misuse problem. They take on the practical and/or emotional caring responsibilities that would normally be expected of an adult. Twice as many carers are found in families living within the most disadvantaged areas than are found within families within the most affluent areas. Recent evidence from the NHSGGC and Glasgow City Schools Survey found that 15.2% of those surveyed, or 1 in 7 secondary school children, had caring responsibilities for someone with

an illness or disability, including problems with alcohol and drugs. Five percent of those responding provided care every day.[56]

5.4 Caring can be an opportunity for young people to show their love and affection for a family member. Young carers, however, often lack information about the conditions of family members for whom they are caring. Many experience their own health problems because their caring responsibilities are an inappropriate burden. There is evidence that children and young people who are carers are more likely than their peers to have educational, social and psychological problems. Child protection concerns relating to this group of children were seven times greater than amongst their peers.

5.5 Carers saw their role as a positive one, which developed their skills and made them feel good. For a small number of children, the role affected their education, contributed to tiredness, and had a negative impact on relationships at school.

5.6 The Glasgow Association for Mental Health (GAMH) Young Carers Project is aimed at young people between the ages of 12-18 who live with an adult who has a mental health problem. The project provides opportunities for young carers to participate in social and recreational activities and to develop their self-confidence and self-esteem.[57]

5.7 Getting It Right For Young Carers 2010 – 2015 makes recommendations for local authorities and NHS boards to identify and assess the health of young carers and to provide preventative support in order to reduce the adverse impact of caring on their health and wellbeing.[58]

5.8 The national Choose Life strategy and action plan for suicide prevention sets out the need for partnership working to bring together strands of work around raising awareness; tackling stigma around mental health needs; improving services, providing training for prevention, and ensuring good care for those bereaved as

the result of suicide.[59] One of the approaches taken was the production of a film, 'It's OK to ask', for 16-19 year olds with key suicide prevention messages, encouraging young people to seek help and support peers.[60]

5.9   The prevalence of teenage pregnancy is more than ten-fold higher in the most socioeconomically deprived communities in comparison with more affluent areas.[29] Teenage mums are more likely to have poorer educational and employment outcomes, be reliant on long-term benefits, have more relationship breakdowns and have lower levels of mental health and wellbeing than those who have their children in their 20s. This finding is true for both planned and unplanned teenage pregnancies. In addition, the children of teenage mums are more likely to have poorer educational and employment opportunities and have worse health and higher mortality rates than children of non-teenage mothers.

5.10   Health Scotland have published guidance, in collaboration with HMIE and Learning and Teaching Scotland, to improve sexual health: Reducing teenage pregnancy: guidance and self-assessment tool.[61] The guidance focuses on:

- Improving knowledge and awareness: developing parenting support for discussing adolescent sexuality
- Developing leadership, coordination and performance management: defining roles, communication across and within agencies, and developing the workforce
- Standards and service provision: drop-in provision for teens, needs assessment using data, health improvement activities, and workforce development
- Young people: access to sex and relationships education should be continuous and progressive. Work on aspirations, confidence and self-efficacy requires workforce development

> **Case Study:** The Girl Power programme in Inverclyde works with 13-18 year olds to deliver knowledge around healthy relationships, self-esteem and confidence building. It aims to improve self-efficacy in order to reduce coercion into early sexual activity, and thus improve sexual health and reduce teenage pregnancy.

5.11   Gang culture and violence has been a feature of life within some areas of Greater Glasgow and Clyde for many years. Since 2008, a Strathclyde Police led initiative called CIRV (Community Initiative to Reduce Violence), funded by Scottish Government and partner agencies, has been in place across North and East Glasgow City.

5.12   CIRV uses intelligence from a wide group of agencies to identify gangs and to use this grouping to create behaviour change. The evaluation in 2010 showed that gangs who had signed up to CIRV saw a 46.5% fall in violent offending compared to a 24.7% reduction on violent offending in a control group from Glasgow who were not engaged in CIRV.[62] Since April 2011, the CIRV initiative has become a mainstream part of police action across the whole Strathclyde force.

5.13   Children who are looked after by the state are a particularly vulnerable group. The Mental Health Care Needs Assessment of Looked After Children in Residential Special Schools, Care Homes and Secure Care identified that this subgroup of looked after children have a greater number and greater complexity of mental health needs than their peers.[63] This group also has particular difficulties in accessing mental health services. The report makes recommendations about clarifying the responsibilities of boards where children are looked after in an area out with their board of usual residence, and

encourages the use of the Framework for Promotion, Prevention and Care as the planning framework through which Child and Adolescent Mental Health Services (CAMHS) should develop and audit their provision for this vulnerable group.

Section 6:   Recommendations

6.1   Parenting programmes must continue for the parents of school age children, focusing on times of transition in their child's life, such as entry into primary one. We will ensure our approaches to parenting reach those families who could benefit most.

6.2   We must work together to bring about the whole school work on health and wellbeing which is envisaged by policy documents and set out in the Curriculum for Excellence. This will require new ways of working across organisations and will become a focus for improving mental health, sexual health and preventative activity around alcohol, tobacco and drugs. The recession is associated with a reduction in wellbeing and a rise in mental health needs across the population. Many young people are leaving school without positive destinations for employment or training. The health impact of these needs will fall on adult health services and on other agencies. However, we will work with education colleagues to develop whole of school approaches, which improve young people's resilience and skills to face this new reality.

6.3   We will ensure that the work of the School Nursing and Health Review considers how best to work with partners to identify and support the health needs of young carers.

6.4   We must build on our recent multi-agency planning work to create a strengthened range of preventative and early intervention services that supports the mental health, resilience and wellbeing of children and young people that better respond

to distress, self-harm and risk of suicide. Such supports should be equitable, evidence-based and better connect with the existing resources of our partners.

6.5   The health service's (or children's services) CAMHS services should have closer working relationships and liaison with schools to identify children and young people at risk of poor mental health as early as possible and put interventions in place which will improve their outcomes.

6.6   We must build the confidence and skills of key frontline workers across services to support and intervene on mental health related issues, including delivery of focused learning inputs, such as suicide prevention skills.

6.7   We should build a comprehensive communication and engagement strategy for children, young people, their parents and carers on mental health themes. This strategy will include utilising multi-media resources, social media approaches and using young people as partners, to ensure a well-informed population, to challenge stigma and discrimination, and to lower the barriers to seeking help and support.

Chapter 5: Mental health and wellbeing of adults

This chapter looks at the mental health and wellbeing of adults in Scotland and in the NHS Greater Glasgow and Clyde (NHSGGC) Board area. It addresses issues about how we can measure the mental health and wellbeing of adults, which can also help us to see if our policies are working. The chapter identifies local approaches to promote positive mental health and wellbeing, with a particular focus on reducing inequalities across a range of population groups, preventing mental health problems including suicide prevention and improving the quality of life of those experiencing mental health problems.

Section 1: Adult mental health and wellbeing in NHSGGC

1.1   A recent report by GCPH examined over 51 adult indicators of mental health and wellbeing.[10] It demonstrated that NHSGGC consistently performed worse than Scotland as a whole; this was particularly notable for depression, anxiety and the drug and alcohol-related indicators. Males in NHSGGC showed a more prolonged association with drugs and alcohol when compared with their counterparts in the rest of Scotland; any decreases in alcohol and drug-related harm occurred at a later age in Males from NHSGGC.

1.2   The high levels of anxiety seen in NHSGGC were largely driven by disproportionately high levels of anxiety in males. Unlike the rest of Scotland, where there was a significant excess of anxiety in females (10% of females compared to only 4% in males), in NHSGGC males have similar levels of anxiety as females (14%). Conversely, the high levels of depression seen in NHSGGC were driven by disproportionately high levels of depression in females. Stark inequalities in mental health and wellbeing across neighbourhoods were identified. Significant differences are seen between the most and least deprived

areas, most notably in mental health related drug deaths (18-fold), mental health related alcohol deaths (8-fold) and suicides (4-fold).

1.3   The indicator set used to describe mental health and wellbeing in NHSGGC includes a broad range of factors that influence mental health and wellbeing, including individual, community and structural factors. NHSGGC compared unfavourably with the rest of Scotland across all 40 contextual indicators and was particularly notable for the drug-use and violence indicators. In addition, a substantial burden of physical ill-health was identified in NHSGGC. Only a minority of the population achieved a healthy lifestyle and a low level of community participation was identified (although these were not limited to NHSGGC, but also observed for Scotland as a whole). Our 2008 Health and Wellbeing Survey asked people about their perceived mental health and wellbeing using the General Health Questionnaire. This assesses a person's current state of mental health and wellbeing. It can also identify minor psychiatric disorders. The higher the score on this scale, the more severe the condition. Results showed that females were more likely than males to have a high score and this increased with age. Higher scores were more common for those in economically inactive households and those with no qualifications. Some measures of positive mental health in Glasgow varied little by national or local geography, sex, age, occupation or deprivation. This surprising finding raises questions about whether we are truly measuring wellbeing. Further work is needed to show how positive mental health is related to other measures of wellbeing such as financial security and perception of crime.

1.4   Alcohol causes a range of mental health and wellbeing problems. Alcohol-related problems are not simply explained by excessive consumption alone but by the combined effects of poor diet, other illnesses and addictions, the environmental setting in which people consume alcohol and other co-factors. Thus, interventions to reduce alcohol-related harm need to go beyond reducing consumption if they are to be effective.

Self-reported weekly alcohol consumption is not higher among NHSGGC residents compared to the rest of Scotland, nor does it vary much by socioeconomic circumstances. However, binge drinking is more common among residents of the most deprived areas and is about 10% higher in the board area compared to the rest of the country. Total alcohol consumption has changed little since 2005 in Scotland, while it has fallen in England and Wales.

Many alcohol-related problems are not visible in routine statistics - such as over-consumption of alcohol at home, domestic violence or lost working days. Over the last few years there has been a national decline in alcohol related deaths from 35.2 per 100,000 in 2006 to 28.5 per 100,000 in 2010. This has also been reflected locally as shown in Figure 5.1.

Figure 5.1: **NHS Greater Glasgow & Clyde and Scotland Alcohol Related Mortality Rates Per 100,000: Persons Aged 20+ (Source: National Records Scotland)**
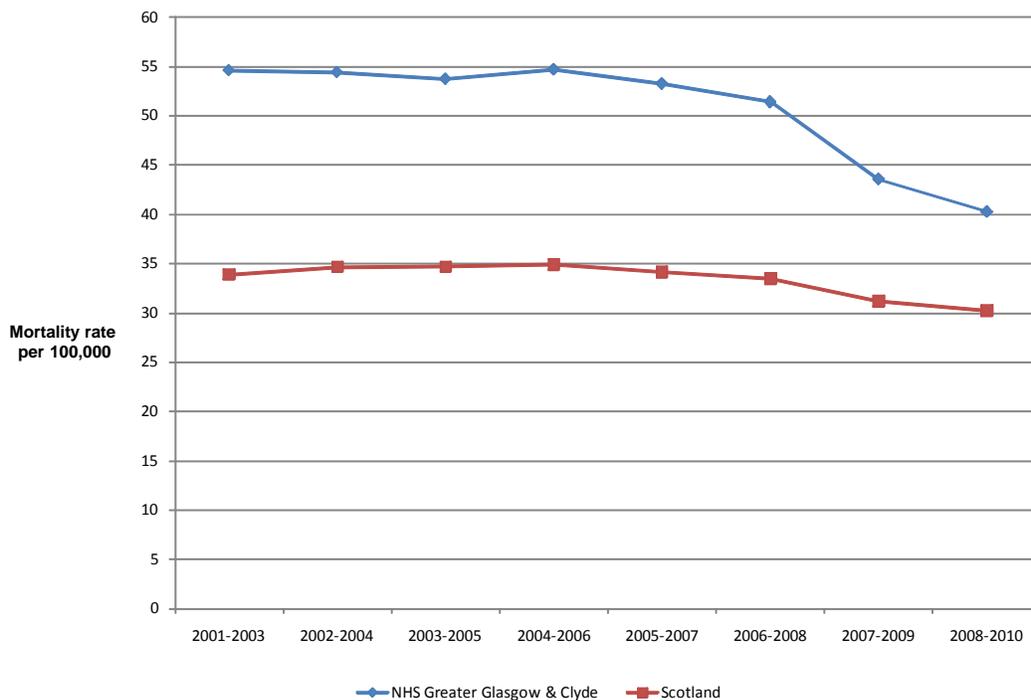
Figure 5.2 shows a decline in male and female mortality rates nationally and this is also reflected locally.

Figure 5.2: **NHS Greater Glasgow & Clyde and Scotland Alcohol Related Mortality Rates Per 100,000 by Gender: Aged 20+ (Source: National Records Scotland)**
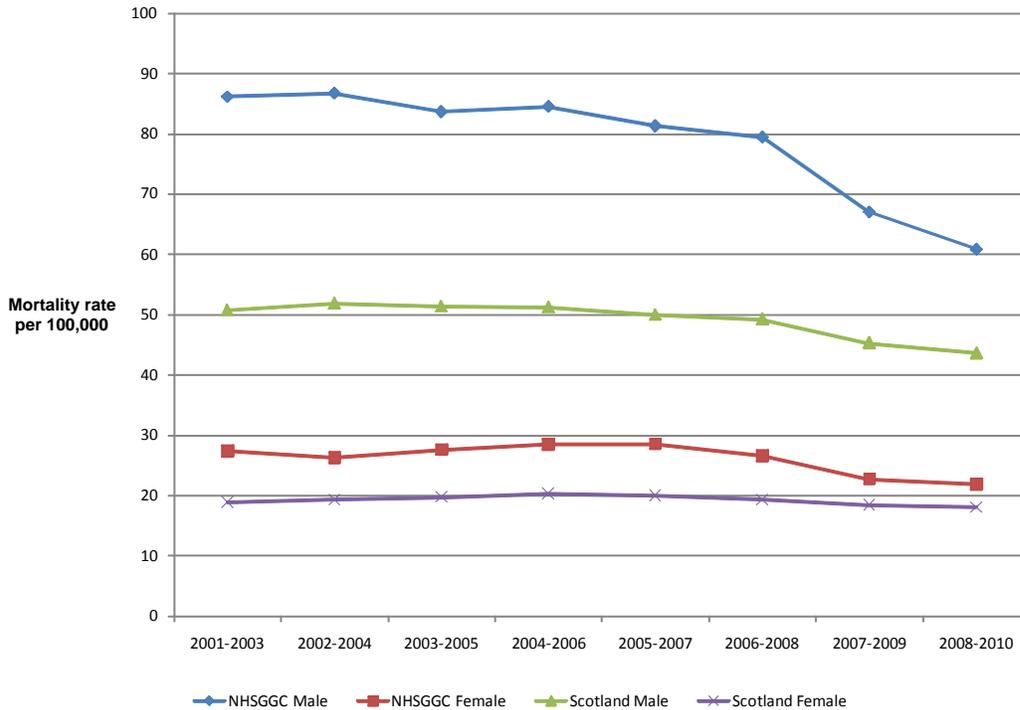
Figure 5.3 shows that deaths due to alcohol are about 3 times more common in males compared with females, at their peak between 45 and 64 years old, and increase steeply with socioeconomic deprivation. As consumption of alcohol is not strongly associated with differences in socioeconomic status, we think that other co-factors make alcohol much more dangerous with every progressive reduction in social and economic circumstances. Mental health related alcohol deaths probably represent only 1 in 8 deaths from alcohol – the other main causes being liver diseases, accidents, heart disease, strokes and cancers.

Figure 5.3: **Mental health related alcohol death rates per 100,000 Population, NHSGGC 2007/9**
Source: GCPH Mental Health Profiles
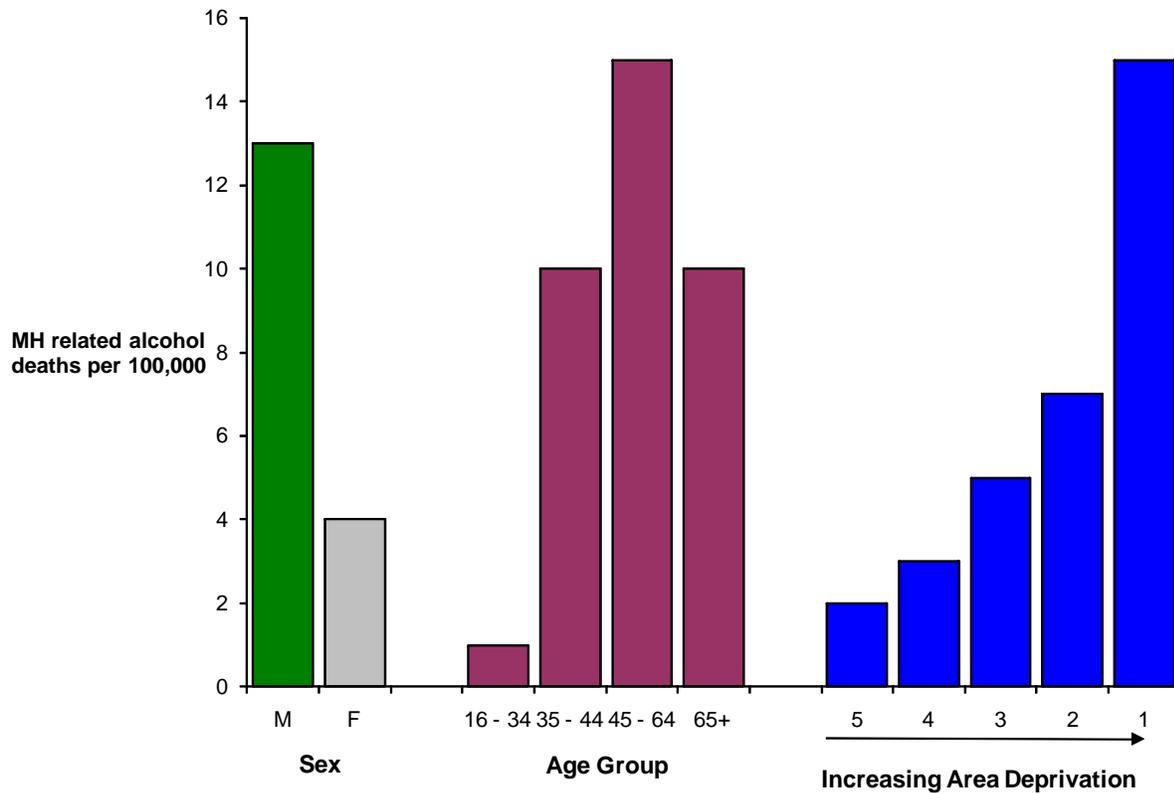
There were more psychiatric hospital admissions for alcohol problems in NHSGGC than any other area in Scotland in 2007/8, with Glasgow City, Renfrewshire and Inverclyde local authority areas having the highest admission rates. The peak age for admission is between 35 and 44 years old. Males are three times as likely to be admitted to a psychiatric hospital for an alcohol problem compared to females. Similarly, in general hospitals, the most frequent age at which patients are admitted for alcohol dependence is between 40 and 44 years old.

Excess alcohol consumption is also more common in patients with severe and enduring mental illness. Hazardous or dependent alcohol use was found in 12% of the Scottish general population[64], but was found in 20% of patients with severe and enduring mental illness.[65]

The previous government attempted to introduce minimum pricing to the Alcohol Bill Legislation 2010. Although this was defeated, the Scottish Government has proposed to reintroduce minimum pricing as policy.

NHS boards have new powers, including the right to appoint a health representative to each licensing forum, the right to be consulted on licensing board policy on overprovision statements and the right to comment on new premises' license applications.

1.5 Suicide is recognised as a major social issue in Scotland and rates are about 20% higher in NHSGGC area than the rest of the country. This may be because deprivation is a major risk factor (Figure 5.4) for suicide and NHSGGC comprises a large proportion of more deprived individuals. Other recognised risk factors include addictions problems, mental illness, and previous attempts to self-harm. Males are much more likely to complete suicide than females, at a ratio of roughly 3:1. Suicide is largely a phenomenon of working-age adults, with a high proportion of victims aged less than 45 years old.[66]

Figure 5.4: NHSGGC suicide rates per 100,000 population in 2009 (2005-9 for SIMD) by sex, age and socioeconomic circumstances (5, most affluent; 1, most deprived)
Source: GCPH Mental Health Profiles
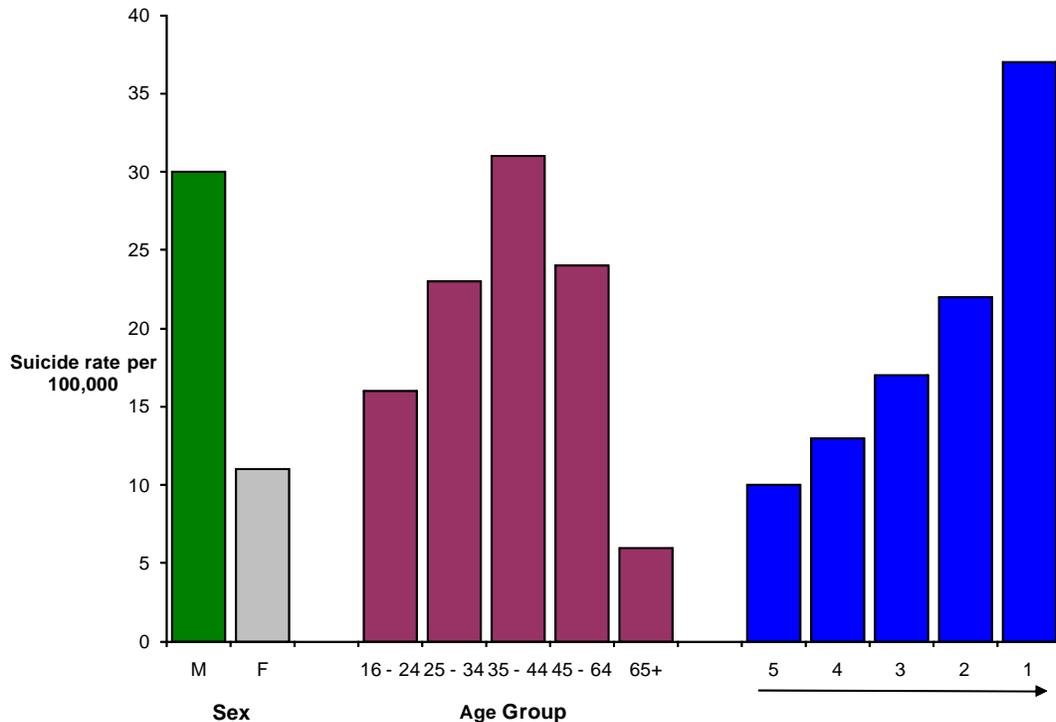
1.6   Mental health problems are important reasons for NHSGGC residents claiming incapacity benefit. Figure 5.5 shows that mental health claimants represent about half of all incapacity benefit claimants. Mental health claims have changed little between 2000 and 2008, while the overall rates of incapacity benefit have fallen by about 25% over the same period. At an individual level, poor mental health may leave someone unable to work; and lack of employment is a risk factor for mental health problems. At a societal level, the economy of the NHSGGC area is weakened by high levels of working-age adults being unable to work because of mental health problems; and socioeconomic deprivation is a risk factor for a range of social and mental health problems.

Figure 5.5:   Total and mental health incapacity benefit claimants per 1000 working age population, NHSGGC, 2000-08

	Feb 2000	Feb 2001	Feb 2002	Feb 2003	Feb 2004	Feb 2005	Feb 2006	Feb 2007	Feb 2008
Total IB claims	141.8	142.8	139.8	138.1	132.6	128.6	122.0	117.4	112.2
Mental Health IB claims	54.0	57.4	59.0	61.2	60.5	60.3	58.4	57.2	55.3
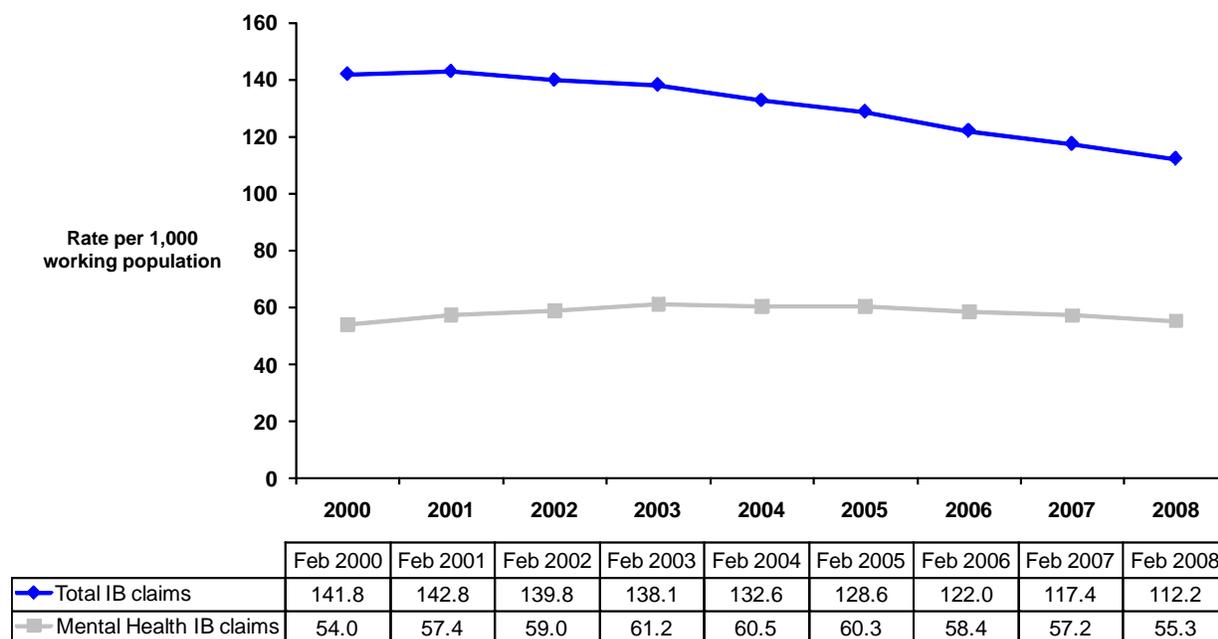
Section 2:   Equalities focused mental health promotion

2.1   Promoting positive mental health and wellbeing is fundamental to good health. Positive mental health is a resource for everyday life, which enables us to manage our lives successfully. It contributes to the functioning of individuals, families, communities and society.

2.2   The principles for promoting positive mental health are contained in the Ottawa Charter: Developing public policy that places mental health promotion on the agenda of all policy makers; moving mental health beyond a focus on the individual to consider the influence of broader social factors; Strengthening community action focusing on the empowerment of communities; Developing personal skills which enables personal and social development; Re-orientating mental health services so that they play a mental health promotion role.[67] This fits with Towards A Mentally Flourishing Scotland, which suggests NHS services can support a wide range of factors, which influence positive mental health. These

can range from timebanks to initiatives to improve safety within neighbourhoods and the wellbeing dimensions of arts participation.

2.3   We know that improving mental health and wellbeing is a complex challenge. The range of factors that influence them is broad, including deep-rooted social inequalities. Greater income inequality is strongly associated with poor mental health.[68] A number of aspects of poverty contribute to this, including being unable to participate in the life of the community, feeling a lack of control over life choices, insecurity and unhealthy social conditions.[69,70] NHSGGC's efforts to promote mental health are focused on areas of deprivation, balancing universal with targeted interventions. They look to improve overall population health and to reduce mental health inequalities.[71, 72]

2.4   Our approach to promoting positive mental health is about ensuring this is embedded in policy and practice within community health partnerships and our local authority and voluntary sector partners. This means mental health improvement is the responsibility of a wide range of partners. Examples are given below:

- **Supporting carers:** A recent survey on the health and wellbeing of carers found that 86% reported they suffered from stress, anxiety and depression and 54% said they felt isolated and could not take part in leisure or social activities or meet with friends and family.[73] Work to promote the mental health and wellbeing of carers has focused on early identification of those at risk, access to good quality carers' assessments and early intervention to support carers to sustain their caring role and improve the quality of life of both the carer and the person being cared for.

- **Alcohol and drugs:** 'The Iceberg of Scotland's Drug and Alcohol Problems' report has recommended a whole population approach to reducing the impact of alcohol and drugs on our society.[74] It proposes: reducing inequalities in Scotland; developing an effective early years' strategy; promoting a broader,

richer life for all citizens; developing meaningful roles and relationships in adulthood; and promoting a radical shift in our acceptance of alcohol and drug misuse in our families, communities and country. In addition, the report recommends that alcohol and drug misuse services develop a holistic or whole person approach to treatment, addressing individuals' wider needs, for example, meeting their mental health needs, addressing issues of homelessness, employment, abusive relationships and debt. This approach to holistic care is defined as 'A circle of care'. Circles are about seeing people as individuals who feel they need support to take more control over their lives. When properly facilitated, the Circle of Care is empowering to all those involved and does not reinforce dependence.

- **Homelessness:** Homelessness will have a detrimental impact on mental health and wellbeing. Specialist homelessness health services work with the most vulnerable homeless people to deliver an assertive outreach model to address the multiple disadvantages experienced by this group, with supporting mental health and wellbeing as a core part of the integrated health and social care response.

- **Prisoners and offenders:** The Sainsbury Centre for Mental Health identified considerable overlap between the populations who have contact with the mental health services and those who have contact with criminal justice services. More than 60% of offenders entering prison in Scotland had a mental illness (compared to 16% of the general population).[75] Joint health and social care initiatives underpin Glasgow's response to tackling the underlying causes of offending behaviour. The aim of supporting mental health and substance misuse is at the core of these (which include prison through-care services, initiatives that seek to tackle persistent offenders and the drug court). The last 15 years has seen a continual rise in the number of females offenders and females in prison. There is a growing awareness that the root causes of females offending and the needs of female offenders are different to those of their male counterparts. Studies show these causes are not addressed by the

current criminal justice system and that fairness of treatment does not necessarily mean equality of treatment between females and males in the criminal justice system.[76] In 2010, an evaluation study carried out on *218 Service*, an alternative to custody service for females in Glasgow, found that the most commonly experienced issues were mental health problems (48%), physical health problems (38%), and that 63% of females reported using more than one substance, including alcohol.[77] The review highlighted that a key strength is the unique combination of NHS health and social care approaches within the same service. Qualitative data in the study indicated that the services can help improve females' mental and physical health, their self-esteem and family relationships. A conservative estimate of the cost benefit of the service suggests that £2.50 is saved for every £1 of investment but that these benefits may be significantly higher if longer-term impacts on female offenders and their families and communities are taken into consideration. The 218 service has produced a 'toolkit' of good practice for policy makers and practitioners.

- **Financial inclusion in the context of recession**: Living in poverty and dealing with money worries because of unemployment or low paid work leads to mental health problems. A recent review of mortality in EU countries since the recession began showed that the downward trend in suicide before 2007 reversed in 2008 and increased by 7% in those younger than 65 years and increased again in 2009.[78] This immediate rise in suicide is an early indicator of the recession crisis. Despite the challenging financial climate, it is important to maintain access to employability support during the coming years so that people who experience inequalities including mental health problems do not become marginalised in the labour market. Debt has particularly negative consequences for mental health.[79] Money advice can improve people's mental health. NHSGGC recognises its role in supporting health workers to refer their patients to financial inclusion advice.

- **Physical activity:** Physical activity is increasingly being seen as an important factor in promoting well being, preventing mental health problems and contributing to improving the life of those experiencing mental health problems or illness. Regular moderate physical activity of 20-60 minutes duration such as walking, cycling, swimming or dancing can help to promote mental health. Increasing physical activity is associated with improvements in perception of wellbeing, self-esteem, cognitive function, sleep and the reduction of stress and anxiety.[80]

2.5   Many other factors relate to the social and environmental context in which good mental health can be supported, such as housing, arts and green space. Supporting policy and practice in these areas also can help to prevent the occurrence of common mental health problems but this requires more focused public health work.

Section 3:   Prevention and early intervention for mental health problems, including suicide prevention

3.1   The evidence for reducing the risk of depression and anxiety includes the development of psychological or behavioural skills, the prevention of discrimination and abuse and the promotion of better physical health.

3.2   NHSGGC offers a stepped model of care for depression and anxiety through a network of primary care mental health teams. This delivers a range of approaches that meet the different needs of patients. They include increased access to psychological therapies, guided self-help, non-pharmacological interventions and prescription of medication. An example of the stepped model of care is the STEPS team in South Glasgow. The STEPS team offers a range of services to people with common mental health problems, which include advice clinics, stress management groups, telephone advice lines, social prescribing and an information directory. The team also has an interest in providing outreach to diverse communities. In NHSGGC there is also a focus upon providing online

self-help materials, for example the 'Living Life to the Full' resources. The voluntary sector also offers counselling services to those requiring help with bereavement, trauma, abuse and relationships. NHSGGC are collaborating with the six universities in the west of Scotland on staff training and research on prevention in order to support students more effectively. NHSGGC are also key partners in the Anti-Stigma Partnership European Network, a Europe-wide public health study developing innovative approaches to reducing stigma associated with common mental health problems.

3.3   Suicide prevention is a priority for the Scottish Government as outlined in the [Choose Life Strategy](#).

3.4   NHSGGC actively liaises with Choose Life programmes in six local authority areas and has supported a programme of innovative developments. Developments within clinical services to provide better support for those at risk of poor mental health and suicide include strengthening the tiers of community based support services and enhanced care planning. We have met the Government's HEAT target for training of frontline staff in suicide prevention skills: nearly 4000 staff have been trained. These include mental health, primary care, addictions, sexual health, and accident and emergency staff.

3.5   We have worked with voluntary, community and other agencies on Choose Life. They include dedicated community based crisis response services and self-harm support, support on loss and bereavement, public campaigning and awareness raising, drug death prevention campaigns, and community development approaches, such as the use of football as a means of engaging with isolated males. There has been work in North-East Glasgow on addressing inequalities in suicide prevention, led by Positive Mental Attitudes and Lifelink.

Section 4: Enhancing quality of life for people with mental illness

4.1   Experiencing a long-term mental health problem can reduce people's quality of life. This is due partly to the impact of symptoms, but it is magnified by social exclusion. People with other illnesses or disorders on top of mental health problems and/or substance misuse can experience particularly poor mental health. Our response therefore involves a dual approach, which involves both mental health services and community work. A major dimension of our approach to promoting quality of life for people with mental health problems is through employment and workplaces.

4.2   Stigma is a term for the combination of inaccurate knowledge, negative attitudes and discriminatory behaviour towards people with mental health problems. It can result in the social exclusion of people with long-term mental health problems. NHSGGC formed a Glasgow anti-stigma partnership in 2004 to tackle this issue. It brings together over 40 national, regional and local partners to develop and then mainstream anti-stigma projects based on good evidence. These projects provide a new way of addressing stigma, discrimination and inequalities. They combine approaches such as community development, empowerment, positive personal contact and social marketing. Initiatives include community workshops, arts events, school lessons, university programmes and workplace training delivered to tens of thousands of people. Our work to tackle stigma has priority within communities, which experience multiple discrimination, where disadvantage is also experienced in relation to migration, ethnicity, race, sexuality and poverty.

4.3   A major development of our services has focused them on recovery. This works from the assumption that people can live well in the presence or absence of symptoms of mental ill-health. The Scottish Recovery Indicator and Wellness Recovery Action Planning are a core part of provision. NHSGGC wants to ensure that the voices of people who use mental health services inform service

provision, so we support the Mental Health Network and Acumen. These are both user-led initiatives, which work to empower people to influence services and communities.

4.4　People with enduring mental health problems have high levels of physical illness. For example, people with schizophrenia are three times more likely to die prematurely from natural causes (mainly cardiovascular disease) compared with people without mental health disorders. We are aware that people may experience discrimination using NHS services and as a result do not seek help for their physical health, which can compound their already poor mental health. Secondary specialist services for mental health need to work closely with primary care services and patients to ensure those with a severe mental illness have their physical health monitored and managed effectively. NHSGGC mental health services are about to launch a physical healthcare policy to ensure that mental health service users have access to the same quality physical health care as the general population. More and more evidence indicates that the physical health care needs of people with a serious mental illness (SMI) are as important as the individual's mental health care needs and should be considered and addressed as part of a holistic package of care. The routine admission of a psychiatric patient should always be accompanied by a detailed physical assessment encompassing physical examination, investigations and a follow-up plan where necessary. One issue is the high prevalence of smoking amongst those with serious mental health problems compared to the general population. We are responding to this by trying to ensure that our smoking cessation services are appropriate for the needs of people with mental health problems.

GP practices have established registers for people with severe long-term mental health problems such as schizophrenia, bipolar disorder and other psychoses as part of the general medical services contract. Most GP practices in NHSGGC provide annual health screens for patients on their mental health registers. The clinical care provided under the contract potentially meets the basic needs for

evidence-based, routine physical health reviews for most individuals with these conditions.

4.5   There are particular issues around supporting adults with mental health problems who are parents. The Royal College of Psychiatrists report 'Parents as patients: supporting the needs of patients who are parents and their children', considers the issues posed by the patient as parent and the implications for children whose parents experience mental disorders.[81] The report concludes that although many parents with mental illness and their children can be remarkably resilient, adverse outcomes for children are associated with parental mental disorder. It recommends that psychiatrists and other mental health professionals consider the family context of service users and the wellbeing and safety of any dependent children at every stage of the care process from assessment to discharge. This will involve working closely with other agencies, across boundaries, and sharing information as appropriate. A key aspect of this is remembering that a child's needs are paramount even in situations where the necessary safeguarding action may impair the therapeutic relationship with the parent. In shaping and developing services, the views of parents and young carers are essential in ensuring their needs are met.

4.6   The impact of the recession on mental health is likely to increase and can be linked to unemployment.[78] Workplaces have a key role to play in protecting their employees' health at times of recession. Handling organisational change and redundancies with employee wellbeing in mind is seen as a crucial way to both achieve public health goals and to retain a competitive and healthy workforce for the future.[82] Important elements of a sensitive approach to change, which are advocated by trades unions and other employee led organisations include: retraining, job search assistance, counselling and financial advice. Furthermore, organisations can prepare for change by creating a resilient workplace, a model that encompasses individual resilience, but also looks wider to include

organisational planning, and team resilience.[83] Health at Work will work with employers in the area to encourage such approaches.

Section 5: Bringing it all together – mental health improvement in key settings and communities

5.1   This section looks at promotion, prevention and support as it has been taken forward in important settings and groups within NHSGGC. It identifies promising practice and approaches and the main principles of successful programmes.

5.2   Depression and anxiety are the most common mental health problems for adults of working age, affecting 20% of the UK working population at a cost to the UK of over £26 billion per year.[84] Families without a working member are more likely to suffer persistent low income and poverty and there is a strong co-relation between lower parental income and poor health in children. We believe that investing in the health of the working population is critical both to secure higher economic growth and to increase social justice. Promoting workplace health and wellbeing can contribute to reducing child poverty and poverty in later life. Mental health problems in Scotland cost employers £1.2 billion. One third of all absences from work are due to stress related illness, which can also lead to poor work performance, motivation and relationships at work.[85] NHSGGC has supported the development of an EU project, which is developing guidelines and a framework for public mental health in workplaces.[86] This includes promotion, prevention, stress management and support.

5.3   NHSGGC Health at Work helps organisations to enhance their mental health policies and practices through campaigns, research, training and stress management. Good employers can gain the Mental Health and Wellbeing Commendation Award. Loretto Housing, for example, gained the award by developing a whole workplace programme, which includes flexible working and a phased return to work for staff with mental or physical health problems, providing information on mental health through training courses and campaigns, and

managing workplace stress by staff supports and providing access to employee counselling.

5.4   NHSGGC fund a range of mental health and employability services, working closely with lots of partners, including Jobcentre Plus, to ensure people with mental health issues are offered access to employability services. There is joint working to facilitate and build practical links between health and social care with Jobcentre Plus. A Peer Support Development Group has developed resources, including research on the barriers to employment, employability guidance and a film 'Journey to Employment' which has attracted international interest.

5.5   Promoting mental health and wellbeing in partnership with black and minority ethnic communities and asylum seekers is a priority for us. The Mosaics of Meaning programme has worked with settled black and minority ethnic communities across NHSGGC to identify mental health concerns and to develop approaches to improve positive mental health and address stigma towards mental health problems. The work has highlighted issues linked to both social disadvantage and cultural factors. Many existing public mental health approaches had failed to reach, engage or influence many sections of these communities. In response, participants developed an extensive outreach programme.

Section 6:   Recommendations

6.1   We must continue to develop multi-agency suicide prevention programmes in community settings combined with extension and consolidation of suicide prevention approaches within statutory sector agencies, including maintaining a high level of front line staff with suicide prevention skills; place particular focus on the connections between addictions and mental health problems.

6.2   Staff health strategies for the public sector should prioritise mental health and all managers should make sure that they understand their role in promoting mental health of their staff.

6.3   As recommended by the Royal College of Psychiatrists, there needs to be full recognition of the parenting role of people with mental health problems and they must be supported in this role for the reasons discussed in earlier chapters of this report.

6.4   We endorse the report of the independent enquiry into drug misuse and recommend that the NHS and local authorities consider the pilots of the Circle of Care approach and look at how this approach can be expanded and sustained.

6.5   The newly formed primary care Deprivation Interest Group should link to NHSGGC planning structures to develop a work plan on mental health and addictions that includes the benefits of physical activity.

6.6   We must do everything possible to improve through-care services for males and females leaving prison including intensive support and addiction services and ensuring a gendered sensitive approach.

6.7   We must ensure that people experiencing mental ill-health are given a holistic assessment to gain a better understanding of their past health and current needs. This should include a comprehensive summary on interventions, social and family context, alcohol and drug misuse and physical problems.

6.8   In relation to alcohol, we must have a stronger focus on the public health objective of licensing legislation, facilitate effective over provision policies and continue to advocate for minimum pricing of alcohol, and banning advertising of and sponsorship by alcohol products.

Chapter 6:   Older adults

Earlier chapters have highlighted the many factors that can either build or erode mental health and wellbeing at different stages of life. Life experiences, circumstances and behaviours accrued over the entire life course play out over many decades, however, their net effects can be seen as coming home to roost in later adult life, when people frequently face new types of challenges, such as declining physical health and confidence, financial insecurity, threats to independence, bereavement and facing life alone, perhaps for the first time. Establishing good reserves of mental health and wellbeing is critical to the ability of older adults to successfully navigate and adapt to these challenges, to contribute effectively to society, make relatively free choices and enjoy life to the full.[87] Mental and emotional resources for health in late life includes cognitive (thinking) ability, flexibility of attitudes and behaviours, continued learning and emotional intelligence (the ability to identify, understand and influence the emotions of self and others).

Building mental health and wellbeing in older adults begins decades earlier, using the types of approaches we will describe in this chapter. Although there is no fixed point at which people stop being 'adults' and suddenly become 'older adults', there is no doubt that the process of ageing does bring particular issues, which will be explored in this chapter.

All this needs to take place in a rapidly changing, relatively turbulent context. Globalisation, the current fiscal and economic crisis, the pace of demographic change, the changing nature of work and new societal structures, all represent significant challenges to human wellbeing. If we are to prosper sustainably in this rapidly evolving environment, it is vital that we take preventive action now. Two actions are particularly crucial, firstly, we must establish protective lifestyles for those in middle age; and, secondly, we must decisively create a new mindset about older age to tackle the stigma

and explicitly value the considerable mental resources of older people for the benefit of all members of society.

Section 1:   Who are older adults?

1.1   As highlighted earlier in the report, we are an ageing society. The percentage of the UK population over 60 is expected to expand from its present level of 22%, to around 29% by 2033, and 31% by 2058.[88] People over 60 now outnumber the under-16s for the first time and the number of over-85s has increased five-fold since 1951. This rapidly shifting demographic is a highly topical issue, usually portrayed in negative terms, as a problem, challenge or burden. Yet this growing population subgroup, with an age span of four decades, represents an enormous diversity of individuals, each with unique perceptions of what it means to be an older person. The meaning of age is created by our cultures, relationships and personal values; a large 2010 survey on behalf of the UK Department of Work and Pensions asked 60-64 year old adults at what stage of life they considered themselves to be; 45% considered themselves to be in middle adulthood.[89]

1.2   In NHSGGC, 18% of our current population of 1,203,870 is of pensionable age, slightly less than the 20% proportion for Scotland as a whole. The number of NHSGGC residents over 65 has been stable for the last decade, but is expected to rise steeply in the near future, mainly because overall life expectancy is improving (Figure 6.1). This trend is predicted to affect some CH(C)Ps much more than others; for example, by 2033 people aged 65 and over will account for 32% and 31% of the total populations in East Dunbartonshire and Inverclyde respectively, contrasting with a projected estimate of only 19% for Glasgow City.
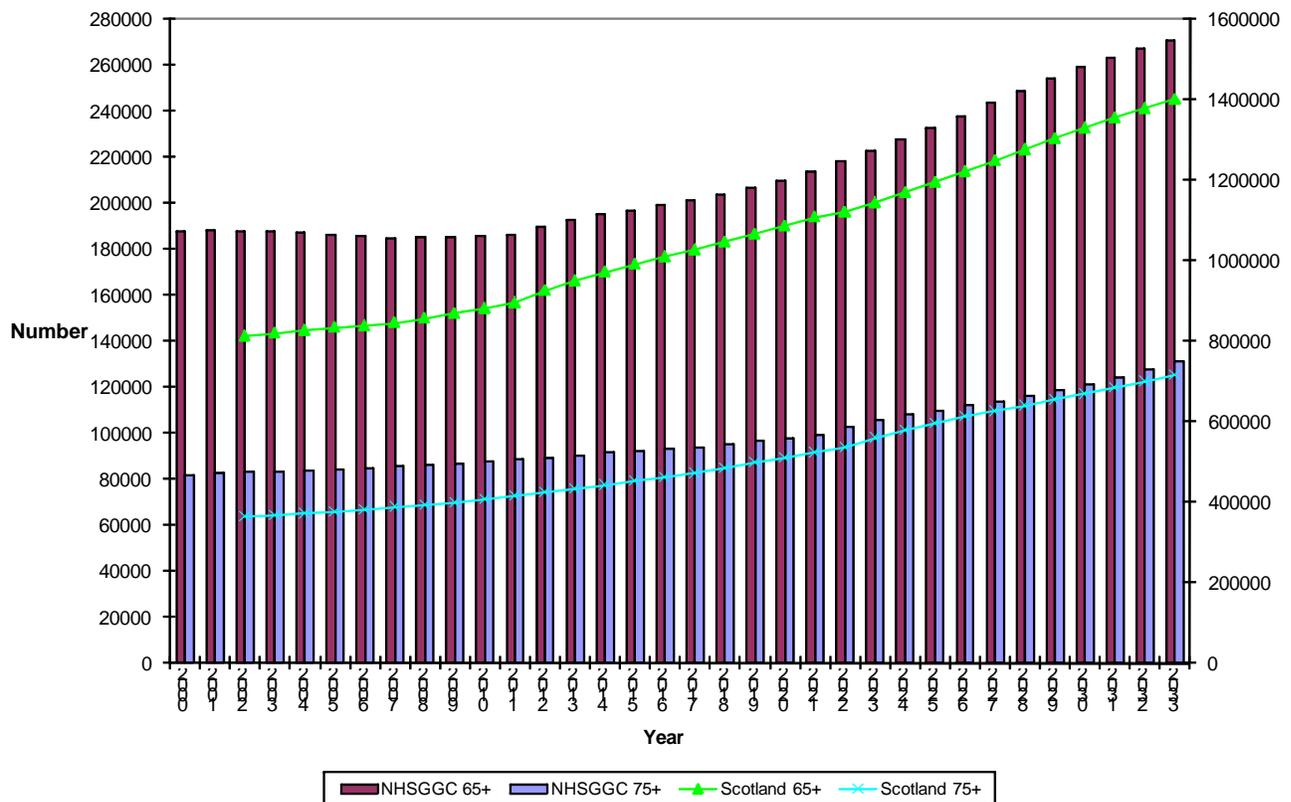
1.3   The current age profile of our local neighbourhoods in NHSGGC varies immensely. Older people account for almost a third of all residents in some localities, but less than one in ten in others, as shown in the map (Figure 6.2). Reasons for these variations include historical patterns of housing, employment and population growth. Local economic and social circumstances also play a major role here because of their strong association with life expectancy in NHSGGC's most profoundly deprived communities, average life expectancy is up to 10 years shorter than in the most affluent areas. This is due to a disproportionately high numbers of premature deaths from preventable conditions.

1.4   Understanding current and future population age profiles is the crucial first step in ensuring that all of our public planning activities, both within the NHS and in our

many partner organizations, jointly promote active ageing, maximise all opportunities for health, and foster community participation and security.

Figure 6.2:   Proportion of individuals aged over 65, by area, 2009
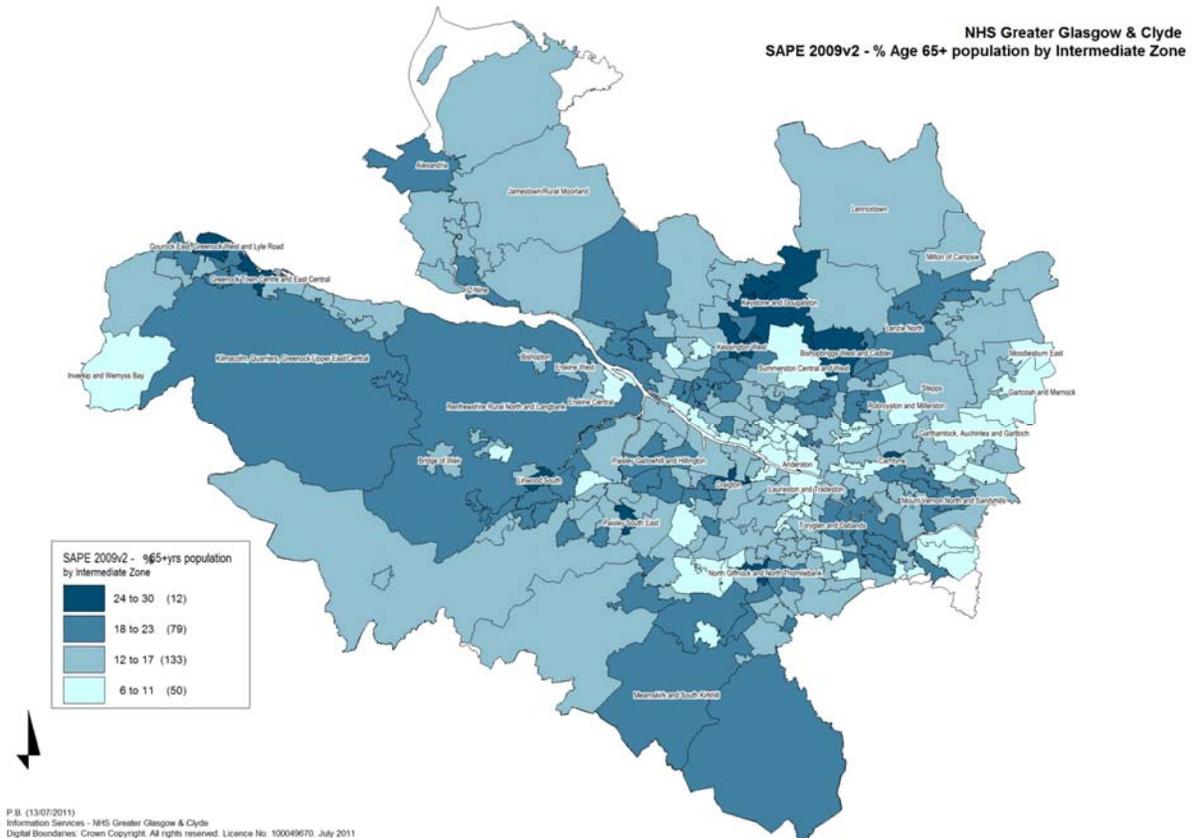
Section 2:   What is our vision of a mentally flourishing older population?

2.1   The key components of mentally healthy later life in Scotland are well articulated in public policy; they are broadly similar to the factors that underpin mental health across the entire life course.[35, 90] They include:

- Reduced discrimination
- Increased participation
- Secure and supportive relationships
- Promotion of physical health

- Supportive environments
- Reduced poverty

2.2　Although securing these assets is necessary for building the foundation of mental health and wellbeing in older adults, this is not sufficient in itself. Some of these factors, e.g. physical health, discrimination issues and opportunities for participation, assume much greater significance and/or change their nature in older adults. It is therefore important to understand and respond to the determinants of mental health and wellbeing among this sub-population through a distinctive older adult lens.

2.3　The World Health Organization's (WHO) 'Global Age-friendly Cities' movement has spawned many innovative projects to translate this aspiration into practical action.[91] [92] It aims to optimise opportunities for health, participation and security and to enhance quality of life as people age, via the following actions:
- recognising the wide range of capacities and resources among older people
- anticipating and responding flexibly to ageing-related needs and preferences
- respecting older people's decisions and lifestyle choices
- protecting those who are most vulnerable
- promoting older people's inclusion in and contribution to all areas of community life

2.4　Promotion of healthy ageing is a key theme promoted by the WHO Healthy Cities Network, of which Glasgow City has been a member since 1988. Although a number of successful healthy ageing initiatives operate in the NHSGGC area, such as the 'Silver Deal Active' partnership that provides physical activity and social interaction opportunities across Glasgow City, in partnership with GHA, Glasgow City Council and NHSGGC, we would benefit from concerted action on several fronts. The 'Age-Friendly New York City Initiative' is an outstanding example of what the 'Global Age-friendly Cities' framework can achieve, at relatively low cost, if supported by visionary political leadership and high quality community engagement. New York City's mayor, Michael Bloomberg, has been

an enthusiastic proponent of the initiative. The 'Age-Friendly New York City Initiative began in late 2007 with a comprehensive assessment of the age-friendliness of New York City, mainly through dialogue with older New Yorkers in a wide range of locations, culminating in development of a series of initiatives intending to reposition New York as an age friendly city, grouped into four main areas; community and civic participation; housing; public spaces and transportation; and health and social services. Access further information on Age-friendly NYC – Select Initiatives. It is currently piloting three 'Aging Improvement Districts' that translate all of this into a local neighbourhood context.

2.5   We could deliver a similar collective vision for NHSGGC. As a starting point, we should build on the following examples of good practice in local areas, moving towards a position where:

- Older people are active participants, valued for their experience and knowledge, with the whole community benefiting from their participation in volunteer or paid work. The Playbusters project in North East Glasgow is just one example of several in NHSGGC, in which older adults teach younger members of the community traditional crafts such as knitting and crocheting and, in return, learn more about modern information and communication technologies.

Playbusters: Connecting Generations

© Playbusters – Glasgow East End

- Older people are valued for their connections between our past, present and future. For example, the SPARR project in South Glasgow mapped the history and shipbuilding heritage of Govan in the 20th century. Young people took the lead as researchers, graphic designers, filmmakers and interviewers, engaging with older people in the community - former shipyard workers and the Gaelic-speaking families who emigrated from the Western Isles to find work in the yards.

2.6   Achieving these aspirations will need substantial and sustained efforts at all levels, from local communities to local and national government, supported by visionary political leadership. The Director of Public Health plays a key role in articulating this vision and advocating for the action we need to deliver, predominantly through partnerships fostered by CH(C)Ps with planning leads, local housing associations, social work teams, local private and voluntary sector organisations, education providers, employability services – but most importantly - with older adults themselves.

Section 3:   What are the drivers of mental health and wellbeing in older adults?

3.1   Among the strongest drivers of the experience of ageing are society's attitudes to old age and later life. Unfortunately, current popular representations of older people as a group are often stereotypical and generally negative, underpinned by three common assumptions:

- older people are all the same
- old age brings inevitable decline
- older people are dependent/a burden on society

3.2   These negative stereotypes have serious consequences. Not only do they directly interfere with older people's enjoyment of life, but they also reduce their confidence and expectations of themselves, impair their will to live and shorten survival. Such negative stereotypes also have a powerful effect on service
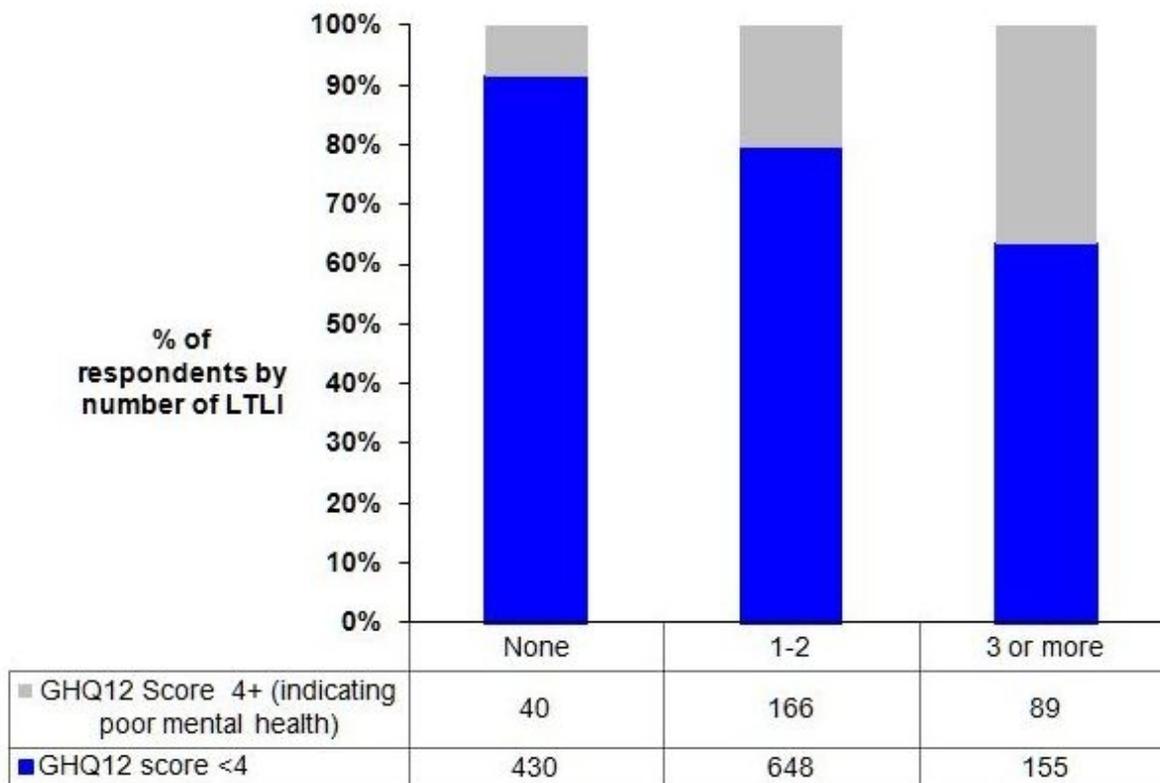
providers, making them less likely to treat older people as individuals and more likely to discriminate actively against them. Conversely, holding positive views of ageing may have very powerful positive effects: a population-based study involving 660 individuals aged over 50 found that older individuals with more positive self-perceptions of ageing, measured up to 23 years earlier, lived 7.5 years longer than those with less positive perceptions. This advantage remained after controlling for age, gender, socioeconomic status, loneliness, and functional health.[8] The Scottish Government launched an initiative [See the person, not the age](#) to help tackle ageism and provide support for change.

3.3 Research on mental health in later life consistently identifies that: being physically fit, having a role in society, good social relationships with family, friends and neighbours, an adequate income and a supportive neighbourhood enhance mental health and wellbeing.[93] Having a positive outlook and maintaining control over one's life are also frequently cited by older people as key features of a good overall quality of life. In contrast, the issues that older people identify as undermining of mental health are: deteriorating health, loss of independence, loneliness, fear of death, living in poor housing, run-down neighbourhoods and decreased income.

3.4 Many of these adverse factors are systematically more likely to affect older people. They especially include a higher prevalence of long-term conditions and more physical disability. However, they also involve having to negotiate major new types of life transition, including retirement, financial insecurity, moving from the family home into sheltered or residential accommodation, loss of partners and adaptation to life alone.

3.5 Older people are also much more likely to experience fuel poverty than the rest of the population. Fuel poverty is defined as having to spend 10% or more of a household's net income on heating the home to an adequate level. Fuel poverty in Scotland has been rising in more recent years, largely because current

increases in fuel prices are only being partially offset by rising incomes and energy efficiency increases. In 2009, 33% of households were in fuel poverty, compared with 13% in 2002. Risk of fuel poverty generally increases with age. Within In those households where the oldest person is aged between 60 and 79, almost a quarter is living in fuel poverty, rising to over a third of the oldest households (80 plus).

3.6   Long-term conditions (LTCs) are an important cause of poor mental health in older adults and the co-existence of long-term physical illness with mental health problems generally worsens outcomes for both conditions. The likelihood of needing medical treatment for one or more conditions rises steeply with age; in our 2008 health and wellbeing survey in NHSGGC, the prevalence of LTCs rose from 12% in those aged 16-24 to 72% in the over 75s.[94] Overall, around 30% of people with LTCs experience poor mental health, compared with only 9% of other adults; the likelihood of experiencing poor mental health increases in proportion to the number LTCs experienced (Figure 6.3).[95, 96] People with diabetes are three times more likely to experience depression and are also more likely to experience it in more severe and enduring forms; however, fewer than a third of affected individuals are diagnosed or treated. Depression worsens diabetic control and increases the risk of diabetic complications.[96] Similarly, up to a third of people experience a depressive episode following a heart attack; those affected have poorer cardiovascular recovery, with one study suggesting a 3.5-fold increase in mortality of depressed patients compared with non-depressed patients within six months of myocardial infarction.

Figure 6.3: GHQ-12 Grouped Score by Number of Long-term Limiting Illnesses Number and % of Respondents Aged 65+ Source: NHSGGC Health & Wellbeing Survey, 2008

	None	1-2	3 or more
GHQ12 Score 4+ (indicating poor mental health)	40	166	89
GHQ12 score <4	430	648	155

3.7   The key challenge to the mental health and wellbeing of older people is the need to adapt successfully to the physical, social, interpersonal and psychological transitions that accompany ageing. The ability to adapt to these challenges varies considerably from person to person - older people who are able to adapt well tend to do better overall. However, the resources and opportunities available to them are shaped by the social context within which they live, which we can directly influence through public health actions.

Section 4:   How do we promote and improve mental health in older adults?

4.1   We are increasingly clear about what a mentally healthy old age looks like - and the factors that either impede or support it. Nevertheless, what are the right kinds

of practical actions and strategies that will move us most effectively and efficiently to this position? Coordinated action is needed at several levels.

4.2   Individual level: by increasing emotional resilience through interventions designed to promote self-esteem, strengthen coping skills and maintain meaningful relationships. One of the most basic but often neglected human needs is reciprocity—the ability to give something in return for receiving. There is strengthening evidence suggesting that reciprocity is a particularly important means of improving health and wellbeing in frail elderly people and may explain the differences between effective psychosocial interventions and those showing no beneficial effects. None of this requires new sets of interventions designed to achieve these outcomes, rather, it means using all contacts with older people to promote confidence, choice and control; fostering reciprocity by providing subtle support that does not diminish self esteem and allows the patient to give back; providing information about opportunities for promoting self-reliance and independence; and helping older people to link into networks and activities.

Regular physical activity is one of the most effective and cost-effective interventions available for enhancing physical, mental and social wellbeing. There is abundant evidence that most adults are not sufficiently active for optimal health.[95, 96] NHSGGC co-delivers a wide range of evidence based physical activity programmes, suitable for people with different physical abilities and medical conditions, such as Live Active, Vitality and Glasgow Health Walks. Silver Deal Active is a Glasgow City-led programme customised for older adults, providing coach-led exercise and 'Active Art' classes to Glasgow residents aged 60 years and over.

© Silver Deal Active – Glasgow Life / Glasgow Sport

4.3   Community level: by increasing social inclusion and intergenerational participation, improving neighbourhood environments, including community safety measures, strengthening support networks. In NHSGGC, an Ageing Population Planning Group was established to plan a system-wide response to the rapid demographic changes we are likely to see in the near future. The group should develop strategies for mainstreaming the types of approaches explored in this chapter that will deliver the types of outcomes we want to see at community level.

4.4   Reduction of structural barriers to mental health: this involves large-scale policy initiatives to tackle discrimination, promote educational and employment opportunities and ensure availability of appropriate housing, services and support for older adults. This can be achieved through changing employment practice to allow employers to benefit from the skills of older people, matching work and working environments to the needs and capabilities of older adults and improving the design of homes and towns to meet the needs of older people, using older people as a key resource for advice. For example, from 6 April 2011, employers will no longer be allowed to issue forced retirement notices to their employees and the default retirement age will be phased out completely by October 2012.

4.5   In August 2012, the World Active Ageing Congress will be held in Glasgow. This offers an opportunity to explore and debate the scientific evidence on active ageing and ultimately to create the type of physical and social environments which promote active participation in society by older adults in NHSGGC.

Section 5:   Identifying and responding to mental health issues in older adults?

5.1   Whilst most people remain fit and well into old age, significant numbers will experience some form of mental ill-health. Depression is the commonest type of mental ill-health in older adults, affecting 10-15% of people over 65. Surveys suggest that the prevalence of depression amongst those in care settings is

much higher, at around 40%. However, we need more systematic age-specific outcome data on the extent to which the needs of older people with depression are met fully in NHSGGC. Given the interaction between mental health and long-term conditions, it is essential that our clinical care systems for all types of illness systematically look for and respond to the psychological needs of patients and their carers. Data from our Local Enhanced Services programme show that approximately 4% of patients with coronary heart disease have significant anxiety and 2% have depression, with a marked social gradient (Figure 6.4).

Figure 6.4:   NHSGGC Coronary Heart Disease Local Enhanced Service: Prevalence of depression and anxiety, by SIMD quintile
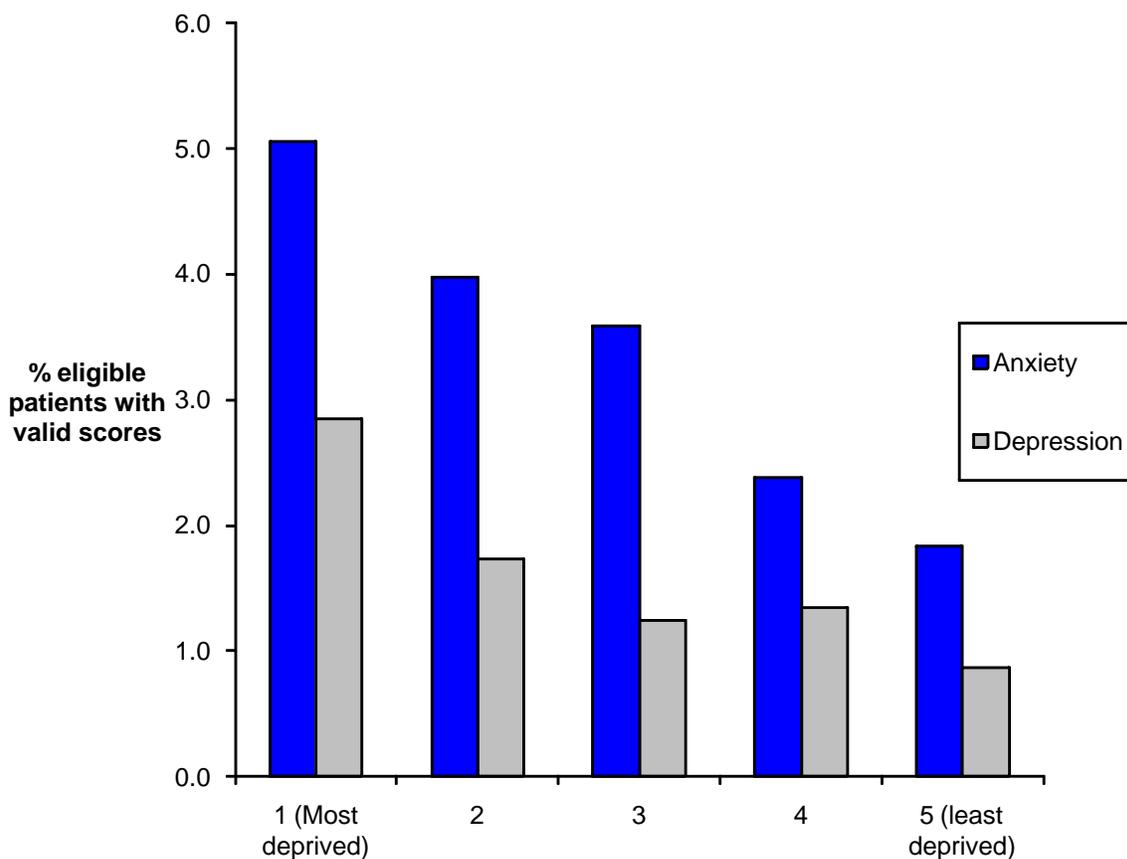
5.2   Ageing of our population means that many more individuals can expect to develop dementia, as age is a key risk factor. Among those aged 80 plus, the prevalence is around 20%; in nursing homes, the prevalence is up to 70%. Over

the next 30 years, the number of people with dementia in the NHSGGC is expected to increase by around 64%, to 23,000 by 2033, exerting major impacts on patients, their families and carers; and the formal health and social care systems (Figure 6.5). In the North West Glasgow Keep Well area, a specific anticipatory care intervention is being piloted to identify and meet the preventive healthcare needs of carers, in order to optimise their own health and support their ability to fulfil a caring role.

Figure 6.5:   NHSGGC Predicted Numbers of Dementia Cases (65+) 2008 to 2033 Source: EURODEM
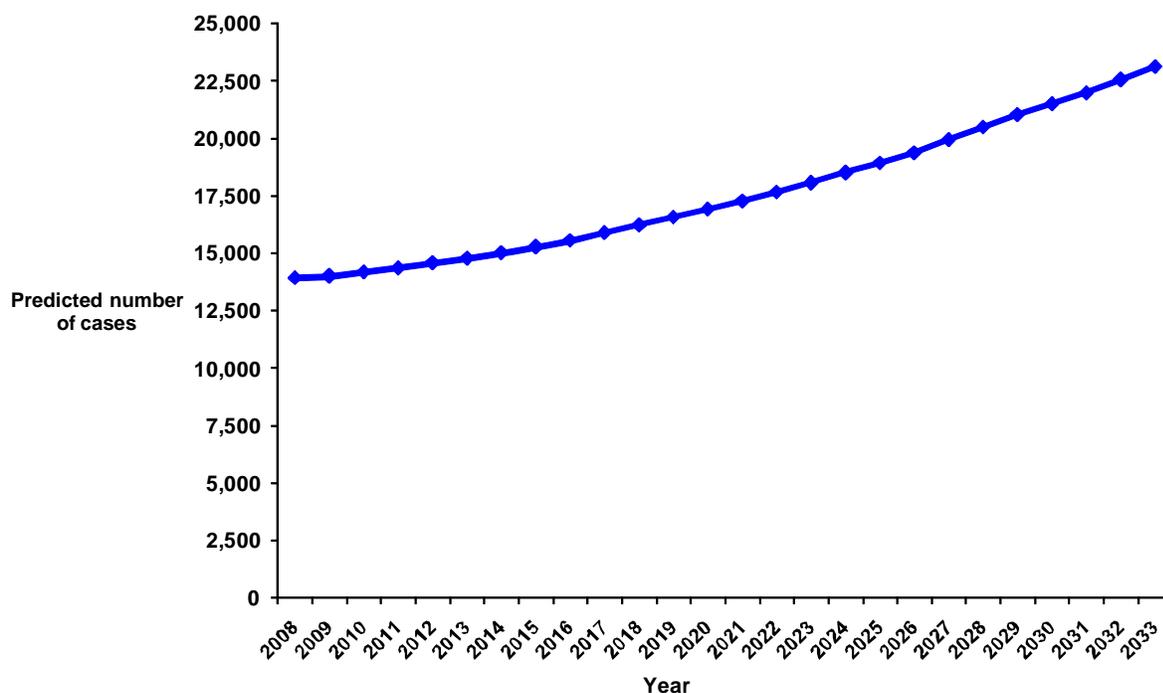
5.3   There is much potential for prevention, which must start early in life, rather than addressing the issue of cognitive decline when it first occurs in older adulthood. Encouraging physical activity in young and middle-aged adults to promote a healthy cardiovascular system, continuing education and learning through the life course and promotion of safe levels of drinking are key to maintaining cognitive (thinking) reserve.

5.4 Early detection of dementia is an area of very active research at present. Although there is some (currently limited) evidence indicating that intensive, multi-component interventions to support carers may delay nursing home admission for people with dementia, most studies of screening have demonstrated few direct benefits for either patients or carers. Examples of positive action to support individuals with early dementia include use of Alzheimers Scotland Dementia Pack for Schools (currently implemented in some primary schools in Glasgow) and awareness raising materials such as 'Changed Days', which support the psychological needs of older patients with dementia and their carers.

5.5 Effective dementia care is critically dependent on effectively integrated services across the primary, secondary and social care systems, genuinely placing the older person at the centre of service planning. Improving the care of people with dementia in acute settings, reducing the use of antipsychotic medication for care home residents with dementia and ensuring consistency of good quality care for patients with dementia are key priorities. NHSGGC held a dementia convention in March 2011,[97] which has now resulted in a set of wide-ranging practical recommendations to take forward the Scottish Government's National Dementia Strategy. These include implementation of agreed pathways and models, new learning and development programmes, and awareness raising among staff, carers and the wider population.

Section 6:   Recommendations

6.1 NHSGGC should consider systematic development and mainstreaming of The World Health Organization's Global Age-friendly Cities' framework, to ensure the right physical and social environment for an ageing population, recognising the importance of digital inclusion.

6.2   Regular physical activity is the single most effective and cost-effective intervention available for enhancing physical, mental and social wellbeing in older adults. An action plan for increasing physical activity in older adults should be established across all NHSGGC localities.

6.3   The NHS must demonstrate leadership in encouraging the active participation of older adults in planning our services, treating all older adults as individuals and challenging negative stereotyping where it exists.

6.4   Given the projected increase in numbers of older people with dementia in NHSGGC, integrated planning should be supported and embedded consistently across all parts of the system, ensuring implementation of the Dementia Convention's[97] recommendations for universally high quality care. This should be supported by an integrated care pathway and clear models of best practice for dementia care, development of an exemplar site, clear actions to increase public awareness and intensified learning and development/training for all staff.

Glossary of Terms

Body Mass Index (BMI)	A number obtained by dividing a person's weight in kilograms by the square of their height in metres
Brief Interventions	A brief intervention is the provision of information, advice and encouragement to a person to consider the positive and negative impact of their behaviour. Help is then provided if the person decides to make changes
CAMHS	Child and Adolescent Mental Health Services
Child Tax Credit	This is made-up of two elements: the family and child element. The family element is paid to each family entitled to CTC (a household income of less than £40,000). The child element is paid for each child, but tapers off at a rate of 39% as earnings increase above £16,040 per year
Community Health Partnership (CHP) and Community Health and Care Partnership (CH(C)P)	CH(C)Ps are organisations that have been developed across Scotland to manage a wide range of community based health services. In some parts of NHS Greater Glasgow and Clyde health board (Glasgow City and East Renfrewshire) these new partnerships will also be responsible for many local social care services and will therefore be called Community Health and Care Partnerships, CH(C)Ps

Community Planning Partners	A range of partners in the public and voluntary sectors working together to better plan, resource and deliver quality services that meet the needs of local people
Economic Indicators	A quantity that is used to measure a particular feature of the economy
General Health Questionnaire (GHQ-12) Score	A measure of current mental health
Glasgow Effect	This expression describes the higher levels of mortality and poor health experienced in Glasgow over and above that explained by its socio-economic profile
HEAT Targets	HEAT targets are a core set of Ministerial objectives, targets and measures for the NHS. HEAT targets are set for a three-year period and progress towards
Health Inequalities	The gap between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds
Intergenerational	Relating to more than one generation
Living Wage	An income that is enough to buy the basic things that are needed, such as food or clothing

Low Income Households	Households that are dependent on out of work benefits OR Child Tax Credit more than the family element
Morbidity	The number of people affected by a particular disease
Needs Assessment	A formal process undertaken to assess the health and social care needs of a given population
NICE	National Institute for Clinical Excellence
Nicotine Replacement Therapy (NRT)	NRT is a way of getting nicotine into the bloodstream without smoking. It stops, or reduces, the symptoms of nicotine withdrawal which can help smokers to stop smoking
Obese/Overweight	Defined as body mass index over 25
Off-sales	A place where alcoholic drinks are sold for consumption elsewhere
SIMD	Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland in a fair way. It provides a wealth of information to help improve the understanding about the outcomes and circumstances of people living in the most deprived areas in Scotland

Socioeconomic	Involving a combination of social and economic matters
Social Exclusion	A situation in which some members of a society do not feel part of that society because they are poor or do not have a job
Social Mobility	The ability to move easily from a lower social class to a higher one
Triple P	Triple P (Positive Parenting Program) is a system of easy-to-implement, proven parenting solutions that helps solve current parenting problems and prevents future problems before they arise
WHO	World Health Organisation
Worklessness	Defined by the Department of Work and Pensions as "people of working age who are not in formal employment but who are looking for a job (the unemployed), together with people of working age who are neither formally employed nor looking for formal employment (the economically inactive)

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