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)
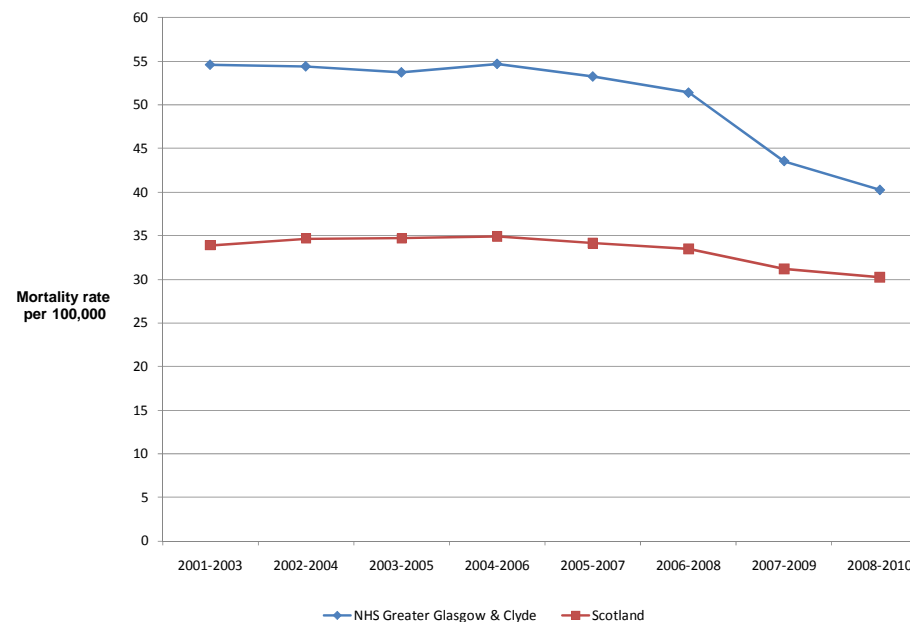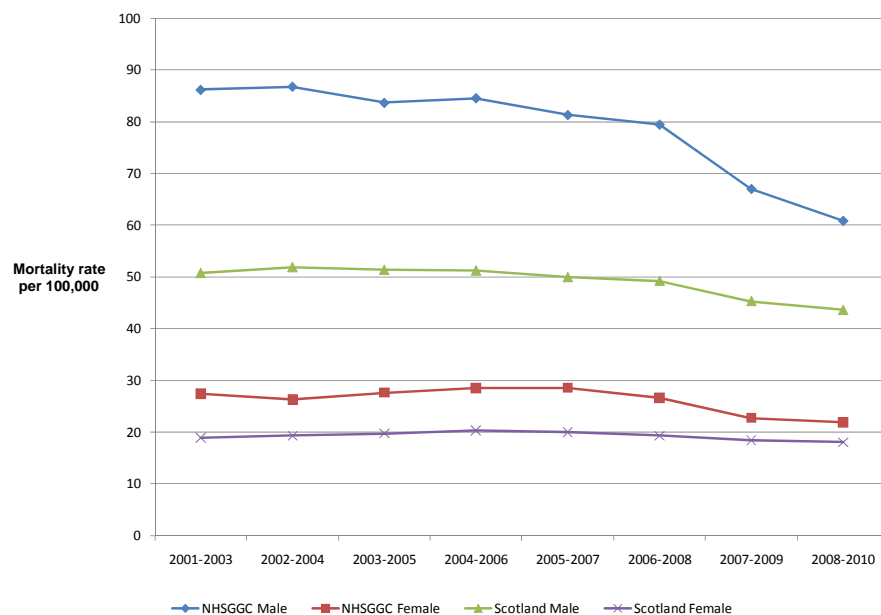

Figure 5.2 shows a decline in male and female mortality rates nationally and this is also reflected locally.

Figure 5.2: NHS Greater Glasgow & Clyde and Scotland Alcohol Related Mortality Rates Per 100,000 by Gender: Aged 20+ (Source: National Records Scotland)

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 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

Figure 5.3: **Mental health related alcohol death rates per 100,000 Population, NHSGGC 2007/9 Source: GCPH Mental Health Profiles**
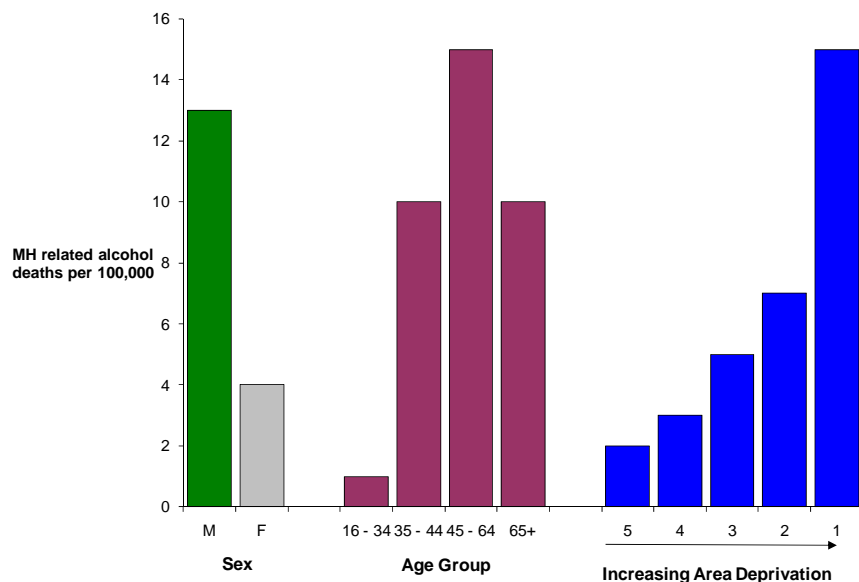
There were more psychiatric hospital admissions for alcohol problems in NHSGGC than any other area in Scotland in 2007/8, with Glasgow City, Renfrewshire and Inverclyde local authority areas having the highest admission rates. The peak age for admission is between 35 and 44 years old. Males are three 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
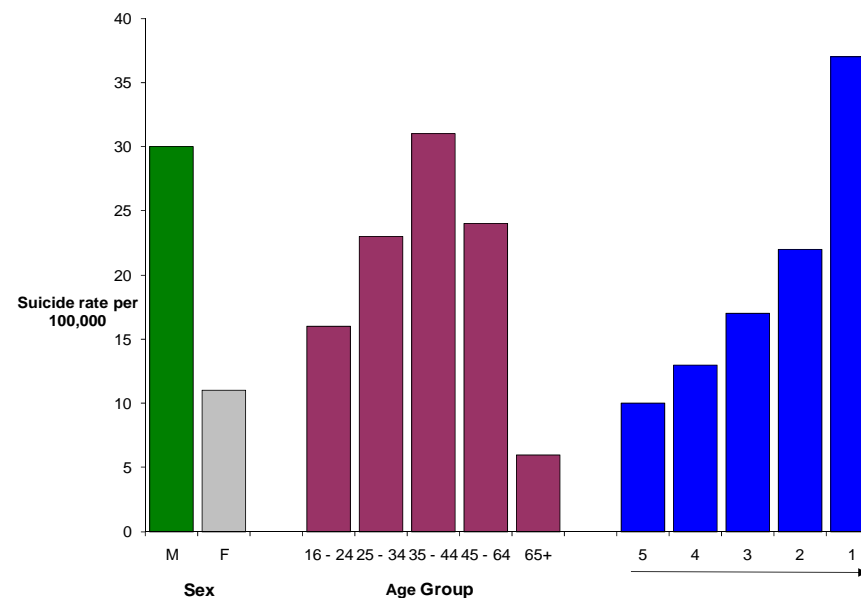
1.6   Mental health problems are important reasons for NHSGGC residents claiming incapacity benefit. Figure 5.5 shows that mental health claimants represent about half of all incapacity benefit claimants. Mental health claims have changed little between 2000 and 2008,

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
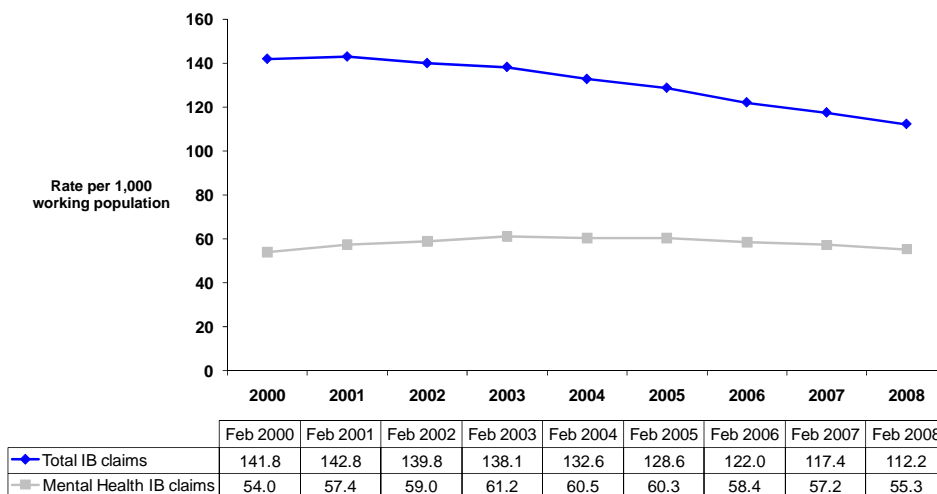
Section 2: Equalities focused mental health promotion

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.