



Healthy Minds

The Report on the health of the population of
NHS Greater Glasgow and Clyde

From the
Director of Public Health

November 2017

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FOREWORD from the Director of Public Health

I am delighted to introduce a new Director of Public Health Report on the theme of Public Mental Health. Good mental health is more than the absence of diagnosable mental health problems, although good mental health can also be an important protective factor against development of some such problems. Rather it is an asset that helps us thrive, be physically healthier and enables us to fulfil key functions and activities including forming and maintaining relationships, learning and working and coping with change or difficult circumstances.

Why should we prioritise mental health? Because caring for minds as well as bodies means people will not only live longer but better. Just as we have effective treatments for physical illnesses, there are therapies, medications and lifestyle interventions that can ease mental suffering, especially if help is provided at the earliest signs of a problem. So often we do not consider mental health promotion or good mental health as important as our health. Andrei Lankov said *"To not have your suffering recognized is an almost unbearable form of violence."* For many people with mental health problems, their suffering is not adequately recognised. A good example from this report is the school survey information showing high levels of distress in the LGB school population.

Stigma remains a major challenge in relation to mental health. As Stephen Fry said, *"1 in 4 people have a mental health problem. Many more have a problem with that."* The report describes ways that this stigma is being challenged and makes the case for more work in this area.

Over the last year, I have particularly enjoyed two areas of work in which I feel privileged to have been involved. One is being the Chair of the Adverse Childhood Experiences (ACES) Hub for Scotland. ACES refer to stressful events occurring in childhood such as abuse, neglect, family conflict, parental drug or alcohol addiction. ACES can create dangerous levels of stress and derail healthy brain development, which can result in long-term effects on learning, behaviour and health. Over the last year, colleagues and I have raised awareness of ACES amongst policy makers and front-line staff to try to help services, schools, communities to be able to respond to

prevent ACES in families and to manage their consequences. I have also been part of the Discovery stage of the national Root and Branch Review of Care. The work by the review team in listening to people with lived experience of Care is a key aspect of being able to change a system that does not always meet the needs of children and young people effectively. Both of these areas of work have had a personal impact on me in re-emphasising the importance of understanding mental health, recognising the need for early intervention and genuinely involving individuals and communities in their care, treatment and developing solutions.

Key messages from this report include:

- Mental health is strongly linked to the social determinants of health – poverty, unemployment, housing etc and therefore tackling mental health issues is an important part of our strategy to address health inequalities;
- The determinants of mental health and public mental health promotion require sustained multi-agency responses;
- There is growing evidence on how to improve public mental health. NHS Greater Glasgow and Clyde (NHSGGC) has an impressive history of innovation and implementation of evidence based interventions to achieve this but we must do more to ensure consistency, targeting and access across all of NHSGGC;
- Promoting mental health is very cost-effective and can provide long term savings in public services including acute care;
- We require greater integration of physical and mental health care as evidenced so starkly in the high morbidity and mortality of people with mental illness compared to those without.

From a public health perspective, a crucial message is to redefine ‘early’ in both our prevention and intervention work. An important and often ignored stage in this is the preconception period. Our collective, on-going push for social justice doesn’t begin at school, or in nurseries, or even at birth. Rather, the roots of inequality, and the wellspring of social justice, can be found long before birth and even before conception occurs. So, that earliest time of opportunity is when we must begin, too.

This report will require further work to develop individual HSCP reports on mental health to ensure that local action is tailored to need, that good practice can be shared and gaps identified.

I would like to thank all those who contributed to this report, in particular to Trevor Lakey, Allan Boyd, Stan Murray, Gillian Penrice, Catherine Chiang and Pauline Innes.

Linda de Caestecker
Director of Public Health

Executive Summary

The DPH Biennial Report 2017 demonstrates the major scale and depth of mental health as a public health issue. It has been demonstrated that there is scope for developing both public mental health population surveillance and services in several general ways as follows:

- There is scope for developing systems of population mental public health surveillance using new sets of population indicators and for improved assessment of mental public health including assessment of unmet need
- The need to raise the status of population mental health issues to equal parity with physical health issues is particularly important
- The interconnectedness of physical and mental health issues must be recognised in the design of all services and interventions
- There are high-risk groups in the population to which specific interventions should be addressed
- There is major scope for developing the evaluation of services and for extending effective models of care to other areas across NHSGGC
- There is a need to develop services geared to prevention and early intervention

These general issues that should inform the collective public mental health effort correspond closely with the five year mental health service transformation agenda, constructed on the recommendations of landmark publications like the Christie Commission. There is a need to strengthen prevention and early intervention efforts and a requirement to better utilise the recovery resources of our communities, as a complement to high quality health and care services for mental health.

Several issues of particular concern emerged in the course of the needs assessment work. These included the following:

General mental health: overall, most of the population of NHSGGC reported good mental health but there were variations in the populations of different HSCPs. These variations should be investigated and addressed.

Suicide: the suicide rate is considered to be an indicator of overall mental health in a population. The variations in suicide rate in the different constituent partnerships of NHSGGC should be investigated and addressed.

Physical health: the issue of impaired physical health in people with mental illness has not previously been recognised. This issue needs to be addressed in the design of future services.

Gay and lesbian community: there was a greater prevalence of overall psychological problems in young gay and lesbian people than in the general population of the same age. This is an example of a particular community for which specific interventions should be addressed.

It is beyond the scope of this report to provide detailed recommendations for action but a number of action areas are highlighted below for consideration by the Health Board and its partners:

1. Provide visible and sustained leadership on this vital area of development, ensuring that mental health issues are treated with equal status to physical health issues (the 'parity of esteem' approach), from the Health Board, Health and Care Partnerships and with Community Planning Partnerships
2. Work to develop resilient communities, and develop emotionally aware populations across the full age range of our population
3. All parts of NHS Greater Glasgow and Clyde and community planning partners should fully adopt the Children and young people and Adult mental health improvement frameworks to guide comprehensive multi-partner action. The Board and IJBs should expect regular reports on their implementation
4. Boost support for families in perinatal period, including social support approaches coupled with effective access to clinical care where needed and work with health visitors to collect more useful information on EMIS web about perinatal mental health
5. Progress comprehensive approaches to child and youth mental health improvement through relevant children's services planning and pan-Board child

planning mechanisms, including close working the Education services to advance schools-based mental health support and enable effective use of the Pupil Equity Fund

6. Embed mental health promotion in all services, for example health visiting or district nursing. This will include staff training on mental health improvement.
7. Ensure that patients with severe and enduring mental health problems are provided with equitable access to the full range of primary care services required to address their current poor health outcomes
8. Ensure that patients with co-morbid mental health and substance misuse issues receive holistic care that addresses both their mental illness and substance misuse. Managing one condition without the other is destined to result in poor outcomes
9. Strengthen access to evidence-based parenting programmes. At the very least protect the small resource already available of staff trained in parenting programmes and plan for growth over time
10. Work closely with and further develop community-level approaches to public mental health, including direct learning from people with lived experience of mental health problems. Make effective use of community assets to promote mental wellbeing and recovery, including building the capacity of community organisations and advancement of social prescribing and link worker models
11. Further progress with the workforce development agenda for multiple partners, ensuring significant upgrading of awareness, knowledge and skills to intervene on mental health themes across multiple settings
12. Further work is required on the pre-conception and perinatal stages of the life course in relation to public health
13. Focus on supporting mental health and wellbeing of the workforce and supporting wider employability initiatives and mental health at work programmes
14. Utilise innovative methods and approaches, including the use of digital technologies, to promote and support mental health. The Board should progress an exploration of the potential of this field, building on initiatives like telecare, *Aye Mind* for young people, linking to the Board's eHealth strategy

15. Further progress mental health literacy and self management, development of peer support and self management resources for a range of settings including social care and housing
16. Continue to progress the multi-agency work on suicide prevention and self-harm support, including further development of the Choose Life programmes in each of our Community Planning Partnership areas and further work to progress staff training and innovations in responding to distress
17. Maintain focus on tackling poverty, inequality, equality, citizenship and human rights dimensions within the public mental health and service delivery – in line with relevant legislative and allied guidance

Chapter 1: The Challenge of Mental Health

The Director of Public Health's Biennial Report provides an overview of public mental health within Greater Glasgow and Clyde Health Board (NHSGGC) and describes opportunities for future development. The report includes:

- an overview of the policy context and research for public mental health
- a summary of the state of public mental health in the area of NHSGGC, across the life-course
- a synopsis of some of the many multi-partner programmes that have been developed within the Board area as a response to the challenge and
- an outline of some of the key opportunities to make further progress.

Mental health, whether good or poor, affects every area of our lives and has close connections to many other areas of our health and wellbeing. Good mental health – for individuals, families and communities – is a resource that can aid coping with the challenges of modern society. Linked to this, there is mounting evidence for the importance of loneliness and isolation as major, independent risk factors, not just for poor mental health, but for overall health¹. This highlights the importance of the many initiatives which seek to build social connection and mutual support as critical elements of wider efforts to improve mental health. Similarly, promoting recovery from mental health problems is a challenge which requires both timely and effective mental health care and treatment, but also access to wider resources in communities.

It is clear from the international evidence on determinants of population mental health that collective action to address underlying risk factors for poor mental health, for example, poverty, poor employment prospects, adversity in childhood as well as stigma and discrimination, needs to be a vital part of the public mental health effort.

¹ [Social Relationships and Mortality Risk: A Meta-analytic Review](#)

Chapter 2: The Policy Context and Developing Research

The development of mental health services in NHSGGC in all phases of the life-course will be informed by several important studies and national statements of policy. These policies are applicable to general mental health in some cases and to specific groups, for example, children and young people, in others.

2.1 Child and Youth Policy, including ‘Getting it Right for Every Child’

The Getting it Right for Every Child (GIRFEC)² strategy approach provides a consistent way of working with children and young people. The authors described how practitioners needed to work together to support families, and, where appropriate, to take early action at the first signs of any difficulty. This will require working across organisational boundaries and putting children and their families at the heart of decision-making. The Scottish Government is committed to enshrining the GIRFEC approach in all its existing policy, practice, strategy and legislation that affects children, young people and their families.

2.2 Adverse Childhood Experiences (ACES)

In recent years, the importance of adverse childhood experiences (ACES), for example, experience of trauma and neglect, has become recognised. Adverse experiences are recognised to have a major effect on many public health issues such as child development, risk of mental illness, risk of substance misuse problems and reduced life expectancy. Greater Glasgow and Clyde is an active partner in the Adverse Childhood Experiences Advisory Group, hosted by NHS Health Scotland. The group is developing an action plan which will contribute to preventing, and responding to, adverse childhood experiences in Scotland. The initial phase of work will be to raise awareness of ACES with education, health and social services staff and to start discussions on training and responses.³

² [Getting it right for every child \(GIRFEC\)](#)

³ [Tackling the attainment gap by preventing and responding to Adverse Childhood Experiences](#)

The powerful findings of the ACES research have important implications for many aspects of service delivery, not only for early years' services and parental support programmes but also for the need for enhanced responses from services both for children and adults affected by adversity in their early years. These developments hold the promise of benefits in multiple areas, including the fields of substance misuse and criminal justice.

2.3 Kings Fund report: “Bringing Together Physical and Mental Health”

Two fundamental principles were articulated in this report.⁴ Firstly, it was argued that mental health issues should be more prominent in overall assessments of population health. Secondly the need for greater integration of responses to poor mental and physical health was emphasised, underlined by several challenges, including the following:

- The prevalence of mental health problems is greater among people with long term physical conditions.
- There are major reductions in life expectancy among people with the most severe mental health problems. In large part, this is related to the higher prevalence of chronic physical diseases in people with severe mental illness.
- An economic case was advanced that savings of £11 billion per year could be made if greater integration of responses could be achieved
- Evidence was also reported that the well-recognised gradient by deprivation category in prevalence of physical long-term condition was not only replicated but increased in patients with serious mental illness

The authors of the Kings Fund report described the need to create more integrated approaches to physical and mental health as “the new frontier in integration.”

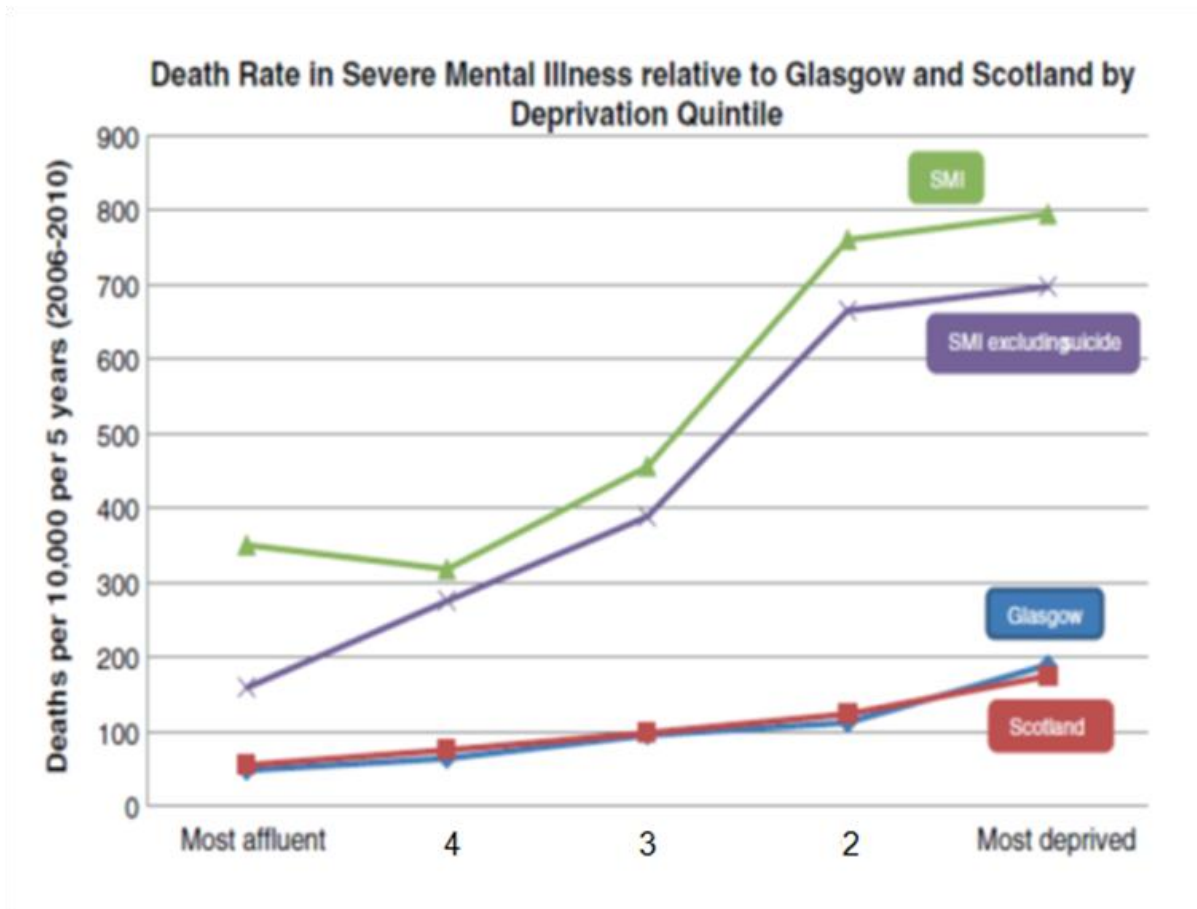
⁴ [Bringing together physical and mental health: A new frontier for integrated care](#)

The increased risk of physical morbidity in patients with severe mental illness was confirmed in a study of a study of mortality in patients with psychotic illness in NHSGGC registered in the PsyCIS register (qv). The authors of the study reported two major findings:

- The well-known gradient in Mortality Rate in the general population by SIMD Quintile was reproduced in the population of patients with severe psychosis i.e. severe psychosis is more common in the most deprived communities
- At any given level of SIMD Quintile, the level of mortality was greater in the population with psychosis⁵

This finding is shown in Figure 1 below.

Figure 1: Death Rate in Severe Mental Illness relative to Glasgow and Scotland



⁵ [Impact of socioeconomic deprivation on rate and cause of death in severe mental illness](#)

2.4 **Scottish Mental Health Strategy 2017-2027**

The themes set out in the King's Fund report are also reflected in the new Scottish Mental Health Strategy 2017-2027⁶, launched in March of this year. In addition, the authors of the strategy have emphasised the following:

- Parity of esteem, or equal status, should be achieved between physical and mental health issues. This aspiration is predicated on an acknowledgement that mental health issues have traditionally enjoyed disproportionately little prominence and status. This would be recognised as a major transformational challenge.
- The response to public mental health issues should include multi-partner responses as well as clinical service development.

The new Scottish strategy includes a set of forty proposals for action, most of which would require partnership commitment for delivery and which span public health and service delivery areas.

2.5 **Report: 'Better Mental Health for All'**⁷

This report was recently published jointly by the Public Health Faculty and the Mental Health Foundation. In the report, a comprehensive overview was given of the evidence for the vital importance of the public mental health agenda and for the need for concerted multi-sectoral action.

The authors presented a convincing clinical, social and economic case for comprehensive action to promote population mental health and to provide approaches based on preventive and early intervention. It is beyond the scope of this paper to provide full detail of this, but two examples taken from social welfare statistics arena may be sufficient to illustrate the scope for action. According to the report:

- poor mental health is the cause of forty percent (40%) of new disability benefit claims each year in the UK.

⁶ [Mental Health Strategy 2017-2027](#)

⁷ [Better Mental Health for All](#)

- Seventy percent (70%) of people with severe mental health problems are economically inactive and on disability benefit, compared with 30% of the general population.

2.6 McDaid Study (London School of Economics)

It has been shown in a study conducted at the London School of Economics⁸ that investment in mental health is economically cost-effective. Detailed analysis of public mental health interventions has shown that:

- for every pound spent on workplace health promotion programmes, the total return on investment is £9.69
- for every pound spent on early detection of psychosis, the return is £10.27
- for every pound spent on school-based interventions to reduce bullying the return is £14.35
- for every pound spent on debt advice services for people with mental health problems the return is £3.55
- for every pound spent on prevention of conduct disorder through social and emotional learning problems the return is £83.73

⁸ [Mental Health Promotion and Prevention: The Economic Case](#)

Chapter 3: Mental Health and Inequalities

- 3.1 There is abundant evidence that mental health status is heavily determined by underlying social factors such as poverty, unemployment, adverse childhood experiences, poor physical environments, bullying, discrimination and social exclusion.

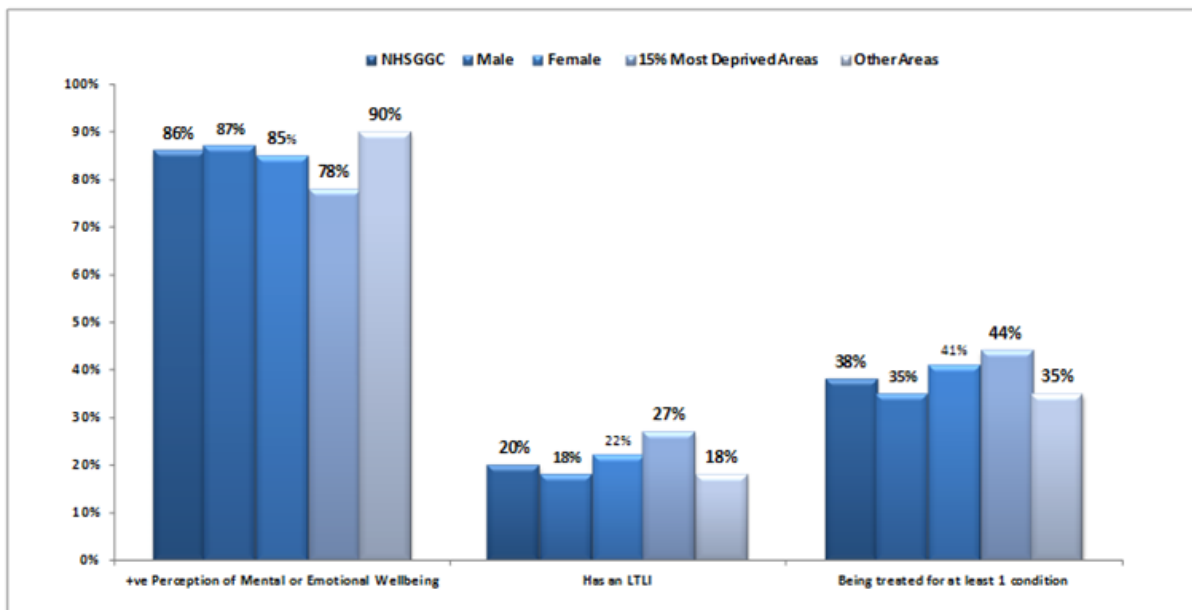
In turn, in a vicious cycle effect, poor mental health tends to generate further social disadvantage, exacerbating poverty and significantly reducing participation levels in the labour market and wider civic life. Mental health issues are often associated with other challenges for people and families, such as long-term physical health and disability issues, employment and financial challenges. In addition, co-morbidity related to substance misuse is common. The wider effects include the significant burden created for carers and wider family members and in particular the challenges for children and young people caring for parents with mental health problems. It is a well-recognised but often poorly responded to fact that carers themselves are at major risk of poor mental and physical health.

- 3.2 In NHSGGC, self-reported mental health is poorer in the more deprived population. As can be seen in Figure 2, 86% of respondents in the Health and Wellbeing Survey (HWBS) reported good mental health status. The proportion was significantly greater in the least deprived populations compared to those in the most deprived areas (90% and 78% respectively). Mental health is poorer in residents of more deprived communities. They are also more likely to report experiencing isolation and not belonging. It was found in the HWBS that those reporting a limiting long term condition were also more likely to live in areas of relative deprivation. This finding was not limited to people who had a physical health disorder but was also valid for people who have more long-standing mental health problems as shown in Figure 2. It is evident that any effective response to population health inequalities needs to incorporate a robust and sustained commitment to addressing population mental health. Work to support employment and

financial inclusion should address mental health and wellbeing issues that are often closely linked, for example, debt and money worries tend to exacerbate mental health problems.

Figure 2: % respondents with a positive perception of Mental Wellbeing or had a long-term limiting condition or were being treated for at least one condition by Gender and SIMD Deprivation Category

(Source: NHSGGC Health and Wellbeing Survey 2014/15)



Chapter 4: Mental health stigma and discrimination

4.1 Stigma and discrimination have been widely recognised as having powerful negative effects on people with mental health problems, often adding additional burdens to people’s life experiences. Stigma can occur within families, communities, workplaces, within services and within wider society. The effect of stigma on the lives of people with mental health problems may be as profound as that of the illness itself. This may impair participation in all aspects of life, may inhibit timely help-seeking in some cases and cause damage to employment prospects.

Stigma needs to be challenged and addressed as an integral part of wider population mental health efforts. NHSGGC and a range of partner agencies have been working over some years to address both the stigma and resulting discrimination that may attach to patients with mental ill health. This includes close links with the national anti-stigma programme, *See Me Scotland*⁹. The See Me programme is promoted in East Dunbartonshire

Developed locally to reduce misconceptions, myths and stereotypes is the Scottish Mental Health Arts Festival. The festival includes more than 250 arts events with active involvement of communities and service user groups, arts and health professionals. More information is available at www.mhfestival.com

East Dunbartonshire HSCP promotes “See Me” with education staff and youth workers

⁹ [See Me](#)

Chapter 5: Mental Health across the life-course in NHSGGC

Mental health in the population of NHSGGC will be considered in three categories which correspond to a life-course approach. The importance of the life-course perspective in considering mental health is predicated on an appreciation of the importance of early life experiences for later mental and physical health. In this paper, mental health will be considered in three main stages of life, the perinatal period, childhood and young adulthood and general adulthood.

5.1 Mental Health in the perinatal period:

The “Getting It Right for Every Child (GIRFEC)¹⁰” strategy is reflected in every development in care for mental health problems in the perinatal period. New mothers are recognised as a highly vulnerable social group in which social connectedness is particularly important and needs to be promoted. Important aspects of mental health issues in the perinatal period are as follows:

- Mental health issues in the perinatal period carry an estimated cost to the UK of about £8.1 billion per year according to a recent report, “Cost of Perinatal Mental Health Problems”¹¹
- Postnatal Depression affects about 1 in 6 mothers and 1 in 10 fathers and remains a leading cause of maternal death (Knight. M, et al., 2014)¹²

One in five women can be expected to experience perinatal mental health problems although only one half of these are recognised.¹³ Women remain at high risk of death from mental illness throughout the first year after giving birth.¹⁴

- Almost a quarter of maternal deaths that occur between 6 weeks and one year are attributable to psychiatric causes.¹⁵

¹⁰ [Getting it right for every child \(GIRFEC\)](#)

¹¹ [Costs of perinatal mental health problems](#)

¹² [Saving Lives, Improving Mothers' Care](#)

¹³ [Mental Health Strategy 2017-2027](#)

¹⁴ [Saving Lives, Improving Mothers' Care](#)

¹⁵ [Saving Lives, Improving Mothers' Care](#)

- Women who have experienced the loss of a child through miscarriage, stillbirth, neonatal death or by the taking of a child into care are at increased vulnerability to mental illness.¹⁶

The need for women who have had experience of, or are at risk of, mental health problems before, during and after their pregnancy to receive extra support is recognised in the NICE guidelines.¹⁷ The establishment of the Perinatal Mental Health Network in 2017, with funding from Scottish Government will help to ensure that women and infants in NHS Greater Glasgow and Clyde receive the most appropriate care.

Findings published in the report '*From bumps to bundles; exploring mental health in the perinatal period*'¹⁸ strongly suggest that social support is vital to supporting good mental health, preventing mental health problems and maintaining recovery from mental ill health in the perinatal period. Women who lack support are at significantly increased risk of impaired mental health. This risk may be increased by a range of additional factors, for example, young age at pregnancy, history of disrupted relationship, family conflict, gender-based violence, addiction issues and deprivation.

¹⁶ [Saving Lives, Improving Mothers' Care](#)

¹⁷ [Antenatal and postnatal mental health: clinical management and service guidance](#)

¹⁸ Donnelly, R., Sloan, H. (Eds). "From Bumps to Bundles", Perinatal Mental Health in NHS Greater Glasgow and Clyde. (2013) Published by NHS Greater Glasgow and Clyde

Family nurse partnership, a home visiting programme, is being rolled out across NHS GGC for first time young mothers. The programme takes a person-centred approach utilising an attachment based therapeutic relationship. The relationship built up between the young women and the Family Nurse is a central part of the programme in the context of trauma or ACEs that the young women have experienced in their life. This support aims to improve parenting and mental health.

Perinatal mental health support does not necessarily need a clinical intervention. There are a wide range of examples of community led and peer support programmes across NHS GGC including:

In Renfrewshire HSCP the New Mum, New You Project provides dietary and physical activity advice. The aim is to reduce social isolation and incidences of post-natal depression.

'What's the Harm' in Glasgow City supports new mothers by providing awareness and skills training with the aim of reducing the prevalence of self-harm.

HomeStart North, a peer support programme in Glasgow City HSCP, offers perinatal peer support. The intervention has had a positive impact on families and their relationships with statutory services

5.2 Mental Health in Children and Young People

Considerable work has been undertaken in the last five years in NHS GGC to advance a strategic approach to the promotion of children and young people's mental health. This has been built on the completion and ratification of a Child and Youth Mental Health Improvement Framework in 2012 (see Table 1).

Table 1: Six Core Elements of Mental Health Improvement Framework for Children and Young People in Greater Glasgow and Clyde

| | | |
|---|--|---|
| <p style="text-align: center;">One Good Adult</p> <p>A dependable adult to support and protect mental health</p> <ul style="list-style-type: none"> • Attachment (parenting), • Mentoring (mentoring, guidance, befriending) | <p style="text-align: center;">Resilience in Schools</p> <p>Whole school approaches to mental health and well-being –a nurturing environment that builds emotional literacy</p> | <p style="text-align: center;">Resilience in Communities</p> <p>Strong network of youth services building achievement and skilled to support and intervene</p> |
| <p style="text-align: center;">Guiding though the service maze</p> <p>Children, families and young people have a range of support options for early intervention and can be helped to find their way to appropriate help quickly.</p> | <p style="text-align: center;">Distress, Self-harm and Suicide Prevention</p> <p>Frontline staff are confident and supported to intervene and help youngsters in situations of distress</p> | <p style="text-align: center;">Peer Help & Social Media</p> <p>Build opportunities for peer help and positive use of social media – given that young people often turn to peers and the internet for help (see Aye Mind work¹⁹)</p> |

5.2.1 A major body of cross-agency work has been developed in the years since its launch, supported by children’s planning systems. Examples of development work and progress include:

- Development of whole school approaches to mental health, including policies and training of schools-based staff in mental health first aid, suicide prevention skills, schools counselling and emotional wellbeing support
- Creation of a school curriculum resource on self-harm (“On Edge”) now in use in schools across the Board area
- Creation and delivery of a major training resource on self-harm awareness and skills (“What’s the Harm?”) which is for whole population, not just for

¹⁹ [Aye Mind](#)

young people. Over 1,000 staff have been trained to use the resource on self-harm awareness and skills (What's the Harm)

- Supporting a growing range of needs for input to a wide range of child and youth agencies in the community and voluntary sector in relation to resilience, mental health and wellbeing.
- Active liaison with colleagues in clinical services, including CAMHS teams, to build better connections to wider supports and community assets for young people and increase referral pathways
- Development of practical responses to the “one good adult” theme, including advent of high quality mentoring programmes for vulnerable young people
- LGBT Youth Charter Mark status in secondary schools across Glasgow City

5.2.2 The school nursing service is currently being reviewed in NHSGGC. In keeping with the recent national review of the role of the school nurse, support for the prevention, assessment and early treatment (tier 1 and 2) of mental health issues is seen as a key priority for the school nursing service in the future. Evaluation of early adopter sites of the refreshed school nursing role indicated that the majority of referrals to the service were for mental health and wellbeing concerns.

5.3 Partnership working in action - Child and Youth mental health improvement networks:

Our child and youth mental health improvement networks are multi-agency, multi-sector groups which work to ensure the best support using a range of resources and activities in our early year's programmes. The programmes focus on preventing the adverse impact of socioeconomic deprivation on the health and education of children and young people through a partnership approach.

Programmes and initiatives across GGC support early year's mental health and wellbeing in the early years in line with GIRFEC principles. For example:

- Emotional literacy programmes delivered to parents of nursery and primary school aged children.
- Seasons for growth which looks at issues of loss.
- One Good Adult sessions promote the importance of a supportive adult in the child's life.
- Loss and Bereavement toolkit
- Creative Confident Children delivered in early years' establishments

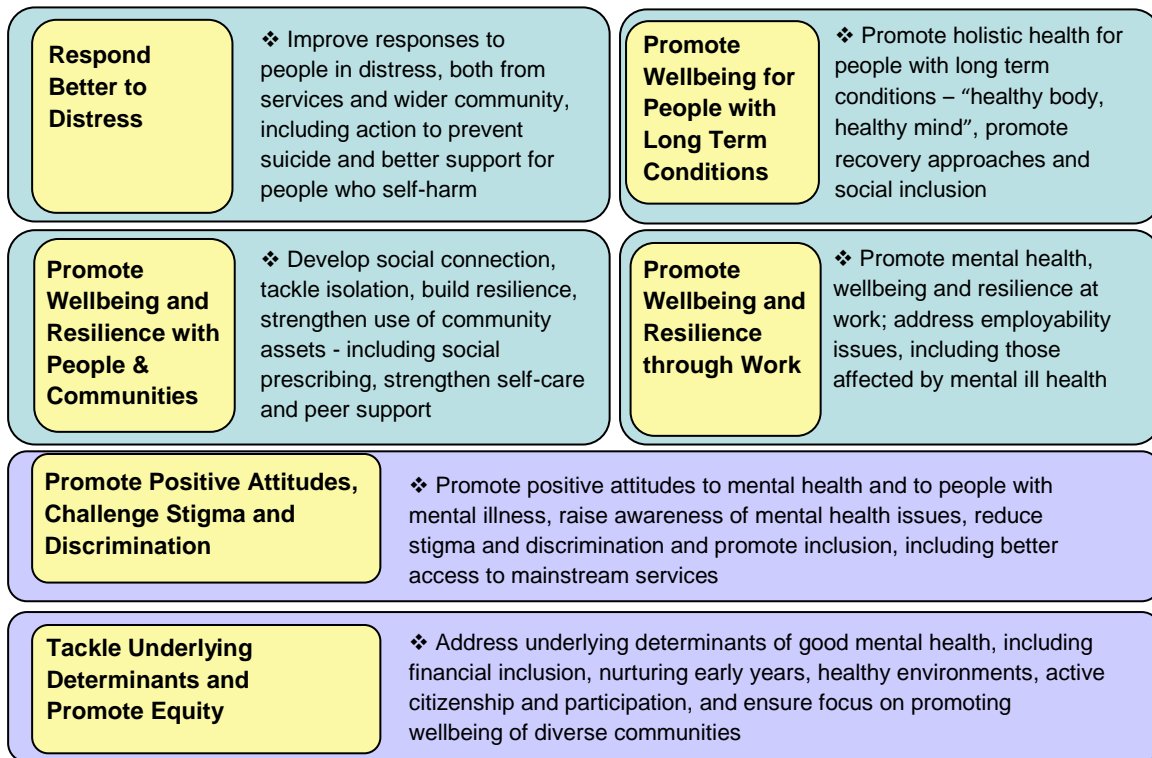
5.4 Mental Health in the adult population

The range of mental illness in adults encompasses such diverse illnesses as mood disorders, neurotic disorders, psychotic illness and alcohol-related morbidity. Mental health issues in adults are associated with considerable unmet need. Mental illness is common, but patients may fail to recognise their own mental illness. Patients who do recognise their illness may be prevented from presenting to services for reasons related to stigma, accessibility, support networks and factors related to family and employment.

5.5 “Healthy Minds” framework for action

An approach based on a collective partnership in Greater Glasgow and Clyde led to the development in 2015 of a comprehensive public mental health framework, “*Healthy Minds*” (Figure 3). The framework includes recommendations for preventive work as a complement to provision of high quality mental health services. There are six domains for collective action by partners.

Figure 3: Healthy Minds – Adult Mental Health Framework, Greater Glasgow and Clyde



- Elements of the framework include an emphasis on developing community resilience, addressing social isolation and loneliness, challenging stigma and discrimination, a focus on long-term conditions, including carers’ health and response to distress, including support for self-harm and preventing suicide.
- Approaches such as social prescribing to link people with mental health issues to wider community supports and resources. Similarly there is a need for sustained work in the field of mental health recovery to ensure that social wellbeing and social functioning are addressed alongside clinical care. An audit of patients on the PsyCIS register revealed that 46% of patients were unemployed. People with mental health problems have a high rate of unemployment and represent the highest number of those claiming sickness and disability benefits.²⁰ Early intervention in the workplace can support people with mental illness to stay in work and

²⁰ [Employment and Mental Health](#)

prevent sickness absence. Good quality employment is also good for an individual's health.²¹

5.6 Financial inclusion support in mental health and allied settings. There is powerful evidence that financial challenges have significant detrimental effect on people's mental health status, and also that poor mental health adds to the financial challenges that people face. Across mental health and allied services in Greater Glasgow and Clyde, a range of services assess and address financial inclusion issues for people with mental health problems, often linking closely with the network of community-based financial support services.

5.7 Mental health and work deserves specific focus, with two areas of action being important:

- (i) Supporting the mental health and wellbeing of employees
- (ii) Providing active programmes to support people with mental health problems to enter employment

5.7.1 The Healthy Working Lives award advocates good practice to support mental health in the workplace. The local Healthy Working Lives Team has assisted our 200 registered organisations with this, including developing mental health and stress policies, delivering Mentally Healthy Workplace Line Manager Training courses and advising on health promotion action plans. Workforces participate in national and local vocational rehabilitation services and build money management issues into their action plans.

²¹ [Employment and Mental Health](#)

Chapter 6: Mental Health Population Needs Assessment

A range of sources of data is available for the assessment of mental Health in the population of NHS GGC. These sources are summarised with a brief critical description in Appendix 1.

Needs Assessment information will be presented separately, for child and adolescent mental health needs and for the needs of adults.

6.1 Child and Adolescent Mental Health Needs Assessment

Most of the available data is derived from locally commissioned Schools Survey, the Strengths and Difficulties Survey and the Scottish Health Survey.

6.1.1 The National Picture

In the Scottish Health Survey in 2015, the WEMWBS tool was used to assess the positive aspects of emotional health. A specially designed tool, the Strength and Difficulties Questionnaire (SDQ), was also used to assess both overall strengths and difficulties and a range of specific difficulties. This provides a picture of the difficulties that groups of children experience and compare one group or area to another.

WEMWBS was used for children aged 13-15 years in 2012-15. The mean score across all facets of the instrument was 51.0. The mean score for boys (52.0) was higher than for girls (49.9). The scores were similar in children aged 13 years (52.3) and in those aged 15 year olds (50.0) and similar patterns were seen in both boys and girls. The WHO publication on Mental Health Resilience and Inequalities²², found that the impact of socioeconomic of resilient communities varied across the life course. It also found that the impact of socioeconomic deprivation was more powerful than resilience, such that even a poorly performing child from an affluent background would outstrip a resilient child in a supportive learning environment as far as

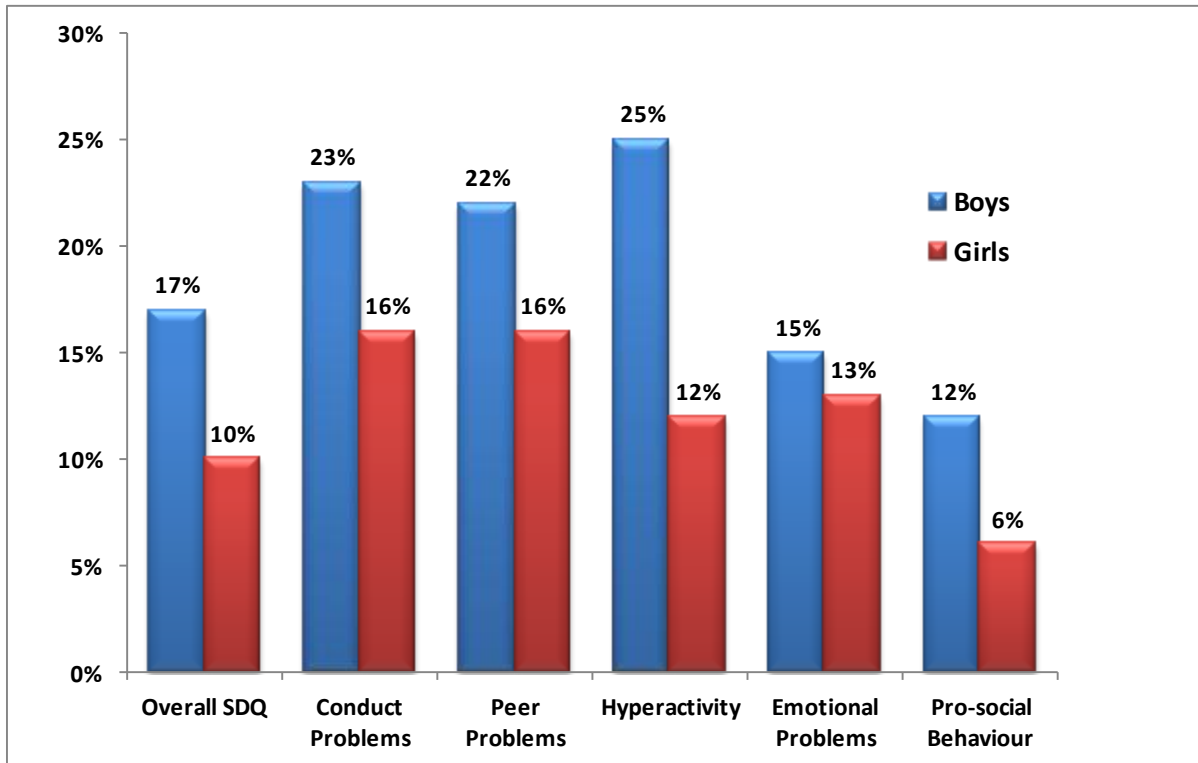
²² [Mental health, resilience and inequalities](#)

education is concerned. Resilience and good mental health is an advantage in populations of equal socioeconomic disadvantage, but cannot compete with the impact of poverty.

A series of locally commissioned Health and Wellbeing Surveys of S1 to S6 secondary school pupils were conducted in Glasgow City, East Dunbartonshire, Inverclyde and Renfrewshire between 2013 and 2015. To allow comparisons to be made between areas, a common set of questions was employed with a few local amendments. The local surveys provided a rich source of information on various aspects of self-perceived health and wellbeing of these children, including mental wellbeing, long-term conditions, worries, bullying, alcohol and drug use. They also allow exploration of differences between the heterosexual and LGB pupils. The key findings of these surveys are outlined later in this section.

Data were also collected from parents in the Scottish Health Survey 2015 using the Strength and Difficulties Questionnaire (SDQ). Nationally, the SDQ was used for children aged 4-12 years. Thresholds have been established with a score of 13 or less considered normal, 14-16 borderline and 17 or more considered abnormal.

Figure 4: % of children from the Scottish Health Survey who had a borderline or abnormal SDQ score by gender
 (Source: Scottish Health Survey 2015)



The proportion of children with borderline or abnormal scores increased with age for emotional symptoms (10% for 4-5 year olds: 17% for 10-12 year olds), and peer problems (17% aged 4-5 : 22% aged 10-12). The proportion with a borderline or abnormal score for hyperactivity decreased with age from 22% (aged 4-5) to 16% (aged 10-12). There was no significant difference by age for conduct problems or pro-social behaviour.

6.2 SDQ: Local Secondary School Surveys

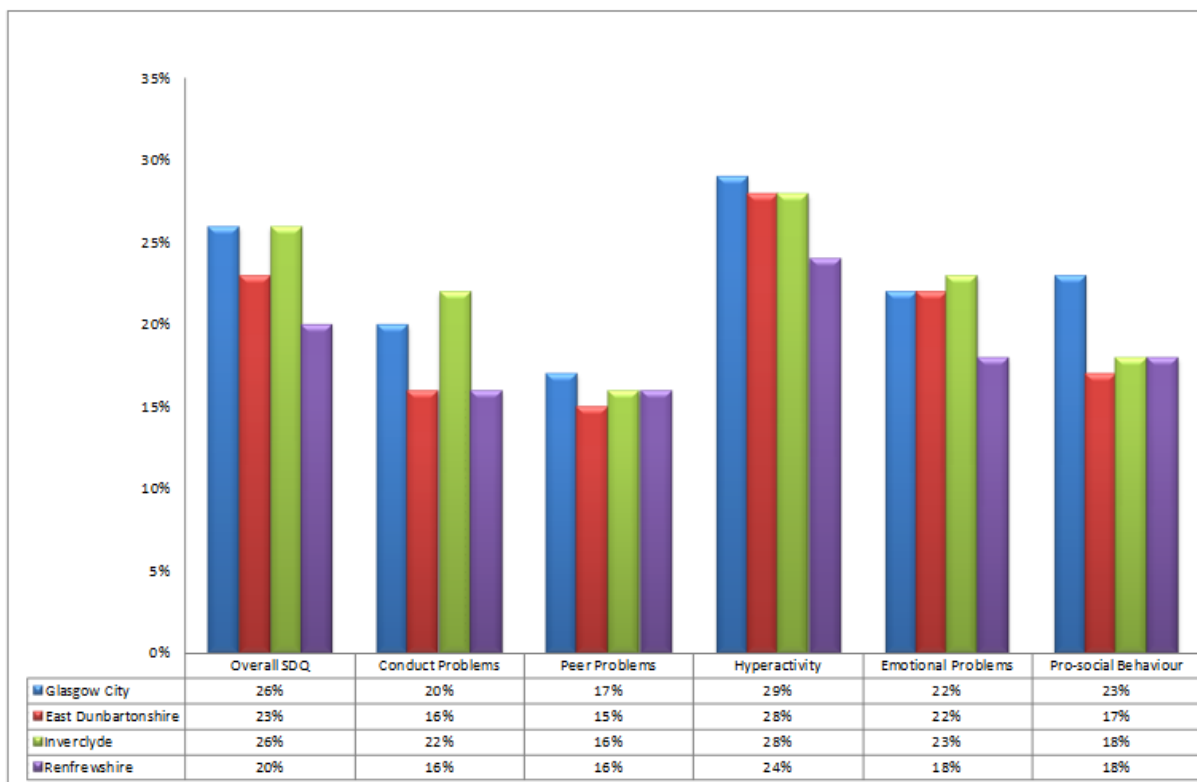
A series of locally commissioned health and wellbeing surveys of S1 to S6 secondary school pupils were conducted in Glasgow City, East Dunbartonshire, Inverclyde and Renfrewshire between 2013 and 2014. To allow comparisons to be made across areas, a common set of questions was employed with a few local amendments. As in the Health and Well-being Surveys, the local surveys provided a rich source of information on

various aspects of self perceived health and wellbeing of these children, including mental wellbeing, long term conditions, worries, bullying, alcohol and drug use. They also allow exploration of differences between the heterosexual and LGB pupils. WEMWBS was not used in the local secondary schools surveys questionnaire as it was not validated for the age groups covered in these surveys.

The SDQ however, was administered in the local schools surveys. Figure 5 shows the proportions of pupils who had a borderline or abnormal score by the different components and area.

Figure 5: Schools Surveys % Borderline/Abnormal Scores by Area

(Source: Schools Surveys 2013 and 2014)

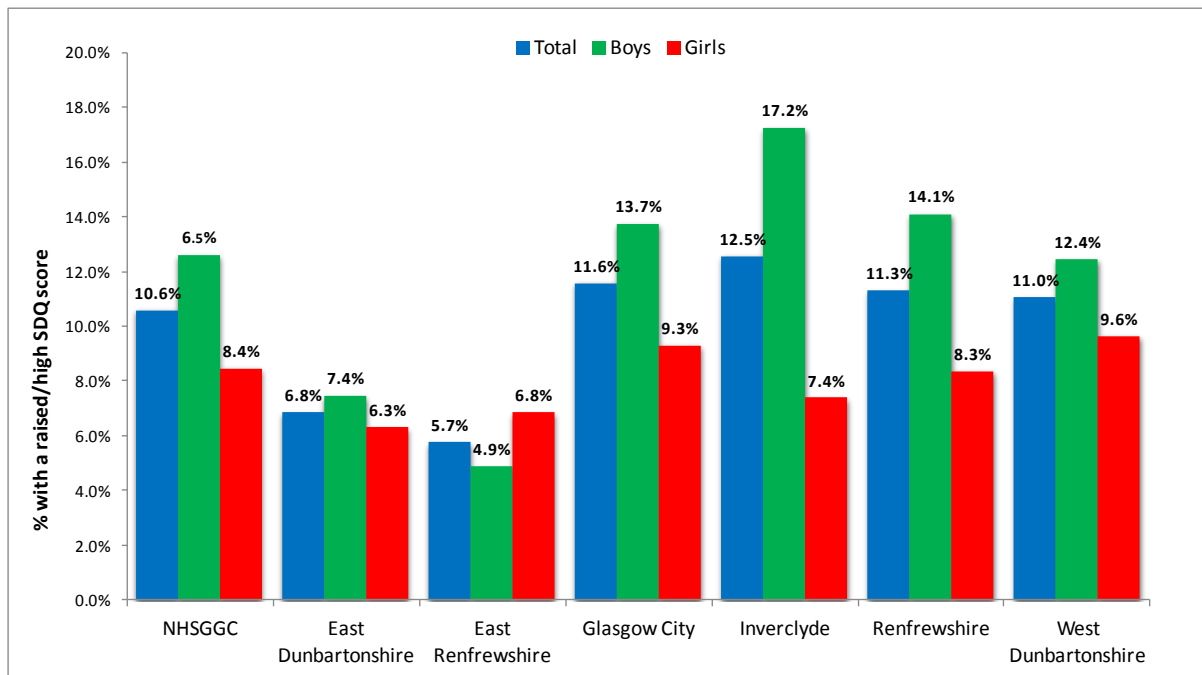


The proportion that experienced any difficulties ranged from 20% in Renfrewshire to 26% in Inverclyde and Glasgow City.

In all areas, girls were more likely to report emotional symptoms compared to boys, while boys were more likely to report conduct problems. There was little difference between the sexes for hyperactivity or peer problems. Girls were more likely to exhibit pro-social behaviour than boys in all localities. In all areas, when considering the composite score, girls were more likely to report a higher level of difficulty than boys. In view of the similar or lower scores in other domains, this high score is likely to reflect mainly the higher prevalence of emotional problems experienced by girls.

Specialist Children’s Services in NHSGGC collects data on SDQ. Data were extracted for 3 to 4 year old children and Figure 6 shows the proportion of children with a raised/high overall difficulties score by gender in 2016/17. The groups categorised as ‘Raised/High’ for these data equate to the ‘Borderline/Abnormal’ groups reported above (a score of 13 plus).

Figure 6: NHSGGC SDQ 'Raised/High Scores by Gender 2016/17, Total Difficulties, Ages 3-4
(Source: NHSGGC Specialist Children’s Services)



Overall 11% of 3 to 4 year olds had a raised or high score at their 1st assessment. With the exception of East Renfrewshire boys had a higher prevalence than girls. The highest proportions were seen in boys in Inverclyde and Glasgow City.

6.3 Emotional and behavioural problems

The prevalence of emotional and behavioural problems in secondary school children is shown in Table 2.

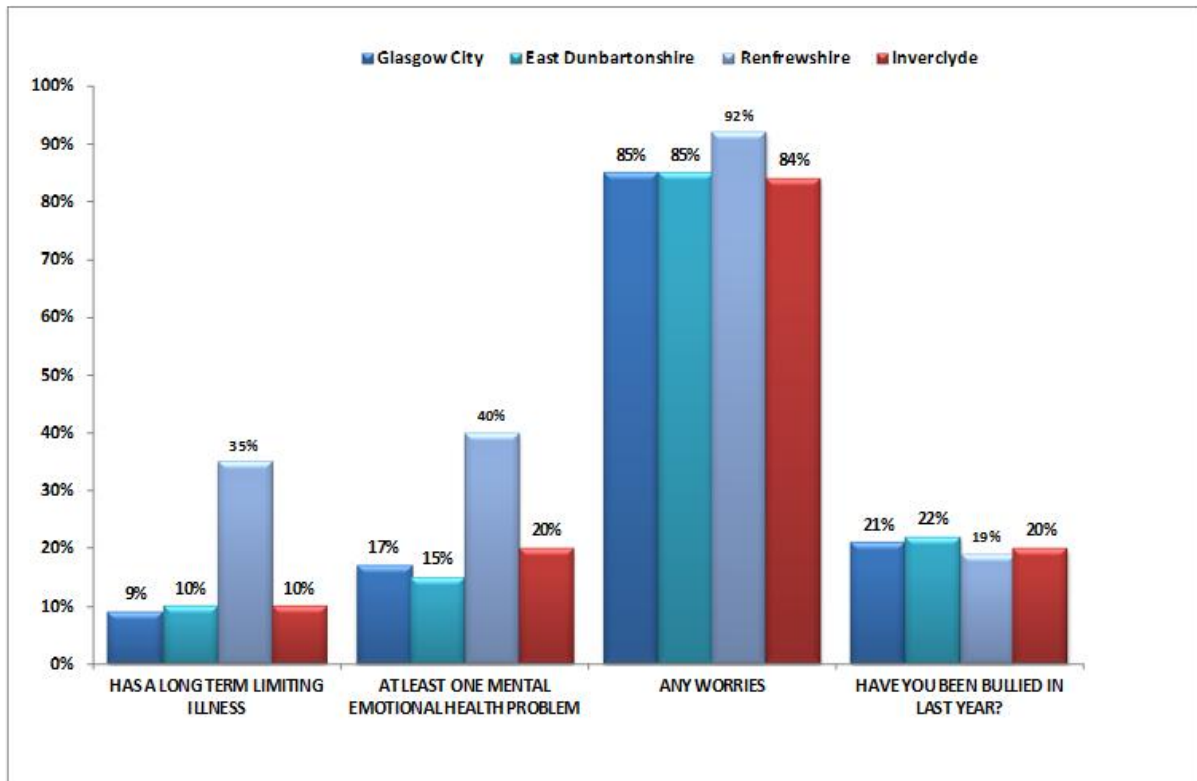
Table 2: Prevalence (%) of Mental and Emotional Problems in Secondary School Children by HSCP
(Source: Schools Surveys 2013 and 2014)

| | East Dunbartonshire | Glasgow City | Inverclyde | Renfrewshire |
|--|------------------------|-----------------|------------|--------------|
| Mental and Emotional Problems | 6% | 5% | 4% | - |
| Attention Deficit Hyperactivity Disorder | 1% | 3% | 3% | 2% |
| Autistic Spectrum Disorder | 2% | 2% | 1% | 1% |
| Dyslexia | 6% | 6% | 11% | 6% |
| Other | 3% | 2% | 4% | 6% |
| At least one | 15% | 15% | 20% | 40% |

6.3.1 A significant proportion of children and young people have at least one of the above disorders, ranging from 15% in Glasgow City and East Dunbartonshire to 40% in Renfrewshire. The most common disorder is dyslexia which is reported in 6%-11% of children.

Figure 7: Glasgow City, East Dunbartonshire (2014), Renfrewshire and Inverclyde (2013): Prevalence of Selected Mental Health and Wellbeing Indicators

(Source: Schools Surveys 2013 and 2014)



6.3.2 Approximately 1 in 10 secondary school children reported having a long-term illness. Girls reported higher rates than boys, 10-11% compared with 8-9%. The greater prevalence reported in Renfrewshire, 33% boys and 37% girls reflect that the question had been posed in a different way again due to the different questions used.

6.3.3 The majority of children reported worries (> 80% in all areas) which included exams, the future and school. Girls worried more than boys, which may well explain their poorer emotional health compared to boys. The most common source of worry for children of either sex was exams (72% in Renfrewshire). The proportion of pupils who had any worries increased with age and the frequency of worry about each topic also increased with age. The largest increase in worry appears to be between S1-S2 and S3-S4, which suggests

that early intervention to support pupils should be targeted at the youngest age group. This might include interventions designed to prevent worries or assist in better management of worries in future.

6.3.4 Respondents reported the experience of being bullied in a number of contexts, including at school and on-line. The prevalence of bullying is shown in Table 3.

Table 3: Prevalence (%) of experience of being bullied in Secondary School Children by area

(Source: Schools Surveys 2013 and 2014)

| | Where Bullied | | | |
|---------------------|---------------|----------------|--------|------------------|
| | At school | Somewhere else | Online | Bullied anywhere |
| East Dunbartonshire | 18% | 7% | 8% | 22% |
| Inverclyde | 16% | 6% | 6% | 20% |
| Renfrewshire | 16% | 10% | 6% | 19% |
| Glasgow City | 16% | 7% | 8% | 21% |

The prevalence of bullying anywhere including at school or on-line ranged from 19% in Renfrewshire to 22% in East Dunbartonshire. Younger children are more likely to experience bullying than older children and there is a steady decline with increasing age.

Episodes of bullying were reported to school staff in less than half the cases (43%-45%). Boys were less likely to report bullying than girls in all areas where this was assessed. In almost one third of cases in which the bullying was reported the situation improved. There was either no change in the remaining cases or no available information.

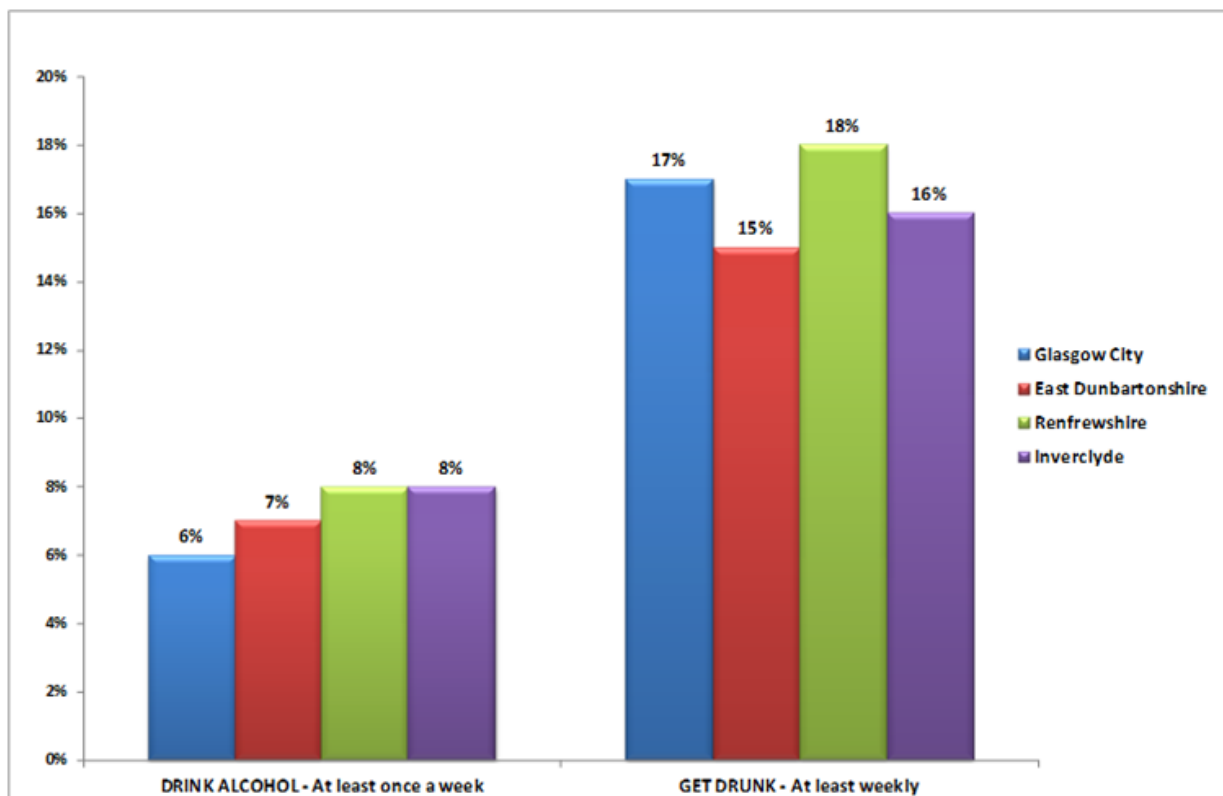
There may be an opportunity for schools to take action to ensure that more cases are reported and more work done to ensure a better outcome. The more stoic attitude of boys to bullying means that they are more in need of help.

6.4 Alcohol consumption is an important risk factor for mental and physical health in young people. It is established that the earlier that children start to drink the more likely they are to progress to regular drinking and problematic drinking in adult life.^{23 24}

Also, as the adolescent brain continues to develop into the early twenties, alcohol can cause permanent neurological impairment.²⁵ This is a particular hazard for young people who binge drink or get drunk. The source of young people's alcohol is frequently friends and family and the drinking experience is often initiated at family parties and celebrations.²⁶

The prevalence of different types of drinking behaviour is shown in Figure 8.

Figure 8: Prevalence of drinking behaviour
(Source: Schools Surveys 2013 and 2014)



²³ [Protective strategies: a mediator of risk associated with age of drinking onset](#)

²⁴ [Age at first alcohol use: a risk factor for the development of alcohol disorders](#)

²⁵ [New SHAAP report: Alcohol and the Developing Adolescent Brain: Evidence Review](#)

²⁶ [Scottish Schools Adolescent Lifestyle and Substance Use Survey \(SALSUS\)](#)

More than fifty percent of young people in each area reported never drinking alcohol. One quarter to one fifth of young people who drink do so rarely. Fewer than 10% of children in all areas consume alcohol once a week or more. Boys are more likely to report being never drinkers and to drinking once a week or more. There is little difference between boys and girls in the proportions who report drinking rarely.

The proportion of secondary school children who reported drunkenness once a week or more ranged from 15% in East Dunbartonshire to 18% in Inverclyde. As anticipated in this survey, the proportion of children who have never or rarely been drunk decreases from the S1-S2 group to the S5-S6 age group. There appears to be a trend toward girls reporting drunkenness more frequently than boys which suggests that more work should focus on why girls drink and whether the increase in drunkenness is linked to poor mental health.

Analysis of data collected in Glasgow City was carried out by sector. There was little difference by sector in the frequency of alcohol consumption by area and there was a similar pattern of increasing alcohol consumption with age. Boys were more likely to report never having drunk alcohol though the proportion who reported regular weekly drinking was 6% and was the same in all sectors for both boys and girls.

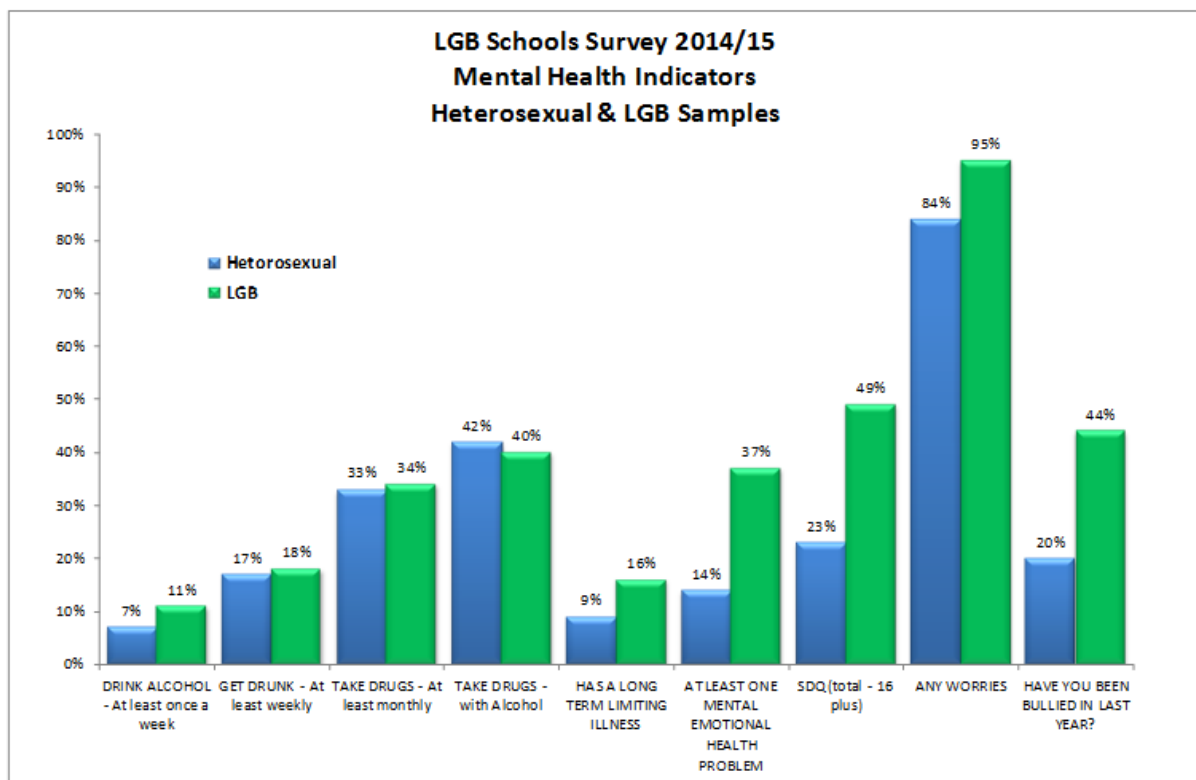
These data from the school survey show that many young people experience mental health problems and concerns and that bullying contributes to this. These findings emphasise the important of school based initiatives and programmes as well as work with parents. The importance of co-production with young people themselves, for example in the development of digital responses, cannot be overemphasised.

6.5 Sexual orientation

A sample of 930 respondents was obtained in whom an alternative sexuality was identified. These subjects were residents of Glasgow City, East Dunbartonshire, Renfrewshire and Inverclyde. These respondents reported sexual attraction to members of the same sex, which could range from equal levels of sexual attraction for both sexes to feelings exclusively for the same sex. The overall prevalence of alternative reported sexuality was about 4.5%.

Figure 9 shows key mental health and wellbeing indicators comparing prevalence between the heterosexual and LGB school survey populations.

Figure 9: Key mental health indicators, Heterosexual and LGB Samples
(Source: LGB Schools Survey Report using 2013/2014 data)



It is striking that with the exception of one indicator, combined alcohol and drug use, LGB pupils experience poorer mental, emotional and physical wellbeing and higher rates of substance misuse, worries and bullying than

the heterosexual sample. They have almost 3 times the rate for mental and emotional health problems, double the prevalence of bullying and high SDQ scores.

6.6 Child and Adolescent Mental Health Service (CAMHS)

The Child and Adolescent Mental Health Service (CAMHS) is a specialist service provided for children and young people with mental health problems. Table 4 shows referral rates of open cases in contact with the services per 1,000 of the child population by age group, gender and area.

Table 4: Specialist Children’s Services CAMHS Open Cases April 2017
(Source: NHSGGC Specialist Children’s Services)

| Area | Rate per 1000 population | | | | | | | | | | | | | | |
|---------------------|--------------------------|--------|---------|--------|--------|---------|----------|--------|---------|----------|--------|---------|---------|--------|---------|
| | 0 to 4 | | | 5 to 9 | | | 10 to 14 | | | 15 to 19 | | | 0 to 19 | | |
| | Male | Female | Persons | Male | Female | Persons | Male | Female | Persons | Male | Female | Persons | Male | Female | Persons |
| East Dunbartonshire | 1.5 | 0.0 | 0.7 | 26.4 | 7.3 | 17.1 | 35.6 | 26.3 | 31.1 | 25.6 | 35.0 | 30.0 | 22.9 | 17.6 | 20.4 |
| East Renfrewshire | 0.0 | 0.0 | 0.0 | 12.9 | 3.1 | 8.1 | 17.4 | 15.3 | 16.3 | 10.5 | 19.7 | 14.9 | 10.4 | 9.8 | 10.1 |
| Renfrewshire | 0.0 | 0.2 | 0.1 | 24.2 | 13.8 | 19.1 | 48.3 | 27.5 | 35.5 | 38.9 | 21.6 | 30.5 | 26.7 | 15.8 | 21.4 |
| Inverclyde | 0.5 | 0.0 | 0.3 | 24.8 | 21.8 | 23.3 | 70.3 | 39.2 | 55.2 | 46.3 | 31.8 | 38.7 | 35.6 | 23.7 | 29.9 |
| West Dunbartonshire | 0.0 | 0.0 | 0.0 | 18.3 | 7.7 | 13.2 | 39.8 | 30.9 | 35.4 | 31.4 | 19.9 | 25.8 | 21.9 | 14.4 | 18.2 |
| G/C North East | 1.5 | 0.6 | 1.0 | 30.1 | 17.5 | 24.0 | 50.1 | 30.0 | 40.1 | 28.6 | 17.7 | 23.2 | 25.8 | 15.6 | 20.8 |
| G/C North West | 0.9 | 0.0 | 0.5 | 30.3 | 16.1 | 23.3 | 41.4 | 25.4 | 33.7 | 26.8 | 13.5 | 20.0 | 23.5 | 12.8 | 18.1 |
| G/C South | 0.6 | 0.3 | 0.4 | 19.6 | 12.1 | 15.9 | 36.9 | 23.3 | 29.7 | 25.5 | 18.9 | 22.3 | 19.1 | 12.7 | 16.0 |
| Glasgow City | 0.9 | 0.3 | 0.6 | 26.0 | 14.9 | 20.5 | 41.8 | 26.0 | 34.0 | 26.9 | 16.7 | 21.8 | 22.5 | 13.6 | 18.1 |
| G/GC | 0.7 | 0.2 | 0.4 | 23.7 | 12.7 | 18.3 | 40.7 | 26.5 | 33.7 | 28.7 | 20.7 | 24.8 | 22.9 | 14.7 | 18.9 |

The overall GGC rate was 19 per 1000 ranging from 10 in East Renfrewshire to 30 in Inverclyde. Male rates were consistently higher than females with the highest rate in males aged 10 to 14 in Inverclyde.

6.7 Adult Mental Health Needs Assessment

Information about population mental health in adults is given in Appendix 2. This information is based on analysis of data from a range of sources and is available for the populations of all six partnerships.

6.8 Self-reported Mental Health

Self-reported mental health is a fundamental measure of population mental health. Several indicators are included in the NHSGGC Health and

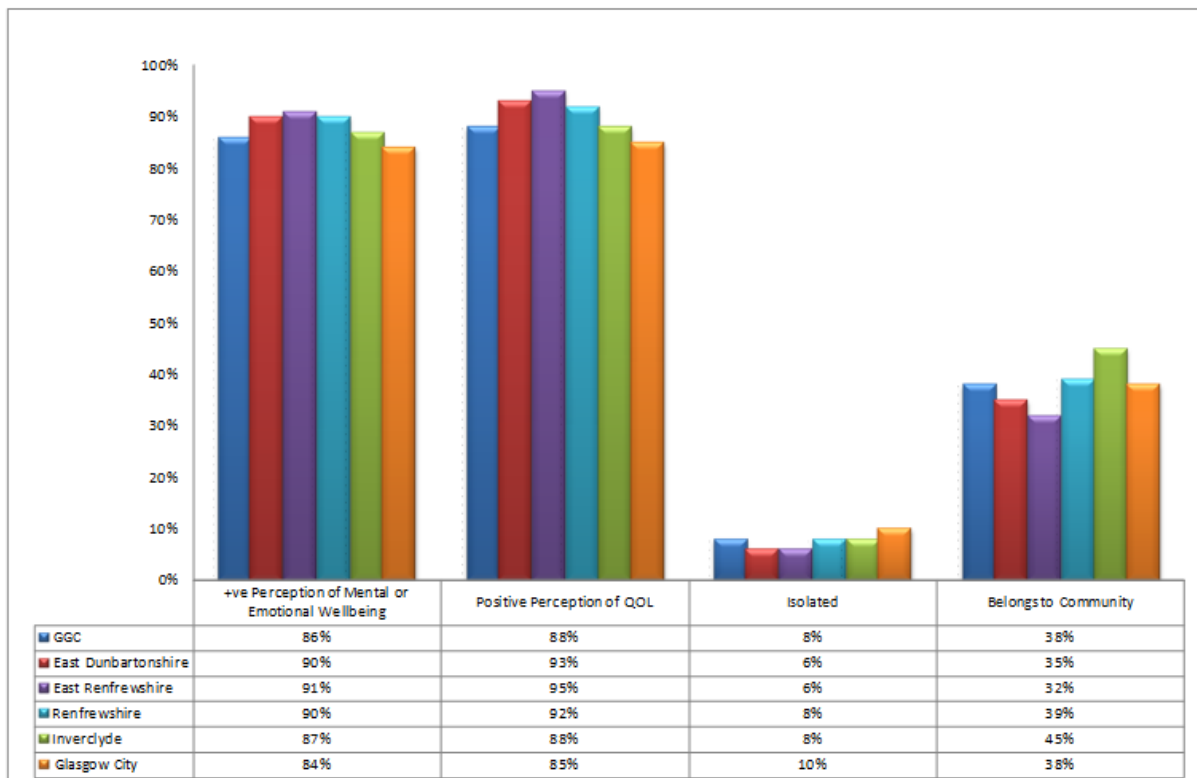
Wellbeing survey which provide a snapshot of the populations' mental and emotional wellbeing.

The significance of this analysis is that it can be used to develop the characteristics of a less resilient subgroup of relatively deprived and isolated people who feel that they do not belong to the areas in which they reside and who are less likely to have good mental health. This means that community interventions designed to promote more resilient communities and to develop social cohesiveness may be directed at these populations.

The most recent Health and Wellbeing Survey was carried out in NHSGGC in 2014. Samples of residents in each local authority area were taken and subjects were asked to report their own mental health status. Figure 10 shows prevalence of self reported mental health indicators by HSCP.

Figure 10: Prevalence of Selected Mental Health Indicators by HSCP of residence

(Source: NHSGGC Health and Wellbeing Survey 2014/15)



- Overall, 86% of respondents reported positive mental health. The highest rate was reported in East Renfrewshire (91%) and the lowest in Glasgow City (84%). Respondents who had a positive perception of their mental health were more likely to be aged less than 35 years. Those aged 45-64 years (80%) and those living in the most deprived areas (76% in Glasgow City) were least likely to report good mental health. Overall 85% of those aged 65 plus, reported good mental health.
- One in 12 respondents overall felt isolated from family and friends. This figure rose to 1 in 10 in Glasgow City. Those who felt isolated were more likely to live in deprived areas.
- Compared to Scotland, more people in NHSGGC felt that they belonged in the area where they lived (81%: 77%).²⁷ Within NHSGGC, the proportion who felt that they belonged ranged from 76% in Glasgow City to 91% in East Dunbartonshire. Those aged 25-35 and those living in deprived areas were least likely to report that they felt that they belonged to an area.

Reaching Older Adults in Renfrewshire (ROAR) provides health and wellbeing clubs to improve mental health and wellbeing and reduce social isolation

6.9 The WEMWBS standardised tool was used in both the Health and Wellbeing Survey in NHSGGC and the national Scottish Health Survey, to measure mental well-being based on assessment of several positive mental attributes. The WEMWBS score for NHSGGC is shown in Table 5.

²⁷ [Scotland's People: Results from the 2015 Scottish Household Survey](#)

Table 5: Mean WEMWBS Score of Population Wellbeing by HSCP of residence

(Source: NHSGGC Health and Wellbeing Survey 2014/15, * Scottish Health Survey 2105)

| East Dun | East Ren | Inverclyde | Glasgow | Renfrewshire | West Dun | GGC | Scotland * |
|----------|----------|------------|---------|--------------|----------|------|------------|
| 55.5 | 55.7 | 52.5 | 52.4 | 53.4 | 55.5 | 53.4 | 49.9 |

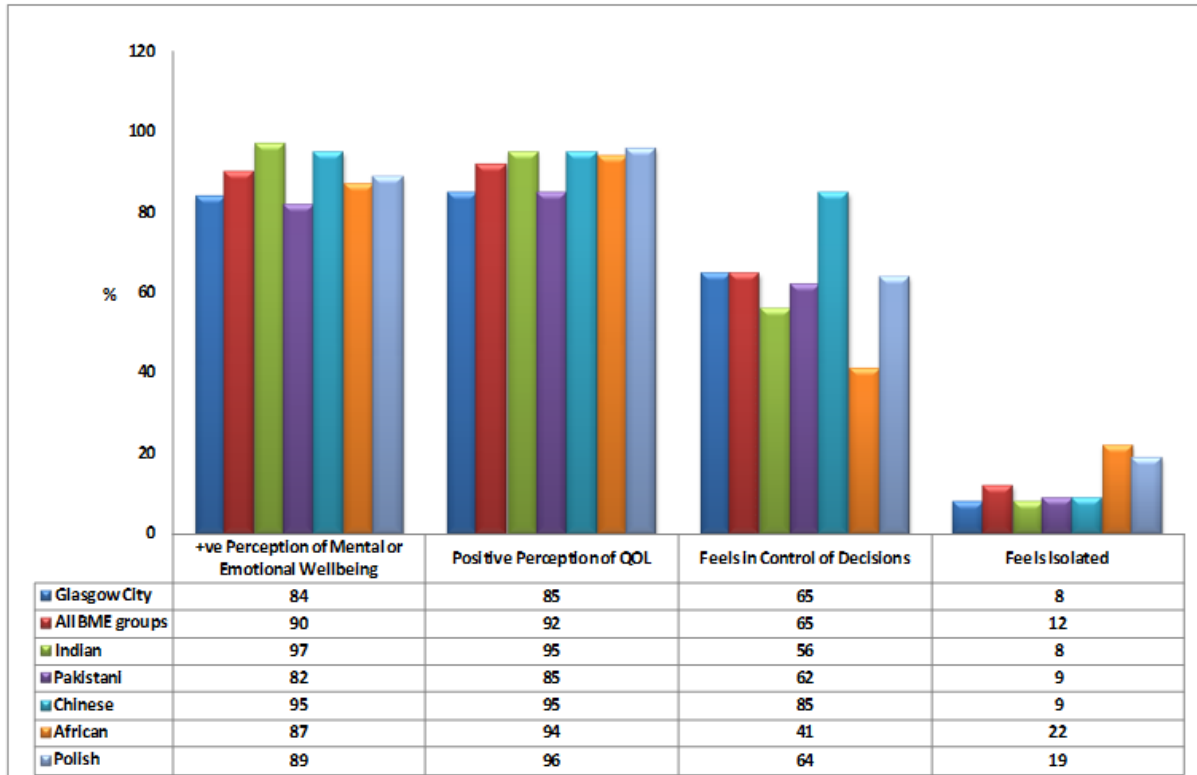
Scottish data showed that the mean score was lowest for adults aged 16-24 years and highest for those aged 65-74 years. This suggests that the mental health of younger people in NHSGGC is better than that found in the national survey.

The national survey found that young women under the age of 24 had a significantly poorer score than older women or men in all age groups. This is similar to the findings in our local schools surveys where adolescent girls had particularly poor mental health.

6.9.1 The general health and wellbeing survey is representative of the population of the NHS Board area. However despite its large size, it did not contain enough responses from BME residents to allow sub-group analysis to be undertaken. In order to explore the health and wellbeing of BME groups, a boosted survey was commissioned in 2016 to gather data on the 5 largest BME communities in Glasgow City. This accounted for 83% of the total BME populations in the city. To allow direct comparisons between the main and boosted samples, the same questionnaire and basic methodology (random sample) were used. The BME sample was identified by assigning ethnicity to the CHI using specialist software (OnoMap). Figure 11 compares the results across a number of indicators by ethnic group.

Figure 11: 2016 BME Health and Wellbeing Survey - Mental Health Indicators. Comparison with 2014/15 Health and Wellbeing Survey ,Glasgow City Survey, sub sample

(Source NHSGGC Health & Wellbeing Survey 2014/15 and BME Survey 2016)



- Compared to the majority population perception of mental wellbeing was largely similar or better. Indians and Chinese reported the highest mental wellbeing and this was greater than the wellbeing reported by the majority white population. Compared with the Glasgow City sample, all ethnic groups had a similar or higher perception of their quality of life and their responses were similar to those in more affluent areas of the board with the exception of the Pakistani population, which was more like Glasgow City. Overall the ethnic minority groups were as likely to feel in control of decisions affecting them as the majority of the population in Glasgow City. However, Chinese were more likely to feel in control than all other ethnic groups by a fairly wide margin, and Africans were least likely to feel in control. All ethnic minority groups with the exception of Indians reported a higher level of feeling of isolation than the majority population. This was particularly so for the African and Polish population.

- Analysis of other indicators showed that compared to the majority population in Glasgow, ethnic minority groups were less likely to experience a limiting long term condition or be treated for at least one condition. With the exception of the Pakistani population all ethnic minority groups had a lower prevalence of illness
- The sample questioned reported generally good mental health, but health service utilisation service was not examined as part of the health and wellbeing survey for any ethnic group. We acknowledge that other surveys show different results from our sample

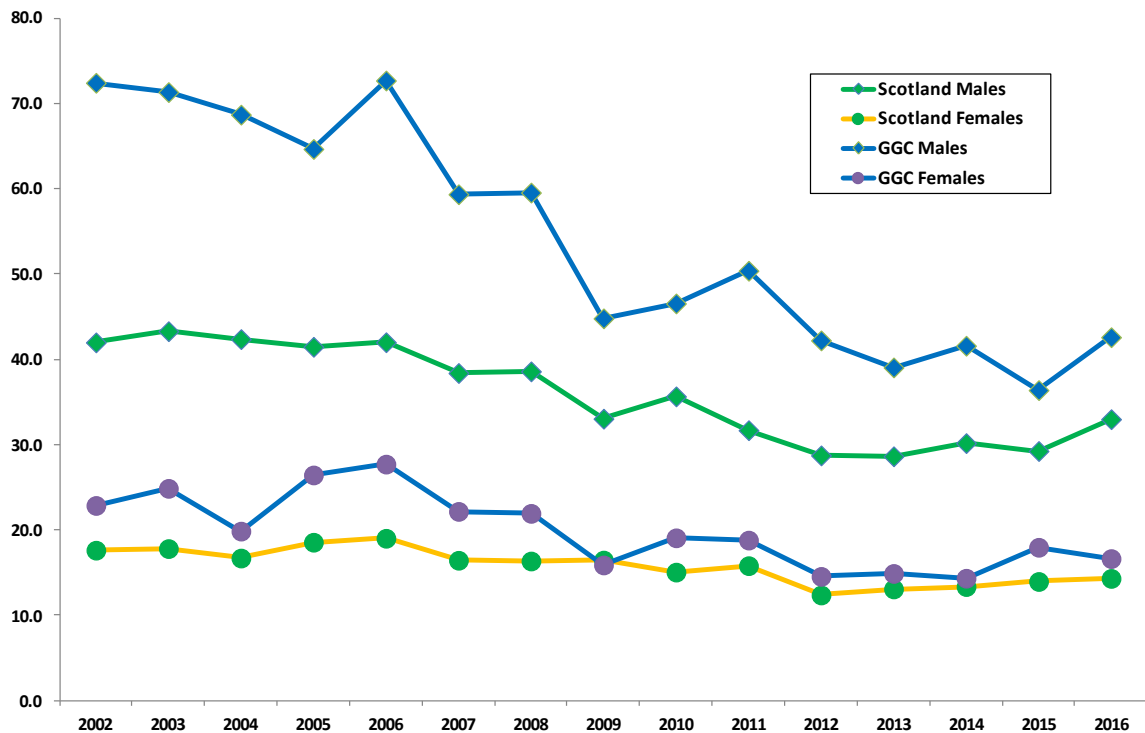
6.10 Alcohol Trends in the Adult Population

The overuse of alcohol can be linked to poor mental health. Some people with poor mental health have a higher risk of alcohol problems.

Alcohol consumption and alcohol related harms are common in Scotland and GGC. Using deaths as an indicator of the most serious outcome of alcohol related harm the rate of alcohol related deaths is approximately twice as high in males compared to females in both Scotland and GGC. The pattern of a decreasing trend in alcohol related deaths since 2006 appears to have flattened and there has been a small increase in alcohol related deaths in Scotland and GGC (Figure 12).

Figure 12: Alcohol Related Deaths – Scotland and NHSGGC, Rates per 100,000 by Gender

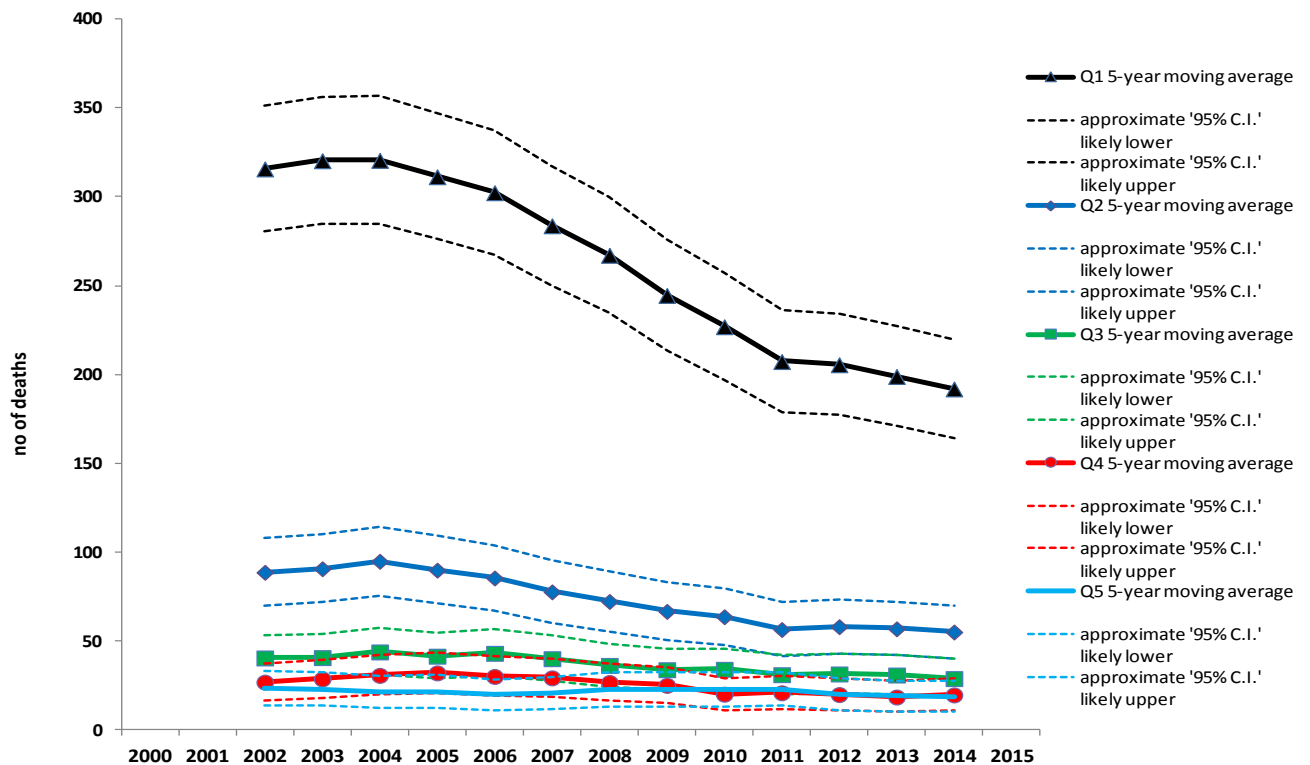
(Source: National Records Office Scotland)



A closer analysis of the data in GGC shows that the majority of deaths have occurred in the most deprived group, which has experienced the greatest decline in deaths (men in deprivation quintile). This is shown in figures 13 and 14 below.

Figure 13: Alcohol Deaths (Date Registered) Trends by SIMD Quintile – NHSGGC

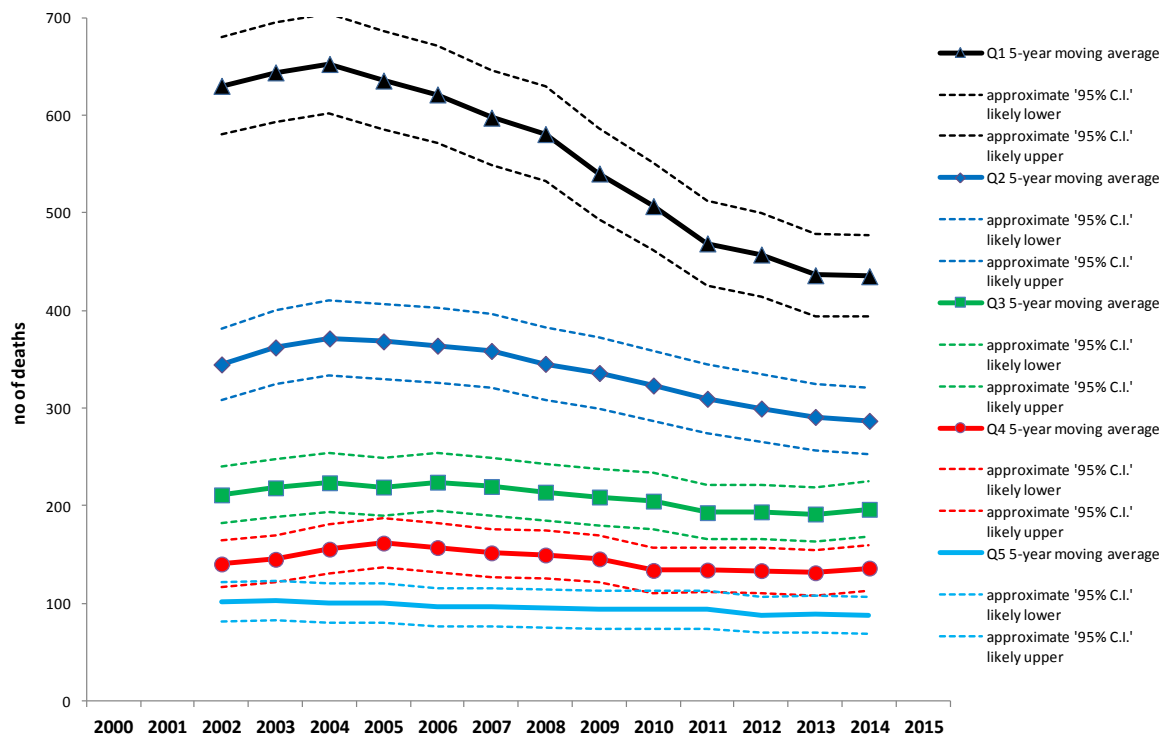
(Source: National Records Office Scotland)



The death rate in Inverclyde and Glasgow city has been consistently higher than that of Scotland, while East Renfrewshire and East Dunbartonshire have lower death rates. West Dunbartonshire rates lie between the average for Scotland and GGC. Many patients with problem alcohol misuse experience high levels of mental illness. Approximately half of the patients in NHSGGC alcohol death audits were prescribed antidepressant medication, while an audit of patients on the PsyCIS register who died revealed that there was a strong, significant association with alcohol misuse. Patient audits in NHSGGC have consistently found a strong association between mental illness and alcohol misuse.

Figure 14: Alcohol Deaths (Date Registered) Trends by SIMD Quintile – Scotland

(Source: National Records Office Scotland)



6.11 Antidepressant Prescribing Rate

The rate of prescribing of antidepressant drugs is a widely-used population indicator in public mental health. Antidepressant therapy is an established mode of treatment for patients with certain mood disorders and anxiety disorders and it has been suggested that the increase in use of antidepressants might be related to the decline in suicide rates.²⁸ However, there is not a clear relationship between anti-depressant prescribing levels and population suicide rates.²⁹

The overall level of prescribing may be used as a proxy measure of prevalence of depressive illness but it is also accepted that over-use of this

²⁸ [The increased use of antidepressants has contributed to the worldwide reduction in suicide rates](#)

²⁹ [Antidepressant prescriptions in England double in a decade](#)

therapy may have adverse results for clinical outcome. In the UK generally, there has been an increase in the prescribing rate in the last two decades.

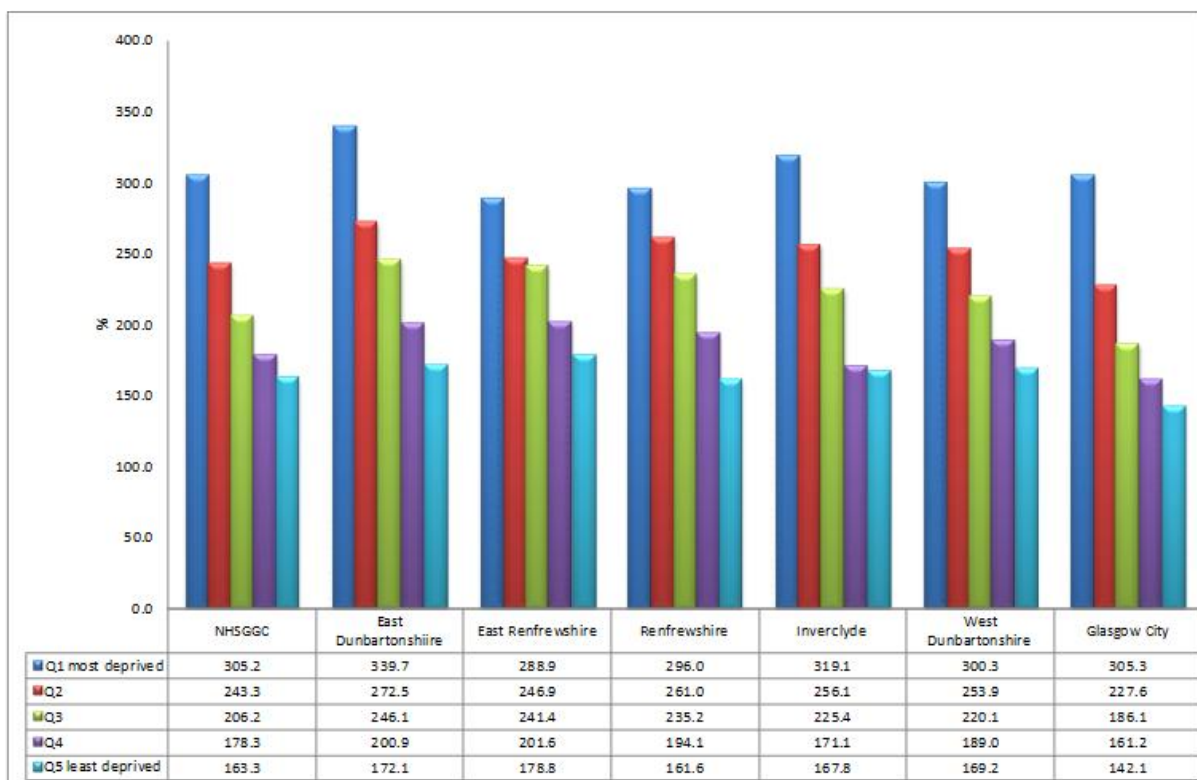
Possible reasons for this increase include:

- Improved recognition of depression
- Development and availability of new antidepressant drugs
- Changes in medical attitudes
- Changes in the ranges of indications
- Change in the epidemiology of mood disorders

Figure 15 shows the antidepressant prescribing rate by SIMD quintile and area in NHSGGC in 2016.

Figure 15: Antidepressant prescribing rate, aged 15 plus by SIMD quintile and area in NHSGGC (2016)

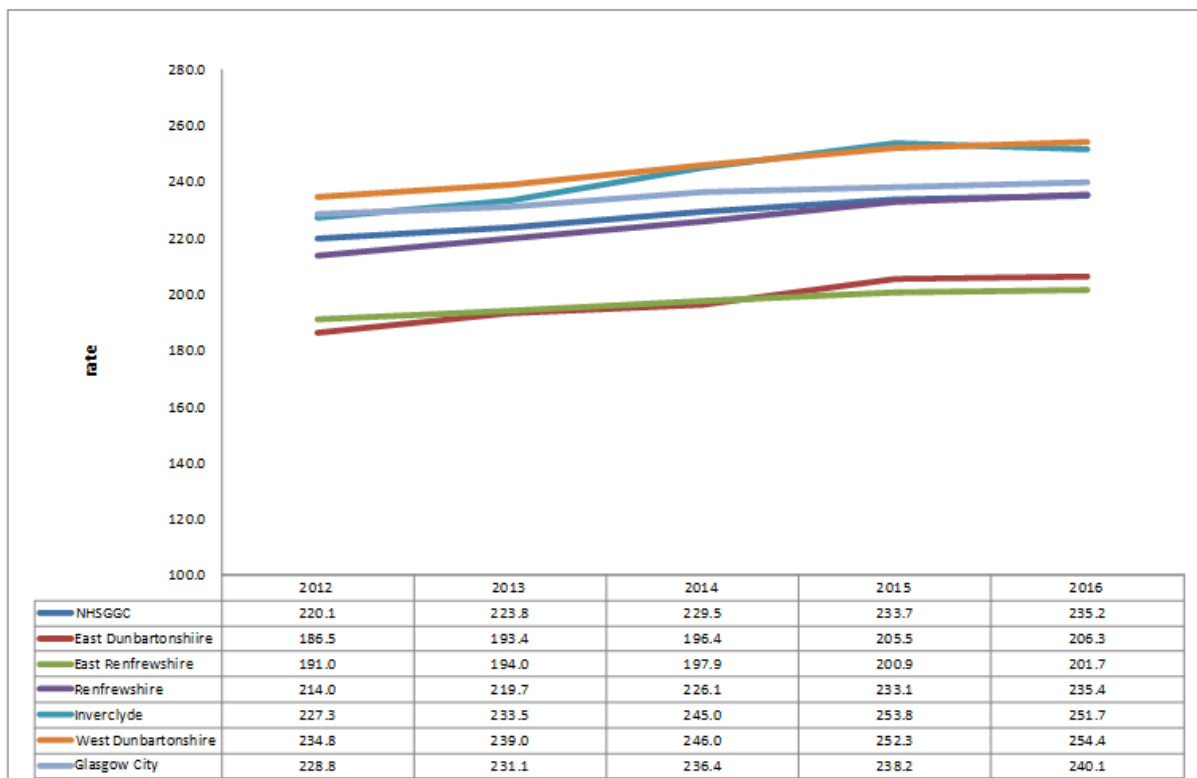
(Source: NHSGGC Prescribing Database)



A well-defined gradient in prescribing rate by deprivation category was evident. The rates were 305.2 and 163.3 per 1000 in the most deprived and least deprived populations of NHSGGC respectively.

The overall rate of antidepressant prescribing in NHSGGC was 235.2 per 1,000. The level of prescribing in females was greater, 288.8 per 1,000, than in males, 176.5 per 1,000. This excess of prescribing for females was evident in all parts of the Board's area. There was variation in the prescribing rate by HSCP of residence. The overall rate ranged from 254.4 per 1,000 in West Dunbartonshire to 201.7 per 1,000 in East Renfrewshire. Some of these differences reflect the different burden of illness in the different populations. Figure 16 shows there has been a steady increase in the use of medication for the management of anxiety and depression in terms of encashed prescriptions during 2012 to 2016 across NHSGGC.

Figure 16: Encashed Antidepressive Prescribing Trends by Area: Rates per 1000, age 15 plus
 (Source: NHSGGC Prescribing Database)

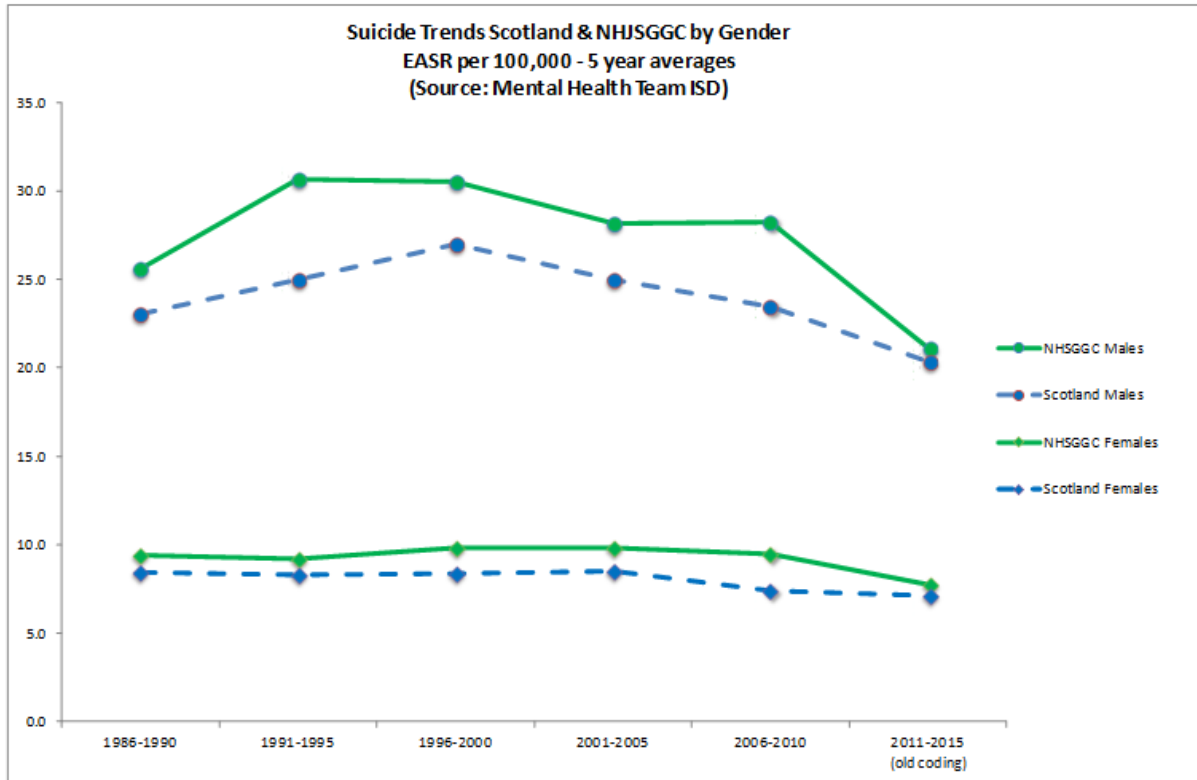


The rise in antidepressant prescribing is difficult to interpret. It is unclear whether this is a result of increased need, increased identification or waiting times for non-pharmacological treatments. Some studies have suggested the recent fall in suicide rates could be partially a result of increased use of medication. This remains the subject of debate. Despite this uncertainty about the cause of the trends in prescribing the key finding of the social gradient in prescribing can be assumed to be due to higher expressed need in the most disadvantaged communities.

6.12 Suicide

The suicide rate is also considered to be an important proxy for the prevalence of psychiatric morbidity in the population. The rate is expressed as an aggregated rate for consecutive five year periods because of the relative rarity of the events. The suicide rates increased slightly in 2016 after having declined since the start of the millennium. Figure 17 shows the European Age Standardised suicide rate (EASR) trends for NHS GGC and Scotland by Gender.

Figure 17: Suicide Trends Scotland and NHSGGC by Gender EASR per 100,000 – 5 year averages
 (Source: Mental Health Team, ISD)



The overall suicide rate in NHSGGC was 14.4 per 100,000. The suicide rate varied from 18.5 per 100,000 in Inverclyde to 10.4 per 100,000 in East Renfrewshire (Table 6).

The overall sex-specific suicide rates were 21.1 per 100,000 in males and 7.7 per 100,000 in females. The male rate exceeded the female rate in every HSCP as shown in Table 6.

**Table 6: European Standardised Suicide Rates (per 100,000) in NHSGGC (five year average for years 2011-2015)
(Source: Mental Health Team ISD)**

| HSCP | Rate | | |
|---------------------|------|--------|-------|
| | Male | Female | Total |
| East Dunbartonshire | 18.8 | 4.7 | 11.7 |
| East Renfrewshire | 17.8 | 3.1 | 10.4 |
| Glasgow City | 21.1 | 8.4 | 14.8 |
| Inverclyde | 28.1 | 8.9 | 18.5 |
| Renfrewshire | 21.3 | 8.8 | 15.1 |
| West Dunbartonshire | 21.6 | 9.5 | 15.5 |
| NHSGGC | 21.1 | 7.7 | 14.4 |

6.12.1 Attempted suicide or self-harm

Self-harm is a sign of emotional distress. It includes acts of self-harm or self-injury and includes suicide attempts as well as instances where no suicidal intention was planned which are the majority. In cases where there is no suicidal intent the self-harming episode may be a means of dealing with emotional distress or as a means of communicating emotional distress or in some instances as a self punishment. Self-harming is more common in women and girls, while suicide is more common in men and boys.

This indicator represents the extent of attempted suicide and self-harm measured by the hospital admission rate. Important aspects of the incidence of parasuicide in NHSGGC were as follows (Table 7):

- The overall rate in NHSGGC was 21.5 per 100,000.
- The overall crude sex-specific self-harm rates were 18.5 per 100,000 in males and 24.2 per 100,000 in females. The female rate exceeded the male rate in every HSCP, with the exception of Inverclyde.

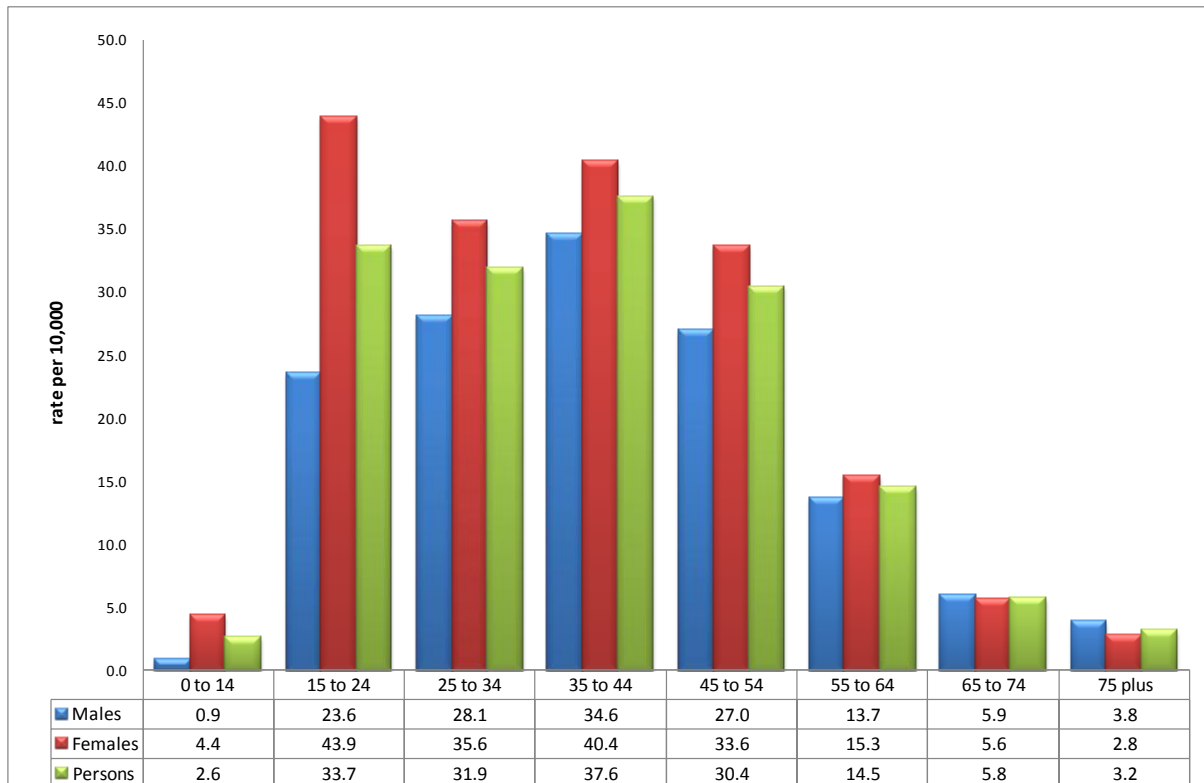
- The suicide rate varied from 25.6 per 100,000 in West Dunbartonshire to 10.4 per 100,000 in East Dunbartonshire (European Age Standardised Rates).

**Table 7: Standardised rates of admission to hospital for attempted suicide or self-harm (per 10,000) in NHSGGC (three year average for years 2013-2014 to 2015-2016)
(Source: SMR01)**

| HSCP | Rate | | |
|---------------------|------|--------|-------|
| | Male | Female | Total |
| East Dunbartonshire | 6.2 | 14.4 | 10.4 |
| East Renfrewshire | 8.7 | 15.1 | 12.1 |
| Glasgow City | 20.8 | 27.1 | 24.1 |
| Inverclyde | 18.9 | 18.3 | 18.6 |
| Renfrewshire | 20.5 | 26.0 | 23.3 |
| West Dunbartonshire | 23.8 | 27.2 | 25.6 |
| NHSGGC | 18.5 | 24.2 | 21.5 |

Analysis of hospital admission data for self-harm in NHSGGC following a self-harm incident by three year rolling average from 2006 to 2016 shows a decreasing trend particularly in the younger age-group. In the majority of age-groups examined with the exception of the 65 and older age-group the admission rates for self-harm were higher in females than males. In the over 65s the reverse was the case. Figure 18 shows the admission rate by sex and age.

Figure 18: Attempted Suicide/Self Harm Admission Rates (3 year average) per 10,000 Admissions by Sex and Age Group
(Source: SMR04 2013 to 2015)



- Analysis of admission for self-harm by deprivation quintile in NHS GGC showed a decreasing trend from the most to the least deprived groups. This was also found in each of the local authority areas. The rate of admissions for self-harm was highest in West Dunbartonshire and Glasgow City and lowest in East Dunbartonshire and East Renfrewshire.

6.12.2 Suicide prevention and addressing self-harm

A major multi-agency effort has been made in NHS GGC to reduce population suicide levels. All six HSCP areas within have initiated active Choose Life programmes throughout this period. One key element of this collective work has been mass provision of a suite of suicide awareness and intervention skills programmes, which include ASIST, SafeTalk and Mental Health First Aid. This has been complemented by work within clinical

services such as creation of a mental health triage tool for Emergency Medicine services.

In addition to widespread training initiatives, a brief flavour of the diverse work underway across the Board area to prevent suicide includes the following examples:

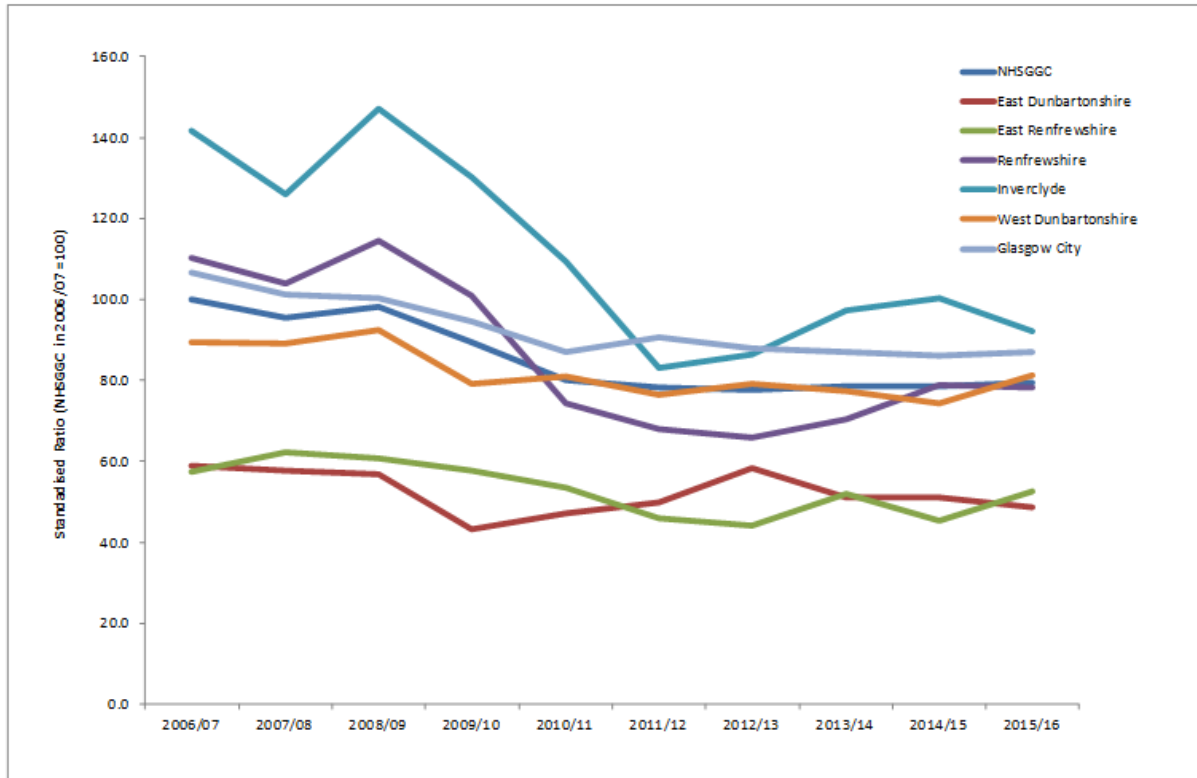
- Development of community suicide prevention forums, such as North East Glasgow; events to support families bereaved by suicide, and work with partners, such as housing providers and residential children's homes
- Self-harm training – Self-harm is a critical public health issue and a curricular resource, "On Edge" gives teachers an effective means of sensitively addressing this issue in the classroom
- The "What's the Harm" self-harm awareness and skills training has now been delivered to over 1000 colleagues from both the NHS and wider partner organisations by a group of 30+ trainers

6.13 Discharges from Psychiatric Hospitals

Patients with more severe types of mental illness may be admitted to hospital. Admission is dependent not only on the severity of illness but also on the level of support available in the community in terms of family/carer and the community mental health team, the availability of hospital beds and the willingness of the patient to be admitted to hospital. A small proportion of patients are admitted under section for severe illness who would not otherwise be admitted. Figure 19 shows that psychiatric admissions have generally declined across all areas, 2006/07 and 2015/16

Figure 19: Trends in Psychiatric Discharges ratio by HSCP, standardised for age and sex

(Source: SMR04)



Discharge rates by age group and sex were reviewed for the year 2015/16 for NHSGGC and in all local authority areas when the total number of males and females together were considered. The discharge rates were higher in males than females. The overall discharge rate from psychiatric hospitals is a process indicator but is usually included as a proxy indicator of population mental health. Important aspects of the discharge rates in NHSGGC by gender are shown in Table 8.

Table 8: Crude rates of discharge from psychiatric hospitals (per 10,000) in NHSGGC by HSCP of residence and sex

(Source: SMR04 2015/16)

| HSCP | Rate | | |
|---------------------|------|--------|-------|
| | Male | Female | Total |
| East Dunbartonshire | 26.1 | 25.9 | 26.0 |
| East Renfrewshire | 30.1 | 24.9 | 27.3 |
| Glasgow City | 55.5 | 40.2 | 47.6 |
| Inverclyde | 52.6 | 47.3 | 49.8 |
| Renfrewshire | 44.3 | 39.9 | 42.0 |
| West Dunbartonshire | 48.3 | 38.5 | 43.2 |
| NHSGGC | 48.3 | 37.9 | 42.9 |

- The overall discharge rate in NHSGGC was 42.9 per 10,000 people of all ages and both sexes.
- The discharge rate varied by HSCP of residence, from 26.0 per 10,000 in East Dunbartonshire to 49.8 per 10,000 in Inverclyde.
- A strong gradient in rate by SIMD quintile was evident. The rate in NHSGGC varied from 68.4 per 10,000 in the most deprived quintile to 16.3 per 10,000 in the most affluent quintile (Table 9).

Table 9: Crude rates of discharge from psychiatric hospitals (per 10,000) in NHSGGC by HSCP of residence and SIMD Quintile

(Source: SMR04 2015/16)

| HSCP | SIMD QUINTILE | | | | | TOTAL |
|---------------------|---------------|------|------|------|------|-------|
| | Q1 | Q2 | Q3 | Q4 | Q5 | |
| East Dunbartonshire | 40.1 | 49.6 | 24.2 | 30.1 | 16.1 | 26.0 |
| East Renfrewshire | 69.6 | 31.2 | 62.3 | 32.9 | 15.3 | 27.3 |
| Glasgow City | 68.0 | 39.0 | 31.7 | 23.6 | 17.8 | 47.6 |
| Inverclyde | 75.2 | 39.4 | 44.5 | 21.5 | 20.4 | 49.8 |
| Renfrewshire | 74.4 | 43.4 | 37.3 | 24.8 | 15.0 | 42.0 |
| West Dunbartonshire | 60.9 | 36.1 | 36.0 | 24.5 | 8.5 | 43.2 |
| NHSGGC | 68.4 | 40.0 | 35.5 | 25.3 | 16.3 | 42.9 |

6.14 Discharges from general hospitals related to alcohol

The overall discharge rate from general hospitals for conditions related to alcohol consumption is an important measure of alcohol-related morbidity at the population level. Important aspects of the discharge rates in NHSGGC were as follows:

- The overall discharge rate in NHSGGC was 83.4 per 10,000 people (Table 10)
- The discharge rate varied by HSCP of residence, from 35.6 per 10,000 in East Renfrewshire to 101.5 per 10,000 in Inverclyde.
- A strong gradient in rate by SIMD quintile was evident. The rate in NHSGGC varied from 145.2 per 10,000 in the most deprived population to 23.2 per 10,000 in the least deprived quintile (Table 11).

Table 10: Alcohol-related discharge rates from general hospitals (per 10,000) in NHSGGC by HSCP of residence
(Source: SMR01 2015/16)

| HSCP | Rate | | |
|---------------------|-------|--------|-------|
| | Male | Female | Total |
| East Dunbartonshire | 59.1 | 23.5 | 40.8 |
| East Renfrewshire | 49.3 | 23.2 | 35.6 |
| Glasgow City | 145.2 | 49.2 | 95.8 |
| Inverclyde | 156.1 | 51.4 | 101.5 |
| Renfrewshire | 125.7 | 41.2 | 81.8 |
| West Dunbartonshire | 127.9 | 49.2 | 86.6 |
| NHSGGC | 126.0 | 43.6 | 83.4 |

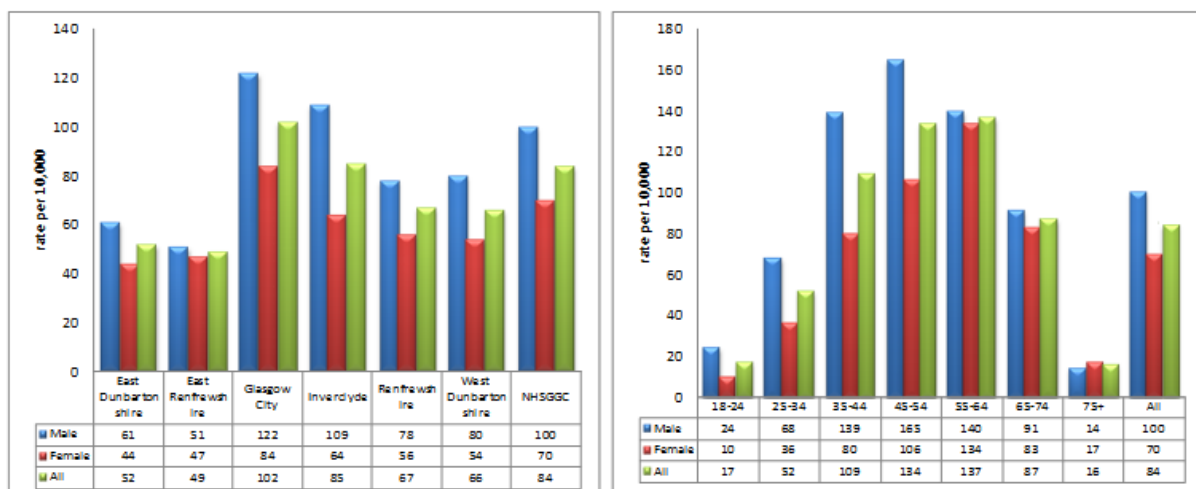
Table 11: Alcohol-related discharge rates from general hospitals (per 10,000) in NHSGGC by SIMD Quintile
 (Source: SMR01 2015/16)

| SIMD quintile | Rate |
|---------------|-------|
| Quintile 1 | 145.2 |
| Quintile 2 | 85.4 |
| Quintile 3 | 50.9 |
| Quintile 4 | 37.6 |
| Quintile 5 | 23.2 |
| NHSGGC | 83.4 |

6.15 Prevalence of psychosis

Psychosis is a clinical syndrome comprising of a range of diseases which can cause distorted perceptions of the world. It includes conditions such as schizophrenia, bipolar disorder and psychotic depression. Important aspects of the prevalence of psychosis in NHSGGC were as follows:

Figures 20 and 21: Prevalence of Psychotic Disorders by Area, Age and Gender Rates per 10,000 population
 (Source: PsyCis register at May 2017)



- The overall prevalence rate in NHSGGC was 84 per 10,000
- The psychosis prevalence varied by HSCP of residence, from 102 per 10,000 in Glasgow City to 49 per 10,000 in East Renfrewshire
- The prevalence peaked in the 45-54 age group in males and in the 55-64 year age group in females

Patients are also identified and followed up by Esteem (first Episode Psychosis Service), the perinatal mental health team, the forensic team and the homelessness service. The importance of follow-up is underwritten by the relatively poor physical as well as poor mental health experienced by these patients.

6.16 Dementia

No report on mental health would be complete without consideration of dementia given our ageing population and the resulting demand on services. However it is a complex subject and this report includes only a short summary of the issues. Importantly in relation to prevention and mental health promotion, there is growing evidence for the value of healthy diet, physical activity, intellectual activity and social connectedness which link to other areas of good mental health.

The diagnosis of dementia encompasses a group of clinical syndromes characterised by progressive global impairment of cortical functions including memory, and impaired capacity to solve problems of day to day living. It is usually an irreversible process. The most common causes of dementia in the UK are Alzheimer's Disease, Vascular and Mixed Dementias. Other causes include Lewy Body Dementia and Alcohol Related Dementia. Age remains the most significant risk for the development of dementia. The highest rates are seen in the oldest age groups, with those aged over 85 having the highest age specific rate for newly diagnosed dementia per 1,000 population.³⁰ In addition to their dementia, older people have a higher rate of co-morbid illness making their management more complex and increasing

³⁰ [Estimated and Projected Rates for Dementia in Scotland 2014-2020](#)

their use of health and social services. In contrast there is a significantly smaller incidence of dementia in those under 60 but a much higher likelihood that genetic predisposition will play a part in the risk. Often the needs of these younger people with dementia are different from those of the older population.

A House of Commons Briefing Library paper³¹ from 2016 indicates that the Crude Prevalence of Dementia in NHS GGC residents in 2015 was 0.6% (crude rates based on age standardised GP registration data). This compares with 0.77% for patients registered with general practitioners in Scotland. The Estimated and Projected Diagnosis Rates for Dementia in Scotland 2014-2020 is the most up to date report of dementia incidence in Scotland. In this report the estimated diagnosed incidence of dementia in NHS GGC is set to rise from 3,389 in 2014 to 3,703 in 2020.³² This report highlights that these are estimates and that the rates have no state of permanence and are subject to change due to ever evolving interventions.

There is evidence of a decline in the prevalence of dementia. A recent study in England³³ noted a fall in prevalence of dementia from 8.3% to 6.5% of the population over 65 in the two decades from 1991 to 2011. The writers have proposed a cohort effect in dementia prevalence with those born in later years of the 20th century having a lower prevalence than those born earlier in the century. It is believed that factors affecting a person in their earlier years can influence the development of dementia disease process. Factors which have shown a definite association with dementia are low educational achievement in early life, midlife hypertension, midlife and probably later life diabetes and smoking.³⁴ These findings seem to support the adage that “what’s good for your heart is good for your head”. It is plausible that changes in health behaviour and provision including smoking cessation and improved management of cardiovascular risk factors such as hypertension

³¹ [Dementia: Policy, Services and Statistics Overview](#)

³² [Estimated and Projected Rates for Dementia in Scotland 2014-2020](#)

³³ [A two-decade comparison of prevalence of dementia](#)

³⁴ [World Alzheimer Report 2014: Dementia and Risk Reduction](#)

have prevented or delayed the onset of dementia at a population level and this should be emphasised in health promotion messages which encourage the adoption of a healthy life style.³⁵

Dementia has been a priority for the Scottish Government since 2007³⁶ and Dementia Strategies have focused on improving the diagnosis, support and care offered to people with dementia and their carers in all settings. As a result Scotland is regarded as a world leader in dementia care. In 2010 the first strategy focused on improving timely diagnosis of dementia. This led to the second strategy with its commitment to Post Diagnostic Support for one year following the diagnosis of dementia. Post Diagnostic Support aims to deliver the principles of Alzheimer's Scotland 5 Pillars approach to Dementia.³⁷ These pillars include Anticipatory Care Planning and NHSGGC have been at the forefront of this with the Power of Attorney Campaign which aims to encourage as many people as possible to consider Financial and Welfare Power of Attorney as part their planning to live well with dementia.

In January 2017 the Scottish Government published its report on NHS Health Board Performance in the delivery of Post Diagnostic Support³⁸. In Glasgow 46% of those diagnosed with dementia received Post Diagnostic Support in 2014/5, compared with the Scottish average of 40%. In terms of referrals by areas of deprivation, 17% of referrals came from the most deprived areas whilst 23% came from lesser deprived areas. Post Diagnostic Support was completed according to Scottish Government standards in 76% of those in the most deprived areas as compared to 70% of those in the least deprived areas.

It has become apparent that many people have a more advanced degree of dementia at the point of diagnosis and this has led to the piloting of the 8

³⁵ [Good news on dementia prevalence—we can make a difference](#)

³⁶ [Mental Health Strategy 2017-2027](#)

³⁷ [Alzheimer's Scotland 5 Pillars approach to Dementia](#)

³⁸ [Dementia Post Diagnostic Support: NHS Board Performance 2014/2015](#)

Pillars Model in Glasgow³⁹ and the contribution by NHSGGC and the Glasgow HSCP to the Scottish Government's evaluation of the 8 Pillar Model. In addition Glasgow Hospitals have been involved in promoting excellence in care for patients in Acute Hospitals and Specialist Dementia Wards.

The third Dementia Strategy was launched in May 2017.⁴⁰ This has proposals to provide a link worker for those diagnosed with dementia from the point of diagnosis, through to palliative care and end of life care, to pilot Post Diagnostic Care within a Primary Care setting and to consider how to develop capacity and capability within the work force to deliver these aims using a person centred approach.

A stated aim of the Scottish Government is that everyone should be able to receive care as close to home as possible. As far as possible, NHSGGC and associated HSCPs are implementing strategies which aim to link people with dementia into their community and provide support to them and their carers. The integration of health and social care and the implementation of the Carers (Scotland) Act⁴¹ in 2018 should help to ensure that people with dementia get the help and support they need to continue to live at home. Appropriate home based support improves the quality of life for the person with dementia and their carers and is more cost effective than institutional or hospital based support

Local authorities can do much to support people with dementia through the introduction of its information and advice service for carers and in the provision of appropriate housing for people with dementia. Local authorities can also contribute to quality of life by improving access to public transport for patients with dementia, designing dementia friendly communities, and

³⁹ [Alzheimer's Scotland 8 Pillars Model of Community Support](#)

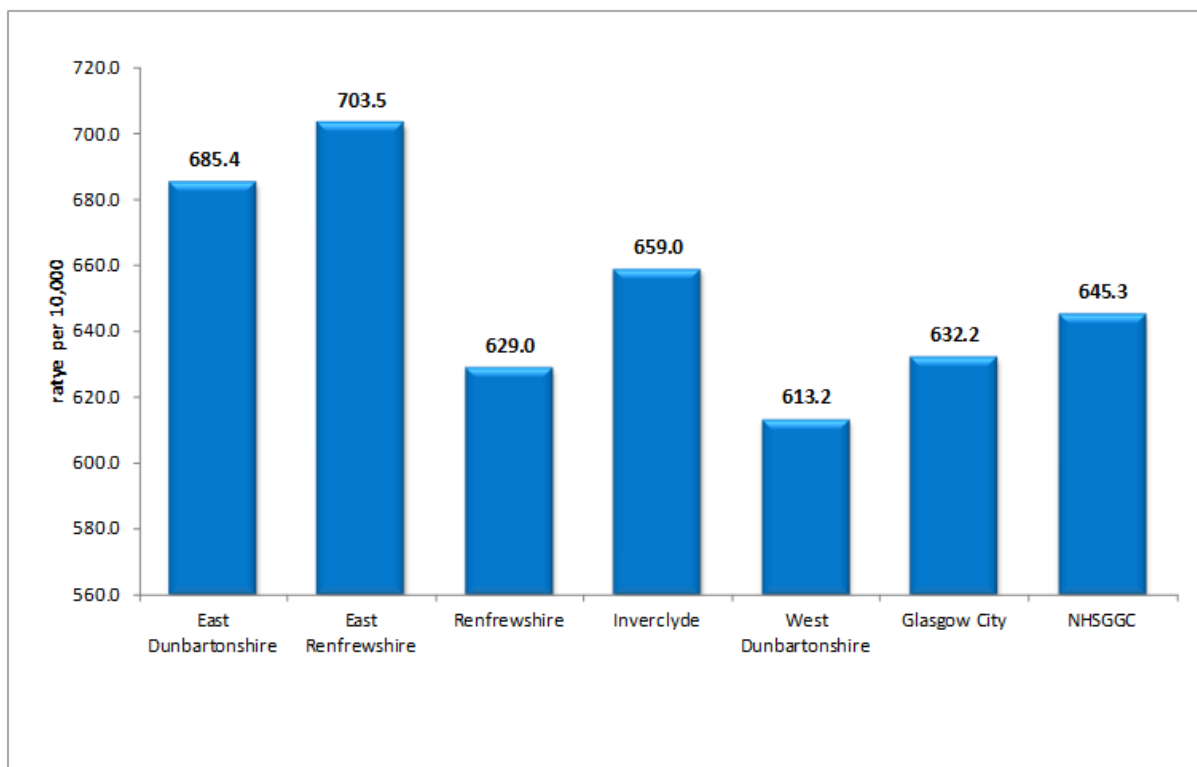
⁴⁰ [Scotland's National Dementia Strategy 2017-2020](#)

⁴¹ [Carers \(Scotland\) Act](#)

promoting the development of social activities that people with dementia can access.

The dementia rate represents the prevalence of dementia in the population. The numbers of cases considered in this section are estimated rates. They do not reflect real epidemiological differences but only the numbers of cases that would be expected if the prevalence rates derived from one study were applied to the HSCP populations. Figure 22 shows the estimated dementia prevalence rates by area based on the application of 2013 EuroCoDe age/gender specific rates to 2016 CHI age/gender population for each HSCP.

Figure 22: Estimates Dementia rates per 10,000 population by Area, Aged 60 plus
(Source: EuroCoDe 2013 estimated rates)



- The overall dementia rate in NHSGGC was 645.3 per 10,000 people aged sixty years or more.

- The dementia rate varied by HSCP of residence, from 703.5 per 10,000 in East Renfrewshire to 613.2 per 10,000 in West Dunbartonshire.

Chapter 7: Services

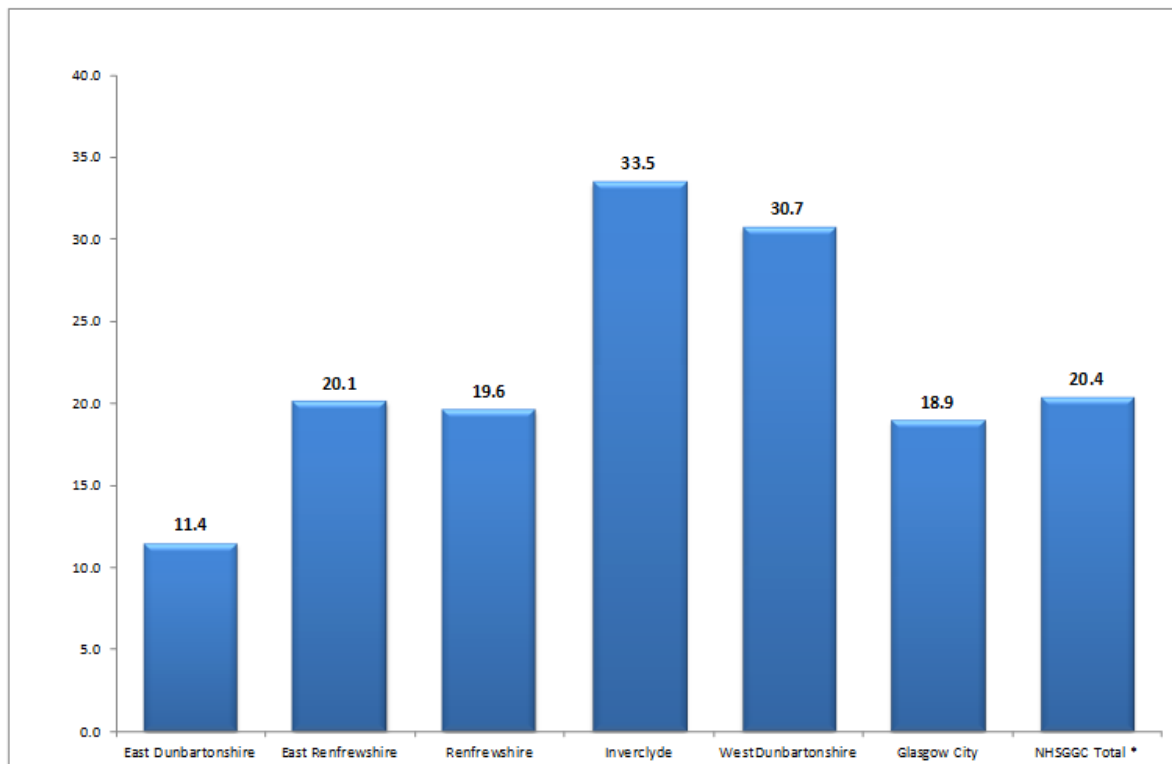
A range of services have been developed in NHSGGC to meet the needs of patients with mental health problems of different kinds. A review of mental health services in NHSGGC is currently underway.

7.1 Primary Care Mental Health Team

Some patients with milder forms of mental illness may not require anti-depressant therapy but may be referred in the first instance to the Primary Care Mental Health team. Patients with issues as diverse as depression, anxiety, phobias and obsessive compulsive disorders, may be candidates for this service. The referral rate provides a measure of level of service use by patients with mental health problems in primary care. The referral rates per 1,000 population aged over 18 years by HSCP ranged from 11.4 in East Dunbartonshire to 33.5 in Inverclyde as shown in Figure 23.

Figure 23: Primary Care Mental Health Team Referrals by Area 2015, Rate per 1,000 population, aged 18 plus

(Source: PIMS)

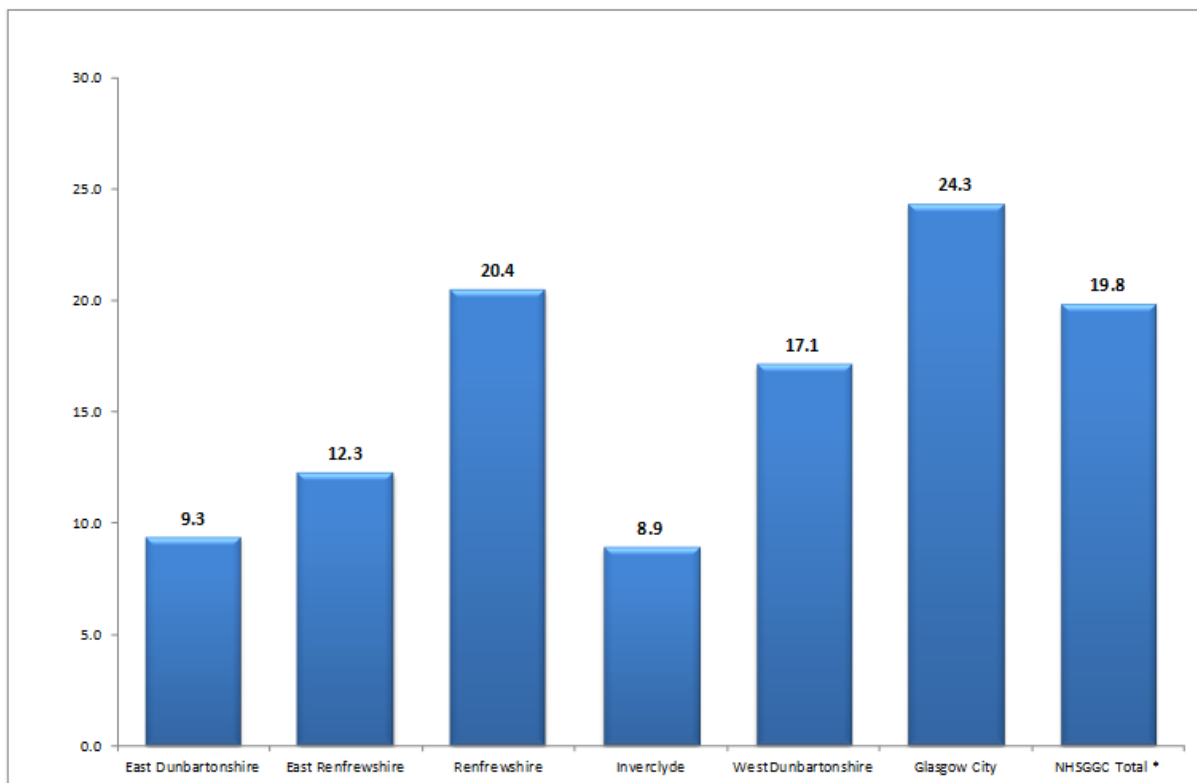


7.2 Community Mental Health Team

Patients with more complex mental health conditions may be referred to the Community Mental Health Teams. Referral rates per 1,000 population aged over 18 years by HSCP ranged from 8.9 in Inverclyde to 24.3 per 1,000 in Glasgow City as shown in Figure 24. Patients attending this service are more likely to have severe and enduring mental health problems such as schizophrenia, bipolar disease and severe depression.

Figure 24: Community Mental Health Team Referrals by Area 2015, Rate per 1,000 population, aged 18 plus

(Source: PIMS)



7.3 Perinatal Mental Health Service

The Perinatal Mental Health Service has been established for treatment of patients with the most severe illness. There is an in-patient unit based at Leverndale hospital, one of only two in-patient units in Scotland. In-patient treatment is provided for about 50-60 mothers and babies each year, two

thirds of whom are residents of NHSGGC. Approximately 1,000 referrals are made each year to the outpatient community perinatal mental health service.

7.4 Tier Three Child and Adolescent Mental Health Service

Contact with services is not equivalent to need for mental health services. Some people will not present to services for a wide range of reasons including failure to recognise that there is a problem, availability of a range of community support services or friends and family which may prevent escalation of mental health symptoms at an early stage in the process, knowledge of and ability to use other resources such as help lines and web based support, approachability of the primary care team and their knowledge and willingness to refer patients to higher tier services and accessibility of higher tier services for the patient. In areas where there is a high contact with specialist services, consideration should be given to all potential causes and interventions in a systematic way to determine the best possible intervention and management to build resilience and improve mental wellbeing and recovery from mental illness.

There is currently a review of all mental health services being conducted and a Transformation plan being developed. The needs assessment can help information these plans.

Examples of community interventions designed to relieve psychological distress and improve population mental health are available at Appendix 3. These are brief listings and will be further developed as individual HSCP reports are produced on public mental health.

Chapter 8: Summary, Conclusions and Approaches for Action

Mental health represents a major challenge area, deserving a high priority and sustained focus. This effort will be cost-effective and has enormous potential for health gain. Promoting positive mental health and preventing and responding to mental ill health needs to draw on the commitment and resources of a wide, multi-agency partnership. Greater Glasgow and Clyde partners already have a positive track record of achievement in this area, but there is significant scope for further progress – with mental health representing a major component of the health improvement and inequalities agendas.

It is beyond the scope of this report to provide detailed recommendations for action but a number of action areas are highlighted below for consideration by the Health Board and its partners:

1. Provide visible and sustained leadership on this vital area of development, ensuring that mental health issues are treated with equal status to physical health issues (the 'parity of esteem' approach), from the Health Board, Health and Care Partnerships and with Community Planning Partnerships
2. Work to develop resilient communities, and develop emotionally aware populations across the full age range of our population
3. All parts of NHS Greater Glasgow and Clyde and community planning partners should fully adopt the Children and young people and Adult mental health improvement frameworks to guide comprehensive multi-partner action. The Board and IJBs should expect regular reports on their implementation
4. Boost support for families in perinatal period, including social support approaches coupled with effective access to clinical care where needed and work with health visitors to collect more useful information on EMIS web about perinatal mental health
5. Progress comprehensive approaches to child and youth mental health improvement through relevant children's services planning and pan-Board child planning mechanisms, including close working the Education services to

advance schools-based mental health support and enable effective use of the Pupil Equity Fund

6. Embed mental health promotion in all services, for example health visiting or district nursing. This will include staff training on mental health improvement.
7. Ensure that patients with severe and enduring mental health problems are provided with equitable access to the full range of primary care services required to address their current poor health outcomes
8. Ensure that patients with co-morbid mental health and substance misuse issues receive holistic care that addresses both their mental illness and substance misuse. Managing one condition without the other is destined to result in poor outcomes
9. Strengthen access to evidence-based parenting programmes. At the very least protect the small resource already available of staff trained in parenting programmes and plan for growth over time
10. Work closely with and further develop community-level approaches to public mental health, including direct learning from people with lived experience of mental health problems. Make effective use of community assets to promote mental wellbeing and recovery, including building the capacity of community organisations and advancement of social prescribing and link worker models
11. Further progress with the workforce development agenda for multiple partners, ensuring significant upgrading of awareness, knowledge and skills to intervene on mental health themes across multiple settings
12. Further work is required on the pre-conception and perinatal stages of the life course in relation to public health
13. Focus on supporting mental health and wellbeing of the workforce and supporting wider employability initiatives and mental health at work programmes
14. Utilise innovative methods and approaches, including the use of digital technologies, to promote and support mental health. The Board should progress an exploration of the potential of this field, building on initiatives like telecare, *Aye Mind* for young people, linking to the Board's eHealth strategy
15. Further progress mental health literacy and self management, development of peer support and self management resources for a range of settings including social care and housing

16. Continue to progress the multi-agency work on suicide prevention and self-harm support, including further development of the Choose Life programmes in each of our Community Planning Partnership areas and further work to progress staff training and innovations in responding to distress
17. Maintain focus on tackling poverty, inequality, equality, citizenship and human rights dimensions within the public mental health and service delivery – in line with relevant legislative and allied guidance

Glossary

| | |
|---|--|
| <p>Family Nurse Partnership (FNP)</p> | <p>Family Nurse Partnership (FNP) is a preventive, intensive home visiting programme offered to first time young mothers (aged 19 and under at LMP) and their families. Young women are offered the programme in early pregnancy, before 28 weeks gestation and are visited by a specially trained family nurse until the baby reaches his or her 2nd birthday.</p> |
| <p>Health Working Lives Award</p> | <p>The Healthy Working Lives Award is a nationally recognised award programme that supports employers and employees to develop health promotion and safety themes in the workplace in a practical and logical way that benefits everyone in their organisation.</p> |
| <p>Psychosis Clinical Information System (PsyCIS)</p> | <p>PsyCIS is a disease register that was established in 2004/2005 by psychiatry and public health to improve the care of patients with psychosis. The aim of PsyCIS is to ensure that patients with psychosis received appropriate care and follow up of their mental and physical health care needs and help to improve the interface between mental health and the primary health care team.</p> <p>It is a good approximation to the prevalence of psychosis in the local population.</p> |
| <p>Strength and Difficulties Questionnaire (SDQ)</p> | <p>This is a behavioural screening tool specially developed for use in children aged 3-16 years. Twenty-five questions are used to provide an assessment of five aspects of children's development, emotional symptoms, conduct problems, hyperactivity/inattention, peer relationships, and pro-social behaviour. A score can be calculated using all five aspects or an assessment of total difficulties score can be assessed by using all domains except the pro-social behaviour. The total difficulties score ranged from 0-40, with a higher score indicating greater evidence of difficulties.</p> |

| | |
|--------|--|
| WEMWBS | <p data-bbox="450 235 1369 271">Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) Scores</p> <p data-bbox="450 320 1380 607">The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is used to assess positive mental health (mental wellbeing). This uses 14 positively worded questions. Scores are derived by summing responses to each of the 14 questions on a 1-5 Likert scale. Thus, the maximum score is 70 and the minimum score is 14. The scale is designed to allow the measurement of mean scores in population samples.</p> <p data-bbox="450 656 1358 692">http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/</p> |
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| | | |
|-----------------------------|---|--|
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| John Hutchison | Web Editor | Public Health, NHSGGC |
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Appendix 1: Indicator Deprivation Table and source of data

| Number | Indicator | Quantity measured | Epidemiological significance | Positive/negative | Direct or proxy | Source | Operational usefulness |
|--------|--|-------------------|----------------------------------|-------------------|-----------------|--------|---|
| 1 | Proportion (%) reporting positive perception of mental well-being | Mental Health | Prevalence of good mental health | Positive | Direct | HWBS | Limited: difficult to relate to operational targets |
| 2 | Proportion (%) reporting positive perception of quality of life | Mental Health | Prevalence of good mental health | Positive | Direct | HWBS | Limited: difficult to relate to operational targets |
| 3 | Control of decisions | Mental Health | Prevalence of good mental health | Positive | Direct | HWBS | Limited: difficult to relate to operational targets |
| 4 | Feelings of isolation | Mental Health | Prevalence of good mental health | Positive | Direct | HWBS | Limited: difficult to relate to operational targets |
| 5 | Long Term Limiting Conditions (LTLCs) | Mental Health | Prevalence of good mental health | Positive | Direct | HWBS | Limited: difficult to relate to operational targets |

| Number | Indicator | Quantity measured | Epidemiological significance | Positive/negative | Direct or proxy | Source | Operational usefulness |
|--------|--|---------------------------|---|-------------------|-----------------|-------------------|-----------------------------------|
| 6 | Alcohol related mortality rate (Crude, per 100,000) | Alcohol-related morbidity | Prevalence of alcohol-related morbidity | Negative | Proxy | Routinely-derived | Considerable |
| 7 | In-patient discharge rate (Crude per 10,000) | All psychiatric morbidity | Prevalence of any psychiatric morbidity | Negative | Proxy | Routinely-derived | Moderate requires interpretation |
| 8 | New out-patient attendances (Crude per 10,000) | All psychiatric morbidity | | Negative | Proxy | Routinely-derived | Limited: requires interpretation |
| 9 | Antidepressant prescription rate (per 1,000) | Affective disorders | Prevalence of affective disorders | Negative | Proxy | Routinely-derived | Moderate: requires interpretation |
| 10 | Suicide rate, 2011-2015 (Crude, per 100,000) | Affective disorders | Prevalence of affective disorders | Negative | Proxy | Routinely-derived | Moderate: requires interpretation |
| 11 | Parasuicide rate (Crude, per 10,000) | | | Negative | Proxy | Routinely-derived | Moderate: requires interpretation |

| Number | Indicator | Quantity measured | Epidemiological significance | Positive/negative | Direct or proxy | Source | Operational usefulness |
|--------|---|----------------------------|------------------------------|-------------------|---------------------------|--------------------|------------------------|
| 12 | Dementia (prevalence per 10,000) in population aged more than 60 years | Dementia | Prevalence of dementia | Negative | Estimate | Published overview | Considerable |
| 13 | PsyCis (prevalence per 10,000) | Psychosis of any aetiology | Prevalence of psychosis | Negative | Direct (disease register) | Routinely-derived | Considerable |

Appendix 2: Indicator Summary Table

| Number | Indicator | HSCP of residence | | | | | | | |
|--------|--|-------------------|-----------------|-----------|--------------|-------------|----------------|---------|----------|
| | | East Dun'shire | East Renf'shire | Inv'clyde | Glasgow City | Ren'shire | West Dun'shire | NHS GGC | Scotland |
| 1 | Proportion (%) reporting positive perception of mental well-being | 90 (3.5) | 91 (5) | 87 (2) | 84 (1) | 90 (3.5) | n/a | 86 | |
| 2 | Proportion (%) reporting positive perception of quality of life | 93 (4) | 95 (5) | 88 (2) | 85 (1) | 92 (3) | | 88 | |
| 3 | Proportion (%) reporting positive control of decisions | | | | | | | | |
| 4 | Proportion (%) reporting feelings of isolation | | | | | | | | |
| 5 | Proportion (%) reporting presence of Long Term Limiting Conditions (LTLCs) | | | | | | | | |

| Number | Indicator | HSCP of residence | | | | | | | |
|--------|--|-------------------|-----------------|--------------|--------------|--------------|----------------|---------|----------|
| | | East Dun'shire | East Renf'shire | Inv'clyde | Glasgow City | Ren'shire | West Dun'shire | NHS GGC | Scotland |
| 6 | CAHMS open cases (per 1,000 population aged less than 20 years). | 20 | 10 | 30 | 18 | 21 | 18 | 19 | |
| 7 | Alcohol related mortality rate (Crude, per 100,000) | 12.2 (5) | 11.8 (6) | 41.5 (1) | 30.7 (2) | 24.6 (4) | 25.7 (3) | 26.9 | |
| 8 | In-patient discharge rate (Crude per 10,000) | 26.0 (6) | 27.3 (5) | 49.8 (1) | 47.6 (2) | 42.0 (4) | 43.2 (3) | 42.9 | |
| 9 | New out-patient attendances (Crude per 10,000) | 40.0 (6) | 90.1 (3) | 241.1 (1) | 76.6 (4) | 129.4 (2) | 71.1 (5) | 93.3 | |
| 10 | Antidepressant prescription rate (per 1,000) | 206.3 (5) | 201.7 (6) | 251.7 (2) | 240.1 (3) | 235.4 (4) | 254.4 (1) | 235.2 | |
| 11 | Suicide rate, 2012-2016 (Crude, per 100,000) | 10.5 | 9.1 | 15.5 | 14.5 | 13.2 | 13.6 | 13.5 | 13.9 |
| 12 | Parasuicide rate (Crude, per 10,000) | 10.4 (6) | 12.1 (5) | 18.6 (4) | 24.1 (2) | 23.3 (3) | 25.6 (1) | 21.5 | - |

| Number | Indicator | HSCP of residence | | | | | | | |
|--------|---|-------------------|-----------------|--------------|--------------|--------------|----------------|---------|----------|
| | | East Dun'shire | East Renf'shire | Inv'clyde | Glasgow City | Ren'shire | West Dun'shire | NHS GGC | Scotland |
| 13 | Dementia (prevalence per 10,000) in population aged more than 60 years | 685.4 (2) | 703.5 (1) | 659.0 (3) | 632.2 (4) | 629.0 (5) | 613.2 (6) | 645.3 | - |
| 14 | PsyCIS (prevalence per 10,000) | 52 (5) | 49 (6) | 85 (2) | 102 (1) | 67 (3) | 66 (4) | 84 | - |
| 15 | Community Mental Health Teams referral rates (Crude, per 1,000) | 9.3 | 12.3 | 8.9 | 24.3 | 20.4 | 17.1 | 19.8 | - |
| 16 | Primary Care Mental Health Teams referral rates (Crude, per 1,000) | 11.4 | 20.1 | 33.5 | 18.9 | 19.6 | 30.7 | 20.4 | |
| 17 | Child and Adolescent Mental Health services (Crude, per 1,000) | 20 | 10 | 30 | 18 | 21 | 18 | 19 | |

Appendix 3: Examples of good practice in improving mental health

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|---------------------------|--------------|--|--|--|---|
| 1 | Perinatal | Renfrewshire | New Mum New You | New mothers | Dietary advice Advice about physical activity | <ul style="list-style-type: none"> • Weight loss • Reduction in social isolation • Reduction in incidence of post-natal depression |
| 2 | General adult and elderly | Renfrewshire | Renfrewshire Anti Stigma Alliance (RASA) | | | <ul style="list-style-type: none"> • Reduce stigma to mental illness |
| 3 | General adult and elderly | Renfrewshire | SOOPER event | Elderly | Increase awareness of elderly people of activities in Renfrewshire | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce social isolation |
| 4 | General adult and elderly | Renfrewshire | Reaching Older Adults in Renfrewshire (ROAR) | Elderly | Provision of Health and Well-being clubs | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce social isolation |
| 5 | Ethnic and refugee | Renfrewshire | Renfrewshire Effort to Empower Minorities | Black and ethnic Asylum seekers Refugees | Integration network | <ul style="list-style-type: none"> • Meet the needs of the local ethnic and refugee community |

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|---------------------------|---------------------|------------------------------|--|---|---|
| 6 | Children and young people | Renfrewshire | Suicide prevention programme | Young people and adults at risk of suicide | Training in recognition of at-risk subjects using ASIST, SMHFA and Safetalk courses | <ul style="list-style-type: none"> • Reduce the incidence of suicide |
| 7 | Children and young people | East Dunbartonshire | What's on your Mind Campaign | Young people in schools | Promote importance of availability of dependable adult | <ul style="list-style-type: none"> • Improve well-being |
| 8 | Children and young people | East Dunbartonshire | | Young people | Provision of advice and information re bullying and stress management | <ul style="list-style-type: none"> • Improve mental health and well-being |
| 9 | Children and young people | East Dunbartonshire | | Young people in schools | Create network of youth services | <ul style="list-style-type: none"> • Improve mental health and well-being |
| 10 | Children and young people | East Dunbartonshire | | Young people in community | Training in recognition of at-risk subjects using SMHFA course | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce the incidence of suicide |
| 11 | Children and young people | East Dunbartonshire | Healthy Reading Scheme | Young people in community | Promotion of Healthy Reading | <ul style="list-style-type: none"> • Improved knowledge of mental health issues |

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|---------------------------|---------------------|-----------------|---------------------------|---|---|
| 12 | Children and young people | East Dunbartonshire | Aye Mind scheme | Children and young people | Promote the 'aye mind' digital resource website | <ul style="list-style-type: none"> • Improve mental health and well-being |
| 13 | Children and young people | East Dunbartonshire | | Children and young people | Increase numbers of education staff and youth workers engaging in Personal & Community Asset Map training | <ul style="list-style-type: none"> • Improve mental health and well-being |
| 14 | Children and young people | East Dunbartonshire | | Children and young people | Training in recognition of at-risk subjects using ASIST and Safetalk courses | <ul style="list-style-type: none"> • Reduce mental distress • Reduce the incidence of suicide |
| 15 | Children and young people | East Dunbartonshire | See Me | Children and young people | Promotion of "See me" programme in education staff and youth workers | <ul style="list-style-type: none"> • Reduce stigma to mental illness • Reduce mental distress • Improve mental health and well-being |

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|---------------------------|------------|---------------------------------------|-------------------------------------|--|--|
| 16 | Children and young people | Inverclyde | Creative Confident Children | Children and young people | Implementation of training workshops for staff | <ul style="list-style-type: none"> • Improve awareness of emotional literacy • Improve understanding of effects of emotional health on capacity for learning |
| 17 | Children and young people | Inverclyde | Mental Wellbeing matter | Children and young people Adults | Implement network of different agencies | <ul style="list-style-type: none"> • Improve mental health and well-being |
| 18 | Children and young people | Inverclyde | Resilience Development in Communities | Children and young people | Training in recognition of at-risk subjects using ASIST and Safetalk courses | <ul style="list-style-type: none"> • Reduce mental distress • Reduce incidence of suicide • Reduce prevalence of self-harm |
| 19 | Children and young people | Inverclyde | One Good Adult | | Implementation of awareness-raising sessions for staff | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce mental distress • Reduction in social isolation |

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|---------------------------|--------------|--------------------|---------------------------|--|---|
| 20 | Perinatal | Glasgow City | Cafe Stork | New mothers | Provision of low-level social support | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce mental distress • Reduction in social isolation |
| 21 | Children and young people | Glasgow City | Resilience toolkit | Children and young people | Implementation of toolkit in schools | <ul style="list-style-type: none"> • Improved resilience. |
| 22 | General adult and elderly | Glasgow City | Mind Waves | Adult and elderly | Implementation of network of community correspondents who share their recovery experiences | <ul style="list-style-type: none"> • Reduce mental distress • Reduction in social isolation |
| 23 | Children and young people | Glasgow City | Aye Mind scheme | Children and young people | Promote the 'aye mind' digital resource website | <ul style="list-style-type: none"> • Improve mental health and well-being |

| Number | Level of Mental Health | Area | Name | Patient group | Intervention | Aim |
|--------|--|--------------|---|--|--|--|
| 24 | General adult and elderly | Glasgow City | Scottish Mental Health Arts and Film Festival | Adult and elderly | Promote the Film Festival | <ul style="list-style-type: none"> • Improve mental health and well-being • Reduce mental distress • Reduction in social isolation • Reduce stigma to mental illness |
| 25 | Perinatal Children and young people Adults | Glasgow City | What's the Harm | New mothers Children and Young People Adults | Development and Implementation of awareness and skills training | <ul style="list-style-type: none"> • Reduce prevalence of self-harm |
| 26 | Children and young people | Glasgow City | Suicide prevention packages | Young people | Training of youth-related professionals in recognition of at-risk subjects using SMHFA | <ul style="list-style-type: none"> • Reduce mental distress • Reduction in incidence of suicide |
| 27 | General adult and elderly | Glasgow City | Suicide prevention packages | Adult and elderly | Implementation of Ten Pillar community initiatives | <ul style="list-style-type: none"> • Reduce mental distress • Reduction in incidence of suicide |



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