Good Mental Health for All Action Planning Day

#gmhfaNorthLan

https://www.facebook.com/elamentlrn/

@elamenttweet

welcome to the day

Bobby Miller
Head of Adult Social Work Services
Health & Social Care North Lanarkshire

Health&Social Care
North Lanarkshire

There is no health without good mental health

Dr Linda Findlay
Consultant Psychiatrist/AMD South Lanarkshire Health and Social Care Partnership

No Health Without Good Mental Health

Mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities

No Health Without Good Mental Health

- Depression is 3x more likely in those with coronary heart disease
- 2-3 x more likely in people with diabetes
- 3x more common in people with Chronic Obstructive Pulmonary Disease
- Common in those suffering from arthritis

No Health Without Good Mental Health

- Someone with depression is 3.5 x more likely to die after a heart attack
- Someone with depression is likely to have poor outcomes in diabetes
- Someone with depression has 50% more exacerbations in Chronic Obstructive Pulmonary Disease

World Health Organisation

Key facts

- Mental health is more than the absence of mental disorders.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- Mental health is determined by a range of socioeconomic, biological and environmental factors.
- Cost-effective public health and intersectoral strategies and interventions exist to promote, protect and restore mental health.

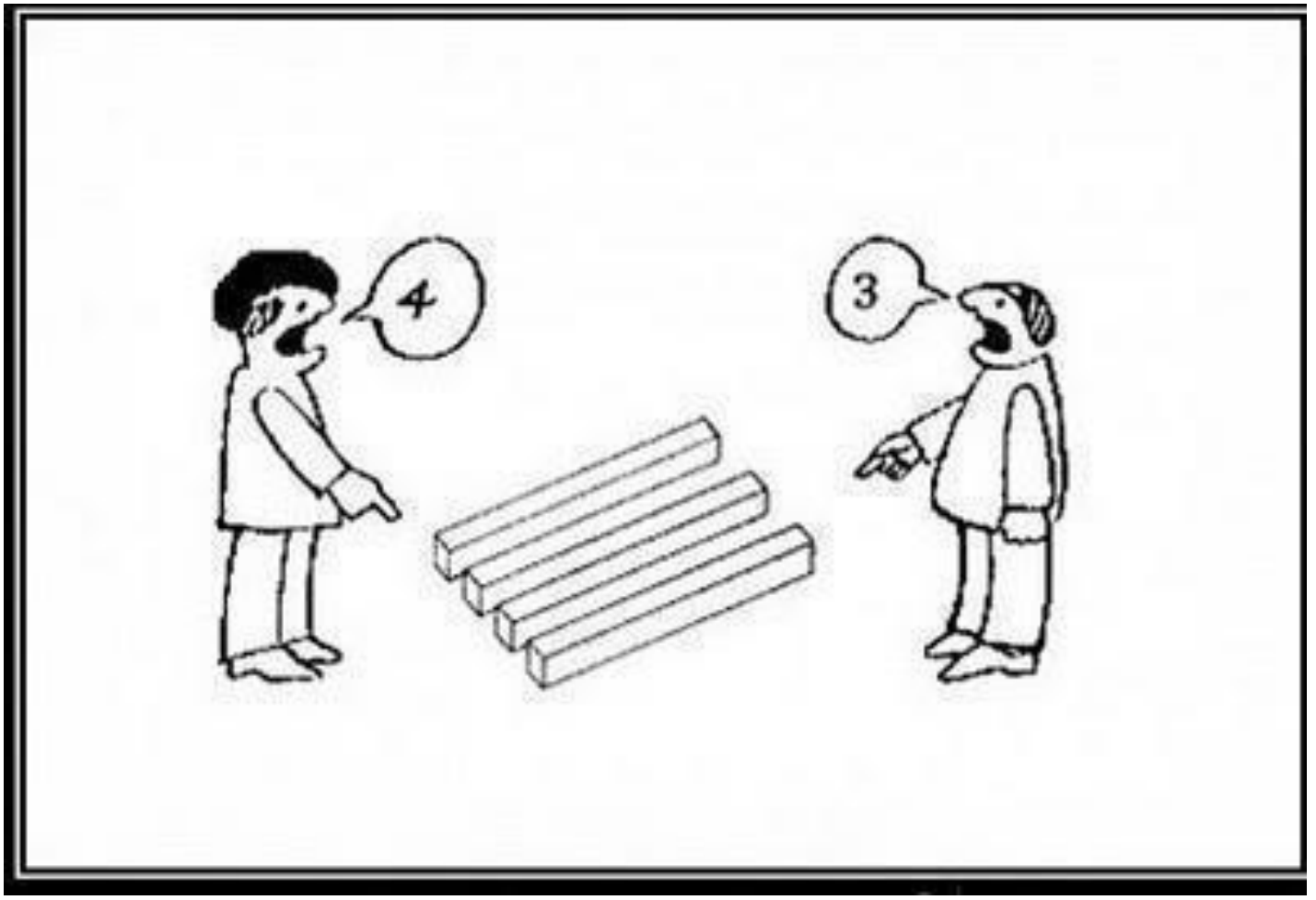
WHO

- Mental health is a **state of well-being** in which an individual **realizes** his or her own **abilities**, can **cope with the normal stresses of life,** can **work productively** and is able to make a contribution to his or her **community.**
- Mental health and well-being are **fundamental** to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the **promotion, protection and restoration** of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.

Not just about Health Services

Working to improve mental health care is not just the preserve of the NHS or the health portfolio. We will be working not only across the Scottish Government, but also across the wider public services to harness the broadest range of opportunities to improve the population's mental health. This work is broad and far-reaching, for example:

- **Poverty**
- **Education**
- **Justice**
- **Social Security**
- **Employment**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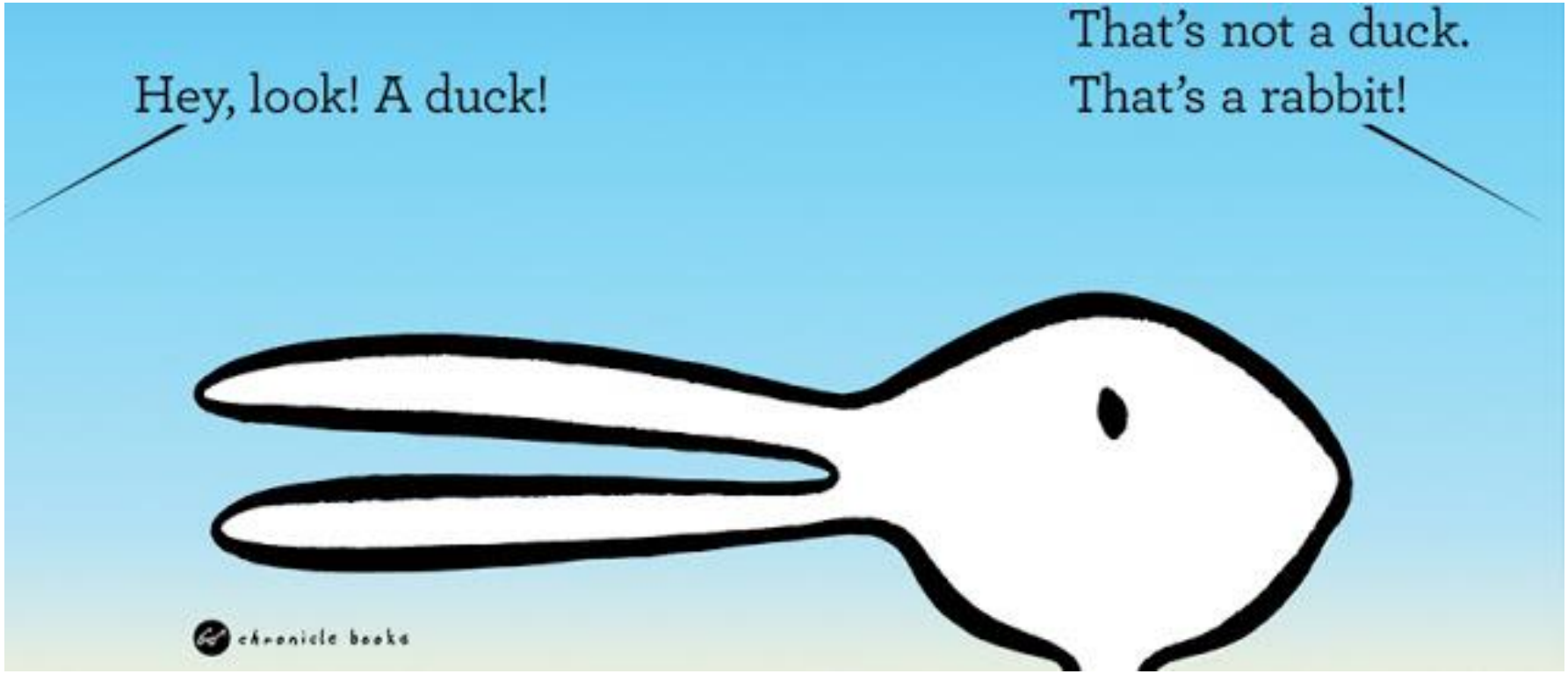

Hey, look! A duck!
That's not a duck.
That's a rabbit!
chronicle books

There is none of us as smart as all of us.

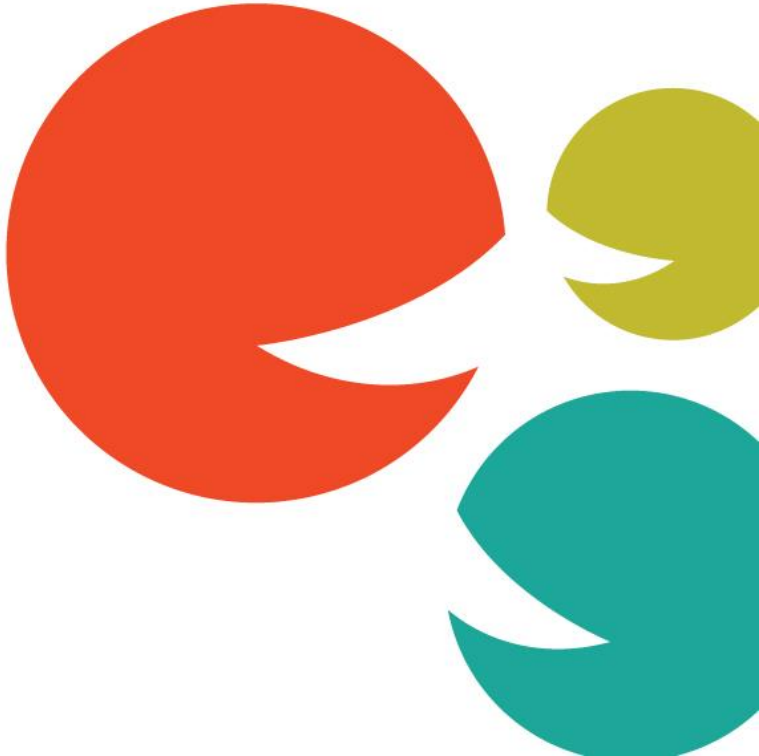
Lets put our heads together to ensure good mental health for North Lanarkshire

Enjoy your day

See Me
End mental health discrimination

Toward Mental Health Inclusion: Ending Stigma and Discrimination in Lanarkshire

Wendy Halliday , See Me



Why we need action to end mental health stigma

- We all have mental health: it changes
- Between 1 in 3 and 1 in 4 of us have a mental health problem*
- 9 out of 10 with MH problems experience stigma and discrimination
- Reaction of others often more damaging than diagnosis

Stigmatising attitudes

- Almost half of people feel that they would not want people knowing about their mental health if they were experiencing a problem

- 17% of people report they would find it difficult to speak to someone with a mental health problem.

- Almost a quarter of people believe people with mental health problems are often dangerous and 28% believe the public should be better protected from them.

Impact of stigma

People that experience mental health problems:

- Face unacceptably high levels of stigma and discrimination.
- Can have their rights legally limited as a consequence of poor mental health. Laws designed to protect their rights are often ignored with impunity.
- Are often excluded from decision making processed that affect their lives.
- Are often denied access to timely acceptable, quality care and support

This applies across life stages

- Affects individuals, their families, friends carers,
- Prevents people from seeking help
- Prevents people achieving their full potential – placing them, at risk of poorer social, educational, employment and health outcomes.
- People with severe mental illness die on average 15-20 years earlier than those without, often from preventable causes

People with lived experience tell us they experience greatest stigma and discrimination in:

- Workplace
- Health and social care settings
- Education
- Their communities

About See Me

- Scotland's programme to end MH stigma and discrimination
- Changing Minds, Changing Policy and Changing Practice > to achieve **behaviour change**
- Potential for significant benefit from MH inclusion
- Encouraging response so far

See Me
End mental health discrimination

Stigma free Lanarkshire Activism and Change in Lanarkshire

Opportunities for working together

SFL - Shared Outcomes

People will live in a society where they don't need to feel ashamed of a mental health problem

People with lived experience are valued and enabled to contribute fully to society and their rights are realised

Stigma & discrimination will be reduced among communities and organisations to have a positive impact on the lives of people with mental health problems and support recovery.

People who have experienced mental health problems will live more fulfilled lives.

Our shared approach

- A public mental health approach
- Mental health inclusion
- Creating and managing opportunities for contact between those who experience mental health stigma and discrimination and those who perpetrate it

A partnership approach

See Me
End mental health discrimination

- Working with those with lived experience across development and delivery
- Shift of emphasis from changing attitudes to changing behaviour, what are you doing within your team and work. What could you do?
- Focus on priority areas - opportunities to work together around these?
- Embedding a focus on reducing stigma and discrimination as core business.

Opportunities

- System wide approach
- Leadership and culture
- Personalisation and person-centred approaches
- Prevention
- Early intervention
- Workforce development and learning
- Mental health and wellbeing of staff

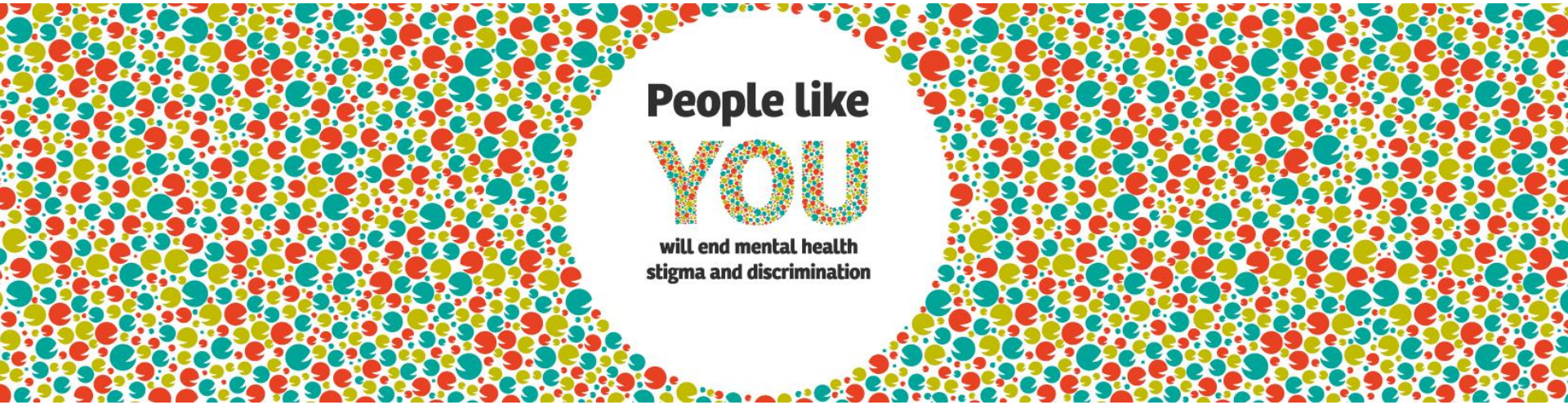
What can help?

Speaking Out

See Me
End mental health discrimination

Your role – our request to you

- **Today**: help inform our joint approach
- **Tomorrow**: to work with us to deliver changes in culture, systems and practice
- **Always**: to challenge mental health stigma and discrimination and champion inclusion.



The See Me launch event - Glasgow

NHS Health Scotland

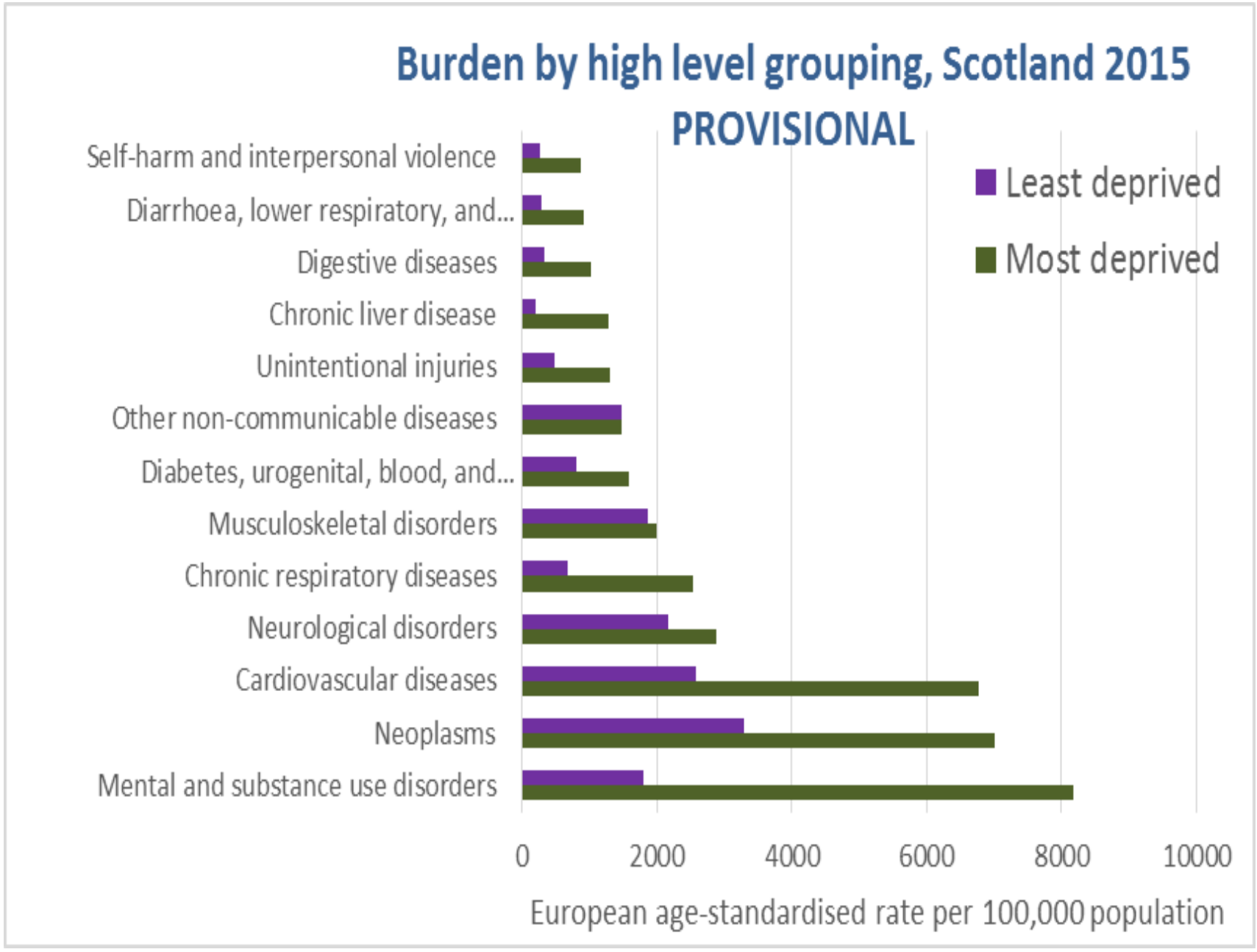
Collective Assets: Mental Health Improvement in Scotland

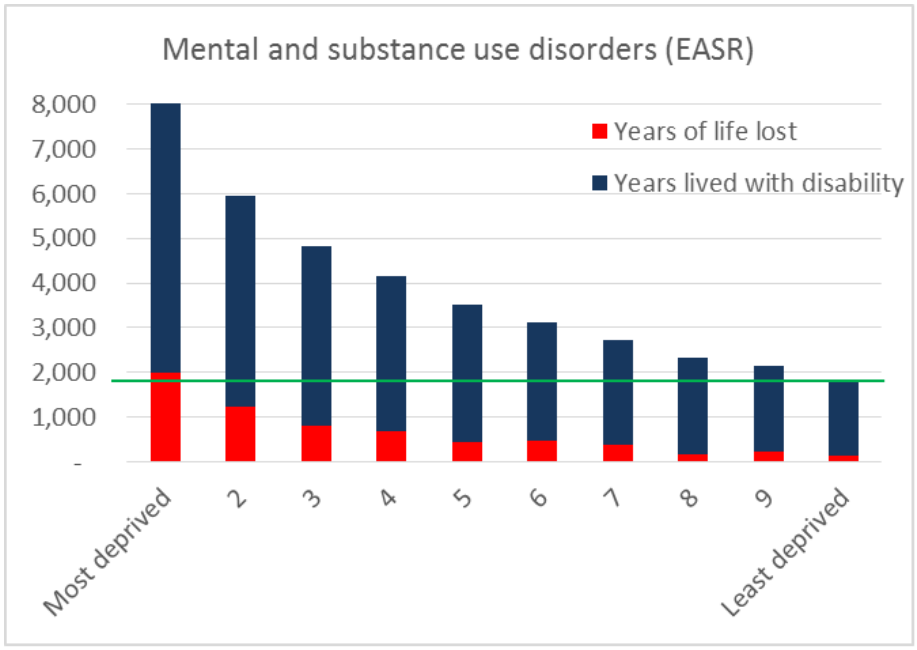
Addressing Mental health and wellbeing

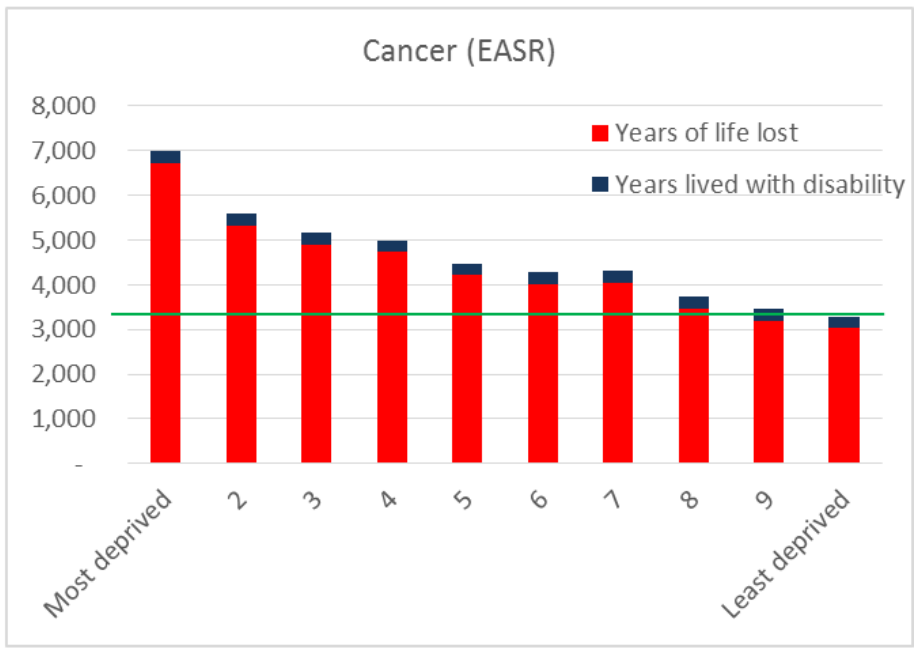
- Scotland's mental health
- The Mental Health Strategy as one policy driver
- Addressing mental health inequalities
- Maximising our collaborative assets

Why tackling is mental health is important

- Approx 1 in 6 adults in Scotland experience a common mental health problem
- But only 1 in 3 access treatment
- 1 in 10 children and young people with diagnosable mental health problem
- Risk factor for suicidal behaviour
- Economic cost est at £10.8 billion
- Significant burden on quality of life


Burden by high level grouping, Scotland 2015
PROVISIONAL
Least deprived
Most deprived
Self-harm and interpersonal violence
Diarrhoea, lower respiratory, and...
Digestive diseases
Chronic liver disease
Unintentional injuries
Other non-communicable diseases
Diabetes, urogenital, blood, and...
Musculoskeletal disorders
Chronic respiratory diseases
Neurological disorders
Cardiovascular diseases
Neoplasms
Mental and substance use disorders
0
2000
4000
6000
8000
10000
European age-standardised rate per 100,000 population


Mental and substance use disorders (EASR)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Years of life lost
Years lived with disability
Most deprived
2
3
4
5
6
7
8
9
Least deprived


Cancer (EASR)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Years of life lost
Years lived with disability
Most deprived
2
3
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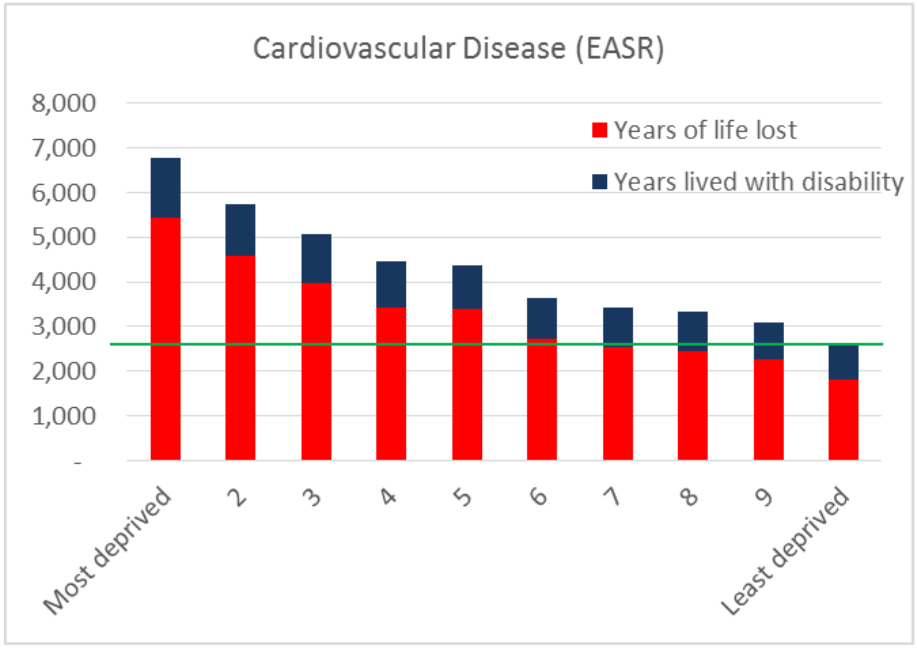
Least deprived


Cardiovascular Disease (EASR)
8,000
7,000
6,000
5,000
4,000
3,000
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Years of life lost
Years lived with disability
Most deprived
2
3
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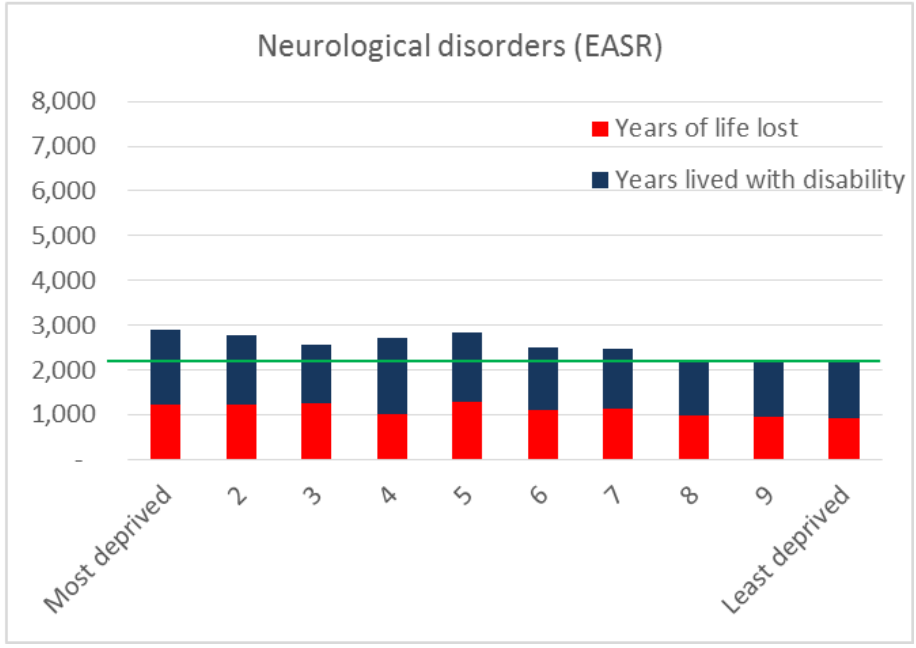
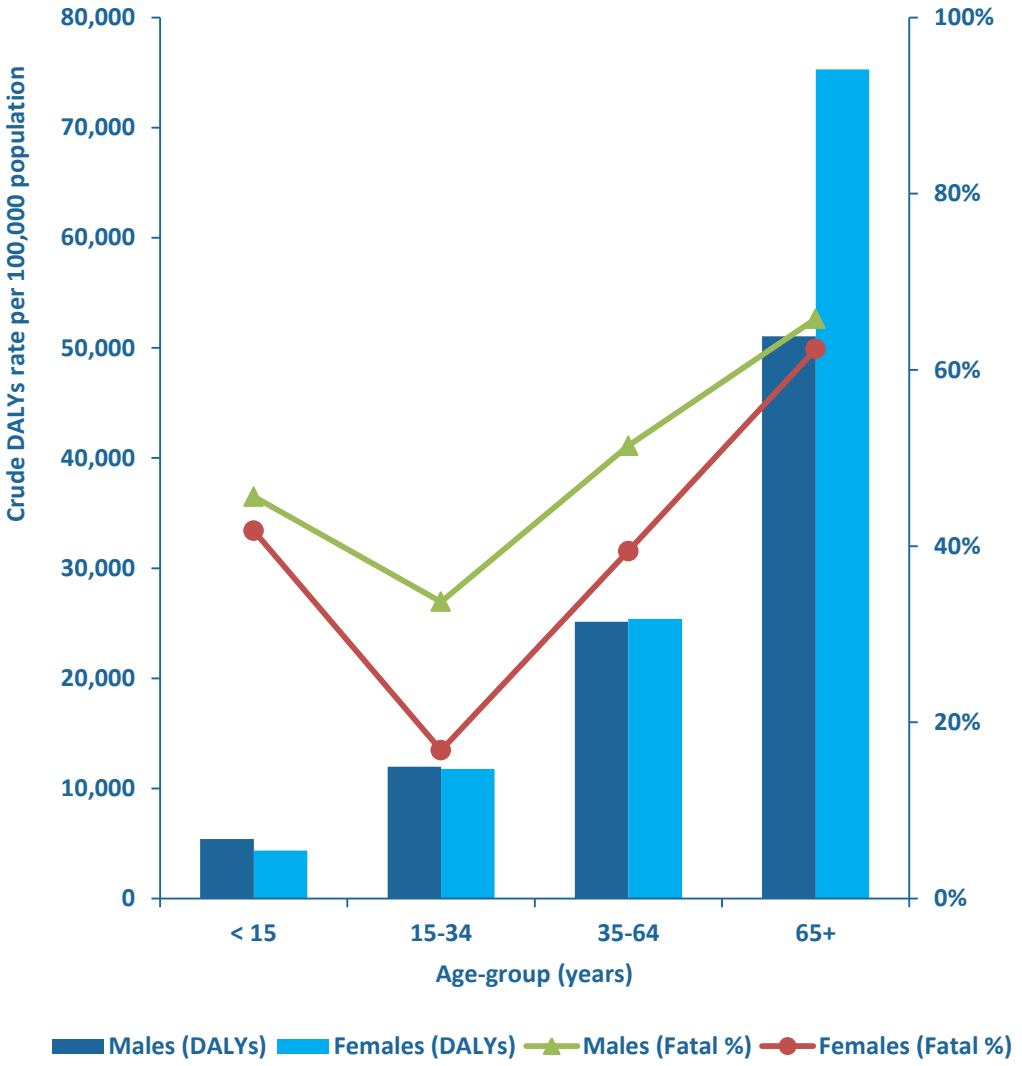
Least deprived


Neurological disorders (EASR)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Years of life lost
Years lived with disability
Most deprived
2
3
4
5
6
7
8
9
Least deprived

Burden by age and gender



0 to 14 years

Congenital anomolies

Neonatal and pre-term birth complications

15 to 34 years

(Both) Drug use disorders, depression, neck/lower back pain

(Males) Suicide and self-harm, alcohol dependence

(Females) Migraine, anxiety disorders

35 to 64 years

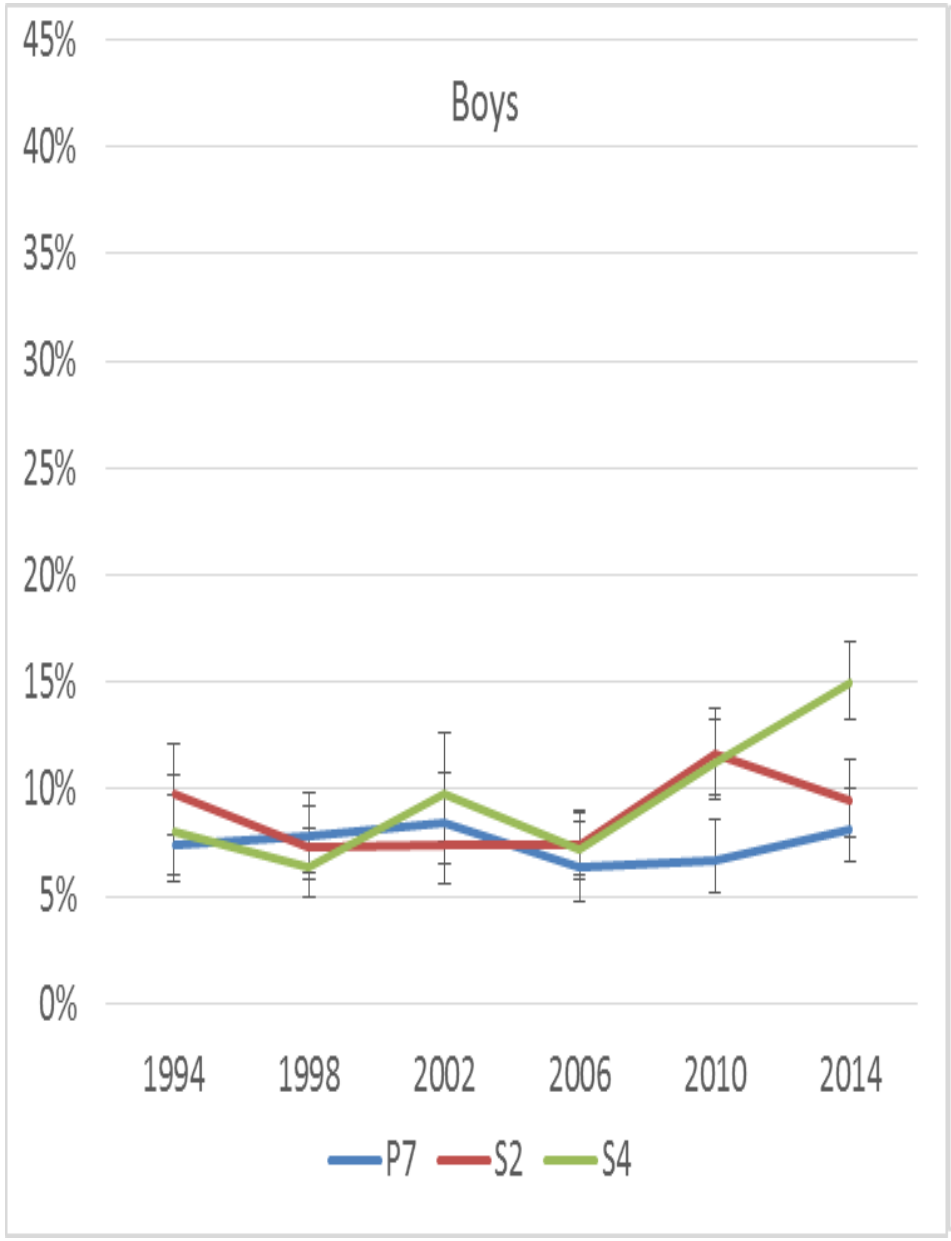
(Both) Depression, neck and lower back pain

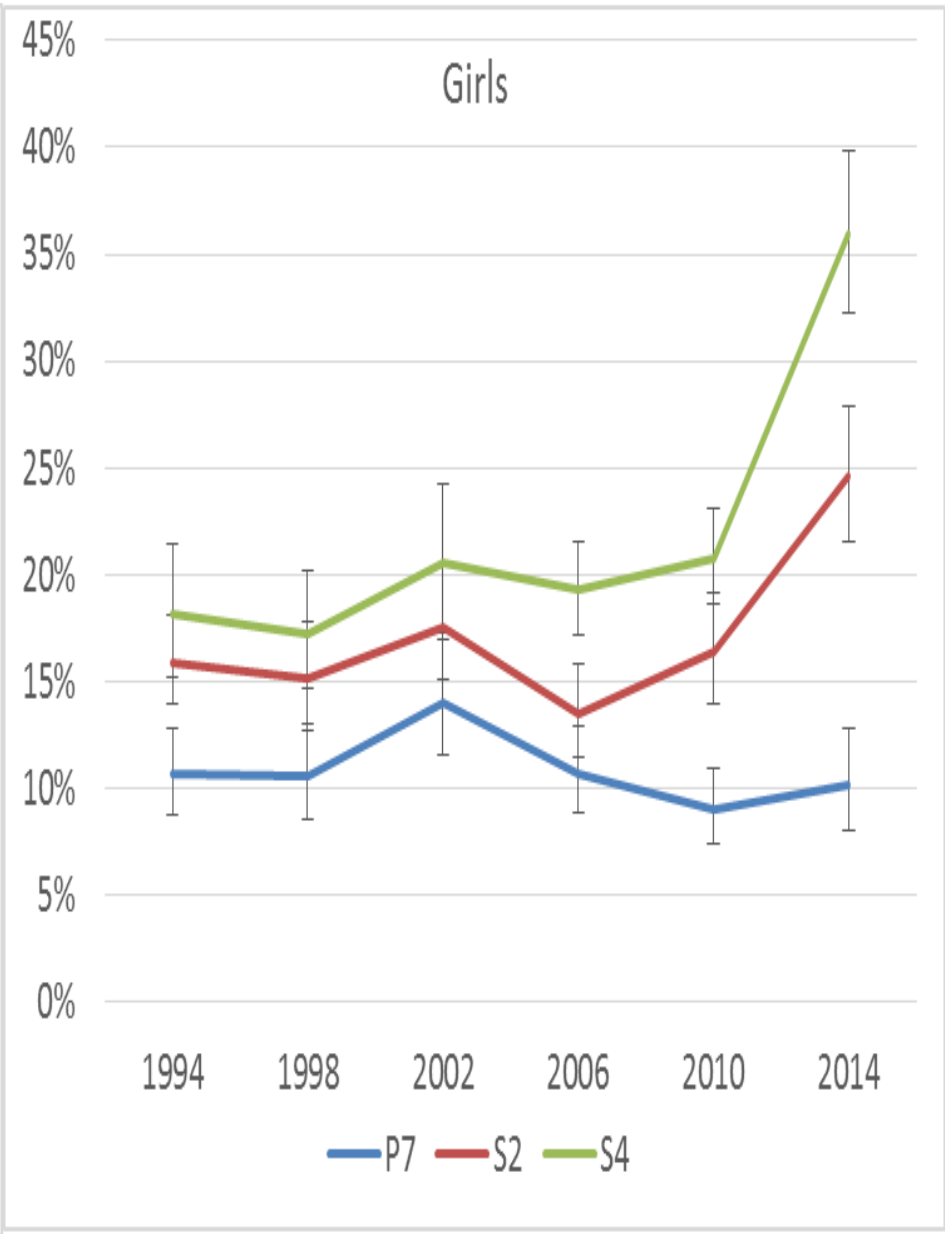
(Males) IHD, cirrhosis, drug use disorders

(Females) Migraine, anxiety disorders, COPD

65 years and above

(Both) IHD, lung cancer, Alzheimer's, COPD, stroke

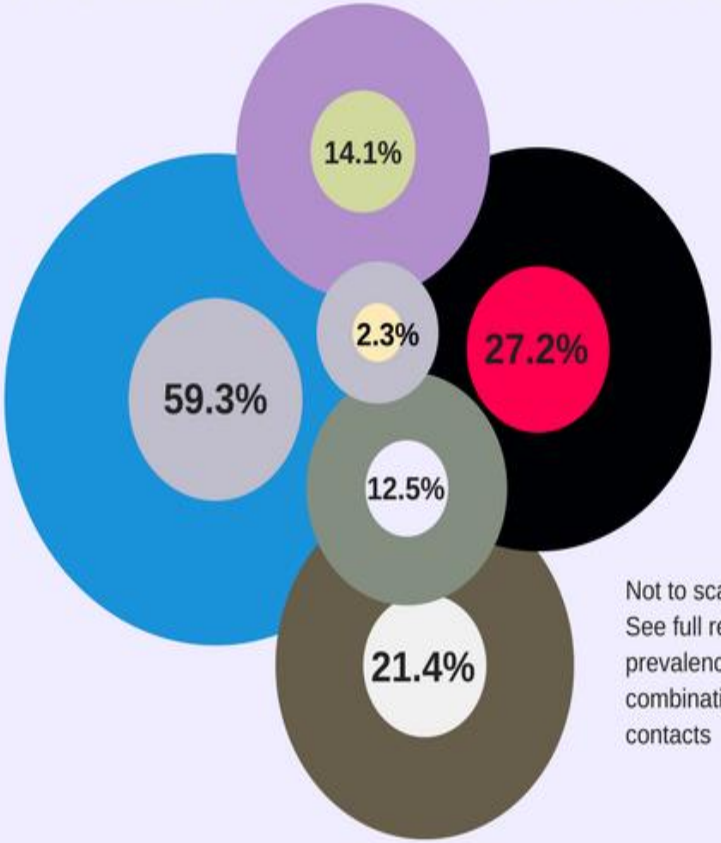

Boys
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
1994
1998
2002
2006
2010
2014
P7
S2
S4


Girls
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
1994
1998
2002
2006
2010
2014
P7
S2
S4


Probable suicides in Scotland 2009 - 2015*
rates per 100,000
16.8
5.4
28.9
9.0
36.3
12.3
32.1
11.8
22.6
8.5
13.6
5.1
14.7
4.1
15 - 24
25 - 34
35 - 44
45 - 54
55 - 64
65 - 74
75 +
* 5 - 14 are not included due to small numbers

Probable suicides in Scotland 2010 - 2015

Health service contact

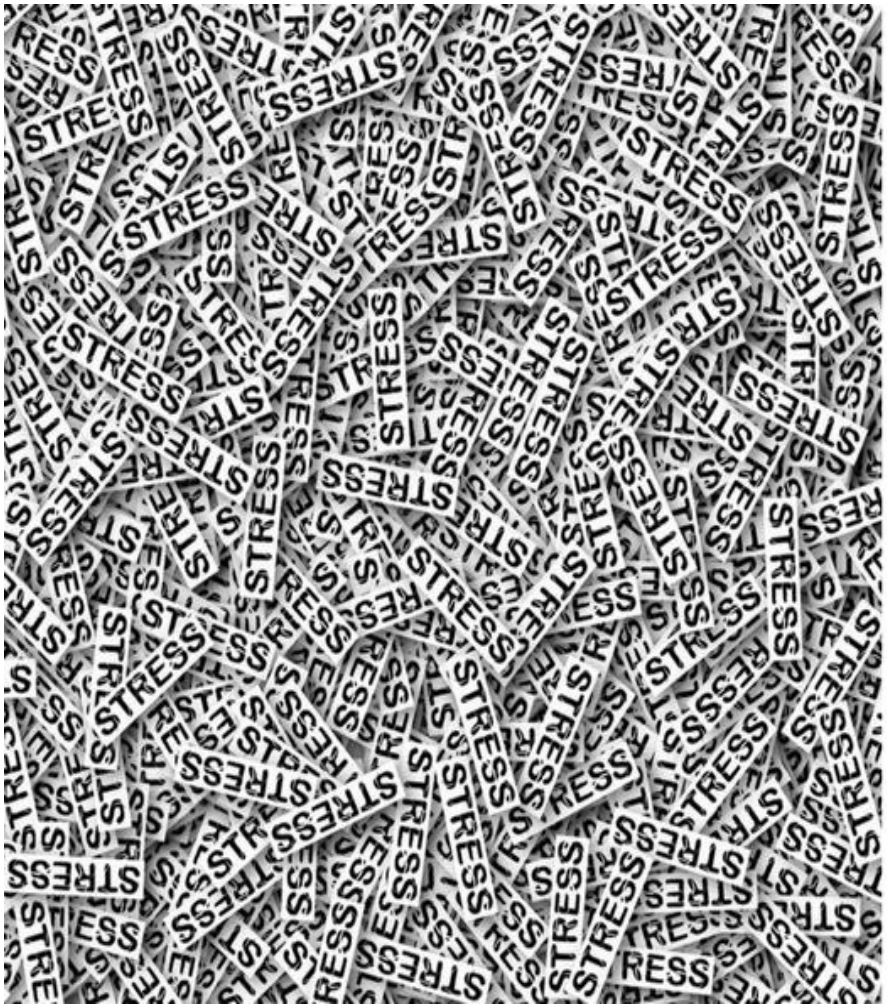


Not to scale.
See full report for prevalence of combination contacts

- **Mental Health Drug Prescription**
- **A&E Attendance**
- **Psychiatric Outpatient Appointment**
- **Acute Inpatient Stay**
  selected diagnoses , primary position
- **Psychiatric Inpatient Stay**
- **Specialist Drug Treatment Initial Assessment**

Multiple combination contacts occur and are counted individually

Workplace mental Health

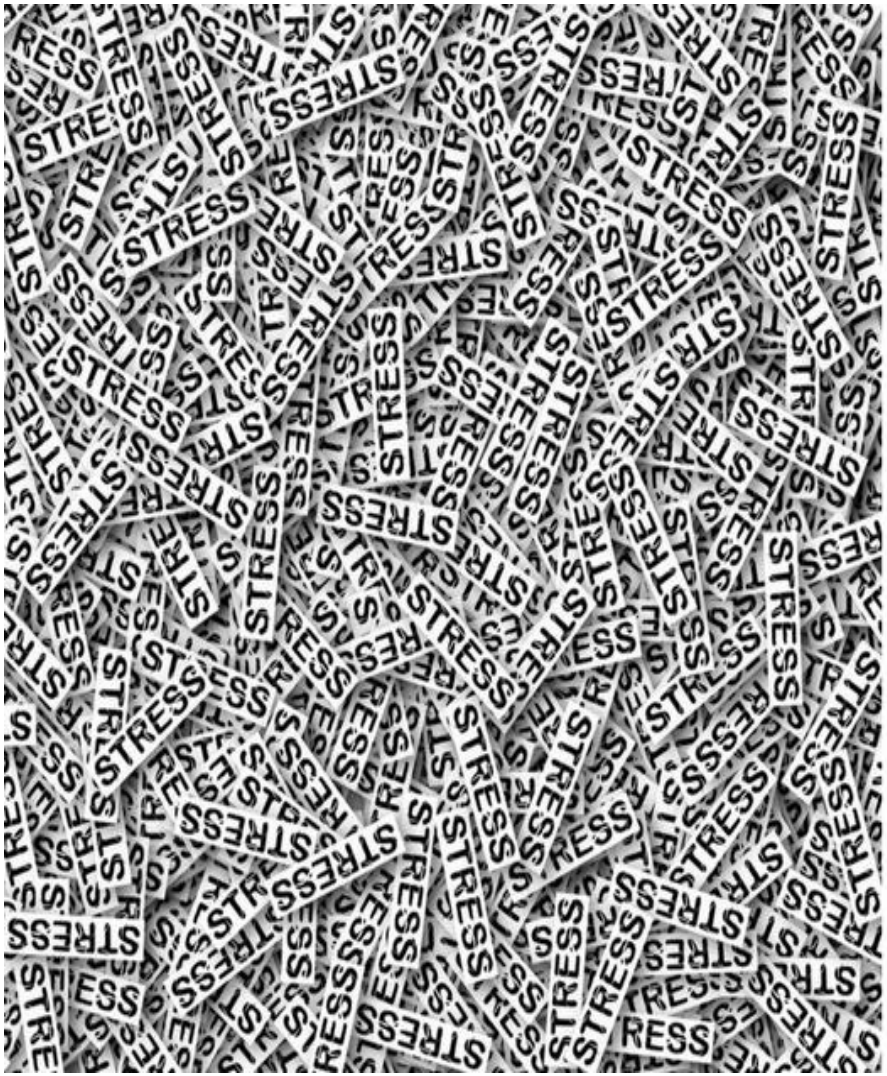


0.5 million

Workers in the UK suffer from work related stress, anxiety and depression*

*New and longstanding conditions 2015 / 2016

Source: Health & Safety Executive 2017



11.7 million

Working days lost as a result

Source: Health & Safety Executive 2017

Good **mental health** for all

Good Mental health:

"is not only the absence of mental health problems but is a state of [mental] wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"

WHO 2007

Mental Health Strategy 2017-27

- 40 initial recommendations
- Key themes
  - Prevention, early intervention and physical health
  - Access to treatment and joined up accessible services
  - Rights, information use and planning

- Promotes parity of esteem
- Challenge stigma and discrimination
- Focus on Ask Once, Get Help Fast (services)


NHS
Health
Scotland
Good
mental health for ALL

What drives inequalities in mental health

Figure 2: Theory of causation

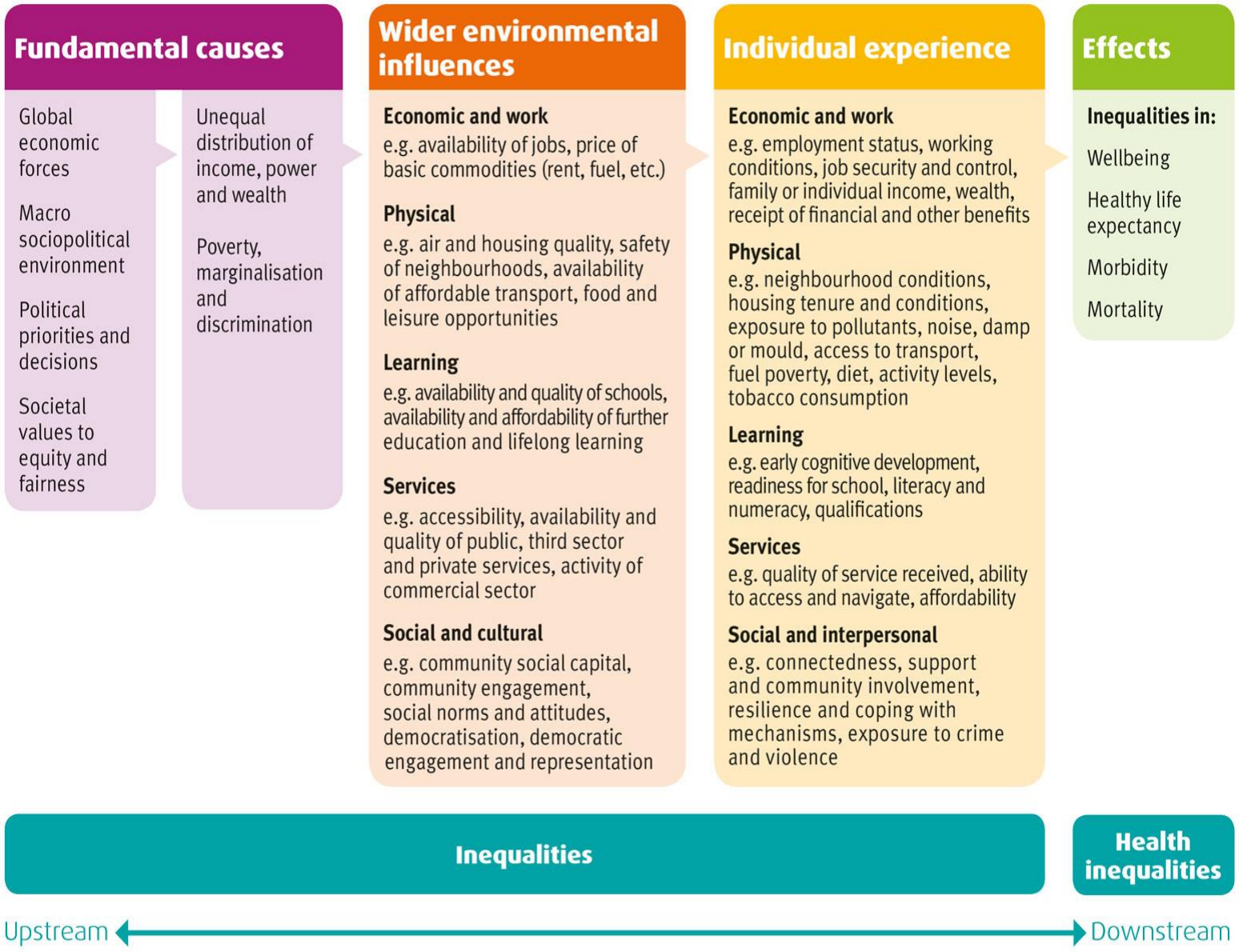


Figure 1: An illustrative list of things that determine our mental health[17,18]

Environmental factors

Protective factors

- Social protection and active labour market programmes against economic downturn
- Equality of access to services
- Safe, secure employment
- Positive physical environment including housing, neighbourhoods and green space

Risk factors

- High unemployment rates
- Economic recession
- Socio-economic deprivation and inequality
- Population alcohol consumption
- Exposure to trauma

Social circumstances

Protective factors

- Social capital and community cohesion
- Physical safety and security
- Good, nurturing parental/care relationships
- Close and supportive partnership/family interaction
- Educational achievement

Risk factors

- Social fragmentation and poor social connections
- Social exclusion
- Isolation
- Childhood adversity (neglect, abuse, bullying)
- (Gender-based) violence and abuse
- Family conflict
- Low income/poverty

Individual factors

Protective factors

- Problem-solving skills
- Ability to manage stress or adversity
- Communication skills
- Good physical health and healthy living
- Spirituality

Risk factors

- Low self-esteem
- Loneliness
- Difficulty in communicating
- Substance misuse
- Physical ill health and impairment
- Work stress
- Unemployment
- Debt

Mental Health Inequalities

- Poor mental health has significant impact on individuals and populations
- Achieving good mental health is the responsibility of all agencies and policy areas
- Where an individual “sits” in society influences their mental health & wellbeing
- Those with poor mental health are at greater risk of social exclusion and poor social and health outcomes
- Experiences in early years impact for the rest of life

Addressing mental health inequalities – key areas

- Early years
- Low income and debt
- Unemployment/poor quality employment
- Violence and abuse
- Poor physical and social environments
- Unequal: access to work; healthcare services
- Stigma and discrimination

Supporting children and young people children

- Support good maternal mental health
- Promote good parent-child relationships
- Prevent mental health and behaviour problems
- Promote readiness for school, especially vulnerable groups
- Reduce impact of child poverty

Low income and debt

- Ensure everyone who cannot earn, have sufficient income for healthy liviing:
  - Promote and deliver financial inclusion services
  - Provide accessible services and support for debt advice
  - Promote non premium rates for essential services
  - Enforce the OFT guidelines on responsible lending

Promoting Healthy Work

- Increase the quantity of work available
- Promote a “living wage” and sustainable employment
- Provide better practical support (childcare, LTC) to help people get and keep jobs
- Improve the quality of work
- Adopt a mentally healthy workplace standard

Improving Physical and Social Environments

- Ensure everyone has access to a quality home that is warm, dry and affordable
- Tackle fuel poverty through warmth and energy efficiency schemes
- Facilitate better access to good quality green space
- Use the Place Standard to engage with communities to integrate health, housing, environment, transport, community and spatial planning

Reducing Social Isolation and Loneliness

- Support improved quality and extent of social networks
- Promote a feeling of neighbourliness and belonging
- Develop wider community safety initiatives
- Sustainable and accessible transport
- Engage local communities in having a say

- Links to work around place

Improving Access to [healthcare] Services

- Develop services based on need and equity to ensure fair access
- Support appropriate training to promote parity of esteem
- Target and tailor activities that promote health and prevent ill health and provide additional support where required

Mitigating against Violence and Abuse

- Develop broad based strategies that challenge norms that lead to/sustain abuse
- Promote routine enquiry approach across all services
- Implement school based problems and early years interventions that support longer-term prevention

How do we maximise our collaborative assets?

Partnership approach

Reduced reliance on services and agents with greater use of self-help and self-management approaches.

Healthier lifestyle, improved physical health, improved quality of life and increased life expectancy, improved recovery from illness and fewer limitations in daily living.

Higher educational achievement and attainment.

Individuals empowered to take action to bring about change in their lives or within their community.

Enhanced mental wellbeing within neighbourhoods and communities through increased participation in community life

Reduction in workplace absence and greater performance and productivity, employment and earnings.

Improved relationships, pro-social attitudes and behaviours and increased social cohesion and engagement and reduction in crime.


Curious Sloth
Photography

To access inequalities briefing paper and other mental health improvement resources, go to www.healthscotland.com/mentalhealth

Shirley.windsor@nhs.net

M: 07500 854 552

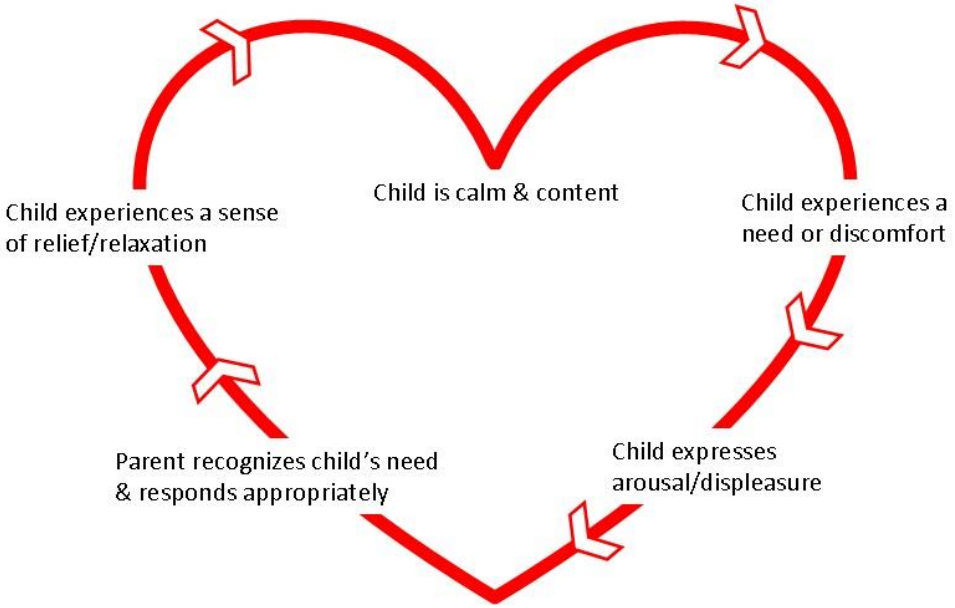
Comfort Break

10.25am to 10.40am

DOES OUR FOUNDATION IMPACT OUR PRESENT

STUART ROBERTSON - NOV 17

WHY ATTACHMENT MATTERS



ADVERSE CHILDHOOD EXPERIENCE (ACES)

Adverse Childhood Experiences Are Common

Household dysfunction:

Substance abuse	27%
Parental sep/divorce	23%
Mental illness	17%
Battered mother	13%
Criminal behavior	6%

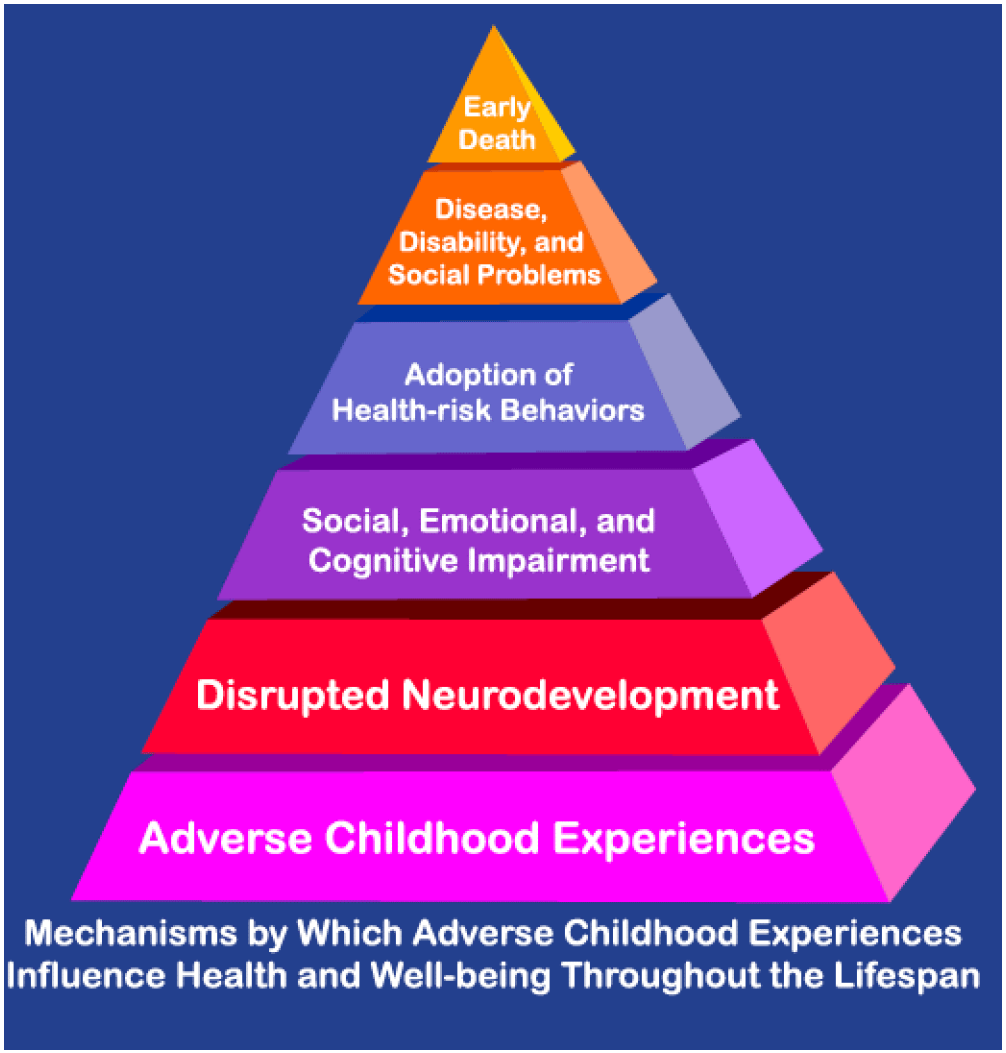
Abuse:

Psychological	11%
Physical	28%
Sexual	21%

Neglect:

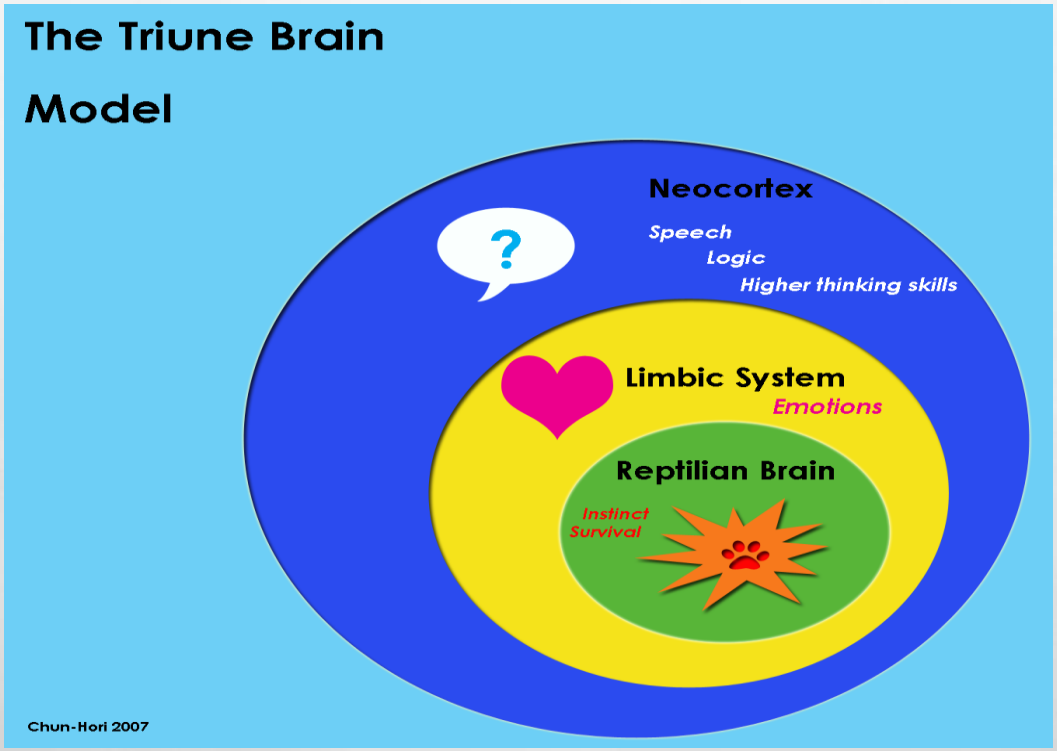
Emotional	15%
Physical	10%

ACES EVIDENCE



EMOTIONAL AVAILIBLITY

TOXIC STRESS & BRAIN DEVELOPMENT



SELF REGULATION V DEFIANCE

- 4 OR MORE ACES
- 32 TIMES MORE LIKELY TO HAVE LEARNING DISABILITIES OR BEHAVIOURAL PROBLEMS

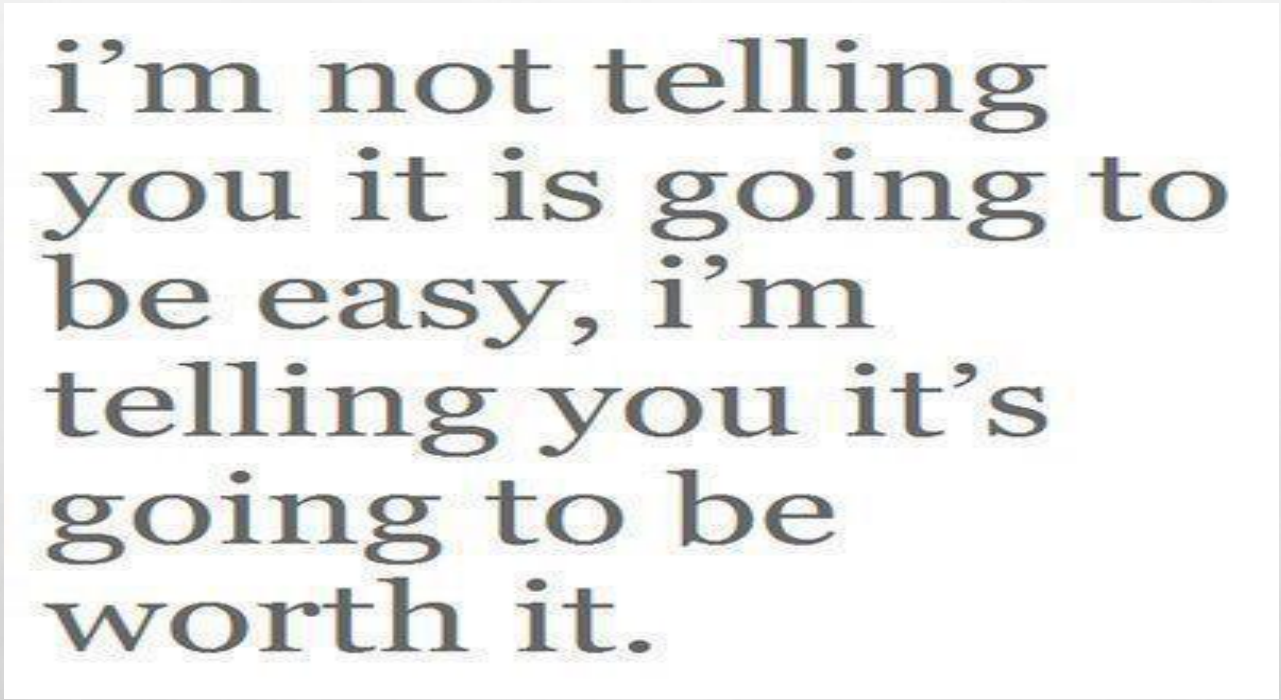
WHY WE MUST BE ATTACHMENT AWARE AND TRAUMA INFORMED IN SCOTLAND

- 80% YOUNG MALES IN PRISON FOR VIOLENT CRIME HAVE BEEN THROUGH THE CARE SYSTEM (ECHR, HOW FAIR IS BRITAIN 2010)
- 27 000 CHILDREN HAVE ONE PARENT IN PRISON (FAMILIES OUTSIDE 2016) (1 XACE)
- 65% OF BOYS WITH A CONVICTED PARENT GO ON TO OFFEND (FAMILIES OUTSIDE 2016
- THE RISK OF PSYCHOSIS IN ADULT LIFE IS INCREASED ALMOST 3 FOLD FOR THOSE WHO HAVE BEEN MALTREATED IN EARLY LIFE *VARESE ET AL 2012*

OKANOGAN & WALLA WALLA COUNTY S

- SINCE TRAINING ALL TEACHERS AND STUDENTS ABOUT ACES AND TOXIC STRESS
- YOUTH ARRESTS FOR VIOLENT CRIME ARE DOWN BY 66%
- INCREASING YOUTH SUPPORT PROGRAMS AND COMMUNITY AWARENESS OF ACES
- YOUTH SUICIDE RATES DOWN BY 59%

ACE AWARE TRAUMA SENSITIVE PRACTICE WILL MAKE A DIFFERENCE TO OUTCOMES IN SCOTLAND



SEE THE CHILD NOT THE BEHAVIOUR

- THANK YOU !
- ANY QUESTIONS ?

The Totem Pole Project

George Simpson
NHS Lanarkshire

Resiliency in Older People, and increasing access to Psychological Therapies

Dr Clive Ferenbach

Senior Clinical Psychologist

Overview of presentation

- Negative stereotypes and beliefs about ageing
- Processes of successful ageing associated with resiliency
- The value of Psychological therapies for Older Adults (OA)

Views of ageing

- **Negative stereotypes of ageing in our Society**

  "you can't teach an old dog new tricks"

  "Well, it's all downhill from here isn't it?" (one of my clients, 2013)

  Ageing commonly associated with sadness and loss

- **View of depression as 'understandable' or 'normal' in old age?**

- **Rates of depression are surprisingly low considering the challenges that can be posed in old age (Sadavoy, 2009).**

- **Prevalence of depression in OA is comparable to younger and middle aged adults (e.g. Blazer, 2010; Jorm 2000)**

Views of Ageing

- **More positive views of ageing**

  "Ageing is not lost youth but a new stage of opportunity and strength."

  Betty Friedan (1921-2006)

  “life just gets more and more fascinating as you get older”

  My Uncle Gordon (1940 - 2015)

- **What factors underlie this apparent resiliency among OA?**
  - Anticipating upcoming life events (Blazer, 2010)
  - Development of emotion regulation
  - Development of wisdom

Improvement in emotional regulation with age

- Evidence for superior self regulation of emotion, decreased lability and surgency, better control of negative emotions in OA. (Lawton et al., 1992)

- Research carried over 10 year period (Carstensen et al., 2010) – tracked same people as they aged:
  - Participants aged 18-94 (almost 200 participants)
  - Emotional experience became more positive into late 60s, then levelled off
  - Intensity of emotions doesn't change
  - Emotional experience becomes more stable
  - Emotional experience becomes more mixed
  - Those experiencing more positive emotion were more likely to survive over course of study

Development of ‘wisdom’

- The 'Berlin Wisdom Project' set out to define wisdom and investigate it empirically (see review by Baltes & Smith, 2008)

- 5 criteria of wisdom:
  - Rich factual knowledge
  - Rich procedural knowledge
  - Life span contextualism
  - Relativism of values and life priorities
  - Recognition and management of uncertainty

Development of 'wisdom'

- Experiment to explore wisdom: have participants spontaneously think aloud about difficult scenarios, e.g.:
  - Receiving a phone call from a friend who is feeling suicidal
  - A 15 year old girl wants to get married right away
  - One of a dual-career couple needs to weigh pros and cons of taking a job in a different state

- Some findings:
  - Intelligence is not most powerful predictor of wisdom
  - Each phase of life fosters specific wisdom about developmental tasks
  - It takes a collision of various factors (psychological, social, professional, historical) to achieve peak wisdom
  - OA are disproportionately represented among top performers

The process of successful ageing

- Continuing to peruse meaningful goals in flexible ways:
  - Adapting to changes in roles and circumstances
  - Adapting to changes in physical and cognitive abilities

- Selection, optimisation and compensation (SOC) theory (Baltes & Baltes, 1990):
  - **Selection**: goal identification, prioritisation, commitment
  - **Optimisation**: using internal and external resources to maximise performance
  - **Compensation**: adapting to limitations

- Need to think about the <u>needs that underlie</u> individuals past activities

The process of successful ageing

Case study: Client experiencing significant pain in her spine. Low in mood, ceased most activity, spends most of day lying on sofa.

Exploration of past activity:

- **Engaging in household tasks** (cleaning, cooking): reflected values of being useful and productive, 'pulling her weight' in relationship
- **Gardening:** values around enjoying nature / outdoors
- **Bowling:** value of mastering a skill, being competitive / winning; also enjoyed social aspect and sense of community / group membership

- **How could this individual adapt to continue with valued activity?**

The process of successful ageing

Developing behaviours that improve well being:

- **Investing in close relationships:** Partner / friends / family
- **Feeling involved in community**
- **Moving your body**
- **Improving physical health:** minimising toxins (e.g. Tobacco / alcohol), eating well, good sleep.
- **Leisure / Fun:** What kind of activities give you a sense of fun, value or meaning? – maybe learn a new skill?
- **Spirituality**
- **Meditation –** can take many forms

Why are OA less likely to be referred for talking therapy?

- Societal beliefs about depression in old age being ‘normal’ or ‘understandable’
- Challenges in recognising distress in OA
- Belief that OA will not want psychological therapy, or that it won’t be effective
- Lack of information about treatments available
- Clients not knowing talking therapies are available

Talking therapies for OA

- Psychological Therapies for Older People have a positive evidence base

Plenty appraoches available beyond CBT:

- **Interpersonal Psychotherapy (IPT)**
- **Mindfulness and Acceptance and Commitment Therapy (ACT)** – groups currently being developed and evaluated
- **Compassion Focussed Therapy (CFT)**
- **Integrative Therapies**

Summary

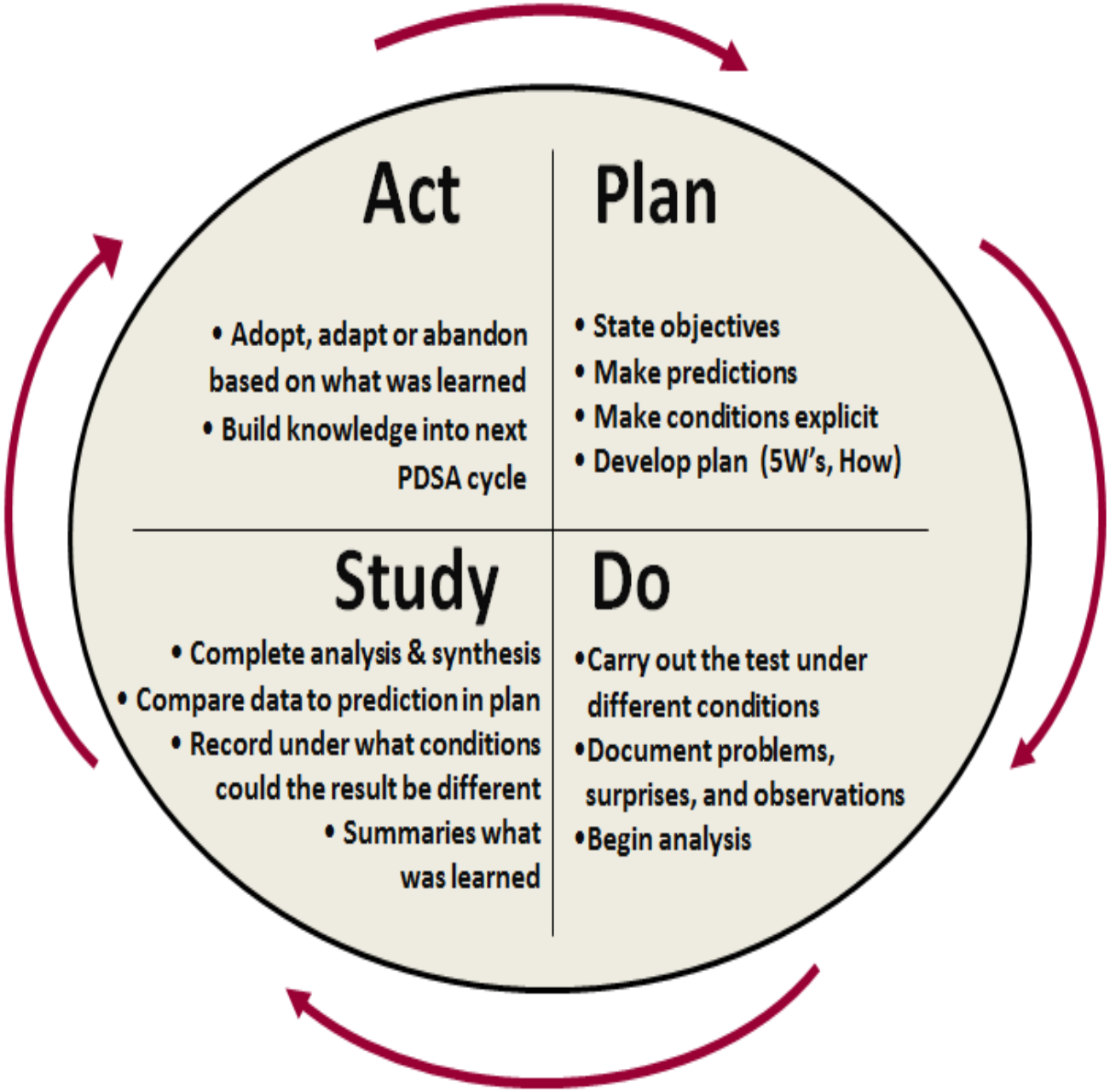
- Ageing involves ongoing processes of psychological and personal development
- OA bring experience and skill to the challenges of ageing
- Positive ageing typically involves a flexible approach to pursuing meaningful goals, and engaging in behaviours that promote well being
- Psychological therapies can benefit OA, an should be widely and readily available

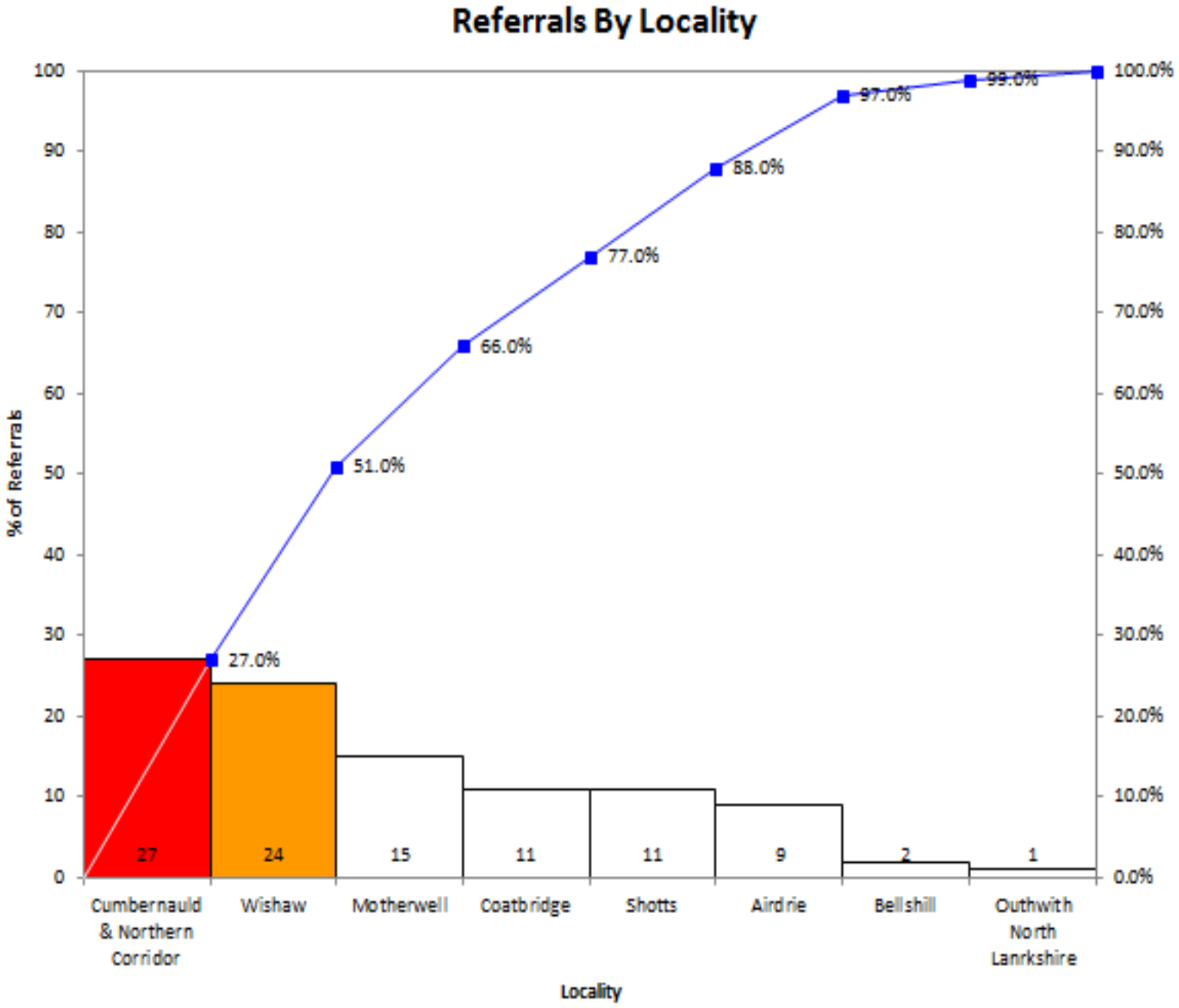
Peer Support:
GP Link Workers & Veterans

Lynne MacDonald, Health & Social Care North Lanarkshire
Deborah Burns, Veteran's 1st Point

GP Frustrations!

GP Link Workers


Act
• Adopt, adapt or abandon based on what was learned
• Build knowledge into next PDSA cycle
Plan
• State objectives
• Make predictions
• Make conditions explicit
• Develop plan (5W's, How)
Study
• Complete analysis & synthesis
• Compare data to prediction in plan
• Record under what conditions could the result be different
• Summaries what was learned
Do
• Carry out the test under different conditions
• Document problems, surprises, and observations
• Begin analysis


Referrals By Locality
% of Referrals
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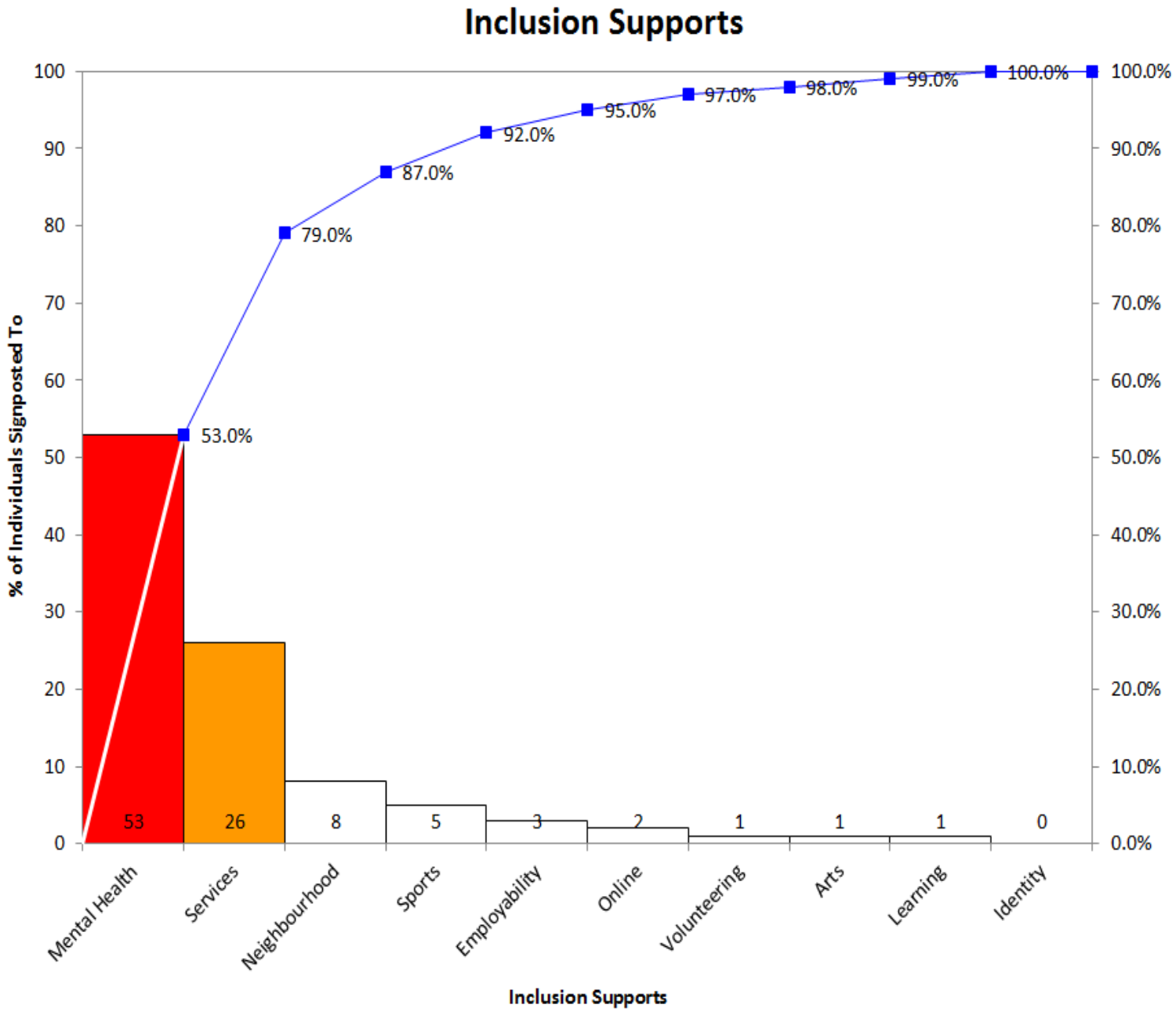
Motherwell
Coatbridge
Shotts
Airdrie
Bellshill
Outwith North Lanrkshire


Inclusion Supports
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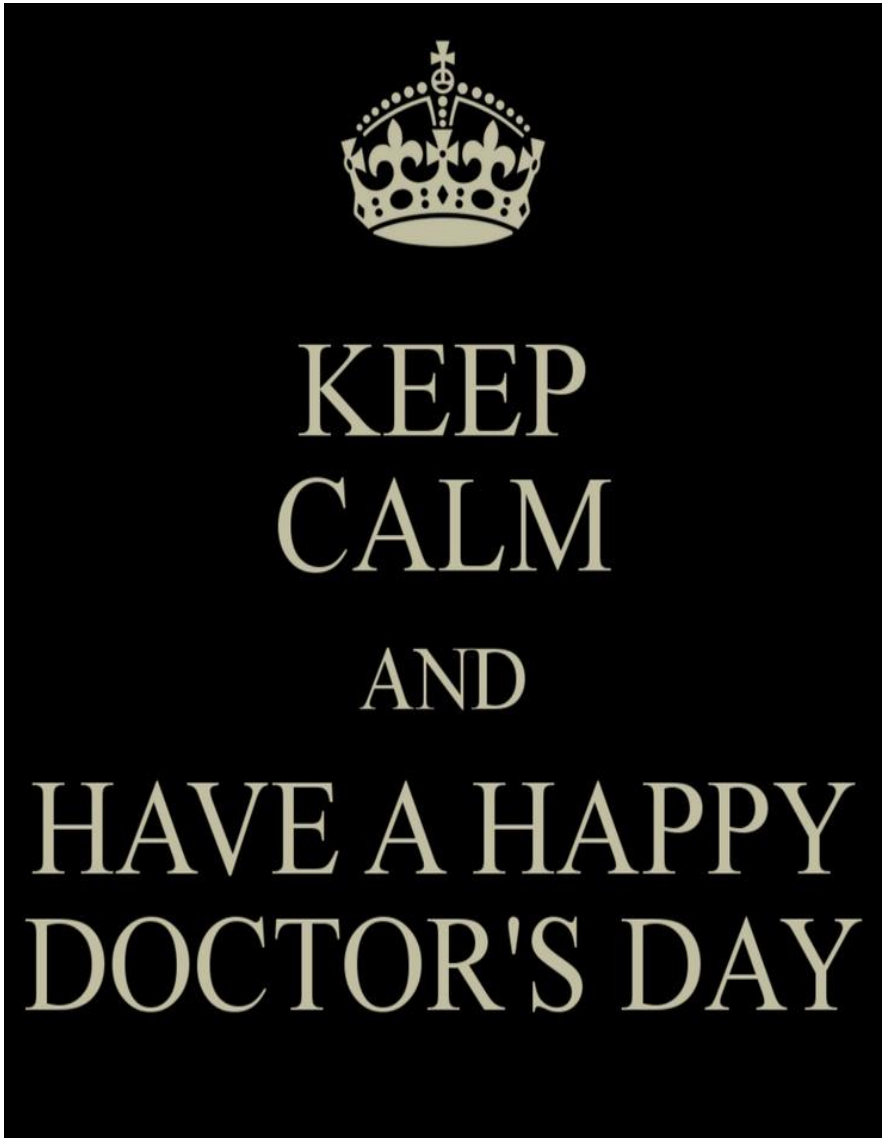
Mental Health
Services
Neighbourhood
Sports
Employability
Online
Volunteering
Arts
Learning
Identity


OUTCOMES

What Next


KEEP
CALM
AND
HAVE A HAPPY
DOCTOR'S DAY

Reflecting on Assets. Feeling Good.

Kevin O’Neill

Distress Brief Intervention Programme Manager

12.05pm to 1.00pm

Action Planning Workshop 1

1.00pm to 2.45pm

Action Planning Workshop 2

2.45pm to 4.00pm

Summing up & Next Steps

Jenny Hutton
NHS Lanarkshire


THANK
YOU!