

Towards a Mentally Flourishing Scotland
Dumfries and Galloway Consultation
Report February 2008

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Introduction

Towards a Mentally Flourishing Scotland: the future of mental health improvement in Scotland 2008-11 is the Scottish Government's discussion document, published in October 2007, which outlines the proposed future direction for the work, building on the National Programme for Mental Health and Wellbeing.

“Mental health improvement and population mental health work have advanced considerably in Scotland since 2001 and Scotland is now recognised internationally for its work. There are areas of excellence, but we need to build on these and do even more, especially to address inequalities and to ensure that the mental health and wellbeing of Scotland's people flourishes.”

Towards a Mentally Flourishing Scotland

Following its launch the document has been out for consultation throughout Scotland, across Health Board and Local Authority areas and within national and local organisations. This report describes how

the consultation process was carried out in Dumfries and Galloway and the results comprise a discussion of responses from the first phase; feedback from the Towards a Mentally Flourishing Scotland event held in Dumfries on February 20 2008; and the responses of the Safe and Healthy Partnership in Annandale and Eskdale and of the group looking at older adults' issues which was convened especially for the consultation. This final version of the report will be circulated to everyone who helped with the consultation and/or attended the consultation event, as well as being sent to the Scottish Government at the end of February 2008.

Dumfries and Galloway: the population and its health

Dumfries and Galloway is a mostly rural region in south-west Scotland. It covers 6,426 square kilometres, with a population of approximately 148,030 (mid-2006 estimate, GROS), nearly half of whom live in areas classified as rural (with less than 3,000 residents). There are no large urban areas: the largest town is Dumfries with a population of 31,100, and over a quarter of the population live further than 30 minutes drive from a large town. This presents a challenge for providing appropriate health care and social support.

adapted from Dumfries and Galloway Health and Community Care Plan 2007-8¹

It also presents a challenge to people wanting to get out and about, to meet others, carry out vital tasks like shopping, and join in social, exercise-related and cultural activities – all of which are important in maintaining positive mental wellbeing. This aspect is recognised in the new Dumfries and Galloway Wellbeing Scale which was piloted across the region in early 2007, and the findings from this are very relevant to and will inform future work in the promotion of mental health and wellbeing.²

While recognising that the term 'mental health' as usually understood refers in fact to mental *illness* and is distinct from 'mental wellbeing', the Wellbeing pilot does show how the two states may be linked and that, for instance, people who suffer from anxiety or depression may

¹ Dumfries and Galloway Health and Social Services (2007)

² Cox, D and Ajetunmobi, T (2007) *Whit Fettle?*

well also have low levels of wellbeing – to be, to use Corey Keyes' terminology, 'languishing'.³

One feature of the Dumfries and Galloway population which marks it out is that we are, on average, older than the rest of Scotland: the average age in Scotland as a whole is 39.4, but in Dumfries and Galloway it is 42.3. Population projections show this effect becoming more marked as our over-65 population increases by 51% by 2024. This is certain to have economic effects for service provision, but in terms of mental wellbeing the possible effects are less clear-cut, as a recent survey showed older people being on average happier than those in middle age⁴. In any case, as Corey Keyes⁵ pointed out in one of a series of recent lectures in Scotland, the forthcoming bulge in the elderly population of the western world comprises the postwar 'baby boomers', a group accustomed to greater agency and a more affluent lifestyle than previous cohorts so they may have a more positive approach to their later years than some of us expect.

The consultation

The discussion document *Towards a Mentally Flourishing Scotland* was available in a full version, a shorter 'easy to read' version with illustrations, and as translations of the latter into Cantonese and Polish with other languages being available on request. Because of the size and rurality of Dumfries and Galloway it was decided to carry out the consultation electronically in the first instance, with hard copies of the documents being provided as required. Thus most of the consultation was done on an individual basis, either through organisations passing the documents on to individual staff members or clients, or by individuals requesting the documents direct if they had seen them featured on the NHS, Council or Community websites. A response form was developed which asked the three questions which are being asked nationally:

1. How can we work together in Dumfries and Galloway to improve people's mental health and wellbeing? Have we got the 'actions' right?

³ Keyes, CLM (2002). 'The mental health continuum: from languishing to flourishing in life' *Journal of Health and Social Behavior* **43** 207–222

⁴ Blanchflower, D and Oswald, A 'Is wellbeing U-shaped over the life cycle?' publication forthcoming, in *Social Science and Medicine*

⁵ See References, p 12, for a link to a Corey Keyes podcast.

2. What help will we need from the Scottish Government and other national organisations?
3. How can we check that what we're doing is really making people's mental health and wellbeing better?

Group consultations were also carried out with a group of carers in Wigtownshire in the west of the region; with a secondary school in the Stewartry; with the Safe and Healthy Action Partnership (SHAP) in Annandale and Eskdale in the east, and with a specially-convened group, looking at the mental wellbeing of older people, in Dumfries itself. The members of the carers' and young people's groups filled in the consultation individually following discussion; the SHAP and older people's group each submitted a collective response and these can be found at Appendices 2 and 3. There were 99 individual responses altogether.

Responses from the first phase:

1 How can we work together in Dumfries and Galloway to improve people's mental health and wellbeing? Have we got the 'actions' right?

People approached this question in a variety of ways. A substantial minority mentioned the useful work that is going on already in the region, including that which has come about as a result of the National Programme:

"We have already begun, for instance with Choose Life...there is great work going forward in training, which needs to be ongoing. I am especially heartened at the training which will be given to front-line staff."

Several respondents stressed the importance of partnership working:

"We already do a number of things quite well and have good practice to build on. We need to ensure robust partnership approaches to this work and reiterate that this is not about mental health services – it's about people's lives and capacity to be content."

and someone else who recognised the difference between wellbeing and mental health problems said:

“I worked [as a Housing Support Officer] with people with severe and enduring mental health problems; I found that good housing support that addressed the issues that at times worry all of us, such as money, housing, family, community networks etc, did not cure their mental health problem but ensured that their lives did not become more difficult. Stability brought wellbeing to some extent, and when their mental health was not so good having everything else in order prevented other areas in their lives becoming difficult.”

Suggestions for additional actions included

“identifying what could give a ‘lift’ to the diverse range of people in our area. We should consider how this could be extended into other occupations or activities – musical entertainment, drama, games, sport, cinema etc.”

and the young people in particular were keen on more counselling provision that was easy for them to access:

“You could set up a clinic for counselling. Also encourage teachers and adults to help the individuals keep well, and everyone in the community. Provide more support to those who need the most help.”

All this is very encouraging. However, not everyone was convinced that partnership working is alive and well:

“As a [housing] agency we have found it difficult to get statutory agencies involved particularly if the client does not have a diagnosed problem or a GP willing to state a problem exists. We have found it nearly impossible to refer people on in these cases. These clients continue to exist within our communities without the support they require.”

and one respondent thought this part of the document lacked focus:

“These appear to be generalised statements of outcomes. Each action needs details of what is being proposed and how that is going to be delivered. It all seems a bit idealistic – needs ‘meat on the bones’ of how it will work in practice.”

It’s a virtue of this type of consultation that those who run it come into contact with those from a wider constituency than they normally reach;

in our day-to-day work we can become embedded in our comfort zones and not realise that others are not having their views heard.

In retrospect it might have been easier for people to respond had this question been divided into its two component parts – people’s response to each was not necessarily similar.

2 What help will we need from the Scottish Government and other national organisations?

The general feeling here was heavily weighted towards funding and central organisation, so that people locally can do the work and have their efforts validated and recognised on a wider scale. One of the young people summed it up:

“Obviously money and working together with organisations will make it more effective.”

and several of the younger respondents referred specifically to ‘see me’ and their anti-stigma work, especially the recent advertising campaign on young people’s mental health – their school is one of those in which ‘see me’ have been researching, so it is good to see the young people referencing the work. Other respondents referred to ongoing work which they wanted to see continued:

“Essential that existing funding streams such as Supporting People funding are continued and developed so work in relation to inclusion, life skills and health can continue.”

Choose Life was also mentioned in this respect. Short-term funding was mentioned several times as a problem: what’s needed, in this person’s view, is

“High level commitment over years. Recognition that there are no short-term fixes and that there are links to poverty and social exclusion to this agenda that are beyond just the NHS and Local Authority’s responsibility alone to address.”

3 How can we check that what we’re doing is really making people’s mental health and wellbeing better?

A very wide range of responses to this question were offered, including

“By asking people and seeing what they think.”

“Face to face evaluation to determine if what is on offer is having an effect.”

“Seek evidence through interagency liaison. For example ...[interagency] meetings to review support services.”

“Do a survey before the new action plan then afterwards to see change.”

(this from one of the young people who had experienced just this as part of the ‘see me’ research);

“Needs predominately to be statistical evidence.”

“Less drugs prescribed
Number of people socially active in communities
Increased knowledge”

“A difficult one, as the referral rate probably increases as people’s awareness is raised.”

which shows how aware our respondents are of the different evaluation methods, as well as some of the pitfalls. The best evaluations are those which use a variety of methods, to present a rounded picture, and we here have a very useful list of methods from which to select.

There was a fourth question, ‘Have you any other comments?’, which not many people answered; but one person who did so referred to a flaw in the ‘easy-reading’ version of the discussion document:

“Protective factors/Risk factors page: The column heading for Risk Factors states ‘We want there to be fewer of these things’ – and physical disability and learning disability are on the list.”

The column heading in the original document is simply ‘Risk Factors’, and physical and learning disabilities are indeed factors that can adversely affect mental wellbeing. Unfortunately, trying to make the document easier to read has resulted in a discriminatory statement

which the respondent describes as ‘an insult to disabled people and people with a learning difficulty.’ It might well serve as a reminder to other people seeking to make formal documents accessible to more people through simplifying their language that the simplification should not change the intended meaning. This instance has already been fed back to the Government.

The event

It was felt appropriate that a ‘Towards a Mentally Flourishing Scotland’ event be held in Dumfries to report on the progress of the consultation, to explore some of the issues more deeply and to gather more ideas and opinions from people interested in the topic – both those who had already contributed and others who had not yet been reached. A half-day event was held in Dumfries on February 20 2008 and, as it happened, extended to almost a full day thanks to the willingness of the keynote speaker, Gregor Henderson of the National Programme for the Improvement of Mental Health and Wellbeing, to stay on after lunch and continue the debate with anybody who was able to stay and join him.

The event was publicised widely and attracted an audience of around 70 people with good representation from the public and voluntary sector, the Users’ and Carers’ Initiative, and people who attended as individuals. A group of students from Castle Douglas High School had intended to come but had to cancel at the last minute: this was unfortunate as their input would have been much valued, but they had at least already contributed to the initial stage of the consultation. Two organisations that come under the umbrella of the National Programme, Breathing Space and ‘see me’, had stalls and there was also a stall run by the local Samaritans group.

Gregor Henderson spoke first and explained the new approach of the Scottish Government to the mental health and wellbeing agenda, and how people’s views expressed through the present consultation process would be used to affect decisions about restructuring the National Programme for Improving Mental Health and Wellbeing, which would be taken over March and April following the close of the consultation at the end of February. Derek Cox, Director of Public Health for Dumfries and Galloway, then talked about the model he is developing for improving wellbeing among the population of the region; and Jocelyn Rose reported briefly on the progress of the consultation so far. The first part of the event concluded with a question and answer session.

The next session aimed to involve participants more directly by inviting them to take part in small-group discussions around the risk and protective factors associated with mental health and wellbeing, and the association of these with the local area. Participants had been allocated their groups in advance, so as to provide a mixture of representation, and a facilitator and notetaker were attached to each group to run the exercise. Notes from the group discussions can be found at Appendix 1. Discussion was lively in the groups and the evaluations showed it was felt to have been a useful exercise.

After lunch a group of 11 people sat down with Gregor Henderson to talk about the issues raised earlier. Again, it was a mixed group with representatives from the NHS and Dumfries and Galloway Council, voluntary agencies, the Users' and Carers' Initiative, and individuals; and the discussion was very lively. Topics covered included

- Early years
- Parents
- Schools
- Volunteering
- Rurality
- 'Professionalism'
- Training within organisations
- The funding of disease and disability and how we go about 'purchasing wellness'.
- Partnership working
- Our ageing population
- People with major mental illness and their carers
- Funding: local or national?

People seized the opportunity to tell Gregor about some of the examples of good practice that are a feature of life and work in Dumfries and Galloway, and the session ended with a very positive sense of everyone having been heard and appreciated.

The evaluation forms showed that nearly everyone had found the event enlightening and useful, and both content and format were commended.

Conclusions

In general the 'Towards a Mentally Flourishing Scotland' document was very favourably received and respondents were pleased that the government was asking their opinion about something that the majority recognised as an important issue.

The consultation provided an opportunity for a large number of people to voice their opinions on the future of the mental health and wellbeing agenda in Dumfries and Galloway, and because all of those people are individuals many of these opinions were specific and idiosyncratic. However, it is possible to identify a number of themes that were apparent through every stage of the consultation process.

Local v national funding: the timing of the consultation meant that many respondents were aware that the Scottish Government's new approach to the funding of mental health improvement initiatives meant that budgets would no longer be ringfenced; and neither would guidelines to Health Board and Local Authority Chief Executives continue to come down from the government. The situation in Dumfries and Galloway is that funding for these initiatives through the Council will continue for one year, during which time the funding situation will be reviewed. There are fears that the Council will have different priorities – for instance that suicide prevention, because of the HEAT targets, will be perceived only as an NHS responsibility - and that much current work, while seen as effective, will be lost.

Multi-agency working: though this is generally regarded as a good thing and is working well in many instances, there are still organisations that feel they are being left out . More work is needed to improve relationships and ensure that everyone is included.

Social exclusion: as organisations recognise the importance of inclusion and 'belonging' as the core of mental health and wellbeing, so society seems to be fragmenting. Communities in Dumfries and Galloway can come apart through rurality and isolation, through poverty and unemployment, through stigma and discrimination, through the loss of our young people to the cities and their failure to return. Responsibility to help people to feel included is not just the responsibility of national or local government, the NHS or the voluntary organisations: it is the responsibility of us all.

And finally: the word 'mental'. Some of the young people who took part in the consultation, although they have been part of an anti-stigma

programme around mental health issues that has been very successful, are still thinking 'mental illness' whenever they hear that word – even if it's in the expressions 'mental wellbeing' or 'mentally flourishing'. One person who was contacted during the first phase of the consultation did not return the form, but emailed back saying "although I have no professional experience of this issue I have read [the document] and like the approach you are taking." This is someone who works in the field of diversity and equality. No professional experience?

Is it time to ditch the word?

References

Blanchflower, D and Oswald, A 'Is wellbeing U-shaped over the life cycle?' publication forthcoming, in *Social Science and Medicine*
Cox, D and Ajetunmobi, T (2007) *Whit Fettle?*
Dumfries and Galloway Health and Social Services (2007) *Health and Community Care Plan*
Keyes, CLM (2002). 'The mental health continuum: from languishing to flourishing in life' *Journal of Health and Social Behavior* **43** 207–222

References for improving mental health and wellbeing in Scotland:

The discussion document Towards a Mentally Flourishing Scotland, on which we are currently consulting, can be downloaded at

<http://www.wellscotland.info/towards-a-mentally-flourishing-scotland-resources>

along with some other related resources.

The National Programme is available at

<http://www.wellscotland.info/mentalhealth/national-programme.html>

and its evaluation can be found at

<http://www.healthscotland.com/documents/2388.aspx>

Much of the current debate on improving mental health and wellbeing is informed by the work of Dr Corey Keyes, Professor of Sociology and Public Health at Emory University in Atlanta, USA. Dr Keyes visited Scotland last year and a podcast of one of his lectures (as well as the Gregor Henderson film) is at

<http://www.wellscotland.info/mentally-flourishing-scotland-interactive.html>

Good coping skills - to cope with bullying
Move in place now to education in home to prevent and manage bullying behaviour
Less acceptance nationally of bullying
Social - good community support (but it can be the opposite in rural areas)
Good to have local training in domestic abuse

Risk factors:

Unemployment

Unemployment is a factor across the region with people falling into the poverty trap and unable to break away from benefits reliance.
People are pushed into jobs that aren't appropriate.
Geography and rurality
Challenge of retirement with limited local opportunities
Signposting to suitable agencies

Social isolation

Challenge of accessing resources that may disadvantage those in a rural community
Homelessness is common
Stigmatisation
Racial and ethnic intolerance is still endemic in D&G

Cultural

Lack (or inappropriateness) of activities (eg aimed at the wrong age group)
Poor awareness of what is available to provide social/cultural interests
Bullying in schools/colleges/work

Social discrimination

People who have mental health or substance misuse problems are discriminated against in small rural communities.
Limited education

Local action

It's difficult to generalise
Secure funding and ask the Scottish Government to guarantee continual funding

Education and training

Parenting skills
Peer rejection
Reducing stigma
Budgeting
Target those who are not good at coming forward to ask for help – focus on them
Scrap adverts on TV for Fairy Liquid and replace them with 'High Production Value' adverts for promoting mental health and wellbeing. (Only half the group had seen the 'see me' adverts.)
Use TV dramas to promote awareness

How do we reach everybody?

Do GPs prescribe antidepressants unnecessarily and as a first resort?

More Self Help please! (3 sessions isn't enough)[refers to the Doing Well by People with Depression programme]

National differences*

Australia

Website technology is more advanced

There are more school counsellors (one per school)

Inter-agency working is similar

Funding

Black Dog Institute – research etc into mood disorders

<http://www.blackdoginstitute.org.au/>

France

You have to pay for treatment and then claim it back – but treatment is better

People can access complimentary therapies

* Group included an Australian and a French woman

Group C

Protective factors:

Add (individual/social level) Working for Families programme – is working very well, needs to be expanded/extended

Risk factors:

Individual – low self-esteem is especially relevant to D&G

Add problematic alcohol and drug use

Social - add stigma

Structural - unemployment and economic insecurity are especially important in D&G, as are poverty, homelessness and social/cultural discrimination

Unemployment and economic insecurity

Unemployment is high across the board, and wages are low compared to the rest of Scotland. Short-term contracts, tied agricultural work, generational unemployment all lead to increased problems – the latter contributes to low expectations and lack of support from home in education/employment aspirations. 50% of young people leave the region for education/work opportunities and few return, which increases social isolation in an area where this is already prevalent.

Stigma

Against people with mental health problems is also prevalent.

Local action

Parents into schools – educating parents and children together in the 'rules of life'
Improve transport/access to services

Recreational facilities especially in rural areas
Encourage children to show their peers and teachers what they can do
Recognise families with poor mental health and work with them sympathetically (non-Big Brother)
Greater strategic emphasis through Community Planning Partnership
The process for commissioning work currently leads to programmes/projects being forced to compete with each other – not a good model for joint working
Structural things would help – access to sports centres, activities
Links with GPs – limitations must be recognised – essential that GPs be involved in moves to demedicalise treatment
Health and wellbeing information person in each GP surgery
Local factory – large scale employment opportunities – providing large-scale employment, increasing manufacturing base etc would increase wellbeing in all areas.

Group D

Individual:

Attachment to family may be less important as a protective factor as family members move away from the region, but the others we do quite or very well. The risk factors all apply in D&G but we are no better or worse than other areas.

Social:

Social belonging is low – lack of peers – on the other hand town/village people know each other

Social isolation is a higher problem, highly applicable as a risk factor
Peer rejection – ‘difference’ is marked out in D&G schools. Local people remember labelled ‘different’ people making it harder to fit in – even years later. Larger communities offer more options.

Structural:

We do well. Safe and secure living environment, people feel safe in D&G
Education experience – we don’t do well. Pressure on youngsters. Lack of diversity in curriculum (problem more acute at secondary level).

Poverty, unemployment, lack of support can all influence a poor educational experience.

Curriculum for Excellence – important in getting youngsters on a positive pathway to jobs, trades for those who are less academic but have skills to offer.

Hall 4 – negative impact. Health workers back off at 8 weeks. Missing chances of early intervention. Circumstances change and problems are being missed. So access to support services is coming in too late.

Access to services – D&G is filled with pilot schemes. We provide services such as Prince’s Trust for 12 weeks: once programme ends problem reoccurs.

CAMHS – primary mental health workers focusing on early prevention – should be built into curriculum.

Local actions

Primary mental health workers in every school

Antenatal focus on after-birth support at prenatal stage. Begin in school – primary curriculum.

All services accessible from start. Toddler-based programmes. Health Visitors not having enough contact to pick up on behavioural problems. Parents not passing on information.

Parents need to be informed of services available and what they are entitled to.

Group E

Protective and risk factors: all important, all in agreement.

If we make a change to one it will impact on others.

Structural level issues such as reducing poverty, providing better housing etc should be tackled first.

Issue of rurality/the rural dimension needs to be looked at, eg lack of support services and compounding effect. Talking to eg young people.

Rurality has an inclusion dimension – eg whether or not people have their own transport. Some people are stranded because of lack of transport.

Inequality in income and resources can lead to ill health.

Social contact and social connection are important to most people.

Some areas of D&G have a sense of community, eg visiting the local Post Office, so withdrawing or reducing such meeting points can have an impact on people's MHWB. Do we need an Impact Assessment when something like closing a rural post office happens?

Local actions to strengthen the protective factors

- Mental health literacy eg suicide prevention
- Cross-cutting exercise eg access to community transport and link with MHWB.
- It's not just about interventions, detection, etc.
- More resources: we need ringfenced money/grants for local action eg Community Transport/taxis
- Identify new social and leisure activities...again, down to lack of resources
- Concentrating effort to Early Years and working in partnership with all agencies. Intensive support. Eg poor children because of poor parents due to lack of resources. They have to use their resilience to survive.
- Lack of maturity of some of the issues – lack of linking up issues and effect on MHWB
- Service users included in discussion? Some able to say they were asked.
- Benefits Agency moved out of Dumfries – local financial problems no longer addressed locally – impact on MHWB. Eg call centres.

Feasible ones

Identifying what we do through Community Planning. Taking positive MHWB into other areas. How does it get on to everyone's agenda?

Ensuring Community Planning partners are involved. Where does the Joint Board fit? Appear to be in isolation. Who's bringing all these issues together?

Immediate response to those in crisis. System in place to deal with crisis.
Reduction in local individual interventions
Aware/mindful of sustainability
Wellbeing team maybe more inclusive. More user-friendly. Feeling that
'Mental'(WB) still has a stigma attached for some. Does 'Wellbeing' have a wider
social context? Discussed which terminology to use:
- Mental Health and Wellbeing?
- Health and Wellbeing?
- Wellbeing?
Who is defining what 'Wellbeing' is and what it includes? It's important to define
these.

Group F

Question 2 a) Most Applicable to Dumfries and Galloway

The group identified that all the examples given in Appendix B would be applicable
to Dumfries and Galloway

They also said that accessibility to support services should be across the sector
not only to 'specifically identified areas'.

The group added to the examples given in Appendix B -

Individual level - emotional literacy (risk factors) especially for men; this could be
provided through group work/sessions/support

Social level - Community development work

The group thought that communication should be in the risk factors.

Question 3

ASSIST in schools

Support/services (non-stigmatised) made available to excluded
youngsters/families

Innovative and new ways of engagement especially with young people

Management and staff quality are important factors

Bottom-up approach

Investment in the voluntary sector (third sector) organisations to develop and
support programmes. This would require clear criteria with 'service level
agreements', which would also need to be flexible enough for outcomes to be
based on need - trust their judgements.

Guided self-help approach

Social Referrals

Question 4

Priority areas for action:

- Investment/support/core funding for voluntary sector (third sector) to enable those organisations to be used as 'delivery vehicles' - facilitate/train the sector to deliver the wellbeing agenda
 - Consultation around the single outcome agreement - engagement from all sectors is crucial
 - Engagement with harder to reach and or excluded groups especially young people - sub-cultures/culture specific a need to understand these.
 - Need safe/comfy street corners - traditionally young people 'hang out' on street corners. Is this bad? Young people build their social networks and life experiences through interactions.
 - Emotional Resilience - especially with young men/communication and sharing of feelings and emotions.
-

Group G

Protective/Risk factors:

At the individual level –

- People are often held back by operational contracts/Supporting people contract/hours. Often they cannot deviate from the topic given – area you have been contracted to help with.
- Individuals tend not to seek help
- Geographic/rural isolation issues is missing as a risk factor
- In rural areas there are confidentiality/stigma issues around seeking help
- Services are centralised in Dumfries – we need more local services or transport system/support for people
- Prevention is an area that gets neither resources nor priority – many are tied into structural contracts eg Supporting People. We need to look at local flexibility in Supporting People projects.

At the social level –

- Social isolation is very important for D&G
- The trend is a decline in social/local based services, support, participation, community resources.
- Parenting skills should be included within Protective factors

At the structural level –

- A lot of disparity around D&G in this area – some localities excellent practice, some non-existent. Is this about rurality or does it exist everywhere?
- Demographic of D&G – is larger proportion of resource going into work with older people?
- Often housing issues (rehousing of homeless people) breeds larger mental health/wellbeing problems.
- People with learning difficulties (mild) are often not diagnosed but then find themselves in inappropriate services/housing etc

Local actions

- Need to provide affordable housing
- Need to improve homeless accommodation
- Need to build capacity of NHS workforce and others to identify positives/prevention/wellbeing
- Change NHS and other organisations' culture with regard to this work – and free up resources for it – eg GPs, practice nurses, physios etc
- 'Identifying positives' – support and development for all people involved in this type of work – building self-esteem/confidence
- Share skills in localities; build on links with projects/organisations
- If identifying positives – must be backed up with opportunities

Realistically – what can we do?

- Balance of focus on illness/wellbeing. Flexibility within projects/organisations to do so
 - Look at other pathways into mental wellbeing – not only through GPs
 - Need to look at benefit allowances for mental health issues – the focus of disability allowance is very much on physical disability
 - Locally we need more small scale events/networking/planning opportunities in Dumfries and Galloway to move it forward
 - Need to free up more resources to work at the prevention end (upstream) – we are firefighting/crisis management
 - Building capacity/engaging with communities to create support/awareness/understanding of wellbeing and being in a position to signpost people into activities, support, self-help
 - Change mindset – build capacity eg GPs etc
 - Training – locally/LHP level
-

Group H

Question 2a - Protective and Risk factors

The group felt that all of the protective and risk factors were relevant to Dumfries and Galloway. But felt that across the region the areas are very different which means different factors relate to different areas.

Question 2b

Unemployment is an important factor – cost implications like rent and mortgage payments.

There needs to be more social housing, which is comfortable, safe and affordable and not just in the “rough” areas.

Lack of job prospects and mass exodus of our youngsters to cities.

Drug issues – knock on effect on crime.

Remote and Rural, this is a major issue and is often overlooked nationally.

Loss of local things like post offices undermines communities.

Poor local transport is a major factor.

The ageing population is a drain on valuable resources.

We should utilise the skills of our older people better.

The community has lost its sense of community spirit.

Pressure to comply to consumerism – The Tesco effect.

Lack of out of hours mental health service provision.

Loss of the extended family unit. Children don't have the support of Granny and Aunts etc.

GP impact – Over use of anti depressants, lack of training, appointment time too rushed.

Poor role models – tv etc.

Workplaces have a major impact on wellbeing, what's being done there?

Homelessness is a major issue. In D&G its quite hidden, not obvious on our streets but lots of people placed in hotels etc.

Question 3

Better transport

Better Housing

Encourage the community spirit

Start at the structural level which will impact on all of the protective factors

24 hour mental health crisis teams

GP's referring properly to appropriate places

GP's need more skills in mental health and wellbeing

GP's must ensure they follow the SIGN guideline

Putting in more support for people in the workplace needs looked at

People need to be taught the personal skills to be able to deal with life situations

Increase peoples self esteem

Treat people as individuals

Top three suggestions

People need the appropriate personal and social skills

People need their basic needs fulfilled, food, warmth, safety etc

GP's need to be better trained in mental health

Appendix 2: response from Safe and Healthy Partnership (Annandale and Eskdale)

Towards a Mentally Flourishing Scotland: please tell us what you think!

After you've read one (or both) of the Towards a Mentally Flourishing Scotland papers, please use this form to tell us what you think about the plan.

1 How can we work together in Dumfries and Galloway to improve people's mental health and wellbeing? Have we got the 'actions' right?

Partnership working is key to any improvements.

Working together brings greater benefits than people working by themselves.

Joined up thinking and joined up working across all sectors. Joint agreements re funding areas of responsibilities and accountability framework.

Central place to get information on organisations who are involved in pieces of work.

2 What help will we need from the Scottish Government and other national organisations?

Information re national Plan and how this may be achieved locally – some ideas for action.

Support for training and disseminating this at local level thereby increasing awareness within communities, empowering communities and increasing capacity within local areas.

A plan for Dumfries and Galloway as to how we might address these issues, who what when. What outcomes will we use to know we are being effective. How will these outcomes be reported to the communities.

Real action on the ground to make this plan a reality. This will require to be well resourced from the point of finance, expertise and knowledge bases.

3 How can we check that what we're doing is really making people's mental health and wellbeing better?

By asking them what they think.

By utilising wellbeing tools as one part of the answer but accepting that this is not the full picture.

By reaching out to hard to reach groups and seeking their opinions.

Acting on that feedback in a positive way which may result in restructuring services to meet these needs.

4 Have you any other comments?

After we've collected together everybody's ideas, there will be a meeting at the Easterbrook Hall in Dumfries on Wednesday February 20 from 10-12.30, followed by lunch, which will give us a chance to share and discuss what people have said. If you'd like to come to the meeting, or if you can't come but you'd like a copy of the report, please tick one of the boxes and add your address underneath.

- Please send me an invitation to the meeting on February 20
- I can't come to the meeting, but please send me a copy of the report

NAME:

ADDRESS:

(postal address or email)

Please return the form by **MONDAY FEB 11** to Jocelyn Rose, NHS Dumfries and Galloway, Lochar West, Crichton Hall, The Crichton, Dumfries DG1 4TG or jocelyn.rose@nhs.net

Thank you for your help.

Appendix 3: report of Older People's issues group

Promoting the mental health and wellbeing of older adults : a response to “*Towards a Mentally Flourishing Scotland*”

On January 24th. 2008, a roundtable discussion was held in Dumfries to consider the TAMFS document and its proposed future direction for policy and action. This discussion was dedicated to the issue and place of older adults' mental health and wellbeing within the wider population context of TAMFS, and was in large part prompted by a lack of explicit focus on older adults in the document itself. The findings of the UK Inquiry into Mental Health and Wellbeing in Later Life (Age Concern, Mental Health Foundation 2006-07) has informed the Scottish Government's "*All our Futures : Planning for a Scotland with an ageing population*", and provides a sound basis for actions in the following key areas :

- **Discrimination**
- **Participation in meaningful activity**
- **Relationships**
- **Physical health**
- **Poverty**

ROUNDTABLE PARTICIPANTS ARE STRONGLY OF THE VIEW THAT MENTAL HEALTH AND WELLBEING PROGRAMMES, AT NATIONAL AND LOCAL LEVELS, INCLUDE OLDER ADULTS AS A PRIORITY POPULATION GROUP; THE RECOMMENDATIONS OF

THE UK INQUIRY SHOULD BE NATIONALLY SUPPORTED, AND INCORPORATED INTO LOCAL ACTION PLANS.

WE ASK THE TAMFS NATIONAL REFERENCE GROUP TO STUDY THESE RECOMMENDATIONS ALONGSIDE THE DISCUSSION NOTED, AND CONSIDER THE ‘WHO’ OF RESPONSIBILITY IN A SCOTTISH CONTEXT, PARTICULARLY THE ROLE OF COMMUNITY PLANNING PARTNERS AND THIRD SECTOR ORGANISATIONS. COMMUNITY PLANNING PARTNERSHIPS SHOULD REPORT ON PROGRESS.

Age Equality and Discrimination TAMFS raises the negative impact of stigma, prejudice and discrimination on mental health. Participants expressed disappointment at the lack of focus on older adults within the TAMFS paper. Widespread **ageist attitudes** result in social and economic exclusion for many older adults, and discriminatory practice towards older people in public service design and provision, specifically the lack of resources and age appropriate care and support, or the **withdrawal or reduction of a service at age 65**; work cessation is often a trigger to mental health problems.

Older adults are often fearful of asking for help; there is a need to raise aspirations and expectations, by ensuring **access to information about rights and appropriate treatment**, and enabling older adults to have real influence on how services are delivered.

The current promotion of **Cognitive Behaviour Therapy** as a cost-effective intervention to improve population mental health was questioned for its appropriateness and effectiveness for older adults, particularly in light of evidence of the social and economic determinants of older adults’ mental health, and their own identification of structural barriers to good health (see evidence to UK Inquiry)

Current **demographic projections** illustrate the rapidly growing number of older adults living with cognitive or learning impairment, dementia, and enduring mental illness; equity must be built into ‘upstream thinking’ and local service planning. **Funding and resourcing** of services to older adults – generic, mental health,

dementia; there is a neglect of older adults through the disproportionate allocation of funds to programmes and projects with a focus on younger population groups.

Objectives and actions: Current and future work around equality and diversity (FAIR for ALL) should provide local leadership for a culture change around old age, and a strong and visible focus on age discrimination to ensure age equality across services (eg, **screen for age equity**). This should include older adults with mental ill-health or dementia; **local community projects** and initiatives should be mapped and monitored for their inclusion of older adults as volunteers, waged staff, and recipients.

National support: All national adult or community mental health promotion programmes and training should ensure issues around age and age discrimination are included. **The findings and recommendations of the UK Inquiry should be the incorporated as the standard for this work.**

All national generic plans, strategies, policies should be **'age proofed'**; government departments should hold public bodies accountable for implementing age equality, seeking out and ending discriminatory attitudes and practice.

Progress and performance : should be monitored locally using nationally agreed indicators; **community planning** has a key role; **local third sector organisations** with a clear remit for promoting the mental health and well-being of older adults must be included in monitoring progress and performance, and enabling older people themselves to participate.

Promotion and Preventative 'services' There is a need to shift the balance of service delivery from 'critical substantial level of need' to more preventative services; these services make a substantial contribution to the mental health and wellbeing of older adults through enabling their independence, continuing access to social networks and community life, self care, and less reliance on care provision; local, community based projects that contribute to social activities. Much of this is carried out by third sector organisations.

Objectives and actions : local decision making bodies need to shift thinking upstream, and fund preventative services; the voluntary and

community sectors provide much of this work –this needs to be recognised, funded, and the sector involved in wider local innovation.

National Support: national co-ordination of community planning partners to advocate for preventative services for their value to older adults, and as a long-term cost-effective alternative or delay to higher levels of support.

Community planning partnerships are pivotal and need to provide the local infrastructure for agencies and older adults to come together to join up service agencies with local older adults in decision-making. The **Third Sector** must provide the leadership in this area, particularly where the funding will not come through the statutory sector.

Progress and Performance : Preventative services are recognised as promoting of older adults' wellbeing, independence and central to quality of life in old age; local authorities, NHS Boards , and community planning partnerships should be accountable for providing and supporting 'low level' services and interventions; monitoring and evaluation should be a shared responsibility; older adults should be involved in this.

Communities: the inclusion and participation of older adults is fundamental to 'cohesive, strong communities'

Objectives and actions: resources are required at grassroots level to ensure the inclusion of older adults in community life; mental health and well-being in later life should be put on the agenda of community initiatives and plans; **communities** should be encouraged and supported in proactively designing their communities to adapt to an older age profile, and specifically consider housing, transport and community support services for people with dementia; prevention and early diagnosis of dementia should be included in health strategies; the mental health and wellbeing needs of older adults with mental health problems and/or dementia should be considered in all older people's programmes

Progress and Performance : community planning partners and community projects should be required to demonstrate a commitment to action; national indicators around age equality/community engagement should be standard.

Participants

Ailsa Black, Service Manager, Alzheimer Scotland – Action on Dementia
Margaret Carlin, NHS Health Improvement Programme Lead ,Older People
Joyce Harkness, Dumfries & Galloway Federation of CVS
Andrew Jack Locality Manager, The Richmond Fellowship
Jean Muir, Strategic Planning and Commissioning Manager, Older People/Mental Health
Morag Musk, Lead Occupational Therapist, DG Mental Health Services
Philip Myers, Health Improvement Programme Lead, Healthy Working Lives (Notetaker)
Penny Nowell, Planning and Commissioning Manager, Adult Mental Health (Chair)
Judith Proctor, Planning and Commissioning Manager, Adults with Learning Disability
Jocelyn Rose, NHS Health Improvement Programme Lead, Mental Health & Well-being
Ann Stephenson, Senior Community Worker, Age Concern Scotland
Sharon Young, Team Leader, Older Adult Community Mental Health

Report by Margaret Carlin 18/2/08.

