NHS Ayrshire & Arran

Director of Public Health
A Life-Course Approach to Understanding Mental Health Report

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Editor: Sally Amor

Acknowledgments

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Public Health Department
NHS Ayrshire & Arran
Afton House, Ailsa Campus
Dalmellington Road
Ayr
KA6 6AB

DPH Office (01292) 885882

https://www.nhsaaa.net/better-health

 : @PublicHealthAAA

 : @betterhealthaaa

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Section 1: Introduction: A Life-course Approach

Defining a Life-course Approach

Life-course approaches focus on population health while drawing attention to the consequences of a range of opportunities and risks as experienced by individuals in the context of family and community life from before birth to death.

A focus on mental health over the life-course presents opportunities to align different Scottish Government policy priorities:

- Tacking Health Inequalities[1]
- Realistic Medicine[2]
- A Trauma-informed Workforce[3]
- Human Rights[4]
- The Promise[5]
- Violence Prevention[6]
- Mental Health and Wellbeing Strategy[7]

Through a life-course approach there is a recognition of the values required within civil, family and community life that support and underpin the creation and nurturing of mental health and wellbeing, of both current and future generations.

A life-course approach recognises:

- There are a wide range of protective and risk factors that influence the experience of mental wellbeing and mental illness/disorder over the lifespan. These are informed and shaped by the experience of family and community life.
- Investment in preconception, pregnancy and childbirth, early childhood, child and adolescent health and development, and care can yield a 10-to-1 benefit to cost ratio in health, social and economic benefits. Time sensitive approaches can reduce the risk of developing of mental illness/disorders in later life.
- The brain can be understood as operating as each person's air traffic control system, with the oversight and co-ordination (integration) of many complex and interacting functions that shape and inform the experience of thoughts and feelings (experience of wellbeing) in the moment and over time.
- Mental health can be enhanced throughout life by understanding the relational and cognitive needs of every person through different stages of life: alongside addressing health inequalities, creating supportive environments within families and communities and relationally informed treatment services.

[1] https://www.healthscotland.scot/health-inequalities
[2] https://www.realisticmedicine.scot/
[3] https://www.gov.scot/publications/adverse-childhood-experiences-aces/pages/trauma-informed-workforce/
[4] https://www.gov.scot/news/new-human-rights-bill/
[5] Home - The Promise
[6] https://www.gov.scot/publications/violence-prevention-framework-scotland/
[7] Scotland's Mental Health and Wellbeing: Strategy (www.gov.scot)

- By altering policies, environments, and societal norms, inequalities affecting the life-course trajectory can be reduced, which can benefit the whole population across life, as well as future generations.
- Mental health and wellbeing benefits from being understood as more than the absence of mental illness or disorder. One can experience mental wellbeing while having a formal diagnosis.
- Maximising the many opportunities to support mental health across life, along with the timely identification and support for people where there is poor mental health, illness and disorder can be understood as key goals of a life-course approach to mental health.

Life-course summaries can be found in the Sub-appendices, detailing the following age bands:

- First 1001 Days (pregnancy/0 to 3 years).
- Childhood (4-11).
- Adolescent (12-18).
- Early Adulthood (19-24).
- Adulthood (25-49).
- Middle Years (50-69).
- Older Adults (70-89).
- Elderly (90+).

These summaries detail examples of what a public mental health approach offers to population and individual mental health wellbeing, with related consideration of mental illness/disorder and what better might look like.

Section 2: Defining Public Mental Health/ Mental Wellbeing/ Mental Illness/Disorder

Language and the framing of mental wellbeing and mental illness/disorder can be complex and a source of much debate. For the purposes of this paper the following definitions apply:

Public Mental Health can be understood as exploring and understanding the relationships and interactions between individuals, families and communities alongside the structural systems and services that are involved in people's lives; day-to-day and over a lifespan. These are, in turn, shaped by the experiences of adversity in childhood and traumatic experiences, physical and psychological health, life experiences and opportunities, identity (religious/spiritual/gender/culture/ethnicity), personal traits and the social demographic circumstances of people's lives.[8] The nature of mental health need and the services that are required to respond with related consideration of costs and evidence/knowledge, alongside people with lived and living experience, is also part of a public mental health approach.

Mental wellbeing has been defined as: 'a state in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' [9]

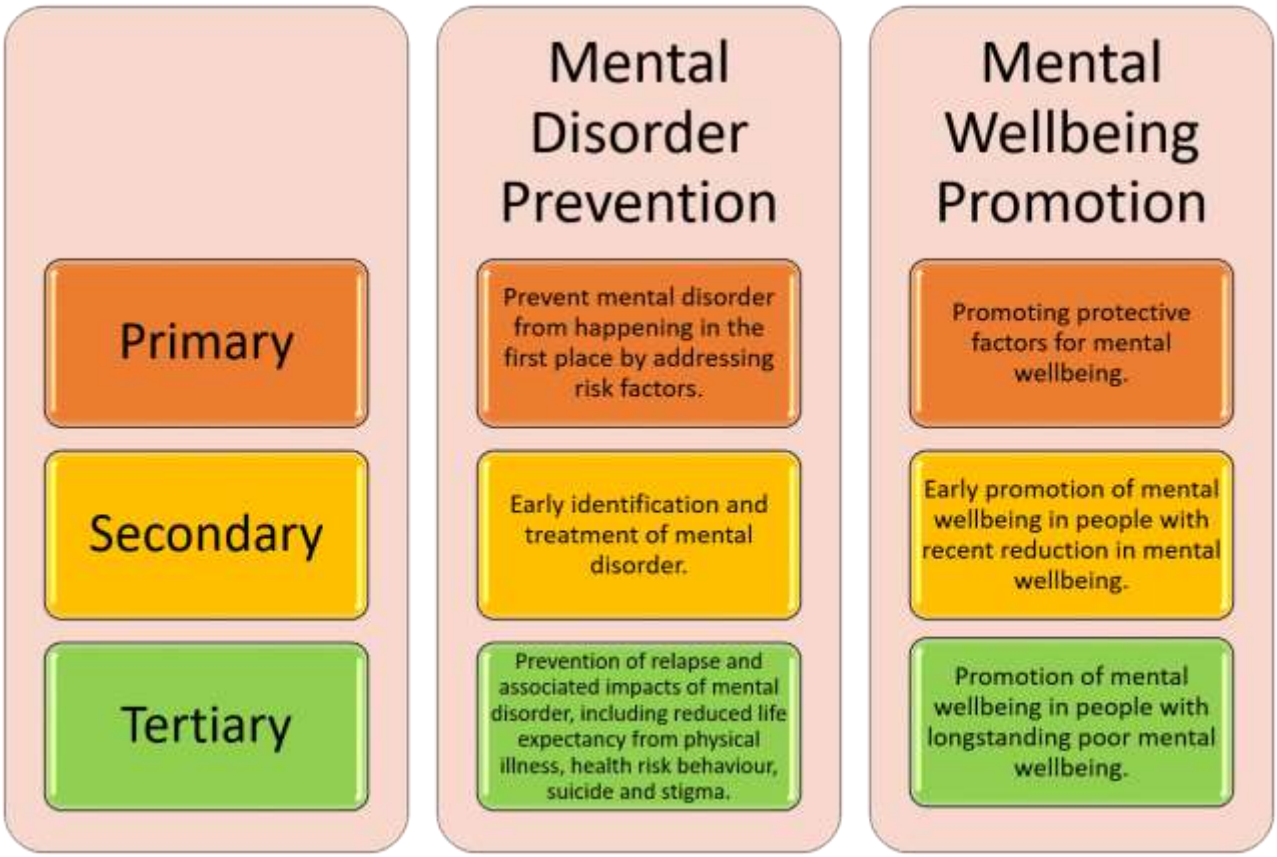
Mental illness refers to depression and anxiety (which may also be referred to as 'common mental disorder') as well as psychosis, schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness).

Mental disorder includes mental illnesses as well as personality disorder, eating disorder, and alcohol and drug dependency'[10]

Understanding the origins of mental health and wellbeing, alongside mental illness/disorder, identifies the shared territory where poor mental wellbeing is recognised as a risk factor for developing a mental illness/disorder. At the same time, supporting mental wellbeing is an important part of recovering and staying well where there is mental illness/disorder.[11]

Mental wellbeing promotion includes the promotion of protective factors for mental wellbeing (primary promotion): early intervention to promote wellbeing in those with poor wellbeing (secondary promotion) and the promotion for those with long standing poor wellbeing (tertiary promotion). All interventions require more targeted approaches for higher risk groups.

[8] 49d9d6_8325d041741742b1b1202af943cb67d2.pdf (publicmentalhealth.co.uk)
[9] Health and Wellbeing (who.int)
[10] 215d040-2753-410e-a39eb30ad3c8b708.pdf (rsph.org.uk)
[11] b215d040-2753-410e-a39eb30ad3c8b708.pdf (rsph.org.uk)



Primary prevention focuses on maximising the potential of high-quality universal services: maternity/health visiting and school nursing (prior to universal schooling) from nursery to primary and secondary school. Here lies the greatest scope to create and sustain good mental health across the whole population. This involves an understanding of the dynamics of relationships, and particularly, supporting parent infant/child and adolescent relationships, as well as ensuring the knowledge/skills capabilities and capacity to understand and support behaviours that can indicate need by the universal workforce. This brings related gains for families and communities.

Secondary prevention is concerned with responding to needs, risks and vulnerabilities as they first become apparent. Timely identification/assessment of need and intervention(s) can prevent further difficulties from developing through offering early intervention and support as needs are identified, assessed and understood to reduce the impact of conditions/illness. There can onward referral to additional services and support. Ensuring families have access to benefits and entitlements reduces pressures on families facing income, housing and food insecurity that contribute to wide-ranging health inequalities. Bringing additional community services (community nursing, youth workers, community policing) to communities that are struggling also serves a preventive function.

Tertiary prevention seeks to prevent further difficulties and deterioration as needs become more complex. This might be as child or young person grows into adolescence, where the influence of a neurodevelopmental condition, or learning disability and related distressed behaviours, become more problematic to their mental health and that of their families and carers, or as an adult with problematic substance use becomes involved with police and justice services.

Section 3: Mental Health as a Resource for Life

Mental health can be understood as a resource for life, underpinned and shaped in the first instance by experiences of relational and environmental safety with parents and primary care givers, informed by genetics and gene expression and wider family and community experiences. Later across life, relationships with friends, peers, and work colleagues, as well as across family and community, also influence and shape mental health.

Mental illness/disorder can present or be problematic across the life-course. The protective role of relational safety in family and community life, as well as experience of services, can both mitigate and reduce the nature and severity of presenting or enduring difficulties.

Mental health, and risks of mental illness/disorder, are shaped and informed by the dynamic interplay of the following:

- Resilience.
- Intergenerational Effects.
- Early Adversity in the Home/Community.
- Toxic Stress.
- Attachment.

3.1 Resilience

"In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways."[12]

In western cultures resilience is often framed as an individualised dogged determination to overcome. A more discerning understanding of resilience can be understood through a culturally-informed socio-ecological approach: a dynamic process that involves individuals having the capacity to look for resources that will meet their wellbeing needs as families and communities. This requires governments and systems to provide the necessary resources in ways that are accessible to all individuals.[13]

Resilience within individuals, families and communities helps all play to their strengths, rather than their vulnerabilities, while necessitating a system, service and practitioner response that meets people at their point of need.

3.2 Intergenerational Effects

Intergenerational psychiatry is interested in the family origins and transmission of distress and mental illness with a focus on[14]:

[12] https://www.mentalhealth.org.uk/our-work/research/resilience-across-uk-during-coronavirus-pandemic
[13] https://journals.sagepub.com/doi/10.1177/1524838013487805

- How mental illness/disorder travels within families with a focus on gene-related transmission.
- The effect of parental exposure to trauma on psychiatric outcomes in the next generation with insights for example, from stress regulation in children of war veterans, independent of children's direct exposure to significant life stressors.
- Fetal programming studies where the uterus can be understood as the first experience of/exposure to relationships.

3.3 Exposure to Early Adversity: Home and Community

The term Adverse Childhood Experiences (ACEs) is used to describe and define a wide range of stressful or traumatic experiences that babies, children and young people can be exposed to whilst growing up.[15] The term was first introduced as part of the American Adverse Childhood Experiences Study[16].

The dose response effect of exposure to more than four of the sentinel markers leaves people at greater risk of poorer physical and mental health, and of health behaviours, that can compromise wellbeing, including problematic alcohol and drug use, being at risk of, or a victim of violence or mental illness and being at higher risk of suicide. Whilst these relationships are understood as correlations, the causal mechanisms have yet to be understood in full. A wide of range of cross-disciplinary research strands are beginning to establish these with optimism of more to follow. These will inform new and complement existing programmes and interventions to offset the pervasive impact of early adversity across people lives.[17]

The Scottish Heath Survey (2019) looked at the population prevalence of adverse childhood experiences in Scotland for the first time. The survey found just over one in seven adults reported four or more ACEs, some 15% of the population. The most common reported experiences were verbal abuse, 47%, physical abuse, 28%, household domestic violence, 24% and parental separation, 23%.[18]

For people living in more deprived areas of Scotland, there was doubling of risk of having experienced more than four of the sentinel markers childhood adversity, with 11% of people in the least deprived communities compared to 20% in the most deprived. Noting these disparities, the burden of adverse experiences across the whole population is not insignificant, the more so when the influence on mental health and wellbeing is better understood.

In NHS Ayshire and Arran this translates a distribution of exposure to childhood adversity across SIMD quintiles as detailed in Table A.

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[14] Intergenerational psychiatry: a new look at a powerful perspective - Duarte - 2020 - World Psychiatry - Wiley Online Library

[15] https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf

[16] Felitti V et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *Am J Prev Med* 1998; 14:245–258. Available from: https://doi.org/10.1016/S0749-3797(98)00017-8

[17] Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity | The National Academies Press (nap.edu)

[18] Scottish Health Survey 2019 - volume 1: main report - gov.scot (www.gov.scot)

Table A

	SIMD					
	1	2	3	4	5	Total
Population	110,249	90,284	65,265	53,236	50,616	369,650
Population 18+	89,739	73,488	53,124	43,333	41,200	300,884
Percentage with 4 or more ACEs	20%	17%	13%	15%	11%	16%
Adults with 4 of more ACEs	17,948	12,493	6,906	6,500	4,532	48,379

Estimates for population from NRS and the Percentage of Adults with 4 or more ACEs, as per Scottish Health survey.

Censuses in 2018 and 2019 of children and young people, in secure care in Scotland[19][20], indicated that 64% of children and young people had encountered more than four adverse childhood experiences in 2018, and 74% in 2019. Such data indicates the burden of adversity for care-experienced individuals and associated risks for mental health and wellbeing, mental illness and disorder and suicide risk. Care experience is not currently reflected in suicide statistics with no evidence of discussion in preparing this report identified since 2013.[21] [22]

A population study in Wales (2018)[23] looking at resilience factors and adversity in childhood concluded that experience of more than four adverse childhood experiences 'substantially increased risks of mental illness'. Compared to individuals with no experience, adults were 3.7 times more likely to be currently receiving treatment for mental illness, 6.1 times more likely to have ever received treatment for mental illness and 9.5 times more likely to have ever felt suicidal or self-harmed. A representative population study in the United States[24] concluded that the accumulation of adverse childhood experiences increased the odds of suicide ideation and attempts: 'compared to individuals with no experiences of childhood adversity the odds of seriously considering suicide, or attempting suicide in adulthood, increased more than threefold among those with three of more adverse childhood experiences'.

3.4 Toxic Stress

Adversity can be understood as a stressor and not all stress is bad: some stress is needed for healthy growth and development. Stress also indicates the presence of risk and threat that can be protective, even lifesaving. Over time, the human basic threat

[19] https://www.cycj.org.uk/wp-content/uploads/2020/07/ACEs-Places-and-Status.pdf
[20] ACEs, Distance and Sources of Resilience (cycj.org.uk)v
[21] Care Inspectorate reports on deaths of looked after children
[22] Understanding suicide and self-harm amongst children in care and care leavers | Iriss
[23] Sources of Resilience and their moderating relationships with harms from adverse childhood experiences (2018) www.wales.nhs.uk/sitesplus/documents/888/ACE & Resilience Report (Eng_final2).pdf
ACEs, Distance and Sources of Resilience (cycj.org.uk)
[24] Associations of adverse childhood experiences and suicidal behaviours in a U.U nationally representative sample. Martie p Thomson J B Kingree Dorian Lamis Child Cre Dev.2019;45(1):121-128 Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample - PubMed (nih.gov)

response evolved because of the presence of predator species that have since declined, even as other threats to survival have emerged.

For humans, stress can be experienced from conception, where the growing fetus is shaped by the mother's cortisol and adrenalin through the placenta, to the last moments of life where nurturing end of life care is understood to support a good death. Too much stress, particularly for infants, children and young people can be harmful and have a powerful influence on their growth and development. The effect can be greater during what are understood as time sensitive developmental windows. Infants set up their primary stress response (taken across life) at 6-12 months, speech and language development is established by 15 months and primary attachment styles by 24 months. These inform the core skills and competencies that underpin how children, young people and adults learn to navigate life, relationships, learning, work and the associated pressures and opportunities of the day-to-day, throughout their lives (resilience). These are the skills that support friendships and peer/workplace relationships, engagement with school and learning and reduce the likelihood of developing clinically defined anxiety and depression and related/escalating mental health conditions.

The United States National Scientific Council on the Developing Child[25] proposed the following taxonomy to describe 3 categories of stress experience: positive, tolerable, and toxic, that can affect the development of children and young people.

Positive stress is characterized by moderate, short-lived increases in heart rate, blood pressure, and stress hormone levels. This can be understood as a normal part of healthy development, in the presence of relationships that are experienced as safe and containing. These create the conditions for the stress response to return to normal. This could be a childhood immunisation or a toddler who is frustrated and angry/overwhelmed who is comforted and reassured by a parent.

Tolerable stress refers to a physiological state where there could be physiological effects that are harmful, but exposure is time-limited and there are adults who confer safety and support that allow the stress response to return to normal. In these circumstances the likelihood of a developing brain being impacted or damaged is reduced, as are the wider effects that the brain influences.

Toxic stress, where strong, frequent, and/or prolonged activates the body's stress-response systems, where there are no adult relationships/support that can buffer the impact. This can occur in circumstances of extreme poverty, enduring physical and emotional abuse and, or, chronic neglect and family violence. In these circumstances, the growing brain can be impacted and other bodily systems (nervous, immune, metabolic, endocrine, genome mechanisms) are impacted through an overactive stress response that can be triggered at a lower threshold across life, with enduring effects and impacts.

[25] National Scientific Council on the Developing Child. Excessive Stress Disrupts the Architecture of the Developing Brain. Working Paper 3. 2005. http://www.developingchild.net/pubs/wp/Stress

3.5 Attachment

''Attachment is the biological need for relationships that all human beings are born with. It is especially important in the early years of life because it shapes the ways our brains and bodies handle emotions.''[26]

The importance of adult relationships that confer safety to infants, children and young people can be understood as key to mitigating the impact of all types of adversity. Infants seek connections and a relationship from the moment they are born. Relationships can be understood as relational food that creates and sustains the emotional life of the infant as they grow and develop.

The primary relationship template, taken through life, is established in infancy and crafted between the infant and parent interactions within family settings and community environments.

For many months, even years, human infants and children are completely dependent for survival on the primary adults (parents and care-givers) in their lives. Attachment can be understood as a fundamental evolutionary survival strategy. Experiences of these very early relationships are wired into the developing brain as the infant experiences their developing world as safe, predictable and secure, or not. How parents understand and are supported to understand and respond to the cues from their infant sits at the heart of the attachment experience. When a baby seeks eye contact, cries with the discomfort of a wet nappy or from hunger, these are the cues: the invitation is there, for the parent to respond. This is understood as serve and return. While there are many situations where the parent might not respond (return) as the infant expects or wants, there are many opportunities to repair any disconnection with the key being the repair to a disrupted interaction: that is the experience that is wired into the infants developing brain circuits. This understanding helps takes away any guilt or shame that parents feel when an infant is distressed even as they seek to reassure.

As such, infants, grow, develop and adapt in the context of the relationships they experience. These early relational experiences create what is understood as an internal working model, a mental representation of the world, of self and others. This shapes how infants, children, young people and adults predict, respond, control and manage or manipulate their interactions with others, how relationships are created and sustained, underpinning our relationships with self and others. From toddlerhood, through to the later years of life.

The capacity and skill of adults to provide a sense of safety and security for infants is informed, in turn, by their own style of attachment and the relational skills and capacity they bring to being a parent.

Awareness of the attachment system and the nature of different attachment styles (secure, anxious, resistant, avoidant or disorganised) brings additional insights in how the experience of early relationships informs the way people relate to themselves and each other, acquiring the skills to make sense of emotions, relationships and critically,

[26] https://suzannezeedyk.com/attachment-suzanne-zeedyk/

mediate internal distress. The legacy of primary attachment relationships are taken into adult relationships, informing personal relationships as well as wider relationships in the home and work and community.

When there is prolonged disruption to these primary relationships and in the absence of repair, there can be a physiological/biological impact that can be problematic, resulting in social, cognitive and emotional difficulties across life. These can leave individuals vulnerable in their relationships with their parents/primary care-givers, poor relationship skills with peers and at school, impulsivity and anger, learning difficulties and children lacking a coherent sense of self.

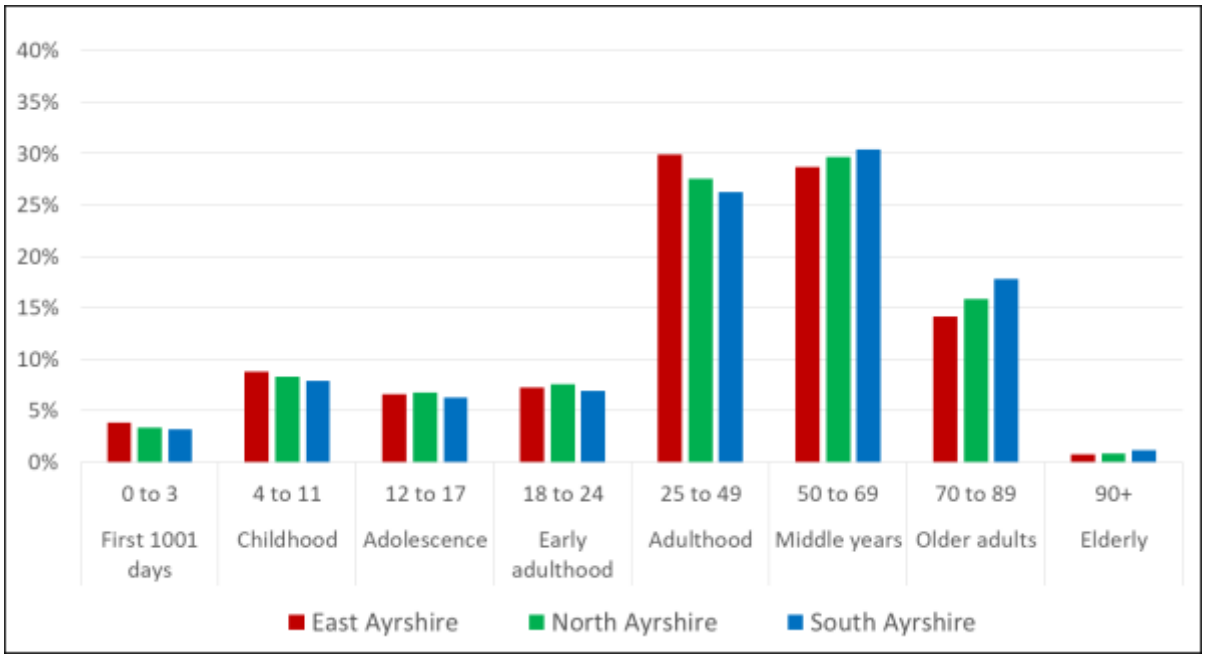
The greatest impact can be where there is an inability to show care for others with little regard for the consequences of their actions on others. These difficulties can also be understood through a lens of psychopathology.

The mental health and relationship consequences of significantly disrupted attachment experiences can be understood in the context of escalating mental health needs, diagnosable mental illness/disorders, addictions and problematic drug and alcohol use and related suicide events. Often these challenges occur alongside homelessness and involvement with police and justice systems.

Section 4: Demography

Understanding the profile of a population, age distribution and profile over time informs an understanding of a population's needs, and related decisions required, for the allocation of resources to meet those needs.

Figure 1: Life-course Stages as a Percentage of Total Population by Partnership Area, 2021



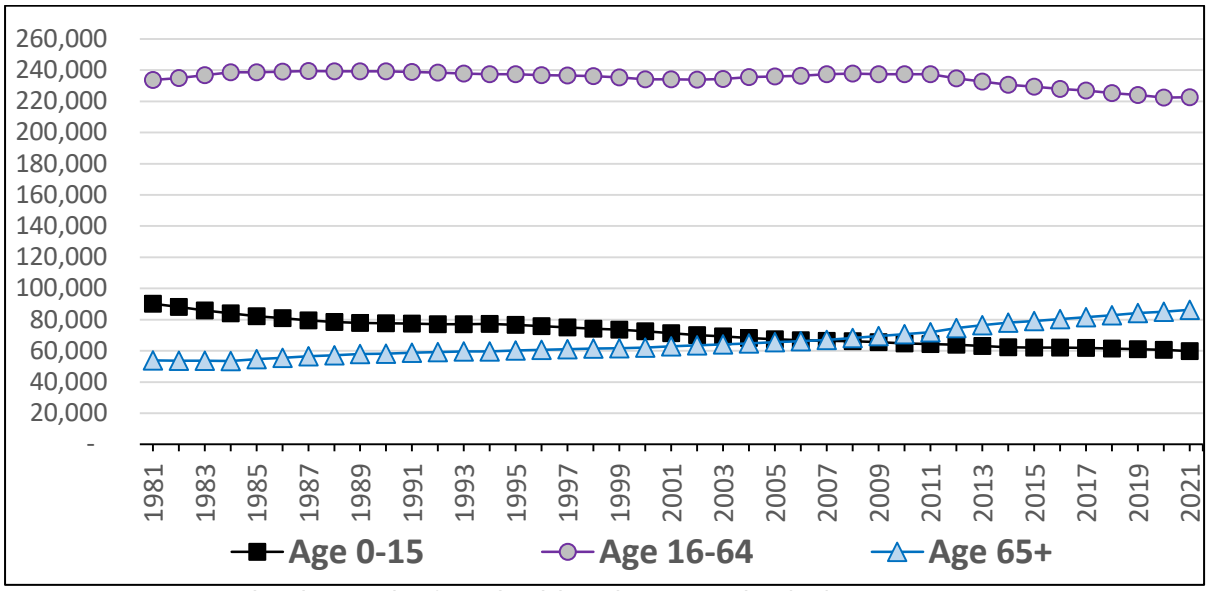
DATA SOURCE: National Records of Scotland (NRS); accessed 01/06/23

Figure 1 shows population statistics by life-course stages for the three local partnership areas in 2021.

The majority of the population are in the range 25 to 69 years (*i.e., adulthood and middle years*) across the three geographical areas.

East Ayrshire has highest representation for age groups in the range 0-11 years old (*i.e., first 1001 days & childhood*) and 25-49 years old (*i.e., adulthood*) while North Ayrshire has the highest representation for age groups in the range 12-24 years old (*i.e., adolescence & early adulthood*). Meanwhile South Ayrshire has the highest representation for all age groups over 50 years old (*i.e., middle years, older adults & elderly*). In essence, East and North Ayrshire populations are relatively younger than South.

FIGURE 2: Mid-year Population Estimates by Selected Age Groups, Ayrshire & Arran, 1981-2021



DATA SOURCE: National Records of Scotland (NRS); accessed 01/06/23
Population Estimates Time Series Data | National Records of Scotland (nrscotland.gov.uk)

Figure 2 shows population changes in Ayrshire and Arran from 1981 to 2021 for three selected age groups: age 0-15, age 16-64 and age 65 or over. Of note are the following observations:

The mid-year population estimates for numbers of children aged 0-15 in Ayrshire and Arran fell from 90,219 in 1981 to 59,927 in 2021. This represents an absolute decrease of more than 30,000 children and a relative one of 34% (a third). The decline in this age group has been fairly steady over the last four decades and looks set to continue.

Over the same period, the population estimates for working-age adults (aged 16-64) fell modestly from 233,655 in 1981 to 222,533 in 2021. This represents an absolute decrease of over 11,000 and a relative one of 5%. The decline in the trend for this group began at the start of the 2010s.

Meanwhile, population estimates for older people aged 65 or above show a contrasting rise over time compared to younger groups, rising from 53,970 in 1981 to 86,230 in 2021. This represents an absolute increase of more than 32,000 and a relative one of 60% (almost two-thirds). The rapid increase in this group has been a persistent trend over the last four decades and looks set to continue.

The demographic data indicates the shifts to an ageing population. The mid-year population estimates for children aged 0-15 first surpassed that of older people aged 65+ in the year 2008 (as evidenced in Figure 2). While trends for the three local partnership areas largely reflect the NHS Board-wide pattern, the turning point when numbers of older people exceeded that of children was the year 2000 in South, 2010 in North, and 2012 in East Ayrshire. The rate of ageing has been fastest in South and slowest in East, however, the changes are clear with associated implications for planning and demand on services in an increasingly public sector resource-constrained environment.

These changes in demography bring challenges to decision-making and investment in prevention. A preventive health approach seeks to maximise the benefits of whole population approaches (primary prevention) where small contributions can produce scale effects (school cultures and ethos[27]/tobacco cessation advice in primary care[28]). It asks that the component parts of a wider system of services, and care, understand and seek to maximise the opportunities to support health (physical and mental) as a resource for life, by working together in a myriad of different ways, improvements in health and experiences of health and other services will benefit individuals and populations.

The contributions services make to a preventive approach to mental health, as a resource for life and mitigating the impact of mental illness/disorder, cannot be underestimated. This can be directly through the provision of services that are informed about and understand the challenges of scarce financial resources in family and community life, as well indirectly by facilitating resilience when people are met at their point of need.

While it is recognised that the best preventive spend is in the first years of life (pre-birth to 3 years), with related enhanced opportunities to address early life adversity to the age of twenty-five years, the demands on health care are often orientated around an ageing and frailer population with multiple long-term conditions. For NHS Ayrshire and Arran, this is compounded by very high levels of deprivation and disadvantage over previous decades that influences family and community life.

[27] Nurture and trauma-informed approaches: A summary of supports and resources | Resources | National Improvement Hub (education.gov.scot)
[28] Helping Smokers to stop smoking (healthscotland.scot)

Section 5: The Nature of the Challenge

5.1 Community

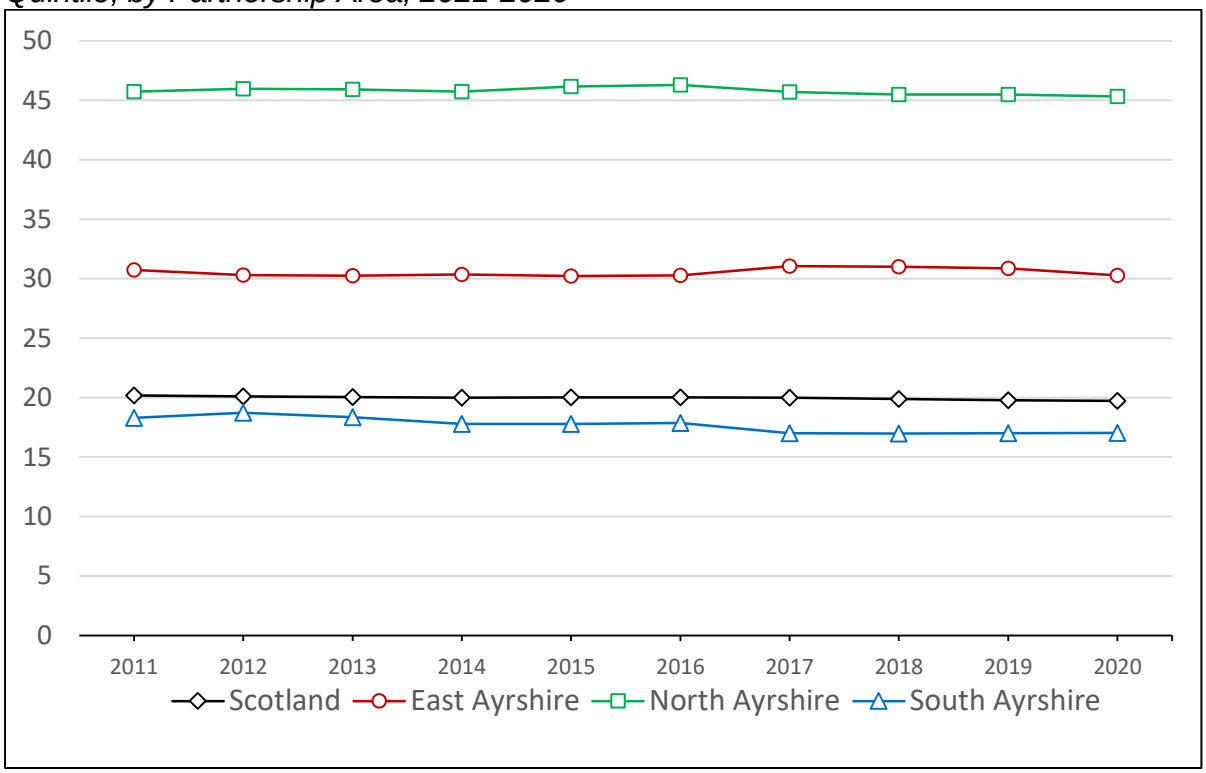
A life-course approach to mental wellbeing and mental illness/disorder brings a broader lens of understanding as to the nature and origins of the mental health need for individuals, families and communities. Rather than the difficulty being located in the individual alone, there can be a wider understanding of what contributes, helps or hinders needs and what related contributions to preventive approaches might be. The resources that communities have at their disposal and related challenges, where there is scarcity or inequality, influence the creation and sustaining of health as a resource for life and across the lifespan. Community resources and strengths interface with family and individual needs in the same way vulnerabilities also have influence.

Understanding the tensions between assets and vulnerabilities informs the way mental health and risks, in relation to mental illness/disorder, can be mitigated and managed to best effect and outcome within family and community life.

Inequality in health outcomes often reflects income inequality and related opportunities to meet basic needs with regard to income, housing and food as well as leisure and recreation. These factors with others are key to developing and sustaining resilience as children grow and develop and across the lifespan and as adults face challenges through their lives.

Insecurity of income can be understood as undermining the ability of a person to meet their or their family's basic needs, such as a home and food, while at the same being a challenge to a person's self-worth and efficacy. This can influence family wellbeing by parents being distracted and less able to be available and attuned to the needs of their children, or there being conflict and distress between parents that impacts children's growth and development. Children who are hungry and/or experiencing damp cold housing will be less able to learn, while their overall growth development and cognitive functioning can be impacted. Furthermore, income inequality results in an inequality in access to activities, social opportunities and clubs which promote positive wellbeing and, without which, can result in potential exclusion and lower attainment.

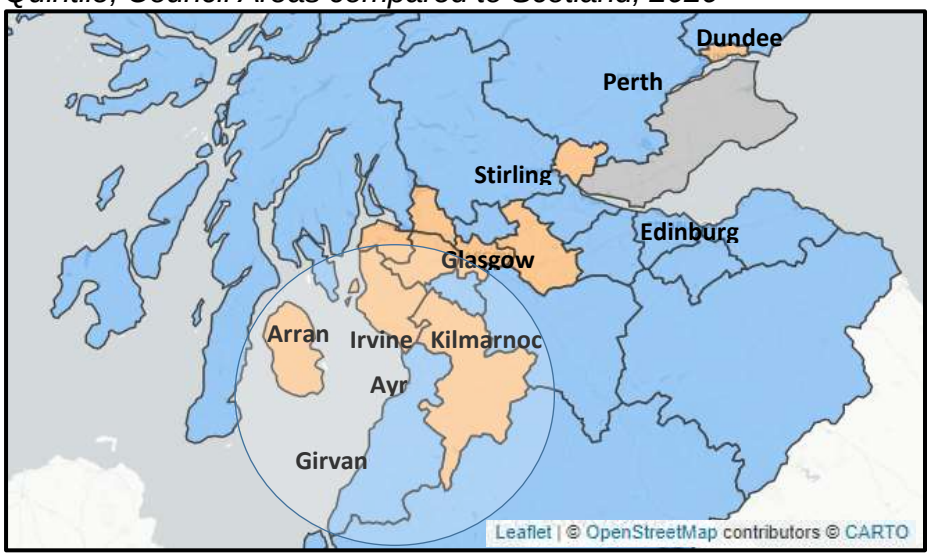
Figure 3: Percentage of Young People aged 0-25 Living in the Most Income-deprived Quintile, by Partnership Area, 2021-2020

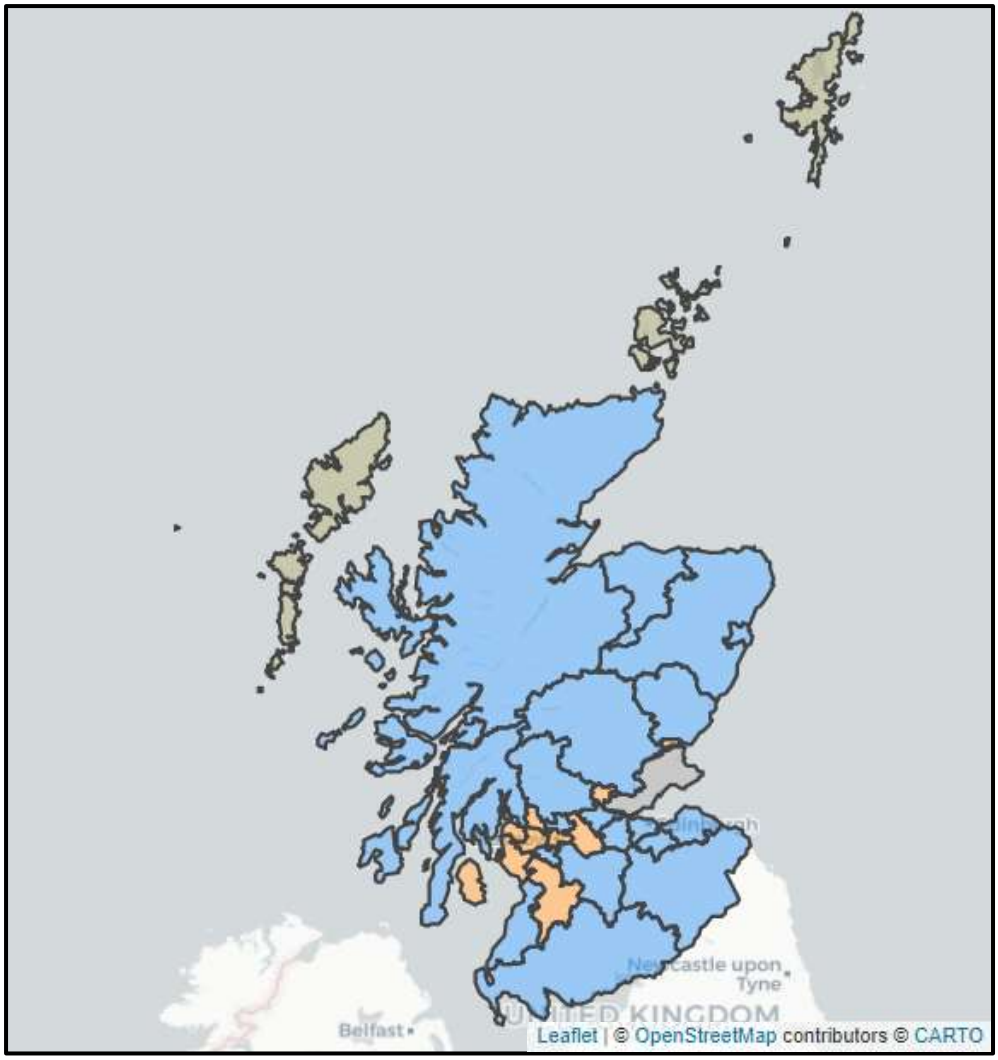


DATA SOURCE: SIMD 2016, Scottish Government and Public Health Scotland
PROVIDER: ScotPHO; accessed 01/06/23

These challenges can be demonstrated by consideration of Figures 3 and 4. Figure 3 shows the percentage of young people aged 0-25 within local partnership areas, and Scotland as a whole, who are living in the 20% most income-deprived areas in Scotland, from 2011 to 2020. [In life-course terms: age 0-25 includes the first 1001 days, childhood, and adolescence, along with the first year – i.e., age 25 - of early adulthood.]

Figure 4: Percentage of Young People Aged 0-25 Living in the Most Income-deprived Quintile, Council Areas compared to Scotland, 2020





DATA SOURCE: SIMD 2016, Scottish Government and Public Health Scotland
PROVIDER: ScotPHO; accessed 01/06/23

MAP COLOUR KEY:
Significantly better than Scotland
No different to Scotland
Significantly worse than Scotland
No differences can be calculated

Figure 4 compares, against Scotland as a whole, all Scottish council area reports in 2020 for percentages of young people living in the 20% most income-deprived parts of Scotland.

The data indicates that relatively greater percentages of young people (aged 0-25) living in East and North Ayrshire live in the 20% most income-deprived parts of Scotland, compared to their South Ayrshire counterparts. East and North rates have been consistently above the national comparator in the last decade, and the South rate just below the Scottish average.

In 2020, rates were as follows (in increasing order): 17.0% in South Ayrshire, 19.7% in Scotland, 30.3% in East Ayrshire, and 45.3% in North Ayrshire. This equates to about 3 in 20 young people in South, compared to 4 in 20 in Scotland, 6 in 20 in East and 9 in

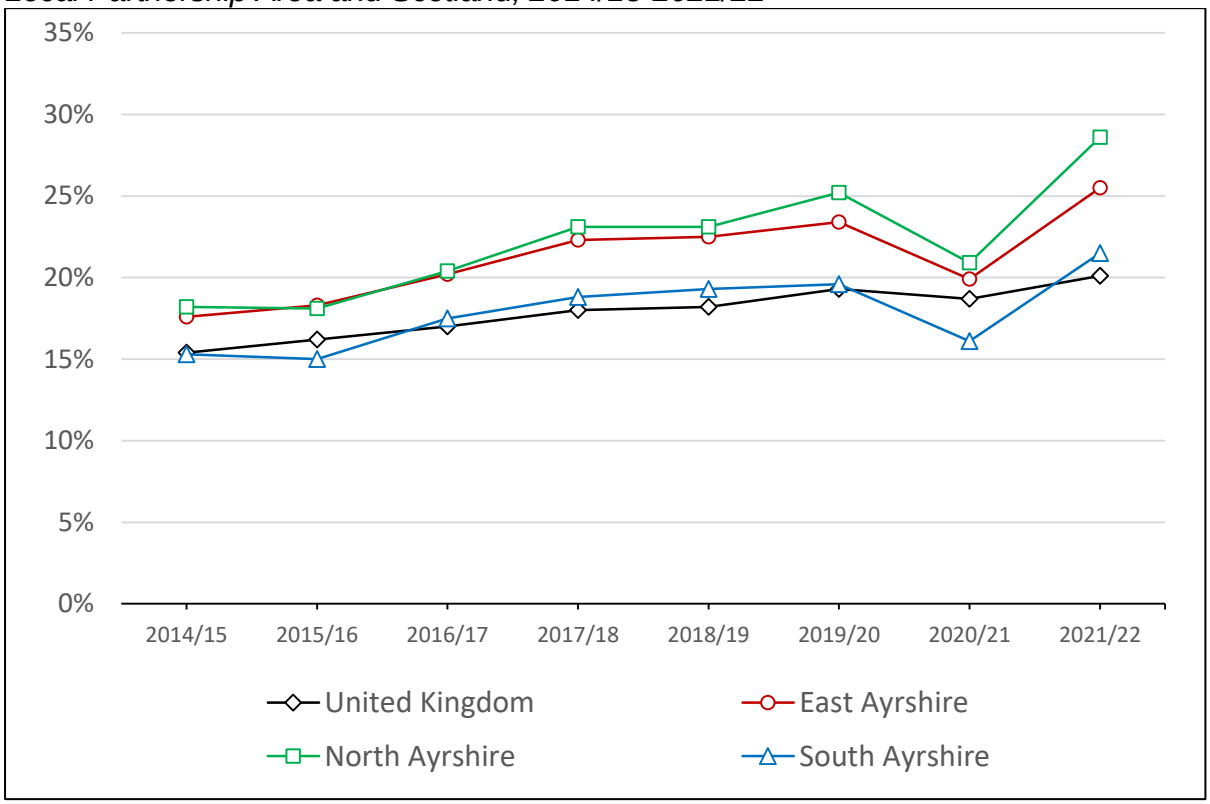
20 in North living in the most income-deprived parts of Scotland. The disparity between North and South is pronounced, with about three times as many young people in North than South living in the most income-deprived parts of Scotland. The number of young people in North Ayrshire is twice as high as the rate for Scotland.

In 2020, the East (30.3%) and North (45.3%) figures were significantly worse (higher) than the national average (19.7%), while that of South (17.0%) was significantly better (lower) than the national comparator.

The challenges within North and East mirror a cluster of council areas in the West of Scotland with comparatively higher proportions of young people living in income-deprived areas. These areas, with rates significantly above the Scottish average, include East and North Ayrshire, Glasgow City, Inverclyde, North Lanarkshire, West Dunbartonshire, and Renfrewshire. Other council areas with rates significantly above the Scottish average include Clackmannanshire and Dundee City.

In addition to understanding the levels of community challenges for young people growing up in NHS Ayrshire and Arran are the challenges for those to the age of 15 where families have relatively low incomes, as detailed in Figure 5. This details the percentage of children aged 0-15 living in relative low income families in East, North and South Ayrshire, and in the UK as a whole, from 2014/15 to 2021/22. [In life-course terms: age 0-15 includes the first 1001 days and childhood, along with the first four years of adolescence – i.e., from age 12 to 15.]

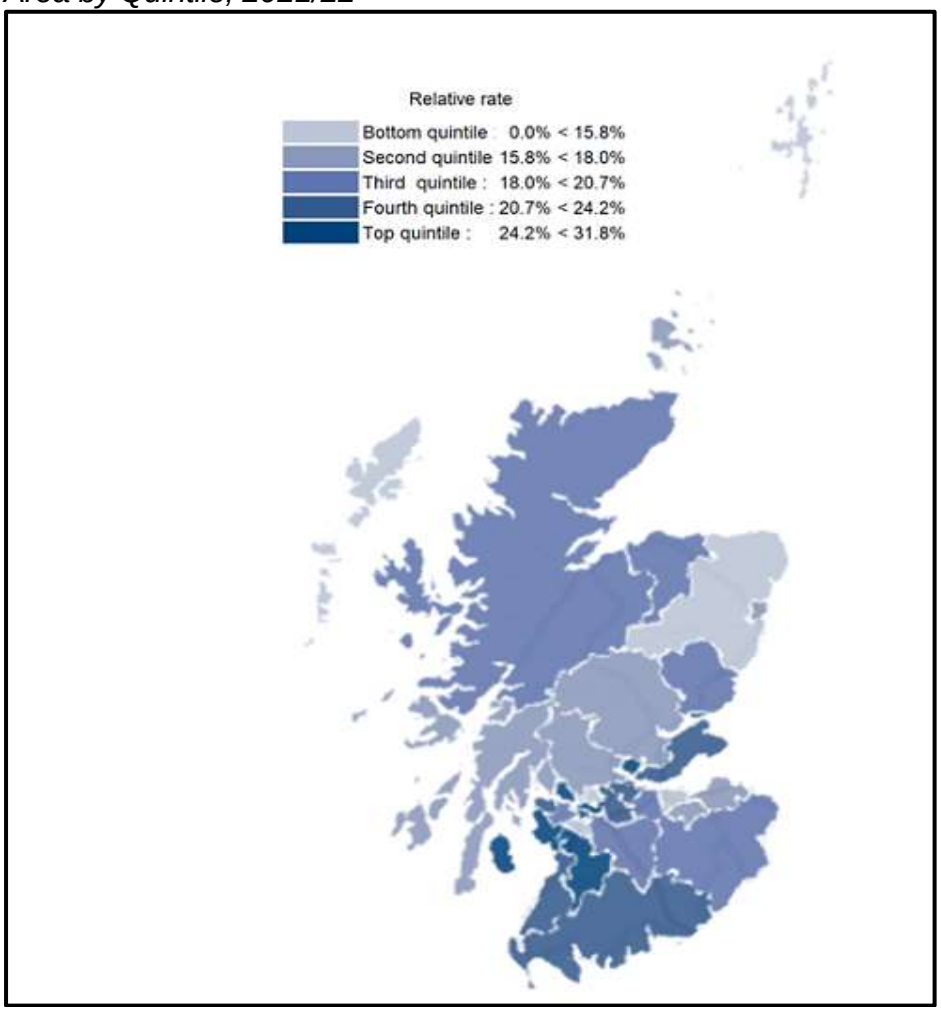
Figure 5: Proportion of Children Aged 0-15 Living in Relative Low Income Families, by Local Partnership Area and Scotland, 2014/15-2021/22



DATA SOURCE: Department for Work and Pensions; accessed 31/05/23
PROVIDER: UK Government
Children in low income families: local area statistics 2014 to 2022 - GOV.UK (www.gov.uk)

DATA DEFINITION: Relative low income is defined as a family in low income *Before Housing Costs* (BHC) in the reference year. A family must have claimed Child Benefit and at least one other benefit (Universal Credit, Housing Benefit, tax credits), at any point in the year, to be classed as low income in these statistics.

Figure 6: Children Aged 0-15 Living in Relative Low Income Families, Scottish Council Area by Quintile, 2021/22



DATA SOURCE: Department for Work and Pensions; accessed 31/05/23
PROVIDER: UK Government
Children in low income families: local area statistics 2014 to 2022 - GOV.UK (www.gov.uk)

Council Area in Scotland	Measure
Glasgow City	31.8%
North Ayrshire	28.6%
Clackmannanshire	25.9%
East Ayrshire	25.5%
West Dunbartonshire	25.5%
Dundee City	24.5%
North Lanarkshire	24.1%
Dumfries and Galloway	23.7%
Fife	23.2%
Falkirk	21.8%

South Ayrshire	21.5%
Inverclyde	21.3%
Angus	20.6%
Moray	20.4%
Renfrewshire	20.0%
West Lothian	19.9%
Scottish Borders	19.7%
South Lanarkshire	19.4%
Highland	18.9%
Perth and Kinross	17.9%
Argyll and Bute	17.8%
Midlothian	17.7%
Stirling	16.6%
Aberdeen City	16.4%
East Lothian	16.1%
Orkney Islands	16.0%
Na h-Eileanan Siar	15.7%
City of Edinburgh	14.6%
Aberdeenshire	12.1%
Shetland Islands	11.6%
East Dunbartonshire	11.0%
East Renfrewshire	10.9%

Figure 6 categorises, into quintiles, Scottish council area reports in 2021/22 for estimated percentages of children aged 0-15 living in relative low income families (see map legend for details). Percentages presented in the corresponding data table are shaded in accordance with the scheme displayed in the map.

Overall, there has been an increase, at local and UK-wide levels, in proportions of children aged 0-15 living in relative low income families. Increases from 2014/15 to 2021/22 were steeper locally than nationally: the absolute percentage increases over this period were a 6.2% rise in South Ayrshire, 7.9% in East and 10.4% in North, compared to only 4.7% in the UK as a whole. In all areas, steady increases over time were interrupted by a temporary dip in 2020/21 before a sharp upward swing again in 2021/22. The impact of furlough and other financial supports, such as the uplift to the Scottish Child Payment, extended to families by the UK Government during COVID-19, likely explain the dip observed in 2020/21.

From 2014/15 to 2021/22, rates in North and East Ayrshire have consistently sat above the UK average, while those in South have been mainly on a par with the rest of the UK. In current times, 2021/22, proportions of children aged under 16 living in relative low income families were as follows (in order of magnitude): 20.1% in the UK, 21.5% in South Ayrshire, 25.5% in East (just over a quarter), and 28.6% in North (nearly a third).

In 2021/22, rates for all council areas based in Ayrshire and Arran were among the eleven highest (of 32) reported in Scotland. South was ranked eleventh highest, East fourth and North second. East and North figures occupied the top quintile of reports, along with those of Glasgow City, Clackmannanshire, West Dunbartonshire, and

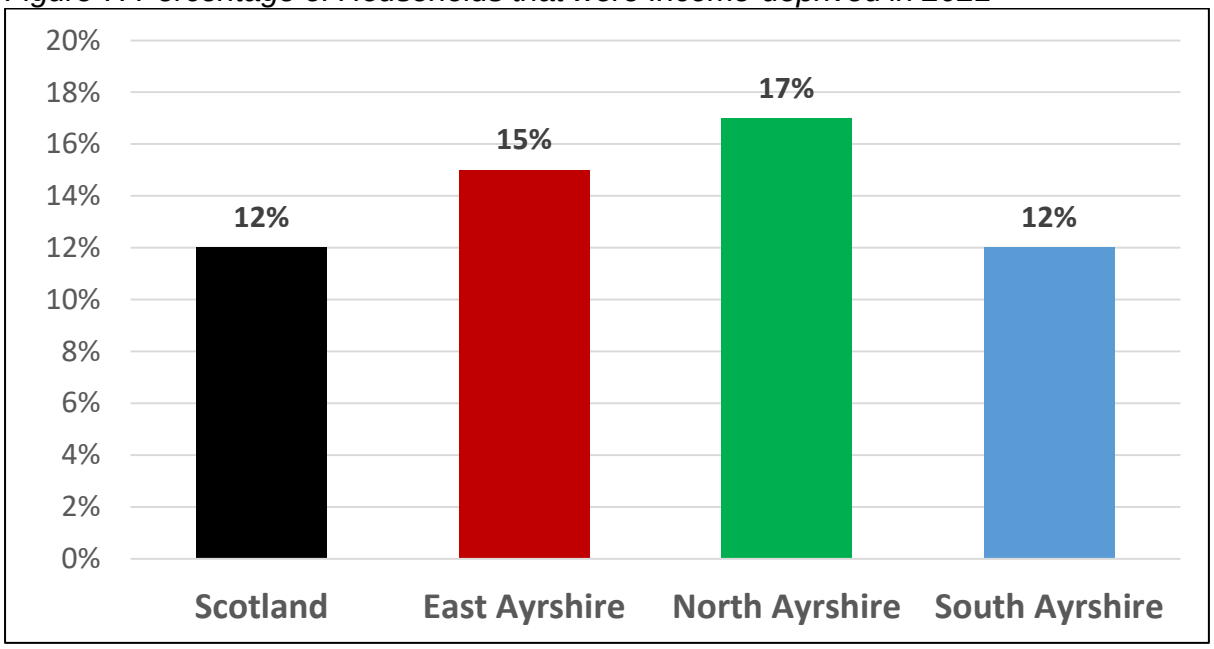
Dundee City. South Ayrshire, though not included in the top quintile, made the second top quintile.

Children in households with relatively low incomes echo those for percentages of young people aged 0-25 living in the most income-deprived quintiles in Scotland (see above), showing good correspondence between the two indicators as might be expected.

Ayrshire households living in poverty (income-deprived) where they may not be children are detailed in Figure 7. There is a similar distribution where South Ayrshire mirrors Scotland, East is greater and North is higher again.

Not all adults with mental health needs or mental illness/disorder will be parents, or in a relationship/living with parents, and there are additional financial and wellbeing challenges in running a home as a single person, where income is constrained, and where the inclination or ability to meet other people may be compromised by a range of factors.

Figure 7: Percentage of Households that were Income-deprived in 2021



DATA SOURCE: SIMD, 2022, https://www.gov.scot/publications/scottish-index-of-multiple-deprivation-2020v2-indicator-data/
PROVIDER: Scottish Government

Uptake of Universal Credit, where people's working incomes are topped up (as recorded at April 2023), are as follows:

	Claimants	Working-age population (age 16-64)	Rate (%)
East Ayrshire	4,617	75,654	6.1%
North Ayrshire	5,203	81,035	6.4%
South Ayrshire	3,665	65,844	5.6%

DATA SOURCE: https://stat-xplore.dwp.gov.uk/webapi/jsf/dataCatalogueExplorer.xhtml

More recent times have seen a growing problem with food insecurity across the UK defined as 'A person is food insecure when they lack regular access to enough safe

and nutritious food, for normal growth and development, and an active and healthy life. This may be due to unavailability of food and/or lack of resources to obtain food'.

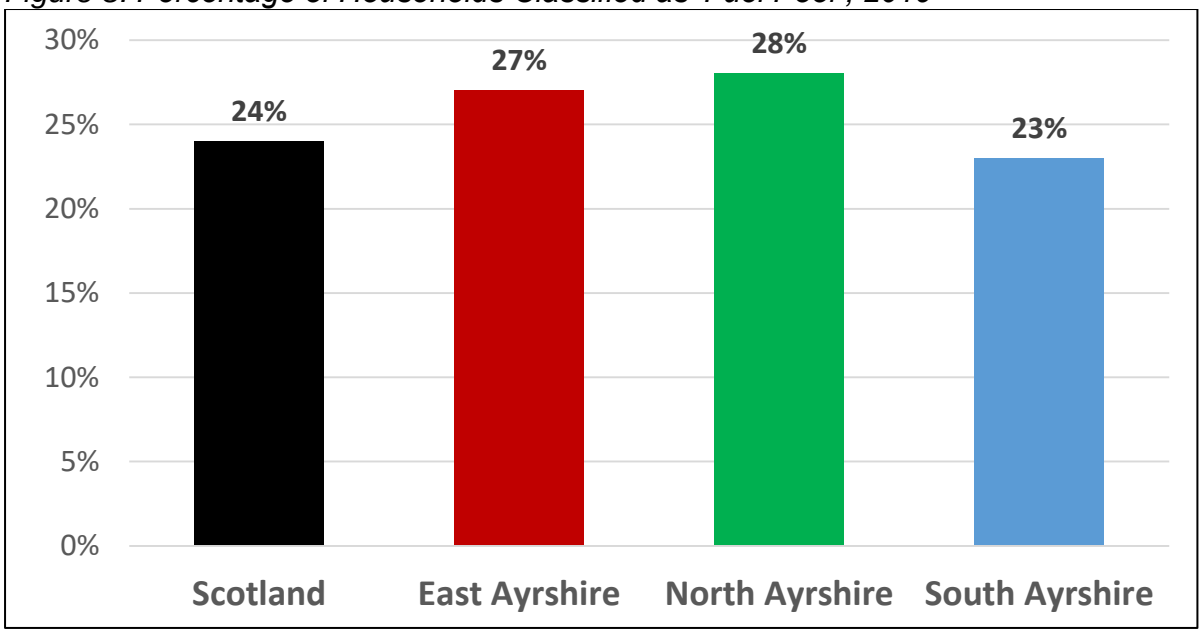
Information on food insecurity in Scotland was first collected in the 2017 Scottish Health Survey. The questions were drawn from the Food Insecurity Experience Scale developed by the UN. Individuals were asked if, during the last 12 months, there was a time when they were worried they would run out of food because of a lack of money or other resources. Across NHS Ayrshire and Arran, East Ayrshire reported the highest level of concern with 13% of the population surveyed expressing concern compared to the Scottish percentage of 9%. North Ayrshire and South Ayrshire were below this at 8% each. Given the challenges of poverty in North Ayrshire this was an interesting result that merits acknowledgment, and exploring, as to why there was less concern over food security than might have been expected.

Food insecurity may have an impact on children and their dietary behaviour if it translates as less household income, and possible corresponding inferior diet, potentially affecting children's cognitive development and more generally their mental health and wellbeing. Moreover, when parents are distracted by concerns over meeting the basic needs of their families, they arguably have less capacity to pay attention to the relational needs of their children.

In addition to food insecurity fuel poverty is also acknowledged as a pressure and risk for communities and families: 'a household is in fuel poverty if the household's fuel costs (necessary to meet the requisite temperature and amount of hours as well as other reasonable fuel needs) are more than 10% of the household's adjusted net income and after deducting these fuel costs, benefits received for a care need or disability, childcare costs, the household's remaining income is not enough to maintain an acceptable standard of living.'

The percentage of households classified as 'fuel poor' is detailed in Figure 8.

Figure 8: Percentage of Households Classified as 'Fuel Poor', 2019



DATA SOURCE: Scottish House Condition Survey, 2019
PROVIDER: Scottish Government

The challenges in community and family life, as presented in this data, demonstrates the pressures that individuals, children, young people and communities are navigating day-to-day. The burden of mental health need and related levels of mental illness/disorder can be understood as an outcome of these pressures and risks, even as there are preventive approaches that seek to mitigate risks and harms.[29]

5.2 Individual

Understanding the nature and need of long-term conditions across NHS Ayrshire and Arran gives insights on the burden of poor health within the community.

More people in Scotland are now living with one or more complex health conditions. They require more health and social care and that requirement will increase as they age. Fewer people are able to work and remain in work as a result of health problems.[30]

A long-term condition is defined as a physical or mental health condition: an illness, sickness or impairment lasting, or expected to last, 12 limiting months or more. Long-term conditions are those which cannot currently be cured, but can usually be managed with medicines or other treatments. Examples of long-term conditions include diabetes, arthritis, high blood pressure, epilepsy, asthma, sensory deficits and some mental health conditions. A long-term condition is defined as *limiting* if the respondent reported that it limited their activities in any way.

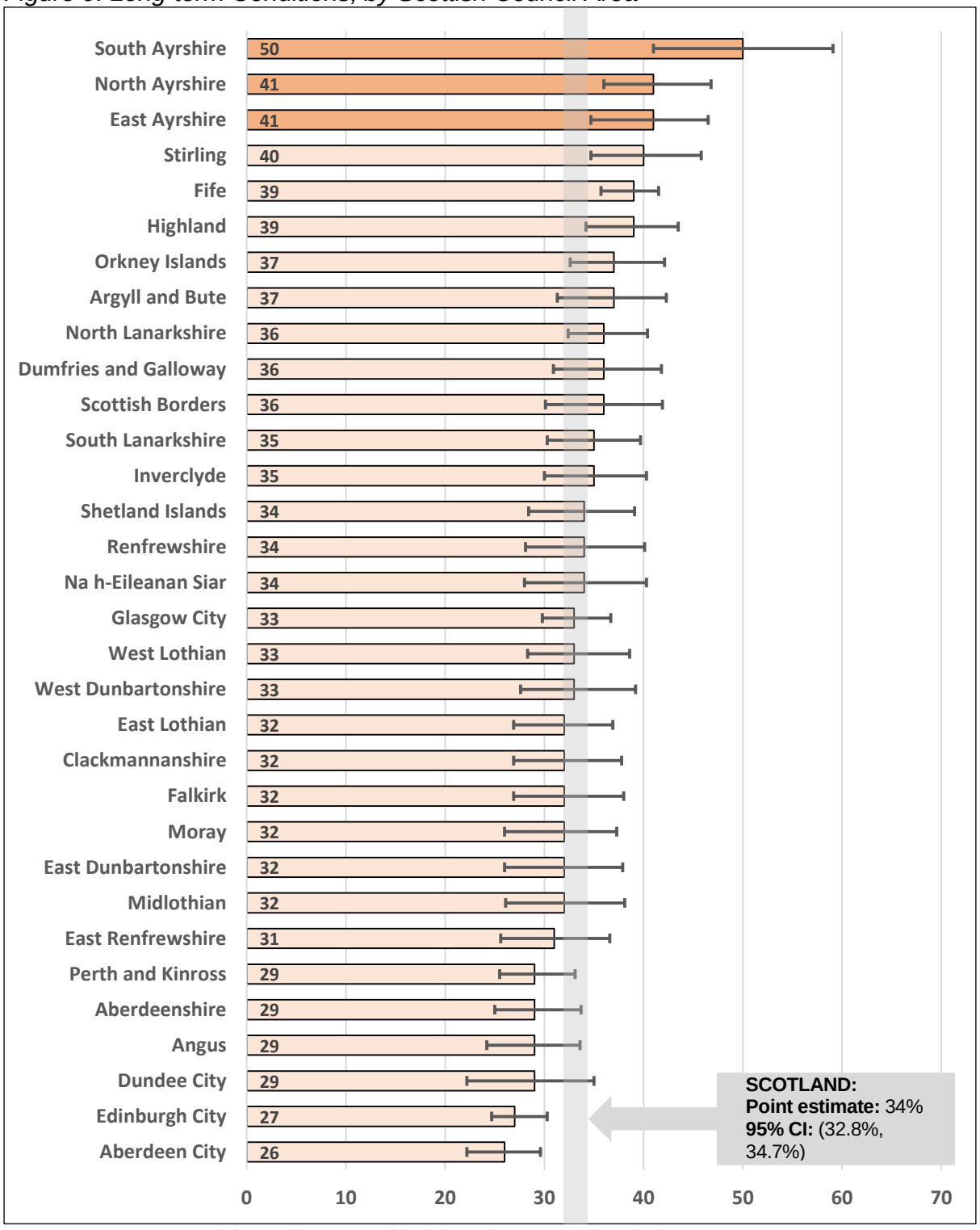
While the proportion of these results attributable to mental health conditions cannot be ascertained, it can be supposed that limiting long-term conditions will nevertheless adversely impact people's mental wellbeing, depending on the nature and severity of the condition. Long-term health conditions may also include a range of mental health diagnosis that impact an individual and their engagement and contribution to family and community life.

Conditions which can be managed well with good self-care or medical intervention (e.g., diabetes) may not be so detrimental to mental health, while other more limiting conditions (e.g., chronic pain) may have a stronger negative impact on mental wellbeing, to the point of contributing to mental illnesses such as a depression and/or anxiety that in term merit mental health service attention.

As detailed in Figure 9, among Scottish council areas, the three highest reports in 2017-21 of limiting long-term conditions were found in East, North and South Ayrshire. Local rates amount to about 4 in 10 adults in East and North and 5 in 10 in South, compared to just over 3 in 10 adults in Scotland as a whole. This represents a considerable burden of health need alongside opportunities to work across a continuum of prevention. This is where the potential of life-course approaches can be realised with the associated challenge of sustaining, if not increasing, preventive approaches across universal health and education/youth services alongside the immediate pressures of acute to community adult care and an increasingly frail and aging population.

[29] How Poverty Gets Under the Skin: A Life Course Perspective (researchgate.net)
[30] Illnesses and long-term conditions - gov.scot (www.gov.scot)

Figure 9: Long-term Conditions, by Scottish Council Area



DATA SOURCE: Scottish Health Survey (dashboard); accessed 06/06/23

5.3 Experience of Violence within the Home and Community

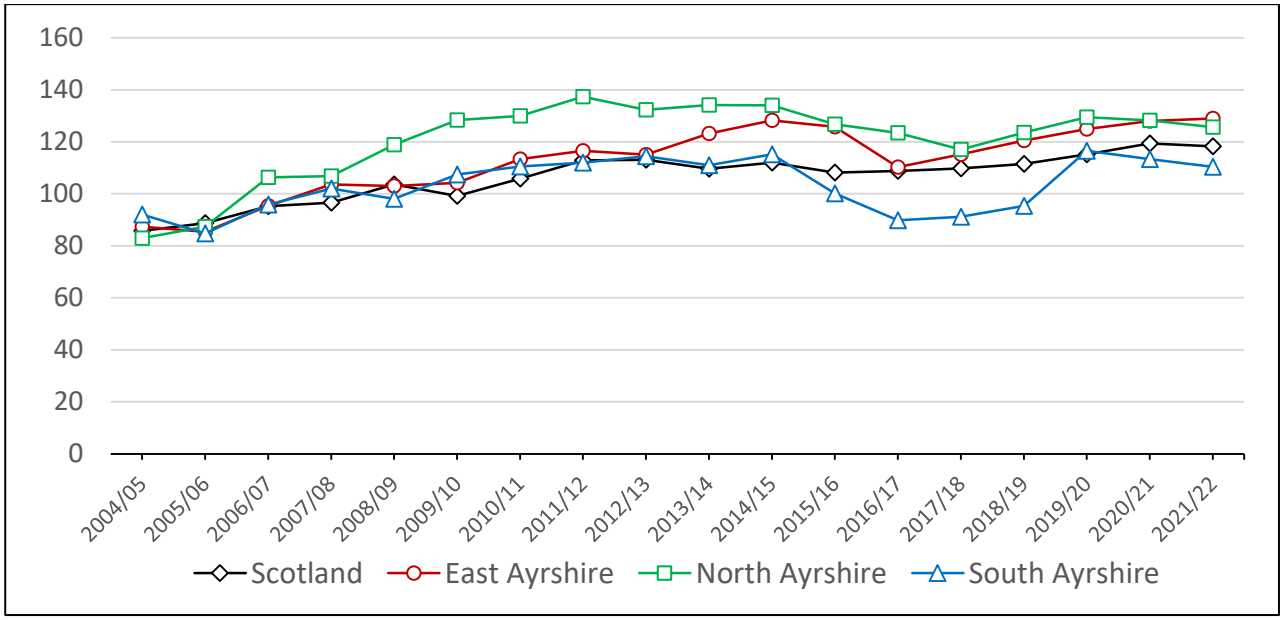
The contribution of distress, conflict and violence between family members, peers and community associates can be both a driver and a contributor to poor mental health and mental illness/disorder. It can also be very impactful on the growth and development of infants, children and young people, shaping the experience of family life in ways that might not be fully appreciated, though touched on elsewhere in this paper.

Domestic abuse data gives insight into the exposure to violence in the home, which is understood to be primarily gendered where women are the victims of male violence.

'Any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and which takes place within the context of a relationship. The relationship will be between partners (married, co-habiting, civil partnership or otherwise) or ex-partners. The abuse can be committed in the home or elsewhere, including online'. [31]

Data on domestic abuse in Figure 10 indicates crude rates recorded by the police, across the three Ayrshires, detailing that rates of domestic abuse incidents recorded have increased over 17 years, locally and nationally. This may indicate changes in police policy or practice, rather than elevated prevalence of domestic abuse, e.g., improved detection of, or focus on, domestic abuse; more rigorous recording procedures and there being greater reporting/requests for assistance, as awareness of the topic has increased and there is greater confidence in the police response. In addition, when compared with other Police Authorities, East and North Ayrshire figures were significantly worse (higher) than the Scottish figure, and the South Ayrshire figure significantly better (lower). [32]

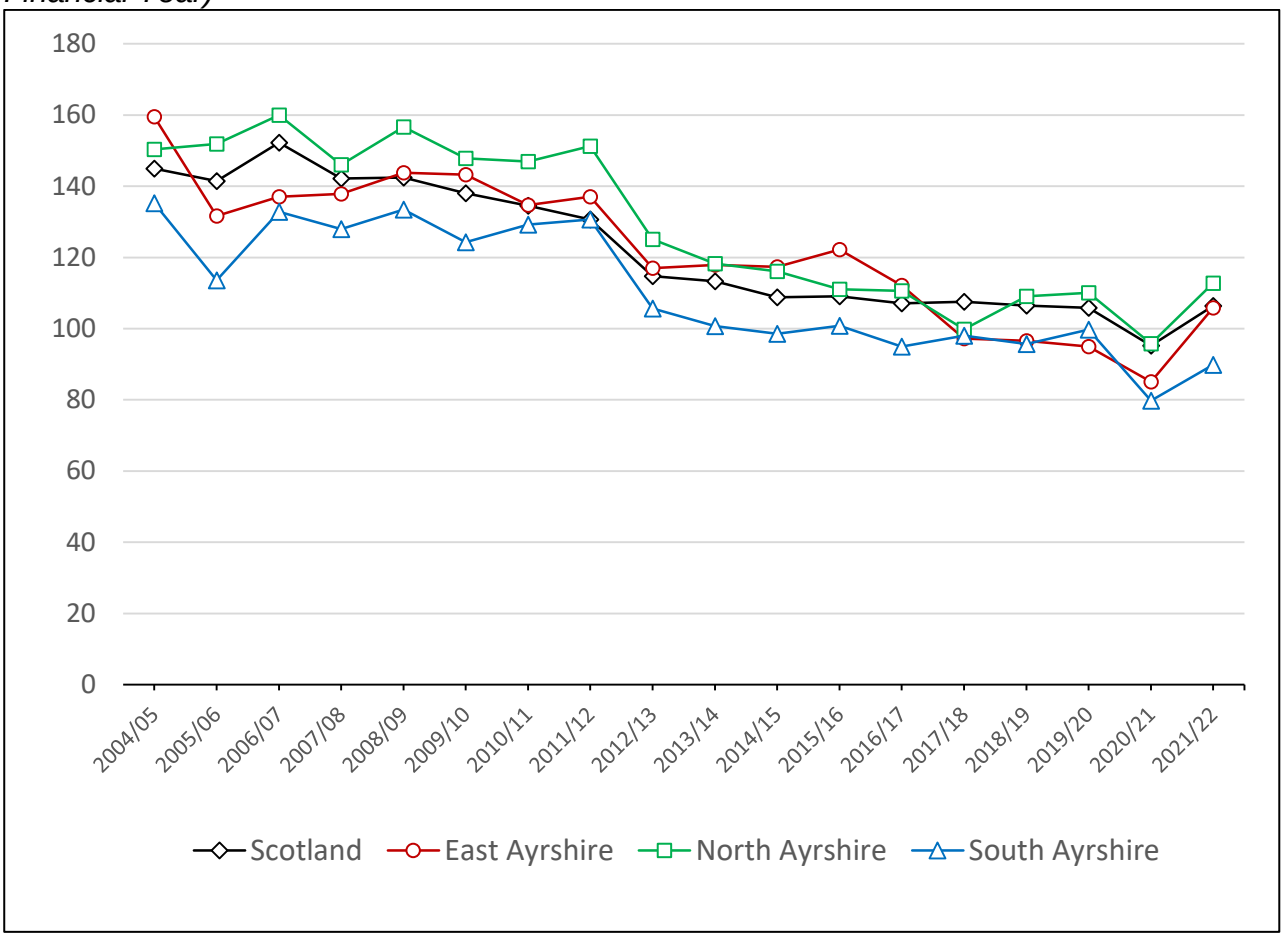
Figure 10: Domestic Abuse Incidents Recorded by the Police: All Persons (Crude Rate per 10,000, Financial Year)



DATA SOURCE: Scottish Government (Scottish Crime Statistics)
PROVIDER: ScotPHO; accessed 06/06/23

[31] Domestic abuse: statistics recorded by the police in Scotland - 2018/19 - gov.scot (www.gov.scot)
[32] Scottish Government (Scottish Crime Statistics)

Figure 11: Common Assaults Recorded by the Police: All Persons (Crude Rate per 10,000, Financial Year)



DATA SOURCE: Scottish Government (Scottish Crime Statistics)
PROVIDER: ScotPHO; accessed 07/06/23

Figure 11 shows the crude rates (per 10,000 population) of common assault recorded by the police within local partnership areas, and Scotland as a whole, from 2004/05 to 2021/22.

South Ayrshire rates have consistently sat below the national comparator over the last 17 years. Rates in North have mostly sat above the national comparator, while those in East have tended to fluctuate around the Scottish average. The current rate in North Ayrshire is significantly greater than the Scottish average. Alcohol is understood to be a feature in both domestic and community experiences of violence.

While there are current concerns in the media of increasing levels of youth violence, these have yet to be evidenced in current data recording. Local and national rates of young victims (aged 15-25) of assault admitted to acute hospitals have decreased markedly over 15 years. This may reflect changes in medical practice rather than prevalence, e.g., improved treatment of injury and avoidance of hospital bed use. It may also reflect increased reluctance among young victims of assault to attend hospital. Local and national rates have somewhat converged and levelled-off since the mid-2010s, presently ranging from 61/100,000 in East to 99/100,000 in North. The dip in 2020/2021 may be due to lockdown restrictions. This will be an area to observe over the coming months and years.

Section 6: The Nature of the Need

6.1 Children and Young People

6.1.1 Mental Health Need and Risks

Defining mental health need amongst children and young people brings challenges. The need is not in dispute; it is very real and evident. However, framing need through an illness and disorder lens runs the risk of pathologising what can be understood as normal needs being expressed, that are proportionate to experiences of primary and informative relationships (alongside life experiences to date) and the innate characteristics of each child/young person. This may include neurodevelopmental and/or learning disabilities that can bring the risk of additional mental health needs, given the additional struggles these conditions can create when needs are not understood or bring challenges of their own.

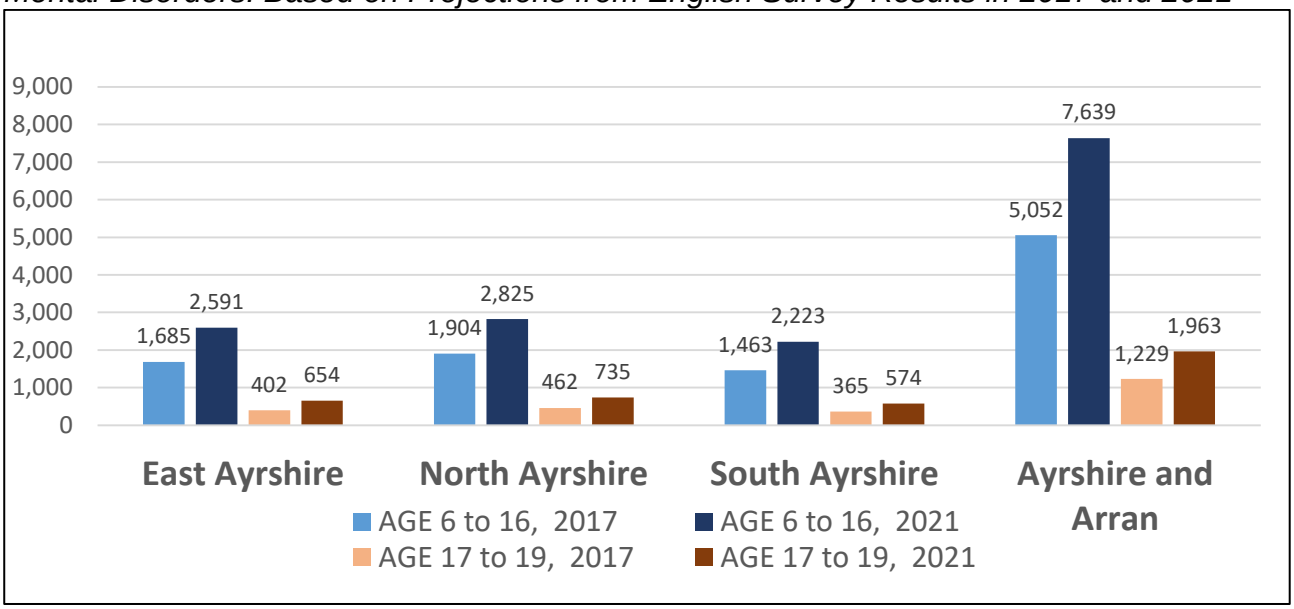
The epidemiology of mental health needs uses population data from England [i] where, in recent years, there have been two epidemiologically-informed population surveys to detail prevalence of mental health need, framed through an illness and disorder lens. There is no comparable data for Scotland. The data should be transferable within a United Kingdom context. Given rates of poverty and inequality in Scotland, a higher burden of adversity in childhood and higher levels of problematic alcohol and drug use in the figures proposed may be an underestimation of population need.

Highlights from the English survey detailing increases in need from 2017 to 2021 are in Table B and estimated numbers of young people with probable mental disorders, in Ayrshire and Arran, are in Figure 12.

Table B

HIGHLIGHT 1 - Rates of probable mental disorders have increased since 2017; in 6 to 16 year olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year olds from one in ten (10.1%) to one in six (17.4%). Rates in both age groups remained similar between 2020 and 2021.
HIGHLIGHT 2 - 39.2% of 6 to 16 year olds had experienced deterioration in mental health since 2017, and 21.8% experienced improvement. Among 17 to 23 year olds, 52.5% experienced deterioration, and 15.2% experienced improvement.
HIGHLIGHT 3 - The proportion of children and young people with possible eating problems increased since 2017; from 6.7% to 13.0% in 11 to 16 year olds, and from 44.6% to 58.2% in 17 to 19 year olds.
HIGHLIGHT 4 - Problems with sleep on three or more nights of the previous seven affected over a quarter (28.7%) of 6 to 10 year olds, over a third (38.4%) of 11 to 16 year olds, and over half (57.1%) of 17 to 23 year olds. Across all age groups figures were much higher in those with a probable mental disorder (59.5%, 74.2%, and 86.7% respectively).
HIGHLIGHT 5 - 10.6% of 6 to 16 year olds missed more than 15 days of school during the 2020 Autumn term. Children with a probable mental disorder were twice as likely to have missed this much school (18.2%) as those unlikely to have a mental disorder (8.8%).
HIGHLIGHT 6 - The proportion of 6 to 16 year olds with a laptop or tablet they could work on at home increased from 89.0% in 2020 to 94.4% in 2021. The proportion receiving regular support from school or college also increased, from 73.7% in 2020 to 79.9% in 2021.

Figure 12: Estimated Numbers of Young People in Ayrshire and Arran with Probable Mental Disorders: Based on Projections from English Survey Results in 2017 and 2021



SOURCE FOR CONDUCTING LOCAL PROJECTIONS: Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey
PROVIDER: NHS England; 2021 survey report accessed 07/06/23

The data suggests an indicative increase in need, with related demand for an increase in access to support and services within family, school and community life based on English survey results conducted in 2017 and 2021; projections onto the local population would suggest a 5-year increase of around 3,300 more young people, aged 6-19 in Ayrshire and Arran, with probable mental disorders (Table C).

TABLE C: INCREASES IN ESTIMATES OVER 5 YEARS

	Increases from 2017 to 2021 in estimated numbers with probable mental disorders		
	AGE 6 - 16	**AGE 17 - 19**	**TOTAL**
East Ayrshire	906	252	1,158
North Ayrshire	922	273	1,194
South Ayrshire	760	209	968
Ayrshire and Arran	**2,587**	**734**	**3,321**

The extent and nature of brain development across adolescence and young adulthood creates opportunities and risks. Opportunities to consolidate positive experiences in life to date and risks that innate vulnerabilities to mental health difficulties may be accentuated or become visible, shaped also, by life experiences to date and real time circumstances.[33]

6.1.2 COVID-19 Influences and Impacts

There is a recognition that the growth and development of children and young people was influenced and impacted by the COVID-19 pandemic and the requirements to manage the risk of transmission and illness.

The pandemic can be understood as having a once in a lifetime effect that will likely play out across generations.

[33] Adolescence and mental health - The Lancet

The mental health needs for children and young people appear to be increasingly challenging following the COVID-19 pandemic with notable increases in mental health need.[34] This suggests that there were influences and impacts on growth and development across age groups during this time.

It is interesting to consider through a life-course approach how changes to maternity care, and the experiences of delivery and the first months and years of being a mother, impacted the experience of the infant before being born with, for some, additional maternal stress hormones and the challenges of caring for an infant in lockdown or periods of isolation.

While for some, the requirements of the pandemic created opportunities for more meaningful time together as a family, for others, being in a confined space where adult relationships may have been under greater pressure with related financial stressors, and in the absence of usual access to school, the experiences would not have been so positive. This is in spite of the best efforts of services to mitigate the impact and risks.

The balance of risks and benefits during COVID-19 is captured in the CEYRIS [ii] surveys with some insights as follows:

Sleep
One in ten children slept better, three in ten children slept worse while six in ten children slept through the night; four in ten had difficulty in sleeping most or every night.

Sleep contributes to healthy growth and development providing time for the body and brain to rest and undertake repairs. Poor sleep contributes to distressed behaviours and difficulties with concentration and impulsivity.

Behaviour and Mood
One in ten children behaved better whilst five in ten had worse behaviour.
One in ten children had a better mood whilst five in ten had a worse mood.

Behaviour and mood provide insights on how well a child is managing the day-to-day challenges and stresses of life. The way adults interpret and respond to behaviour and mood contributes to learning skills in managing thoughts and actions in positive ways or less so. These all contribute to developing resilience and mental health as a resource across life.

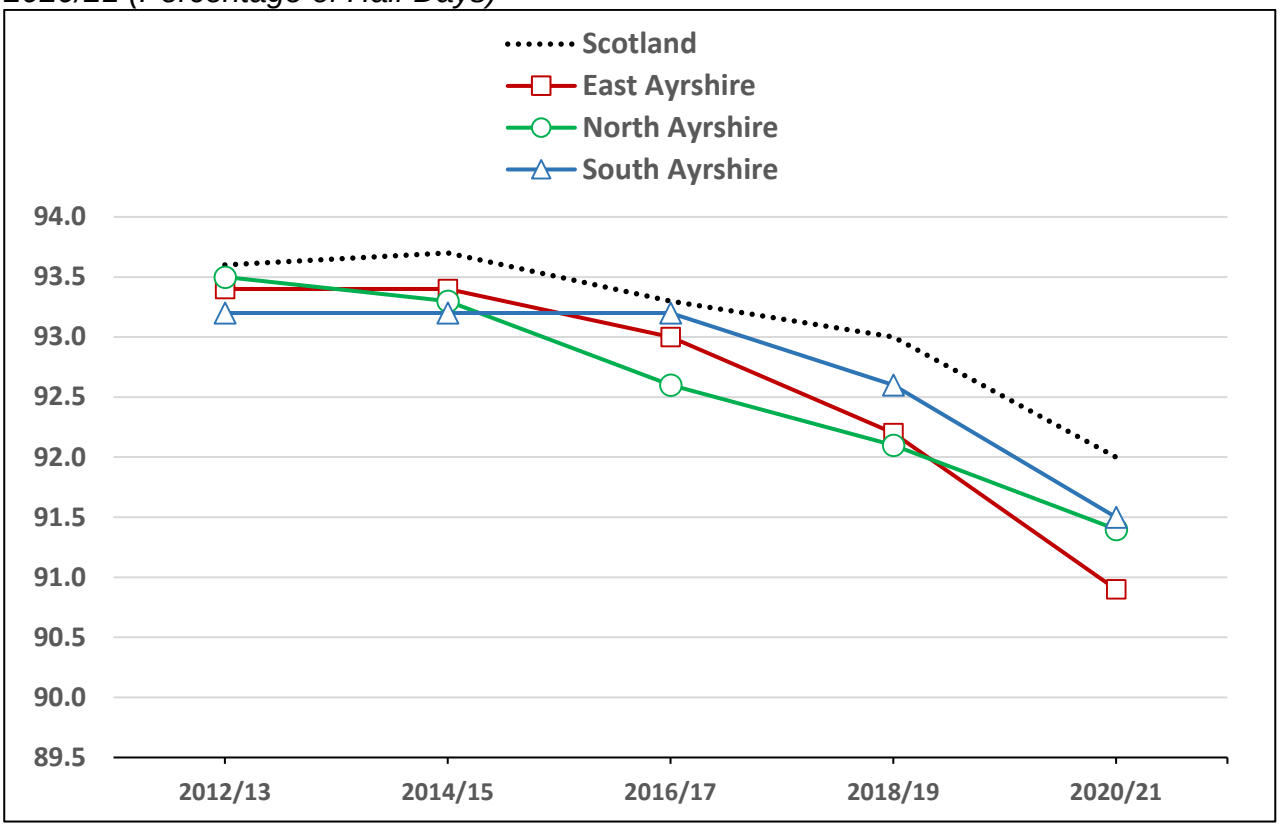
The effects of the pandemic may be reflected in national data collected at the 27-30 child health developmental review.

Where children indicated one or more developmental concerns there was a modest increase in the Scottish rates over time: amounting to an absolute 3-year increase of 1.8% and a relative increase of 12%. This was from the second quarter of 2020 to the third of quarter of 2021, largely concurrent with Covid-19 restrictions and thus possibly indicative of a pandemic effect. It is noted that national rates have gradually started falling again over the last couple of quarters.

A further consideration of the impact of the pandemic on children and young people is the drop-off in school attendance (figure 13).

[34] Adolescent wellbeing in the UK - The Lancet Child & Adolescent Health

Figure 13: Attendance Rates – Schools Open in Scotland and Local Areas, 2012/13 to 2020/21 (Percentage of Half Days)



ORIGINAL DATA SOURCE: School Education Statistics: Scottish Government, Learning Directorate.
PROVIDER: East Ayrshire Council; data received from council on 26 May 2023.

Where school cultures are informed by relationship-orientated and inclusive approaches, school can be understood as protective and buffering of life events. This is the more so when there are challenges in home and community life. Understanding the challenges in returning to school will present opportunities for children and young people to access support and also learn, attain and be connected to positive experiences that contribute to resilience that contributes to success in school, subsequent learning and the workplace.

6.2 Adults and On

6.2.1 Mental Health Needs and Risks

There are two population scoring tools that are available to understand mental health need and mental wellbeing in the adult population.

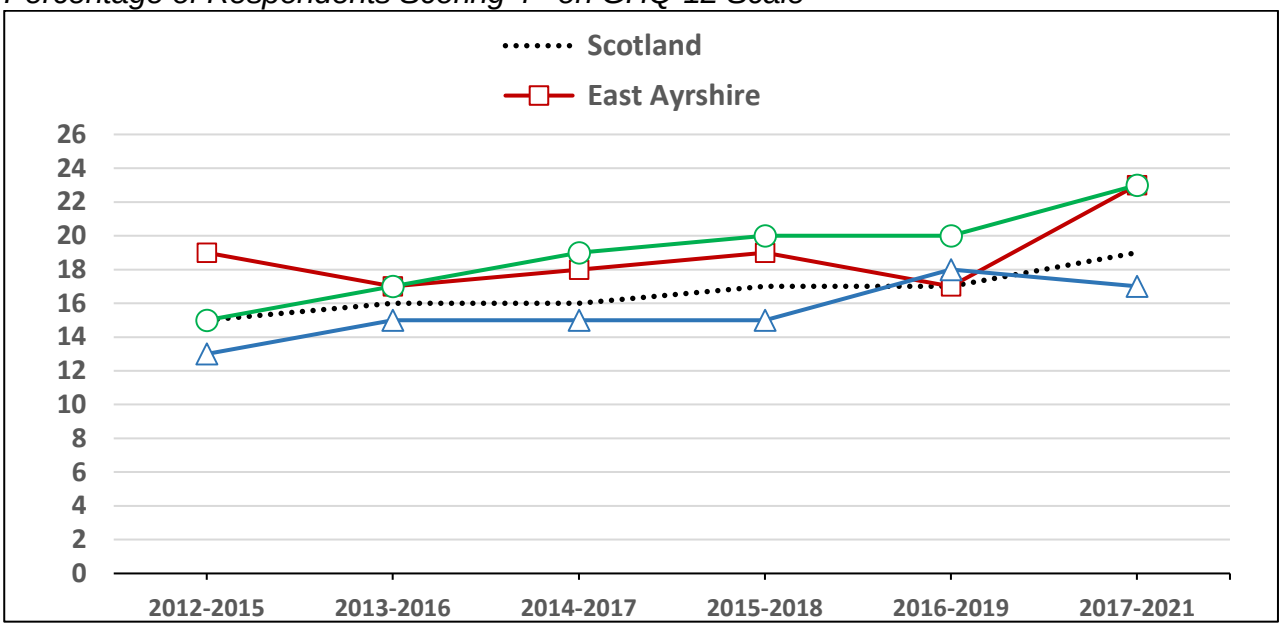
The General Health Questionnaire (GHQ-12) captures the range and level of mental health need for people over the age of 16 years. This is a standardised scale which measures mental distress and mental ill-health. It was developed as a screening tool to identify those likely to have, or be at risk of developing, psychiatric disorders.

The Warwick-Edinburgh Mental Wellbeing scale (WEMWBS) was developed to enable the measuring and monitoring of mental wellbeing in the general population, and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. There are 12 questions which cover concentration abilities, sleeping patterns, self-esteem, stress, despair, depression, and confidence in the past few weeks. The tool measures recent changes to

someone's typical mental health functioning and, therefore, cannot be used to detect chronic or enduring conditions. A score of over four indicates a mental health need.

The GHQ-12 survey results from the Scottish Health Survey (2017-21) are detailed in Figure 14.

Figure 14: General Health Questionnaire (GHQ-12), All Persons Aged 16 or Over – Percentage of Respondents Scoring 4+ on GHQ-12 Scale



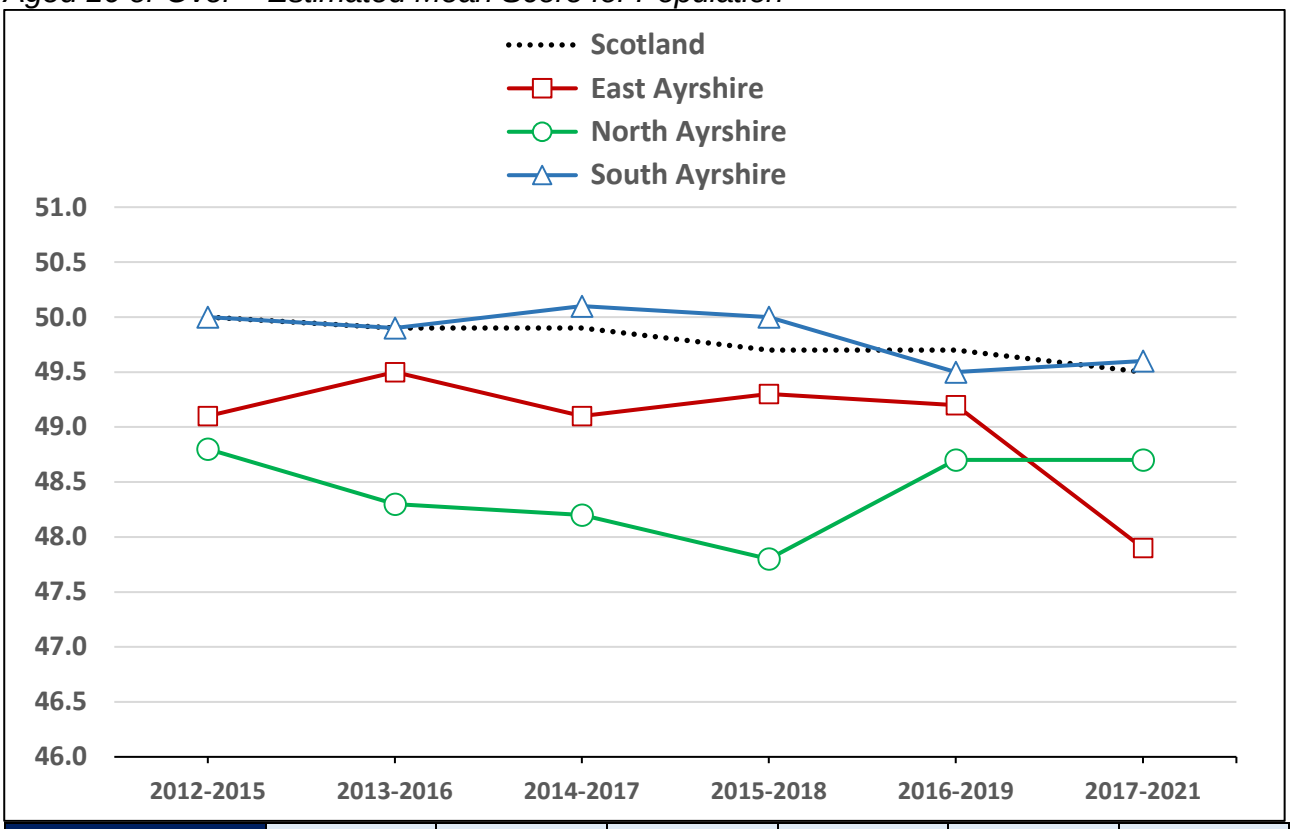
DATA TABLE:	2012-15	2013-16	2014-17	2015-18	2016-19	2017-21
East Ayrshire	19	17	18	19	17	23
North Ayrshire	15	17	19	20	20	23
South Ayrshire	13	15	15	15	18	17
Scotland	15	16	16	17	17	19

DATA SOURCE: Scottish Health Survey dashboard; accessed 16 May 2023.

The level of mental health in North and East Ayrshire is above the Scottish level with a notable increase in East Ayrshire over more recent times. South Ayrshire is currently below the Scottish level, however, this does not mean that there are not communities and individuals were levels of need are high. There appears to be a moderate increase in mental health need over the last ten years. The lower scores in South Ayrshire may be attributable to lower uptake in the survey by female participants.

Across Scottish local authorities, North Ayrshire has the second highest scores and East Ayrshire the fourth. West Dumbarton had the highest score and Glasgow city the third. This can be understood as reflecting the burden of deprivation and inequality across the South West of Scotland as seen in related metrics.

Figure 15: Warwick-Edinburgh Mental Wellbeing Scale WEMWBS (14-ITEM), All Persons Aged 16 or Over – Estimated Mean Score for Population



DATA TABLE:	2012-15	2013-16	2014-17	2015-18	2016-19	2017-21
Scotland	50.0	49.9	49.9	49.7	49.7	49.5
East Ayrshire	49.1	49.5	49.1	49.3	49.2	47.9
North Ayrshire	48.8	48.3	48.2	47.8	48.7	48.7
South Ayrshire	50.0	49.9	50.1	50.0	49.5	49.6

Source: Scottish Health Survey dashboard; accessed 18 May 2023.

In the most recent period 2017-21, mean adult WEMWBS scores were as follows (where higher scores are indicative of greater wellbeing – Figure 15): 47.9 in East Ayrshire, 48.7 in North, 49.5 in Scotland, and 49.6 in South. Local results were not significantly different from the national comparator.

When comparing area scores over the entire 10-year period, East and North figures have been consistently below the Scottish average, while those of South have been closer to the national comparator, sometimes on a par or slightly above.

Slight downward shifts in wellbeing scores and modest upward shifts in reports of common mental health problems (reported above) demonstrate a degree of congruence. This congruence would be expected since the same respondents provided reports for both indicators at each administration of the survey, with both indicators representing general aspects of mental health and wellbeing.

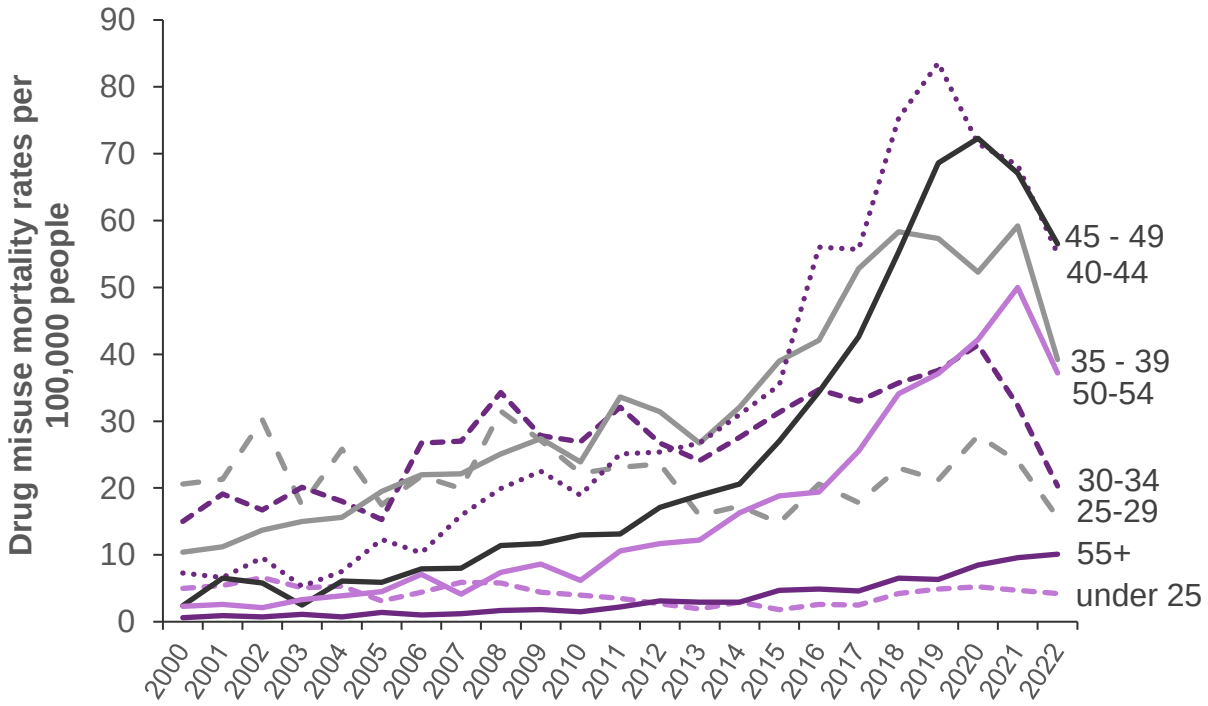
In essence, there are higher levels of mental health need than in previous times and reduced levels of wellbeing. There are a number of challenges in both Scottish, UK and internationally that may be influencing population mental health need and wellbeing. This presents opportunities to consider preventive approaches that reduce need and risk as well as seeking to promote mental wellbeing for all.

6.3 Problematic and Dependant Drug Use

The journey into difficulties with drugs often begins through experiences of childhood adversity alongside genetic vulnerability and multiple community disadvantages (insecurity of income/housing/food and family/community distress/violence).

Drug deaths represent the poorest avoidable outcome and are distributed across the life-course with the related consideration of the intergenerational transmission of distress explored in this paper. A notable reduction in drug death rates occurred from 2021 to 2022, Figure 16. While this is a welcome reduction, rates are still considerably higher than for England (2.7 higher) while indicative data for the first six months of 2023 suggests drug deaths are 7% higher than for the preceding period in 2022. The wider legislative framing of drug control (Misuse of Drugs Act 1971) is increasingly being debated as to its relevance to current times and as a barrier to coordinated policy to reduce the risk of drug deaths[35].
In 2022 rates did fall in almost all age groups, with notable declines observed in the younger adulthood category (People aged 30-39). The highest death rates in 2022 were for those in later adulthood (People aged 40-49).

Figure 16: Drug Deaths in Scotland, Age-specific Mortality Rates per 100,000 by Age Group, 2022

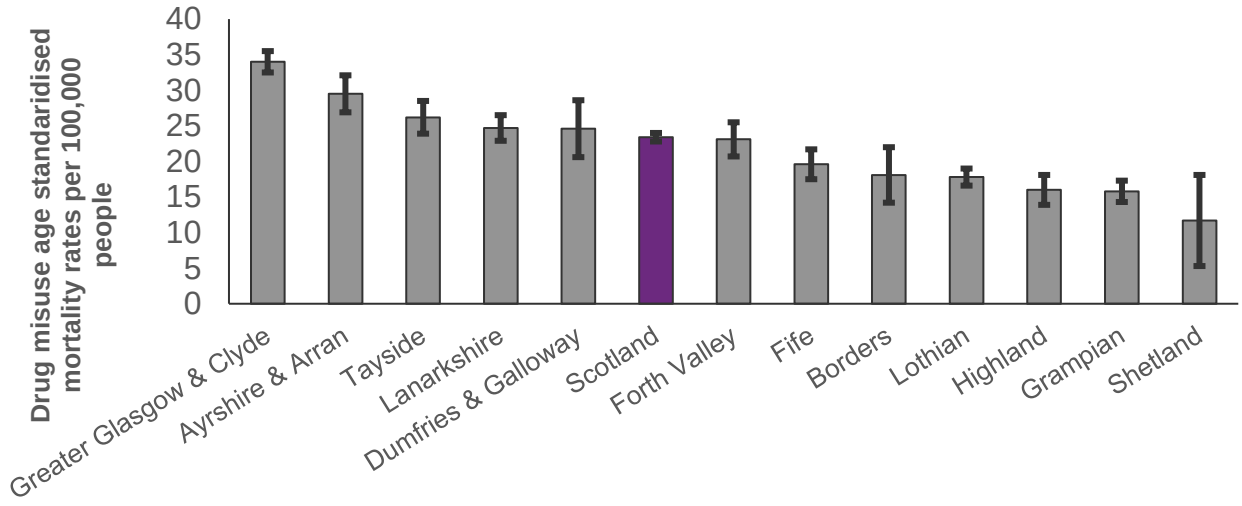


DATA SOURCE: National Records of Scotland (NRS)
Drug-related Deaths in Scotland in 2022 | National Records of Scotland (nrscotland.gov.uk)

In 2022, NHS Ayrshire and Arran had the second highest drug death rate for a Health Board (29.5) after NHS Glasgow and Clyde (34.0), Figure 17.

[35] A Caring, Compassionate and Human Rights Informed Drug Policy for Scotland (www.gov.scot)

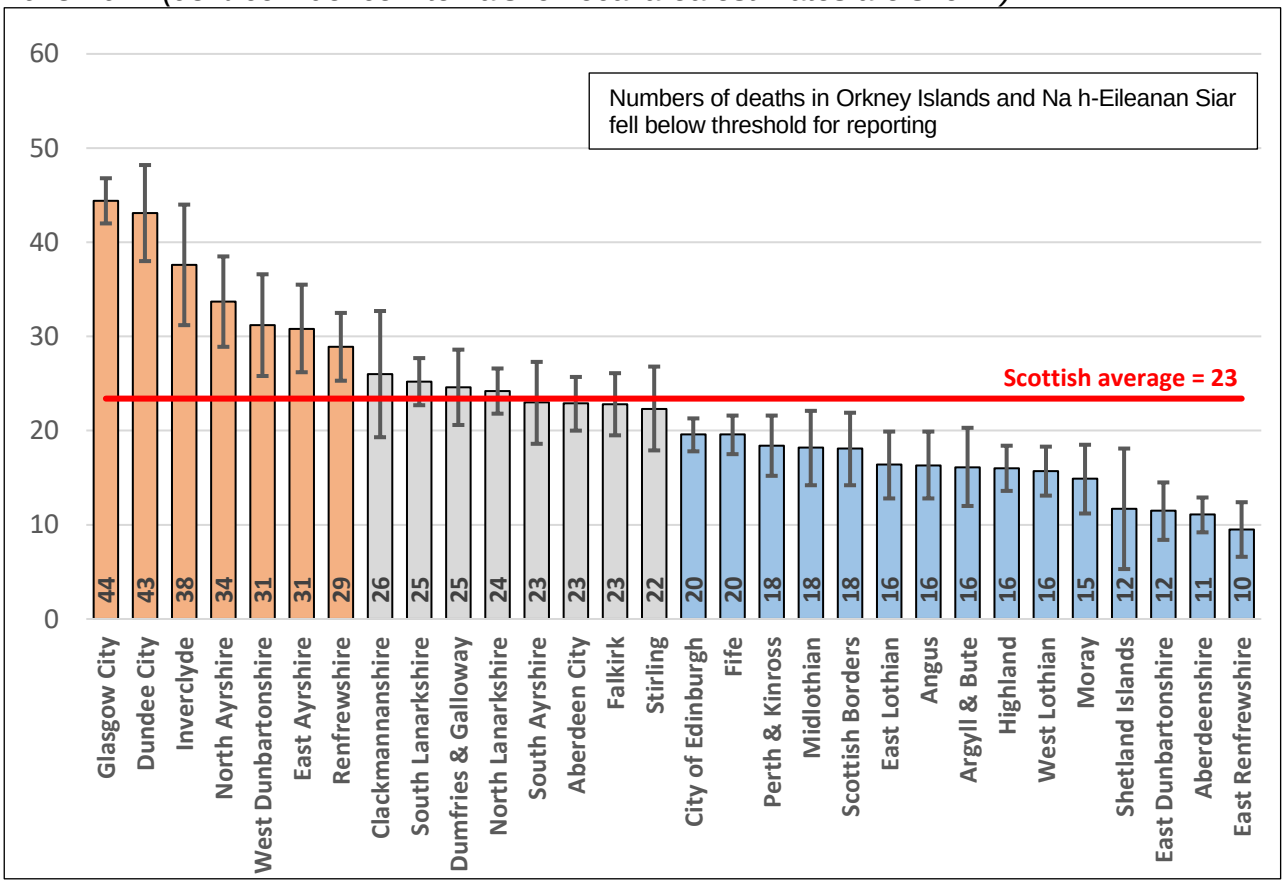
Figure 17: Drug Misuse Deaths for Selected NHS Board Areas, Age-standardised Death Rates per 100,000 of Population, 2018-2022



DATA SOURCE: National Records of Scotland (NRS)
Drug-related Deaths in Scotland in 2022 | National Records of Scotland (nrscotland.gov.uk)

Figure 18 demonstrates that, in 2022, North Ayrshire had the fourth highest drug death rate (33.7) out of the thirty-two local authorities, East Ayrshire had the sixth (30.8) and South Ayrshire was just below the Scottish drug death rate (23.4) at 23.0. Scotland's drug death rate is notably higher than England and Wales drug death rates in Western Europe.[36]

Figure 18: Drug Misuse Deaths: Age/Sex Standardised Rate per 100,000, by Council area, 2018-2022 (95% confidence intervals for local area estimates are shown)



[36] Drug-death rates - comparisons with other countries - 2016 2017 and 2018 (nrscotland.gov.uk)

BAR CHART COLOUR KEY:
Significantly better than Scotland
No different to Scotland
Significantly worse than Scotland

DATA SOURCE: National Records of Scotland (NRS)
Drug-related Deaths in Scotland in 2022 | National Records of Scotland (nrscotland.gov.uk)

Postcode data indicates that deaths cluster in particular communities across all the three Ayrshires. There are associated mental health and wellbeing costs for families, peers and the communities where people lived and often grew up prior to their death. Some of these are linked to the erosion of hope for better times amidst associated stigma and the exhausting nature of repeating cycles of grief and loss, alongside alcohol and suicide-related deaths.

A public health life-course informed approach to this topic demonstrates the need and value of whole system restorative approaches to address the underlying contributing factors that inform vulnerability to poorer mental health and/or mental illness/disorder while also supporting creation and nurture.

Children and young people grow and develop within the societal and human resources that are available to them. In the context of problematic drug use/addiction there is a growing recognition that neither the police and courts, nor treatment services alone, have the answers to addressing what could be understood as a wicked problem. An understanding of the drivers and solutions are more complex than is understood and the more challenging, therefore, to solve. The policy drivers differ from problematic/dependant alcohol use due to the current legislative approach, as detailed in the 1970 Substance Misuse Act, whereby a range of drugs are deemed illicit and, therefore, the police, courts and prison can be involved when drug use presents. Until more recent times a criminal justice response has led policy and practice rather than a public health and treatment-informed approach. This is now the preferred direction of travel for drug policy in Scotland. [37]

6.4 Problematic and Dependant Alcohol Use

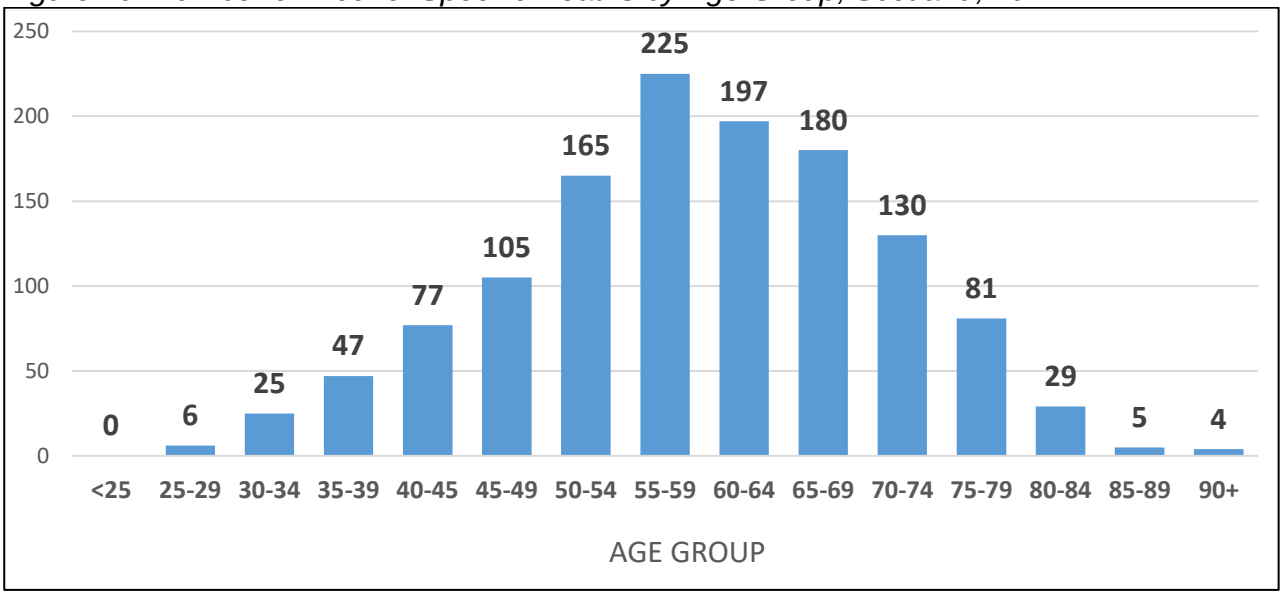
Problematic/dependant alcohol use can be understood as a reflection of mental health need resulting in an adult mental disorder, as defined in this paper.

Problematic/dependant alcohol use be understood as a response to a range of life experiences where alcohol serves a purpose in dampening difficult feelings that exist as a response to life events as a child and/or in later life. This may involve a predisposition to dependency mediated by a genetic predisposition/vulnerability for addiction and/or family circumstances and community environments when growing up, where alcohol use is normalised and where there are readily accessible options for purchasing and consuming alcohol.

Across the life-course, analysis of the Scottish 2022 figures by age group shows a distinct peak in numbers of alcohol-specific deaths occurring in middle years (age 50-69) (Figure 19) - this demographic accounted for 767 (60%) of the 1,276 deaths recorded that year, amounting to three-fifths of the total. The average age at death was 59.5 years.

[37] A Caring, Compassionate and Human Rights Informed Drug Policy for Scotland - gov.scot (www.gov.scot)

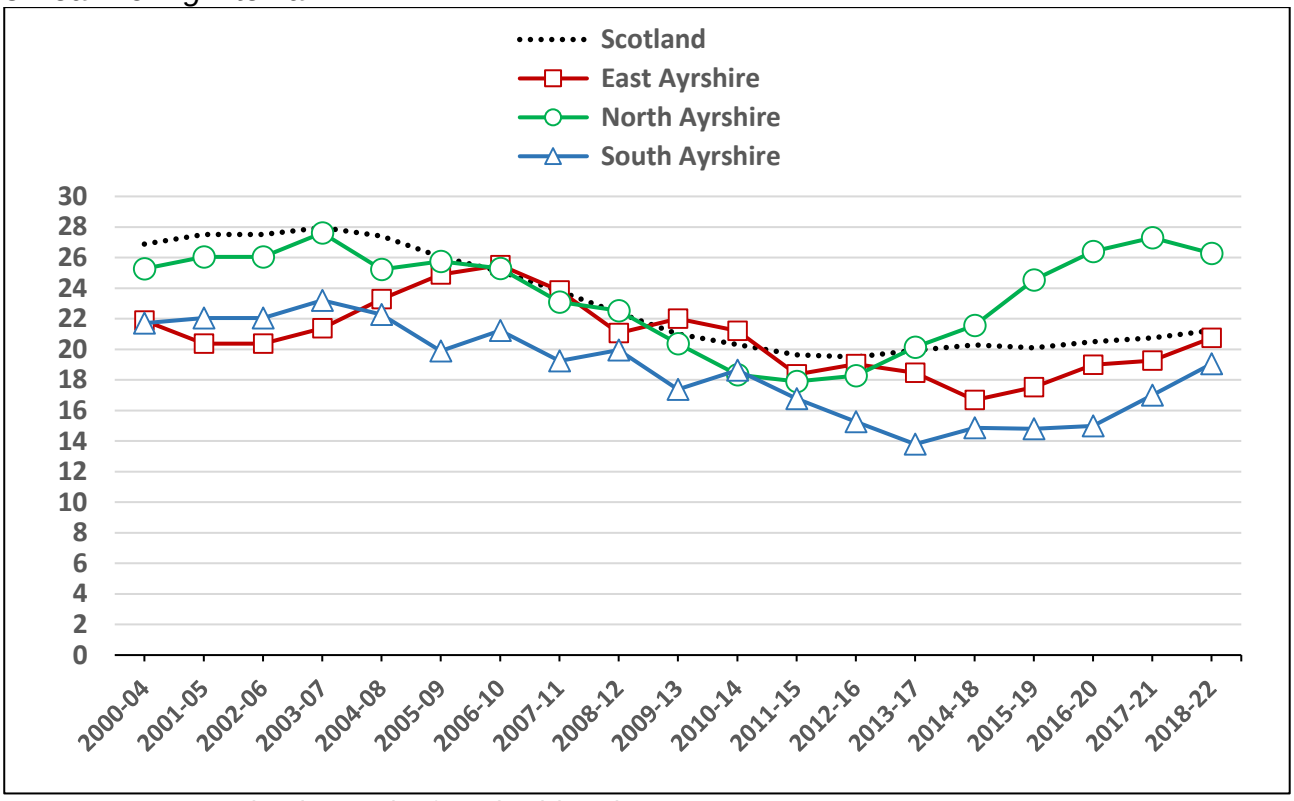
Figure 19: Number of Alcohol-Specific Deaths by Age Group, Scotland, 2022



DATA SOURCE: National Records of Scotland (NRS)
Alcohol-specific deaths | National Records of Scotland (nrscotland.gov.uk)

These can be understood as essentially preventable deaths, had the excessive and prolonged consumption of alcohol been avoided.

Figure 20: Alcohol-specific Deaths, All Persons – Age/Sex Standardised Rate, per 100,000, 5-Year Rolling Interval



DATA SOURCE: National Records of Scotland (NRS)
Alcohol-specific deaths | National Records of Scotland (nrscotland.gov.uk)

Figure 20 details the burden of alcohol-related risks and harms across NHS Ayrshire and Arran, in relation to the rest of Scotland. Over the last 20 years, South rates have generally been lowest among the three local partnership areas, North has been highest and East frequently in-between. While a small drop in the North rates is noted from 2021 to 2022, rates continue to rise in East, South and Scotland as a whole. Within these trends, more men than women are dying as a result of alcohol.

An additional challenge where high alcohol consumption is accepted and normalised in family and community and across society, is the risk of infants in-utero being exposed to alcohol when consumed at any point during a pregnancy. This can result in FASD (Fetal Alcohol Spectrum Disorder), a neurodevelopmental condition which brings challenges across life in learning, family and peer relationships, as well as employment and social interaction, while life expectancy is notably shortened with studies indicating as just thirty four years.[38]

6.5 Suicide

Every life lost to suicide is an enormous tragedy with many ripple effects for family, friends, peers and communities.

There is a clear response to the need to work across systems and the life-course to address suicides in Scotland in Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032

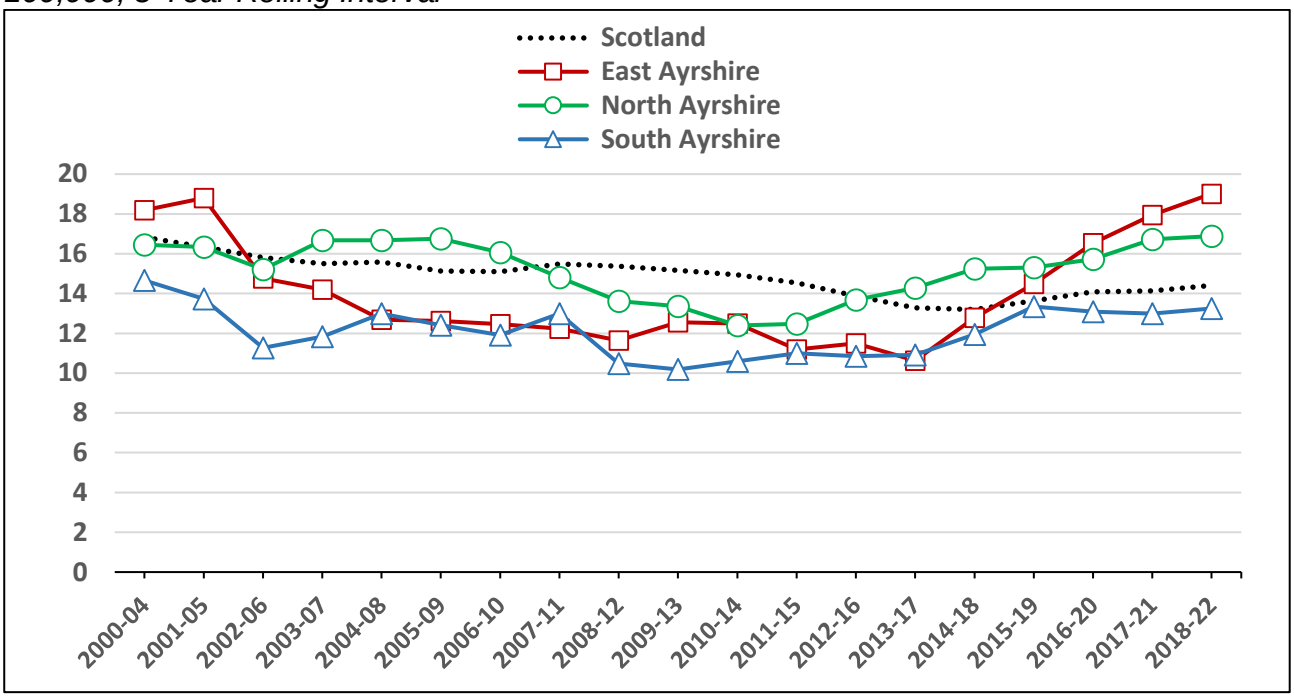
Suicide is complex, and there is no single explanation of why people die by suicide. There are many different risk factors, including:

- Previous suicide attempts, or previous self-harm. Many people who self-harm don't want to die. However, research shows that people who self-harm are at higher risk of attempting or dying by suicide.
- Being unemployed.
- Having a physical health problem, including chronic pain.
- Living alone.
- Being dependent on alcohol or drugs.
- Having mental health problems.

Suicide is a challenge across NHS Ayrshire and Arran. Figure 21 shows area trends from 2000 to 2022 of age-sex standardised rates (per 100,000 population) of death from probable suicide, and Figure 22 shows area trends by gender. Figure 23 shows national suicide data trends by selected age group from 1994 to 2022.

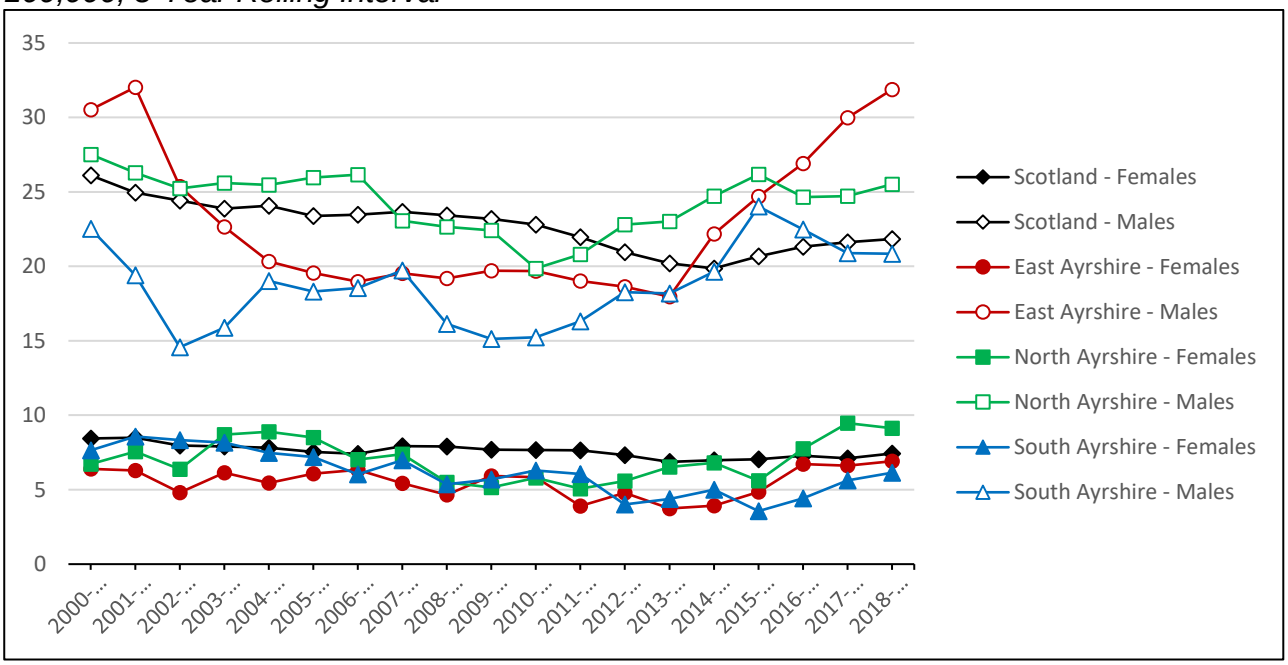
[38] Life Expectancy of People with Fetal Alcohol Syndrome - PubMed (nih.gov)

Figure 21: Deaths from Probable Suicide, All Persons – Age/Sex Standardised Rate per 100,000, 5-Year Rolling Interval



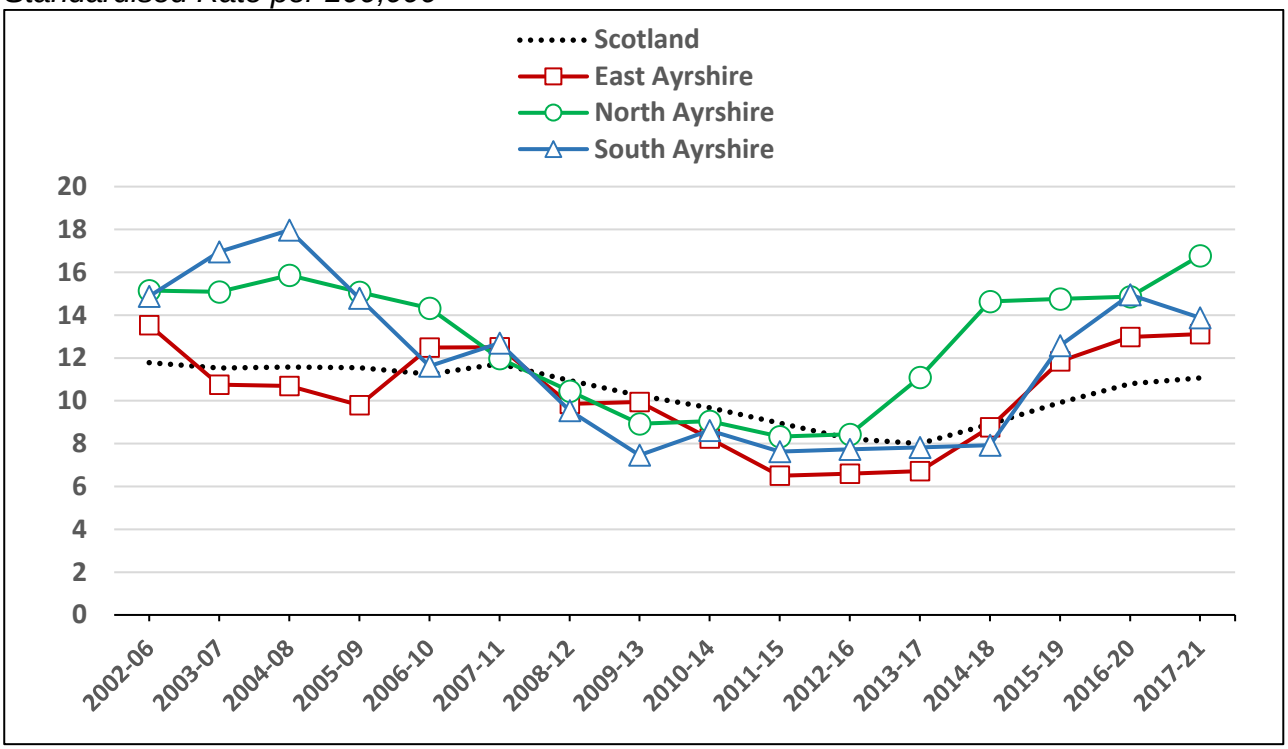
DATA SOURCE: National Records of Scotland (NRS)
Probable Suicides | National Records of Scotland (nrscotland.gov.uk)

Figure 22: Deaths from Probable Suicide, by Gender – Age/Sex Standardised Rate per 100,000, 5-Year Rolling Interval



DATA SOURCE: National Records of Scotland (NRS)
Probable Suicides | National Records of Scotland (nrscotland.gov.uk)

Figure 23: Deaths from Probable Suicide, Scotland, Age 11 to 25, 2002-2021 – Age/Sex Standardised Rate per 100,000



DATA SOURCE: National Records of Scotland (NRS)
Probable Suicides | National Records of Scotland (nrscotland.gov.uk)

Data indicates that rates of probable suicide largely declined during the 2000s, locally and nationally (Figure 19). Since the early 2010s, however, rates have risen locally, while staying relatively level in Scotland as a whole - from 2011-15 to 2018-22, rates increased by 21% in South, 35% in North, 70% in East, and decreased narrowly by 1% in Scotland (though the national trend has been gradually rising since the mid-2010s). Looking closer at local area trends, rates have been steadily climbing in North since 2011-15, in East have been rapidly escalating since 2013-17, and in South have been falling again since 2015-19.

In the most recent period 2018-22, area rates of probable suicide per 100,000 population were as follows (in order of magnitude): 13.3 in South, 14.4 in Scotland, 16.9 in North, and 19.0 in East.

Analysis of the data by gender shows consistently higher rates of probable suicide among males than females, locally and nationally (Figure 23). In 2018-22, male to female suicide rates were higher by a factor of 2.9 in North, 3.4 in South, and 4.6 in East. This compares to a factor of 2.9 in Scotland as a whole. Of note is the large male-to-female disparity in East Ayrshire rates, which is attributable to a severe upswing in male suicides which began in 2013-17. East females have also seen a rise in probable suicide rates over the same period, but the scale of increase has been far more gradual than that of their male counterparts.

Looking at trends for younger ages, presented from 11 to 25 years – (local area data for this demographic in 2022 was not available at time of reporting) - the pattern of probable suicides over the last two decades has been one of initial decline during the 2000s followed by increase since 2011-15, somewhat mirroring the trends for all persons, all ages. Setting 2011-15 as baseline, the increases since then have been, in order of magnitude, 23% in Scotland, 82% in South, 101% in North, and 102% in East.

These figures demonstrate that, while absolute numbers of young people completing suicide remain low, the changes over the last decade in relative terms have been more extreme for this demographic than for people of all ages. Essentially, all local area rates for age 11-25 have doubled or nearly doubled in the last decade, while the national rate has inflated much more modestly.

This represents another driver to ensure the developmental and relational needs of the youngest citizens remain a priority for preventive investment and attention.

6.6 Dementia

Dementia results from a variety of diseases and injuries that affect the brain. Alzheimer disease is the most common form of dementia and may contribute to 60–70% of cases. Dementia is currently the seventh leading cause of death and one of the major causes of disability and dependency among older people globally.

Table D
Estimated proportions (%) of people diagnosed with dementia by age groups, 2020 Figures

	Under 60	60-69	70-89	90+
Scotland	0.01%	0.40%	11.24%	6.75%
Ayrshire & Arran	0.01%	0.39%	11.51%	6.96%

Source: Supporting documents - Estimated and projected diagnosis rates for dementia in Scotland 2014-2020 - gov.scot (www.gov.scot)

Table D details the Scottish and NHS Ayrshire and Arran NHS Board area in 2020 percentage contribution of selected age groups to the total projected numbers, in a given area with a diagnosis of dementia. The data shows that the 80-84 year old group yields the biggest contribution to projected numbers in all NHS Board areas, estimated to make up around a quarter of all individuals with a diagnosis of dementia; moreover, the 80-84 and 85-89 age groups combined account for almost half.

Both childhood poverty and experiences of childhood adversity are understood as risk factors for developing dementia in later life. It is instructive to understand the long reach of these factors as children grow and develop to appreciate the need to focus on the needs of the youngest citizens, even as there are pressures to respond to an ageing population.

6.7 Prescribing for Mental Health

This paper explores the many opportunities to work preventively to address mental health needs and reduce the risk of developing mental illness/disorder across life from before birth and into later years.

In addition, the importance of timely access to the assessment of (and need and risk to reduce) escalating mental illness/disorder is no less important.

The space between mental health need and a framing of illness and disorder is contested within lay and professional/clinical communities. This has been driven in part by the space increasingly being filled by pharmaceutical prescribing. This is often in the absence of

additional supportive measures such as counselling and set against a backdrop of widespread experience of childhood adversity and disrupted attachment.

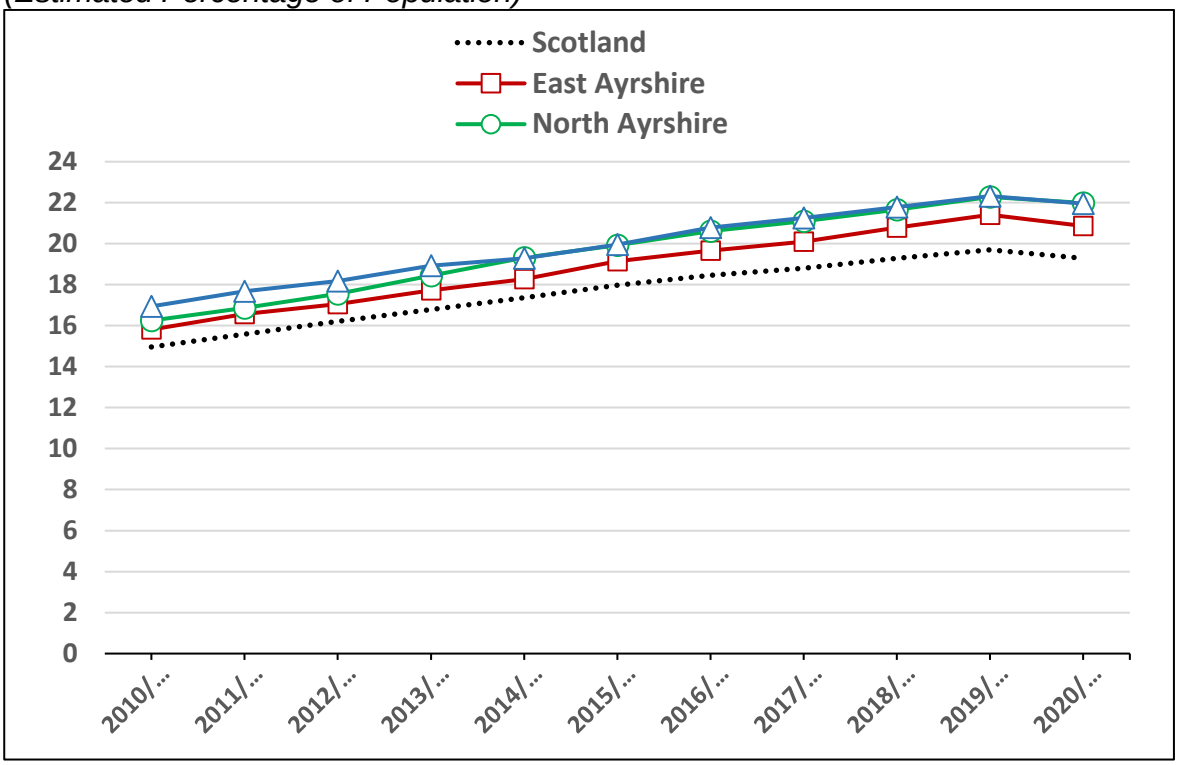
Alongside innate vulnerabilities within individuals/families, the additional experiences of relational and social isolation and the wider challenges of living in poverty and wider community inequalities create a continuum from mental health need, to illness/disorder.

Routine prescribing can be understood as a timely response to need that has become core to a health care response to need as it presents. The increasing critiquing of the evidence behind mass-prescribing is informed by concerns over the role of big pharma in promoting prescribing. The challenge is whether prescriptions have become a standard response to need in the absence of capacity and time for different responses, such as counselling and options for addressing loneliness and social isolation.

It is beyond the scope of this paper to go into any further detail, however, it merits consideration.

Figure 24 shows area trends for the percentage of the population (all persons) prescribed medicines that are predominantly used in the treatment of psychiatric conditions (depression, anxiety, psychosis).

Figure 24: Population Prescribed Drugs for Anxiety/Depression/Psychosis – All Persons (Estimated Percentage of Population)



DATA SOURCE: Public Health Scotland (Prescribing Information System)
PROVIDER: ScotPHO; accessed 20/06/23.

When comparing prescribing rates across Scottish council areas in 2020/21, against Scotland as a whole, the three Ayrshire local authorities have prescribing rates that are significantly higher than other parts of Scotland. In 2020/21, percentages of the population prescribed medicines, largely used for psychiatric purposes, were as follows (in order of magnitude): 19.3% in Scotland, 20.9% in East Ayrshire, and 22.0% in North and South Ayrshire. Local rates were all significantly higher than the national comparator.

Complementing, or serving as an alternative to pharmaceutical prescribing, is social prescribing (befriending services, practical information including benefits and financial advice, community activities, arts and culture and physical activities, and those that take place in nature can alleviate issues relating to loneliness, stress, mild to moderate depression, and anxiety).

These are service models that can address some of the more common mental health difficulties experienced by individuals in the UK. These are increasingly being explored across Scotland. Whilst there is a lot of varied evidence to suggest that social prescribing plays an important role in alleviating mental health concerns, more robust evidence is needed.

Section 7: Conclusion

The main aim of progressing a life-course approach to mental health will involve maximising the many opportunities to promote mental health and wellbeing across all of the life stages, through preventive approaches and timely access and intervention/support for people where a mental health need and mental illness/disorder presents.

A preventive approach to public mental health seeks to maximise the benefits from a whole population level, and whole system approach, to creating the family and community experiences where all can thrive and where services are accessible and culturally-aligned, where mental illness/disorder presents.

Such an approach will reflect the core values of human rights-based approaches. It will present opportunities to further develop cultures and practices in organisational life that are trauma-informed and responsive and aligned to the needs of communities, individuals and families while reflecting the ambition of realistic medicine.

The evidence of early years and life-course experiences influence on mental wellbeing is increasingly clear. The challenge lies in the reorientation of system and service cultures and practice to allow for changes in financial decision-making. This is required to realise the preventive spend potential of a life-course approach. Finance and budget constraints may not allow improvement to be realised within current planning cycles.

APPENDICES

Appendix A: First 1001 Days (pregnancy/0 to 3 years)

What Do We Know About Mental Health Need And Risks?

A key time to create the opportunities to create and sustain health equity across the life course.

Early brain development can be understood as a powerhouse of opportunity with a million neurons being developed per minute in the first years of life.

It creates the foundation of human adaptability and resilience: the interface between cognitive and emotional skills, (ability to learn, social skills and resilience when there is stress).[*i. The mental wealth of nations, Nature https://www.nature.com/articles/4551057a*]

The impact of exposure to negative influences can be pervasive across the life-course.

What Helps?

- Security of income, housing and quality nutrition that underpins family and infant/toddler health and wellbeing.
- Parent/primary care giver responsiveness to needs.
- Parent/primary care giver parenting capacity/capabilities/skills.
- Understanding the importance of time sensitive developmental windows for creating health as a resource for life: stress response (6-12 months, language 13-15 months, attachment 12-24 months). [*ii. Time Developmental Windows*]

What Hinders?

- Family experiences of poverty and inequality. [*iii. Society to cell: How child poverty gets "Under the Skin" to influence child development and lifelong health ScienceDirect https://www.sciencedirect.com/science/article/pii/S0273229721000381*]
- Early exposure to stress/adversity in the home/community: the more so where this occurs across generations.
- In utero and early life exposure to tobacco, alcohol, drugs, air pollutants, poor/insufficient nutrition/neglect/abuse.
- The absence of safe meaningful relationships for parents seeking help.

What Are The Challenges To Doing It Better?

- Financial pressures across adult health and social care requiring savings across early years/family support services to manage financial pressures and risks within HSCPs.
- Time, capacity and resource to work over long periods of time with families where there is evidence of the effect of entrenched poverty and inequity/inequality in family and community life.

What Might Better Look Like?

- Whole systems cultures that can evidence they are trauma informed/responsive across service design/delivery/experience of care.

Example of Current Practice: Exploring the Cost of the Pregnancy Pathway

- The relationship between lack of material resources and poor health, including during pregnancy, is well established, and the birth of a new baby can result in those close to the poverty line falling below it.
- The national and local efforts to tackle child poverty and the cost of living crisis identifies the need to help low income families, including support for income maximisation services through health settings.
- While NHS services are 'free at the point of access' there may be other cost-related barriers to accessing healthcare including but not limited to loss of earnings and travel costs.
- A piece of research commissioned by Public Health Scotland, HS Ayrshire and Arran, NHS Greater Glasgow and Clyde, Public Health Scotland and Glasgow Centre for Population Health aimed to investigate the financial impacts of pregnancy for expectant and new families and explore feasible options to reduce these barriers.
- A number of recommendations were made, including:
  - Addressing the cost of travel, particularly in rural areas, with the provision of vouchers/passes being preferred over retrospective reimbursement
  - The provision of clearer awareness-raising and signposting of specialist money advice/welfare rights services is needed with staff able to discuss financial inclusion and opportunities to have partners on-site
  - Access to childcare facilities, specifically for those attending more frequently for additional care appointments
  - Greater flexibility to accommodate individual circumstances when arranging appointments.
  - A more decentralised service delivery model, for example, a hub-and-spoke model, particularly in rural areas
- A Cost of Pregnancy Group is now in place and progressing a number of recommendations from the report.
- Project Title (gcph.co.uk) https://www.gcph.co.uk/assets/0000/7967/Exploring_the_Cost_of_the_Pregnancy_Pathway_report_Sept_2020.pdf

Appendix B: Childhood (4-11)

What Do We Know About Mental Health Need And Risks?

Children at this age have a disposition to curiosity and an interest to learn.

Even as the impact of exposure to negative influences can be pervasive across the life-course, positive childhood experiences are protective and can offset prior exposure to early adversity.

Children who do not have experience of adversity as they grow, yet lack positive childhood experiences. are also at risk of poorer outcomes.

Learning is possible and enhanced when the school and wider learning environments are attuned to and supportive of a range of needs.

The pandemic has had a wide-ranging impact on the health and wellbeing of children in their early years that is working through to school aged children. [COVID-19 Early years resilience and impact survey - CEYRIS - Publications - Public Health Scotland; https://publichealthscotland.scot/publications/covid-19-early-years-resilience-and-impact-survey-ceyris/]

What Helps?

- Good nutrition, play, sleep, friendships. The absence of bullying.
- Parents/primary care givers remain aware of and are responsive to children's relational and developmental needs.
- Supportive early education environments where teachers are developmentally, and relationally informed and school cultures and practice are attuned and able to respond to the differing needs of pupils.
- Teaching and Education leadership having roles in creating supportive environments for all school staff as the feelings and emotions of adults are increasingly understood to to shape the way children feel and behave.
- Early recognition of needs and risks and timely support/referral on.

What Hinders?

- Enduring adversity stemming from wider determinants of health: damp housing/community distress/violence.
- Where parents are not able to access support/help for tobacco, alcohol, drugs mental health needs.
- Enduring adversity in the home: parental distress/violence, neglect/abuse, poor/insufficient nutrition.
- Where relational and behavioural needs in early education/school are not understood and where opportunities to support are lost.
- The impact of the pandemic can be seen across a range of health and wellbeing indicators for children.

What Are The Challenges To Doing It Better?

- The cost-of-living crisis and high levels of childhood poverty brings additional pressures for children's mental health and wellbeing.
- Challenges in community life: the influence of problematic drug and alcohol use and related violence and coercion and threat in community life.
- The impact of the COVID-19 pandemic is recognised to have impacted on early growth and development of young children and this presents opportunities to mitigate the impact and risks of the benefits are not realised.
- Acknowledging the impacts of early adversity of child growth and development and how this influences small children being ready/able to learn: is the child school ready, or the is the school ready for the child as needs present?
- Resource constraints within health and social care and education budgets.

What Might Better Look Like?

- Better links with CPP on prevention and early intervention, particularly in relation to the wider school communities and where children, families and carers are within these communities.
- Greater awareness of the risk and protective factors and how to build them in to everyday life to support good mental health & wellbeing
- Creating environments that allow children, young people, families and others around them to make choices that support good mental health & wellbeing
- A shift away from short-term funding which makes it difficult to affect change.

Example of Current Practice 1: Whole School Approach to Mental Health and Wellbeing

- Public Health are currently supporting Education partners to implement the Scottish Government Framework for Schools to support CYP MHWB. This helps to create educational environments that are preventative, universal and include targeted interventions to ensure that all members of a school community can flourish and sustain a state of being mentally healthy. A whole school approach to mental health and wellbeing needs strong leadership to ensure that it can be taken forward across the whole school community. Other key factors include:
  - using a holistic model of health;
  - being proactive rather than reactive;
  - focusing on ethos, relationships, policies and pedagogy;
  - taking account of the wider contextual determinants of mental health and wellbeing;
  - involving parents/carers and wider community partners;
  - focusing on processes and not just programmes; and
  - developing skills in both staff and children, young people and parents.
- Whole school approaches develop all staff's understanding and support skills in mental health and wellbeing (including leadership and management); develop resilience and mental, emotional, social and physical wellbeing in children and young people; help engage with and improve the capacity of parents and caregivers to understand and support mental health and wellbeing, and, work towards removing stigma and discrimination. A whole school approach to mental health and wellbeing also links well with whole school relationship-based and nurturing approaches, is trauma-informed and strengths-based.
- A specific example of this is the adoption and evaluation of a whole school approach to mental health and wellbeing in Forehill Primary School in South Ayrshire. Through pupil discussions (P1-P5) they highlighted the school as promoting mental wellbeing through opportunities to be active, creative activities, fun activities, clubs, the school environment and school staff and peers. Support available was identified through school staff, nurture and through the wider ethos and kindness of the school environment.

Example of Current Practice 2: Building Understanding and Capacity of those Working with Children

- We are building the capacity of frontline staff by continuing to develop a range of training, printed & digital resources, and self-help tools including the Better Health MHWB website page, list of Apps, Websites & Helplines and individual Self Help Guides for Mental Wellbeing, Young People and Children. This provides a suite of resources across the life course that front line staff can use to support the mental health and wellbeing of children and families. All resources are cascaded and also available on our partners' digital platforms to ensure easy access. Mental Health & Suicide prevention training has been delivered widely to key stakeholders including teachers, education support staff, early years' practitioners, family link workers, youth services and third sector organisations.

Additional Contributing Author(s): Karen Lee, Health Improvement Officer and Heather Fraser, Health Improvement Practitioner.

Appendix C: Adolescence (12-18)

What Do We Know About Mental Health Need And Risks For This Age Group?

Adolescence and early adulthood is a crucial period in the development of lifelong mental health where a myriad of co-occurring changes in the brain present both risks and opportunities.

These changes take energy and can be understood as an explanation for changes in mood and personality as resources are diverted to meet the additional demands of brain changes.

This is a period when there is an increase in executive function, where literacy and numeracy skills are tested and where self-esteem and a positive sense of self can reflect attachment and early relationship experiences.

Positive relationships with family, peers and school protect mental health while poor relationships, bullying and exclusion from school creates risk.

This age group remain vulnerable to the influence of toxic stress on healthy growth and development. This can increase the risk of developing problematic relationships with drugs and or alcohol and increase vulnerability to developing mental illness/disorder, This may be further exacerbated by a period of self exploration regarding self identification and where young people feel they 'fit' within their homes, families, peer groups and communities.

It is also a time when there can be challenges with parent relationships as young people begin to seek autonomy and independence which can be understood as a healthy developmental task (individuation).

This is when intergenerational risks for mental illness and disorder may begin to present: for example, early onset psychosis.

Rates of mental health need/illness/disorder (through presenting population based epidemiological studies) in young people in the UK has risen in recent years.

What Helps?

- Young people continue to benefit from parents, and a wider range of adults/peers, who are attuned to their needs and are aware of the challenges of adolescence.
- Engagement with school/higher education, youth services and activities such as drama, crafts and sport are protective, the more so where there can be difficulties at home.
- Timely access to developmentally and age-appropriate services where additional needs are identified with related assessment of learning and neurodevelopmental difficulties as required remain important.

What Hinders?

- The impact of the COVID-19 pandemic impacted on young people who had less time at school: for some this created positive opportunities within family life. For others, the impact was more problematic, where there was less relief from family chaos and/or distress, anger and violence. This may have exacerbated the risks of using tobacco, alcohol or drugs and developing problematic use.
- Exclusion from school is a recognised risk factor for poorer mental health with associated risks of developing problematic relationships with drugs and alcohol, peer groups and gang involvement with poorer outcomes into adulthood.
- Not being in higher education or employment is also noted to be a risk factor for poorer health outcomes.
- Experience of family poverty and/or challenges in family relationships can impact on opportunities and self-identity and the ability to engage with learning and achieve through school/college.

What Are The Challenges To Doing It Better?

- The enduring impact of the cost-of-living crisis and challenges in family life over income, housing and food insecurity continues to shape the growth and development of adolescents and the culmative effects can be influential if opportunities to mitigate the impact are not recognised or understood.
- Creating sustainable youth friendly options for young people in communities is a related challenge for services as short term funding for projects makes it difficult to sustain support.
- A more discerning understanding of the developmental needs of adolescents and the shaping of services to reflect these would increase the likelihood of their needs being met. The challenges of this age are more than just hormones.
- The challenges of underlying neurodevelopmental and learning needs may become more apparent at this age even as resources to assess and support are under pressure to allow for timely assessment of need and related intervention.

What Might Better Look Like?

- Better links with CPP on prevention and early intervention, particularly in relation to the wider school communities and where children, families and carers are within communities.
- Creating environments that allow children, young people, families and others around them to make choices that support good mental health & wellbeing
- Working with young people who are not attending school to ensure their health and wellbeing needs are met through other routes
- Greater awareness of risk and protective factors and how to build them in to everyday life to support good mental health and wellbeing and reduce the likelihood of developing mental illness/disorder.
- A range of services that are developmentally informed by the differing needs of adolescents, particularly where there are high levels of need and risk presenting.
- Ideally these will span the years to twenty-five to maximise the time sensitive developmental window of a brain that is still adjusting to life experiences to date.

Example of Current Practice 1: A Wellness Model (North Ayrshire)

- Development of a revised wellness model is underway in North Ayrshire through a partnership led by Education and Public and including representation from CAHMS, School Nursing, Education, Police, Primary Care, HSCP and Third Sector. The roll of this group is to review and revise the Ayrshire & Arran Wellness Model in North Ayrshire.
- The Ayrshire and Arran Wellness Model has significantly influenced, managed and changed the demand pressures placed on specialist mental health services to children and young people in a locality. By identifying tier 2 community level services and supports the Wellness Model aims to promote other means of protecting and promoting mental health while reducing inappropriate referrals to specialist services to allow those individuals with serious mental health concerns to be seen timeously and appropriately.
- This model fits around children and young people's needs using a broader lens for mental health services, and one that incorporates the wider system, supporting young people wherever they are.

Example of Current Practice 2: Young People's Mental Health

- Public Health have supported partners to implement a new mental health resource for young people aged 14-24 across East Ayrshire. This is being funded by some of East Ayrshire's allocation from the Community Mental Health and Wellbeing Services Framework. This web based platform called Kooth (accessed on www.Kooth.com) can provide resources and supports for young people needing further help with their emotional wellbeing. This platform is designed to provide early help strategies and preventative tools that young people can access themselves or with the support of a parent to allow them to self-manage low grade emotional wellbeing concerns, although more targeted 1-1 support is available to them should this be required. Kooth has no referrals, thresholds or waiting lists. Young people can access this service anonymously by signing onto the Kooth site. The platform provides unique out of office hours' provision and is open 7 days per week, 365 days a year, with live support and counselling available from noon until 10pm weekdays and from 6pm until 10pm on Saturday and Sundays. There is also added value with moderated, scheduled forums and self-help articles (many written by service users) to provide peer led and self-help support.

- A similar service – SHOUT – is available in South Ayrshire.

Additional Contributing Author(s): Karen Lee, Health Improvement Officer and Heather Fraser, Health Improvement Practitioner.

Appendix D: Young Adult (19-24)

What Do We Know About Mental Health Need And Risks For This Age Group?

Young adults continue to seek autonomy and independence as part of an ongoing developmental process.

The pre-frontal cortex of the brain matures last, not finishing until around the age of 25.

This means that executive functions such as reason, long-range planning and impulse control might not be fully operational into early adulthood.

This may be the more pronounced when prior developmental phases were not completed in optimal conditions.

What Helps?

- Certainty of income, housing and food.
- Environment that enables physical activity/leisure experiences that minimise impulsivity.
- Access to education and learning.
- Employment opportunities that are rewarding.
- The continued presence of attuned and safe adults is no less important even as peers become more important and influential.

What Hinders?

- Loneliness and isolation/disconnected from family and community.
- The influence of the COVID-19 pandemic and cost of living pressures.
- Limited opportunities for education and employment.
- Involvement with peer groups where alcohol, drugs are a feature of daily life.
- Experience of violence and behaviours that are understood as anti-social.
- Latent effects of adversity in childhood reflected in impulsivity.

What Are The Challenges To Doing It Better?

- Community anxiety of youth/young people where relationships are absent of where behaviours create uncertainty and fear.
- Stigmatisation and discrimination.
- Ensuring developmentally adult services that understand the impact of childhood adversity and subsequent experiences of trauma.
- Under recognition of neurodevelopmental presentations and learning difficulties.

What Might Better Look Like?

- Increase community awareness of the needs of young people to belong and be part of the community.
- Understand how the mental health needs of young people can present.
- Understand the opportunities when the journey/transition from children to adult services is planned well/matched to the needs of individuals.

Additional Contributing Author(s): Julia Takahashi, Public Health Research Officer - Health Improvement.

Example of Current Practice 1: Routine Enquiry Training

- The main aim of Routine Enquiry Training is to provide early, appropriate intervention and care by identifying and assessing service users who have or are experiencing domestic abuse. A disclosure of abuse also means that the therapeutic intervention offered by the service can consider the specific needs of the individual.
- GBV is primarily experienced by women and mostly perpetrated by men. Although most abusers are men, most men are not abusers. Evidence indicates that young people aged between 16 and 25 years old are at the highest risk of experiencing one of the most common forms of gender-based violence, domestic abuse. All forms of gender-based violence can have a negative impact on mental health.
- Maternity, sexual health, health visiting and family nurse partnership services have a significant number of women service users who have experienced domestic abuse, and are therefore staff groups who are targeted with this training.
- Multiple full courses and refresher sessions have been delivered by the Health Improvement Team over the past year. Additional training is being developed to support the identification of domestic abuse in healthcare settings. Currently, training aimed at Health Care Assistants is being finalised and will be piloted with assistants from the Health Visiting Team with an aim of reaching young mothers. The training will then be offered to healthcare assistants across all priority settings, as these staff have a key role in identifying and responding to domestic abuse.

Example of Current Practice 2: Ask For Angela Campaign

- NHS Ayrshire and Arran's Public Health Team supported the roll out of the Ask for Angela campaign across the three Ayrshire localities via the multi-agency Violence Against Women Partnerships. The Ask for Angela campaign was originally launched in England in 2016 and is used by bars and other licensed venues to keep people safe from sexual assault by using a codeword to identify when they are in danger or find themselves in an uncomfortable situation. A person who believes themselves to be in danger can "Ask for Angela", a fictitious member of staff. The staff will then help the person get home discreetly and safely by either escorting them to a different room, calling them a taxi and escorting them to it, or by asking the other party member to leave the establishment. In extreme circumstances Police can be contacted.
- The North Ayrshire Violence Against Women Partnership, of which a Health Improvement Officer supports, produced a letter for licensee's to accompany the campaign packs containing information posters for display in bar/restaurant areas, staff guidance posters for staff rooms, and additional materials such as branded drinks coasters, pens, face masks, and straws that were distributed at the time of the campaign launch.

Example of Current Practice 3: Supporting the Mental Health and Wellbeing (MHWB) of the Gypsy/Traveller Community

- Public Health are currently working with NAHSCP MH Engagement Officer, KA Leisure and Minority Ethnic Carers of Older People Project (MECOPP) Gypsy/Traveller Community Health Worker to support the MHWB of the travelling community. There is longstanding evidence that Gypsy/Travellers living in the UK experience major health inequalities with worse outcomes than the general population and other disadvantaged groups. Existing literature also suggests that travellers experience poorer mental health and higher rates of suicide compared to the general population. It is well accepted that there is a lack of culturally appropriate engagement, and existing supports are thought to be inadequate and not thought to meet the specific needs of Traveller community. The MECOPP Community Health Worker service is a two-year programme in which Gypsy/Traveller Community Health Workers (CHWs) are trained to provide health advocacy for their community on a wide range of health and social care issues. We are currently working to build the capacity of the local CHW, who is also a member of the travelling community, to support members with their mental health & wellbeing. Staff and key travellers are currently being trained in 'Mental Health Improvement – a practical approach' which will enable them to provide information, self-help strategies and appropriate signposting to support to travelling community members in a culturally appropriate way. Their Women's Group will be a focus for support in the first instance. There is also a large Mission Event in Eglinton Park, Irvine in August where 500 travellers will be sited for 5 days. This event will host a culturally appropriate Wellbeing Drop in service on site for travellers to come along for advice on MHWB and other health related concerns. It is hoped that these two projects are the beginning of future engagement locally to improve the MHWB and reduce health inequalities within the local travelling community.

Appendix E: Adulthood (25-49)

What Do We Know About Mental Health Need And Risks For This Age Group?

The relationship skills and competences (resilience) that are acquired through attachment experiences and the processes of self-individuation into early adulthood are taken into the adult years.

They inform adult relationships with family members, peers, work colleagues, community members and intimate partners as well as relationships in family life where there are children.

Healthy relationships can be understood as protective for mental health and deterioration of mental illness/disorder while loneliness is a risk factor.

Some pregnant women may experience poorer mental wellbeing when pregnant and a small number can be at greater risk of mental illness. The mental health needs of men/partners during pregnancy, in the early years, is better recognised than in times past. As is the impact on infants/children.

Significant mental health need and the related diagnosis of illness and disorder continue to present to services. Timely diagnosis and support/treatment can reduce risk and support improved outcomes.

This age group (along with middle-aged adults) have the highest suicide rates across the life course.

Many people who complete suicide are not known to, or involved with, mental health services.

What Helps?

- A wider appreciation across society, and within services, as to how the wider determinants of health can contribute (positively or negatively) to mental health/wellbeing and the presentation of illness/disorder as an adult.
- Outcomes for people can improve further when they can access supports that address financial vulnerability and create opportunities for friendship and community connection: through work and experience of community.
- Having a place where people feel safe whether this be home, work or your community can be understood as meeting primary attachment needs.
- Ensuring people can access mental health services when they are in need with clear routes to accessing wider interventions and supports (not necessarily specialist/NHS).
- Adults with emerging or identified mental health illness/disorder benefit from developmentally-informed and trauma-informed and responsive cultures and practice within mental health and addition services as well partner agencies such as social work, police, fire and rescue and the Department for Work and Pensions. Preventive approaches to mental well-being can be powerful in sustaining people with mental illness/disorder to be well: through primary care as well as family/community supports.
- Tackling stigma and discrimination where there is experience of mental illness/disorder. There are key opportunities to improve family/peer/community awareness of suicide risk and how to respond where there are concerns for a person.

What Hinders?

- Insecurity of income, housing and food/unemployment and social isolation.Lack of understanding regarding how early experiences shape our adult years and circumstances that can shape the need for, access to and experience of services.
- Social isolation or peer groups that can influence decision making that hinders better mental health/exacerbates risks related to mental illness/disorder.
- Problematic relationships with drugs and/or alcohol.
- Experiences of crime, violence (perpetrator or victim) and involvement with police and justice services.
- Indirect impacts of the COVID-19 pandemic which have had a disproportionate effect on those who were already experiencing mental health problems and other concerns prior to the pandemic.
- The tension that can exist between framing access to service and support challenges as hard-to-reach clients or hard-to-reach services.
- Finite service capacity set against presenting need.

What Are The Challenges To Doing It Better?

- Continuing challenges for people being able to realise their human rights with ongoing and increasing risks to finance, employment, housing and food.
- The increasing demands and stressors on people in this age group leaving them with little personal capacity for self-care and other activities.
- Fully maximising the preventive spend opportunities within universal health and education services.
- Challenges in investing to save where resources are tight when preventive investment in the early years and adolescent and early adulthood will take for 5-10-15 years to demonstrate better outcomes.
- Budget and service pressures within health and social care and partner agencies.

What Might Better Look Like?

- Improved understanding of and capacity for communities to play a role in public mental health. Proactive attention to maximising the resources within universal health services to support the capabilities and capacity of parents who struggle with meeting their own needs as well as their children's due to mental health needs and risks and/or problematic drug and alcohol use.
- Working more closely with our community planning partners to develop trauma-informed and responsive cultures and practices that will improve the experience of care for service users.
- Evidencing a journey of change to develop trauma-informed and responsive cultures and practice within services and frontline teams.
- Ensuring the voices of people with lived and living experience shape and inform service design and delivery.

Example of Current Practice 1: Workplace Health

- The Workplace Health Team provide a range of health, safety and wellbeing support to our local workplaces. The Team recently supported an event organised by the Fishermen's mission charity, working alongside a dental charity van, the Liver foundation and Prostate cancer. In collaboration with the Men's Health Outreach the KA Leisure Activator Van was funded to attend along with two health coaches to carry out basic health checks. Health checks were completed for fishermen and harbour side staff. Some health concerns identified were reports of high blood pressure (advice given to contact own GP) and reports of elevated blood sugars (BMs) in men who were diagnosed diabetics. Quit Your Way staff were also in attendance. A range of health information and free condoms were given to each of the fisherman. Discussion topics focused on poor working conditions and drug misuse. This event will allow the Team to further develop support for this sector with a better understanding of their working conditions and health concerns.

Examples of current Practice 2: Community Wellbeing

- The Nest, a new community wellbeing hub in Cumnock being developed with support from CVO East Ayrshire, What Matters to you and The Corra Foundation. The Nest will provide a welcoming space at the heart of the community. The community-led approach that has been adopted will encourage a better sense of togetherness locally by helping create a space that is built around people's strengths, interests and aspirations.

Examples of Current Activity 3: Food Larders

- Despite North Ayrshire having the highest levels of poverty across the Ayrshires this is not reflected in the data relating to being worried about food. This may be in part down to the role of the Food Larder network. There are 14 food larders operating in North Ayrshire and in addition to providing people with emergency food they work closely with a range of partners to provide wider advice and support including:
  - Working in partnership with the Money Matters team to offer income maximisation for users of the larders.
  - Work with the Health Improvement Dietetic Team to build capacity of larder volunteers and users through the Cheap and Nutritious (CAN) Toolkit. This provides recipes for cheap and nutritious meals as well as advice on energy use for cooking.

Additional Contributing Author(s): Mhairi Strawhorn, Health Improvement Officer and Lindsey Murphy, Health Improvement Lead.

Appendix F: Middle Age (50-69)

What Do We Know About Mental Health Need And Risks For This Age Group?

The capacity for resilience and coping skills acquired across life to date alongside subsequent traumatic experiences/events and related life challenges inform the presence of mental wellbeing or poorer mental health and wellbeing/exacerbation of mental illness/disorder.

People in this life stage are more likely to become unpaid carers for family members with women predominantly assume caring roles. This can take a toll on mental wellbeing and may result in loneliness and isolation.

The development of long-term physical health conditions begins to increase during this period. These can be cumulative and impact on mental health/wellbeing.

However, as the adult years progress the underlying challenges of poor mental health or mental illness/disorder need not remain fixed and progressively poor in outlook.

It is now understood that the brain has capacity to recover over the life course: facilitated by positive family/peer and community relationships and therapeutic treatment and care.

There are risks though: along with adults (20-49), the middle years have higher rates of suicide than other life stages, particularly for men where rates are twice as high as for women.

What Helps?

- Connection to others and positive work/home relationships alongside participation in the life and activities of local communities.
- Meaningful work and/or other activities that bring purpose and meaning.
- Feeling safe in communities and at home.
- Good physical health and feeling 'healthy'.
- Understanding employers and services who are aware of the different needs people may have and how best to support them i.e. caring, menopause, health conditions.
- A mental health service that is aligned to the needs of this age group and can be accessed directly through primary care.

What Hinders?

- As people age, they are more likely to experience bereavement which can have an impact on mental health and contribute to feelings of loneliness.
- Limiting long term conditions (not necessarily mental health condition).
- Lack of support and connection for those experiencing a transition period when people may be leaving work, children leaving home, etc.
- Separation and divorce/the breakdown of longstanding relationships.
- Treatment and care that does not take into account the wider lifestyle factors affecting this age group

What Are The Challenges To Doing It Better?

- There can be a lack of understanding of the capabilities and skills of this age group with emerging stigmatising views of aging e.g. workplace and employment.
- As people live longer lives they are required to do all they can to have a good quality of life for as long as they are able.
- This can be the more challenging for people with low incomes, poorer pension provision where there is a need to work longer even as there can be an increase in long term health conditions.
- Working better to support specific groups who are vulnerable to challenges in aging i.e. those who are homeless, in prison or being released into the community after serving long sentences.

What Might Better Look Like?

- Build capacity and understanding of mental health/wellbeing as a resource to be nurtured across life, among community planning and third sector partners. Increased social and green prescribing with a shift away from medication where other activities may be more appropriate.
- Learning more about the benefits to mental health from activities such as green health and men's sheds.
- Refresh and refocus efforts on tackling social isolation and loneliness.
- Build capacity of other organisations and partners in understanding the menopause and what can help i.e. increasing understanding and skills of employability agencies to ensure women are not stigmatised and do not face additional inequalities due to the menopause.
- Increase in support/services which provide wraparound support for all aspects of life.
- Decrease in people needing to access so many services and continually repeating their story to get the support they need.

Case Study 1: Menopause

- In NHS Ayrshire and Arran, 45% of employees are females over the age of 45, and over 75% of our workforce are female, therefore, we have a duty to support our staff as they navigate the menopausal transition.

- In October 2022, NHS Ayrshire and Arran launched our menopause workplace guidance, which will provide line managers with clear guidance on how to support employees through peri-menopause and beyond. It is designed to be inclusive of all gender identities and draws together guidance from the Faculty of Occupational Medicine, the British Menopause Society and the National Institute for Care and Excellence (NICE). The launch event was well attended by managers and senior leaders in the organisation, along with local elected members. The vision is to build a culture of awareness and support in all levels of the organisation, ensuring that every staff member has access to the right support and information.

Case Study 2: Social and Green Prescribing

- The Green Health Partnership in North Ayrshire works with communities to encourage people to spend more time outdoors in contact with nature through activities like green volunteering, recreation, learning and active travel. One community project going from strength to strength is the **Eglinton Community Gardens**. Health services can offer green prescriptions for the gardens with a range of activities being delivered by partners including Turning Point Scotland and the Community Learning and Development Team.

- **Breaking Ground** is a social and therapeutic horticultural service for people living within North Ayrshire. It offers support, training and recovery for individuals experiencing short-term mental health problems, using gardening activities as a means to achieve this. As a green prescription therapy, individuals are referred to the project from health service organisations.

- **Ground Force** is a tree nursery project funded by the Armed Forces Covenant Fund in partnership with North Ayrshire Council and is aimed at both serving and ex-serving personnel and their families. Not only is the project focused on the production and management of trees led by tree professional Eadha Enterprises, it covers a variety of green health gardening related activities, contributing to the aims and objectives of the community gardens. A highly sociable and productive group, with seasonal family focused activities interspersed throughout the year

Additional Contributing Author(s): Mhairi Strawhorn, Health Improvement Officer and Lindsey Murphy, Health Improvement Lead.

Appendix G: Older Adults (70-89)

What Do We Know About Mental Health Need And Risks For This Age Group?

Scotland is ageing faster than the rest of the UK with rural and island populations doing so at a greater extent as birth rates decline more rapidly.

Learning and mental activity across the life stages and into later life can protect against age-related cognitive/physical decline and related impacts on mental health wellbeing and experience of mental illness/disorder.

Working into later years can be protective and rewarding through new learning and a sense of purpose.

For some though, where there is a necessity to work to cover basic wants and needs, less satisfying and rewarding work that is physically demanding brings challenges.

The increased prevalence of long-term conditions into later years can be for both physical and mental health conditions, with increased challenges with frailty.

The latent effects of childhood adversity play out across life with increased risk of heart disease, stroke, some cancers and respiratory conditions alongside mental health needs and related mental illness/disorder as people age.

What Helps?

- The enduring value of meaning/purpose in life and connected healthy relationships continuing as people transition into later years.
- This can be facilitated by involvement in decision-making and experience of being treated with dignity and respect in family and community life, as well as through engagement with services.
- Maintaining preventive approaches that sustain capacity and capabilities, as age-related challenges present.
- Information technology brings opportunities and may help limit cognitive decline as difficulties present - but access and support with use may be needed.
- The benefits of security of income, housing and food that align to needs.
- Accessible transport and connectivity with local and wider community and services.
- Access to support for unpaid carers such as respite, day services, financial or peer.
- When physical and mental health needs are met in conjunction with each other by services

What Hinders?

- The cumulative effects of childhood adversity and subsequent traumatic experiences, in the absence of relationships that buffer the impact, continue to take their toll into later life.
- Limited incomes can compromise social engagement and access to leisure.
- Ageing can bring a loss of identity or independence or fulfilment, the more so where there is experience of multiple bereavements of family/friends.
- Experience of elder abuse from partners, family members or wider scamming can be devastating.
- Where recovery has been challenging the effects of chronic mental illness/disorder can play into risk for more problematic later years.
- Changes that are not informed by sensitivities to age and frailty can compromise mental wellbeing and increase vulnerability where there is mental illness/disorder. Examples include transition to different care environments, age discrimination, understanding capacity issue, loss of control, and reduced choice.

What Are The Challenges To Doing It Better?

- Age discrimination with stigmatising generational attitudes can be problematic within the workforce and across society.
- There are older people population subgroups where needs remain poorly understood or explored, for example, older frail residents in prison.
- More work is required to outline and develop mental wellbeing and mental illness/disorder related metrics/outcomes.
- With a rapidly ageing population there is a higher demand for services and challenges in meeting pre-existing and emerging age-related mental health needs.
- Information sharing barriers can persist.

What Might Better Look Like?

- Understanding the gap between income groups where a life expectancy is of sufficient size that some will never experience their older years.
- Better understanding of the needs of older people where community distress and violence is no less of a problem as they age.
- Demonstrating evidence that services for ageing populations with a range of mental health needs are trauma-informed and responsive as needs and difficulties present in later life.
- The development of data sets that capture and reflect the needs of an ageing population.
- Valuing lived experience of older people who have navigated adversity and trauma across their lives and where there is learning for all. A parallel approach for people who have spent years navigating mental health systems to better understand where change may be needed.

Current Example of Practice 1:

Health Promoting Care Homes (HCPH) Framework

- In 2015, NHS along with other agencies launched the Health Promoting Care Homes framework, developed by a multi-agency partnership group from NHS Ayrshire and Arran, Scottish Care, Third sector & accompanying toolkit.

- The HPCH framework aims to:
  - Help to secure the best possible outcomes for people living in care homes.
  - Encourage the involvement of families, residents and carers in health improvement activities.
  - Focus on prevention by recognising the sources of health, not just disease or illness.
  - Promote the importance of staff health & wellbeing.

- Following a successful six month pilot, the framework was rolled out to care homes across Ayrshire & Arran, with positive feedback received from participating care homes.

Current Example of Practice 2:

Caring for Ayrshire

- In 2020, NHS Ayrshire & Arran and the three Integration Joint Boards of the health and social care partnerships in East, North and South Ayrshire launched their "Caring for Ayrshire" vision, outlining how health and care services could be delivered over the next ten years across Ayrshire and Arran.

- The Caring for Ayrshire vision is that "care shall be delivered as close to home as possible, supported by a network of community services with safe, effective and timely access to high quality specialist services for those whose needs cannot be met in the community." This work will especially benefit our older and elderly population, given the specific risks that these age groups face – rurality, digital exclusion, mobility issues, etc. As a key partner, Public Health will continue to support the Caring for Ayrshire agenda, ensuring prevention work is considered as this work progresses.

Current Example of Practice 3:

Ageing Well Strategy

- South Ayrshire has joined the UK Network of Age-Friendly Communities - a growing movement led by the World Health Organisation. South Ayrshire are only the second in Scotland, after South Lanarkshire to sign up.

- An Age-Friendly Community is a place that enables people to age well and live a good later life - somewhere that people can stay living in their homes, take part in activities they value and contribute to their communities for as long as possible.

- With our Public Health Assistant Director sitting on the South Ayrshire Ageing Well Strategy group, Public Health will have an opportunity to feed into this work as it progresses.

Additional Contributing Author(s): Nicola Halligan, Health Improvement Officer and Robyn Scott, Health Improvement Practitioner.

Appendix H: Elderly (90+)

What Do We Know About Mental Health Need And Risks For This Age Group?

The numbers of people living into their tenth decade has increased at a rapid rate over recent decades.

Experiences of childhood adversity are increasingly understood as influencing the ageing process, demonstrating the long reach of such experiences across the life course.

More needs to be known about the mental health challenges of later living where there can be further disparity of need and risk: as people age into the last years of life there can be wider variation between individual experiences.

More work is also required to understand the needs of greater numbers of people living to elderly ages to inform care models and treatment options.

This is a time when failing physical health, frailty and deteriorating mental capacity and cognitive function can align, even as some people experience high levels of independence and freedom from long term conditions.

These can mirror wider inequalities, noting that for poorer communities, fewer people live into their tenth decade.

However, there is no reason why good mental health should not be possible in very late years, or that treatment services for mental health illness/disorder should be any less available/accessible. The ageing process can play out over long periods of time and many older people report better mental health than younger/older adults.

What Helps?

- Encouraging independence and involvement in decision-making, and ensuring dignity and respect remains central to meeting people at their point of need.
- Better understanding and awareness-raising of how the wider determinants of health impact on this age group and their mental health.
- Awareness-raising with older people's workforce (e.g. care home staff) and mental health workforce on mental health issues specific to this age group.
- Understanding the impact of dementia and frailty, and preventive approaches that reduce decline and maintain function.
- Ensuring integrated care and treatment across primary and secondary and elderly care teams is key to supporting mental wellbeing and addressing mental illness/disorder in the later and last years of life.

What Hinders?

- Finite and limited personal and family resources impacting security of income, housing and food choices.
- Age discrimination: e.g. sharing struggles viewed as capacity issue, loss of control, reduced choice.
- Poorer physical health impacts on mental health at this point no less than at any other age, where resilience/sense-making cognitive functioning may also be the more challenging.
- Multi-morbidity, higher prevalence of long-term conditions.
- Transitions to different care settings: from independent living to care homes.

What Are The Challenges To Doing It Better?

- Lack of specific data, for this age group.
- Moving beyond pilots of innovative practice to mainstreaming.
- Age discrimination/generational attitudes

What Might Better Look Like?

- Community Safety - gather evidence from local older people and take action.
- Intergenerational activities - encourage intergenerational practice and progress to intergenerational spaces for living, learning, working and playing.
- Lifelong learning – skill building opportunities/informal learning to encourage community participation.

Current Example of Practice 1:

Health Promoting Care Homes (HPCH) Framework

- In 2015, NHS along with other agencies, including Local Authorities and the Care Sector, launched the Health Promoting Care Homes framework, developed by a multi-agency partnership group from NHS Ayrshire and Arran, Scottish Care, Third sector & accompanying toolkit.
- The HPCH framework aims to:
  - Help to secure the best possible outcomes for people living in care homes.
  - Encourage the involvement of families, residents and carers in health improvement activities.
  - Focus on prevention by recognising the sources of health, not just disease or illness.
  - Promote the importance of staff health & wellbeing.
- Following a successful six month pilot, the framework was rolled out to care homes across Ayrshire & Arran, with positive feedback received from participating care homes.

Curerent Example of Practice 2:

Caring for Ayrshire

- In 2020, NHS Ayrshire & Arran and the three Integration Joint Boards of the Health and Social care partnerships in East, North and South Ayrshire launched their "Caring for Ayrshire" vision, outlining how health and care services could be delivered over the next ten years across Ayrshire and Arran.
- The Caring for Ayrshire vision is that "care shall be delivered as close to home as possible, supported by a network of community services with safe, effective and timely access to high quality specialist services for those whose needs cannot be met in the community." This work will especially benefit our older and elderly population, given the specific risks that these age groups face – rurality, digital exclusion, mobility issues etc.
- As a key partner in, Public health will continue to support the Caring for Ayrshire agenda, ensuring prevention work is considered as this work progresses.

Current Example of Practice 3:

Ageing Well

- South Ayrshire has joined the UK Network of Age-Friendly Communities - a growing movement led by the World Health Organisation. South Ayrshire are only the second in Scotland, after South Lanarkshire, to sign up.
- An Age-Friendly Community is a place that enables people to age well and live a good later life - somewhere that people can stay living in their homes, take part in activities they value and contribute to their communities for as long as possible.
- With our Public Health Assistant Director sitting on the South Ayrshire Ageing Well Strategy group, public health will have an opportunity to feed into this work as it progresses.

Additional Contributing Author(s): Nicola Halligan, Health Improvement Officer and Robyn Scott, Health Improvement Practitioner.