



**Dealing with Distress**  
**Director of Public Health**  
**Annual Report 2005**

# **Report of the Director Of Public Health 2005**

**The cover of this report has been designed from a painting by the Chinese-American artist, Diana Ong, who was born in 1940.**

**The picture is called 'Teardrop' and represents the theme of 'distress' which runs through my Report.**

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## Foreword

Several issues important to improving the health of the people of Dumfries and Galloway were highlighted in the last Director of Public Health Report 'Doing things differently'. There is progress to report on most of these.

- The salary costs of the core staff in our Healthy Living Centre movement 'Building Healthy Communities', have been secured on a permanent basis, allowing the project to move forward with the production of a refreshed strategy and framework for measuring success. This will allow us to start the expansion of the project into other geographical areas.
- Through our Community Planning partnership with Dumfries and Galloway Council, Scottish Enterprise Dumfries and Galloway, and others, we now have a draft Workplace Health Strategy in place, which is making issues of job control and organisational justice central to its implementation.
- A number of initiatives have been taken forward that encourage higher levels of physical activity, and valuable work has been carried out in Annandale and Eskdale, the Stewartry, and in North West Dumfries, which is improving the diet of people living in these areas.
- The introduction of the ban on smoking in public places was associated with a temporary upsurge in people requesting smoking cessation advice but an increased level of service was able to cope with this upsurge. In addition, the implementation of the newly agreed Tobacco Control Strategy is proceeding rapidly.
- A Partner Notification Nurse has been employed to follow up cases of sexually transmitted infections. This is already providing us with the ability to implement all of the recommendations contained in the previous report about controlling the epidemic of Chlamydia.

Although the provision of more resources would allow us to make progress more rapidly, new resources have been provided for the improvement of health and progress is undoubtedly happening. We need to continue and accelerate this trend.

In this, as in the last Report, there is a statistical Appendix providing an overview of health and illness in Dumfries and Galloway. Once again these statistics would suggest a slightly healthier population than is the average for Scotland. Nevertheless, as will be apparent from the rest of this Report, these good illness data may not reflect accurately some other serious health issues within our population. I am happy to include a brief section on dental health since this ought to be the last report that indicates the problems caused by lack of dentists in Dumfries and Galloway. As at the time of writing there has been a significant upsurge in the number of general dental practitioners working in our region, and being unable to register with an NHS dentist should soon be a thing of the past in Dumfries and Galloway. However, because they are important, serious and

somewhat neglected topics, I have decided to concentrate this report largely on those common mental health problems that are a cause of so much distress, disability, economic deprivation and consumption of health service resources. Some current thinking on the solutions to these problems is discussed. The resources required to implement these new approaches would have to be spent through the health service. There are corresponding resources that would be saved by reducing the burden of these mental health problems but these savings would accrue mostly through the Benefits system and the tax system. To implement these recommendations fully therefore would require considerable political support.

Dr. Derek Cox  
Director of Public Health  
October 2006

## **1. Distress – Why Does it Matter?**

This report is not about serious psychiatric disease such as schizophrenia and bipolar depression, whose prevalence in the community is relatively low and reasonably stable<sup>1</sup>. The report concentrates on what might be termed mild to moderate mental health problems. These issues are sometimes confused by the medical and lay terminologies used to describe them. In planning for this report I was initially thinking that the emphasis would be on “stress”. This, however, is a term that is much used, but less understood.

Hans Selye was one of the founders of research into stress. He formed the view in the 1950s that stress is not necessarily something bad. Selye pointed out that the stress associated with exhilarating, creative, successful work is beneficial, while stress associated with failure or humiliation is detrimental<sup>2</sup>. A widely accepted definition of stress (due to Richard Lazarus) is that stress is a condition experienced when a person perceives that demands or pressures on him or her are greater than the personal and social resources the individual can call upon<sup>3</sup>. The experience of stress is not a medical diagnosis, but the persistent experience of stress can lead to both depression and anxiety, or a mixture of the two. Many people do not wish to have the way they feel categorised with these medical diagnostic labels and might be more comfortable with words like unhappiness. As will be seen in a later chapter the psychological approach that might be adopted in tackling these problems with people is broadly similar regardless of the diagnostic label and so, in order to simplify the discussion of these mild to moderate mental health problems, I have where possible used the word ‘distress’ to embrace all of these concepts.

Why then should distress be considered important enough to form the bulk of a report into the state of health of the population of Dumfries and Galloway? There are two reasons for according it this degree of importance.

Firstly, these problems are common and becoming commoner. The World Health Organisation predicts that depression will be the second commonest cause of loss of disability adjusted life years in the world by 2020 (second only to AIDS)<sup>4</sup>. There is nothing to suggest that such a predicted increase in depression might not apply in Dumfries and Galloway. Antidepressant drug prescribing has increased in Dumfries and Galloway from 37,151 prescriptions in 1992 to 1,117,993 in 2005, a 215% increase over 12 years or roughly 18% per year. It is difficult to be sure about the number of patients that this volume of prescribing might represent. Current recommendations are that once started on a course of antidepressant drugs patients should stay on this course for six months<sup>5</sup>. On the assumption that there will be many patients who discontinue medication earlier than this, and some who will continue for longer or even indefinitely, it might be reasonable to estimate the number of patients on the assumption that on average each patient takes treatment for between six and nine months and that the tablets are dispensed once per month. On this basis, it is possible to estimate that in 2005 between 13,104 and 19,656 people in Dumfries and Galloway were thought to be depressed to the extent that drug treatment was indicated for them. These figures may slightly overestimate the numbers since there are some indications for antidepressant drugs other than for depression (e.g. chronic pain).

Drugs classified as ‘anxiolytics’ have a sedative effect and may be prescribed for a variety of anxiety disorders. Despite national advice reserving their use for short courses to alleviate acute conditions<sup>6</sup>, their use continues to be widespread. In Dumfries and Galloway prescribing of anxiolytics has increased from 23,610 prescriptions in 2001 to 33,124 in 2005, a 40.3% increase. Since the recommendation to use these drugs only in short (three week) courses has been reinforced during that period it can be assumed that the rise in the numbers of patients treated with these drugs is actually greater than the rise in the number of prescriptions would suggest. The number of people presenting with anxiety to their doctors seems to be a problem which is also on the increase.

Tables 1 and 2 in chapter 4 show that for all episodes of sickness absence from work, stress is the second commonest cause in non-manual workers and the fourth commonest cause in manual workers and, more dramatically, in considering only long term sickness absence, stress and mental ill-health are the first and second commonest causes of absence in non-manual workers and the third and fifth commonest causes in manual workers.

It is clear from all of the above that distress, in all its guises, is a common and increasing problem that results not only in much human misery but that also has important and negative economic effects on society as a whole<sup>1</sup>.

The second reason for regarding these issues as important ones is because their consequences extend beyond psychological distress and negative economic effects. They are also responsible for a significant amount of physical ill-health. There is a burgeoning research literature which is increasingly showing the cause and effect relationship between psychological distress and the development of physical ill-health. Many such examples could be cited commonly linking psychological distress with coronary heart disease and cancer but a single example will suffice to illustrate the point. In a population in Canada, amongst 20-50 year olds depression increased the risk of developing diabetes by approximately 23%<sup>7</sup>. Many health promotion interventions aimed at reducing the incidence of such diseases are almost certain to be less effective than they might be if issues of psychological distress are not included in the programmes.

Although the Scottish Executive has recently raised the profile of these issues through its Mental Health and Wellbeing and Choose Life programmes, the issues attract media attention, provoke public debate and attract financial investment at a level disproportionately low in comparison to the importance of these topics. This report in part sets out to try to redress this imbalance. In doing so it concentrates on three issues that are commonly associated with distress, but there can be many other circumstances in people’s lives that cause them distress, and these are all equally important in determining not just the state of psychological health in the community, but also as important predictors of physical illness throughout Dumfries and Galloway.

## 2. Drinking Away Distress

Research shows that alcohol's anticipated stress relieving effect is a primary motivation for many people to consume alcohol, despite the often harmful consequences of drinking<sup>1</sup>. This is not a modern phenomenon. It has been well documented through the centuries that alcohol has been used to combat distress. For example, more than 2500 years ago the Greek lyric poet Alcaeus suggested drinking as a way to cope with distress:

*"We must not let our spirits give way to grief...Best of all defences is to mix plenty of wine and drink it".*

William Shakespeare referred to alcohol's stress reducing properties in his play Julius Caesar (Act IV, Scene III):

*"Speak no more of her. Give me a bowl of wine. In this I bury all unkindness".*

The concept that alcohol can 'calm the nerves' is, in fact, widely held across many cultures including Scotland. In western societies the media and entertainment industry perpetually reinforce this message as they consistently portray drinking as a way of relieving stress<sup>2</sup>.

### **The links between alcohol and distress**

There is a clear association between excessive alcohol consumption and distress. Whether this relationship is one in which alcohol is used to relieve distress or one in which the excessive use of alcohol is the cause of distress is not always clear<sup>3</sup>.

The question of which comes first is dependant on a range of factors, including the amount of alcohol consumed, the duration of excessive alcohol use, and whether or not the person has a diagnosed anxiety disorder or is merely experiencing some lesser level of distress. There is a widespread belief that alcohol can act to dispel feelings of distress. For example, many socially anxious people believe that alcohol helps them cope and feel more comfortable in social situations<sup>4</sup>. In this case alcohol is fast acting and temporarily relieves feelings of stress. The problem arises when people need to drink more to 'self medicate' their distress, but in so doing further their level of distress in the long term. As people become more dependent on alcohol over time they will experience the negative consequences, which include mood swings, depression, sleep disturbance, and physical problems such as high blood pressure or an increase in their weight.

There is a wealth of research literature that attests to the validity of the model in which distress is the cause of excessive drinking. For example, it is clear that people who have experienced abuse (both physical and sexual) in childhood have a greater likelihood of developing problem alcohol use in adulthood. More than 50% of women undergoing detoxification give a history of childhood sexual abuse<sup>5</sup>.

On the other hand, there is also good evidence that problem alcohol use may be a direct cause of both depression and anxiety in people who had neither problem before their heavy drinking started<sup>3</sup>. It seems therefore that both cause/effect models can apply in different individuals. For those trying to help or to treat people, this demonstrates the necessity of enquiring about alcohol in people presenting with symptoms of distress and of enquiring about previous causes of distress in those presenting with problem alcohol use.

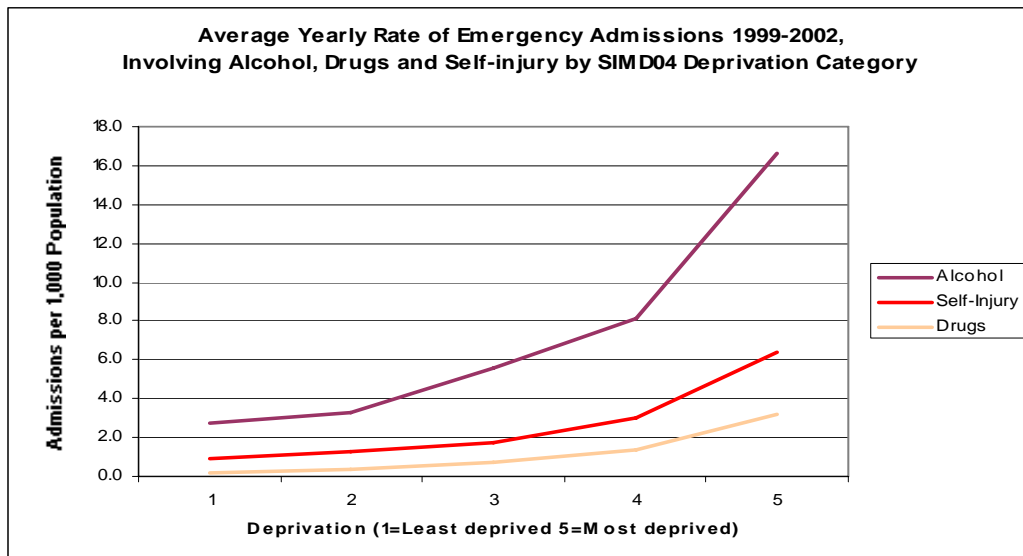
## The situation in Dumfries and Galloway

The majority of people in Dumfries and Galloway drink alcohol without any problems. Indeed many people will benefit from drinking moderate amounts of beer, wine or spirits and there is evidence that shows some protection against coronary heart disease and stroke<sup>6</sup>. For many people, moderate drinking provides opportunities for socialising with family and friends – a great stress reliever in itself and a powerful predictor of happiness.

Sadly this is not the case for all of the population. The most recent survey in Dumfries and Galloway (2000) showed that 14% of men and 13% of women drank more than the recommended weekly alcohol intake. 21% of men and 11% of women said that they drank primarily in binges. This could represent approximately 15,000 people in the region who may be drinking to excess, and a significant proportion of these will be suffering some form of distress, either as the cause of their drinking or as a result of their drinking.

There is a clear relationship between psychological distress and relative socioeconomic deprivation<sup>7</sup>. This relationship can also be seen in relation to problem drinking. Figure 1 shows the rate of emergency admissions to hospital in Dumfries and Galloway due to alcohol (and also self harm and illegal drugs), showing the steep increase in such admissions from the most deprived communities.

**Figure 1: Admission rates for alcohol, drugs and self-injury by deprivation for Dumfries and Galloway.**

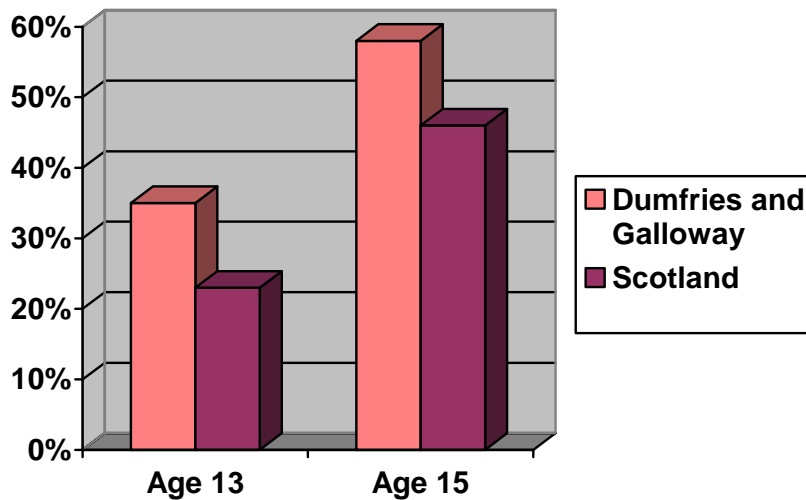


In an average year there are over 900 emergency admissions where alcohol was a factor, 140 drugs related emergency admissions and over 300 admissions for self-inflicted harm.

## Children, Alcohol and Distress

Concern is frequently expressed about the increased amount of alcohol being consumed by children and young people and there is a worrying increase in what has become known as 'binge drinking'. A survey in 2002<sup>8</sup> (SALUS) asked school aged children under 16 in Dumfries and Galloway when they last had an alcoholic drink. 58% of 15 year olds and 35% of 13 year olds had drunk alcohol in the last week. This figure for both age groups was significantly higher than reported national figures. (Figure 2)

Figure 2: Percentage of children who have drunk alcohol in the past week



The rise in alcohol consumption amongst children is paralleled by a rise in referrals to child and adolescent mental health services, and some studies show that 80% of adolescents (aged 14-18) with alcohol problems also have psychiatric disorders.

## What sort of distress can cause people to drink?

There are many stressors in the world today and each individual will experience stressors in different ways. Below are some examples divided into two groups:

### Personal and individual factors:

- Personality traits such as being able to control anger or levels of happiness
- Self esteem and feelings of confidence (this can also be linked to body image, adverse childhood experiences, including abuse, and weight management issues)

- Gender; women generally tolerate less alcohol than men but also drink for different reasons
- Ability to appraise and then cope with different situations

### **Life Circumstances:**

- Work - poor management or lack of control over how the job is done
- Home - domestic abuse, financial worries, caring responsibilities to either young or older dependants
- Major life events - moving house, changing job, changes in health status, serious injury, dealing with the loss of a loved one or birth of a baby
- Catastrophic events - war, effects of terrorism or a natural disaster such as a Tsunami.

### **What needs to be done?**

Having identified that there is a link between alcohol and distress, and that these problems are on the increase the question arises as to why present policies towards alcohol use and distress are being less effective than would be desirable.

It seems likely that the first thing that is required is better recognition of both problems. There needs to be a greater use of screening tools to detect both problem drinking and unrecognised distress. These screening tools should be used regularly not just by health care professionals. The levels of detection of these problems would be greatly enhanced if these tools were used by social workers, community workers, school teachers and police officers as well as by GPs, hospital doctors, nurses, and pharmacists.

Once one of these problems has been detected (either excessive alcohol use or distress) the individual should be screened for the other. Formal tools for the detection of childhood physical and sexual abuse should, in particular, be brought in to more widespread use in order to detect this common but largely hidden cause of distress and alcohol use. The evidence suggests that for some people, their depression or anxiety states disappear when the person achieves abstinence. However there is also evidence that where underlying causes exist, achieving abstinence is both more difficult and of shorter duration when these underlying problems have not been addressed. The evidence therefore supports a model of management for individuals with both identified mental health problems and alcohol use, in which the alcohol use and the causes of distress are addressed together<sup>3</sup>

Whilst good quality individual management of people who present with combined alcohol/distress problems is important, it is equally important that what can be achieved to address the life circumstances that predispose to these problems are indeed achieved. In this respect the influence of the workplace is emphasised elsewhere in this report, and all Dumfries and Galloway employers have a responsibility to ensure that their workplaces do not contribute to distress in their workforce.

As far as children are concerned there is substantial evidence that those children who are able to delay gratification to gain future advantage experience alcohol later and with fewer problems than children less able to delay gratification<sup>9</sup> This ability to delay gratification is associated with particular styles of parenting, and it has to be assumed that changing parenting styles to those that encourage the delay of gratification might reduce early and excessive alcohol use in their children.

## Costs to Society of Alcohol misuse

Whilst the focus of this chapter is on the relationship between alcohol and distress, the other serious problems associated with excessive alcohol use should not be ignored. The main problems are those of physical ill health, damage to social and family life, criminal behaviour, loss of productivity in the workplace and loss of personal income. Excessive alcohol use in Scotland, and in this region, has profound cost implications for both the NHS directly and to the wider society. Table 1 shows the level of costs incurred in 2002/3.

**Table 1 Summary of Annual Costs of Excessive Alcohol Use: 2002/03**

<b>Resource Category</b>	<b>2001/02 annual cost (£ million)</b>	<b>2002/03 annual cost (£ million)</b>	<b>*Estimated costs for D&amp;G (£ million)</b>
NHS Scotland	95.6	110.5	3.2
Social Work Services	85.9	96.7	2.8
Criminal justice & emergency services	267.9	276.7	8.1
Wider economic costs	404.5	417.8	12.2
Human costs	216.7	223.8	6.5
<b>Total cost to society</b>	<b>1070.6</b>	<b>1125.5</b>	<b>32.8</b>

*Source: Costs to Society of Alcohol Misuse in Scotland – Scottish Executive October 2001*

*\*Estimated costs for Dumfries and Galloway based on the Scottish 2002/3 figure*

It is obvious that the excessive use of alcohol and levels of distress are increasing and that they are interlinked. Across Dumfries and Galloway there are many excellent services (some of which are listed at the end of this article) that provide advice, help and support. However, if the issue is to be tackled on a sustained and long term basis, providing limited services for currently detected individuals with these problems is only part of the solution. Major changes are required in

- Screening for excessive alcohol use
- Screening for the common causes of distress (including childhood abuse)
- Therapeutic interventions for both (simultaneously)
- Workplace practices that reduce workplace stress

- The encouragement of parenting styles that improve children's ability to delay gratification.

If all agencies were to work more closely together, and if mechanisms could be identified to recognise that savings in one part of the public service (such as prison and criminal justice systems) might reasonably be invested in costs in other parts of the public service (such as health and social services), it should be possible to invest at least part of the estimated £32 million per year that excessive alcohol use costs Dumfries and Galloway, in greatly improved screening and interventional services in order to alleviate this massive cause of human distress in our community.

*Alcohol and Drug Action Team  
South West Scotland Addiction Services  
Cameron House  
Turning Point*

### **3. Carers' Distress**

#### **Carers**

The term 'carer' refers to anyone who routinely helps others who are limited by chronic medical conditions. "Formal" carers are volunteers or paid employees connected to the social service or health care systems. The term "informal carer" refers to family members and friends, who are the primary source of care for nearly 75% of the impaired old adults in the community. Carers assist with such basic tasks as bathing, dressing, preparing meals, and shopping. Some have the added responsibilities of delivering medication, making sure that an immobile person is turned frequently to avoid developing pressure sores, and other tasks relating to the older person's illness or disability. This chapter looks at the distress experienced by these informal carers.

#### **How many carers are there in Dumfries and Galloway?**

Survey work has estimated that there are 305,100 carers in Scotland<sup>1</sup>. This would equate to about 9,150 carers in Dumfries and Galloway. To test if this figure is about right it is possible to look at the numbers of people receiving benefits. Attendance Allowance is a benefit for people over the age of 65 who are so severely disabled, physically or mentally, that they need a great deal of help with personal care or supervision. In Dumfries and Galloway, 4,095 individuals are claimants for Attendance Allowance. This amounts to 14.5% of the population aged 65 or over. Disability Living Allowance is a benefit for people who become disabled before the age of 65. It consists of both a care component for people who need help with personal care and a mobility component for those who need help with getting around. In Dumfries and Galloway at August 2004 there were 6,855 people in receipt of the care component of the Disability Living Allowance<sup>2</sup>. If all of these individuals had a single carer there would be 10,900 carers in Dumfries and Galloway. This would tend to suggest that the figure of over 9,000 is likely to be a reasonable estimate.

#### **Who are carers?**

The profile of carers varies depending on who is being cared for. In an analysis of carers of elderly parents or parents-in-law<sup>3</sup>, most were between the ages of 45 and 65 years, the majority were female and they were providing more intensive forms of care. The latter is more likely if the older person is mentally impaired.

With regard to spouse carers, 70% were aged over 65 years, 21% were aged over 75 years, and 90% were retired. The division between men and women was about equal. With many carers being elderly themselves, it has been reported that half of older carers suffer a long-standing illness or disability, one third provide 50 hours of care per week, and one in five struggles to pay essential bills. In addition, it was revealed that the majority of older people who live with the person they care for, receive no regular visits from health, social services, or home care agencies. They were also unlikely to ask for help in the first place and one third of them never had a break.

## The Distress of Caring

The Care 21 Unit of the Scottish Executive instigated a survey of carers from across Scotland<sup>3</sup>. Unfortunately the response rate was low at 17%. However the data from the carers' survey provides some insight into the levels of stress experienced by those who provide informal care for others. The table below shows how common several stress-related aspects were among respondents from Dumfries and Galloway, Scottish Borders (an adjacent area that is also rural in nature) and the whole of Scotland.

	No. of respondents	% of Respondents				
		General feeling of stress	Feeling depressed	Feelings of anxiety	Physical strain	Short tempered/ irritable
Dumfries and Galloway	66	60.6%	60.6%	63.6%	45.5%	56.1%
Scottish Borders	213	65.7%	57.7%	59.6%	33.3%	54.9%
Scotland	4,267	71.2%	60.7%	64.2%	44.9%	61.9%

The low response rate greatly limits the conclusions that may be drawn from these data. However, they appear to indicate that stress-related symptoms are common among informal carers from across Scotland including Dumfries and Galloway. If 60% of our 9,150 carers are experiencing some sort of distress, this amounts to some 5,400 people in Dumfries and Galloway who are distressed as a result of their caring role.

## Identifying distress in carers

There is a growing body of knowledge about what leads to distress in carers. In caring for carers two things are necessary: to assess the level of carer burden and distress and to intervene where necessary in order to reduce or alleviate carer distress.

Social care and health professionals can assess the degree of carer burden and distress both by using informally gathered data and formally developed tools. Sensitive listening and careful observation for telltale behaviours and appearance can help to identify carers who are under significant burden or distress. There are also several formal instruments that can be used to assess carer burden such as the Zarit Burden Index<sup>4</sup>, the Care-giver Strain Index<sup>5</sup> or the Screen for Care-giver Burden<sup>6</sup>.

Whenever possible, assessment of carer burden should begin by obtaining the patient's consent to speak to the carer. To ensure uninhibited responses, the discussion should preferably not take place in the presence of the patient. Professionals should ask clear non-judgemental questions to identify the areas of most concern to the carer. The social support network of the carer should be assessed and it is particularly important to monitor carers for depression<sup>7</sup>.

## **Financial costs**

A key factor that is often ignored is the financial cost of caring. This does not just apply to loss of earnings and pension provision. Consideration has to be given to the carer's lack of time such as the purchase of convenience foods, or greater use of a car or taxi for shopping, and the cleaning and replacement of clothes. As it is considered desirable for older people to be cared for in their own homes instead of in residential care, there is a significant price paid by carers if adequate support is not put in place.

## **Abuse within caring**

Sometimes there is a complete breakdown in relationships between carers and patients and abuse occurs. This is not uncommon where the person being cared for is old (elder abuse) but it can occur in any age group. It can present with physical assaults, verbal aggression, improper use of funds or property, or physical neglect. Carer distress is the main cause of abuse in about 25% of cases.<sup>8</sup> There are 'red flags' to watch for. Drawing from what is currently known about caregiver abuse, the following factors may be a cause for concern:

The caregiver:

- Fears that he will become violent
- Suffers from low self esteem
- Perceives that she is not receiving adequate help or support from others
- Views care giving as a burden
- Experiences emotional and mental 'burnout', anxiety or severe depression
- Feels 'caught in the middle' by providing care to children and elderly family members at the same time
- Has 'old anger' toward the care receiver that can be traced back to their relationship in the past

The care receiver:

- Is aggressive or combative
- Is verbally abusive
- Exhibits disturbing behaviours such as sexual 'acting out' or embarrassing public displays

The caregiver and the care receiver:

- Live together
- Had a poor relationship prior to the onset of the illness or disabling condition
- Are married and have a marital relationship that is characterised by conflict

## Managing distress in carers

### 1. Prevention

The prime goal should be to prevent carer burnout and distress whenever possible. The table below gives some recommendations.<sup>7</sup>

	<b>General recommendations to help prevent carer burnout</b>
1.	Speak regularly with the carer(s).
2.	Be available to talk with carers in times of need
3.	Simplify the patient's management as much as possible.
4.	Be sensitive to the frequency of appointments and the time spent waiting at visits.
5.	Recommend that carers seek and regularly spend time away from the carer role.
6.	Provide information about community support services and refer carers to appropriate services.

Other issues important in preventing carer distress are social support and work-life balance. There is some evidence that the presence of emotional support and of social participation has a benefit for carers<sup>9</sup>. In addition, working relieves economic concerns and working outside the home offers relief from social isolation and improves self-esteem<sup>10</sup>.

It is therefore important for professionals to encourage carers to maintain or expand their social networks and to support the positive aspects for carers of working outside the home.

Encouraging carers to prepare strategies for dealing with problems in advance may alleviate stress for those who react to change as a crisis. Pre-planning increases stability and control over a situation that otherwise might seem unmanageable. This may include discussions about long-term care, powers of attorney or advance directives.

### 2. Intervention

The general principles of managing distress set out later in this report apply equally to carers as to any other distressed people, but there are some interventions that specifically apply to carer distress and the prevention of elder and other abuse. Some interventions may be more acceptable to some carers than to others so it is important to be aware of different options. Aspects that may help include:

- Education
- Self-care
- Therapy

## Education

Carers may benefit from improving their knowledge and skills in relation to the care they are providing for their loved ones. Education may deal with the condition or illness, medications, warning signs to look for and techniques of care.

## Self-care

Care-givers often tend to neglect their own health and social needs. They should be reminded therefore of the importance of respite and self-care. They should avoid isolation. Participating in support groups or pursuing hobbies can give carers respite and help them perpetuate ties that will remain after the loved one dies. Carers should also monitor their own wellbeing and learn to recognise such warning signs as increased sadness or depression, changes in sleep patterns, increased or decreased appetite, excessive worry and anxiety, and increased use of alcohol or prescription medications.

## Therapy

A small scale randomised controlled trial offers support to the value of a cognitive behavioural therapy approach in managing psychological morbidity in carers for people with Parkinson's disease<sup>11</sup>. 30 carers were randomised to receive either a course of 12 to 14 sessions of cognitive behavioural therapy or to a no-treatment control group. Outcomes were measured by the 28 item general health questionnaire (GHQ-28), the Care-giver Strain Index and the Care-giver Burden Inventory. Significantly greater improvement was found on the GHQ-28 after three months in the group treated with cognitive behavioural therapy. Similar findings were seen in the Care-giver Strain Index and the Care-give Burden Inventory, with the benefits being maintained over a subsequent three months follow up. Whilst this study suggests that a psycho-therapeutic approach to distress in carers can be effective, it may be that less intensive interventions will be as effective in reducing carer distress. This is discussed later in this report.

It is likely that carers assessed as suffering from major depression will benefit from anti-depressant drug treatment, but this should not be used in isolation of the other available psycho-therapeutic approaches outlined later.

## **Elder and other abuse**

With specific regard to reducing the likelihood of abuse, there are things that can be done both by caregivers and statutory agencies.

Caregivers can:

- Get help. Making use of social and support services, including support groups, respite care, home delivered meals, adult day care and assessment services, can reduce the stress associated with abuse.
- Learn to recognise their 'triggers', those factors that cause them the greatest stress and anxiety

- Learn to recognise and understand the causes of difficult behaviours and techniques for handling them more effectively
- Develop relationships with other caregivers. Caregivers with strong emotional support from other caregivers are less likely to report distress or to fear that they will become abusive
- Get healthy. Exercise, relaxation good nutrition and adequate rest have been shown to reduce stress and help caregivers cope
- Hire helpers. Attendants, chore workers, homemakers and personal care attendants can provide assistance with most daily activities. Households that cannot afford to hire helpers may be able to use the benefits system.
- Plan for the future. Careful planning can relieve stress by reducing uncertainty, preserving resources and preventing crises. A variety of instruments exists to help plan for the future including powers of attorney, advanced directives for health care, trusts and wills.

Agencies can:

- Carefully screen caregivers and patients for the risk factors associated with caregiver abuse
- Provide caregivers with information and support to lower their risk.
- Provide respite services
- Provide the therapeutic services described above.

## **What needs to be done?**

A Carer's Strategy for Dumfries and Galloway has been developed in partnership between Dumfries and Galloway Council, NHS Dumfries and Galloway and Voluntary Sector partners. The strategy has led to a number of improvements:

- The development of a range of services for carers.
- The ongoing identification of previously unknown carers.
- The implementation of national legislation relating to carers.
- Focus on the specific needs of young carers.

A number of initiatives have been undertaken locally in addressing the health needs of carers:

- Over 900 previously unknown carers have been identified through primary care.
- A carer support worker appointed in partnership with social services has been in post in Dumfries and Galloway Royal Infirmary since 2001. Over 300 referrals have been made through the carers support worker over a four year period.
- Training courses for carers are provided through the Princess Royal Trust. A variety of courses targeting carer needs and self-esteem are offered across the region. Courses offered include: Care for the Carer; Moving and Handling Skills; Autism Awareness; Healthy Cooking. During 2004 almost a hundred carers attended the courses on offer.
- Funding has been provided for specialist individual counselling sessions for carers. During 2004 26 carers used this service.

- A range of complementary therapies are provided in a variety of settings across the region. During 2004 almost 300 individual therapy sessions were provided.

Whilst this progress is to be welcomed, it is clear that the number of people benefiting from these developments falls far short of the 5,400 estimated at the beginning of this chapter who might be in need of assistance. Major developments that are needed in future include:

- Reviewing and updating carer information booklets to take account of current knowledge.
- Adoption of a standard instrument to measuring carer distress across Dumfries and Galloway. This should then be used with all identified carers. Whilst community nurses, practice nurses and general practitioners are all well placed to take responsibility for the administration of this instrument, anyone from health, social services or the voluntary sector who are in any contact with carers should be encouraged to use the selected instrument.
- Having substantially increased the detection rate of carer distress, the services available to provide the education, support and therapy for them must also be greatly expanded.

# Distress and the Workplace

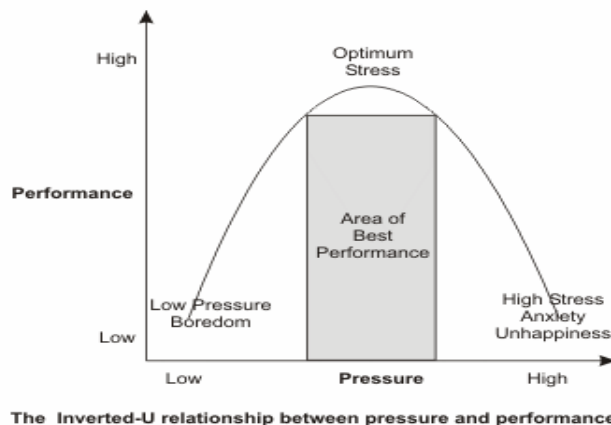
## Introduction

Being employed can enable people to meet some of the basic and higher level needs identified by Abraham Maslow, such as providing for their dependents, belonging to a work group, having status and responsibility, and giving an opportunity for personal growth<sup>1</sup>. For many people, meaningful employment contributes greatly to wellbeing and enables the individual to make a contribution to the rest of society. This is very positive, but the converse is that work-related distress is also very common, with one in five employees in the UK saying that they find their work extremely or very stressful. Each case of stress-related ill health leads to an average of 29 working days lost<sup>2</sup>.

## How does pressure at work relate to performance?

Pressure at work is normal and up to a certain point, an increase in pressure improves performance, productivity, personal growth and quality of life. However if the pressure experienced by an individual employee becomes excessive, it loses its beneficial effect and becomes harmful. This is shown in the “inverted - U” relationship between pressure and performance shown in Figure 1.

Figure 1: The inverted - U relationship between pressure and performance<sup>3</sup>



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When there is very little pressure to carry out an important task (as on the left side of the graph), there is little incentive to focus energy and attention on it. As demands increase somewhat, we enter the area of best performance (centre of the graph) where there is enough pressure to focus our concentration but not so much that it disrupts our performance. If demands increase further however (right side of the graph), then difficulties, anxieties and negative thinking begin to crowd our minds and these reduce concentration on the task. The graph indicates that this disruption of performance can be like a slippery slope, so that if a person is

already under excessive pressure, a small increase in pressure may cause a large reduction in performance. Situations near the extremes are sometimes called burn outs, where demands are much greater than an individual's capability to meet them, or rust outs, where demands are much less than capabilities<sup>3</sup>.

This model of work-related stress indicates that the challenge for every organisation is to get the right balance between stimulating a sense of purpose in employees and not causing excessive pressure.

### **What causes work-related distress?**

External causes of work-related distress vary from organisation to organisation, department to department and job to job. Factors that can lead to stress include<sup>4</sup>:

- the job itself (too much or too little to do, conflicting roles and responsibilities, badly designed shifts or rotas)
- the working environment (physical surroundings, office or factory design, facilities available)
- organisational culture (poor communication, unsupportive management, insecurity and poor handling of change, lack of personal control over workload and workplace)
- interpersonal relations at work
- role in organisation (role ambiguity, too high or too low a responsibility)
- career development (career uncertainty, stagnation, status, pay and conditions, social valuation of the job)
- home/work interface (dual career problems, conflicting demands of work and home life)

### **The effects of work-related distress**

Distress in the workplace can have negative effects on the individual employee, the work team and the organisation. An employee suffering from work-related distress may show a decline in work quality or productivity, uncharacteristic errors, decreased or increased time spent at work, or sickness absence.

The employee's work team may also show decreased productivity, performance, friction between remaining members of the team, a decrease in morale and resentment towards the employee suffering the distress.

For the organisation, distress may lead to increasing levels of sickness absence, high staff turnover, a need for retraining of staff into other roles, a poor public image, difficulty in recruiting new staff and the possibility of claims for compensation.

Though distress in the workplace is common, there is evidence that the level of distress varies between different types of organisation and employee groups. Data are needed to study variations in work-related distress. Two indicators are used for which routine data are increasingly available - sickness absence and staff turnover.

## Sickness absence

The Chartered Institute of Personnel and Development (CIPD) carry out annual UK surveys of sickness absence and absence management. The 2005 survey is based on replies from 1,038 human resources practitioners in organisations employing a total of more than 2 million people<sup>5</sup>.

The main causes of overall sickness absence for manual and non-manual employees as found in the 2005 CIPD survey are shown in Table 1. Stress is the fourth commonest cause of sickness absence for manual workers and the second commonest cause for non-manual workers. However stress may have a certain amount of stigma and it is likely that some cases of sickness absence attributed to a cause other than stress may actually relate to, or be made worse by, stress.

**Table 1: Causes of all episodes of sickness absence (CIPD Absence Management Survey 2005<sup>5</sup>)**

<b><u>Ranking</u></b>	<b><u>Manual</u></b>	<b><u>Non-Manual</u></b>
1.	Minor illness *	Minor illness *
2.	Back pain	Stress
3.	Musculo-skeletal injuries	Recurring medical conditions
4.	Stress	Back pain
5.	Recurring medical conditions	Home/family responsibilities
*e.g. colds and flu		

The pattern for long term sickness absence, defined as a period of at least four weeks absence, is different, with distress assuming an even greater importance. Table 2 shows the main causes in order of ranking. Stress is the third most common cause of long term sickness absence in manual workers and the commonest cause in non-manual workers, and mental ill health now shows up in the top 5 causes in both groups.

**Table 2: Causes of episodes of long term sickness absence (CIPD Absence Management Survey 2005<sup>5</sup>)**

<b><u>Ranking</u></b>	<b><u>Manual</u></b>	<b><u>Non-Manual</u></b>
1.	Musculo-skeletal injuries	Stress
2.	Back pain	Mental ill health
3.	Stress	Acute medical conditions
4.	Acute medical conditions	Recovery after operations
5.	Mental ill health	Back pain

The survey records variations in overall sickness absence by type of organisation, though it is not possible to identify different levels of absence due to stress. Figure 2 shows the level of sickness absence for four sectors of employment (manufacturing and production, private services, public services and not-for-profit organisations). Sickness absence levels are given for three examples of organisation types for each employment sector.

**Figure 2: Average level of sickness absence by type of organisation<sup>5</sup>**

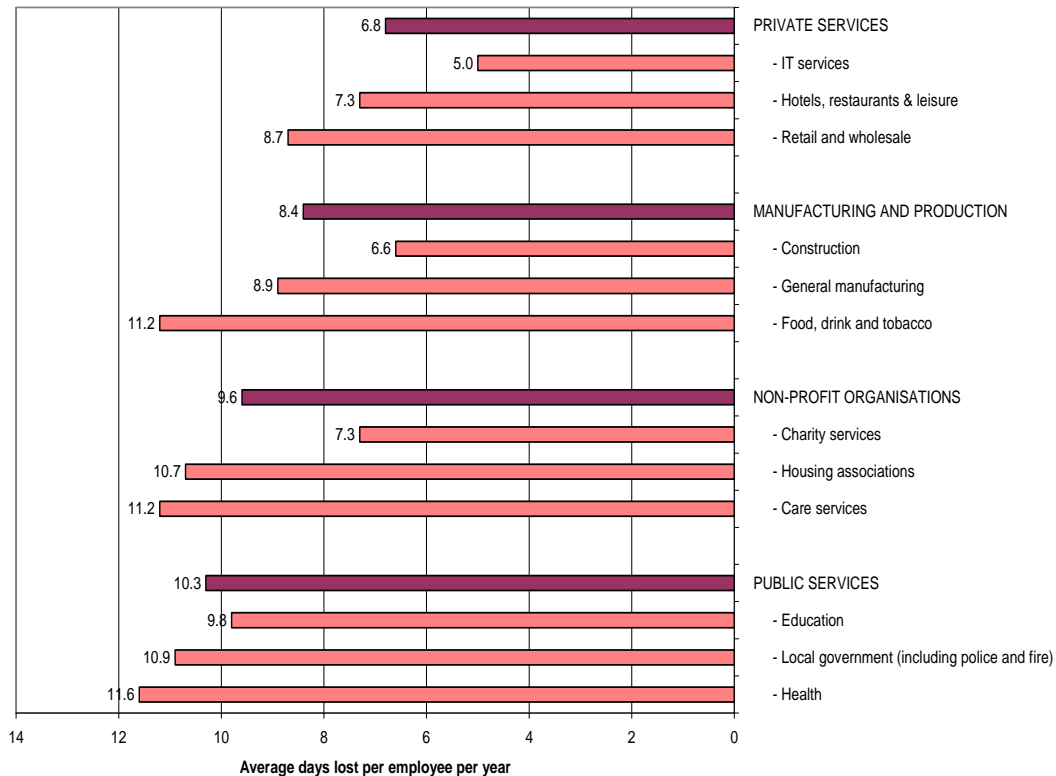
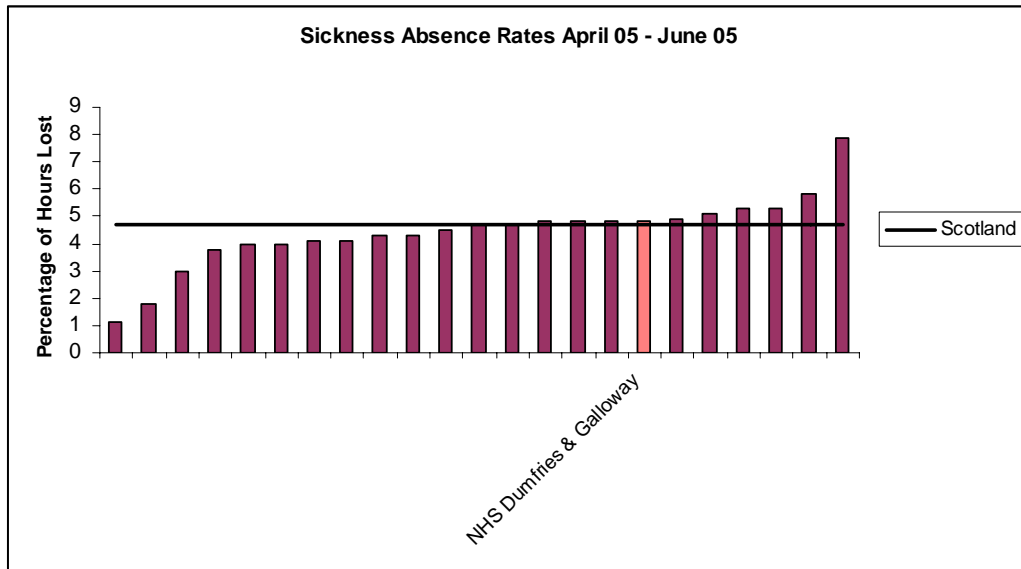


Figure 2 shows that public services generally have the highest levels of sickness absence and private services have the lowest levels. The highest level of all is seen in the health sector.

It is worth looking in detail at sickness absence rates across the NHS in Scotland. Figure 3 shows the staff sickness absence rates for the period April to June 2005 for each NHS Board. Sickness absence rates varied from 1.1% to 7.9%. Dumfries and Galloway’s rate of 4.8% represents approximately 10.8 working days lost per year per employee. The effect of this is somewhat akin to giving everyone in the organisation an extra two weeks off per year! Of this it is likely that a third is due to distress, and about 40% of this is due to distress directly caused by the working situation. So we lose the equivalent of 1.5 days work every year from each of our 5,500 staff from causes that in theory should be under our control.

**Figure 3: Days lost per member of staff due to sickness absence by NHS Board**



Source ISD Scotland

## Staff Turnover

Another indicator of work-related distress is the turnover of staff. Employees leave an organisation for many different reasons: the attractions of a new job (“pull” factors), dissatisfaction with their present job (“push” factors), domestic or personal circumstances (neutral factors), or a mixture of these.

Research suggests that push factors are very significant in many resignations<sup>6</sup>. It is important to appreciate that the reasons people give at exit interviews for their resignations may often be untrue or only partially true, as these may be conducted by a manager who could later be asked to provide a reference for the departing employee. Common push reasons for leaving are job insecurity, perception of unfairness or discrimination, a poor relationship with a line manager, a lack of opportunity for career development, unrealistic early expectations about a job, and inflexibility on working hours. The level of pay is unlikely to play a major role unless it is notably below the market rate, though higher pay elsewhere can act as a pull factor.

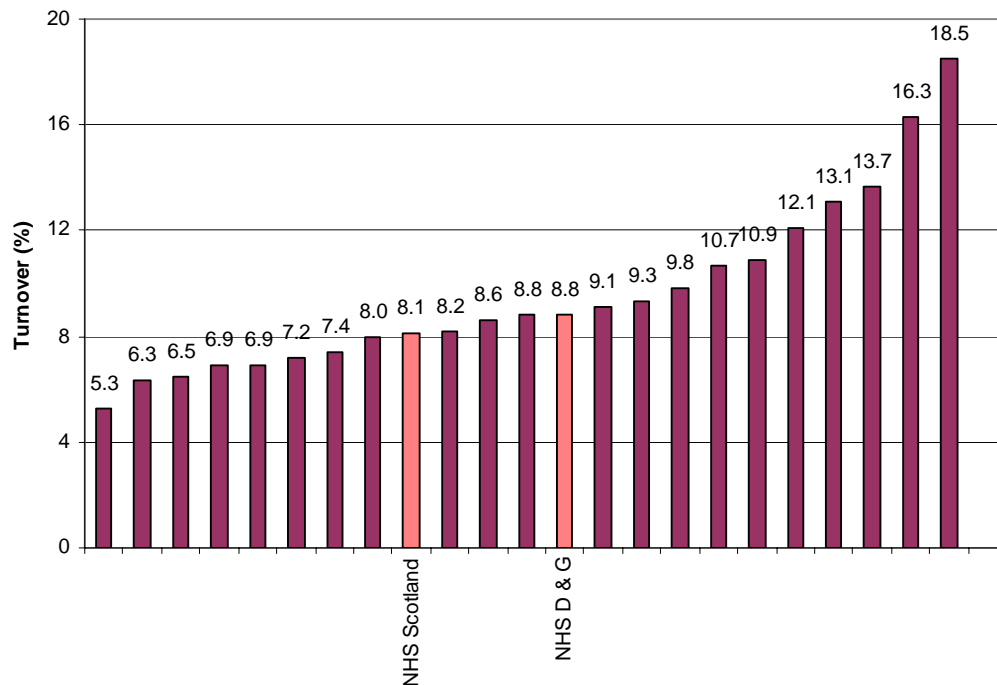
Where levels of staff turnover differ substantially, it seems likely that the major reason is to be found in push factors. Pull factors could be important where there are many competing employing organisations but this would be less important in a rural area like Dumfries & Galloway. The importance of neutral factors such as relocating with a partner who has a new job would be expected to be broadly similar in most areas.

Staff turnover levels vary widely from industry to industry. Staff turnover is calculated as the number of staff leaving over a period (usually a year) divided by

the average number of staff in post during the period. The highest levels of staff turnover, which are in excess of 50% per year, are seen in retailing, hotels and restaurants, call centres and other lower paid private sector services.

The lowest levels of turnover (below 10%) are found among civil servants, fire fighters, the police and other public sector groups who are relatively highly skilled and well paid. This would include many staff groups in the NHS, yet substantial differences in staff turnover are seen in different parts of NHS Scotland. Figure 4 shows staff turnover rates for the period October 2003 – September 2004 for NHS organisations in Scotland<sup>7</sup>.

**Figure 4: Staff turnover for NHS Scotland organisations<sup>7</sup>**



## Tackling work-related stress

The definition of stress due to Lazarus given in Chapter 1 suggests two ways in which work-related stress, and its consequent distress, may be tackled:

1. Keep work pressures at an adequate but reasonable level;
2. Increase the personal and social resources the worker can muster to deal with the demands.

Organisations tend to focus on the first of these as the external demands on staff are usually more likely to be within the organisation’s control. The Health and Safety Executive (HSE) has developed a management standards approach to tackling work-related stress<sup>2</sup>. This approach sets standards in six areas, encourages a risk assessment, measures the current situation using surveys and

other techniques and promotes active discussion with employees to help decide about practical improvements that can be made. The six areas included in the standards are:

• <i>Demands</i>	(e.g. workload, work patterns and the work environment)
• <i>Control</i>	(how much say the worker has in how he/she does his/her work)
• <i>Support</i>	(encouragement, resources provided by the organisation, line management and colleagues)
• <i>Relationships</i>	(promoting positive working relationships and dealing with unacceptable behaviour)
• <i>Role</i>	(a worker understanding her/his role within the organisation and the organisation ensuring that she/he does not have conflicting roles)
• <i>Change</i>	(how organisational change is managed and communicated in the organisation)

The HSE has indicated that the standards will be used as evidence against employers that continue to ignore their responsibilities in managing stress. In 2003, the HSE issued its first ever improvement notice under the Health and Safety at Work Act 1974 against an employer, West Dorset Hospitals NHS Trust, for failing to take steps to identify and manage stress, following a complaint by an employee.

From a public health perspective, preventing work-related stress from developing is better than having to manage its consequences. Actions can and should be taken to prevent work-related stress from developing, but because of the interplay between individuals and their work environment, it will also be necessary to manage the problem of stress in individual workers. Actions may be taken by the organisation or the individual worker. This leads to a four quadrant model to reduce problems from work-related stress that includes both the prevention and the management of stress, as shown in Figure 5.

**Figure 5: Four quadrant model of reducing work-related stress**

	<b>Organisation</b>	<b>Individual worker</b>
Prevention of work-related stress	<p>Actions by the organisation to prevent work-related stress include attention to aspects of work:</p> <ul style="list-style-type: none"> <li>• Demands</li> <li>• Control</li> <li>• Support</li> <li>• Relationships</li> <li>• Role</li> <li>• Change</li> </ul>	<p>Actions by the individual that can help prevent work-related stress include attention to<sup>8</sup>:</p> <ul style="list-style-type: none"> <li>• Life goals</li> <li>• Work-life balance</li> <li>• Personal development e.g. time management, assertiveness, conflict management</li> <li>• Healthy lifestyle, especially diet and physical activity</li> <li>• An activity that promotes relaxation, e.g. meditation, yoga, tai chi</li> </ul>
Management of work-related stress	<p>Actions by the organisation to deal with established stress can include:</p> <ul style="list-style-type: none"> <li>• Modification of work patterns</li> <li>• Mentoring</li> <li>• Sickness absence management</li> <li>• Change in line management</li> <li>• Alteration to working hours</li> <li>• Occupational health or other professional advice</li> </ul>	<p>Actions by the individual that may help deal with established work-related stress include:</p> <ul style="list-style-type: none"> <li>• Family/friend/peer support</li> <li>• Discussion with line or another manager</li> <li>• Coach/mentor</li> <li>• GP/Occupational health/other professional</li> <li>• Setting appropriate goals</li> <li>• Attention to relevant preventive factors in quadrant above</li> </ul>

### **Tackling work related distress in Dumfries and Galloway:**

Out of a workforce of approximately 50,000, and taking the CIPD average figure of 10 working days per employee lost to sickness absence, it can be calculated that the effect of this is a reduction in the total workforce of approximately 3,550 people. Estimates suggest that around one third of this total (1,187) will be due to stress or mental health problems. Most studies suggest that approximately 40% of absence due to stress and mental health problems can be directly attributable to problems in the workplace. It can therefore be estimated that there are, in effect, the equivalent of 475 employees lost to the workforce because of distress caused by workplace factors that are within the control of employers. It is clear that it is not only in the best interest of employees that their employers should do everything within their powers to address those aspects of working and management practices that cause distress, but it is also in the best interests of the employers themselves.

NHS Dumfries and Galloway is the second largest employer in the region with approximately 5,550 employees, who lose on average 10.8 days per year to

sickness absence and has a rate of staff turnover that is slightly higher than the average for the NHS in Scotland. There are many issues across the organisation that can lead to work-related distress and it is essential that these are addressed at an organisational level, to allow the NHS locally to set standards of good practice that can be emulated by employers throughout the region.

NHS Dumfries and Galloway is already taking a number of actions to reduce work-related distress. Examples include the following. Along with partner public sector organisations in the region, NHS Dumfries and Galloway supports a wide programme of personal and professional development learning. A mentoring programme has been introduced on a trial basis involving twenty mentor/mentee pairs. This programme has been running since January 2005 and has been well evaluated. The Director of Psychological Services is undertaking a programme of assessments of each service and department within NHS Dumfries and Galloway. The programme consists of talking to all members of staff, making observations, offering suggestions and recommending changes at an appropriate level where needed. This programme of visits has been running since early 2005 and will take approximately eighteen months to complete. These examples demonstrate that NHS Dumfries and Galloway is taking seriously its responsibilities to reduce work-related stress. However there is much more to do.

### **What could we do differently?**

Last year's Director of Public Health Annual Report was entitled *Doing Things Differently*. Here are three simple and practical ways of doing things differently that can support further reductions in work-related stress:

1. Exit interviews for staff leaving an organisation should be conducted by a manager who is not the line manager and who is preferably from a different department. This would help the organisation identify more accurately the push factors that may be encouraging members of staff to seek employment elsewhere.
2. Sickness absence should be monitored at the level of individual department or ward. This would give an indication of where work-related distress might be a particular problem. It would then be possible to investigate departments that had consistently high sickness absence, and to provide appropriate remedial action.
3. Every member of staff should be offered the possibility of having a coach or a mentor. This would be entirely voluntary and a member of staff would only take up the offer if he or she felt that this would be helpful. If a member of staff wished to work with a coach or mentor, dedicated time would need to be set aside but this would not be great, perhaps one hour per month.

## **Newer Approaches to the Management of Distress**

As indicated earlier in this report, there is considerable and increasing prescribing of drugs for the treatment of both depression and anxiety states in Dumfries and Galloway. The question arises as to the appropriateness of this approach in all people presenting with these problems.

No data is routinely collected that would allow the establishment of the prevalence of depression or anxiety in Dumfries and Galloway. Because of this it is necessary to rely on surveys that have been carried out elsewhere<sup>1</sup>. Taking depression as the example, the surveys give variable results but mid point estimates taken from these surveys, suggest an annual period prevalence for major depression of 29/1000 for males and 52/1000 for females. The prevalence of less severe forms of depression (mild and moderate depression and mixed depression and anxiety) is known to be about three times more common than major depression in males, and about four times more common in females. Based on these assumptions, it is possible to calculate that the number of people in Dumfries and Galloway who suffer from all levels of depression in a year, is around 17,900. Given the extent of the assumptions that have to be made around the use of these figures, there would appear to be reasonable agreement between the estimates based on prescribed drugs (13,100 – 19,600 - see Chapter 1) and these based on data from other surveys. There are, however, two surprising aspects to this level of agreement.

Firstly, most surveys suggest that of all people with any level of depression, only some 50% of them will receive any form of health care intervention, partly because they do not present to their doctor, or, if they do, the diagnosis goes unrecognised<sup>1</sup>. The conclusion for Dumfries and Galloway must be one of three logical possibilities.

- Most people in Dumfries and Galloway who are depressed do present to their doctor and have the diagnosis made OR
- Substantial numbers of people who are not depressed are being prescribed antidepressant drugs OR
- There are many more depressed people in Dumfries and Galloway than would be predicted from other surveys

The first two of these seem unlikely to be the explanation of the figures, leaving the likeliest explanation that there is indeed more depression in Dumfries and Galloway than might be expected.

The second, slightly surprising aspect of these estimates, concerns expected changes in practice. Since 2001 there has been a guided self help programme available in Dumfries and Galloway, offering a non-drug based intervention to people with mild to moderate depression (and anxiety). Initially this was on a pilot basis with just two GP practices, but has subsequently been rolled out across the region as funding became available. Despite the availability of this service and the raised awareness of non-drug treatment options that the service has achieved, there were only a total of 1800 referrals to the service since its inception up to the beginning of 2005. Throughout this period antidepressant drug

prescribing continued to increase and these drugs are dispensed to around 15,000 people each year. In addition, the most recent consensus guidance on the management of depression published at the end of 2004, advises that people with mild depression should not be prescribed antidepressant drugs<sup>1</sup>, and so, if this guidance is being followed, the number of people with diagnosed depression in 2005 should be greater than the number of people prescribed antidepressant drugs. Once again therefore the data might suggest that there are more people in Dumfries and Galloway with depression than might be expected from data from elsewhere. Without knowing more accurately the incidence and prevalence of these conditions in Dumfries and Galloway it is difficult properly to plan to deal with them appropriately. Determining these must be a priority.

In the meantime what conclusions can we come to based on the data that we have? Perhaps the best case scenario is that the extrapolation of survey data from elsewhere gives us the most accurate estimate of the point prevalence of depression in Dumfries and Galloway, giving us around 18,000 cases in any year. The worst case scenario might be that the maximum estimated number of people being prescribed antidepressant drugs really does only represent 50% of depressed people in the region, giving us around 39,000 cases in a year. Of these, there is little argument that those with major depression (between around 4,000 and 9,000) should be treated with antidepressant drugs. This leaves between 14,000 and 30,000 who are suffering from lesser severities of depression, and about whom there is less complete agreement concerning the most appropriate management. Current UK guidance suggests that it is inappropriate to prescribe drugs to those with mild depression or mixed depression with anxiety. The guidance does suggest the use of antidepressant drugs, along with non-drug treatments for those with moderate depression, but the strength of the evidence supporting this is weak, and there is conflicting evidence that suggests that this degree of depression can also be successfully managed with non-drug treatments<sup>2</sup>,

If all people in the region with mild to moderate depression were to be offered a non-drug treatment what would we need to do and what are these treatments?

The guidance issued at the end of 2004 recommended guided self help based on cognitive behavioural therapy (CBT) as the treatment of choice<sup>1</sup>, and this is the very method that has been on offer locally since 2001. The guidance suggests 6-8 sessions are required, but the experience of our local project suggests that much less than this can be equally as effective. Based on each person having only two one hour sessions, each whole time equivalent (wte) 'therapist' seeing five people each day, and delivering this on 200 days per year (taking account of annual and study leave, supervision etc) we would need to employ between 28 and 60 wte guided self help workers. Are these figures out of line with other thinking in this area of work? Professor Richard Layard, an economist at the London School of Economics, and an advisor to the present government has recommended that for the population of England a total of 10,000 new cognitive behavioural therapists should be trained and employed specifically for this group of people<sup>3</sup>. On a pro rata basis of the populations this would equate to 1,000 new therapists for Scotland and to 30 new therapists for Dumfries and Galloway, and so the lower estimate of 28 new therapists being required is not outwith current thinking elsewhere.

There are other approaches that could be used to try to reduce the reliance on trained therapists and reach more people who might not wish to engage in face-to-face therapy. Recent guidance recommends the use of a computer delivered CBT programme 'Beating the Blues' for the treatment of mild to moderate depression<sup>4</sup>. This provides an intensive interactive programme for the patient and requires much less therapist intervention, which can be provided by less qualified staff. In addition there are several self help CBT books available (so called 'bibliotherapy') which have been well evaluated, although not in randomised trials. Internet-based self help CBT has been trialled with promising results<sup>5</sup>.

Could 28 therapists be afforded? If the commonest grade of therapist was to be a basic grade clinical psychologist, the cost to the NHS Board would be around £1.12 million. At the present time the Board spends around £2 million per year on the prescription of antidepressant drugs and around £110,000 per year on anxiolytics. If all patients with anxiety and all patients with mild to moderate depression were treated with non-drug therapy, approximately three quarters of these prescriptions would be unnecessary, producing a saving of more than £1.5 million. If the reductions in spending due to less excessive alcohol consumption, fewer breakdowns of carer arrangements, fewer days lost at work in the health service, fewer episodes of drug overdose and self harm, and the barely quantifiable reductions in costs due to reductions in the physical illnesses that can be precipitated by mental health problems, are all taken into account the question might more reasonably be "Can the NHS afford *not* to employ an additional 28 therapists?" If the non-NHS savings in fewer days lost at work, fewer early retirements, reduced use of the criminal justice and prison systems, greatly reduced levels of incapacity benefit etc., are also taken into account these interventions take on a wider societal importance<sup>3</sup>.

### **So what needs to be done?**

- We must carry out a survey of the adult population to determine the true extent of these problems to assist with more rational planning.
- We must open discussions with general practitioners, their post graduate advisers, clinical psychologists, others, and members of the public, to decide how we move forward towards full implementation of the current treatment guidelines for anxiety and depression.
- We must open discussions with the above about the way in which we introduce computer aided CBT, internet based packages and bibliotherapy as options in the management of these conditions.
- We must decide how best to introduce screening for distress amongst the population.
- We must start to plan for the training and employment of significant additional numbers of therapy staff to respond to a greatly increased demand for their services. If this is done incrementally over several years the costs released through the initial investment should eventually fund the following year's new investment.

## **Dental Services**

The Government's Action Plan for improving Oral Health was published in March 2005. Amongst its key principles were, firstly, that oral health should be an integral part of overall health improvement and, secondly, that services for children and young people should be focussed on prevention. Amongst the Plan's many initiatives, two of the main initiatives to support these key principles were the issue of dental health packs for infants aged 6 to 8 months and to all those starting nursery school, and supervised fluoride tooth brushing schemes in nursery schools and in P1 and P2 classes of the most deprived primary schools. Whilst many areas in Scotland are having to initiate these schemes from scratch in order to comply with the Action Plan, Dumfries and Galloway has had such schemes running for the last ten years. This means that, in this Health Board area, we have a head start because we can build on the success of the existing scheme.

The success of the existing scheme can be demonstrated by reference to the National Dental Inspection Programme report of the 2004 Programme which was published in June 2005 and, in that year, examined Primary 1 children. It showed that, for Dumfries and Galloway, the proportion of P1 children with no obvious decay experience in 2004 was 52.5% - above the Scottish average of 50.7% - but still some way from the national target of 60% by 2010.

The report postulates a Care Index to describe the level of Restorative Care. This index is based on the number of filled teeth compared to the obviously decayed, missing and filled teeth. For Dumfries & Galloway the Care Index is 13.8 compared to the Scottish average of 8.9 (and the Scottish Health Board range of 5.9 – 20.5).

Given the relative under-provision of dentists in this Health Board area over recent years, the Care Index figure suggests that our local dental practitioners have been providing a good service for the children in the area.

# Statistical Appendices

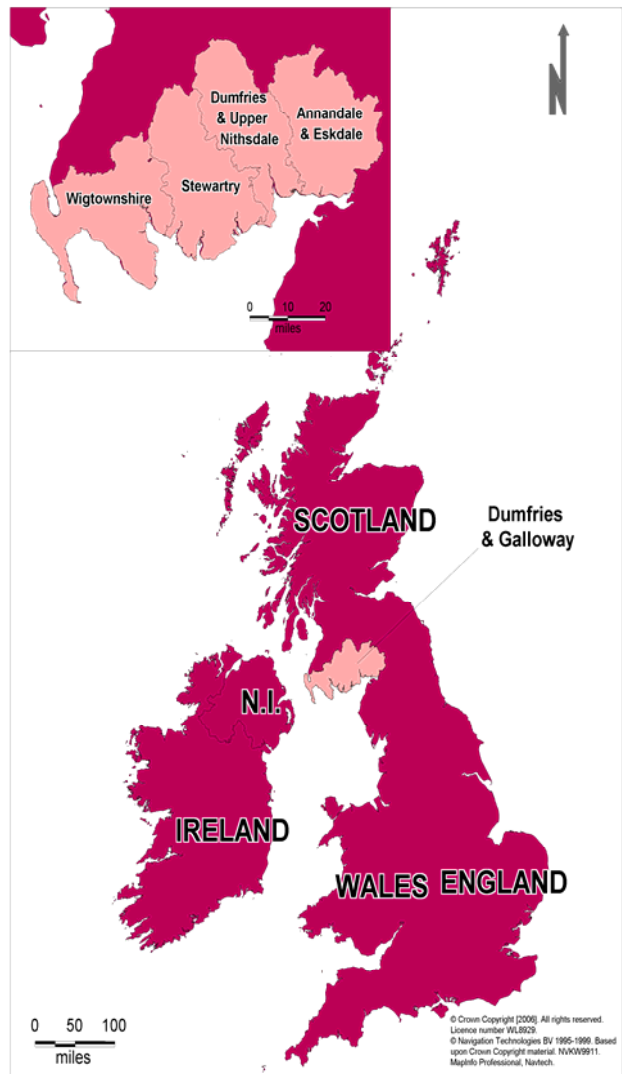
## Dumfries & Galloway

Dumfries & Galloway is mostly rural area of Southwest Scotland, covering 2,500 square miles, which is home to 147,930 people (GROS estimate for 2004).

The main towns in the region are Dumfries (approximately 31,000 residents), Stranraer (11,000), Annan (8,400) and Lochaberbriggs (6,000). All other towns and settlements have populations of under 5,000 residents. At the 2001 Census, one third of people in Dumfries & Galloway were living in settlements with less than 500 people.

Our region is divided into four traditional localities, shown below with population estimates from the 2001 Census.

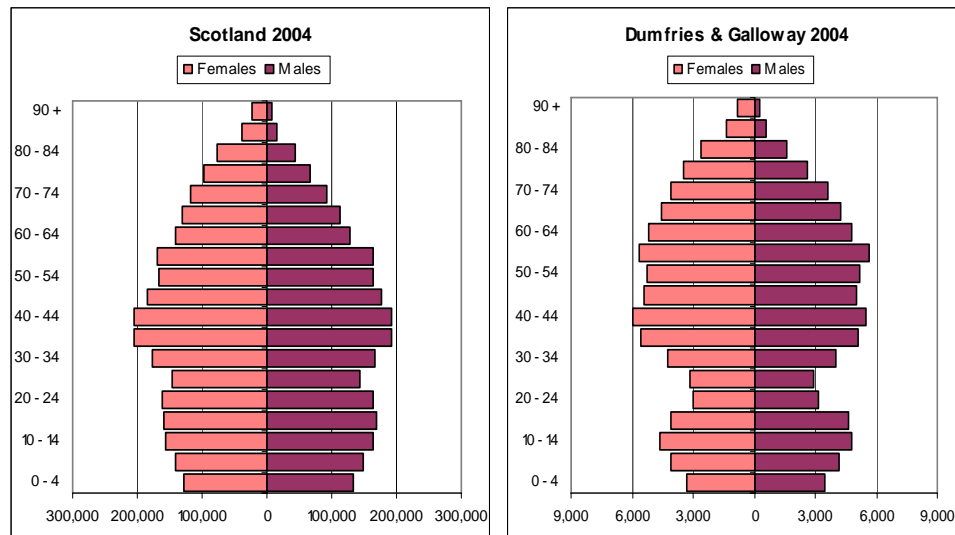
<b>Wigtownshire</b>	
Under15	5,300
15 to 29	4,200
30 to 44	5,900
45 to 64	8,300
65 and Over	5,700
All Ages	29,400
<b>Stewartry</b>	
Under15	3,800
15 to 29	3,200
30 to 44	4,700
45 to 64	6,700
65 and Over	5,400
All Ages	23,800
<b>Nithsdale</b>	
Under15	10,500
15 to 29	8,900
30 to 44	12,900
45 to 64	15,100
65 and Over	10,100
All Ages	57,500
<b>Annandale &amp; Eskdale</b>	
Under15	6,400
15 to 29	5,500
30 to 44	8,000
45 to 64	10,000
65 and Over	7,000
All Ages	36,900



## Population

Our current population is substantially different from the Scottish population profile, with a larger proportion of older people and a markedly smaller proportion of young people. The average age in Scotland is 39.6 while the average age in Dumfries & Galloway is 42.6.

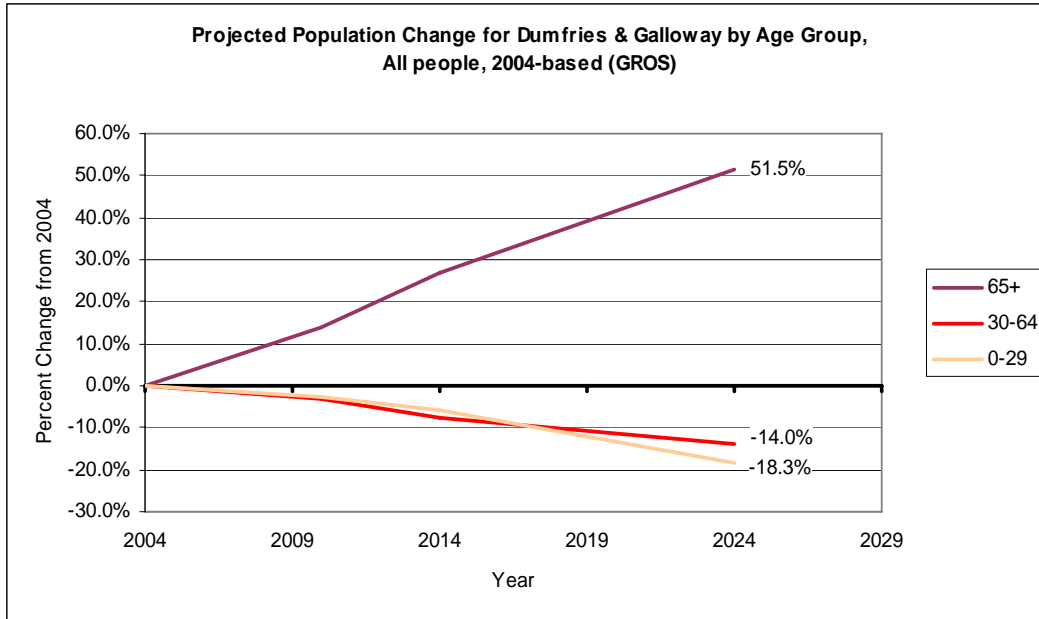
**Figure 1: Population Pyramids for Scotland and Dumfries & Galloway, 2004**



*Source: General Register for Scotland, Mid-year Population Estimates.*

The gap between older and younger populations is likely to widen over time. Population projections from the GROS based on the year 2004 show that our adult population of 30-64 year olds is likely to drop by 14% by 2024. While our over 65 population is likely to grow by 51% in the same period (Figure 2), which is a larger gap than was previously predicted. These dramatic changes will result in greater demands on the social and health care systems and a reduced work force who would normally be responsible for providing care. It seems inevitable therefore that recruitment and retention issues, which are already difficult in some services, will become even more of a challenge in the future.

**Figure 2: Projected Population Change in Dumfries & Galloway**



Source: General Register for Scotland, 2004-based Population Projections

## Life Expectancy

Scotland ranks lowest for UK life expectancy for both men and women, as shown below, although Dumfries & Galloway life expectancies are higher than average and life expectancy in all Scottish local authorities are rising over time.

**Figure 3: UK Life Expectancy Figures**

	2002-2004	
	Men	Women
United Kingdom	76.3	80.7
England	76.6	80.9
Wales	75.8	80.3
Scotland	73.8	79.0
<b>-Dumfries &amp; Galloway</b>	<b>75.4</b>	<b>79.6</b>
Northern Ireland	75.9	80.6

Source: Office for National Statistics

## Mortality

The biggest cause of death in Scotland currently is malignant neoplasm (cancer), which was responsible for the deaths of just over 15,000 people in 2004 (provisional figures, GROS). The next biggest killers are coronary heart disease (10,800), respiratory disease such as pneumonia (6,700 altogether) and stroke (6,200).

We may compare how many deaths we had of these types against what we might expect if our population was distributed the same as the Scotland population. This comparison is known as a Standardised Mortality Ratio or SMR; a ratio of 1.0 is the same as the Scotland average, more than 1.0 is more deaths than Scotland and less than 1.0 is less than Scotland.

In comparison with the Scottish population as a whole, the health of the people of Dumfries & Galloway is broadly better than average. We have lower mortality rates for a range of diseases and while this year's SMR for female stroke deaths is slightly above the Scottish average, it is not significantly different from the Scotland rate. The SMR for coronary heart disease in men is significantly lower than the Scotland average this year.

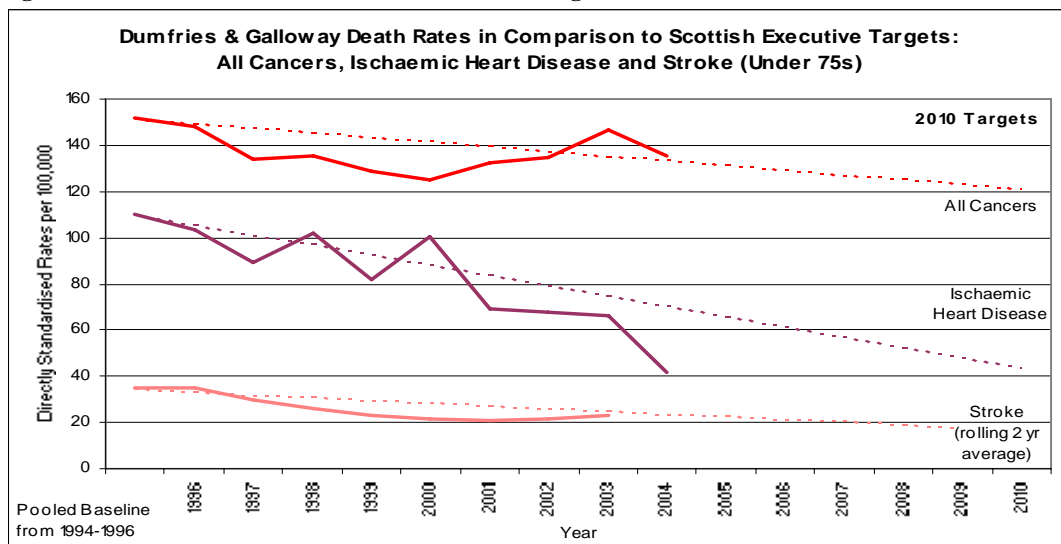
**Figure 4: SMR for the largest causes of death in Dumfries & Galloway, 2004**

Dumfries & Galloway	All Cancers	Coronary Heart Disease	Stroke	Respiratory Disease
Men	0.98	0.79*	0.87	0.95
Women	0.97	0.94	1.05	0.91

Source: GROS, 2004 provisional \*statistically significantly lower than Scotland

The Scottish Executive has targets to reduce 'premature deaths', which are defined as a death before reaching the age of 75. We monitor premature deaths by the most common causes and have targets to reduce the number of premature deaths by 2010.

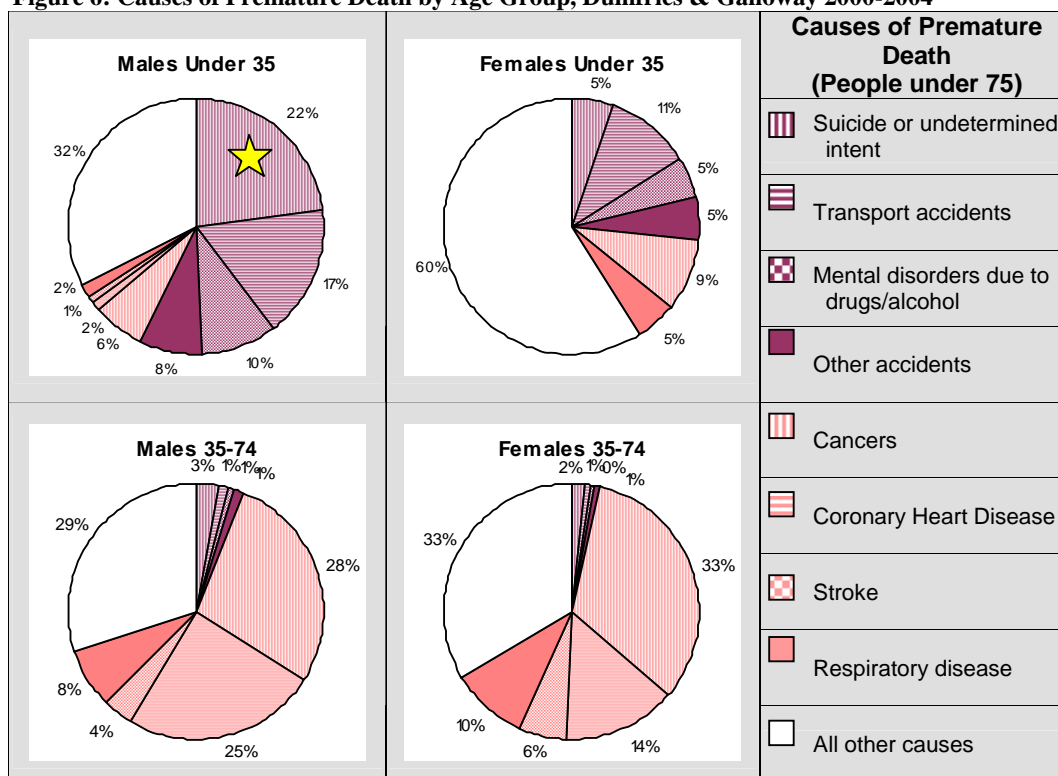
**Figure 5: Premature deaths vs. Scottish Executive targets for 2010**



Source: ISD and Scottish Cancer Registry, ISD

Measuring premature deaths under 75 does not highlight the difference in mortality between younger and older people. When we look at deaths under the age of 35 compared to deaths in people aged 35 to 74 we can see that disease plays a much smaller role in younger people. The biggest cause of death in Dumfries & Galloway men under the age of 35 is suicide (yellow star below), closely followed by transport accidents; whereas, in people over 35 and under 75, these causes only account for between 4-6% of all deaths.

**Figure 6: Causes of Premature Death by Age Group, Dumfries & Galloway 2000-2004**



Source: General Register for Scotland, Death Registrations

### Suicides and Deaths of Undetermined Intent

Deaths due to unnatural causes, (i.e. deaths that are not due to disease) are relatively rare compared to cancers, heart disease and stroke, making up only 4.3% of all deaths in Scotland in 2004. However, when we look at causes of death by different age groups, unnatural cause make up a much larger proportion of deaths in young people.

Labelling a death as a suicide is still a sensitive issue for both the family and the health professionals involved. Some of these deaths get mixed in with unhappy accidents and events that are qualified as being of ‘undetermined intent’, where we aren’t sure if self-harm was intended. In Scotland, we combine the suicide and undetermined intent categories together.

In Dumfries & Galloway there are typically fewer than 30 of these deaths per year, with the split between male and female reflecting the national trends. Across Scotland for the last 25 years the suicide rate has been climbing in men,

while remaining fairly static in women. Over the last few years the male rate has slowed, but more monitoring is required to see if the tide has genuinely turned.

**Figure 7: Deaths due to Self-Harm or Undetermined Intent, Scotland**



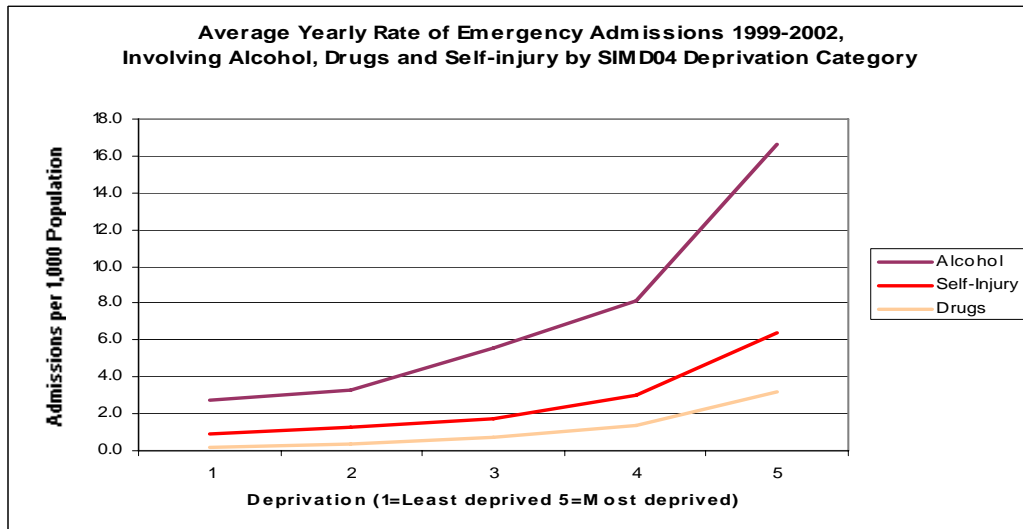
Source: General Register for Scotland, Death Registrations

## Emergency Admissions

When we look at emergency admissions we see distinct gradients between people living in the most deprived neighbourhoods compared to the most advantaged neighbourhoods.

For admissions involving alcohol the admission rate from deprived areas in D&G are 6 times as high as the most advantaged areas, for self-injury admissions the rate is 7 times and for admissions involving drugs the difference is 21 times as high.

**Figure 8: Rates of Emergency Admission Over 4 Years, by SIMD2004 Deprivation Category**



Source: Scottish Neighbourhood Statistics, Scottish Index of Multiple Deprivation 2004

In an average year there are over 900 emergency admissions where alcohol was a factor, 140 drugs related emergency admissions and over 300 emergency admissions for self-inflicted harm in Dumfries & Galloway.

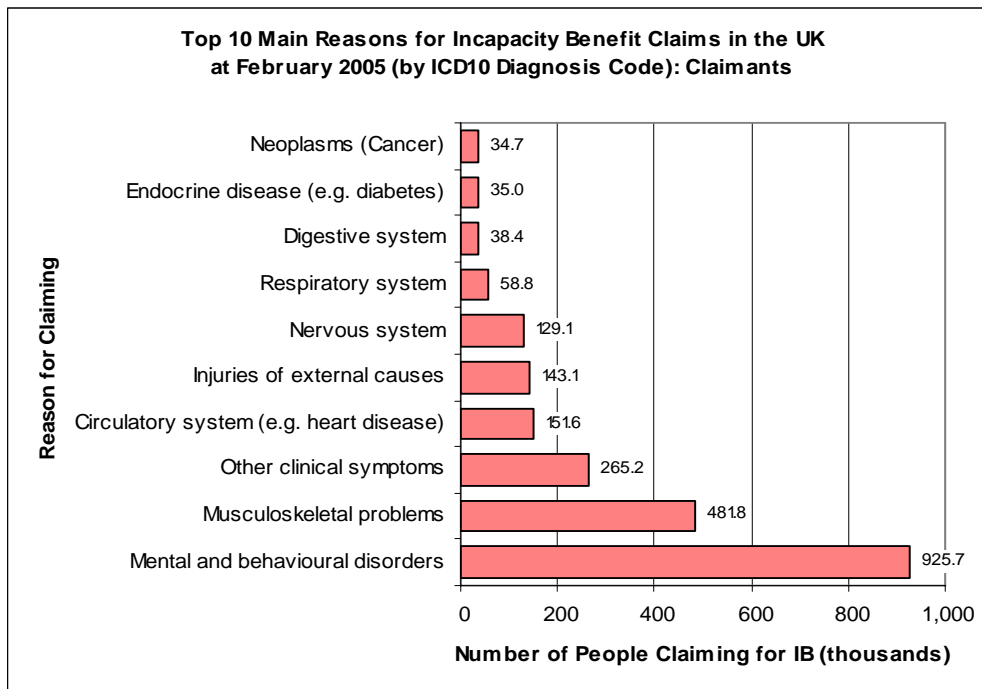
## The Magnitude of Mental Illness

### Incapacity Benefit

It is difficult to arrive at a definitive number of people who are suffering with mental illness at any one time. We have no way of measuring directly who might be having troubles because it is such a subjective area. However, we can form an impression of the magnitude of the problem by assessing how many people are seeking help for their problems.

Across the UK, the most common reason for people to be claiming Incapacity Benefit is mental and behavioural disorders, accounting for roughly 2 in 5 claimants. This is more than twice as common as people being unable to work because of musculoskeletal problems such as back pain or joint injuries.

**Figure 9: Main Reasons for Claiming Incapacity Benefit in the UK**



Source: Department for Work and Pensions

In February 2005, there were approximately 6,500 people in D&G making claim for some level of Incapacity Benefit, although we don't know how closely they reflect the pattern seen for the UK.

## Severe Mental Health Problems

The GPs in Scotland have recently signed a new contract, which focuses on caring for people with chronic illness. In February 2005 all GP Practices were asked to take a head count of the number of patients they treated with particular illnesses. One of the illnesses they were asked to count was 'Severe Mental Illness'. The definition of this illness was left quite open-ended but GPs in Scotland counted over 25,000 people that they felt met this definition (one person in every 185). This equates to approximately 650 people in Dumfries & Galloway and these are only the most severe cases that have been counted.

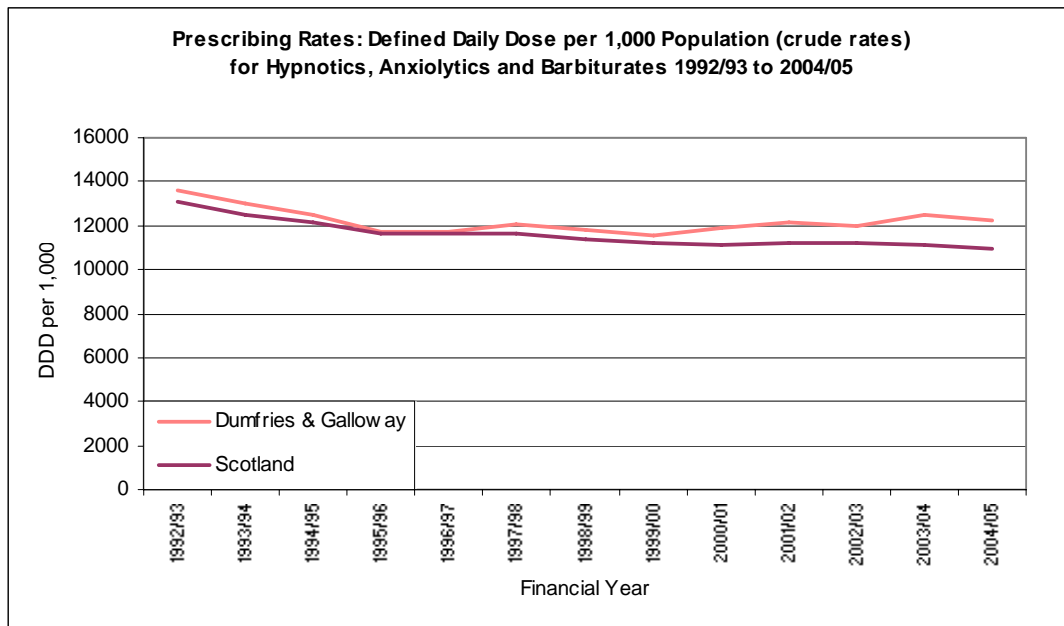
## Prescribing of Hypnotics and Anxiolytics

Drugs in the family of hypnotics and anxiolytics are essentially sedatives and are used to alleviate anxiety and insomnia. This is what the Performance Assessment Framework from the Scottish Executive had to say about them.

"Hypnotics and anxiolytics are often over prescribed and may be repeated unnecessarily. In 1998, the Committee of the Safety of Medicines declared that the use of benzodiazepines should be reduced, as dependence was becoming a subject of concern. High prescribing in this area is seen as inappropriate."

NHS Dumfries & Galloway spent £179,000 in 2004/05 on hypnotics and anxiolytics. The amount of these drugs being prescribed does not appear to be falling over time as has been recommended.

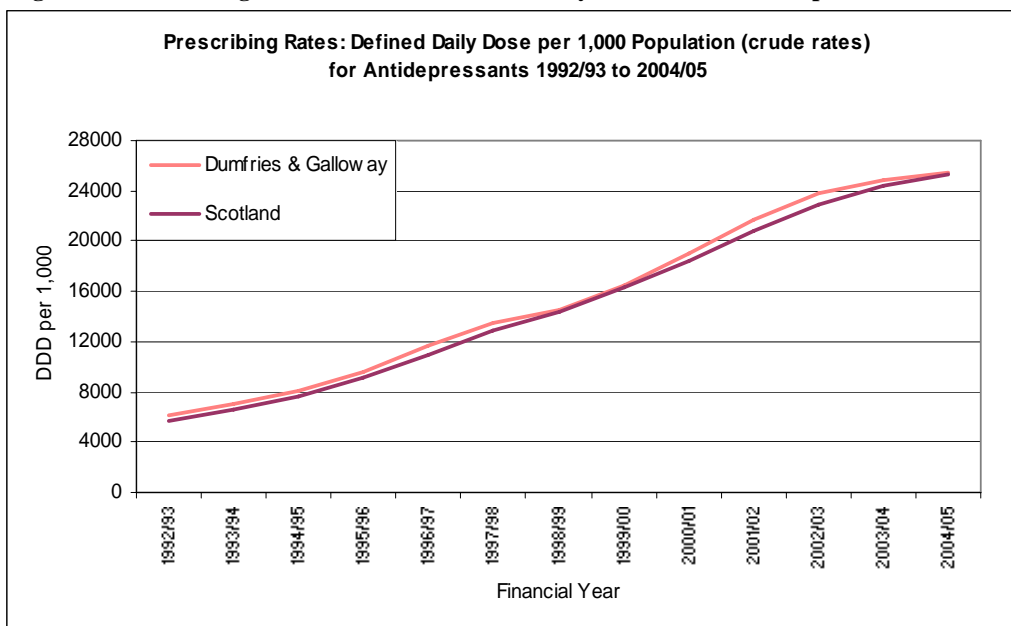
**Figure 10: Prescribing rates for Dumfries & Galloway vs. Scotland: Hypnotics, Anxiolytics and Barbiturates**



Source: National Statistics Prescribing Stats Released December 2005

Antidepressant prescribing has steadily increased over time in Scotland, and Dumfries & Galloway has followed suit.

**Figure 11: Prescribing rates for Dumfries & Galloway vs. Scotland: Antidepressants**



Source: National Statistics Prescribing Stats Released December 2005

## GP Contacts

We don't have access to pooled figures from all our GPs showing how many of their appointments are for patients discussing mental health issues, but we can estimate a rough figure from the ISD Practice Team Information (PTI). ISD has the consultation statistics for 45 practices spread around Scotland, from which estimates have been calculated for depression and anxiety consultations.

	Estimated number of contacts for Dumfries & Galloway			
	Anxiety	Anxiety	Depression	Depression
	Males	Females	Males	Females
Under 14 years	59	79	9	23
15-24	599	1,098	537	1,377
25-44	2,154	4,552	2,520	5,826
45-64	2,072	4,722	2,592	4,988
65-74	393	1,206	455	909
75-84	245	753	260	520
85+ years	47	166	60	108
All Ages*	5,569	12,576	6,432	13,750

\* All ages includes some patients where age was unknown

If Dumfries & Galloway has the same rate of contacts as the PTI practices, we might expect to have in the region of 18,000 GP contacts for anxiety every year and 20,000 GP contacts for depression. Women are more than twice as likely to go to the doctor about a mental health problem than are men.

## Web Links: Useful Internet addresses

General Register Office for Scotland	<a href="http://www.gro-scotland.gov.uk/">www.gro-scotland.gov.uk/</a>
Scottish Executive Statistics Online	<a href="http://www.scotland.gov.uk/Topics/Statistics">www.scotland.gov.uk/Topics/Statistics</a>
Scottish Neighbourhood Statistics	<a href="http://www.sns.gov.uk/">www.sns.gov.uk/</a>
Scotland's 2001 Census Online	<a href="http://www.scrol.gov.uk/scrol/common/home.jsp">www.scrol.gov.uk/scrol/common/home.jsp</a>
Statistics for England and Wales	<a href="http://www.statistics.gov.uk/default.asp">www.statistics.gov.uk/default.asp</a>
Reports on Scottish Health	<a href="http://www.scotland.gov.uk/Publications/recent.aspx">www.scotland.gov.uk/Publications/recent.aspx</a>
NHS Health Scotland	<a href="http://www.hebs.scot.nhs.uk/">www.hebs.scot.nhs.uk/</a>
Healthy Living	<a href="http://www.healthyliving.gov.uk/">www.healthyliving.gov.uk/</a>
Mental Health Foundation	<a href="http://www.mentalhealth.org.uk/">www.mentalhealth.org.uk/</a>
'Well?' Magazine: Mental Health and Wellbeing in Scotland Issue 7 Winter 2005	<a href="http://www.scotland.gov.uk/Publications/2005/10/06151457/15016">www.scotland.gov.uk/Publications/2005/10/06151457/15016</a>
Young Minds – for children's mental health	<a href="http://www.youngminds.org.uk/index.php">www.youngminds.org.uk/index.php</a>
The New Mental Health Act: The Role of the Mental Welfare Commission - Information for Service Users and their Carers	<a href="http://www.scotland.gov.uk/Publications/2005/12/01102702/27030">www.scotland.gov.uk/Publications/2005/12/01102702/27030</a>
Addressing Mental Health Inequalities in Scotland	<a href="http://www.scotland.gov.uk/Publications/2005/11/04145113/51135">www.scotland.gov.uk/Publications/2005/11/04145113/51135</a>
The New Mental Health Act An Easy Read Guide	<a href="http://www.scotland.gov.uk/Publications/2005/10/12110604/06042">www.scotland.gov.uk/Publications/2005/10/12110604/06042</a>
Scottish Public Health Observatory	<a href="http://www.scotpho.org.uk">www.scotpho.org.uk</a>
Public Health Institute of Scotland	<a href="http://www.phis.org.uk/index.asp">www.phis.org.uk/index.asp</a>
Health Protection Agency	<a href="http://www.hpa.org.uk/default.htm">www.hpa.org.uk/default.htm</a>
Urban Rural Classification	<a href="http://www.scotland.gov.uk/library5/rural/seurc-00.asp">www.scotland.gov.uk/library5/rural/seurc-00.asp</a>
Scottish Index of Multiple Deprivation 2004	<a href="http://www.scotland.gov.uk/library5/society/siomd-00.asp">www.scotland.gov.uk/library5/society/siomd-00.asp</a>

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