

**MENTAL HEALTH PROMOTION
EXPERT WORKING COMMITTEE**

Draft Report

APPENDICES

MENTAL HEALTH PROMOTION EXPERT WORKING COMMITTEE

Draft Report

Committee Members

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- Mr Irwin Pryce – School Teacher
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Suicide & The NI Review of Mental Health & Learning Disability

The World Health Organisation (WHO) (1999) has reported that every year one million people across the world die by suicide. This equates to one suicide death every 40 seconds. They also advise that every year there are more people dying by suicide than by all the deaths due to the current conflicts across the globe.

This is equally true for Northern Ireland where the history of the conflict over some thirty years is well known. According to Fay et al (1997) found in the thirty years from 1969 to 1999, that more people died here by suicide than as the result of the conflict. On average since 2000, deaths due to suicide have exceeded deaths on the road.

Suicidal behaviours place a heavy human and financial burden on society in Northern Ireland. Figures from DHSSPS (2002) indicate that there are on average one hundred and fifty suicide deaths every year in NI, 80,000 working days are lost to illnesses related to attempted suicide; and that there are over 4,000 hospital admissions annually as the result of suicidal behaviour. The estimated annual cost to the economy of suicidal behaviour is £170m. Although suicide accounts for 1% of all deaths annually it equates to 7% of potential years of life lost, indeed the expected years of life lost to suicide is estimated to be 4,400.

Concerning the psychological and social impact on the family and society is estimated that up to fifty people are significantly affected by a suicide death (WHO), Bland (1994) listed twenty-eight different relationships to a person who died by suicide for those who came forward for help. If the figure of fifty is accurate, then each year in Northern Ireland 7,500 people are impacted as the result of suicide. Estimating the burden of suicide in terms of disability-adjusted life years (DALYs) in 1998 suicide was responsible for 1.8% of the total burden of diseases worldwide.

“This is equal to the burden due to wars and homicide, roughly twice the burden of diabetes, and equal to the burden of birth asphyxia and trauma”. (WHO, 2000)

Suicide Prevention Strategy

Reaction driven responses to suicide are costly in the short term, both financially and emotionally. A well planned, resourced and a co-ordinated strategy to suicide prevention would be cost effective in the longer term (Ramsey & Tanney, 1996). Suicide is a multi dimensional issue and the Australian government highlight

“The complexity of the interaction between risk factors, and the capacity for health care and social interaction to influence individuals choices, suggests that

government and society have a responsibility to act” (Commonwealth of Australia, 2000).

The moral obligation rests on the principle of beneficence (Kuitert, 1995) and responses are required at the individual, community and government levels.

Limitations of the Present ‘Promoting Mental Health Strategy’ Re. Suicide Prevention

It would appear that the Ministerial Group on Public Health did not take responsibility for the overall Strategy and Action Plan. As a result, a lack of strategic leadership, accountability and a inter-departmental approach was evident.

The Implementation Group, whose task it was to report on progress, met infrequently and therefore was unable to oversee and drive forward the actions. Furthermore, the financial resources and support were insufficient to deliver and ensure co-ordination on the actions.

Though the current Mental Health Promotion Strategy is to be welcomed, there is more involved in suicide prevention than mental health promotion. Mental health promotion plays a fundamental role in enabling the positive self-esteem of individuals. It also seeks to strengthen individual and community resilience. Suicide Prevention initiatives build on these efforts by seeking to: - raise awareness about suicide at the whole population level; seek to intervene with those at risk of suicide; follow up those who have attempted to end their lives and provide care and support for those bereaved by suicide.

The Benefits of a Regional Suicide Prevention Strategy

According to the US Government, a National Strategy for suicide prevention can:-

- Raise awareness and help make suicide prevention a national priority. This can help direct resources of all kinds to the issue.
- Provide an opportunity to use partnerships and the energy of survivors to engage those who may not have considered suicide prevention within their purview. It supports collaboration across a broad spectrum of agencies, institutions, groups and community leaders as implementation partners.
- Link information from many prevention programmes to avoid unintentional duplication and disseminate information about successful prevention interventions.
- Direct attention to measures that benefit the whole population and, by that means, reduce the likelihood of suicide before vulnerable individuals reach the point of danger.
- Bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels such as the family, the individual, schools, the community and the health care system.

- Help develop in an equitable way and provide technical assistance with valuable types of expertise to strengthen community programmes.

An evidence-based strategy can maximise success when recommendations are implemented locally. Sound evaluation of community programmes, in turn, builds the evidence base. (US Dept. of Health & Human Services, 2001)

The following goals outline the range of outcomes that would support the aim of a national strategy:

1. Preventing premature death due to suicide across the life span.
2. Reducing the incidence and prevalence of other suicidal behaviours.
3. Reducing the morbidity associated with suicidal behaviours.
4. Providing opportunities and settings to enhance resilience, resourcefulness, respect, and inter-connectedness for individuals, families and their communities. (United Nations/WHO, 1993)

An evidence base guiding strategic work on suicide prevention is essential.

“...there may be political and social imperatives to be seen to be doing something about suicidal behaviour...scientists need not necessarily be pessimistic about such programmes, even though they may not meet the rigorous criteria essential for scientific research” Goldney, (2000)

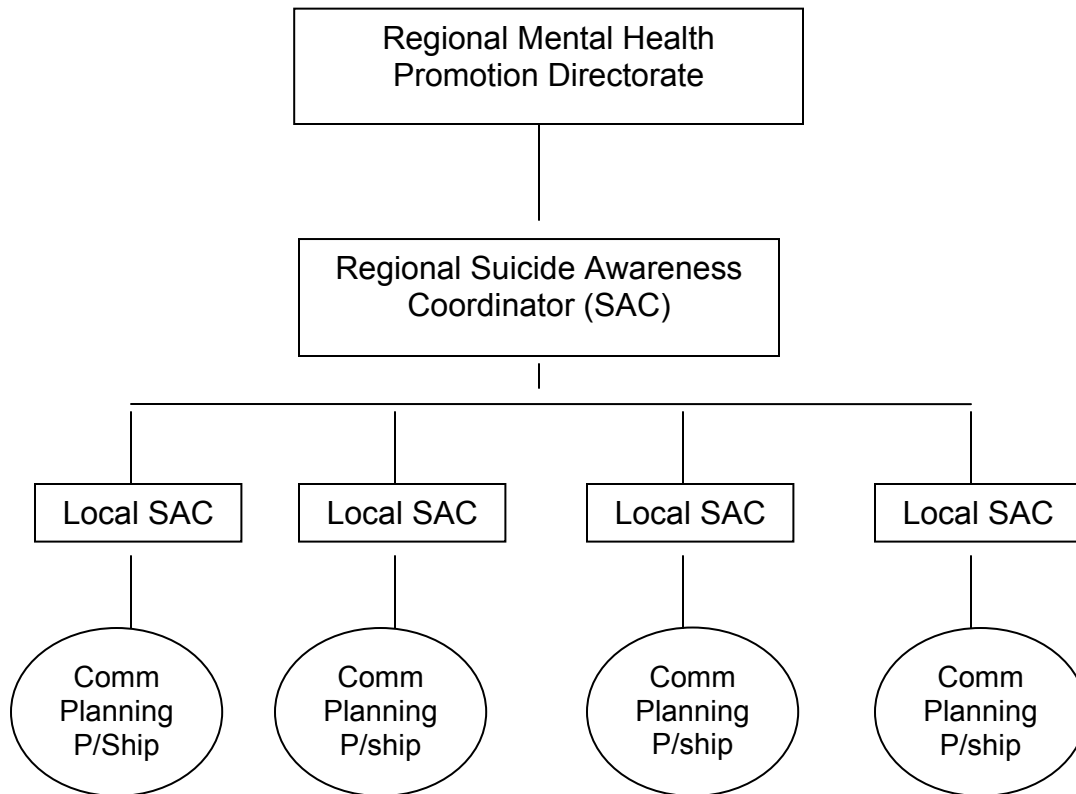
The groundswell of opinion is that urgent action is required and international evidence exists to guide the way forward.

Recommendations

- The Regional Mental Health Promotion Directorate needs to ensure that suicide prevention is a regional priority and the proposed suicide prevention strategy is implemented.
- A broad coalition of suicide survivor representatives, suicide prevention activists, researchers and community representatives needs to be created for the development and implementation of the strategy.
- Suicide prevention needs to be placed as a public health priority.
- A suicide prevention strategy needs to be developed with an identified action plan with target dates, responsibilities and be properly resourced.
- A system for collating data on self-harm in NI should be established linking it to the European WHO Multi-Centre Study on Parasuicide.
- The recommendations within Safety First need to be co-ordinated and implemented on a regional basis.
- Closer co-operation between our colleagues, North, South, East and West, in keeping with Investing in Health recommendations, should be encouraged and supported.
- A Postvention service needs to be made a priority. Co-ordination and enhancement of the care provided to those bereaved by suicide must begin immediately.
- A suicide prevention research centre must be supported and resourced where local and international evidence can be accessed.
- A major culture change is required in our society that encourages help-seeking as a sign of strength not weakness.
- Community development is one of the foremost ways of advancing suicide prevention and should be promoted through capacity building.
- Applied Suicide Intervention Skills Training (ASIST) should be provided as standardised training for all those who work with vulnerable people.
- Training for those providing long term care to suicidal persons needs to be reviewed and developed.

Appendix vi (a)

Proposed Implementation Framework



Authors: Pat McGreevy, Lecturer/Practitioner
Barry McGale, Suicide Awareness Co-ordinator (2005)

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Identification of Need – Summary of Key Issues

3.1 PROMOTION OF MENTAL HEALTH & WELL-BEING FOR ALL IN THE POPULATION AT LARGE

Key Issues to be Addressed

3.1.1 Home

- Factors which promote resilience in children under 5 help those children to do well despite adversity, therefore early intervention is vital. Evidence shows, for example, that Promoting Parenting Skills Programmes improve the mental health of both parents and children. This is an area which should be further encouraged.
- *Action 18 of the mental health promotion regional strategy relates to parenting skills and links with the ongoing work being undertaken to implement the teenage pregnancy and parenthood strategy and action plan.*
- *According to the Implementation Group's Draft Annual Report, all HSS Boards are undertaking some action, for example the delivery of skills training to Surestart staff on building self esteem and handling child behaviour.*

3.1.2 Schools

It is recognised that schools can have a vital role to play in protecting the health of young people. Interventions such as the Resourceful Adolescent Programme in Australia and the Health Promoting Schools initiatives have been proven to be effective in promoting children's mental health. Proper resources and cross sectoral working are needed to implement a province-wide schools strategy. Whilst the current work being carried out in Northern Ireland on the Health Promoting School Initiative is valuable and points for the potential for the future, there are important issues which need to be addressed such as:-

- **Funding** – A significant source of funding, long term needs to be identified and committed to the project.

- **Cross-Sectoral Issues** – Funding currently comes via the DHSSPS - with no involvement of the Department of Education. For an educational issue such as this, there needs to be a commitment by both the Department of Education and the DHSSPS for it to be successful.
- **Curricular Issues** – There should be a proper curricular approach, with the “Health Promoting School” initiative dovetailing into other existing curricular programmes such as personal development.
- **Training** – Teacher training needs to be reviewed, with teachers at the point of entry into teacher training, receiving proper training on mental health.

3.1.3 The Workplace

A negative working environment can lead to a range of problems such as sickness absence: labour turnover: bullying and harassment and ineffective working, what helps is to promote a healthy culture, with good quality of relationships, communication and support to staff.

Employers have a duty under health and safety legislation to take measures to protect the health of their employees at work.

- Policies should approach the topic in a comprehensive way, from recruitment and training, right through to actual support for vulnerable staff and guidance on handling issues such as staff sickness and absenteeism. Training for managers in implementing such a policy is recommended.
- All employers, as a minimum, should have in place a Mental Health in the Workplace Policy which seeks to address, even as a staged process over a period of time, issues relating to prevention of negative factors where possible, and support to those who may be in a stressful environment, or going through a difficult period.

3.1.4 Communities and Neighbourhoods

- Interventions designed to increase social inclusion such as social prescribing should be encouraged as part of community development.
- Actions in the Investing for Health regional strategy need to be progressed and assessed.
- Research programmes addressing the needs of marginalized groups need to be resourced, with a view to mainstreaming.
- Training for relevant community and professional agencies on mental health awareness and ways to reduce stigma should be provided.

- The benefits of interventions such as Arts on Prescription for increasing social inclusion and strengthening communities should be explored especially in particularly disadvantaged areas.
- As the Communities That Care (CTC) Programme appears to have proved to have successful outcomes, not only in the USA, but elsewhere in Europe and the UK, this approach should be considered in Northern Ireland, especially with its particular needs and often fragmented social networks and lack of cohesion.

3.1.5 Further & Higher Education

- There are positive associations between education and both physical and mental health. Facilitating access to further and higher education opportunities for those who are psychologically vulnerable is an important issue in itself. In addition it is important for students, especially young adults, to feel supported in a pressured and transitional time in their lives.
- The Health Promoting University/College is an initiative which has been implemented in England. Its approach could be assessed for its usefulness in the Northern Ireland context.

3.1.6 Primary Care

Professionals

- **Training for GPs** – Approximately 50% of GPs have no formal psychiatric training and few practice nurses have had such training (Croft 2000). As most GPs have opted to go into physical medicine, they may have very little experience of mental ill health. There is a need for better training for GPs
- **Research** – Increased research into the effectiveness of work being done is needed.
- **Resources, Targets & Priorities** – With the contracting system, there is the opportunity to target resources for mental health promotion. GPs are particularly well placed due to working within an overall health promotion setting, where potentially mental health promotion can be dovetailed with general health promotion initiatives.
- **Role of Voluntary Agencies** – There should be an increased use of services provided by voluntary agencies and increased direct liaison into primary care priorities.

Public

- **Support Available/Information Services** – Primary care environments could be better used as an information resource, perhaps with access to a practice library with self help literature.
- **Self Help** – Increased promotion of the ethos of empowerment for those who are vulnerable due to mental health problems would potentially speed recovery.
- **Users' Role in Promoting Mental Health at Primary Care Level -**
There are opportunities for mental health service user groups in helping to improve mental health issues within primary care. (Foy 2004).

3.1.7 Rural Areas

- As rural areas have been identified as being particularly prone to risk factors such as isolation and specific problems related to the farming community, and are particularly at risk of suicide, a province-wide strategy is required to help raise awareness of issues involved, help and people identify where to get support.
- Stigma has been identified as a major barrier in people seeking help – therefore a strategy to address issues relating to stigma, especially young men in rural areas should be outlined.
- The actions relating to rural areas in the regional strategy need to be progressed.

3.1.8 Faith Communities

- An accepting and non judgmental attitude needs to be promoted – those in a caring role need not always “do” anything except listen and afford the individual dignity and respect.
- Training in mental health would be beneficial for those being ordained in all denominations.
- Information/workshops should be provided for those in the community who may benefit from pastoral care, and may not be affiliated to any particular faiths.
- The wider dissemination of the work of the Special Interest Group on spirituality within the Royal College of Psychiatrists may benefit practitioners not currently involved.

3.2 THE PREVENTION OF MENTAL HEALTH PROBLEMS IN KEY AT RISK GROUPS

3.2.1 Children & Young People

In terms of mental health promotion, early intervention and the development of emotional resilience have been identified as crucial in helping young people cope with pressures through adolescence into early adulthood.

There is a range of potential interventions, school, home and community based which can be effective in this regard. Social skills training, for example – involving coaching and cognitive problem solving approaches is particularly effective with isolated children.

The education and health sectors need to collaborate further on programmes with children and young people.

Peer education and support can be a relatively cost effective approach, with considerable positive impact.

The Expert Working Committee on Child and Adolescent Health will report in some detail of issues relating to this target group in their report.

Members of this Committee discussed with our Committee some of the main issues they seek to address in their report which include:-

- Child and adolescent health needs to be society's agenda – not just a healthcare issue solely.
- The Education and Health Sectors need to work together.
- Early attachment and infant mental health is important in later life.
- There should be quick and appropriate referral procedures in the event of first onset psychosis.
- There are significant gaps in child and adolescent services.
- "Looked After" children is an issue itself.
- Access to support is important to young people – there is potential in peer education approaches.
- There is a regional strategy "Bright Future" but not enough emphasis on children.
- There needs to be a ministerial commitment to drive any such strategy forward.
- Other international and national models can be useful to draw upon, eg. New Zealand's Diversity Model and the Scottish "Pathway" approach.

3.2.2 Those with Acquired Deafness

- One good practice example, which Northern Ireland could learn from, is that of the peer education process model adapted by the LINK Peer Education Centre in Eastbourne.
- There is a need for research into this area in the UK generally and Northern Ireland in particular.
- Programmes to increase understanding and awareness of the issues relating to various types of deafness need to be implemented.

(Please also refer to the Expert Working Committee's Section of Services for Deaf People with Mental Health Problems – A Strategic Framework for Adult Mental Health Services – May 2004).

3.2.3 Learning Disability

(The Learning Disability Working Committee will report in detail on these issues)

It is estimated that 20-50% of all those with learning disability have a mental health problem. (Devine 2004) outlines 15 recommendations for actions.

These include:-

- The need for mental health promotion for people who have a learning disability to be made more specific in mainstream strategies and policies.
- Emphasis should be given within all relevant sectors to building positive mental health.
- A responsibility to enhance emotional well-being and build resilience should be a central component of any school curriculum.
- There needs to be a recognition that people with a learning disability need to have improved opportunities for meaningful work/day opportunities.

3.2.4 Ethnic Minorities

- There is a need for greater public education and awareness about ethnic minorities in Northern Ireland.
- There is a need to further explore issues relating to the mental health of these groups.
- Research into identification of need would help to begin to address how to reduce barriers and increase social inclusion for the increasing number of ethnic groups in the province.

3.2.5 Older People

- The prevalence of mental health disorders, such as depression, is relatively high in later life. Programmes such as pre-retirement, the provision of telephone support and prevention of suicide in later life should be implemented within the community.
- Community development programme should be developed to enhance levels of social support for older people.
- Exercise on prescription through primary care should be encouraged.

3.2.6 The Unemployed

- Given Northern Ireland's higher levels of deprivation and unemployment, any regional strategy should directly address those issues with suggestions for strategic cross sectoral action.
- It is essential for employers to have more education and awareness of mental health issues to ensure there is no discrimination against individuals seeking employment who have a background of mental illness.
- Any Northern Ireland strategy on prevention of suicide should include specific reference to dealing with unemployment (eg., it has been calculated that if there were full employment in the UK, the suicide rate would drop by 11% - Lewis, Hawton and Jones 1997).
- Interventions with a strong focus on job search, self efficacy, social and emotional coping skills and building social support should be encouraged.

3.2.7 The Physically Ill

Mental health and physical health are deeply interdependent. For the integration of mental health into general health care to be successful policy makers and practitioners both need to be fully aware of the mind-body link. This is of particular importance at primary care level. Training is recommended for GPs and other professionals in mental health awareness.

For integration of mental health into general health care to be successful, policy-makers need to consider the following:

- General health staff must have the knowledge, skills and motivation to treat and manage people living with mental disorders.
- There needs to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels.
- Basic psychotropic drugs must be available at primary and secondary care levels.

- Mental health specialists are required to provide support to monitor general healthcare personnel.
- Effective referral links between primary, secondary and tertiary levels of care need to be in place.
- Investment in primary and community care can deliver better outcomes both in primary and secondary care.
- Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities.

(World Health Organisation, 2001 World health Report)

3.2.8 Those with Gender and Sexuality Issues

- The psychological and emotional distress of young gay men appears to be reasonably well documented. A gap in identified need seems to be that of young lesbian women's emotional and psychological needs.
- Given that questions over sexual identity can arise in adolescence and early 20's, awareness amongst staff in school and further/higher education of these individuals' particular needs seems vital.
- Public education and awareness of gender issues to promote understanding and tolerance of them is required.
- Youthnet recommend as a result of their research that lesbian, gay and bisexual training, awareness training programs to all those involved in the development and implementation of services to gay people should be delivered.

3.2.9 Offenders within the Criminal Justice System

It is recommended that it would be beneficial to take such action as:

- Focusing on early interventions.
- Encouraging the courts to use alternatives to custody for men with mental health problems who have committed minor offences.
- Increase the number of court diversion schemes available across the country so that offenders who are acutely, ie. not at risk of suicide, can be given hospital places or the treatment they need.
- Ensuring the Prison Service meets NHS Standards, policies and protocols, particularly regarding the use of medication, service user initiatives, training for doctors and health care staff.

- The Restorative Justice Model has also been proven to be effective as an alternative to long term imprisonment. This should be explored in Northern Ireland.

3.3 IMPROVING THE QUALITY OF LIFE FOR THOSE WHO HAVE EXPERIENCE MENTAL HEALTH PROBLEMS

The Key Issues to be Addressed:

3.3.1 Those with Enduring Serious Mental Illness

The Expert Working Committee on Adult Mental Health has provided a strategic framework for the provision of services in this area.

However, in terms of mental health promotion, there is now a body of evidence to show that mental health promotion can contribute to the prevention of certain disorders, such as anxiety, depression and substance abuse. It can also contribute to the health improvement of people whether they are at risk of mental illness as well as for those with mental health problems.

- An educational programme in Sweden improved the detection and management of depression. Evidence in England suggests that an educational package aimed at improving the interviewing skills of primary care physicians produced the same results.

It is suggested that this training could be applied here in a primary care setting, with all primary care professionals.

3.3.2 People with Eating Disorders

- Examples of good practice in terms of prevention include: life skills training programmes and programmes which focus on improving self image and reducing body dissatisfaction in young people.
- Given that early recognition means that treatment is most effective, in terms of mental health promotion, programmes should focus on early intervention.

3.3.3 Those at Risk of Suicide

- A suicide prevention strategy, based on the UN/WHO guidelines and Safety First recommendations and drawing on good practice in the rest of the UK, needs to be developed and resourced with an identified action plan with target dates, identified responsibilities, etc.
- Please see Appendix xi for a further paper with detailed recommendations on suicide prevention.

3.3.4 The Emotionally & Physically Traumatized

- It is recommended by the WHO that preventive efforts to reduce the onset of mental disorders (such as anxiety depression and PTSD) in post conflict societies should focus primarily at early interventions after trauma, rebuilding the country's physical and mental health services and social infrastructures, mental health education and offering emotional, societal and economic support to victims. (WHO 2004).
- Cognitive Behavioural therapy as a treatment for Post Traumatic Stress Disorder (PTSD) has been shown to be effective through the work of the Northern Ireland Trauma and Transformation Centre.
- Family therapy approaches in North and West Belfast HSS Trust have also reported positive individual and family effects following therapy and treatment.
- Over and above actual treatment, additional resources should be provided for day to day support and training of those who help people in the community affected by the conflict and to help enhance social capital.
- Consistent with WHO recommendations for post-conflict societies, preventive initiatives are required to reduce the onset of mental disorders such as anxiety, depression and PTSD focusing primarily on early interventions after trauma, rebuilding our community's physical and mental health services and social infrastructures, mental health education and offering emotional, societal and economic support to victims (WHO 2004).
- The development and expansion of evidence based services, including CREST guidelines, to address psychological trauma and including adult survivors of childhood trauma should be taken forward as a priority.

3.3.5 Those Involved in Substance Abuse

Both the Strategic Framework for Adult Mental Health services and the Alcohol and Substance Misuse Working Groups deal with the issues relating to those who have developed alcohol or drug problems

- Availability of alcohol is a factor and therefore there may be political aspects to dealing with the problem away from excess drinking. Politicians should be lobbied in this regard.
- The Health Promotion Agency could have a significant role in developing a strategy province-wide to help promote healthier drinking, drawing on examples of good practice and research nationally and internationally.

**WHO European Ministerial Conference
on Mental Health
Facing the Challenges, Building Solutions
Helsinki, Finland, 12–15 January 2005**

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**Mental Health Action Plan for Europe
Facing the Challenges, Building Solutions**

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next five to ten years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

- i. foster awareness of the importance of mental well-being;
- ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
- iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- iv. address the need for a competent workforce, effective in all these areas;
- v. recognize the experience and knowledge of service users and carers¹ as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next five and ten years.

1. Promote mental well-being for all Challenge

Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

Actions to consider

- i. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.
- ii. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.
- iii. Develop and offer effective programmes for parenting support and education, starting during pregnancy.

¹ The term "carer" is used here to describe a family member, friend or other informal care-giver.

- iv. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psychosocial functioning in children and young people.
- v. Improve access to healthy diets and physical activity for older people.
- vi. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.
- vii. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.
- viii. Encourage the consumption of healthy products and reduce the intake of harmful products.
- ix. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.
- x. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.
- xi. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

2. Demonstrate the centrality of mental health Challenge

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multidisciplinary approaches.

Actions to consider

- i. Make mental health an inseparable part of public health.
- ii. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.
- iii. Include mental health in programmes dealing with occupational health and safety.
- iv. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.
- v. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

3. Tackle stigma and discrimination Challenge

Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

Actions to consider

- i. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.
- ii. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.
- iii. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.
- iv. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.
- v. Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.
- vi. Establish constructive dialogue with the media and systematically provide them with information.
- vii. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.
- viii. Stimulate the creation and development of local and national nongovernmental and service user-run organizations representing people with mental health problems, their carers and the communities they live in.
- ix. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.
- x. Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

4. Promote activities sensitive to vulnerable life stages

Challenge

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment which creates many long-term benefits for individuals, societies and health systems.

Actions to consider

- i. Ensure that policies on mental health include as priorities the mental health and wellbeing of children and adolescents and of older people.
- ii. Incorporate the international rights of children and adolescents and of older people into mental health legislation.
- iii. Involve young people and older people as much as possible in the decision-making process.
- iv. Pay special attention to marginalized groups, including children and older people from migrant families.
- v. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.
- vi. Promote the development of community centres for older people to increase social support and access to interventions.
- vii. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.
- viii. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.
- ix. Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.
- x. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at national and international levels, as well as collaboration between their respective networks.
- xi. Ensure parity of funding in relation to comparable health services.

5. Prevent mental health problems and suicide

Challenge

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk.

Actions to consider

- i. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.
- ii. Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.
- iii. Establish self-help groups, telephone help-lines and websites to reduce suicide, particularly targeting high-risk groups.
- iv. Establish policies that reduce the availability of the means to commit suicide.
- v. Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.
- vi. For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.
- vii. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.
- viii. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.
- ix. Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.
- x. Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.
- xi. Monitor work-related mental health through the development of appropriate indicators and instruments.
- xii. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.

- xiii. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

6. Ensure access to good primary care for mental health problems

Challenge

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

Actions to consider

- i. Ensure that all people have good access to mental health services in primary health care settings.
- ii. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.
- iii. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.
- iv. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain illhealth.
- v. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.
- vi. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.
- vii. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

7. Offer effective care in community-based services for people with severe mental health problems

Challenge

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and

experience in many countries support the development of a network of community-based services including hospital beds. There is no place in the twenty-first century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

Actions to consider

- i. Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.
- ii. Plan and implement specialist community-based services, accessible 24 hours a day, seven days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.
- iii. Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.
- iv. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.
- v. Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.
- vi. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.
- vii. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.
- viii. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.
- ix. Design programmes to develop the caring and coping skills and competencies of families and carers.
- x. Scrutinize whether benefit programmes take account of the economic cost of caring.
- xi. Plan and fund model programmes that can be used for dissemination.
- xii. Identify and support leaders respected by their peers to spearhead innovation.
- xiii. Develop guidelines for good practice and monitor their implementation.
- xiv. Introduce legal rights for people subject to involuntary care to choose their independent advocate.
- xv. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.
- xvi. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

8. Establish partnerships across sectors

Challenge

Essential services which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

Actions to consider

- i. Organize comprehensive preventive and care services around the needs of and in close cooperation with users.
- ii. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.
- iii. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through coordination with other services.
- iv. Educate staff in other related services about the specific needs and rights of people with mental health problems and those at risk of developing mental health problems.
- v. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

9. Create a sufficient and competent workforce

Challenge

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers, benefit officers, the clergy and volunteers need to be modernized in order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

Actions to consider

- i. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.
- ii. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.
- iii. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.
- iv. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.

- v. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.
- vi. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.
- vii. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of “train the trainers” programmes.
- viii. Educate and train mental health staff about the interface between promotion, prevention and treatment.
- ix. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.
- x. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.
- xi. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

10. Establish good mental health information

Challenge

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

Actions to consider

- i. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.
- ii. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.
- iii. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.
- iv. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.
- v. Monitor existing mental health programmes, services and systems.
- vi. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies,

strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.

- vii. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

11. Provide fair and adequate funding

Challenge

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

Actions to consider

- i. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.
- ii. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.
- iii. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.
- iv. Evaluate whether coverage is comprehensive and fair in social and private insurancebased systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

12. Evaluate effectiveness and generate new evidence

Challenge

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

Actions to consider

- i. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.
- ii. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.

- iii. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.
- iv. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.
- v. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.
- vi. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.
- vii. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.
- viii. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.
- ix. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.
- x. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

Mental Health for Europe: Facing the Challenges

Milestones

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
2. scrutinize the mental health impact of public policy;
3. include the prevention of mental health problems and suicide in national policies;
4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;
6. develop partnership for intersectoral working and address disincentives that hinder joint working;

7. introduce human resource strategies to build up a sufficient and competent mental health workforce;
8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.

**MENTAL HEALTH PROMOTION
EXPERT WORKING COMMITTEE**

**SCOTTISH NATIONAL PROGRAMME FOR IMPROVING
MENTAL HEALTH & WELL-BEING**

Mental Health Promotion Draft Report

Work on Public Mental Health in Scotland is taken forward, facilitated and co-ordinated through the Executive's National Programme for Improving Mental Health and Well-being.

This work forms part of the wider Scottish Executive agendas on Mental Health, Social Inclusion and Health Improvement/Public Health.

The National Programme is hosted within the Executive's Mental Health Division with national funding support from the Executive's Health Improvement Funds of £9m per annum.

Key areas of the National Programme's work:

1. Raising Awareness and Promoting Mental Health and Well-being

- Scotland's Mental Health First Aid Course
- By March 2008 over 300 SMHFA trainers will be trained delivering SMHFA courses to over 40 000 people.
- Public information leaflets on mental health have been produced
- Mental Health Promotion national training programme to be rolled out across Scotland following launch in June 2005.
- Preliminary work on public promotion of Positive Mental Health and Well-being to start 05/06
- Making mental health and well-being a priority area for NHS Health Scotland over the next five years

2. Eliminating Stigma and Discrimination

- Continuing to fund 'See Me', Scotland's National Anti-stigma campaign, approximately £700k per annum – 2005/2008

Public Attitude Results 2004 compared with 2002

	% agreeing	
	2002	2004
I would keep a mental health problem a secret if I had one	50	45
People with mental health problems are difficult to talk to	20	15
Public should be better protected from people with mental health problems	35	24
People with mental health problems are often dangerous	32	15

- Building on the success of the Dementia Awareness campaign and undertaking further campaigning activities
- Ensuring that work on inequalities and mental health is taken forward as part of general work on inequalities in health, and wider work on equality
- Scotland has been asked by World Health Organisation (WHO) Europe to help support and lead the co-ordination of work across Europe around the key theme of eliminating stigma and discrimination and promoting social inclusion

3. Preventing Suicide

- 'Choose Life' is the Scottish Executive's National Strategy and Action Plan to prevent suicide in Scotland. £3m per annum (2003-2006) has been allocated across Local Authority areas in Scotland to develop local 'Choose Life' suicide prevention action plans in conjunction with Community Planning Partnerships.
- 32 local suicide prevention Action Plans now in place in each Local Authority areas, developed by local Community Planning Partnerships
- Suicide Asist Training – there are now 142 ASIST trainers in Scotland delivering the intensive, interactive workshop
- Over 2500 participants have now completed the course

This is part of a National Suicide Prevention training strategy.

4. Promoting and Supporting Recovery

- Launch of Scottish Recovery Network (SRN) 16 December 2004
- The first three in a series of SRN discussion papers have been published and include a review of important elements of recovery, a consideration of community involvement and issues on researching recovery
- Stories will be gathered at events around Scotland and the outcomes used to influence SRN's future work
- Development of training to promote and support recovery
- Scottish Recovery Network is currently engaging with up to 60 individuals to take part in an ambitious research project to gather personal testimonies of recovery from mental health problems.
- Scottish Recovery Network is collaborating with the Royal College of Psychiatrists on a training day to be integrated into postgraduate education.