

**MENTAL HEALTH PROMOTION  
EXPERT WORKING COMMITTEE**

**Draft Report**

**MENTAL HEALTH PROMOTION –  
A PERSONAL, PUBLIC & POLITICAL ISSUE**

October 2005



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# MENTAL HEALTH PROMOTION EXPERT WORKING COMMITTEE

## Executive Summary

### 1.0 VISION

There must be a recognition at all levels in Northern Ireland:

- that everyone has mental health needs;
- that mental well-being underpins all health and well-being;
- that mental health, like physical health, is a resource to be protected and promoted
- that mental health promotion strategies and practice are in keeping with human rights and equality legislation

We also want to see a society where everyone plays a role in and takes action to create an environment that promotes the mental health and well-being of individuals, families, organisations and communities.

This is particularly important in Northern Ireland, where social capital has been in many communities destroyed due to the legacy of 30 years of conflict. Communities need to grow and develop, enhancing levels of trust, sense of belonging and participation to promote emotional well-being.

Although some progress has been made towards this vision, much still needs to be achieved.

### 2.0 PRIORITIES FOR PROMOTING MENTAL HEALTH IN NORTHERN IRELAND

In reviewing progress on mental health promotion in Northern Ireland, the following areas have emerged as crucial to achieving effective delivery:

- prioritisation of key risk groups
- capacity building
- research
- co ordination
- cross sector partnership and working
- compliance with equalities and human rights legislation
- dedicated resources, both additional and with a realignment or reconfiguration of existing resources to facilitate mental health promotion and prevention.

### 3.0 RECOMMENDATION

In order to achieve these priorities for action, the following recommendations are outlined.

### **3.1 PRIMARY RECOMMENDATION – THE CREATION OF A REGIONAL MENTAL HEALTH/PROMOTION DIRECTORATE**

In order to achieve strategic, co-ordinated, cross-sectoral and multi-agency action on mental health promotion, a Regional Mental Health Promotion Directorate, with a Regional Director should be established. This Directorate should be sited within that section of DHSSPS with responsibility for mental health and disability and not be part of a generic health promotion structure. A properly resourced directorate would increase awareness and visibility of mental health promotion, facilitate the achievement of existing mental health promotion targets as well as setting targets for the future. This would provide a necessary degree of permanence, leadership and sustainability to drive forward mental health promotion in Northern Ireland whilst creating ownership of mental health promotion across all sectors and relevant agencies and groups.

**Key functions of the Directorate would include:**

#### **3.1.1 Co-Ordination**

Mental health promotion is an element of or relevant to a wide range of existing policies in Northern Ireland, as well as being the focus of specific strategies e.g. the Promoting Mental Health Strategy and Action Plan 2003-8. The co-ordinating role of the Regional Mental Health Promotion Directorate involves:

- Identifying how mental health promotion contributes to the goals of policy across all sectors
- Supporting the delivery of existing policies relevant to mental health promotion
- Raising awareness of mental health promotion
- Moving mental health promotion up the policy agenda

#### **3.1.2 Cross Sector & Partnership Working**

Effective delivery of mental health promotion will require contributions from many different sectors, in addition to health and mental health. The Regional Mental Health Promotion Directorate will provide a focus for liaison between different government departments, sectors and professional bodies, as well as voluntary and community groups with an interest in mental health. This will also involve liaising with, learning from, and contributing to mental health promotion activity in the UK and internationally.

### **3.2 OTHER MAJOR RECOMMENDATIONS**

These have been listed under the 3 headings in the Health Education Authority “map” for mental health promotion (HEA 1997):

- Settings for Action
- Stages of Life (At Risk Groups)
- Levels of Action

### 3.2.1 Settings for Action

There is good evidence to show that mental health can be promoted in a range of settings, such as schools and the workplace. The following have been identified as priority areas for action:

- Schools
- Further & Higher Education
- Rural Areas
- Communities including Marginalized Groups & Faith Communities
- Primary Care

### 3.2.2 Stages of Life – At Risk Groups

The promotion of positive mental health is identified as necessary at all life stages. Early intervention for children and adolescents has been proven to enhance resilience.

Older people too, a growing population, have particular needs:

In terms of priority the following 3 groups have been identified:

- Children & Adolescents
- Older People
- Those in Receipt of Statutory Mental Health Services

### 3.2.3 Levels of Action

**Building Capacity (Regional, Organisational & International Levels)** - The effective delivery of mental health promotion in all sectors and settings in Northern Ireland will depend on building knowledge, expertise and capacity. This should include:

- training
- information and guidance
- research.

There is a growing body of research on the effectiveness of mental health promotion and a robust evidence base on specific interventions. However, the focus of much mental health research is on mental illness, as opposed to mental health. Key priorities for mental health research include:

- Examples of good practice

- Developing indicators and measuring success
- Effectiveness of non clinical interventions for mental health problems

**Identification of Dedicated Resources (Regional and Local Levels)** - The resource allocation for mental health promotion should reflect the cost of mental ill-health in Northern Ireland and the potential savings from achieving an improvement in the mental well-being of individuals, families, organisations and communities. Funding in the region of £5-6 million over a three year period from 2006-2008 is required, with a commitment to sustainability for the future.

**Reducing Discrimination & Increasing Awareness** - A key element of tackling the social exclusion and discrimination experienced by people with mental health problems is ensuring awareness of and compliance with equalities and human rights legislation.

**Prevention of Suicide** - It is recommended that a suicide strategy be developed for Northern Ireland, separately resourced to the Mental Health Promotion Directorate.

- There needs to be a sense of urgency brought to this phenomenon of suicide in order for it to be considered a national priority.
- An actual suicide prevention strategy, based on the UN/WHO guidelines, needs to be developed with an identified action plan with target dates, responsibilities and be properly resourced. (for full list of recommendations – see Appendix ii)

**MENTAL HEALTH PROMOTION  
EXPERT WORKING COMMITTEE  
INTRODUCTION  
DRAFT REPORT**

This report outlines the findings and recommendations of the Mental Health Promotion Expert Working Committee, one of ten Expert Working Committees established to take forward key aspects of the independent Review commissioned by the DHSSPS of policy, practice and legislation relating to mental health and learning disabilities.

The fact that a specific expert working committee on mental health promotion has been established as part of the overall DHSSPS Review of Mental Health & Learning Disability in Northern Ireland has ensured that mental health promotion will be seen as being an important, indeed underpinning dimension of the Review, which helps increase the sense of commitment to the promotion of mental health regionally.

**1.1 THE AIMS OF THE MENTAL HEALTH PROMOTION EXPERT WORKING COMMITTEE**

The Terms of Reference for the Mental Health Promotion Expert Working Committee were to consider how best to promote positive mental health in society, with particular reference to the impact of the Promoting Mental Health Strategy and Action Plan 2003-08 (DHSSPS 2003), and how best to meet the needs of people at risk of suicide.

The Committee did not consider its remit to draft an alternative strategy to the Promoting Mental Health Strategy and Action Plan 2003-08, however it did consider it important to comment on its implementation to date, seeking views from key stakeholders. Neither does this document attempt to be a comprehensive account of mental health promotion per se or to map all existing practice in the province in this field. Rather it is intended to offer a vision for the future of mental health promotion in Northern Ireland, providing examples of evidence based good practice and views on where mental health promotion should “sit” at policy level.

Although the remit of the Committee has included the task of exploring the needs of those at risk of suicide, this report does not include a suicide prevention strategy. However, one major recommendation relates to the prevention of suicide, and a paper (Appendix ii) outlines in some detail suggestions for this.

Therefore, the Mental Health Promotion Working Committee set out to:-

- analyse the current situation in Northern Ireland in terms of mental health promotion, including a commentary on the current strategy
- identify gaps in provision
- explore examples of good practice regionally, nationally and internationally, looking broadly from policy issues through to interventions and considering how they might translate to the Northern Ireland context
- comment on the relationship of mental health promotion to some of the issues addressed by other working committees
- provide a vision for the future, highlighting innovative thinking in the area of mental health promotion and prevention

## 1.2 VISION & PRINCIPLES

### **Vision – Mental Health for All**

Mental health is a matter of universal concern; the importance of mental health is gaining growing recognition within Northern Ireland, in the UK and across Europe. The World Mental Health Organisation, at the European Ministerial Conference on Mental Health, Helsinki (12<sup>th</sup>-15<sup>th</sup> January 2005), produced a “Mental Health Action Plan for Europe, Facing the Challenges, Building Solutions”.

This Mental Health Action Plan (2005) proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries in the WHO European Region, requiring action in 12 areas (please see Chapter 4, page 84 and Appendix iv for more information).

We want to see a recognition at all levels in Northern Ireland that everyone has mental health needs; that mental well-being underpins all health and well-being; that mental health, like physical health, is a resource to be protected and promoted. We also want to see a society where everyone plays a role in/takes action to create an environment that promotes the mental health and well-being of individuals, families and communities.

### **Principles**

- Mental health underpins all aspects of our health and social well-being and therefore should be seen as an integral part of all health and well-being services provision
- There is a need for increased cross-sectoral collaborative work with other key agencies and central government departments -partnerships between health and social services and education agencies hold particular potential.

- Mental health needs to be promoted in the context of social justice, equality and citizenship.
- Socio-economic and environmental factors need to be highlighted;- deprivation increases risk of mental health problems across the spectrum of disorders, and fragmented environments are risk factors for depression and suicide.
- Mental health promotion is relevant to all life stages – from birth to old age.
- Mental health promotion can take place with whole populations, individuals at risk, vulnerable groups and in key settings – long-term strategies need to look at the bigger picture and see how the different dimensions can be integrated.
- There should be flexibility in terms of the use of language; there may be a need for different terms and language for different audiences.
- The increasing amount of evidence-based research into effective mental health promotion needs to be drawn upon.
- A strategic approach to mental health needs to include action to improve treatment, services and quality of life for people living with enduring mental illness, to tackle stigma and discrimination, and to promote mental health for the whole population.

### **1.3 ADDRESSING INEQUALITIES:- PROMOTING INCLUSION & EQUALITY OF OPPORTUNITIES VIA MENTAL HEALTH PROMOTION**

Mental health problems are both a cause and a consequence of deprivation and inequalities (Rogers and Pilgrim 2003). Poor mental health is not a random misfortune but is strongly associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events, for example, racial discrimination, bereavement, violence, bullying and abuse ([Fryers et al 2003](#); Melzer et al 2004). Other risk factors include a family history of psychiatric disorder, childhood neglect and family breakdown. Bereavement, financial strain and long-term caring are risk factors across the life cycle, and especially in later life ([Milne et al 2001](#); Godfrey and Denby 2004).

Stigma and discrimination have been identified as the greatest barrier to social inclusion, quality of life and recovery for people with mental health problems (Social Exclusion Unit 2004). Stigma may also inhibit people from seeking help and contributes to the isolation experienced by many people with mental health problems, their families and carers. Key issues include public attitudes, negative and distorted media coverage, and lack of access to mainstream opportunities e.g. education and leisure.

As Williams points out, much stigma and prejudice is based on fear and a wish, from a sense of insecurity, to banish differences and retain a sense of “them” and “us”. (Williams 2004).

Recent years have seen a greater focus on tackling stigma and discrimination across the UK, both nationally and locally. In Scotland, the National Programme on Improving Mental Health and Well-being includes a major campaign to challenge stigma;- ‘See Me’ (<http://www.seemescotland.org/>). The results of the second national Scottish Attitudes Survey are encouraging (Scottish Executive 2004) and point to the high visibility and impact of See Me and some positive shifts in attitudes towards those with mental health problems since the last survey two years ago.

In England, the National Institute for Mental Health (England) (NIMHE) has launched ‘*From here to equality*’, a 5 year anti-stigma and discrimination programme (NIMHE 2004), responding to the Social Exclusion Unit’s report on mental health which found that over 80% of respondents in the research identified stigma as the biggest barrier affecting people with mental health problems.

Liz Main, the Programme Leader says:-

*“National initiatives are good at providing the framework and resources but it is **local initiatives** that work. We also know that simply handing out information packs is not effective. What works is **personal contact**, encouraging people with mental health problems to tell their story”.*

More broadly, a review of the evidence suggests that progress on tackling stigma and the social exclusion of people with mental health problems is more likely to be effective if interventions form part of a population based strategy to promote mental well-being. (Gale et al 2004).

Mental health can be promoted in the following ways:-

**Promotion of Mental Health & Well-Being for All in the Population at Large -**

Mental health promotion can promote mental health and well-being for all, particularly through a healthy settings approach. The workplace is one example of an arena with much potential for promoting good mental health by providing a supportive culture and reducing undue stress. Employers however are often reluctant to address the often complex and subtle issues relating to mental health.

**The Prevention of Mental Problems in Key At Risk Groups -**

The prevention of mental health problems can be helped by factors such as reducing isolation, bullying, racism, etc. However, discrimination and inequalities still exist and people if they feel socially excluded are at risk of developing mental health problems such as depression.

**Improving the Quality of Life for Those Who Have Experienced Mental Health Problems** - Mental health promotion can improve the quality of life of people with mental health needs. Stigma has long been particularly associated with this group as a problem and can be difficult to address in terms of changing attitudes. Assessing to what extent various agencies comply with the relevant equality legislation can be one approach.

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**MENTAL HEALTH PROMOTION**  
**EXPERT WORKING COMMITTEE**  
**Chapter 1 – The Scale of the Problem**  
**DRAFT REPORT**

**1.1 INTRODUCTION**

Mental health promotion is a personal, public and political matter. Mental health promotion is concerned with how individuals, families, organisations and communities think and feel. It is drawn from a growing body of evidence that mental well-being influences, and is influenced by, health and social outcomes across a wide range of domains, including health behaviours, educational achievement, employment, physical health and crime. There must be a recognition at all levels in Northern Ireland that everyone has mental health needs, that mental well-being underpins all health and well-being, and that mental health, like physical health, is a resource to be protected and promoted.

Essentially the case for mental health promotion and prevention starts from the fact that, whatever the metric, mental illness imposes an enormous burden on society. There are three main reasons:

- **Firstly**, mental health problems have very high rates of prevalence
- **Secondly**, the problems are often of long duration, even lifelong in some cases.
- **Thirdly**, both because of their intrinsic nature and because of additional factors such as stigma and discrimination, mental health problems have extremely widespread repercussions, with adverse impacts on many areas of individuals' lives including education, employment, income, housing, personal relationships and social participation.

Many initiatives on mental health promotion are happening at local level and the hard work and commitment of individuals and groups must be acknowledged, as well as the potential of the current DHSSPS Mental Health Promotion Strategy. However, what we still lack is an effective, focused regional structure, properly resourced sustainable, and able to drive forward and build on existing policy. Such a structure is necessary to achieve effective mental health promotion outcomes in the broader public health arena for all the citizens of Northern Ireland, within an acceptable timeframe. It is also necessary to ensure that a much wider range of agencies, sectors and settings play a part in promoting mental health: mental health promotion needs to feature on the agenda for those involved in education, employment and the workplace, housing, criminal justice, culture and the arts, sports and leisure and local government.

## 1.2 THE COST OF MENTAL HEALTH PROBLEMS

It is difficult to assess the costs of promoting mental health across Northern Ireland's society through all government departments and agencies, through schools and through workplaces. However, the cost of not promoting mental health is beginning to be quantified (Mental Health Foundation 2005). The total cost of mental illness in Northern Ireland (2002-03) was £2,852 million. (Counting the Cost NIAMH, Sainsbury).

In both England and Northern Ireland the aggregate costs of mental illness are more than the total amount of public spending on health and social care for all health conditions combined. For example, the estimate of £2.8 billion for the costs of mental illness in Northern Ireland compares with a total HPSS budget in 2002/03 of £2.4 billion. In another comparison (available for England only), it was found that the costs of mental illness appear to be greater than the total costs of crime.

The share of Health and Social Services budget spent on mental health in England is 11.8% compared to 9.3% in Northern Ireland.

To match the English share, spending on mental health in Northern Ireland needs to increase by 26% or £60 million.

It is worthy of note that the share of mental illness in total NHS spending is significantly lower than its share of the overall burden of disease as measured by the World Health Organisation and very much lower than its share of total morbidity and disability.

### 1.2.1 The Global Burden

WHO work on the global burden of disease uses a composite non-monetary measure, the disability-adjusted life year or DALY, to combine morbidity and premature mortality in a single figure. Estimates for Western European countries, including the UK, show that mental illness now accounts for more DALYs lost per year than any other health condition. Thus the figures for 2002 indicate that 19.3% of the total burden of disease was attributable to mental illness (including suicide), compared with 17.1% for cardiovascular disease and 16.5% for cancer. No other condition exceeded 8%.

The WHO work also includes an analysis of the overall burden of disease by major risk factor. This shows, for example, that in the Western European countries as a group 12.2% of total DALYs lost per year are associated with smoking, 6.7% with alcohol misuse, 6.4% with raised cholesterol and 5.4% with obesity and overweight. According to these figures, the costs of mental illness are thus greater than those of smoking and drinking combined.

Of the total disease burden in Western Europe, just under half is attributable to premature mortality, and just over half to non-fatal outcomes of morbidity and disability.

Mental illness has a much bigger impact on the latter, accounting for less than 5% of all premature mortality but for over 30% of all morbidity and disability. No other single health condition accounts for more than 10% of the total burden associated with non-fatal outcomes. Therefore, in Northern Ireland we are spending 9.3% of our Health and Social Services Budget on mental health when 30% of all morbidity and disability, in fact, can be attributed to mental ill health.

## **1.2.2 Prevalence of Mental Health Problems**

### **Northern Ireland**

The 2001 Health and Well-being Survey indicated that 21% of the population aged over 16 in Northern Ireland consider themselves to be depressed and that a similar percentage had a potential psychiatric disorder. Women were one and a half times more likely than men to report having suffered from mental health problems. Such rates are over 20% higher than in England and Scotland. People who said they have been affected a lot by the troubles were almost twice as likely to show signs of a possible mental health problem (34%) as those who had not been affected much (18%).

The 2002 Health and Lifestyle Survey conducted by the Health Promotion Agency found that a quarter of respondents (23% of men and 26% of women) showed signs of a possible mental health problems by scoring highly on a GHQ questionnaire. Those with no qualifications and those on a low weekly household income were more likely to show signs of a possible mental health problem. Depression and anxiety were greatest in the 35-54 and 55-69 year age groups. (HPA 2005).

In terms of the scale of the problem, prevalence figures for mental health problems in Northern Ireland are 25% higher than in England. (DHSS (DHSSPS, 2003), Effectiveness Evaluation: Health & Social Care (chapter 7 on mental health).

The high prevalence of mental ill health is compounded by our particular risk factors, including the effects on mental health of economic and social deprivation, unemployment and recovery from the trauma of the troubles.

Suicide trends over the last 10 years show a 27% increase in Northern Ireland, (and a similar increase in the Republic)<sup>1</sup> compared to a 9% decrease in the UK overall (<http://www.nisra.gov.uk>).

**Figures from a range of UK studies suggest that:**

- At any one time, one adult in six has a mental health problem, commonly anxiety, depression, phobias, obsessive compulsive and panic disorders. Around half of people with common mental health problems are limited by their condition and one fifth are disabled by it. (Melzer et al 2004). In the past year, one in 200 adults had a psychotic disorder and one in 25 a personality disorder. (Singleton et al 2001; Melzer et al 1996). GPs spend one third of their time on mental health issues.
- 10% of children aged 5 to 15 experience a clinically defined mental health problem and the prevalence of problems has been increasing over the past 50 years. These include anxiety disorders (4%), conduct disorders (5%) and hyperactivity (1%). Autistic disorders, tics and eating disorders were attributed to half a percent of the sampled population. Prevalence of mental health problems is greater among boys than girls: 11% compared with 8%. Rates of depression and anxiety among teenagers have increased by 70% in the past 25 years. (Collishaw et al 2004).
- Gender has a significant impact on risk and protective factors for mental health. Rates of suicide are four times as high in men as in women (with the exception of young Asian women) and the difference is increasing. (Meltzer et al 1996). However, women are at greatly increased risk of depression and anxiety, eating disorders and self-harm. (Piccinelli and Wilkinson 2000, Department of Health 2002).
- Among older people, 10-15% of people over 65 have depression and 3-5% severe depression. Poor levels of mental well-being in older people are both a cause and a consequence of social isolation and also impact on health outcomes for chronic diseases (Godfrey and Denby 2004).

### **1.2.3 Risk Factors Impacting on Mental Health**

Northern Ireland faces a particular challenge given its particular legacy of the conflict over the past 30 years.

As the Strategic Framework for Adult Mental Health Services points out in terms of impact of 30 years of civil conflict:

*“In a random sample of 1,000 adults, Cairns and Mallett found 16% to be “direct” victims and 30% “indirect” victims of civil conflict. Perceptions of*

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<sup>1</sup> Data for the Republic of Ireland refers only to deaths recorded as suicide and is therefore not accurately comparable with data from England, Scotland, Wales and Northern Ireland.

*being a victim were consistently associated with poorer psychological well-being”.*

Whilst socio, economic and environmental factors have greatly improved, and paramilitary activity has reduced over the past decade or so, there are still in many sectors of society thinly veiled underlying threats of violence, intimidation. There is still much work to be done societally, to help improve a sense of social cohesion, trust, safety and sense of participation – all key elements of social capital and emotional well-being.

Both bullying and being bullied are associated with outcomes with a high social and economic cost: criminal behaviour and alcohol abuse (bullies), and depression and suicidal behaviour (victims of bullying). Anti-bullying schemes which involve the whole school, parents and the community, e.g. the Campaign against Bully-Victim Problems, are effective. Follow-up found a 50% reduction in bully/victim problems for boys and girls across all grades with more marked effects after two years. There were also significant reductions in anti-social behaviour such as vandalism, fighting, truancy, theft and drunkenness **and significant** long term impacts on criminal behaviour, alcohol abuse, depression and suicidal behaviour (Olweus 1993;1995).

### 1.3 THE ACTION

Although there is a pressing need for robust studies of cost/benefits of specific interventions, there is sufficient evidence to support the case for greater investment in mental health promotion. The clear relationship between poor mental health in children;- for example anxiety, depression and behavioural problems, and poor school outcomes, poor physical health, self harm and risk taking behaviour means that even small improvements in mental health contribute to improved physical health, productivity and quality of life. (Mental Health Foundation 2005; Meltzer et al 2000; Department for Education and Skills 2001).

A number of studies are beginning to calculate the economic cost of failing to address early signs of emotional problems in childhood. Scott et al found that the cumulative costs of public services used through to adulthood by individuals with ‘troubled behaviour’ were 10 times higher than for those with no problems. Conduct disorder was the most significant predictor, with greatest costs incurred for crime, followed by extra educational provision, foster and residential care, and state benefits (Scott et al 2001). One pilot study of children aged 4-8 referred with conduct disorder, found that the mean extra cost was £15 282 a year (range £5411-£40 896). Of this, 31% was borne by families, 31% by education services, 16% by the NHS, 15% by state benefit agencies, 6% by social services, and less than 1% by the voluntary sector (Scott et al 2001).

The cumulative cost of childhood conduct disorder for each 1-year cohort in the UK is a minimum of £1.9 billion and in all likelihood several times higher.

According to the same study on which this figure is based, the cost of a typical parenting programme is around £600 per child. For every cohort of 600,000 children, a population-wide programme would therefore cost £360 million. Is it worth introducing such a programme? This depends on its effectiveness, but one can easily work out that the programme needs to reduce the prevalence of conduct disorder by at most around 20% (and almost certainly only a fraction of this if the full costs of conduct disorder were properly measured) to be a justifiable use of resources. (Scott et al).

There is now a growing body of evidence that positive mental health cannot be gained by treating mental disorders alone (WHO 2004). For example, providing the most effective evidence based treatment for one half of all people with depression would only reduce the current burden of depression by less than one quarter. On the other hand, evidence demonstrates that mental health promotion and prevention can lead to health, social and economic gain, increases in social inclusion and economic productivity, reductions in the risks for mental and behavioural disorders and decreased social welfare and health costs (Jane Llopis and Anderson 2005; WHO 2005).

The remaining chapters in this report look at what is required to strengthen the position of mental health promotion in Northern Ireland. It is our hope that this report will contribute to the debate, encourage appropriate action and lead to mental health promotion becoming a greater priority across all sectors.

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