

MENTAL HEALTH PROMOTION EXPERT WORKING COMMITTEE Chapter 3 – Identification of Need



(Health Education Authority, 1997)

3. INTRODUCTION

In this chapter we approach the identification of need by looking at **firstly** the promotion of mental health and well-being for all in the population at large and identifying the settings in which this can take place.

Secondly, we have identified some of the key at risk groups within the population and have addressed the prevention of mental health problems within these groups and protective factors which could be employed.

Thirdly, we have considered those who have experienced mental health problems and ways in which their quality of life could be improved.

The Committee is aware that there is a pool of good practice in Northern Ireland. The local examples provided in this report have been randomly selected. However, we have recommended that one of the priorities of a newly established Regional Directorate of Mental Health Promotion should be a comprehensive “mapping” exercise.

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

Aim: To promote mental health and well-being for all.

In the first section the emphasis is on different environments, or settings through which the population at large can be reached. Given that mental health is influenced by a range of protective and risk factors, many of which are environmental, these broader factors need to be addressed, not simply focusing on the vulnerable individual.

Settings include:

- Home
- School
- Workplace
- Communities & Neighbourhoods
- Further and Higher Education
- Primary Care
- Rural Areas
- Faith Communities

3.1.1 Home

The Case for Action

Children & Families

Poor mental health in children such as anxiety, depression and behavioural problems, is a significant risk factor for poor school outcomes, poor physical health, poor social skills and suicidal behaviour. (Mental Health Foundation 1999).

Factors which promote resilience in children under 5 help those children to do well in spite of adversity (Titterton et al 2002; Mental Health Foundation 1999).

Factors which strengthen resilience include family harmony, co-operation, relationships between parents, opportunities to succeed, and internal locus of control. (Mentality 2002).

Home – What Works?

Ample evidence exists that early intervention programmes are a powerful prevention strategy. The most successful programmes addressing risk and protective factors early in life are targeted at child populations at risk, especially from families with low income and education levels (Brown & Sturgeon, 2005). They include home-based interventions during pregnancy and infancy, efforts to reduce smoking during pregnancy, parent management training and preschool programmes.

- **Promoting Parenting Skills** - Group based parenting training programmes improve the mental health of both parents and children (Barbour et al 2001) and may be more acceptable to parents than clinic based programmes for individuals/parents.
- **Home-based interventions** – Evidence from home visiting interventions during pregnancy and early infancy, addressing factors such as maternal smoking, poor social support, parental skills and early child-parent interactions, has shown health, social and economic outcomes of great public health significance (Brown & Sturgeon, 2005). These include improvement of mental health both in the mothers and the new-borns, less use of health services and long-term reductions in problem behaviours after 15 years. Evidence also shows that such interventions can be cost-effective, especially when long-term outcomes are taken into account.
- **Improving the Mental Health of Mothers** - Early support during pregnancy for mothers in difficult social and economic circumstances has been shown to have a positive impact on birth weight and family relationships. Professional emotional support for women caring for their existing children can decrease the rate of post natal depression. (Hodnett 2000: Scott et al 1999).

Home – Northern Ireland Example

Lifestart Foundation

Lifestart which has offices in Northern Ireland and the Republic of Ireland, is a home based educational programme for parents of children aged from birth to 5 years. Its aim is to enable parents to make informed, relevant decisions about the upbringing of their children.

Key Issues to be Addressed



- 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 School

The Case for Action

It is recognised in the literature that schools can have a vital role to play in protecting the health of young people. Resnick et al (1997) have identified an association with academic failure and lost school days with anti-social behaviour and emotional problems.

Pryce & Twyble et al (2004) in their paper "Mental Health Promotion Among Young People" state that:

"Schools have a significant influence on the behaviour, attitudes and development of young people. The Department for Education and Skills in England in their guidelines "Promoting Children: Mental Health Initiatives Early Years & School Settings" emphasises the importance of schools in the promotion of mental health of children".

The regional strategy document "Promoting Mental Health – Strategy & Action Plan 2003-08" identifies specific actions relating to the promotion of young peoples' mental health.

Action 9 within the document refers specifically to pupils' mental health. It states "DE in partnership with DHSSPS, Health Promotion Agency (HPA), schools and the voluntary and community sectors will develop a regional education resource fro the promotion of pupils' mental health and emotional well-being including anti-bullying approaches for use in school. Target date: March 2004.

Schools – What Works?

Characteristics of the health promoting school include features such as shared decision making and planning; community participation; a

supportive physical and social environment; good school – community relations; clearly articulated health policies, and access to appropriate health services.

The Resourceful Adolescent Programme (RAP) - Australia

This programme was developed to meet the need for a universal depression preventative programme for teenagers that could readily be implemented in a school setting.

A universal programme targets all teenagers in a particular grade as opposed to those at higher risk of depression. It is easier to recruit and engage adolescents in a universal approach if they do not face the risk of stigmatisation by being singled out for intervention.

An eleven-session programme has been designed to be implemented in the classroom as part of the curriculum.

The programme aims to build resilience to depression in pre-teenagers and younger adolescents and has been shown to be effective in reducing rates of depression. (Dodds et al, 1997).

➤ **The Health Promoting School**

Action has been taken by the Health Promotion Agency (HPA) to take an initiative forward – that of the Health Promoting School. This initiative, proven to be effective at an international level, offers a vehicle for change in Northern Ireland, but there are issues, such as lack of long term funding and the fact that only 10% of schools are currently targeted in Northern Ireland.

An Ofsted Report, published in July 2005, refers to the vital role of schools in providing for pupils with mental health needs and the current barriers to this. They refer to the need for whole-school approaches to promoting good mental health.

In a survey of schools in Great Britain carried out by Ofsted in 2004 (published July 2005, HM1) it was stated that:

“The best schools promoted emotional health and well-being by valuing and respecting every individual. In the schools visited, those which introduced a value system that embraced all children identified fewer children with mental health problems. These schools promoted many and varied opportunities for pupils to share their thoughts and feelings. They used the curriculum to develop pupils’ listening skills and an understanding of other people’s points of view: this culture permeated school life.”

In Northern Ireland, the impact and effectiveness of the initiative is still to be reported on.



Key Issues to be Addressed

- **School Interventions** - 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

The Case for Action

The workplace is an important environment for the individual in life.

Work can be a source of stimulation, satisfaction and support, leading to an increased sense of well being and reduced incidence of stress related sickness absence (Sainsbury Centre for Mental Health 2000; Stansfeld et al 2000).

Yet a negative working environment can lead to a range of problems such as sickness absence; stress related problems; labour turnover; bullying and harassment; poor interpersonal relations, and ineffective working.

A company with 1,000 employees can expect between 200-300 people to experience depression or anxiety in any year (The Industrial Society 2003). The loss of sickness absence attributable to mental health problems was estimated to be £4 billion in the UK in 2001 (Sainsbury Centre for Mental Health 2003).

The Dynamics of Work Stress

Stressors potentially affecting health include: factors intrinsic to the job such as work over or under load; lack of job control, and repetitive tasks. Factors relating to role in the organisation can include too much or too little responsibility. Relationships may be poor, with even bullying and harassment a factor. Career development pressures may mean over promotion or under promotion. Factors relating to the overall culture and environment of the organisation are very important. If people feel supported and valued at work, with a sense of genuine participation and involvement, there is a lesser likelihood of stress developing even with a large volume of work.

Finally, the home-work balance can be hard to sustain, with domestic difficulties spilling over into work, and work related stress having a negative impact on home life.

The Legislative Imperative

Employers are under a general duty to take responsibility to ensure the health and safety of employees whilst at work.

The law states that mental health should be viewed in the same light as physical health.

There are a number of Health and Safety Regulations that are of relevance; in particular:

- Health & Safety at Work (NI) Order 1978
- Management of Health & Safety at Work Regulations 1992
- Health & Safety (Consultation with employees) Regulations 1992
- Employment Rights Act 1996
- Working Time Regulations 1998
- Safety Representation & Safety Committee Regulations 1977
- Disability Discrimination Act 1995
- Human Rights Act (1998)

What Works?

The Health and Safety Executive issued a workplace health strategy Working for Health (Action 10 Regional Strategy) in April 2003. The strategy aims to promote mental health in the workplace with specific reference to work related stress.

Some actions which have been shown to be effective include the following examples:

- **Culture of Openness to Mental Health Issues** – Studies have shown that facilitating an environment that generates positive attitudes to positive well-being can help reduce stigma for those experiencing problems.

- **Support at Work** – Emotional support can be very powerful. It is a particularly protective factor against high job demands (HSE 2001).
- **Job Control and Decision Making Aptitude** – Having control over work reduces the risk of sickness absence. (Stansfeld 2000). Individuals need to have some influence over decisions made and work at different levels.
- **Mental Health in the Workplace Policy** - Having a strong, comprehensive Mental Health in the Workplace Policy including the responsibilities of both the individual and organisation is a key factor.
- **Employee Assistance Programmes** – Employee Assistance Programmes (EAPs) which provide individual support and counselling, but also address organisational issues via the implementation of stress/organisational audits, risk assessment for mental health and mental health policies, have been shown to be effective in enhancing employees' health and well being (HEA, 1999: Holloway et al 2000).

Key Issues to be Addressed

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 & Neighbourhoods

The Case for Action

People with mental health problems are amongst the most excluded groups. Social exclusion is therefore a major public health issue.

Regionally Promoting Social Inclusion (PSI) is an element of the New Targeting Social Need Policy which focuses on promoting issues to be tackled to improve and enhance the life and circumstances of the most deprived and marginalized people in society:-

“The Department has established a cross departmental PSI Working Group on Mental Health which will consider factors that cause people with mental health problems to be at risk of social exclusion and develop a co-ordinated inter departmental study through which relevant agencies will work together to systematically tackle them. This Strategy will support their work”. (Investing for Health 2002).

Section 75 of the Northern Ireland Act 1998 requires public authorities in carrying out their functions to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation, gender, disability and persons with dependants or without.

Northern Ireland experiences higher levels of deprivation than Britain or Europe. (The Family Expenditure Survey Report for Northern Ireland 1998/99). There is a clear link between poor mental health and living in those neighbourhoods which both are economically disadvantaged and have experienced greater exposure to the “Troubles”. (Nicore 1999).

Various actions with the regional strategy document in mental health promotion refer to community development:-

Action 5 – “Health and Social Services (HSS/Boards and Trust through the Investing for Health Partnerships will further develop policies and programmes to promote mental health, taking account of the particular needs of all vulnerable groups including homeless people and victims of the conflict, across all services, and report annually to the Implementation Group”. Target Date: Ongoing

Action 11 – Refers specifically to the support of “the development of a rural support network.

Action 14 – develops the need for information about local sources of help and support is developed.

It is to date unclear to what extent these specific actions have been programmed.

Communities & Neighbourhoods – What Works?

Characteristics of communities which promote mental health and well being include:

- Equitable access to resources and services.
- Support for parents and carers
- Activities that bring members of the community together
- Effective sharing of local information



- Tolerance and trust
 - Friendly physical environment
 - Dealing effectively with crime and anti-social behaviour
 - Robust local democracy and opportunities to participate
- (Mentality 2003 (Adapted from Department of Health 2001))

Strengthening Community Networks - Many community interventions have focused on developing empowering processes and building a sense of ownership and social responsibility within community members. An example of such an intervention is the Communities that Care (CTC) Programme, which has been implemented successfully in several hundred communities in the USA and is currently being adopted and replicated in The Netherlands, England, Scotland, Wales and Australia. The CTC prevention operating system is a field-tested strategy for activating communities to implement community violence and aggression prevention systems (Hawkins, Catalano & Arthur, 2002). The strategy helps communities use local data on risk and protective factors to identify risks and develop actions. To date the CTC system has only been evaluated in the USA, with pre-post designs and comparisons with baseline data involving about 40 communities in each field test. These evaluations have indicated improvements in youth outcomes. Examples include decreases in school problems (30% decrease), weapons charges (65%), burglary (45%), drug offences (29%) and assault charges (27%).

Reducing Fear of Crime - Within the Nottingham Social Action Research programme, a project in the Clifton Neighbourhood Ward shifted focus from a crime/anti-social behaviour enforcement role to community development and building social capital as a way of reducing the fear of crime.

Training, support, and the development of neighbourhood wardens have led to an increase in feelings of trust and safety, confidence amongst residents and the building of networks and a framework for reciprocity.
(Nottingham SARP 2002 – Social Action Research)

Stress Workshops for the General Public - Large scale self-referral stress workshops are effective in reaching people whose problems are not picked up in primary care. A randomised control trial showed that participants were less anxious, less distressed and more able to cope than those in the control and placebo groups. (Brown & Cochrane 1999).

Key Issues to be Addressed

- 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

The Case for Action

There are a number of dimensions to the relationship between learning and mental health. On one level Hammond, in a review of literature, found robust evidence for positive associations between years of education and health, especially relating to depression. Outcomes included improved self-esteem, self efficacy and improved trust.

The wider benefits of learning include:-

- Positive associations between education and both physical and mental health.
- Learning builds self-esteem, feelings of being in control of one's life, and resilience to stress.
- Education that is accessible and makes sense to all members of society will reduce inequalities, challenge prejudices and empower people to keep on learning.

(Hammond, C (2002) Learning to be Healthy, London Institute for Education)

Facilitating access to further and higher education opportunities for those who are vulnerable is an important issue in itself and not without its difficulties. As the further and higher education environment can be a pressured experience even for those not vulnerable due to mental health needs.

Some key documents published by the Education and Health Sectors include:-

- Universities UK (previously CVCP), Guidelines on Student Mental Health Policies and Procedures for Higher Education, (June 2000)



- Universities UK (previously CVCP), Reducing the Risk of Student Suicide: Issues and Responses for Higher Education Institutions (2002)
- Royal College of Psychiatrists (RCP), The Mental Health of Students in Higher Education, (January 2003).

Further & Higher Education – Good Practice Example (1)

The Health Promoting University – In 1995 the University of Central Lancashire (30,000 students and 2,000 staff) became one of the first universities in Europe to establish a Health Promoting University initiative (HPU). (Dooris, 1999).

The aims are:

- To integrate within the University's culture, processes and structures, a commitment to health and to developing its health promoting potential.
- To promote the health and well-being of staff, students and the wider community. Its effectiveness depends on an holistic, organisation wide approach, rather than simply focusing on the vulnerable individual, whether student or staff.

Further & Higher Education – Good Practice Example (2)

Learning Diversity – Accommodation in Colleges and Universities for Students with Mental Illness.

The Canadian Mental Health Association sets out guidelines for facilitating access to further and higher education for those with mental health needs.

Support services include:

- An academic coach or “buddy”
 - Increased outreach counselling services
 - Assistance with early problems identified
 - Peer support groups, emotional support
 - Increased training of faculty on mental health issues
 - Support in disclosing the disability to an instructor/professor
- (Canadian Mental Health Association 1993)

Further & Higher Education – Northern Ireland

The whole concept of a health promoting university or college is still relatively new – most institutions concentrate largely on student counselling services as the main resource.

However, both Northern Ireland's Universities have strategies for the improvement of students' mental health in place:-

- The University of Ulster's work through its Mental Health Task Force and
- Queens University, Belfast – Mental Health Strategy whose aims are outlined below.

The QUB's Mental Health Strategy is a comprehensive document and has five key aims:

- To improve mental health promotion and awareness across the University community, by ensuring an integrated approach to developing strategies and activities for the promotion of good mental health.
- To ensure that all those who contribute to the provision of mental health care have adequate training, supervision and support and are well informed of contemporary good practice commensurate with their level of access to students.
- To develop a greater range of necessary expertise within the Counselling Service in order to respond more effectively to students' needs.
- To locate individual and organisational accountability for the processes and procedures which will help promote the emotional and mental well-being of students.
- To identify the key areas of responsibility and support for students who encounter emotional and mental difficulties during their time at University.

This is based on current research as detailed above as well as DOH strategy documents.

Key Issues to be Addressed

- 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

The Case for Action

As stated in one Western Board General Practitioner's paper on Mental Health Promotion in Primary Care (Foy 2004): -

"Opportunities for mental health promotion present themselves to all members of the primary care team, including the general practitioner, health visitor, social worker, community midwife, district nurse, practice nurse, community pharmacist and others".

Primary care has a crucial role to play in supporting people with long term mental health problems. Primary care also has a role in early identification and treatment of common mental health problems; notably anxiety, depression and phobias, as well as a wider role in promoting mental health and well being, along with the promotion of physical health.

The majority of mental health problems are managed within primary care and a huge percentage of problems presented in primary care are psycho-social. On average GPs spend 30% of their time on mental health problems. Of all mental health conditions, anxiety and depression take up most of GP's time. (Foy 2004).

Chapter 3 of the Adult Mental Health Committee's Review Report states that:-

"There is increasing evidence that investment in primary care actually produces better healthcare outcomes in both primary and secondary sectors. There are fewer inequalities in health when primary care systems are well developed". (Stansfeld 2001).

In their briefing paper "Radical Mentalities - Making it Effective - A guide to evidence based mental health promotion" (Mentality 2003), Friedli and others describe new models of primary care offering opportunities to develop services at the interface between primary care and social population; to reach out to socially excluded groups including refugees, homeless people and those with substance misuse problems and to address inequalities.

Primary Care – What Works?

➤ Promoting Exercise

The National Consensus Statements on physical activity and mental health (Grant ed. 2000) show that exercise prevents clinical depression and is as effective in treatment as other psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self esteem.

Encouraging an active lifestyle also helps reduce isolation and the promotion of social networks.

➤ Social Prescribing



Social prescribing is a vehicle for offering patients in primary care alternative opportunities for support within the local community.

Examples of social prescribing include exercise on prescription, prescription for learning and arts on prescription.

Quite widely used for those with mild to moderate mental health problems, positive outcomes can include enhanced self esteem, reduced low mood, opportunities for social contact, increased self efficacy, transferable skills and greater confidence. (Huxley 1997: Fox 2000).

Key Issues to be Addressed

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).

Social Prescribing



- Social prescribing including exercise, learning and arts on prescription, as an adjunct or alternative to medication have been proved to be effective elsewhere in the UK and internationally.
- There is a need for this approach to be further employed in the province.

3.1.7 Rural Areas

The Case for Action

The current regional strategy highlights the needs of people living in rural areas in Northern Ireland:-

“People living in rural areas may experience particular problems including: social isolation; unemployment; poor housing; lack of public transport and public amenities. In addition, recent years have brought a succession of crises affecting farming which have increased financial stress and led to further job losses”. (DHSSPS 2002)

Action II of the Strategy states:

“Department of Agriculture and Rural Development (DARD) and DHSSPS will support the development of a rural support network to develop appropriate interaction strategies in rural communities”. Target Date: Ongoing.

It is not clear at present to what extent this action has been implemented.

One study carried out in Ireland: Mental Health Promotion in a Rural Context: Resources and Realities for a Community Based Initiatives in Northern Ireland. (Barry, O’Doherty et al 1999), based in the Homefirst Trust, exploring awareness of depression and suicide in rural areas found the following results:-

- Levels of awareness about knowledge of depression and suicide were generally high with 80% of respondents aware of the rise in suicide rate in Northern Ireland.
- 43% reported concern in relation to access to mental health services in rural areas.
- 68% reported little confidence in their own authority to advise someone who was suicidal.
- Men were significantly less likely than women to believe in the effectiveness of the GP.
- The under 40 year old group was significantly less likely to seek help from a psychiatrist.
- Social stigma was a barrier cited to seeking help.
- 22% referred to reluctance to disclosing problems.

Rural Areas – What Works?

The Rural Health Partnership (Homefirst Community Trust, NHSSB)

This partnership aims to deliver a programme of support that aids the reintegration of people who have suffered from mental ill health, back into the home and community life.

The programme, which includes training, health promotion and information, has a particular focus on young men, carers and children living with mental illness in farming communities.

Key Issues to be Addressed

- 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 and to 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

The Case for Action

Those with enduring serious mental illness may experience their lives as a process of fragmentation and disintegration. Recovery and well being needs therefore to focus on the restoration of a sense of wholeness. Holistic care needs therefore, due to the link between mind, spirit and soul, to include care for spiritual needs.

Spirituality can be defined as “a core set of beliefs and experiences about our relationship to the universe and our place in it” (Lea, 2004).

People experiencing mental health problems seek understanding and meaning.

In an age of a decline in organised religion, it seems even more important to acknowledge this dimension of experience, where people non affiliated to particular faith communities still seek succour and hope.

Religion and spirituality have proven protective effects for mental well being. For example:



- People with spiritual or religious affiliation are up to 40% less likely to become depressed than people who do not have such affiliation, and if they do get depressed, they recover faster.
- Depression affects up to 35% of people with a serious health problem or illness. One study that used multi-dimensional measures showed that for every 10-point increase in the intrinsic religion score, there was a 70% increase in the speed of remission from depression.
- Religious/spiritual commitment correlates with lower levels of substance abuse. The risk of alcohol dependency is 60% greater when there is no religious affiliation. (Powell, 2000).

In 1999, the Royal College of Psychiatrists set up a special interest group – Spirituality and Psychiatry. Its aim is to provide a forum for psychiatrists to explore the influence of the major religions which shape the cultural values of the psychiatrist and patient both.

A growing number of studies emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Mental Health Foundation 2000). Yet there is a need for some caution in being sensitive to cultural mores – other studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness. If a person fears that mentioning their spirituality may be interpreted as a further symptom of their illness, it will block the proven benefits of an holistic therapeutic approach. (Friedli. 2000: Clay 1999).

Faith Communities – What Works?

Spiritual Assessment – (Swinton, 2001), describes a number of models of “spiritual assessment” involving a dialogue.

Powell (2003) from the special interest group lists some learning outcomes for training of psychiatrists in spirituality including an understanding of:-

- Spiritual crises, meditation, prayer and altered states of consciousness, including near death experiences.
- The spiritual significance of anxiety, doubt, guilt and shame.
- The spiritual significance of love, altruism and forgiveness and their relation to mental health.
- The influence of materialistic goals on personal identity and self-esteem.
- The reciprocal relationship between culture and spiritual/religious beliefs and practices and the consequences for psychiatric practice.



- How to take a spiritual history from a patient.
- How the presence or absence of spiritual/religious beliefs and practices in mental health care workers may influence decision making.
- The role in clinical management of spiritual/religious support networks, including chaplaining and pastoral care as well as those in the community.

Key Issues to be Addressed

- 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 PROBLEMS IN KEY AT RISK GROUPS

Aim: To prevent mental health problems through increasing protective factors

The Committee felt it important to identify those particularly at risk in terms of their mental health. Some of these groups, such as young men at risk of suicide, have been also highlighted in the regional strategy.

The main aim of interventions with at risk groups would be that of increasing protective factors (eg. social support, job control, benefit uptake) and reducing risk factors (eg. racism, violence, bullying, isolation, etc.).

Some of the key groups identified as at risk:

- Children & Adolescents
- Those with Acquired Deafness
- Learning Disability
- Ethnic Minorities
- Older People
- People who are Unemployed
- People with a Physical Illness
- Those with Gender & Sexuality Issues
- Offenders within the Criminal Justice System

In addition to identifying needs, good practice, and making recommendations relating to different settings and mental health promotion, we feel it important to highlight at risk groups of which we are currently aware.

Outlined below are brief summaries of the current situation. The issues, also suggesting future actions to help address the issues.

3.2.1 Children & Young People

The Case for Action

- Around the globe, up to 20% of children and adolescents suffer from a mental illness, with 3-4% requiring treatment.
- Suicide worldwide is the 3rd leading cause of death in adolescents. (WHO, 2003).
- Research indicates mental health problems such as sleep disorders, stress, anxiety and behavioural problems affect 1 in 5 adolescents (Health Promotion Agency 2000).

Risk factors which may compromise mental health amongst young people include:-

- Lack of bonding and appropriate attachments
- Family or community conflict or tension
- Feelings of isolation
- Lack of self esteem
- Negative peer pressure
- Poverty and poor physical environment
- Difficult life events

(Promoting Mental Health – Strategy Action Plan 2003-08)

What Works?

Pre-School & Psychological Interventions – There is strong evidence that early interventions starting at age 2 that promote basic reading skills and engage children in conversations with their parents about picture books and improve reading skills and facilitate the transition to school. (Valdez-Menchaca & Whitehurst 1992).

Within the Review there is an Expert Working Committee on Child and Adolescent Mental Health (Convenor: Ms Moira Davren) which will report in some detail on issues relating to children and young people.

Mental health literacy & help-seeking at onset of disorder – Given the high prevalence of mental health problems in young people, the fact that the 12-26 year age range represents the peak period for onset of mental disorders across the lifespan (Moon, Meyer & Grau, 1999; Patton, 1996) and evidence that early detection and treatment of

depression and psychosis improves outcomes (Kupfer, Frank and Perel, 1989), population-based, indicated prevention and early intervention strategies may provide valuable opportunities to minimise the considerable burden of these disorders.

Young People in Community Settings

The school setting has been discussed earlier in the report in terms of its role in promoting young people's mental health.

There are also opportunities to promote the mental health of young people outside the school setting and to work with networks of young people in the community.

This is particularly important as children grow older and often spend more time with their friends than with their family (Morrow 2002). Peer group pressure is particularly significant in early adolescence. (Heaven 1994).

Social Skills Training – Social Skills training, eg. Coaching and cognitive problem solving is particularly effective with isolated children (Erwin 1994).

One example of good practice is that of the "Insight" Project in Plymouth. This project is currently being fully evaluated by the Sainsbury Centre. The project aims to minimise the barriers young people face when they have complex needs. The service is delivered at street level where young people can access it directly in a non-stigmatising environment.

Key Issues to be Addressed

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

The Case for Action

Deafened people are in a totally different situation from those with pre-lingual deafness who to a great extent are a recognisable community with their own language (signing) and culture. They are also clearly distinguishable from the vast majority of people with a hearing loss – those who develop a mild to moderate loss (usually in later life) who can often obtain much benefit from hearing aids.

The needs of deafened adults are rarely given attention despite the fact that for every deaf person using sign language, there will be at least 3 deafened people.

These individuals have a much higher incidence of reactive depression than either the general population, or the Deaf community and will encounter barriers when attempting to use resources for mental health needs because of the communication difficulties.

There is little literature on the psychological effects of acquired profound deafness. Most research focuses on the effects of mild or moderate hearing loss or the experience of those who are born deaf. (Wood, 1987).

What Works?

The Link Centre for Deafened People

The LINK Centre (Eastbourne, East Sussex) for deafened People was established in 1972, and is the only centre in the UK providing specialist intensive rehabilitation to groups of deafened men and women. LINK runs week-long programmes which aim to assist adjustment to deafness and to improve the quality of life for individuals and families affected by deafness.

Peer Education

The process model that LINK adopts is that of peer education, whereby the focus of the programme centres on the lived experience of deafened people dealing with problematic communication situations. Most facilitators are deafened themselves (or lead sessions with their hearing partner) and many have attended a LINK programme in the past. It is immensely important that participants meet people who have gone through similar situations as themselves and who have managed to sustain a positive life. Facilitators have first hand knowledge about the problems and can provide valuable insights.

Although focusing on rehabilitation, the approach is very much concerned with the whole person and the promotion of health and emotional well being in a social context. Therefore it is very much a mental health promotion intervention.

Key Issues to be Addressed

- 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 Case for Action

People with learning difficulties experience the same range of mental health problems in virtually all categories of psychiatric disorders.

It is estimated that 20-50% of those with learning disability may have a mental health problem. (Bouras 2003)

It is important to implement active mental health promotion strategies for people with learning disability and their families. A proactive preventative approach would be characterised by promotion of positive mental health from childhood onwards; a multi-agency partnership between health, social care and education; targeted support at times of change; social networks; dedicated access to services and improved awareness of mental health issues for people working in all services providing for people with learning disabilities.

What Works?

A mental health promotion approach, helping to build resilience and other protective factors is recommended. In his paper Mental Health Promotion for People with a Learning Disability, Devine lists 15 recommendations for action. He emphasises promoting positive health from childhood; the need for a multi-sectoral partnership between all relevant agencies; responsibility to enhance well-being and build resilience as a central component of any school curriculum; support at transitional times; enhancing social networks; improved access to services and awareness in staff with learning disability of mental health issues. (Devine, 2004).

“Count Us In” – The Report of the Committee of Inquiry into meeting the mental health needs of young people with leaning disabilities is an excellent source of information and examples of good practice in this field.

Outlined below are two evidence based examples taken from the document;-

Oaklands College – Students with learning disabilities are part of the college and are entitled to a common curriculum. Equality is about matching the education to particular needs to deliver that entitlement. Delivering this curriculum requires strategic planning and a multi-agency approach. Other agencies have to sign up because putting the package together will identify needs and show up gaps in the care provided.

Community Involvement Project, Larkhall near Glasgow – The project was set up in 1999 to provide training for employment to adults who have learning disabilities. It took five years and 386 meetings to get agreement to set up.

Forty six people with learning disabilities use the project. All start part time and 23 students are on site at any one time. The students receive a varied programme of laundry, kitchen and catering activities and develop confidence, which results in them undertaking customer service tasks in the tearoom. They are also involved in undertaking



Scottish Vocational Qualifications in a range of activities. Six students have so far gained employment but there are issues of benefits versus income. (Count Us In, 1998).

Key Issues to be Addressed

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

(Devine 2004) outlines 15 recommendations for action.

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/vocational opportunities.

3.2.4 Ethnic Minorities

Culture & Mental Health

Although the qualities included in the concept of mental health may be universal, their expression differs individually, culturally, and in relation to different contexts. It is necessary to understand a particular community's concepts of mental health before engaging in mental health promotion. The broad nature of mental health also means that it is not just the preserve of the mental health professionals.

The Case for Action

The regional strategy (DHSSPS 2000) takes into account to some extent needs of ethnic minorities.

There are two actions (16 and 17) which refer to the Department of Health, Education and HSS Boards and Education & Library Boards charging them with the task of:-

“carrying out a review of professional training to ensure that the promotion of mental health and emotional well-being is fully included and takes account of the particular needs of disadvantaged groups including ethnic minority, disability and sexual orientation”.

One report, published by the University of Ulster in 1997, “Ethnic Minorities in Northern Ireland” looked at the then 4 main ethnic minorities in Northern Ireland – the indigenous travelling community, the Chinese, Indian and Pakistan communities.

The report highlights Northern Ireland’s particular cultural environment due to the conflict in Northern Ireland:-

“the long drawn out inter group conflict in Northern Ireland between the 2 major communities has tended to occlude the existence of a vibrant and growing ethnic pluralism within Northern Ireland”.

It points out that the understanding of community relations has related the the 2 major communities.

The report did not seek to assess levels of mental health in the 4 communities, but experience of harassment and prejudice (risk factors for mental health) was experienced, particularly in the Chinese community –

- 44% experienced verbal abuse.
- 50% had received criminal damage to their property
- 61% believed there was racial prejudice in Northern Ireland and half of all interviewed believed that this trend would increase rather than decrease over time.

Better Access to Services -One of the greatest problems experienced by the ethnic groups was in accessing services, particularly due to language difficulties.

Better Opportunities for Training & Employment – Chinese and Travelling Communities interviewed in the report experienced some difficulties in accessing training and employment opportunities. It was suggested that consultation should take place to see whether a role for employment bodies exists in expanding employment choices.

What Works?

There is a number of examples of good practice in the rest of the UK.

Assertive, But Sensitive – Advice Shop Black – Black people with mental health problems benefit from the work of assertive outreach teams, provided team members are experienced, understand users’ concerns and avoid race stereotyping (Ratna, 2000).

Culturally Sensitive Mental Health Services Through Quality Improvement (2000) — An urban mental health service undertook a quality improvement programme to involve staff in the identification and resolution of cross-cultural issues. The programme involved clinical file audits, staff surveys and work-shops, and a focus group for consumers and their carers. It was found that non- English speaking patients received a different spectrum of services from English

speaking patients. Non-English speaking patients were found to receive more pharmacological treatments and less cognitive behavioural therapy. In seeking to address these issues and improve their service delivery to all patients, the mental health service is now in the process of developing cross-cultural training; revising policies and procedures; and engaging bilingual mental health counsellors in a revision of their roles, particularly to increase their availability to staff as cultural consultants.

Key Issues to be Addressed

- 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 Case for Action

The elderly represent an important group within the population. The number of older people within the UK has increased from 1900 when there were 1.7 million people over the age of 65, to 1994 where there were over 8.8 million in this age group. (Jenkins and Paykel 1994).

The increase is projected to continue – by the middle of the 21st century there will be in excess of 12 million older people in the UK. The prevalence of mental health disorders is relatively high in later life. About one third of all admissions to psychiatric care involve people over the age of 65, as do one third of referrals to community oriented mental health services.

The mental health promotion regional strategy outlines some factors potentially negatively affecting older people's mental health such as adjustment problems to socio economic difficulties associated with retirement; isolation and decline in social activity; bereavement and loss; mobility problems, and less support due to smaller families.

With an increasing growing population, this is a group whose needs (often quite complex) must be addressed (The Review's Expert Working Committee on Older People will be reporting on this in detail). (Convenor: Nevin Ringland).

Action 19 – seeks HSS Boards and Trust to develop programmes in collaboration with voluntary and community sectors around at improving coping strategies, particularly around time of bereavement.

Prevention of psychiatric disorder in the elderly will have major benefits for individuals and the community.

Depression

Depression is the most common psychiatric disorder of late life affecting 15% of the 65 year age group.

Unresolved depression is associated with reduced life expectancy and death.

What Works?

Prevention of physical ill health and programmes to prepare people for the inevitable changes with later life, such as retirement, loss and bereavement, should in theory reduce the incidence of depressive mood and other affective changes.

Many programmes which have been identified as being effective in promoting mental health in the general population should also be available to older people; notably exercise, social support. and arts for creativity.

Pre-retirement programmes have been seen to be of value.

In brief, below are some examples:

- **Pre-Retirement & Older People** - These programmes, often involving group activities, discussion, etc. can alleviate isolation and loneliness. Also bereavement support and counselling have been found to be effective. (Cattan 2002).
- **Telephone Support** - A telephone based support source provided through the Social Work Service in the USA concluded that this sort of outreach strategy was moderately affective by targeting older adults with depressive symptoms, social isolation and unmet needs (Morrow et al 1998 – Randomised Critical Trial).
- **Preventing Suicide in Later Life** - An evaluation on initiatives to identify and prevent elderly suicide at the Centre for Elderly Suicide Prevention, USA concluded that community agencies with specialised programmes for older adults showed promise. (Fiske & Arbore 2000 – Controlled Trial).

Dementia

Dementia is the second most common psychiatric disorder among the elderly. It is a syndrome characterised by an acquired impaired imperative memory and other cognitive functions, changes of personality and a progressive erosion of social skills.

The most common causes of dementia are senile dementia of the Alzheimer's type, and vascular dementia.

Prevention of Dementia

Strategies for prevention include the avoidance, early detection and treatment of those physical illnesses or other psychiatric disorders which produce dementia-like syndromes.

Ageing Mentally Healthy

Different types of universal, selective and indicated interventions have been successful in improving the mental health of elder populations (Jané-Llopis et al., 2005). Exercise interventions and improving social support through befriending are examples of universal strategies.

Exercise Interventions

Recent cross-sectional studies and controlled trials have suggested that exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits in elder populations (eg. Li et al., 2001). These benefits include greater life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure.

Enhancing Social Support

Some studies suggest the positive effects of friendship on the well-being of older people, especially older women. Befriending is a widely used strategy to increase social support and to reduce loneliness and depression among the elderly. So far only one quasi-experimental outcome study is available confirming that befriending programmes for older women can significantly reduce loneliness and increase the making of new friends (Stevens and van Tilburg, 2000). Replication studies are urgently needed.

Key Issues to be Addressed

- 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 Those Affected by Unemployment

The Case for Action

There is a higher level of unemployment and associated deprivation in Northern Ireland than in the rest of the UK. (DHSSPS 2002).

The proportion of unemployed males who are long term unemployed is higher (29.5%) than in Britain (17.6%). The unemployment rate here for males under 30 years of age is 9.6% compared to an overall rate of 6.2% (DHSSPS 2002).

Unemployment and deprivation are risk factors for mental health. People with mental health needs often experience difficulty in gaining employment despite the fact that Disability Discrimination legislation forbids exclusion solely on the grounds of evidence of a mental illness.

Promoting social inclusion (PSI) is an element of the New Target Social Need Policy which focuses on a sense of priority issues to be tackled to improve and enhance the life and circumstances of the most deprived and marginalized people in society.

There is not however a specific action within the Promoting Mental Health – Strategy and Action Plan 2003-08 which addresses the issue of unemployment, despite acknowledgement in the document that, for example 60% of suicides in Northern Ireland were those who were either unemployed or on long term sick.

Job Loss & Unemployment

What Works?

Job Clubs – A number of intervention programmes have been developed and tested for effectiveness in helping unemployed workers return to paid employment, such as the Job Club and the JOBS Programme (see review by Price and Kompier, 2005). These low-complexity and low-cost programmes combine basic instruction on job search skills with enhancing motivation, skills in coping with setbacks, and social support among job seekers. The JOBS programme has been tested and replicated in large-scale randomised trials in the USA (Caplan et al) and Finland (Vuori et al, 2002). It has been shown to have positive effects on rates of re-employment, the quality and pay of jobs obtained and increases in job search self-efficacy and mastery and to reduce depression and distress.

In Northern Ireland, there are a number of O.T. led Job Clinics which are run locally in partnership with employers (eg. Foyle Trust).

Employment Support & Placement Services

New Horizons Employment Service – Action Mental Health – The New Horizons Employment Service. It provides a specialist placement and support service for individuals recovering from mental ill health in a variety of work, education and training settings.

The Employment Service operates from 12 locations throughout Northern Ireland. The Service provides its expertise to the ACCEPT centres and works in partnership with 21 job clinics.

The Mental Health Promotion Awareness Unit - in South London and Maudsley NHS Trust works especially to address the problems that people have in accessing services and employment in the community as a result of their mental health problems. The Unit offers mental health awareness training to key local agencies, involving service users in its delivery. The aim is to reduce the stigma linked to mental health problems. (Mentality 2002).

Key Issues to be Addressed

- 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

The Case for Action

Mental well-being cannot be separated from physical well-being. Mental and physical illness represent crucial parts of life that are deeply interdependent.

Examples:-

Diabetes – Diabetes can have a significant impact on the quality of life for individuals, their families, friends, carers and wider society. The emotional and social effects are often underestimated. People with diabetes are more likely to experience anxiety and depression.

Cancer – There can often be uncertainty and distress associated with the diagnosis and treatment of the illness. There is likely to be significant impact on the family, occupational and social environments.

The illness and its treatment may cause fatigue, worry and mood change.

Cardiovascular Distress – There is a circular relationship between heart disease and depression. The presence of each increases the risk of the other. A rational health promotion strategy should take account of both physical and mental health needs in seeking to support lifestyle changes, both before and after the diagnosis of heart disease. Primary care has many demands on its resources, however, it seems particularly important for primary health care practitioners to be fully aware of the mind-body link (as outlined in Liam Foy's paper earlier).

Key Issues to be Addressed

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 & Sexuality Issues

The Case for Action

There is considerable evidence of discrimination and bullying of gay people. In Northern Ireland the problem has been identified through two

studies. There is much work to be done in helping the whole community understand issues of sexual identity and orientation.

The Strategic Framework for Adult Mental Health Services of the Review also outlines some of the needs of this group (Sect. 6.55, P126).

Research commissioned by the Department of Education in 2001 indicates that between 2% and 10% of the population in Northern Ireland may be lesbian, gay or bisexual.

One study points to the level of homophobic bullying of both lesbian, gay and bisexual young people at school.

- 75% of gay men experienced homophobic bullying at school. (Birkett, S & Foyle Friend "The Experience of Lesbian, Gay & Bisexual People at School in the North West of Ireland)

Another source quoted in the regional strategy also highlights bullying as an issue:

- 52% of gay men had been bullied at school.
- 64% of gay men who were bullied at school considered committing suicide.
- 25% of gay men had been sexually assaulted and only 27% of these had received subsequent counselling.

48% of those who had been sexually assaulted had considered committing suicide. (White, R G, McCracken and the Rainbow Project – How Hard Can it Be? – Attempted Suicide of Gay Men – the Psychological Stressors and Associated Risk Factors, Rainbow Project 1999).

Key Issues to be Addressed

- 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

The Case for Action

Prevention of Offending and Re-Offending

- Two thirds of men in prison are diagnosed with a personality disorder and two fifths show symptoms of at least one neurotic disorder such as depression, anxiety and phobias. Among the general population less than a fifth of men are affected by these disorders.
- Men in prison have a high rate of severe mental health problems such as schizophrenia or delusional disorders – nearly ten per cent compared to less than one per cent of the general population.
- One in five men in prison are on prescribed medication such as antidepressants or antipsychotic medicine and there is evidence that use of medication increases whilst in custody.
- One in five male prisoners have attempted suicide at some stage in their life and the same number have previously been admitted for inpatient psychiatric care. (MIND, 2004). Ref. MIND & Prison Reform Trust Conference May 2004; “Troubled Inside” – Responses to the Mental Health Needs of Men in Prison.
- Womens’ mental health needs also need to be addressed, particularly because women in prison are nearly always the primary carer and often single parents. (Prison Reform Trust 2004 – “Young Parents from Custody to Community”).

What Works?

Cognitive behavioural programmes, real life skills and generic problem solving skills are effective in reducing or preventing youth violence. Individual analytical therapy, psychiatric and intensive counselling are deemed less effective or not effective. (Tolan & Guerra 1998).

Key Issues to be Addressed

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

- Focusing on early intervention.
- Research needs to be conducted into the needs of women within the criminal justice system.
- 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 continue to be explored in Northern Ireland.

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

Aim: To improve quality of life for people with mental health problems

Improving the quality of life for those with existing mental health problems by reducing discrimination, social exclusion, and by maximising skills and opportunities for employment is a third vital area for mental health promotion.

Quality of Life Approach

Quality of life is defined by WHO as “*an individual’s perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns*” (WHOQOL Group 1995). This definition reflects a broad view of well-being encompassing the person’s satisfaction with social, environmental, psychological, spiritual and health status. The concept of quality of life describes health, including mental health, in terms that capture positive as well as negative aspects of coping, resilience, satisfaction, and autonomy, among others.

Those identified include:

- Those with Enduring Mental Illness
- Those with Eating Disorders
- Those at Risk of Suicide
- The Traumatized
- Those Involved in Substance Abuse/Dual Diagnosis

It is beyond the remit of this Committee and its report to address all the above in a totally comprehensive fashion. The Committee however has attempted to highlight important current issues, identify some examples of evidence based good practice, and highlight some practical, locally sensitive key issues to be addressed which include, where appropriate, reference to the existing regional strategy.

The Strategic Framework for Adult Mental Health Services of the Review addresses clinical aspects of care and treatment in some depth with a vision of a “whole system of care” (p. 79) with an emphasis on recovery models.

This report aims to highlight some examples of preventative good practice, at primary, secondary and tertiary levels.

3.3.1 Those with Enduring Mental Illness

The Case for Action

In discussing the issues surrounding mental health promotion with those people with enduring mental illness, the debate about prevention in relation to mental health promotion inevitably comes into play.

Traditional public health definitions of prevention (Caplan, 1964) are:-

- Primary prevention efforts are those directed at reducing the incidence in the community. Primary prevention efforts are directed at people who are essentially “normal”, but believed to be at risk from the development of particular disorders.
- Secondary Prevention involves efforts to reduce the prevalence of the disorder by reducing its duration. The goal is to shorten the duration of the disorder by early and prompt treatment.
- Tertiary Prevention is designed to reduce the severity of disability associated with a particular disorder.

Recently it has been shown by a body of evidence that mental health promotion can contribute to the prevention of certain disorders, eg. anxiety, depression and substance abuse. It can also contribute to the health improvement for people whether or not they are at risk of mental illness as well as for people with mental health problems. (Mental Health Foundation 2000).

Primary Prevention

What Works?

School-Based Programmes – Universal protective factors among populations has been found to reduce depressive symptomatology. Examples include school based programmes targeting cognitive, problem-solving and social skills of children and adolescents and exercise programmes for the elderly.

Some of these programmes such as the Resourceful Adolescent Programme in Australia found reductions in high depressive symptom levels of 50% or more one year after the intervention (Schochet et al 2001).

Parenting Skills -_Parenting interventions for parents of children with conduct problems aimed at improving parental psychological well-being by information provisions and by training in behavioural childrearing strategies have shown reduction in parental depressive symptoms of about 30% with improvements in children’s outcome. (Newton, 1988).

Secondary Prevention

What Works?

Specific Mental Health Disorders - As there is a necessity to be selective for the purposes of this report we have chosen to explore the issues for the 2 potentially psychotic disorders affective disorders, whether unipolar or bipolar, and schizophrenia.

Schizophrenia - Early Intervention - It seems that early drug treatment of schizophrenic episodes may improve the prognosis. Two studies (Crow et al 1986 and May et al 1981) seem to indicate that a delay in institution of treatment leads to poorer long term outcome; that persistence of symptoms untreated by neuroleptic drugs leads to abnormality which cannot be completely reversed by subsequent treatment.

Affective Disorders – Education for Primary Care Professionals – Affective disorders are essentially a community problem: only one per thousand of the population are admitted to hospital annually in England because of severe illness (Bebbington 1978).

However, approximately 3% are seen annually by GPs with recognised depression with about an equal number unrecognised and a community six month prevalence of 3-5%. (Smith & Weissman 1992).

In Sweden, Rorsman et al (1990) described a programme that improved detection and management of depression. Evidence from England (Gask et al 1987) suggests that an educational package aimed at improving the interviewing skills of primary care physicians produces similar results.

Opportunities for Employment

Supported Employment – Supported employment within a normal working environment is more effective in improving employment prospects for people with long term mental health problems than sheltered workshops or pre-vocational training (Crowther et al 2000).

Tertiary Prevention

What Works?

Social Skills Training - One of the main assumptions underlying social skills training is that people with schizophrenia have either not learnt, or have forgotten, the behaviours necessary for successful social interaction and interpersonal relationships (Halford and Hayes 1992).

A typical social skills approach is to set up an educational class with 1 or 2 trainers and 5-10 patients as students.

Studies reviewing SST for people with schizophrenia conclude that SST is effective in increasing patients' ability, comfort and assertiveness in social situations (Birchwood & Spencer 1999).

Sheltered Housing – A range of agencies in Northern Ireland, both statutory and voluntary, provide sheltered accommodation in the community for those with enduring mental health needs.

The ethos may vary from organisation to organisation but most seek to empower the individual and promote maximum independence within a supported setting. Helping to increase individuals' social networks and opportunities for involvement in the local community are core factors.

The Key Issues to be Addressed:

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

The Case for Action

- In Northern Ireland, approximately 50-120 people develop anorexia nervosa per year, and 170 develop bulimia nervosa. As not all sufferers seek treatment, it is often difficult to assess the full scale of the problem, however it is estimated that approximately 340-1,700 have suffered from anorexia, with 1,700 suffering from bulimia.
- Around 100 people are admitted to hospital each year in Northern Ireland with an eating disorder.
- About 50% of patients with anorexia recover, 30% make a partial recovering and 20% remain anorexic. Bulimia shows a recovery rate of 2 out of 3 over a 5 year period. Treatment is most effective when provided early. (DHSSPS (NI) 2002).

- The DHSSPS Consultative paper of 2002 on Eating Disorders states that a paper by the Royal College of Psychiatry recently described services here as “woefully inadequate”.

What Works?

Examples of Good Practice in the Prevention of Eating Disorders

Life Skills Training Programmes – Life skills training have been included in a number of eating disorder prevention programmes. A review of these programmes (Levine and Piran 1999) reported that 85% of the programmes that included a life skills training component was effective compared with a 56% effective rate amongst those programmes that did not include such a component.

Eating Disorders in An Educational Setting

The Eating Disorders Project, Gloucestershire

Attempts to prevent the development of eating disorders within schools have been shown to be ineffective. (Fairburn 1995).

However recent studies have shown that a multi-dimensional approach has better outcomes. In some studies preventive effects have been found for eating related attitudes, interpretation or acceptance of societal ideals of appearance, feelings of ineffectiveness, body dissatisfaction and dietary behaviour.

Body Image

The Everybody’s Different Programme in Australia which focussed on improving self-esteem was effective in reducing body dissatisfaction in young people and altering weight control behaviour in girls. (O’Dea and Abraham 1999).

This programme showed that even 12 months after the programme participants showed improved body satisfaction, more positive self esteem, social acceptance, and low drive for thinness.

The Key Issues to be Addressed:

- 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

The Case for Action



There has been a dramatic increase in the number of young people taking their own lives.

Within Northern Ireland, suicide now exceeds road traffic accidents (RTAs) as a cause of death with 163 dying by suicide and 129 dying by RTAs in 2000. According to statistics from the Registrar's Office, 2001, suicide is the number one cause of death in people aged between 15-34 years and the rise is particularly concerning amongst young males.

What Works?

Suicide Prevention Strategies

There are a number of strategies in place in Northern Ireland. The WHSSB's Suicide Prevention Strategy represents the Board's firm commitment to tackle suicide and provides a context for a multi-agency approach to tackling suicide among the resident population.

The Strategy, based on WHO guidelines for suicide prevention consists of four key elements:-

- **Education:** education of the public through campaigns; education of professionals in the statutory, community and voluntary sector; and education in schools and colleges.
- **Environment:** reducing access to the means of suicide such as the introduction of Paracetamol legislation. (Hawton, 2002).
- **Media:** working with the media to recognise the protective role sensitive reporting can have, eg. producing media guidelines.
- **Research:** recognising the importance of co-ordinating research programmes in order to avoid overlap or duplication of research projects.

Since the inception of the strategy significant progress has been made in developing a range of programmes in all of the 4 key areas. These programmes have been the outcome of the successful collaboration of the members of the Foyle and Sperrin-Lakeland local forums on Suicide Prevention supported by the Suicide Awareness Co-ordinators.

North and West Belfast Trust has shown similar innovation by appointing a Suicide Awareness Co-ordinator who has been instrumental in implementing many initiatives.

10 specific action points have been identified in the Promoting Mental Health Strategy under the preventing suicide section. Much has been achieved at local level to ensure these action points have been realised, however someone needs to take regional responsibility to ensure consistency across Northern Ireland.

Public Awareness



It is important to provide information to the public about major health issues including mental health and suicide. As suicide may be seen as an extreme result of poor mental health then it is important that the public are informed about the possible signs of depression and other forms of mental illness and the sources of help.

Research would indicate that a better-informed public is more likely to access services at an earlier date. Action 13 of Promoting Mental Health recognises the need for a public and professional information campaign however if this is to happen it should be properly resourced similar to RTA campaigns.

The Strategy states that “All HSS Boards have taken action to ensure that information about local sources of help on mental health issues is available and accessible (Action 14).

Examples include the design and production, in consultation with young people, of a flyer and poster and development of the Heads Away Campaign by North & West Belfast Trust and health promotion leaflets on depression and suicide.

ASIST (Applied Suicide Intervention Skills Training)

In line with Action 25 funding was obtained from the DHSS&PS, Health Promotion Branch, to bring Living Works Incorporated, Canada over to NI to deliver the Training for Trainers course on ASIST. This course is available worldwide and has been adopted as the standardised training programme in Canada, Australia, Norway, and many of the States of American and the US Army and Air Force and is now being delivered throughout NI. A similar approach and commitment, as that adopted for the ASIST programme, is required for each of the other 29 action points of the strategy

The Key Issues to be Addressed:

- 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 ii for a further paper with detailed recommendations on suicide prevention.

3.3.4 The Emotionally & Psychologically Traumatized

The Case for Action

Since the conflict began in Northern Ireland 3,600 people have been killed; 40,000 injured. This is within a population of 1.5 million.

Whilst most researchers now agree that the Troubles have had an effect on the health and well being of our community, the extent of the impact of the Troubles on mental health has been disputed and under estimated for a number of reasons. (Duffy 2004).

The DHSSPS Report of 1998; “Living with the Trauma of the Troubles” has an impressive list of recommendations for action, including:

- The development of crisis support teams
- A proper review of the appropriateness and quality of counselling services for those affected by conflict.
- Services to be registered.
- Information to be made available by all Trusts and via other agencies.
- Better co-ordination of services

The Bloomfield Report “We will Remember Them” took a 2 strand approach; practical help such as criminal injuries compensation; a non-physical memorial scheme and a physical memorial scheme. The Bloomfield Report lists 20 recommendations on a range of issues. Two have a particular mental health promotion slant:-

(b) Employers should be sensitive to the special circumstances of victims and their carers, and specific actions should be taken by public sector employers to assure this.

And

(p) consideration should be given to the creation of a fund to assist in particular children and young people affected by the deaths or injury of a parent.

Wars and serious societal conflict such as the “troubles” have a severe impact on post-war societies. They tend to lead to the break down of infrastructures, loss of social capital and lead to major risk factors in terms of psychotic morbidity and suicide.

Alleviating the Effects of Violence – What Works?

(Please refer to “A Strategic Framework for Adult Mental Health Services” the Review of Mental Health & Learning Disability (NI) (June 2005) Section 6.29, pp 116-119).

Local & International Examples of Good Practice

Social Capital – Individuals, Organisations & Communities Under Stress Post Conflict



Recent research on social capital and inequality suggest that how individuals and communities feel – lack of trust, tolerance and participation – may be a critical factor in determining health (Wilkinson 1996 & 2000).

The impact of the conflict, such as residential segregation, population, movement and displacement, stigmatisation of certain neighbourhoods, bereavement and trauma is acknowledged in the regional strategy (DHSSPS 2002).

Action 5 refers specifically to the promotion of mental health with vulnerable groups such as victims of the conflict.

- 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.

Key Issues to be Addressed

- 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/Dual Diagnosis

The Case for Action



Chapter Four of the Strategic Framework with Adult Mental Health Services document deals with the issue of people with severe mental disorder and substance misuse (dual diagnosis) (4 E).

It seems an issue that those with a dual diagnosis can “fall between two stools” with mental health and addiction services accepting responsibility for their treatment needs. The report gives recommendations for different treatment approaches.

Substance Related Disorders – The prevention of mental and behavioural disorders due to psychoactive substance use includes the prevention of acute intoxication, harmful use and dependence. The term “psychoactive substances” encompasses tobacco, alcohol and illicit drugs (eg. opioids, cannabinoids and cocaine) as well as psychoactive prescription drugs and solvents. Globally, tobacco as a risk factor causes 4.1% of the total burden of disability (WHO 2002c). In the 21st Century, it is estimated that tobacco will be the cause of one billion deaths worldwide, with three quarters of these deaths occurring in low income countries. Worldwide, about two billion people consume alcoholic beverages and over 75 million are diagnosed with alcohol use disorders (WHO, 2004). Alcohol as a risk factor causes 4.0% of the total burden of disability (WHO, 2002).

Given the particular concern about binge drinking, especially in the young, and the limits of this report in terms of scope, the focus in this section is on alcohol abuse.

Northern Ireland

What Works?

Dr Diana Patterson, Consultant Psychiatrist at the Shaftesbury Square Hospital, Belfast and Chair of the Alcohol and Substance Misuse Expert Working Committee responded to our request for views on mental health promotion and substance abuse as follows:-

Adult Services – Within the broad areas of alcohol misuse it has been accepted for many years that there is significant improvement in morbidity and mortality when population wide interventions are employed. Interventions which affect the price (or relative price) of alcohol to the consumer are those which are likely to have the greatest beneficial health effect on our population. Others, targeted at reducing the overall volume of alcohol consumed by our population can be shown to have dramatic effects on morbidity and mortality from alcohol misuse. Other more directly targeted interventions such as screening and “early interventions” have been shown to be efficacious and may properly be considered as part of Health Promotion rather than considered as individual direct interventions. As these early interventions now form a major part of the importance within the field of Health Promotion.

Young Peoples' Services:- with regard to this group, even greater emphasis must be placed on health education and its preventive role. The future adults of our society have a right to education about alcohol and drugs so that they can make informed choices about these substances.

What Works?

Selective & Indicated Interventions – Brief interventions are highly effective as well as cost-effective for reducing hazardous and harmful alcohol consumption. Brief advice from a general practitioner routinely given to all patients who smoke and drink leads to about 40% attempting to stop and about 5% stopping for at least 6 months (a strong predictor of permanent success). (Lacaster & Stead 2004).

Community Interventions – Community mobilisation has been used to raise awareness of problems associated with on-premises drinking, develop specific solutions to problems and pressure bar owners to recognise that they have a responsibility to the community in terms of bar-related issues such as noise level and patron behaviour. Evaluation suggests that community mobilisation can be successful at reducing aggression and other problems related to drinking in licensed premises. For example, a comprehensive, locally designed intervention under the Saving Lives Project, including media campaigns, business information programmes, speeding and drunk driving awareness days, speed watch telephone hotlines, police training, high school peer-led education, college prevention programmes and other activities, led to a 25 % decline in fatal crashes, a 47% reduction in the number of fatally injured drivers who were positive for alcohol, a 5% decline in visible crash injuries and an 8% decline in crash injuries affective those aged 16-25 years (Hingson et al., 1996).

There are some examples of good practice in Northern Ireland in this area. The Drug and Alcohol Strategy Team, through its encouragement of interdepartmental Governments structures, has influenced the Department of Education in Northern Ireland to provide a comprehensive education package which is now available to all schoolchildren for their appropriate ages through the mainstream education process. Within this process, alcohol and drugs education is delivered through a larger Health Promotion programme and is not designed as a “stand alone” piece of education.

Risk Taking Behaviour

Brief interventions in primary care are effective in reducing alcohol consumption in heavy drinkers (Wilk et al 1997).

Reducing Alcohol Consumption



There is strong case for taking an alcohol history, followed by brief interventions in accident and emergencies departments, using an approach developed at St Mary's Hospital NHS Trust in Paddington, London (Huntley et al 2001). Over half the men who present to hospital after deliberate self harm regularly drink excessive amounts of alcohol and 23% are alcohol dependent. (Merrill et al 1992).

Key Issues to be Addressed

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.

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