

The influenza immunisation campaign during the 2001/02 winter was the most successful so far with 72% of people over 65 years receiving the vaccine. A second vaccine against pneumococcal infection – the most common cause of pneumonia, was also offered to people at the same time as they received their ‘flu jab’. Protecting older people against these infections helps reduce illness and premature deaths. It also leads to a reduction in the need for admission to hospital for chest infections and other respiratory illnesses.

Data from the 2001 census became available last year. It provides an accurate picture of our population structure which is important for the planning and delivery of health and social care services. The number of young people in our population is falling due to the sustained decrease in the birth rate and the number of older people is increasing due to improvements in life expectancy. These demographic changes have significant implications for the future delivery of services.

Dr Henrietta Campbell
Chief Medical Officer

Chapter



The Health of the Public - Some Facts and Figures

Introduction

It is important to have an accurate count of the population. This information is essential in the future planning and funding of public services such as those for health, education, and transport. The census provides a count of the population and of households. It is usually carried out every ten years. Between one census and the next, mid year population estimates are calculated for each year. These estimates take into account the number of births and deaths in the previous year as well as the net effect of migration into and out of Northern Ireland.

The Census

The first census in Ireland was carried out in 1813 but the work was deemed unsatisfactory and it was not until 1841 that a total comprehensive count of the population was achieved. Since then the census has generally taken place every ten years, with some exceptions. Table1(i) details the census history in Ireland from 1813 to 2001.



Table 1(i)

Census history in Ireland 1813 to 2001

1813	First census in Ireland
1821-1911	Census every 10 years coinciding with the census in Great Britain
1921	Census postponed (civil unrest)
1926	Census in Ireland (North and South)
1937	Shortened version of census in Ireland (North and South)
1941	Census postponed (2nd World War)
1951-2001	Census every 10 years to coincide with the census in Great Britain

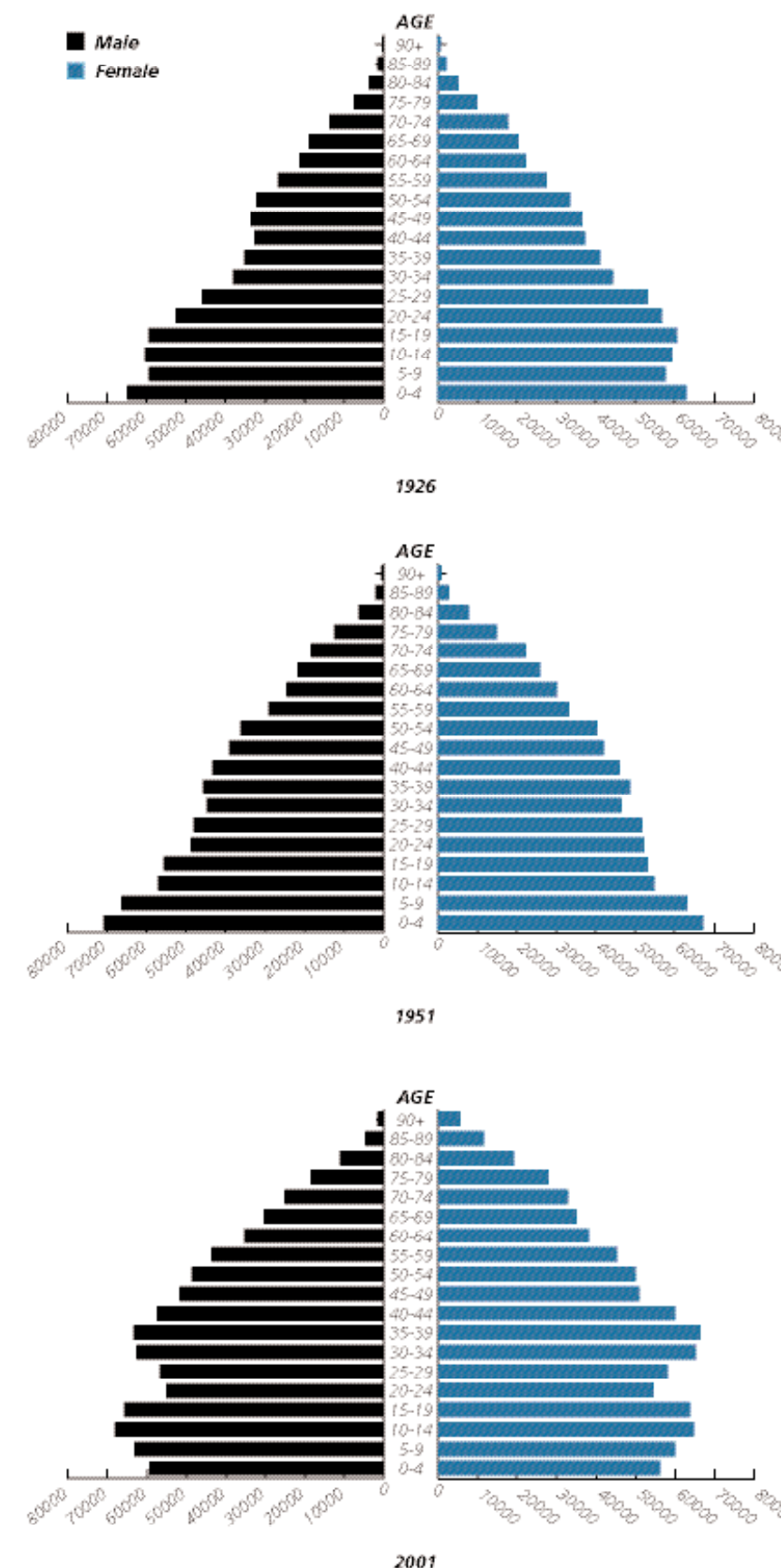
Source: NISRA

The 2001 census was conducted on 29th April 2001. The first results from it were published on 30th September 2002 and provided a count of the Northern Ireland population by age and sex. The population on Census Day was 1,685,267. This is slightly less than the estimated population for 2000 and confirms the difficulty in predicting the population size as we get further away from the previous census year.

‘Population pyramids’ are used to illustrate the age structure of populations. The age structure in Northern Ireland in 1926 did resemble a pyramid (Figure 1(i)). There were large numbers of young people at the base and very few older people at the peak of the pyramid, reflecting a high birth rate and a high mortality rate. The population pyramid in 1951 is more bell-shaped, as more children survived to adulthood. By 2001 the shape of the population pyramid had changed quite dramatically. This is due to the sustained decrease in the birth rate, the large reduction of deaths in children and the increase in life expectancy with many more adults living after the age of 65.

Figure 1(i)

Changes in the Census Population - 1926, 1951 and 2001



Source: NISRA



Compared with England, Scotland and Wales, Northern Ireland has the youngest population. Twenty four per cent are under the age of 16 compared with 20% in the UK as a whole. Conversely, Northern Ireland has proportionately fewer people of pensionable age (16%) compared to the UK (18%).

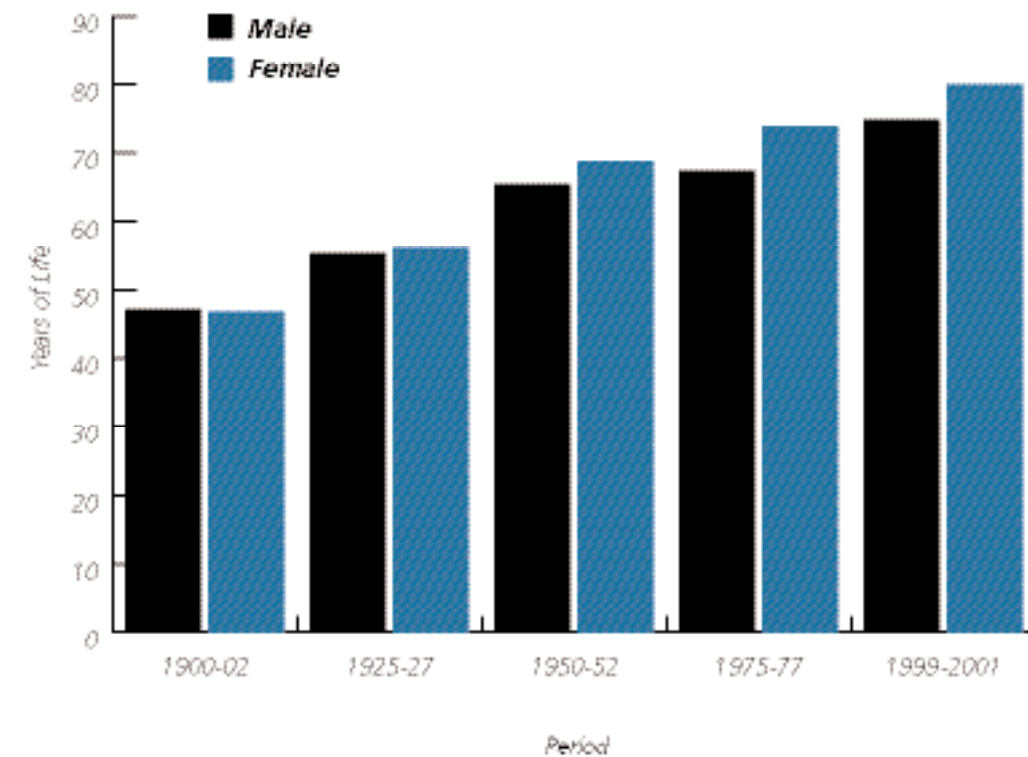
ADDITIONAL INFORMATION FROM THE 2001 CENSUS

- *Two out of every five households reported at least one person with a limiting long-term illness, health problem or disability which limits daily activities or the work they can do. One in five of the population reported having a condition of this nature.*
- *One in ten of the population provided unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health, disability or health problems related to old age.*
- *When asked about their general health, 70% indicated their general health had been good over the last 12 months.*

Life Expectancy

The life expectancy of men and women continues to increase. A male born today can expect, on average, to live for 74.8 years and a female for 79.8 years. This compares with a life expectancy of 55.4 years and 56.1 years respectively for males and females born in 1925. Figure 1(ii) shows how life expectancy has improved over the last century.

Figure 1 (ii)
Expectation of life at Birth 1900-2001



Source: NISRA

Births

The number of babies born each year in Northern Ireland has been falling steadily over the past 40 years. In the 1960s there were approximately 33,000 births each year. This compares with 22,074 in 2001. The crude birth rate (the number of births per 1000 population) has fallen by almost a third in the last 15 years, from 18 in 1986 to 13 in 2001.

Childhood Mortality

Deaths in the first year of life are a fair reflection of the health status of the population. In Northern Ireland the infant mortality rate (number of deaths in the first year of life per 1,000 live born babies) has been falling steadily for many years

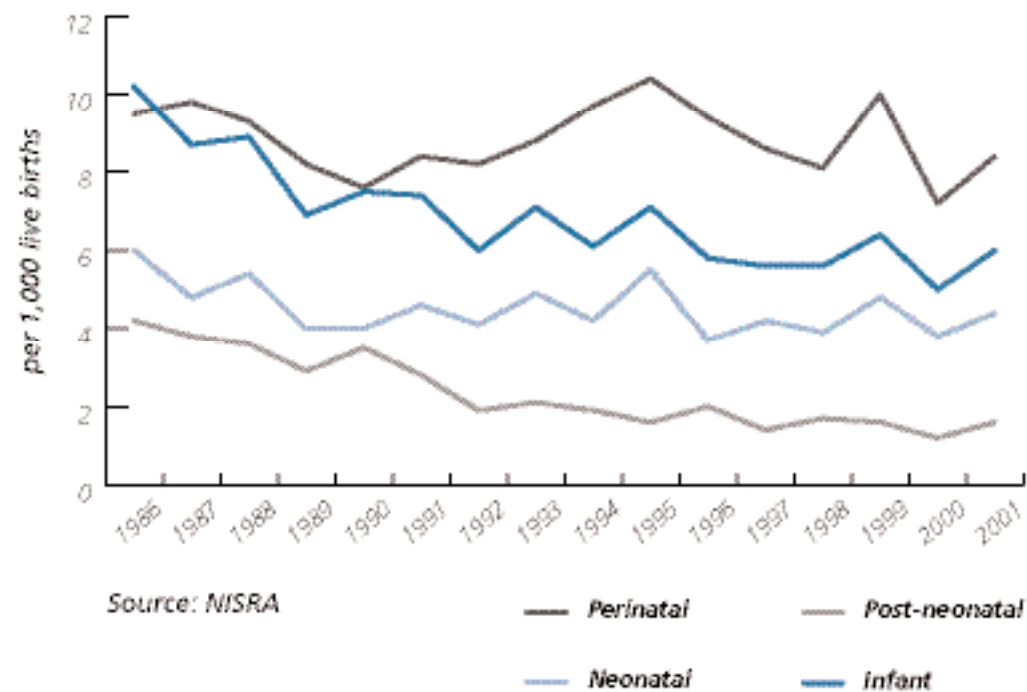


and the rate of 5.0 in 2000 was the lowest ever recorded (Figure 1(iii)). In 2001 it increased slightly to 6.0. However, as the absolute numbers of babies who die are relatively small, year to year fluctuations can alter the rate considerably. When interpreting these figures it should be remembered that multiple births are a risk factor for infant death as these children tend to have lower birth weights. The number of multiple births in Northern Ireland has increased steadily over the last few years, possibly due to in-vitro fertilisation (IVF) and other fertility treatments. The age of the mother is also a risk factor; proportionately more babies are now being born to older mothers.

The leading causes of death in infancy (less than 1 year old) are conditions associated with prematurity and low birth weight, and congenital malformations. In children aged between 1 and 14 the main causes of death are accidents, cancer, congenital malformations and infection.

Figure 1(iii)

Infant mortality rates in Northern Ireland 1986-2001



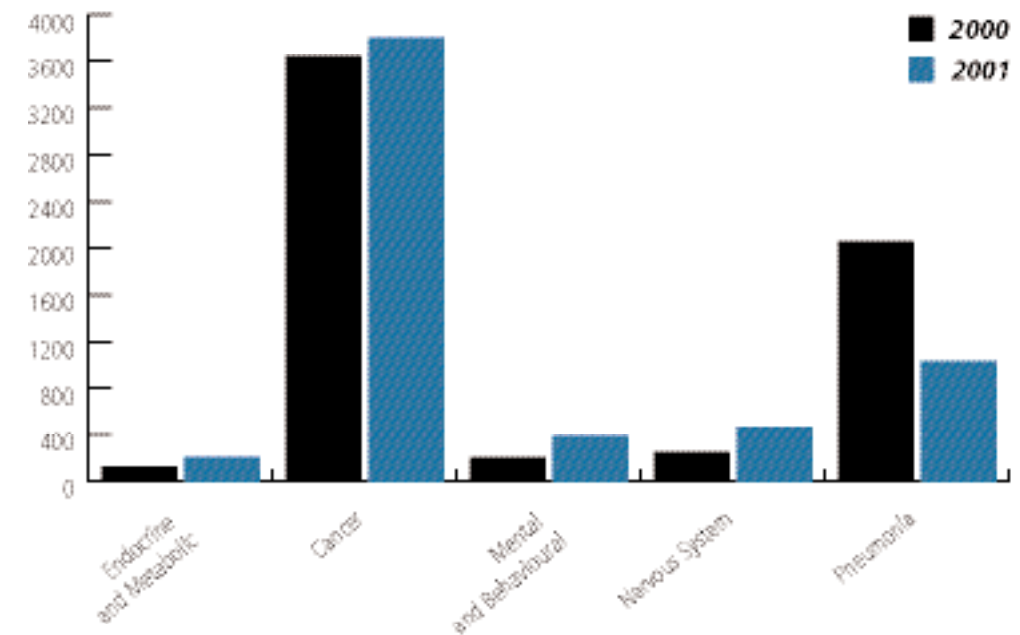
Adult Mortality

Heart disease and cancer continue to be the major causes of death in adults. Lifestyle factors such as smoking, excess alcohol consumption, poor diet and lack of exercise are major contributors to both these conditions. Smoking is the single greatest cause of premature death and avoidable illness. It is responsible for approximately 3,000 deaths each year in Northern Ireland.

Pneumonia has always been a major cause of death in Northern Ireland. However in 2001 a thousand fewer people were registered as having died from this condition. This reduction can be explained by the introduction of an updated coding system in 2001 – the tenth revision of the International Classification of Diseases (ICD10). The new coding rules for ICD10 accept that pneumonia is often a complication of an underlying condition such as cancer, stroke or dementia. From 2001 if an underlying condition is mentioned on the death certificate it is to be coded as the main cause of death rather than pneumonia.

Figure 1(iv)

Changes in the Number of Deaths in Certain Disease Categories between 2000 and 2001



This reclassification of deaths due to pneumonia has resulted in an increase in deaths from other causes (Figure 1(iv)). The increase in deaths due to diseases of the nervous system and from mental and behavioural diseases are due to more accurate coding where Alzheimer’s disease and dementia have been the underlying condition to pneumonia.

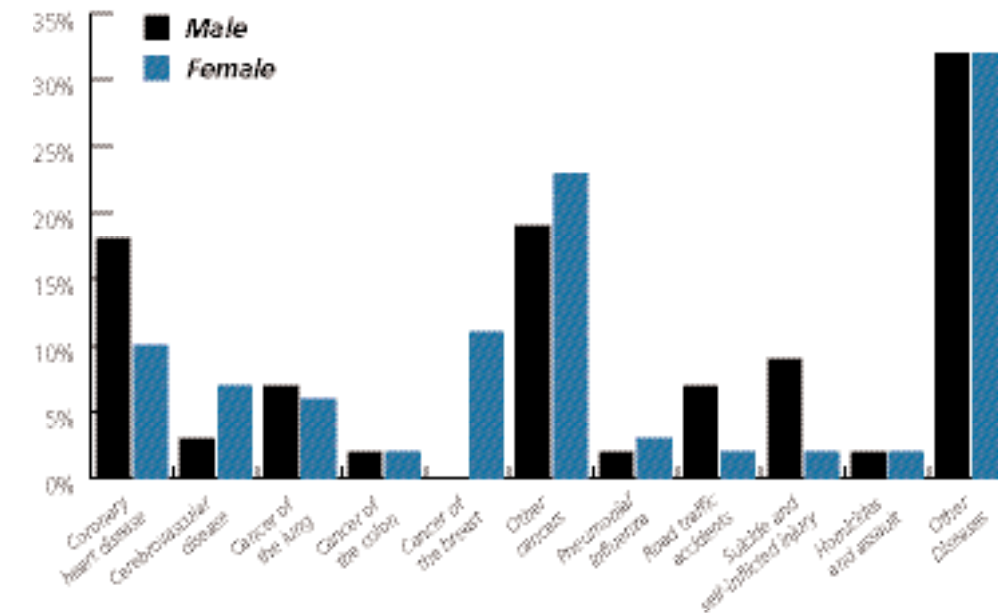
Potential Years of Life Lost

The concept of potential years of life lost (PYLL) is used to measure the contribution made by specific causes of death before the age of 75 years. Cancer and coronary heart disease are the main causes of years of life lost (Figure 1(v)). Suicide is another major cause and therefore is an important public health issue. Although the actual number of deaths from suicide is less than for a number of other diseases their contribution to years of life lost is important because they often occur at a relatively young age. Figure 1(vi) illustrates how suicide rates have changed since 1991. Although rates have fallen in older men and women they have risen in young men.

Estimated costs of Suicides and Intentional self harm

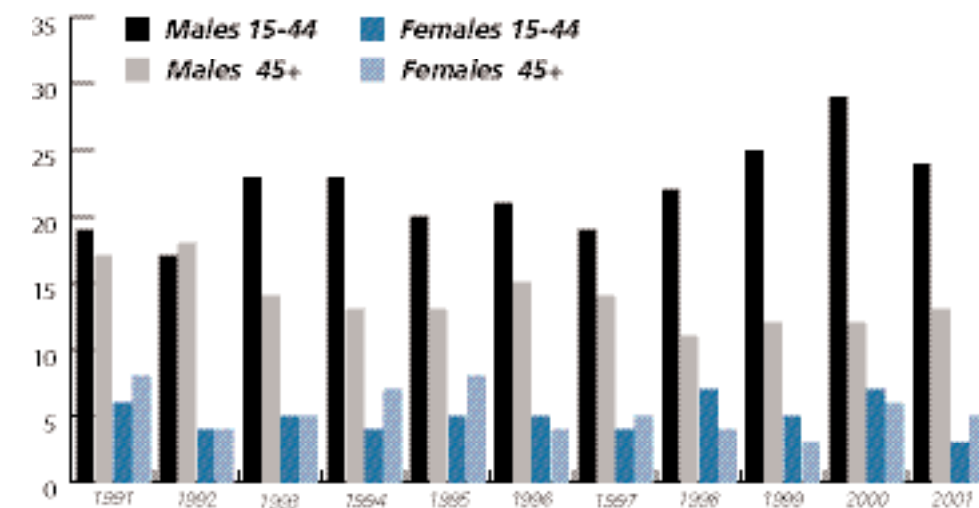
- 150 deaths
- 4,000 hospital admissions
- 4,500 years of life lost
- 8,000 working days lost

Figure 1(v)
Potential Years of life Lost by Cause - Northern Ireland 2001



Source: NISRA/DHSSPS

Figure 1(vi)
Standardised Death Rates for Suicide in Northern Ireland 1991-2001



Source: NISRA

Suicide is more common among people known to have mental health problems than in the rest of the population. Since 1997 Northern Ireland has been included in the National Confidential Inquiry into Suicide and Homicide by people with mental illness. In the first three years of this inquiry, 140 of the 502 people who committed suicide in Northern Ireland had been in contact with mental health services in the previous year. Of those known to have had a mental health problem:

- 79% were male;
- 50% were aged 39 years or under;
- 71% were single, divorced, separated or widowed;
- 60% were either unemployed or long-term sick;
- 34% lived alone.

The commonest mental health disorders from which they suffered were depression, alcohol dependence, schizophrenia and personality disorder.

Conclusion

Mental health and emotional wellbeing are fundamental to our quality of life and may have a greater impact on individuals and the community than chronic physical diseases. A link has been identified between mental wellbeing and physical health. Chapter 2 looks at the mental health of the population in more detail.

Chapter 2 Mental Health

Introduction

Good mental health contributes significantly to our sense of wellbeing and quality of life. Mental and emotional wellbeing is influenced by many factors including childhood experiences, life events, social networks and wider social and economic circumstances. How we feel emotionally impacts upon our view of ourselves, others around us, and our surroundings.

Promoting Mental Health

The value which people place on good mental health was a common theme in many of the responses to the consultation on the Investing for Health Strategy. It was the issue most frequently highlighted as a priority and has now become one of the targets for action.

INVESTING FOR HEALTH

- Objective:** *To promote mental health and emotional wellbeing at individual and community level.*
- Target:** *To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ12 score) by a tenth by 2010.*

The DHSSPS has just published 'Promoting Mental Health – Strategy and Action Plan 2002-2007'. The Strategy aims to improve people's mental and emotional wellbeing and reduce the incidence and impact of emotional distress, mental illness



and suicide. These aims will be realised through an integrated approach involving a broad range of partners, including statutory, voluntary, community and business sectors working in areas such as education, employment and neighbourhood regeneration. It also aims to increase the coping skills of individuals and communities and decrease the risk factors to mental health such as substance abuse, violence and social isolation.

MENTAL HEALTH PROMOTION WORKS AT THREE LEVELS

- **Strengthening individuals** – by increasing emotional resilience through interventions to promote self esteem, life and coping skills.
- **Strengthening communities** - by increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, child care and self help networks.
- **Reducing structural barriers to mental health** – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

Mental Health in our Population

Mental health problems are among the most common forms of ill health. It is estimated that, at any one time, 1 in 6 people suffer from some type of mental health problem – almost 300,000 people in Northern Ireland. This high level of poor mental health is confirmed by findings from the 2001 Northern Ireland Health and Wellbeing Survey.

“Mental illness is not a personal failure. It doesn't happen only to other people”

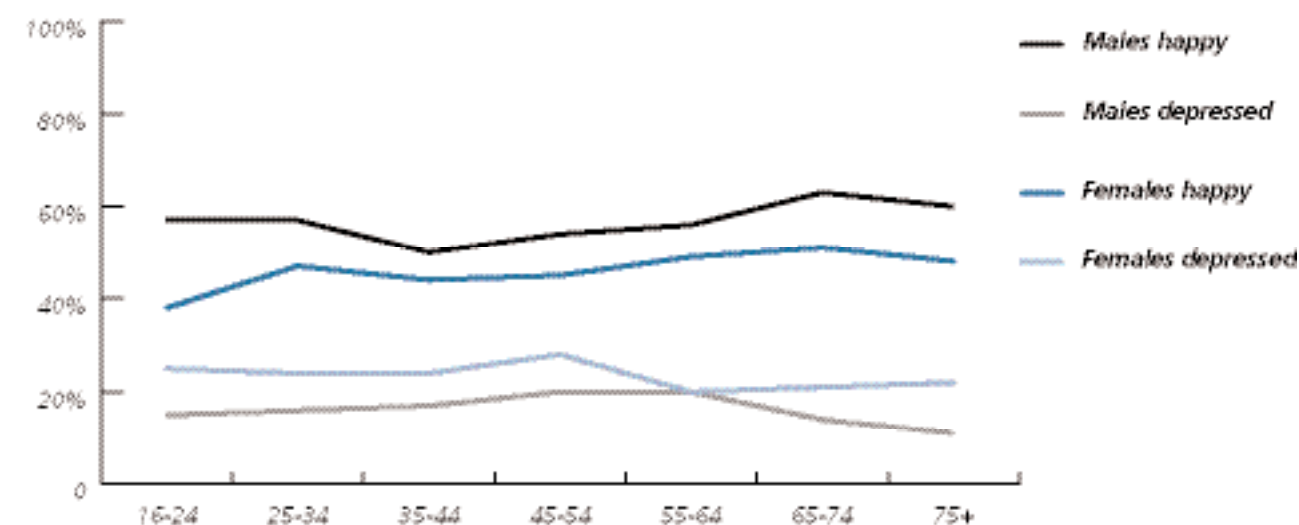
WHO

In it the mental health and psychological wellbeing was assessed using the General Health Questionnaire 12 (GHQ12). A fifth of people aged 16 and over showed possible signs of a mental health problem as indicated by a GHQ12 score of 4 or more. Higher levels of mental health problems were reported in people who were female, divorced or separated, unemployed, not in good health, in a lower socio-economic group and regular cigarette smokers.

Although there was no association between age and presence of mental illness, there appeared to be an association between advancing age and increased levels of happiness (Figure 2(i)). Men were also found to have higher levels of happiness than women.

Figure 2(i)

Mental Health Score by Age and Sex - Northern Ireland 2001



Source: NI Health and Wellbeing Survey 2001

Analysis of prescribing patterns for drugs used to treat mental illness has shown a much higher level of prescriptions for certain medications in Northern Ireland compared to elsewhere in the UK. In Northern Ireland there are 66% more prescriptions for drugs for psychosis and related disorders and 37% more for antidepressants. Also, a higher proportion of

the mental health budget is spent on inpatient care than anywhere else in the UK. Factors such as socio-economic deprivation and the effects of the Troubles will have played a part in increasing the level of mental ill health in our population.

STRESS AND THE WORKPLACE

Work can have both positive and negative influences on health and wellbeing. For many it provides a sense of purpose, social contact, status, income and a sense of belonging, all of which make important contributions to health in the broadest sense. In some cases, however, workplace risks threaten health and result in personal suffering, family hardship and losses for the economy and ultimately to society as a whole.

Work related stress has emerged as a significant issue in many workplaces and is now the second most commonly self-reported work condition. Stress can be defined as *the adverse reaction which people have to excess pressure or other types of demand placed upon them* and, if short lived, is unlikely to have health consequences. However, if prolonged it may affect the cardiovascular system, immunity and mental wellbeing. From the organisation's perspective the consequences include low morale, increased levels of absence, higher employee turnover, reduced productivity and a lack of innovation.

Tackling stress at work is therefore a major priority for employers. It requires intervention on three levels; addressing the root causes, strengthening employees' coping resources and finally supporting an employee who is suffering from stress. Of these, addressing the root cause is the most important and will make the greatest impact across an organisation.

Communities Working to Improve Mental Health

Northern Ireland has a mix of both urban and rural communities, each with their own characteristics. Often the traditional support networks of family, church or community have broken down. For the many people who experience feelings of depression, loneliness and anxiety the best outcomes are seen in those who receive early interventions. These interventions provide support to see them through the crisis and which put them in touch with networks in their local community. The following examples illustrate how urban and rural communities have responded to improve the mental health of those living in them.

Mental health in the city

Two projects, IMAGO and COPE in operation in East Belfast aim to make a real difference to the mental health of the people in their community.

The IMAGO project was devised by a local general practitioner. It aims to help people who have, or are suffering from depression, social isolation or bereavement. It provides support by linking people into local community, educational health and social activities. This inclusive approach helps to raise awareness in the local community. Local people have been trained to provide the type of support that individuals need. The COPE project is available to people who need more specialist help. It provides a rapid response to people in crisis, offering counselling and problem-solving therapies as required.



THE
IMAGO
PROJECT

"Imago helped me see the light at the end of a very black tunnel"

Imago Client

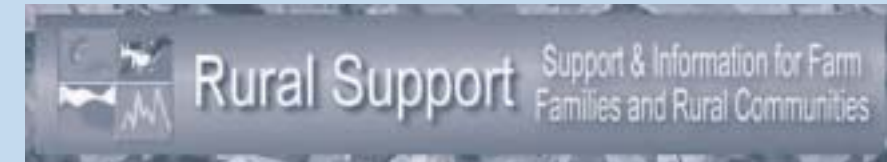
A rural response

For many people, living in the countryside has considerable benefits over living in towns and cities. Low levels of pollution, more attractive environmental conditions, improved child safety, lower levels of crime and more space and freedom. However, for a number it is associated with social isolation, unemployment, poor housing, lack of public transport and more recently a succession of crises in farming.

One example of a rural community's response is the Rural Health & Social Wellbeing Project which is based in Draperstown. Mental health issues are now more openly discussed and health and wellbeing is on the agenda of several district wide initiatives. Through the project a number of events and training programmes have been held to ensure that appropriate skills and knowledge of health issues are available to the community. Those trained in the Active Listening Skills are now supporting farming families across the Homefirst Community Trust area. Another programme, Chasing Rainbows is aimed at improving confidence levels among women with low self esteem. The project is supported by Homefirst Community Trust and the Northern Health and Social Services Board but takes its direction from a cross-sectional advisory group which has representation from the voluntary, community and statutory sectors.

"Mental health is such an important focus for us all. Through this project we see practical things being done for all of our community".

Male community representative



THE FARMING COMMUNITY – RURAL STRESS INITIATIVE

The farming industry has faced many challenges over recent years including BSE, and Foot and Mouth disease. This has had an alarming impact on the health and wellbeing of the farming community. Rural families are reporting feelings of stress, worries, isolation and even suicide as they face the latest uncertainty to hit their industry. A new charity called Rural Support has been set up by the Armagh and Dungannon Health Action Zone. Rural Support is funded jointly by the Department of Agriculture and Rural Development and the Department of Health, Social Services and Public Safety. It has already initiated a number of innovative projects to help relieve the stress being experienced by farming families. These include a telephone helpline 0845 606 7607 and website, www.ruralsupport.org.uk

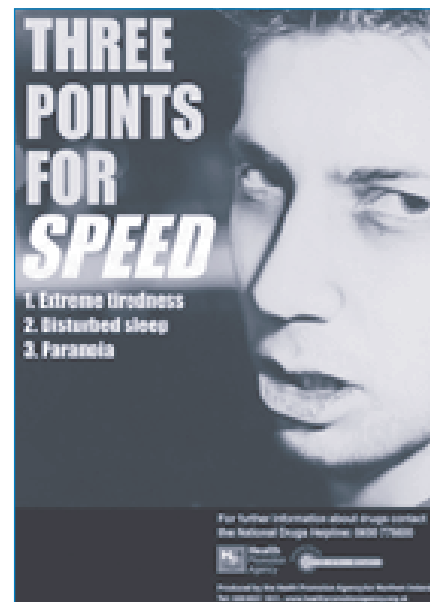
Communities Tackling Drug and Alcohol Misuse

The use of drugs is more common than ever before. Their negative social consequences have become more apparent. School children are now experimenting with drugs from an increasingly early age. Many young people view their use of drugs as 'normal' and some mistakenly believe that some drugs are 'safe'.

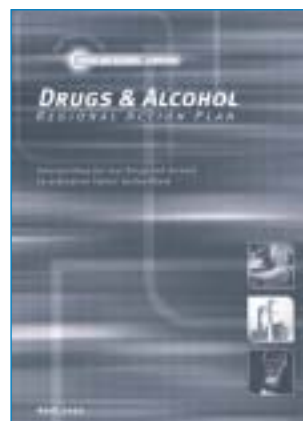
Drugs and alcohol misuse have a negative effect on mental health. Research from Australia found that frequent cannabis use in teenage girls is a marker for depression and anxiety in later years. This is of particular concern as data from the

Northern Ireland Drug Misuse Database for 2001/02 indicate that cannabis is the main drug of misuse for 34% of drug users presenting for treatment. In terms of alcohol, almost a third of those included in the 2000 Survey of Young People's Behaviour and Attitudes reported regular use. These figures highlight the potential for increased mental health problems in the future, and the likelihood of them presenting at a younger age.

Drugs and alcohol problems are often first noticed at a local level. Also, they can be unique to the particular locality in which they are found. In such circumstances it makes sense for local communities, working in partnership with others, to develop their own response to the problem. Through the Drugs and Alcohol Strategies funding has been made available to communities to support local initiatives. To date over 80 projects have been funded. Examples of these projects include:



- Counselling services for young people;
- Work with street drinkers in the Derry area;
- Outreach work with intravenous drug users in South Belfast;
- Tackling teenage drinking in Cookstown;
- The development of a family support programme in Ballymena; and
- Peer education programmes in the Southern Health & Social Services Board area.



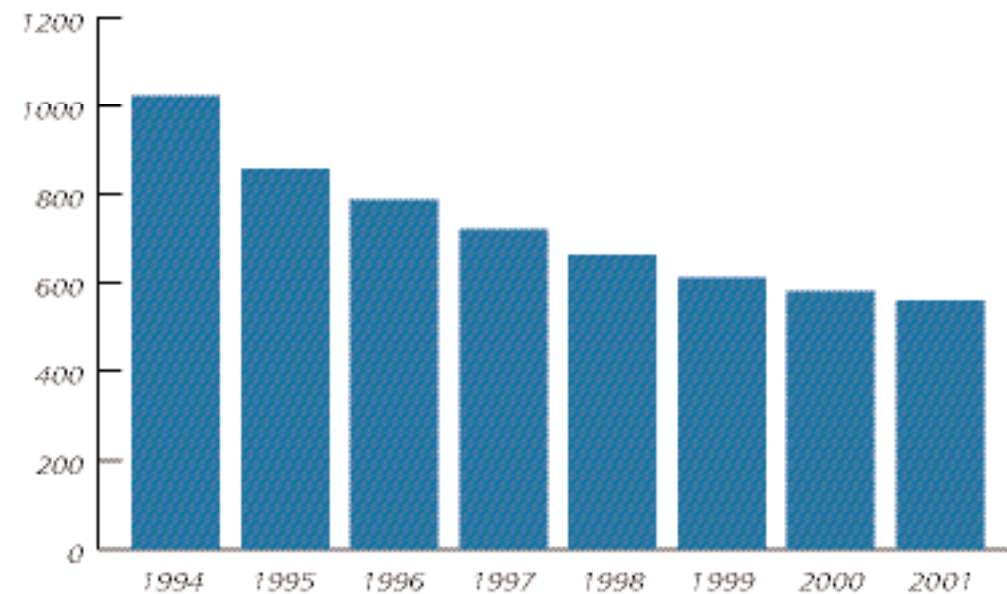
Care in the Community

The shift over the past few decades to providing mental health services that meet patients needs within the community is reflected in the move from a model of hospital inpatient care towards community alternatives. Figure 2(ii) shows progress over the past 8 years in reducing the number of patients with a mental illness who have been in hospital for more than a year. Further reduction in the long-stay inpatient numbers will require investment in new models for providing community care, for example, assertive out-reach, crisis response, and early intervention services:

- Assertive out-reach services, which are in use in other parts of the UK, work with patients in their own community. By keeping in regular contact they aim to reduce the likelihood of the patient requiring hospital care. Experience has shown that regular contact increases stability in the lives of patients and their carers thus improving social functioning and overall co-operation with treatment and care.
- Crisis response teams aim to provide assessment and care in the community as an alternative to hospital admission for those presenting with mental health difficulties at a particular crisis point in their lives.
- An early intervention team is based at Windsor House, Belfast City Hospital. It focuses on young people admitted to hospital for the first time and on their families. It aims to make their stay in hospital as short and as effective as possible. The team deals with all the issues which the young person and their family have around diagnosis, treatment and readjustment following an episode of illness. It provides a range for services for the young person and their families including information, specific treatments and ways to solve problems.

Figure 2(ii)

People with Mental Illness in Hospital for more than 1 year 1994-2001



Source: DHSSPS

Shaping Mental Health Services – a Partnership Approach

People who have experienced a mental illness can play an important role in shaping the future of mental health services. An example of how their input can be achieved is through the Mental Health Alliance. This is a partnership which involves users of mental health services, carers and providers, working together to achieve positive mental health for all. The Alliance places great importance on the training of users to strengthen their voice, and on the training of professionals by users. The work of the Alliance is supported by a programme of research which includes studying the experiences of those treated in hospital, their discharge from hospital and the setting up of a new life in the community.

LIFE IN THE COMMUNITY

The experience of individual patients provides a useful insight into the problems which they face when moving from hospital to the community. Three patients with a total of over 40 admissions to hospital gave the following views on the realities of life outside hospital:

“The hospital nurses tried to prepare me for living in the community.... I felt frightened and panicky ... I needed more support, time and advice. It took me a long time to go into town”.

“Sometimes when I was discharged I went into a hostel. This was a good service to get you into the way of living on your own again”.

“My main problems after discharge were day to day things such as shopping or housework”.

While life outside hospital can have its difficulties, good quality day care can provide a life-line in the community. A recent review of day care services by the Northern Ireland Association for Mental Health identified a number of things which made a real difference to patients, these included practical help, information and advice, the opportunity to build support networks and find friends, and for younger attenders help with employment and further education.

Carers

Carers are seen as forming the backbone of care in the community. They play a vital role in looking after those who are sick, disabled, vulnerable or frail. The 1997 Health and Wellbeing Survey found that 18% of respondents were informal carers. These are individuals who look after someone who is living with them or provide care for a dependant living