Chapter 4 Screening

Introduction

Screening is very different from traditional medicine when generally the patient comes to the doctor with a particular problem and they are then offered treatment if appropriate. Screening aims to detect a condition or disorder in people who have no symptoms and so would not have had any reason to seek medical attention. It does so by inviting healthy individuals to attend for screening for a particular condition. An example of this is inviting women between the ages of 50 and 64 to attend for breast screening every three years.

SCREENING

The systemic application of a test or enquiry to identify individuals at sufficient risk of a specific disorder to warrant further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder.

National Screening Committee

Benefits of Screening

There are many benefits of screening. Early identification of a particular condition means that treatment can be offered at an earlier stage. This in turn will mean an improved outcome for the person and, in some cases, the treatment required may be less radical. Treating diseases before they progress should also result in savings in health service resources.

It is important that the public understand the limitations of screening. A screening programme is often described as a 'risk reduction programme', that is, it reduces your risk of having a particular condition but is not a guarantee of diagnosis and cure. A screening test will not identify everyone with the condition. All screening tests will incorrectly identify some people as suffering from a disease or condition when they are in fact healthy. It will also give false assurance to others by giving them a clear result when in fact they have the disease. These are known as false positive and false negative results. The aim is to ensure that the number of such results are as small as possible. It would be irresponsible to introduce a screening programme if it were likely to yield a high number of false positives as too many people would be subject to unnecessary worry and, in some cases, a medical procedure they did not need.

THE UK NATIONAL SCREENING COMMITTEE

The United Kingdom National Screening Committee was established in 1996 to advise Government and the four UK Health Departments on population screening programmes. There are two main strands to its work - policy and quality. The policy strand is concerned with the question of whether particular screening programmes should be introduced, continued or discontinued. The quality strand is concerned with ensuring that screening is provided to consistently high standards. All screening programmes are based on the best evidence and have in built quality and information systems, with benchmarks, to monitor standards. The advice from the National Screening Committee on screening for a range of conditions can be found on its website http://www.nelh.nhs.uk/screening/vbls.html.

This chapter give details of some of the screening programmes which have been recommended by the National Screening Committee and the current position in Northern Ireland. It

includes antenatal screening, screening of babies and adult screening programmes.

Antenatal Screening

Pregnant women are offered a range of screening tests routinely as part of antenatal care. Some of these tests identify significant conditions which can affect the health of the mother and the baby, for example HIV. Other tests detect conditions in the fetus, for example spina bifida. Pregnant women should be properly informed of the screening tests available, their purpose and implications. Professional support and counselling should also be available if required.

Antenatal Infection Screening

For many years women here have been screened antenatally for infection with hepatitis B and syphilis and for rubella immunity. Following a recommendation from the National Screening Committee all pregnant women, from April 2003, are also offered screening for HIV. The number of pregnant women identified here each year with one of these infections is very small however numbers are increasing. This is due to an increase in the number of people in the community with sexually transmitted infections and an increase in the number of people injecting drugs.

HIV is a serious infection which can pass from infected mothers to their babies during pregnancy, at the time of birth or by breastfeeding. Without any treatment, HIV infection in children causes chronic disease, with about one in five of them developing AIDS or dying in their first year of life. The aim of antenatal HIV screening is to ensure that HIV infected pregnant women are diagnosed at an early stage, so that they can be offered advice and treatment that will reduce the risk of their baby being infected. This includes antiviral drug treatment, careful obstetric management including caesarean

section, and bottle feeding. Early identification and treatment significantly reduces the risk of transmission to the baby - from 1 in 4 to 1 in 20. Since HIV screening began here in 2003 it has been very well received by pregnant women, with over 90% of them accepting the offer of screening. In the first 18 months of this new programme, seven pregnant women were identified with HIV.

Babies born to mothers who are hepatitis B positive have a high risk of acquiring hepatitis B infection. Those who acquire hepatitis B at birth often develop chronic infection and, as they get older, are at risk of serious liver damage and in some cases liver cancer. However vaccination is 90% effective in reducing the risk of infection. The baby must be immunised shortly after birth and complete a full course of vaccination. Over 20 babies are born each year to hepatitis B positive mothers and this number is steadily increasing.

It is very rare in Northern Ireland to identify a pregnant woman with syphilis. However it is important that such cases are identified early because, if left untreated, syphilis can result in miscarriage, a stillbirth or the baby being born with serious complications which may result in death.

Babies of mothers infected with rubella in early pregnancy are at risk of being born with serious abnormalities of the heart, brain and eyes and also of being deaf. Screening for rubella immunity means that pregnant women, who are not immune, will be offered vaccination soon after the birth of their baby in order to protect them and their babies against rubella in future pregnancies.

Screening of Newborn Babies

After the initial joy of the birth, parents do not like to think about the possibility of there being something wrong with their baby. However early detection and treatment of certain

conditions will result in a much better outcome for the baby. For many years screening for a range of conditions has been offered to parents during the early weeks of their baby's life.

All babies are given a physical examination at birth and at 6-8 weeks. In particular they are all examined for dislocation for the hip, defects of the heart, abnormalities of the eye and undescended testes in boys. If any of these are detected the baby is referred for further assessment, and if the condition is confirmed, appropriate treatment is provided.

Another important programme is bloodspot screening. This involves babies having their heel pricked when 6-8 days old in order to collect a few spots of their blood. These bloodspots are then tested for a number of conditions including phenylketonuria (PKU), congenital hypothyroidism (CH) and cystic fibrosis. Screening for these conditions has been carried out in Northern Ireland for over 20 years. Each year around 20 children are diagnosed with one of these conditions. It is important that PKU and CH in particular are identified early as the baby needs to be started on treatment within the first few weeks of life if long-term complications, such as learning disability, are to be avoided.

Newborn Hearing Screening

Approximately one in every 1,000 babies born will have a significant hearing loss (25 per year in Northern Ireland). Currently infants have their hearing assessed by Health Visitors at around seven months of age. The test is called the infant distraction test. It is relatively crude and as a result the hearing problem may not be detected in some children until they are two or three years old. A new screening test which can check babies hearing soon after birth is now available. The National Screening Committee has recommended that, using the new technology, all newborn babies are offered screening for severe hearing impairment. Research has found

that detection and treatment of a permanent hearing loss, before six months of age, results in substantially better development of speech and language and communication skills. This has important long term benefits for the child in terms of social and psychological well-being, educational achievement and employment prospects.

The DHSSPS has provided funding for the implementation of a newborn hearing screening programme in Northern Ireland. This programme is currently being rolled out across the province. It builds on the experience gained through the pilot which has been running at the Royal Victoria Hospital for over two years. By October 2005 all newborns will be offered hearing screening. The implementation is being overseen by a Regional Steering Group which has wide representation, including the National Deaf Children's Society and the Royal National Institute for the Deaf.

The aim is to screen the newborns prior to them being discharged home with their mothers, however, those who are discharged early will be followed up in the community. The screening will be done by trained hearing screeners. It is quick, does not hurt and will usually be done while the baby is asleep.

Adult Screening Programmes

Screening programmes for breast and cervical cancer have been in place across the United Kingdom since the late 1980's. More recently the National Screening Committee has supported screening for bowel cancer, but has advised against screening for prostate cancer. It has also recommended that all people with diabetes should be offered screening for diabetic retinopathy.

Breast Screening

Breast cancer is the leading cause of cancer and cancer-related deaths in women in Northern Ireland, claiming the lives of 287 women during 2003. Breast screening, which has been in place here for over 15 years, can detect small cancers before they have caused any symptoms or signs and are at a stage when they are more amenable to treatment and cure. All women aged between 50 and 64 are invited for screening every three years. A recent Report from the Northern Ireland Cancer Registry indicated that the death rate from breast cancer has been falling, on average there are eight fewer women dying from breast cancer each year. Part of this reduction is due to the Breast Screening Programme. In contrast the death rate in the Republic of Ireland, which has just started to introduce screening, has remained the same. The benefits of screening are dependant on a high proportion of women coming forward for screening. Although the number attending has been increasing steadily, there is considerable variation in uptake between the Health Boards (Figure 4(i)).

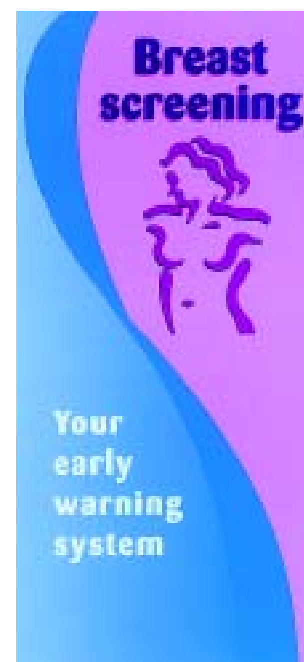
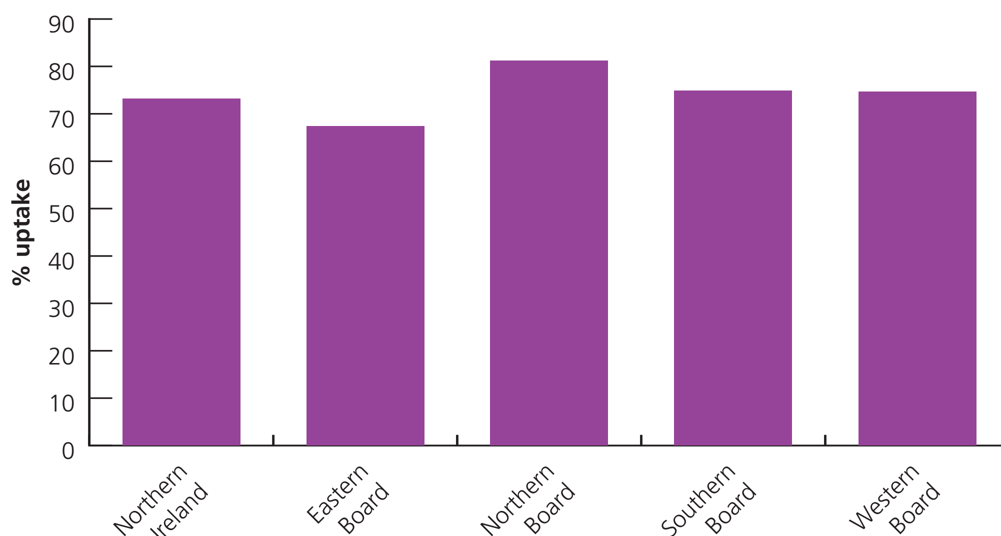


Figure 4(i)

Uptake rate for breast screening for Northern Ireland and by Health Board - 2002/03



Source: QARC (NI)

The National Screening Committee has recommended that the breast screening age range should be extended to include women up to age 70. Northern Ireland plans to extend its programme to include older women however, this cannot be achieved until current staffing difficulties are resolved. The priority is to maintain the quality of the existing programme.

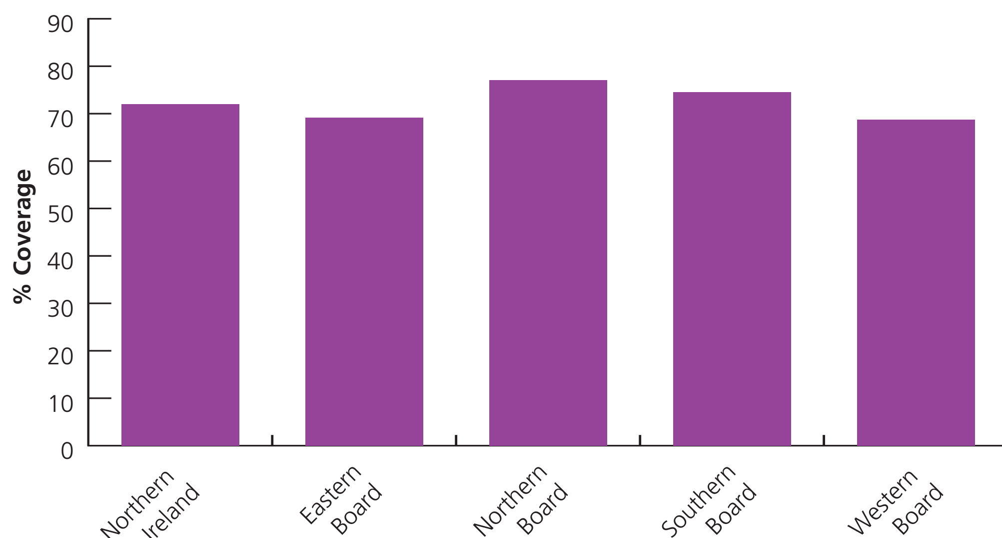
The majority of women who develop cervical cancer have never had a smear test.

Cervical Screening

Each year there are on average 80 new cases of cervical cancer and around 30 deaths, yet it can be prevented. The smear test detects early changes at the neck of the womb at an early stage, before any cancer is present. These early changes can easily be treated to prevent cancer developing. Currently women aged between 20 and 65 are invited for screening every five years. The coverage rates by Health Boards and Northern Ireland are shown in Figure 4(ii).

Figure 4(ii)

Coverage rate for cervical screening for Northern Ireland and by Health Boards - 2002/03



Source: QARC (NI)

Based on new research evidence, changes have been recommended to the frequency that women are invited for screening. It is now advised that women receive their first invitation for screening at age 25. Women aged 25-49 years should then be invited every three years and every five years from 50-64 years. These new screening intervals will be introduced in Northern Ireland.

Bowel Cancer Screening

Bowel cancer is the second largest cause of cancer death in Northern Ireland. Around 1,000 new cases are diagnosed here each year and in 2003 there were 461 deaths. There is now strong evidence that some of these deaths could be prevented by earlier diagnosis and treatment. Bowel screening can detect abnormalities in the bowel that may later develop into cancer, and early stage cancer in people who have no symptoms.

The screening test involves laboratory examination of a stool sample for blood. It is known as faecal occult blood testing (FOBT) as the blood is not visible to the naked eye. Those who have a positive result require further investigation by colonoscopy, that is, a special tube with a fitted camera is used to examine the bowel. At the same time biopsies can be taken of any abnormalities seen. Based on this research evidence, the National Screening Committee established a pilot programme in 2000 to evaluate the feasibility of introducing bowel cancer screening, using FOBT, to the general population. Almost half a million men and women aged between 50 and 69 were invited to take part in the pilot. The evaluation found that it was feasible to introduce it into everyday practice, though it had a considerable impact on workload in acute hospitals.

In October 2004, the Secretary of State for Health announced that bowel cancer screening would be rolled out across England from April 2006. We would wish to have a similar

programme in Northern Ireland. The establishment of such a programme will pose significant organisational issues. It will also have considerable resource implications including additional staff.

PROSTATE CANCER SCREENING

In 1997 the National Screening Committee advised that a screening programme for prostate cancer should not be introduced. The main reason was that the current screening tests have limited accuracy and so follow up procedures could cause unnecessary harm to healthy men. As yet there has been no new research evidence which supports the introduction of a prostate cancer screening programme.

Men who are anxious about prostate cancer may ask their GP for a Prostate Specific Antigen (PSA) test. However, to enable them to make an informed decision about the PSA test, they need to know about the limitations of the test and the potential side effects which may occur following prostate surgery, these include incontinence and impotence. A Prostate Cancer Risk Management Programme has been developed to assist in this decision making process. Information leaflets are available from the cancer screening website: www.cancerscreening.nhs.uk/prostate.

Diabetic Eye Disease

Diabetes is a common lifelong disease. Over time it can cause damage to small and large blood vessels, resulting in a range of complications, one of which is diabetic eye disease (retinopathy). Diabetic retinopathy is the leading cause of blindness in the UK in people of working age. Early detection and treatment have been shown to be effective in preventing the onset of visual impairment.

The National Screening Committee has advised that there should be a national programme to screen for diabetic eye disease. They recommend that screening should be offered annually to all people with diabetes, aged 12 years and over, and that the screening test should be a digital photograph of the back of the eye (retina). For a number of years there has been a limited diabetic retinopathy screening service in place in Northern Ireland with screening being undertaken at a number of GP practices using a mobile camera.

Diabetic retinopathy is the leading cause of blindness in the UK in people of working age.

Work is ongoing to extend the screening programme to all people with diabetes who are over 12 years of age (approximately 40-50,000 people). It includes the recruitment and training of additional staff, the purchase of new equipment and the development of a quality assurance framework. The aim is to have a comprehensive programme in place by April 2007.

Chapter 5 Cancer

Introduction

The number of new cases of cancer and the number of cancer deaths continue to increase. Cancer has now overtaken heart disease as the number one killer in Northern Ireland. There are about 6,200 cancers (excluding non-melanoma skin cancers) diagnosed each year in Northern Ireland, with around 3,500 cancer deaths annually. About 40,000 people in Northern Ireland are currently living with cancer. These numbers are expected to increase significantly over the next 20 years.

One in three of us will develop cancer and one in four of us will die of it. However the risk of developing cancer is not evenly distributed in the population with, for example, non smokers less likely to develop cancer than smokers.

Cancer detected at an early stage is often curable. Early detection can also reduce the need for expensive second line treatments such as chemotherapy and radiotherapy and improve survival rates. Investment in prevention and screening services will help reduce the incidence of cancer.

The demands for cancer diagnostic, treatment and review services are all increasing. Additional resources are required to support these services and to meet the costs of new drug treatments and other clinical and technological developments.

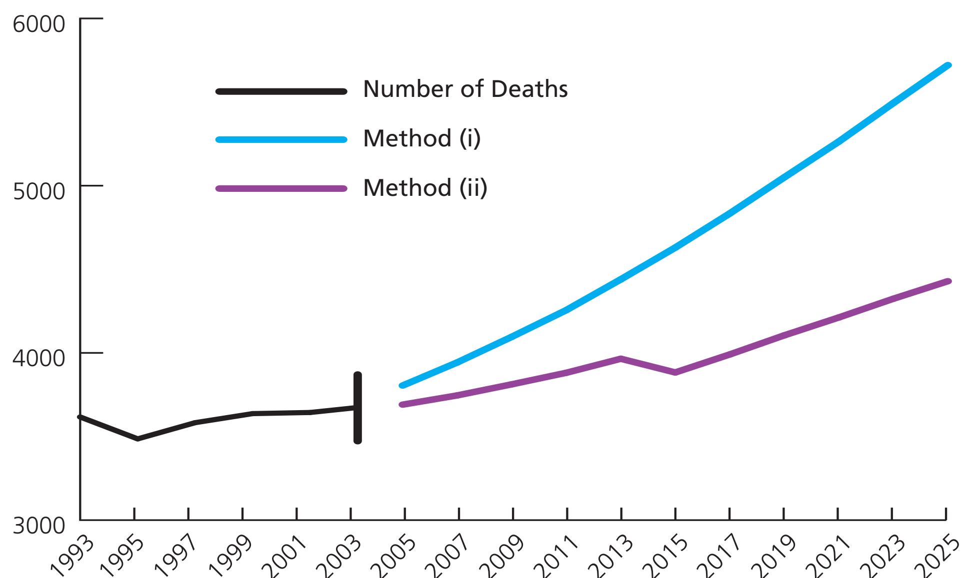
Predicted levels of Cancer

Cancer is more common in older people. It is predicted that by 2025 the population of Northern Ireland will increase by 8% to 1.83 million, 18% of whom will be over 65 years. As a result of the increasing number of older people, the numbers of new cancers per year (excluding non-melanoma skin cancers) is predicted rise to 8,210 (30% increase) by 2015 and to 9,770 (54% increase) by 2025. However, if the proportion of smokers were to fall from 27%, as at present, to 20%, the predicted rise in cancer deaths would be to 7,165 (13% increase) by 2015 and to 8,140 (28% increase) by 2025.

Figure 5(i) shows the current trend in cancer deaths and the projected increase in cancer deaths to 2025 as a result of population growth and ageing (method (i)). It also illustrates the impact that reducing the proportion of men and women who smoke to 20% would have (method (ii)).

Figure 5(i)

Numbers and Projected Numbers of Cancer Deaths 1993-2025



Source: Northern Ireland Cancer Registry/NISRA

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In Northern Ireland between 1993 and 2001 there has been a small reduction in the number of new cases of certain cancers. In men there has been a fall in smoking related cancers, eg, lung, lip and mouth. Bowel cancer has fallen in both men and women. Breast cancers have increased by about 12 per year in women but deaths have fallen by 8 per year. These reductions will moderate the increase due to population change alone from a predicted 54% to a 30% increase by 2025. Figure 5(ii) shows the projected percentage increase in certain cancers as a result of population change and how the above trends would affect this increase.

Figure 5(ii)

Predicted Percentage Change in Cancers in Northern Ireland by 2025

Source: Northern Ireland Cancer Registry/NISRA

Regional Cancer Services Framework

A European wide study of outcomes for patients affected by cancer in the late 1980s and early 1990s found that patients in the United Kingdom had poorer survival rates compared with most other countries. This finding led to a concerted effort to improve cancer services in Northern Ireland and the

publication of "Cancer Services – Investing for the Future" (the Campbell Report) in 1996. The report made 14 major recommendations for cancer services improvement.

A Regional Cancer Services Framework group was established in February 2004. It was tasked with considering the ongoing development of cancer services over the next 20 years. It will make recommendations for a programme of action for cancer services up to 2008 and outline recommendations for the development of cancer services up to 2015.

The Group is reviewing the current services and achievements since the Campbell Report "Cancer Services – Investing for the Future" and the Palliative Care Report "Partnerships in Caring" which were published in 1996 and 2000 respectively. It will also assess the level of the future cancer care, taking account of changing patterns of cancer and demographic and social trends. Other issues being considered include prevention, screening, early detection, palliative and supportive care, service modernisation, workforce development and skill mix.

The aim is to ensure the provision of a uniformly high standard of care for people of all ages with cancer. The Group will develop recommendations for improving the quality and accessibility of cancer services in primary, secondary, tertiary and community care taking account of emerging research, new treatments and technologies and the impact of policy changes, and best practice elsewhere.

Cancer Centre development

The Campbell Report envisaged major changes in the way cancer services for patients would be delivered. The first major objective was the establishment of the four cancer units in Altnagelvin, Antrim, Craigavon and the Ulster hospitals. A cancer centre was also established at the Belfast City Hospital working closely with the Royal Group of Hospitals.

The Cancer Units are now the main focus for the delivery of services for people with the more common cancers. In addition, some services for other less common cancers are provided from Cancer Units in conjunction with the Cancer Centre on a shared care basis.

Prior to October 1999 all chemotherapy was provided at Belvoir Park Hospital. After that date, chemotherapy services began to be provided from each of the Cancer Units. Now a significant proportion of chemotherapy services are provided at the Cancer Units.

In addition to its regional role, the Cancer Centre should act as a Cancer Unit to its local population. The decision was made to build a new Cancer Centre building at the Belfast City Hospital site to house radiotherapy, chemotherapy and a range of outpatient, day case and inpatient services for those affected by cancer. The planned facilities take account of the increased level of need projected for the period up to 2015.

Construction of the new Cancer Centre building on the Belfast City Hospital site commenced in 2002. The work is progressing well and is on schedule, for opening for clinical service in spring 2006.

New Cancer Centre - Belfast City Hospital

"The Bridgewater Suite" opened in April 2003 in the Belfast City Hospital Tower. Outpatient chemotherapy activity from the Belvoir Park Hospital transferred there at the end of June. The resulting facility, which combines the Outpatient Chemotherapy activity of Regional Haematology and Oncology services, now constitutes one of the biggest Haemato-Oncology day hospitals in the UK. The physical environment of the facility is first class.

Cancer Research

Northern Ireland is fast becoming a widely recognised centre for excellence in cancer research. A new Centre for Cancer Research, which is being established at Queen's University, will complement the new Cancer Centre at the Belfast City Hospital. Also, the development of a Cancer Clinical trials unit at the City Hospital has provided greatly increased opportunities for Northern Ireland cancer patients to be entered into the latest clinical trials. A new Centre for Molecular Biosciences was opened at the University of Ulster at Coleraine in February 2004.

NORTHERN IRELAND CANCER NETWORK (NICaN)

A managed clinical network for cancer services in Northern Ireland (NICaN) was established in February 2004. Its function is to secure an ongoing improvement in the quality of care for all patients with cancer. The care will be patient centred and it will be delivered by multidisciplinary teams working to agreed standards. The network will support groups of health and social care professionals, persons with a cancer experience and voluntary sector representatives to work together in a co-ordinated way across geographical, organisational and professional boundaries.

The NICaN Team comprises a lead clinician, lead nurse, lead GP, network manager and administrative support. The focus for the first year is to establish the foundations for the development and sustainability of the Network.

Palliative Care services

The Palliative Care Report "Partnerships in Caring" was published in 2000. Since then dedicated specialist palliative care teams have been established in each Board area. In

addition there is a network of nine GP facilitators in palliative care funded by Macmillan Cancer Care and supported by the Boards. Joint nursing posts between the community trusts and voluntary sector have also been established.

A Regional Children's Paediatric Palliative Care Nursing Team was established in 2001.The team continue to contribute to the palliative care of children alongside other services.

A cancer and palliative care online resource centre – CAPriCORN was launched in June 2004. It contains information on statutory and voluntary cancer and palliative care service providers in Northern Ireland. It also provides access to a range of resources on educational events, reports, news and advice on where to get help and support.
The site is for patients, carers and professionals. Further information can be accessed through the CAPriCORN website: www.capricorn-ni.org

BREAKING BAD NEWS

Giving bad news to patients, families and carers is never easy. It is important however that it is delivered in a caring and compassionate way. Regional guidelines to support staff in the delivery of bad news to patients, families and carers were launched in February 2003. They are research-based and have been developed through a consultative process, led by the Northern Ireland Group of the National Council for Hospice and Specialist Palliative Care Services. The guidelines have been disseminated widely. They can be accessed through the DHSSPS web site www.dhsspsni.gov.uk

Lymphoedema Services Review

Lymphoedema is a tissue swelling due to failure of lymph drainage. It is chronic and incurable and may occur in any limb, the trunk, genitalia, head or neck. Primary lymphoedema occurs due to either congenital abnormality or absence of lymphatic tissue. Secondary lymphoedema, which is more common, mainly occurs due to disruption of the lymphatics arising from cancer or its treatments (surgery or radiotherapy). More than a quarter of women undergoing treatment for breast cancer go on to develop lymphoedema in the arm next to the treated breast. This makes it difficult for the patient to use the affected arm, and causes swelling, pain, weakness, problems with clothing and is associated with diminished quality of life.

The Lymphoedema Services Review was commissioned in February 2003 to establish the extent of current lymphoedema services and to make recommendations to help commissioners, providers and the primary care sector meet the needs of those who suffer from it. The Report estimates that there are around 2,260 people in Northern Ireland living with lymphoedema, though accurate information on the number requiring treatment is difficult to obtain.

The Review Group has developed a series of recommendations for the development of a specialist lymphoedema network in each Health and Social Services Board area to facilitate the implementation of a high quality standard of lymphoedema care. Their report is currently out for consultation and can be accessed on the Department's website www. dhsspsni.gov.uk.

Northern Ireland Cancer Registry

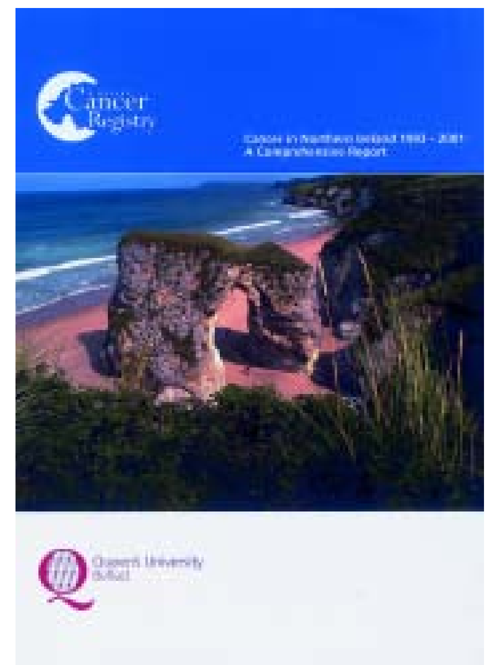
Information on cancer has been collected by a central register in Northern Ireland since 1959. Up until 1994, clinicians looking after cancer patients sent registration cards to the Registry at the then Department of Health and Social Services.

However ascertainment of cases was incomplete and data was poorly verified. In 1994 a new Northern Ireland Cancer Registry was established as a population based registry. It collects details on all cancers diagnosed in Northern Ireland and also provides information on cancers for research, education and planning of services.

The Registry has complete data on all cancers diagnosed between1993 to 2002 and has data on all cancers diagnosed by pathology within one month. The Registry also has historic data on melanoma and leukaemia/lymphoma, in some cases going back to the mid 1970s.

The Registry has produced six reports accessible electronically on www.qub.ac.uk/nicr.

i. Cancer Deaths in Northern Ireland - An Analysis of Patterns and Trends
ii. Cancer Incidence in Northern Ireland 1993-95
iii. All Ireland Cancer Statistics 1994-96 in conjunction with the National Cancer Registry of Ireland
iv. Survival of Cancer Patients in Northern Ireland 1993-1996
v. Cancer in Northern Ireland 1993-2001: A Comprehensive Report
vi. All Ireland Cancer Statistics 1998-2000 (in conjunction with the National Cancer Registry of Ireland)



Chapter 6 Mental Health

Introduction

Our mental well being affects every aspect of our lives and has a major impact on our physical health and how we interact with others. Defining mental health is difficult. One approach is to consider how you can tell when you have good mental health. This involves considering how you feel about yourself, other people and the general demands made by life. Unfortunately many people do not feel comfortable with themselves, others or life's various demands.

IS IT ME?

I FEEL COMFORTABLE ABOUT MYSELF

I am not overwhelmed by my emotions – such as fear, anger or love.
I can take life's disappointments in my stride.
I have a sense of humour and I can laugh at myself.
I have self-respect.

I FEEL RIGHT ABOUT OTHER PEOPLE

I can give and receive love and consider the interests of others.
I have personal relationships that are long lasting.
I expect to like and trust others and assume that others will like and trust me.
I respect the many differences found in other people.
I feel part of the group.

I CAN MEET THE DEMANDS MADE BY LIFE

I do something about the personal problems of life,
as they arise.
I recognise and accept my responsibilities.
I can adjust to my environment when this is necessary.
I welcome new experiences.
I set realistic goals for myself.
I put my best effort into whatever I try to do.

Promoting Mental Health

Mental health problems are among the most common forms of ill health. They affect approximately 280,000 people (1 in 6) in Northern Ireland at any one time and thus create a heavy burden on the individual, their family and carers and also society.

As a result of the increasing recognition of mental illness as a major public health issue, there is now a greater emphasis on improving the populations' mental and emotional health. The Northern Ireland 'Promoting Mental Health Strategy' adopts a health improvement approach which includes the need to address the wider determinants of mental health. Many factors can affect mental health, some of these are shown in Table 6(i).

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Table 6(i) Factors Affecting Mental and Emotional Health

Internal Factors	External Factors
• Poor quality of relationships; • Feelings of isolation; • Experience of disharmony, conflict or alienation; • Physical illness, infirmity or disability; • A lack of self esteem.	• Poverty and unemployment; • Social exclusion and discrimination; • Poor physical environment; • Negative peer pressures; • Experience of abuse and violence; • Family or community conflict or tension.

The Cost of Poor Mental Health

Poor mental health is one of the largest single health problems in our society. Caring for people with poor mental health has significant costs for health and social care.
In 2002/03 the Northern Ireland Association for Mental Health, in collaboration with the Sainsbury Centre for Mental Health, examined the total costs of mental illness in Northern Ireland. They estimated that the cost of treating people with mental health problems was £228.9 million. Table 6(ii) gives a breakdown of how the money is spent.

Table 6(ii) Estimated Spending on Mental Health Services in Northern Ireland - 2002/03

Hospital Services	**85.6m**
Community Health Services	**25.4m**
Personal Social Services	**39.8m**
GP Consultations	**34.1m**
Drug Prescriptions	**44.0m**
TOTAL	**228.9m**

Source: Northern Ireland Association for Mental Health and Sainsbury Centre for Mental Health

Poor mental health has significant costs for the economy as a result of their inability to work. The Confederation of British Industry found, in their 2001 report, that 30% of sickness absence was due to mental illness. It is estimated that in the UK, 60 million working days are lost each year due to depressive disorders. There also are significant human costs, particularly the impact on the quality of life of the individuals.

Healthy Working Lives

Work is an integral part of the lives of 700,000 people in Northern Ireland and their output sustains the economic and material basis of our society.

Both work and our workplaces have the potential to influence our mental well-being which, in turn, affects every aspect of our lives, including our physical health and how we interact with others. When work is well organised and managed, it provides a sense of purpose, social contacts, status, income and a sense of belonging. All of these make important contributions to health and well-being. On the other hand, workplace health risks which are poorly managed have the potential to cause physical and psychological ill health and this is reflected in the 70,000 people who suffer from work-related ill health.

In some work environments, research has shown that the health of senior employees is better than those in lower grades. About a quarter of this social gradient is accounted for by levels of smoking, obesity, high blood pressure and other aspects of lifestyle. The way work is organised, social influences, the work climate and influences from early life also contribute. It follows that interventions to address these factors have the potential to improve health and to reduce health inequalities. In Northern Ireland actions to address these issues are being taken forward through twin strategies of “Investing for Health” and “Working for Health”.

EFFECTS OF MENTAL ILLNESS ON EMPLOYMENT

As in other areas of their lives, many people who suffer from a mental illness face stigma and are discriminated against in the workplace. Less than 4 in 10 employers say they would consider employing someone with a history of mental health problems, compared with 6 in 10 for someone with a physical disability. Similarly figures suggest that only 13% of people with long-term mental health problems are in employment compared with around a third of people with other disabilities. This lack of paid employment precludes independence and is a major barrier to social inclusion.

Stress in the workplace

Stress is said to occur when pressure exceeds our ability to cope. Organisational aspects of work can cause stress, such as the demands of the work, the amount of control one has in how to do the work, support available at work, relationships with others and the reward we receive for the effort we put in. Self-reported work related stress, depression and anxiety are the second most common group of work-related health problems. There is growing evidence that stress in the workplace also increases the risk of physical ill health and disease. Work-related stress and its health consequences are major challenges for our working population of the 21st Century.

Workplace Interventions to Prevent Mental Ill Health

Workplace interventions to address mental ill health share similarities with the approach to mental health promotion. They address the psychosocial determinants of health and seek to strengthen the individual and thus enable mental health growth. Interventions include measures to reduce stress at

work, stress management training, policies on harassment, and policies on alcohol and drugs.

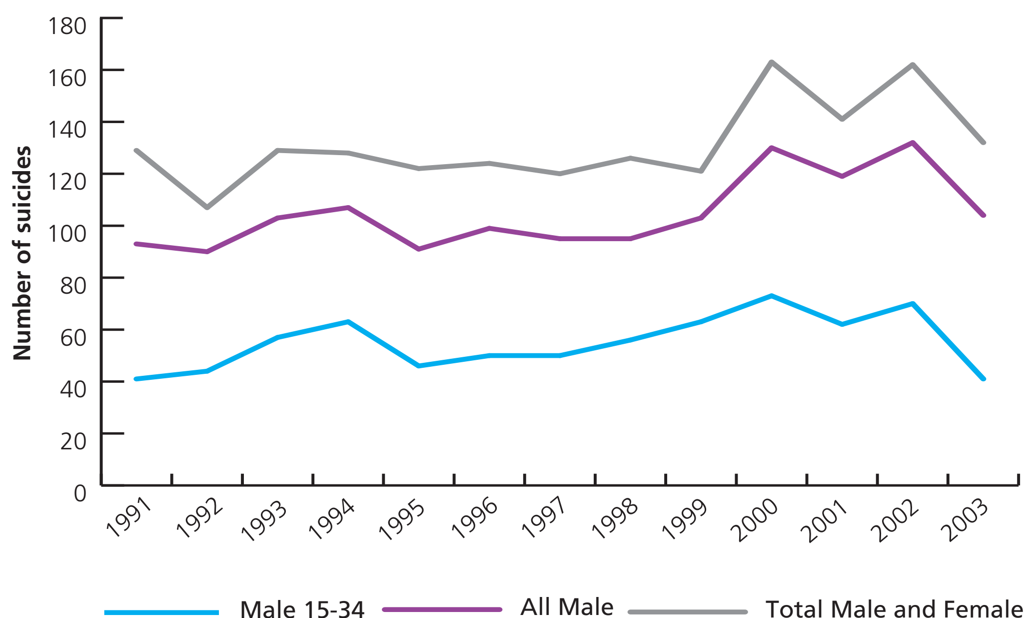
Work based interventions are more likely to be successful if there is senior management commitment and employee participation. As well as the stress interventions for individual workers, management needs to identify and rectify the causes of stress in the workplace. In this way the workplace can play its part as a setting of everyday life where mental health is promoted.

Suicide

One of the most drastic outcomes of poor mental health is suicide. Of particular concern is the number of young people who commit suicide and the significant impact that their death has on family and friends. In Northern Ireland there are

Figure 6(i)

Suicides - total, all males and males 15-34 – Northern Ireland 1991-2003



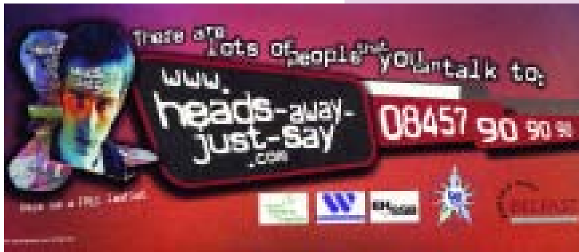
Source: NISRA

on average about 140 deaths from suicide each year. Almost half of these are in young men under 35 years of age (Figure 6(i)). Youth suicide is a complex area and as well as poor mental health, many other factors such as substance misuse, social deprivation, unemployment, poor family circumstances and availability of means play a role.

Many more young people also commit self-harm, a number of whom require admission to hospital as a result of the injury. Research has found that 1 in every 100 will commit suicide in the year after an episode of deliberate self-harm. This figure rises to 3 in 100 committing suicide within five years. The careful assessment and management of deliberate self-harm is therefore a key area to be addressed for future suicide prevention.

Action to decrease suicide among young people cannot just be focused on those who have a history of self-harm or mental ill health. It requires a broader approach with co-ordination and co-operation of many agencies across a spectrum much wider than just health and social services. Such agencies include the voluntary and community sector, the Health Promotion Agency, The Youth Council for Northern Ireland, Education and Library Boards and Schools. While no specific intervention has been found to be universally effective in preventing suicide, the importance of promoting self esteem, life and coping skills, working to increase social inclusion and participation and early identification of mental or emotional distress is recognised.

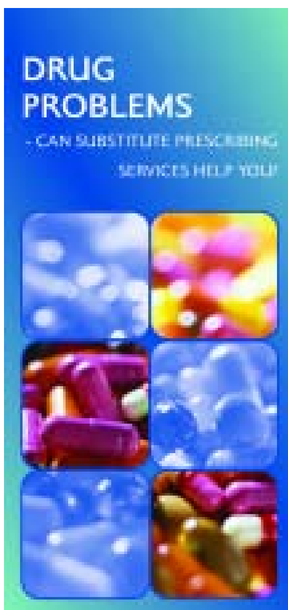
The Institute of Public Health in Ireland considered the evidence behind various interventions aimed at preventing youth suicide. This included areas such as school-based programmes, primary care initiatives, family interventions, the role of the media, restricting access to means of suicide, and targeting those most at risk. While recommending initiatives to be taken forward, the review also highlighted the many areas where future research and evaluation would be useful. [http://www.hda.nhs.uk/evidence]



HEADS-AWAY-JUST-SAY

Young men often find it difficult to talk to someone about their emotions. In an attempt to change this attitude and promote a culture of openness about young men seeking help, North & West Belfast HSS Trust developed a "Heads Away, Just Say" initiative this year. This involved a television and radio campaign, cinema advertisement, a website and a wide range of promotional material aimed at reaching as wide an audience as possible.

Illicit Drug Use – Harm Minimisation



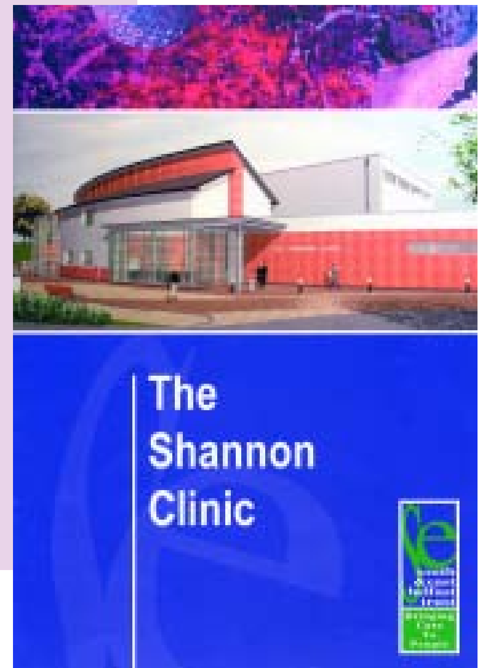
Tackling heroin use and in particular injecting heroin, with the associated increased risk of overdoses, blood borne viruses and other physical complications, continues to be an important local issue. The number of heroin users is increasing though it is only those who seek help and come to the attention of services that are known about.

Accepting that it is not possible to prevent drug use, it is necessary to minimise the harm that this use can cause. One way of reducing the risk of harm to injecting drug users, their families and friends and the general public is the Needle and Syringe Exchange Scheme. This scheme, which began in 2000, provides clean needles and syringes at participating community pharmacies in exchange for returned used injecting equipment. It reduces the risk of spreading hepatitis or HIV through accidental injury or by drug users sharing their equipment. In 2003/04 there were over 7,500 visits to the scheme with more than 82,000 needles and syringes issued and in approximately 60% of cases used equipment was returned.

As part of the overall care for heroin users, Substitute Prescribing Services have been developed to provide controlled prescribing of medication to substitute for their illicit drug use. This has been shown to break the dependency on illicit drugs while reducing risks of side effects of heroin. Research shows that this approach can improve the heroin user's engagement with services. It can also reduce overall heroin use and its associated harm, contribute to stabilising the lifestyle of addicts and therefore their carers and dependents and also reduce drug-related criminal activity.

THE SHANNON CLINIC

A medium secure unit for patients with serious mental illness and who require conditions of security opened in April 2005. This purpose built facility, which has accommodation for 34 patients, is the only one of its kind in Northern Ireland. It is located at Knockbracken Healthcare Park in Belfast and is known as 'The Shannon Clinic'. It will provide local assessment, treatment, care and rehabilitation required by patients who previously would have had to be transferred to Scotland or England. These patients who generally suffer from serious mental illness will be managed by specialist multi-disciplinary teams. Since such patients may be there for some time, the design of Shannon Clinic not only provides security but also a comfortable and positive environment.



Review of Mental Health and Learning Disability

Looking to the future, the independent Review of Mental Health and Learning Disability, which began in 2002, has been progressing. Initial reports on Adult Mental Health and Learning Disability have been published. The main thrust of

these documents has been the development of community alternatives to traditional inpatient services, coupled with meaningful empowerment of service users and carers in all stages from the planning to the evaluation of services. The review has had widespread involvement and consultation among users of the services, their carers and the many other stakeholders.

The Review is due to finish at the end of 2005. Working committees of the Review will be issuing further reports on addressing forensic mental health, child and adolescent mental health, mental health promotion, social justice and citizenship, legal issues, dementia and mental health issues of older people, alcohol and substance misuse, and needs and resources and finally legal issues. Progress can be followed using the Review's website www.rmhldni.gov.uk .