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PROMOTING MENTAL HEALTH

Strategy &
Action Plan
2003-2008



Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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PROMOTING MENTAL HEALTH

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CHAPTER 1
WHY WE NEED A STRATEGY

CHAPTER 1

WHY WE NEED A STRATEGY

1.1 In the Programme for Government, the Executive committed itself to five priorities for action, one of which was working for a healthier people. Within this priority, it undertook to take specific measures to promote mental and emotional health and reduce suicides.

1.2 The *'Investing for Health'* Strategy provides the framework for the attack on preventable disease, ill-health and health inequalities. It identifies mental health as a priority and sets a target:

"To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ –12* score) by a tenth by 2010."

*This is a set of twelve questions from the General Health Questionnaire which indicates the possible presence of psychiatric disorder.

The Promoting Mental Health Strategy outlines an integrated approach, which addresses the wider determinants of mental health and focuses particularly on inequalities.

1.3 Mental health problems are among the most common forms of ill health. They place a heavy burden on individuals, their families and friends and the community at large. They also impose substantial economic costs on the Health Service and society as a whole. It is estimated that as many as 1 in 6 people, at any point in time, suffer from a diagnosed condition such as depression or anxiety. Between 10%-20% of our teenagers will suffer from depression at some

time. The Health and Social Wellbeing Survey¹ shows that people in Northern Ireland are at greater risk of mental ill health than people in England and Scotland. Many factors affect mental and emotional health. These are outlined in Appendix 1. Some, such as poverty and community conflict, affect people here to a greater extent than elsewhere.

1.4 Increasing recognition of mental illnesses, notably depression, as a major public health issue has led national and international public policies to place greater emphasis on improving the population's mental and emotional health status.

1.5 Recent evidence based policies adopt a health improvement approach, which takes a broader view than the traditional psychiatric model of mental health. This approach is directed at promoting good mental health, preventing mental ill health and ensuring early intervention when mental health problems occur. It involves looking beyond prevention, to the relationship between mental well-being and physical health; behavioural problems; violence; child abuse; domestic violence; drug and alcohol misuse; living and working conditions such as homelessness, poverty, and unemployment; and risk taking behaviour such as smoking and unsafe sex. It means addressing the mental health impact of public policies, programmes and plans.

- 1.6 Everyone has mental health needs, whether or not they have a diagnosis of mental illness. Mental and emotional health promotion involves any action to enhance the mental wellbeing of individuals, families, organisations or communities.
- 1.7 Mental health promotion works at three levels: and at each level, is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems.
- **Strengthening individuals** – or increasing emotional resilience through interventions to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
 - **Strengthening communities** – this involves 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, childcare 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.²
- 1.8 The Department of Health, Social Services and Public Safety (DHSSPS) has consulted on the draft mental health strategy “Minding our Health”³ published in April 2000. Responses to the consultation have helped to shape this Strategy and Action Plan. In addition, in the responses to the ‘*Investing for Health*’ consultation process mental health was the issue most highlighted as a priority for action. The voluntary and community sectors in particular highlighted the issue in relation to disadvantaged groups who may be vulnerable to mental health problems. These respondents drew attention to the importance of social support and personal and social development.
- 1.9 Promoting Social Inclusion (PSI) is an element of the New Targeting Social Need policy which focuses on a series of priority issues to be tackled to improve and enhance the life and circumstances of the most deprived and marginalized people in society.
- 1.10 The Department has established a cross-department 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 strategy through which relevant agencies will work together to systematically tackle them. This Strategy will support their work.

1.11 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. DHSSPS together with its associated bodies, conducted a 2-stage joint consultation exercise on the equality implications of all their policies between December 2000 and June 2001. This helped to identify priorities for an Equality Impact Assessment programme which includes in year 1 the promotion of positive mental health as a new policy requiring Equality Impact Assessment (EQIA). A Working Group representative of the main interests involved, was established to develop the Strategy and an EQIA.

1.12 The Human Rights Act 1998 came fully into force in October 2000. It provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on Human Rights. There are some 18 Convention rights and protocols which range from the Right to Life to the Right to Education. The Act requires legislation, wherever enacted, to be interpreted as far as possible in a way which is compatible with the Convention rights; makes it unlawful for a public authority to act incompatibly with the Convention rights; and, if it does, allows a case to be brought in

a court or tribunal against the authority. DHSSPS will ensure that this Strategy and Action Plan is compatible with the Human Rights Act.

1.13 **Chapter 2** describes the aims of the Strategy, **Chapter 3** outlines an Action Plan to support mental and emotional wellbeing and **Chapter 4** sets out how the Strategy will be taken forward. **Annex 1** defines mental and emotional health and identifies some of its main determinants. **Annex 2** outlines the aims of mental health promotion and describes some effective interventions. **Annex 3** deals with the specific issue of suicide. **Annex 4** outlines the equality implications.

CHAPTER 2

AIMS OF THE STRATEGY

CHAPTER 2

AIMS OF THE STRATEGY

2.1 Mental health is the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of wellbeing and an underlying belief in our own and others' dignity and worth.⁴

2.2 This Strategy's aims are to:

- **improve people's mental and emotional wellbeing, in particular that of people at risk or vulnerable, and people with identified mental health problems, their carers and families;**
- **prevent, or reduce the incidence and impact of, mental and emotional distress, anxiety, mental illness and suicide;**
- **raise awareness of the determinants of mental and emotional health at public, professional and policy making levels and reduce discrimination against people with mental health problems;**
- **ensure that all those with a contribution to make are knowledgeable, skilled and aware of effective practice in mental and emotional health promotion.**

2.3 These aims will be realised through an integrated partnership approach including the statutory, voluntary, community and business sectors. The partners will include

organisations working in areas such as education, employment, and neighbourhood regeneration. Settings will include the home, school, community and workplace.

2.4 The Strategy sets the following target:

To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) to 19.5% by 2008.

(Source: Health and Wellbeing Survey. Baseline: 21% in 2001)

2.5 The Strategy will encourage policy development and support mental and emotional health in two main areas:

life circumstances – providing social and physical environments which assist people in obtaining help and resources to support them through challenges or crises; and

life skills – enabling and empowering people to improve their own mental health by promoting positive wellbeing and self esteem.

Principles

2.6 This Strategy adopts the framework of values and principles set out in the *'Investing for Health'* Strategy. In addition, the following principles are appropriate for mental health promotion. The two sets of

principles provide the criteria against which interventions, services, and practices will be evaluated.

i. A holistic approach to mental health

Addressing an individual's physical, social, emotional and spiritual health in their everyday social context.

ii. Empowerment

Supporting individuals by enhancing their knowledge and skills to promote emotional wellbeing.

iii. Respect for personal dignity

Recognising that all people have dignity, and deserve social justice, fairness, respect and equality of opportunity.

Taking the Strategy Forward

2.7 The Strategy comprises a number of actions grouped under four areas:

- a) policy development;
- b) raising awareness and reducing discrimination;
- c) improving knowledge and skills;
- d) preventing suicide.

2.8 Chapter 3 sets out for each of these areas, the actions to be taken, initial target dates and the main partners.

CHAPTER 3

ACTION PLAN

CHAPTER 3

ACTION PLAN

3.1 Mental and emotional wellbeing is influenced by many factors including childhood experiences, life events, individual ability to cope, social networks, and wider social and economic circumstances. Many of these factors lie outside the control of the health and social services, and indeed of Government.

3.2 Good mental health promotion depends on expertise, resources and partnership across all sectors and disciplines. It is relevant to the implementation of a wide range of policy initiatives including New Targeting Social Need, the equality agenda, neighbourhood regeneration and community development.

3.3 To support mental and emotional wellbeing the following actions are to be taken forward:

Policy development

Action 1

The Department of Health, Social Services & Public Safety (DHSSPS) will establish a Multi-Agency Implementation Group to steer and oversee implementation of the Strategy and Action Plan.

Target Date: February 2003

Action 2

The Implementation Group will report progress on implementation of the Strategy and Action Plan annually to the Ministerial Group on Public Health.

Target Date: Ongoing

Action 3

All Departments and their Agencies will assess the health impact, including mental health, of all new major policies and programmes.

Target Date: Ongoing

Action 4

DHSSPS will in partnership with Department of Culture, Arts and Leisure (DCAL), Department of Education (DE), Department for Employment and Learning (DEL) and Department of Regional Development (DRD) continue to support and develop initiatives under the Physical Activity and Drug & Alcohol Strategies.

Target Date: Ongoing

Action 5

Health and Social Services (HSS) Boards and Trusts 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 progress annually to the Implementation Group.

Target Date: Ongoing

Action 6

HSS Boards in partnership with HSS Trusts and the voluntary and community sectors will develop programmes to improve social support and reduce isolation for those who care for people who are elderly, disabled or mentally ill.

Target Date: September 2004

Action 7

HSS Boards in partnership with all acute and community HSS Trusts will ensure that service providers have in place a policy on mental health promotion and a programme of action to support positive mental wellbeing including the availability for older adults to participate in physical activity.

Target Date: Ongoing

Action 8

DE in partnership with DHSSPS, Education & Library (Ed&L) Boards and HSS Boards will develop a policy for the promotion of mental and emotional health of children and young people.

Target Date: March 2004

Action 9

DE in partnership with DHSSPS, Health Promotion Agency (HPA), schools and the voluntary and community sectors will develop a regional educational resource for the promotion of pupils' mental health and emotional well-being including anti-bullying approaches for use in schools.

Target Date: March 2004

Action 10

Department of Enterprise, Trade and Investment (DETI) in partnership with the Health and Safety Executive will ensure that the Workplace Health Strategy addresses the issue of work-related stress.

Target Date: April 2003

Action 11

Department of Agriculture and Rural Development (DARD) and DHSSPS will support the development of a rural support network to develop appropriate intervention strategies in rural communities.

Target Date: ongoing

Action 12

The Prison Service will provide access to appropriate services to those in prison with recognised mental health problems.

Target Date: Ongoing

Raising awareness and reducing discrimination

Action 13

DHSSPS in partnership with the HPA, HSS Boards, the voluntary and community sectors will develop a public and professional information campaign to raise awareness and understanding of mental health issues and reduce the stigma attached to mental health problems.

Target Date: September 2005

Action 14

HSS Boards and HSS Trusts in partnership with Ed&L Boards and the voluntary and community sectors will ensure that information about local sources of help and support is developed, available and accessible.

Target Date: June 2003

Action 15

DE, DEL and HSS Boards and HSS Trusts will through Investing for Health Partnerships ensure that strong links are maintained between schools and local health and social services.

Target Date: Ongoing

Improving knowledge & skills

Action 16

DHSSPS in partnership with HSS Boards and professional and voluntary bodies will carry out a review of professional training to ensure that the promotion of mental health and emotional wellbeing is fully included and takes account of the particular needs of disadvantaged groups including ethnic minority, disability and sexual orientation.

Target Date: March 2005

Action 17

DE in partnership with DEL, Ed&L Boards and professional bodies will carry out a review of professional training to ensure that the promotion of mental health and emotional wellbeing is fully included and takes account of the particular needs of disadvantaged groups including ethnic minority, disability and sexual orientation.

Target Date: March 2005

Action 18

DHSSPS in partnership with the HPA, HSS Boards and HSS Trusts, the voluntary and community sectors will assess the need for and review the extent and content of parenting skills initiatives on offer and ensure that guidance, training and regular updating of staff is available.

Target Date: December 2003

Action 19

HSS Boards in partnership with HSS Trusts and the voluntary and community sectors will develop programmes aimed at improving coping capabilities among older people, particularly around times of bereavement.

Target Date: December 2004

Action 20

DE in partnership with DHSSPS, Ed&L Boards, HSS Boards and HSS Trusts will develop training to support youth workers in understanding early recognition of risk and effective approaches to support young people's mental and emotional health.

Target Date: April 2004

Preventing Suicide

3.4 Suicide is a difficult and emotive subject. It is important to raise awareness of the problem and its causes, and to respond in a practical and effective way. The actions outlined above to promote mental health will help, but in addition the following specific actions are to be taken forward.

Action 21

DE and DEL in partnership with Ed&L Boards, schools, Youth Council for NI, HPA and HSS Boards will implement programmes on awareness of suicide for teachers and youth leaders.

Target Date: April 2004

Action 22

DE in partnership with the Youth Services, Youth Council for NI and voluntary and community sectors will continue to develop outreach work with young people in areas of need and especially young males.

Target Date: Ongoing

Action 23

HSS Boards will develop a suicide awareness programme in each Board area.

Target Date: April 2004

Action 24

HSS Boards in partnership with HSS Trusts and the voluntary and community sectors will develop a support service and provide an information booklet for those bereaved by suicide.

Target Date: April 2004

Action 25

HSS Boards and HSS Trusts in partnership with Primary Care, and voluntary and community sectors will ensure that a suicide risk assessment training programme is initiated for health and social services personnel and staff in the voluntary and community sectors working with vulnerable people.

Target Date: April 2004

Action 26

HSS Boards and HSS Trusts in co-operation with Primary Care will develop and deliver a Depression Awareness Training Programme for GPs.

Target Date: September 2004

Action 27

HSS Boards and HSS Trusts in partnership with the voluntary and community sectors will as part of policy development, consider how best to provide appropriate information on services available to people contemplating suicide.

Target Date: December 2003

Action 28

The **Prison Service** will ensure that all remand and sentenced prisoners continue to receive initial and ongoing monitoring of their mental health and assessment of the risk of suicide.

Target Date: Ongoing

Action 29

The **Prison Service** and the **Police Service** will continue to address whatever steps are necessary to avert any opportunity for suicide to take place among those at risk.

Target Date: Ongoing

Action 30

The **Prison Service** and the **Police Service** will ensure that suicide awareness is part of the in-service training for police and prison officers.

Target Date: Ongoing

CHAPTER 4 MAKING IT HAPPEN

CHAPTER 4

MAKING IT HAPPEN

4.1 It will take time and partnership working in a range of settings to achieve the overall mental health target set in the *'Investing for Health'* Strategy. The actions set out in Chapter 3, when implemented, will help to promote mental health and wellbeing and achieve the target.

Managing the Plan

4.2 The Ministerial Group on Public Health (MGPH) will be responsible for the overall monitoring of the Strategy and Action Plan. DHSSPS will establish a Multi-Agency Implementation Group to oversee and drive forward the actions outlined in Chapter 3. The Implementation Group will report progress to MGPH annually. It will also report progress to the Taskforce on Employability and Long-Term Unemployment to ensure that mental health issues are included in future policy development. The Strategy will be reviewed after five years.

Research

4.3 The Health and Wellbeing Survey 2001 has been used as a baseline to set the overall target in *'Investing for Health.'* Subsequent surveys will be used to monitor and measure progress against this target. The Implementation Group will wish to consider the need for additional research to help monitor progress.

Resources

4.4 DHSSPS will be making £200,000 available in this and the following two financial years to implement the Strategy and Action Plan.

ANNEX 1
MENTAL AND EMOTIONAL HEALTH

ANNEX 1

MENTAL AND EMOTIONAL HEALTH

1. Mental and emotional health is a resource which we need for everyday life, and which enables us to manage our lives successfully.
 2. Factors which support or influence our mental health and wellbeing include: a stable and secure environment; the ability to engage in lasting meaningful relationships and maintain self-esteem; the emotional skills to manage change and survive difficulties in our lives; coping and life skills to enable us to control our lives and deal with stressful circumstances effectively.
 3. Mental health and emotional wellbeing depend both on our internal psychological processes and on the values and resources of the outside world. They develop according to the support they receive from their social environments. They result in a sense of being in control of oneself and able to cope with events in the outside world.
- What Affects Mental and Emotional Health**
4. The natural capacity of people to make decisions about what is or is not good for them can be compromised by either internal or external factors, or both.
 5. **Internal factors** which may make us more vulnerable to poor mental or emotional health include:
 - poor quality of relationships;
 - feelings of isolation;
 - experience of disharmony, conflict or alienation;
 - physical illness, infirmity or disability;
 - a lack of self-esteem.
 6. **External factors** which may compromise mental or emotional wellbeing include:
 - poverty and unemployment;
 - social exclusion or discrimination;
 - poor physical environment;
 - negative peer pressures;
 - experience of abuse or violence;
 - family or community conflict or tension.
 7. Many factors affect mental and emotional health. Some affect people here to a greater extent than elsewhere, such as poverty and community conflict. Others affect us irrespective of age, such as family breakdown, sexual or emotional abuse, social exclusion or discrimination, domestic violence and bullying. Others have particular affects at different stages of our lives - during childhood, young adulthood or when we are older. The following paragraphs highlight some of these.

Poverty

8. Northern Ireland experiences higher levels of deprivation than Britain or Europe.⁵ The proportion of people on social security benefits here is higher than in Britain. One of the major causes of poverty and deprivation for families here is unemployment. 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%⁶.
9. Poverty, low wages, unemployment, poor housing and poor education have a substantial impact on people's health. Economic or financial disadvantage increases stresses, including everyday pressures to pay bills or to purchase food and clothing. It limits access to activities which enhance independence and wellbeing. There is evidence that people who are socially or economically disadvantaged may not readily report mental health complaints to health care workers.

The Conflict

10. The impact of the conflict on different communities was acknowledged in the report "Living with the Trauma of the Troubles"⁷. Residential segregation, population

movement and displacement, the stigmatisation of certain neighbourhoods, bereavement and traumatisation all have negative effects on mental health. 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 Troubles⁸. The Victim's Strategy⁹ also acknowledges the psychological difficulties faced by victims of the conflict.

Rural Areas

11. 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.

Physical Factors

12. Northern Ireland has the highest prevalence of disability in the UK (17.4% compared to 14.2% in Great Britain)¹⁰. Chronic medical conditions and physical and sensory disability can lead to depression, anxiety, isolation and substance misuse. Sensory loss and the greater likelihood of illness and disability make older people

especially vulnerable to mental health problems. Physical disability can also have a negative impact on the mental health of parents and siblings.

Carers

13. Caring for someone can be physically, emotionally and financially draining. 65% of carers admit that their own health has suffered. Many are pensioners themselves and some are children who are taking on inappropriate levels of caring responsibility. Carers often feel isolated, unsupported and alone.

Factors Affecting Children

14. The formation and maturation of close relationship bonds is a critical part of child and adolescent development. When there is a failure to develop appropriate attachments, or where there is disruption of these relationships through separation, death or family break up, mental health problems may result. Children are at particularly high risk of mental health problems when there are distortions in relationships such as through physical or emotional neglect, or through physical, sexual or emotional abuse or bullying.

Factors Affecting Young People

15. There is evidence that boys enjoy less emotional support than girls. Greater personal isolation during teenage years may make boys and young men more vulnerable to mental health problems.
16. Research indicates that adolescents who reside in areas with low socio-economic status tend to perceive their neighbourhood as more dangerous than those in high socio-economic status areas. There is a direct relationship between the degree to which an area is perceived to be dangerous and threatening and reported levels of depressive symptoms, anxiety and conduct disorder¹¹.

Factors Affecting Adults

17. Research evidence suggests that men do not have such strong peer/external support mechanisms as women for coping with bereavement, emotional issues, abuse, stress and depression. This difficulty is reportedly compounded because many men are not experienced at asking for help, may not perceive their problems to be serious, and may be less willing to consult services.
18. For women factors such as abortion, the psychological impact of giving birth, having young children, post-natal depression and the menopause have important associations with mental health problems.

Factors Affecting Older People

19. Adjustment problems and socio-economic difficulties associated with retirement constitute significant risk factors for emotional distress in older people.
20. Various factors contribute to social isolation and increased risk of mental health problems. These include a decline in social activity; deaths of friends and relatives; transportation and mobility problems; less support due to smaller family size and living alone.

ANNEX 2
EFFECTIVE MENTAL AND
EMOTIONAL HEALTH
PROMOTION

ANNEX 2

EFFECTIVE MENTAL AND EMOTIONAL HEALTH PROMOTION

1. Effective promotion of mental and emotional health aims to meet the needs of:
 - the well population; and
 - the 'at risk' population.
2. Mental health promotion is most effective when Departments and Agencies work together to provide information and support. The messages can be reinforced in a wide range of settings including the media, the workplace, primary care, schools, libraries, places of worship, leisure centres and other community settings.
3. Approaches which have proved to be effective include:
 - promoting good social relationships, for example, through training for social skills, assertiveness, communication and relationships;
 - developing effective coping skills, for example, problem solving and parenting;
 - providing social support, for example, home visits from health workers to support new parents, supporting bereaved families;
 - policy development, for example, tackling bullying in schools and workplace harassment.
4. Physical activity, either alone or as part of organised programmes, can improve emotional wellbeing. It can also prevent the onset of mental health problems and improve the quality of life for people with such problems.
5. Mass media campaigns can increase awareness of mental health issues and reduce the stigma associated with them. They can also be used to increase knowledge of how to cope with difficult circumstances and to identify sources of help and support.
6. Effective interventions will also take account of the specific needs of minority ethnic groups and people with disabilities. For example, the mental health needs of people with a learning disability can often be overlooked or attributed to their other identified difficulties; and deaf children who have limited access to the kinds of incidental hearing that support the development of social understanding may need particular support and help to build confidence and develop problem solving skills.

Children

7. Since childhood mental distress is strongly predictive of poor mental health and social outcomes in adult life, preventive interventions for children have clear potential to bring long-term psychological, social and economic benefits.

8. Effective interventions for children from disadvantaged communities and high risk families/children include:

- high quality pre-school and nursery education;
- support visits for new parents; and
- home based programmes to strengthen the relationship between the child, parent or care giver.

Young People

9. A number of effective school-based programmes have been developed and evaluated. These are characterised by:

- focusing on improving social skills;
- reducing substance misuse and aggressive behaviour;
- developing coping skills to deal with life situations.

10. Participation in creative arts has also proved to benefit young people experiencing personal, social and behavioural problems.

11. Research has shown that both being a bully or a victim of bullying is a good predictor for later problems¹². Effective anti-bullying schemes involving the whole school have been shown to be effective and have significant long term impacts on

criminal behaviour, alcohol misuse, depression and suicidal behaviour.

Adults

12. There is a range of effective interventions to promote the mental wellbeing of adults. These include:

- general health promotion programmes involving the whole community in a participatory manner on healthy living;
- community based support groups for the mildly depressed, divorced or separated people, unemployed, carers and recently bereaved people;
- home visiting programmes focusing on parenting skills and specific interventions to reduce postnatal depression;
- positive working conditions, including increased control at work, greater social support and pre-retirement interventions.

13. Brief interventions, such as simple advice, have proved to be effective in reducing excessive alcohol consumption. More severe alcohol related problems can be reduced by approaches which focus on skilled or specialist help, for example, in primary care services, addiction services or self help groups.

ANNEX 3 SUICIDE PREVENTION

ANNEX 3

SUICIDE PREVENTION

SUICIDE PREVENTION

1. Suicide, may be seen as an extreme result of poor mental and emotional health. Many of the contributory risk factors are common with those discussed in Annex 1. This Annex complements and reinforces Annexes 1 and 2.
 - 71% were single, divorced/separated or widowed;
 - 60% were either unemployed or long-term sick; and
 - 34% lived alone.
2. Concern has been expressed that the incidence of suicide, especially among young men, may be increasing. However, it should be noted that there are difficulties in the formal recording of suicide. A commonly accepted definition for data collection purposes has not yet been developed.
3. The traumatic impact of suicide on families, relatives, friends and communities warrants a specific focus by those involved in promoting mental health and emotional wellbeing.
5. The commonest diagnoses were depression, alcohol dependence, schizophrenia and personality disorder.
6. Other risk factors include combined alcohol and drug misuse, hopelessness, previous suicide attempt, low self esteem, unemployment, childhood neglect or abuse, bereavement, parental death during childhood, break-up of a relationship, social isolation, being unmarried and living alone.

Primary Risk Factors

4. There is an acknowledged relationship between mental illness and suicide. The Report - Safety First: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) - reported the following findings in relation to suicide by people in Northern Ireland with a mental illness:
 - 79% of all suicides were male;
 - 50% were aged 39 years or under;
7. Prisoners are in a vulnerable position and at higher risk of committing suicide.

Prison

Prevention of Suicide

8. While no specific intervention has been found to be universally effective, these risk factors must be addressed as part of a broader approach to mental and emotional health. Preventive measures include: reducing access to the means of suicide; promoting coping skills in

the general population; targeted work with vulnerable groups; well managed and responsive health and social services which can recognise mental problems early and make timely interventions.

9. Specific actions which may contribute to the prevention of suicide include:
- early identification of mental or emotional distress;
 - immediate access to sources of support and treatment especially for depression;
 - support for individuals and families after a suicide has occurred;
 - information and research into the complex interaction of risk factors and precipitating events that may lead on to a suicide.

These actions can be tackled through a wide range of settings and sectors.

ANNEX 4

EQUALITY IMPLICATIONS

ANNEX 4

EQUALITY IMPLICATIONS

1. Introduction

Northern Ireland Act 1998

1.1 Section 75 of the Northern Ireland Act 1998 requires the Department of Health, Social Services and Public Safety (DHSSPS) in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity –

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

1.2 In addition, without prejudice to the above obligation, DHSSPS should also, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Background

1.3 Mental health problems are one of the most common forms of ill health. Approximately 1 in 6 adults will at any one point in time, have a

diagnosed condition such as depression or anxiety. In September 1998, DHSSPS commissioned the Health Promotion Agency to lead and facilitate a regional multi-disciplinary Task Force to develop a Strategy and Action Plan for mental health promotion with targets for implementation. The terms of reference were:

“The Strategy and Action Plan should address issues which affect mental health; it should have a mental health rather than a mental illness focus and should aim to cover the needs of individuals and communities, not just those with existing mental health problems. It should also aim to increase understanding about mental health, develop education programmes and plan a media strategy to support the framework.

The Strategy and Action Plan should focus on the differing needs of children, young people, adults and elderly people and identify groups, within each of these age ranges, which might benefit from specific intervention to promote good mental health and wellbeing.

It should specifically address the problems associated with suicides particularly among young people and include measures to help young people develop a positive self-image and healthy and satisfying relationship with peers and family.”

1.4 Following consultation and discussion with a wide range of interested organisations a draft Strategy "Minding our Health" was published for consultation in April 2000. Given DHSSPS's commitment to promote equality of opportunity and good relations the consultation invited views on the extent to which the draft Strategy was consistent with these principles.

1.5 Responses were received from 38 organisations and individuals. The majority of responses were generally favourable and considered that the terms of reference had been met. With regard to equality some responses considered that more specific recognition needed to be given to the needs of vulnerable people such as homeless, minority ethnic groups, disabled people and postnatal women. These responses have been taken into account in the further development of the Strategy and Action Plan.

2. Aims of the Strategy and Action Plan

2.1 The aims of the Mental Health Promotion Strategy and Action Plan are to improve the mental and emotional wellbeing of the general public, particularly those at risk or more vulnerable and those with identified mental health problems, their carers and families. It also aims to prevent, or reduce the incidence and impact of, mental and emotional distress, anxiety, illness and suicide, raise awareness of

mental and emotional health at public, professional and policy making levels, and reduce discrimination against people with mental health problems.

2.2 The policy has been defined by DHSSPS. It will be implemented by DHSSPS and its agencies in conjunction with other Departments, statutory bodies and the voluntary and community sectors.

2.3 The policy will increase awareness and understanding of mental health issues, address inequalities by targeting vulnerable groups, and ensure that those with continuing mental health problems have access to the same opportunities as others in the community. The outcome of the policy is to prevent and reduce the number of people with mental ill health, reduce discrimination, promote early intervention in mental health problems and reduce the number of suicides.

3. Groups Affected by the Policy

3.1 The policy will affect the health and wellbeing of the population generally. It will therefore affect all of the Groups listed in 1.1.

4. Consideration of Available Data and Research

4.1 When considering the equality implications of the Strategy and Action Plan account was taken of information provided by existing surveys and also information

through discussion with voluntary organisations as set out below.

i. Source: Health and Social Wellbeing Survey 2001

Results indicate that a greater proportion of the population is at an increased risk of mental ill health when compared to England and Scotland. These were people who had a score 4 and above when assessed using the twelve questions of GHQ 12 (General Health Questionnaire 12) which indicates the possible presence of psychiatric disorder. In Northern Ireland 17% of men and 24% of women reached this threshold compared with 13% of men and 18% of women in England and Scotland.

Marital Status – 19% of people who are married and living with their partners showed signs of a possible mental health problem compared to 33% who are divorced.

Respondents who were divorced were over twice as likely to have experienced a great deal of worry or stress (23%) compared with those who are married and living with their partners (11%).

Religion – 19% of Protestants showed signs of a possible mental health problem compared with 23% of Catholics.

12% of Catholics and 11% of Protestants experienced a great deal of worry or stress in the previous twelve months.

Gender – 17% of men and 24% of women showed possible signs of a mental health problem. Women in most age groups with the exception of those aged 55-64 years were more likely than men to show signs of mental health problems.

Women were more likely to have experienced a great deal of worry or stress than men, 14% compared with 10%.

ii. Source: 1997/98 Health Behaviour of School Children

Gender/age - one quarter of all pupils surveyed (24.9%) had experienced bullying, for 60% of this group it had occurred only once or twice.

Boys are more likely to be bullied than girls.

Younger children are more likely to report being bullied.

Almost one in five (19.8%) of the survey group admitted to having taken part in bullying, only 1.2% admitted to frequently bullying others. Those who have been bullied themselves are more likely to bully others.

FREQUENCY OF BULLYING BY THOSE WHO HAVE BEEN BULLIED THEMSELVES			
	Never been bullied (%)	Been bullied sometimes (%)	Been bullied frequently (%)
Bullied others frequently	1.1	2.2	11.0

27.7% of the survey group said they felt pressured by schoolwork - 10% said they felt under a lot of pressure.

The proportion of young people who feel pressured increases as they get older. There is a large increase in the number of both boys and girls reporting they felt under pressure in year 12 (GCSE year) – in primary 7 less than 1 in 10 felt stress while in year 12 over 1 in 4 reported stress.

iii. Source: National Deaf Children’s Society

Disability/Age - deaf children are more likely to be impulsive, with limited social problem solving skills, and greater difficulty in identifying and naming their own and other people’s emotional states (Kusche and Greenburg 1987). Deaf children are at greater risk of developing mental health problems than their hearing peers (Hindley, Hill, McGuigan and Kitson 1994).

iv. Source: Birkett, S and Foyle Friend, “The Experiences of Lesbian, Gay and Bisexual People at School in the North West of Ireland”

75% of gay men experienced homophobic bullying at school.

v. Source: White, RG, McCracken, A., and the Rainbow Project, How Hard Can It Be?: Attempted Suicide of Gay Men - the Psychological Stressors and Associated Risk Factors, Rainbow Project, 1999

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 considered committing suicide.

vi. Source: Toner, F., McCracken, A., McIlwrath, K., and the Rainbow Project, Express Yourself!: An Investigation into the Counselling Needs of Gay Men in Northern Ireland, Rainbow Project, Belfast, 1999

61% of gay men reported suffering emotional abuse from school mates.

vii. Source: Safety First: National Confidential Inquiry into suicide and homicide by people with mental illness (2001)

From April 1997 – April 2000 there were 502 notified suicides and probable suicides in Northern Ireland. Of the 502:

Gender - 79% were male;

Age - 50% were 39 years or under, 7% were over 65 years;

Marital Status - 71% were single, divorced/separated or widowed.

There was no information on religion, political opinion, racial group, disability, sexual orientation and persons with dependents and persons without.

5. Assessment of Impact

5.1 The policy aims to promote the mental health and wellbeing of the population generally as well as those at risk. Responses to the consultation on "Minding our Health" identified certain groups at risk – post natal women, young men and women, ethnic minorities, Travellers, people with learning disability and deaf children. They also highlighted the need for appropriate training such as disability awareness and the need for accessible information for ethnic minority groups and disabled people.

5.2 Consideration of the data in paragraph 4 indicates that women, divorced people and Catholics are more likely to have poor mental health, boys are more likely than girls to be bullied and men are more likely to commit suicide than women. Discussions with voluntary

organisations have also highlighted issues around sexual orientation and deafness.

5.3 DHSSPS recognises that all of these groups have particular needs and professionals in the areas of health, social services and education need to be aware of these needs and have the knowledge and skills to deal with them. The Strategy and Action Plan has been developed with this in mind and it is the DHSSPS view that it should not have an adverse impact on any of the groups. It should promote equality of opportunity by ensuring that professionals receive relevant training and skills and are aware of the particular needs of different groups, and that the groups have access to accessible information and services.

6 Monitoring of Impact

6.1 An Implementation Group is to be established to take forward the Strategy and Action Plan. This Group will advise on a research programme and report progress on an annual basis to the Ministerial Group on Public Health. Surveys will be used to monitor progress. In addition the DHSSPS regularly meets voluntary organisations and will use these opportunities to monitor progress and identify any adverse impacts of implementation of the Strategy and Action Plan.

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REFERENCES

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NOTES



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