

THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY  
(NORTHERN IRELAND)

**MENTAL HEALTH IMPROVEMENT  
AND WELL-BEING -  
A PERSONAL, PUBLIC  
& POLITICAL ISSUE**

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# **MENTAL HEALTH IMPROVEMENT AND WELL-BEING – A PERSONAL, PUBLIC AND POLITICAL ISSUE**

## **CONTENTS**

<b>EXECUTIVE SUMMARY</b>	<b>PAGE</b>
<b>1. THE CHALLENGE</b>	<b>i</b>
<b>2. VISION AND PRINCIPLES</b>	<b>i</b>
<b>3. PRIORITIES FOR PROMOTING MENTAL HEALTH IN NORTHERN IRELAND</b>	<b>ii</b>
<b>4. RECOMMENDATIONS</b>	<b>iii</b>
 <b>CHAPTER 1 - INTRODUCTION</b>	
<b>Context</b>	<b>1</b>
<b>The Aims of the Mental Health Promotion Expert Working Committee</b>	<b>1</b>
 <b>CHAPTER 2 – VISION AND PRINCIPLES</b>	
<b>Vision – Mental Health for All</b>	<b>3</b>
<b>Principles</b>	<b>3</b>
 <b>CHAPTER 3 – THE ACTION</b>	
<b>Prevalence of Mental Health Problems</b>	<b>5</b>
<b>Key Domains for Mental Health Promotion</b>	<b>5</b>
<b>Northern Ireland</b>	<b>7</b>
<b>Risk Factors Impacting on Mental Health</b>	<b>8</b>
<b>The Cost of Mental Health Problems</b>	<b>9</b>
<b>The Global Burden</b>	<b>9</b>
<b>Health Not Disorder</b>	<b>10</b>
<b>The Action</b>	<b>10</b>
 <b>CHAPTER 4 – DEFINITIONS AND AIMS OF MENTAL HEALTH PROMOTION</b>	
<b>Aims of Mental Health Promotion</b>	<b>13</b>
<b>Promotion of Mental Health and Well-Being for All</b>	<b>13</b>

<b>Addressing Inequalities: Promoting Inclusion and Equality of Opportunities via Mental Health Promotion</b>	<b>14</b>
<b>Long Term Investment</b>	<b>14</b>
<b>The Prevention of Mental Health Problems for At Risk Groups</b>	<b>15</b>
<b>Mental Health Promotion for People with Mental Health Problems</b>	<b>17</b>
<b>The Benefits of Promoting Mental Health</b>	<b>17</b>
<b>What and Who Works to Promote Mental Health?</b>	<b>18</b>
<b>Evaluation of Success</b>	<b>18</b>
<b>Social Capital and Mental Health</b>	<b>19</b>

## **CHAPTER 5 – IDENTIFICATION OF NEED**

<b>Introduction</b>	<b>21</b>
<b>Promotion of Mental Health and Well-Being for All in the Population at Large:</b>	<b>22</b>
• <b>Home</b>	<b>22</b>
• <b>School</b>	<b>24</b>
• <b>The Workplace</b>	<b>26</b>
• <b>Communities and Neighbourhoods</b>	<b>29</b>
• <b>Further and Higher Education</b>	<b>31</b>
• <b>Primary Care</b>	<b>34</b>
• <b>Rural Areas</b>	<b>36</b>
• <b>Faith Communities</b>	<b>38</b>
• <b>Prisons</b>	<b>40</b>
<b>The Prevention of Mental Health Problems in Key At Risk Groups</b>	<b>40</b>
• <b>Children and Adolescents</b>	<b>41</b>
• <b>People who are Deaf or Hard of Hearing</b>	<b>44</b>
• <b>People with a Learning Disability</b>	<b>46</b>
• <b>Ethnic Minorities</b>	<b>47</b>
• <b>Older People</b>	<b>49</b>
• <b>People Affected by Unemployment</b>	<b>52</b>
• <b>People with a Physical Illness</b>	<b>53</b>
• <b>People with Gender and Sexuality Issues</b>	<b>55</b>
• <b>People Traumatized by Sexual Abuse</b>	<b>56</b>
• <b>People within the Criminal Justice System</b>	<b>56</b>
<b>Improving the Quality of Life for People Who Have Experienced Mental Health Problems</b>	<b>58</b>
• <b>People with Enduring Mental Illness</b>	<b>59</b>
• <b>People with Eating Disorders</b>	<b>62</b>
• <b>People at Risk of Suicide</b>	<b>63</b>
• <b>People Emotionally and Psychologically Traumatized Due to the Northern Ireland “Troubles”</b>	<b>65</b>
• <b>People Involved in Substance Abuse/Dual Diagnosis</b>	<b>67</b>

**CHAPTER 6 – POLICY ISSUES**

<b>The Policy Environment – Introduction</b>	<b>71</b>
<b>National Policies</b>	<b>71</b>
<b>Northern Ireland</b>	<b>71</b>
<b>Response to Promoting Mental Health – Strategy and Action Plan 2003-2008</b>	<b>72</b>
<b>Implementation – Progress to Date</b>	<b>72</b>
<b>National Service Framework for Mental Health – England</b>	<b>74</b>
<b>Mental Health in Scotland – A National Programme Approach</b>	<b>75</b>
<b>International Policy</b>	<b>77</b>
<b>WHO Ministerial Conference on Mental Health</b>	<b>78</b>
<b>Summary</b>	<b>79</b>

**CHAPTER 7 – RECOMMENDATIONS**

<b>Primary Recommendation</b>	<b>81</b>
<b>Key Functions and Responsibilities of the Directorate</b>	<b>82</b>
<b>Recommendation 1: Settings, Stages and Levels for Action</b>	<b>84</b>
<b>Settings for Action</b>	<b>84</b>
<b>Stages of Life</b>	<b>85</b>
<b>Levels of Action</b>	<b>85</b>
<b>Recommendation 2</b>	<b>87</b>
<b>Recommendation 3</b>	<b>87</b>

<b>ANNEXES</b>	<b>1</b>	<b>Mental Health Promotion Expert Working Committee Membership, Acknowledgements &amp; Contributions</b>	<b>89</b>
	<b>2</b>	<b>Suicide and the Review of Mental Health and Learning Disability (NI)</b>	<b>92</b>
	<b>3</b>	<b>Identification of Need – Summary of Key Issues</b>	<b>98</b>
	<b>4</b>	<b>Mental Health Action Plan for Europe – Facing the Challenges, Building Solutions Jan 2005</b>	<b>109</b>
	<b>5</b>	<b>Scottish National Programme for Improving Mental Health and Well-Being</b>	<b>125</b>

<b>REFERENCES</b>	<b>128</b>
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## **FOREWORD**

Mental health is as important as physical health. Mental health promotion, therefore, is not just for those with mental health problems. Mental well-being underpins all health and well-being: it is a resource which must be protected and promoted. For these reasons, the Review established a specific Expert Working Committee on Mental Health Promotion. Like all of the Committees it adopted an evidence-based approach, drawing on existing relevant information and research and examples of best practice, locally, nationally and internationally.

Mental health promotion is also central to achieving the Review's vision and principles for the reform and modernisation of mental health and learning disability services. The subject matter of this Report, therefore, overlaps with and impinges upon most of the Review's other Working Committees, and is an underlying principle of all our reports.

The task for Government is to address these challenges and the recommendations necessary to realise them.

I thank Professor Alan Ferguson and his Committee for their work in producing this Report, which I commend to you.

This is the first report of the Review since the passing of our Chairman, Professor David Bamford. We have lost a true friend and inspirational leader. The Review owes him a great debt and it is our hope that the reports and their subsequent impact on service reform will be a fitting tribute to his life and work. In recognition of David's contribution to our work, the Minister, Shaun Woodward, has agreed to our request that the Review will now be recognised as the Bamford Review of Mental Health and Learning Disability (Northern Ireland).

**Roy J McClelland (Professor)**  
**Chairman**

# **MENTAL HEALTH PROMOTION**

## **Executive Summary**

### **1. THE CHALLENGE**

Mental well-being and improvement is a personal, public and political matter. Mental health promotion is concerned with how individuals, families, organisations and communities think and feel.

Over 19% of the total burden of disease in Western European countries was attributable to mental illness compared with 17% for cardiovascular disease and 16% for cancer. In 2002 no other condition exceeded 8% (World Health Organisation, WHO 2004).

Of the total disease burden in Western Europe, just over half is attributable to non-fatal outcomes of morbidity and disability, of which mental ill health accounts for over 30%. No other health condition accounts for more than 10%. In Northern Ireland we are only spending approximately 9.3% of our Health and Social Services Budget on mental health.

The 2001 Northern Ireland Health and Well-Being Survey found that 21% of our population aged over 16 considers themselves to be depressed and a similar percentage had a potential psychiatric disorder. The Department of Health, Social Services and Public Safety (DHSSPS) estimate that in terms of the scale of the problem, prevalence figures for mental health problems in Northern Ireland are 25% higher than in England.

Addressing these challenges for the whole community in Northern Ireland, as exemplified by the WHO Action Plan for Europe (WHO 2005), is a long-term investment. That investment must reflect the growing body of evidence that positive mental health cannot be gained by treating mental disorders alone.

### **2. VISION AND PRINCIPLES**

The Review has considered how best to promote positive mental health for the whole community and the impact of the Promoting Mental Health - Strategy and Action Plan 2003-08 (DHSSPS 2003). It also considered how best to meet the needs of people at risk of suicide.

The following vision is central to the success of a mental health improvement strategy.

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

- everyone has mental health needs;
- mental well-being underpins all aspects of health and well-being; and
- mental health, like physical health, is a resource to be promoted and protected.

The Vision must be underpinned by the following principles.

To achieve a society where everyone plays a role in and takes action to create an environment that promotes the mental well-being and improvement of individuals, families, organisations and communities, there is a need for:

- increased cross-sectoral, collaborative work among key agencies and central government departments – partnerships between health and social services and education agencies hold particular potential;
- mental health to be promoted in the context of social justice, equality and citizenship;
- socio-economic and environmental factors to be highlighted - deprivation increases risk of mental health problems across the spectrum of disorders, and fragmented environments are risk factors for depression and suicide;
- mental health promotion to take place with the whole community, individuals at risk, vulnerable groups and in key settings - long-term strategies need to look at the bigger picture and see how the different dimensions can be integrated; and
- understanding that poor mental health is not a random misfortune but is strongly associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events.

These values and principles are especially important in Northern Ireland, where social capital has in many communities been greatly diminished by 30 years of conflict. Communities need to grow and develop, enhance their levels of trust and sense of belonging and participation in order to promote emotional well-being.

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

### **3. PRIORITIES FOR PROMOTING MENTAL HEALTH IN NORTHERN IRELAND**

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

- cross-sector partnership and working;
- co-ordination;
- dedicated resources, both additional and with a realignment or reconfiguration of existing resources to facilitate mental health promotion and prevention;
- compliance with equality and human rights legislation;
- capacity building;

- prioritisation of key risk groups; and
- research.

#### **4. RECOMMENDATIONS**

To realise the vision for mental health promotion there is a need for a focused, resourced, centrally driven, cross-sectoral, cross-departmental and prioritised approach.

##### **Primary Recommendation – The Creation of a Regional Mental Health Promotion Directorate at the Heart of Government**

In order to achieve these objectives, the Review is recommending the establishment of a Regional Mental Health Promotion Directorate with a Regional Director.

The Review, having agreed and recommended a Directorate as necessary for providing strategic, co-ordinated, cross-sectoral and multi-agency action on mental health promotion, then considered the appropriate structures and siting to achieve this function.

The Review considered where the centre of gravity should be for this recommendation. Should it be focused within the health sphere or if we are looking to wider contributions, including those of education, culture and employment to produce the change we want, what mechanism and approach is most effective in making those linkages?

The Review considers that it is necessary, in order to achieve this strategic vision, to place the Mental Health Promotion Directorate at the heart of Government. The Review's recommendation is that to ensure mental health promotion is a policy priority across the whole of the public sector the Directorate would best be placed within the Office of the First Minister and Deputy First Minister (OFMDFM).

The assigning of the Directorate to a single Department or Quango should be avoided to ensure that ownership of mental health promotion is not perceived as being the sole responsibility of a single Department, such as Health and Social Services. The assigning of a Directorate for Mental Health Promotion to OFMDFM fits in well with the portfolio of responsibilities already assumed by this Department. These include such issues as equality, children and young people, disability, human rights, as well as the Department's responsibility for promoting co-operation between Government Departments in Northern Ireland.

##### **Key Functions of the Directorate**

A properly resourced Directorate would increase awareness and visibility of mental health promotion, facilitate the achievement of existing mental health promotion targets as well as setting targets for the future. This would provide a necessary degree of permanence, leadership and the sustainability to drive forward mental health promotion in Northern Ireland, whilst creating ownership of mental health promotion across all sectors and relevant agencies and groups.

A Mental Health Promotion Directorate sitting within the heart of Government, would ensure that mental health promotion contributes to the goals and policies across all sectors, supports the delivery of existing policies relevant to mental health promotion, raises the awareness of mental health promotion and moves mental health promotion up the policy agenda in all Government Departments and agencies. The Directorate would be responsible for ensuring that the HSS Authority and the new Education Authority take on the responsibility for operationalising the impact of this policy in these 2 important sectors.

### **Other Recommendations**

The Report recommends that for the initial strategic period the settings, stages and levels of action approach to mental health promotion, as outlined in Chapter 5, would be the firm basis for action. Recommendations to achieve this are set out in Chapter 7.

**Recommendation 1:** Settings, stages and levels for action:

- Settings for Action schools, primary care, workplace, further and higher education, communities, including marginalized groups and faith communities;
- Stages of Life children and adolescents, older people, people in receipt of statutory mental health services;
- Levels of Action regional level/building capacity.

**Recommendation 2:** Deals with the identification of resources and recommends a resource allocation in the region of £5-6 million over the initial 3 year period.

**Recommendation 3:** Suicide prevention is an integral part of mental health promotion and the recommendation is that suicide prevention needs to be placed as a public health priority and a Regional Mental Health Promotion Directorate needs to ensure that a separate suicide prevention strategy is implemented as part of its overall responsibility.



# CHAPTER 1

## INTRODUCTION

### Context

- 1.1 This Report outlines the findings and recommendations of the Mental Health Promotion Expert Working Committee, one of 10 Expert Working Committees established to take forward key aspects of the independent Review commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) of policy, practice and legislation relating to mental health and learning disability.
- 1.2 The fact that a specific expert working committee on mental health promotion has been established as part of the overall Bamford Review of Mental Health and Learning Disability in Northern Ireland has ensured that mental health promotion will be seen as being an important, indeed underpinning dimension of the Review, and will increase the sense of commitment to the promotion of mental health regionally.

### The Aims of the Mental Health Promotion Expert Working Committee

- 1.3 The Terms of Reference for the Committee were to consider how best to promote positive mental health in society, with particular reference to the impact of the Promoting Mental Health Strategy and Action Plan 2003-08 (DHSSPS 2003), and how best to meet the needs of people at risk of suicide.
- 1.4 The Committee did not consider its remit was to draft an alternative strategy to the Strategy and Action Plan 2003-08, however, it did consider it important to comment on its implementation to date, seeking views from key stakeholders. Neither does this document attempt to be a comprehensive account of mental health promotion per se or to map all existing practice in Northern Ireland in this field. Rather, it is intended to offer a vision for the future of mental health promotion in Northern Ireland, providing examples of evidence-based good practice, and most importantly, a recommendation on the key issue of where the responsibility for mental health promotion should lie.
- 1.5 Although the remit of the Committee included the task of exploring the needs of those at risk of suicide, this report does not include a suicide prevention strategy. This has been addressed in a separate Government Report, “Protect Life, A Shared Vision, The Northern Ireland Suicide Prevention Strategy and Action Plan 2006 - 2011”. However, one major recommendation relates to the prevention of suicide (Annex 2 outlines key recommendations on suicide prevention - McGale & McGreevy 2005).
- 1.6 Therefore, the Committee set out to:
  - analyse the current situation in Northern Ireland in terms of mental health promotion, including a commentary on the current strategy;

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

## CHAPTER 2

### VISION AND PRINCIPLES

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

- 2.1 Mental health is a matter of universal concern; the importance of mental health is gaining growing recognition within Northern Ireland, in the UK and across Europe. The World Health Organisation, at the European Ministerial Conference on Mental Health, Helsinki (12-15 January 2005), produced a “Mental Health Action Plan for Europe, Facing the Challenges, Building Solutions”.
- 2.2 This WHO Action Plan (2005) proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries in the World Health Organisation (WHO) European Region, requiring action in 12 areas (for more information Chapter 6 and Annex 4).
- 2.3 We want to see a recognition at all levels in Northern Ireland that everyone has mental health needs; that mental well-being underpins all health and well-being; that mental health, like physical health, is a resource to be protected and promoted. We also want to see a society where everyone plays a role in/takes action to create an environment that promotes the mental health and well-being of individuals, families and communities.

#### **Principles**

- 2.4
  - Mental health underpins all aspects of our health and social well-being and, therefore, should be seen as an integral part of all health and well-being services provision.
  - There is a need for increased cross-sectoral collaborative work with other key agencies and central Government departments - partnerships between health and social services and education agencies hold particular potential.
  - Mental health needs to be promoted in the context of social justice, equality and citizenship.
  - Socio-economic and environmental factors need to be highlighted; deprivation increases risk of mental health problems across the spectrum of disorders, and fragmented environments are risk factors for depression and suicide.
  - Mental health promotion is relevant to all life stages - from birth to old age.
  - Mental health promotion can take place with whole populations, individuals at risk, vulnerable groups and in key settings - long-term strategies need to look at the bigger picture and see how the different dimensions can be integrated.
  - There should be flexibility in terms of the use of language; there may be a need for different terms and language for different audiences.

- The increasing amount of evidence-based research into effective mental health promotion needs to be drawn upon.
- A strategic approach to mental health needs to include action to improve treatment, services and quality of life for people living with enduring mental illness, to tackle stigma and discrimination, and to promote mental health for the whole population.

## CHAPTER 3

### THE ACTION

#### Prevalence of Mental Health Problems

- 3.1 Mental health promotion is a personal, public and political matter. Mental health promotion is concerned with how individuals, families, organisations and communities think and feel. Drawn from a growing body of evidence it is obvious that mental well-being influences, and is influenced by, health and social outcomes across a wide range of domains, including health behaviours, educational achievement, employment, physical health and crime. The need for a cross-sectoral approach to mental health promotion cannot be over emphasised, particularly the fact that it is not solely a matter for the health service.
- 3.2 Essentially the case for mental health promotion and prevention starts from the fact that, whatever the metric, mental illness imposes an enormous burden on society. There are three main reasons:
- **Firstly**, mental health problems have very high rates of prevalence.
  - **Secondly**, the problems are often of long duration, even lifelong in some cases.
  - **Thirdly**, both because of their intrinsic nature and because of additional factors such as stigma and discrimination, mental health problems have extremely widespread repercussions, with adverse impacts on many areas of individuals' lives including education, employment, income, housing, personal relationships and social participation.
- 3.3 Many initiatives on mental health promotion are happening at local level and the hard work and commitment of individuals and groups must be acknowledged, as well as the potential of the current Strategy and Action Plan 03-08. However, a single Department approach has not delivered on a focused outcome. What we still lack is an effective, focused regional structure, properly resourced, sustainable and able to drive forward and build on existing policy. Such a structure is necessary to achieve in effect mental health promotion outcomes in the broader public health arena for all the citizens of Northern Ireland within an acceptable timeframe. It is also necessary to ensure that a much wider range of agencies, sectors and settings play a part in promoting mental health: mental health promotion needs to feature on the agenda for those involved in education, employment and the workplace; housing, criminal justice, culture and the arts; sports and leisure and local Government.

#### Key Domains for Mental Health Promotion

- 3.4 The Review has identified three key domains for the promotion of mental health which inform the approach of this Report and its recommendations.

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

3.6 **The Prevention of Mental Health Problems in Key at Risk Groups** - the Review has identified some key groups as being particularly at risk. These include:

- children and adolescents;
- people who are deaf or hard of hearing;
- people with a learning disability;
- ethnic minorities;
- older people;
- people affected by unemployment;
- people with a physical illness;
- people with gender and sexuality issues;
- people traumatised by sexual abuse; and
- people within the criminal justice system.

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

Groups include:

- people with enduring mental illness;
- people with eating disorders;
- people at risk of suicide;
- people emotionally and physically traumatised due to the NI “Troubles”; and
- people involved in substance abuse/dual diagnosis.

## Northern Ireland

- 3.8 The 2001 Health and Well-Being Survey indicated that 21% of the population aged over 16 in Northern Ireland consider themselves to be depressed and that a similar percentage had a potential psychiatric disorder. Women were one and a half times more likely than men to report having suffered from mental health problems. Such rates are over 20% higher than in England and Scotland. People who said they have been affected a lot by the Troubles were almost twice as likely to show signs of a possible mental health problem (34%) as those who had not been affected much (18%).
- 3.9 The 2002 Health and Lifestyle Survey conducted by the Health Promotion Agency (HPA) found that a quarter of respondents (23% of men and 26% of women) showed signs of a possible mental health problem by scoring highly on a General Health Questionnaire. Those with no qualifications and those on a low weekly household income were more likely to show signs of a possible mental health problem. Depression and anxiety were greatest in the 35-54 and 55-69 year age groups (HPA 2005).
- 3.10 In terms of the scale of the problem, prevalence figures for mental health problems in Northern Ireland are 25% higher than in England (Effectiveness Evaluation: Health and Social Care, DHSSPS 2003, Chapter 7).
- 3.11 The high prevalence of mental ill health is compounded by our particular risk factors, including the effects on mental health of economic and social deprivation, unemployment and recovery from the trauma of the Troubles.
- 3.12 Suicide trends over the last 10 years show a 27% increase in Northern Ireland, (and a similar increase in the Republic<sup>1</sup>) compared to a 9% decrease in the UK overall (<http://www.nisra.gov.uk>).
- 3.13 **Figures from a range of UK studies suggest that:**
- At any one time, one adult in 6 has a mental health problem, commonly anxiety, depression, phobias, obsessive compulsive and panic disorders. Around half of people with common mental health problems are limited by their condition and one fifth are disabled by it (Melzer et al 2004). In the past year, one in 200 adults had a psychotic disorder and one in 25 a personality disorder, (Singleton et al 2001; Meltzer et al 1996). GPs spend one third of their time on mental health issues.
  - 10% of children aged 5 to 15 experience a clinically defined mental health problem and the prevalence of problems has been increasing over the past 50 years. These include anxiety disorders (4%), conduct disorders (5%) and hyperactivity (1%). Autistic disorders, tics and eating disorders were attributed to half a percent of the sampled population. Prevalence of mental health problems is greater among boys than girls: 11% compared with 8%. Rates of depression and anxiety among teenagers have increased by 70% in the past 25 years (Collishaw et al 2004).

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

- Gender has a significant impact on risk and protective factors for mental health. Rates of suicide are four times as high in men as in women (with the exception of young Asian women) and the difference is increasing (Meltzer et al 1996). However, women are at greatly increased risk of depression and anxiety, eating disorders and self-harm (Piccinelli & Wilkinson 2000, Department of Health 2002).
- Among older people, 10-15% of people over 65 have depression and 3-5% severe depression. Poor levels of mental well-being in older people are both a cause and a consequence of social isolation and also impact on health outcomes for chronic diseases (Godfrey & Denby 2004).

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

- 3.14 Northern Ireland faces a particular challenge given its particular legacy of the conflict over the past 30 years.
- 3.15 As the Strategic Framework for Adult Mental Health Services points out in terms of impact of 30 years of civil conflict:
- “In a random sample of 1,000 adults, Cairns et al found 16% to be “direct” victims and 30% “indirect” victims of civil conflict. Perceptions of being a victim were consistently associated with poorer psychological well-being”.*
- 3.16 Whilst socio economic and environmental factors have greatly improved, and paramilitary activity has reduced over the past decade or so, there are still in many sectors of society thinly veiled underlying threats of violence and intimidation.
- 3.17 There is still much work to be done societally, to help improve a sense of social cohesion, trust, safety and sense of participation – all key elements of social capital and emotional well-being.
- 3.18 Both bullying and being bullied are associated with outcomes with a high social and economic cost: criminal behaviour and alcohol abuse (bullies), and depression and suicidal behaviour (victims of bullying). In a school setting, anti-bullying schemes which involve the whole school, parents and the community, eg the Campaign against Bully-Victim Problems, are effective. Follow-up found a 50% reduction in bully/victim problems for boys and girls across all grades with more marked effects after 2 years. There were also significant reductions in anti-social behaviour such as vandalism, fighting, truancy, theft and drunkenness **and significant** long term impacts on criminal behaviour, alcohol abuse, depression and suicidal behaviour (Olweus 1993; 1995).

## **The Cost of Mental Health Problems**

- 3.19 It is difficult to assess the costs of promoting mental health across Northern Ireland's society through all Government departments and agencies, through schools and through workplaces. However, the cost of not promoting mental health is beginning to be quantified (Mental Health Foundation 2005). The total cost of mental illness in Northern Ireland (2002-03) was £2,852 million (Counting the Cost NIAMH, Sainsbury 2003).
- 3.20 In both England and Northern Ireland the aggregate costs of mental illness are more than the total amount of public spending on health and social care for all health conditions combined. For example, the estimate of £2.8 billion for the costs of mental illness in Northern Ireland compares with a total HPSS budget in 2002/03 of £2.4 billion. In another comparison (available for England only), it was found that the costs of mental illness appear to be greater than the total costs of crime.
- 3.21 The share of (HPSS) budget spent on mental health in England is 11.8% compared to 9.3% in Northern Ireland (NI Department of Finance and Personnel 2002 Executive Budget and Public Expenditure Plans).
- 3.22 To match the English share, spending on mental health in Northern Ireland needs to increase by 26% or £60 million (Counting the Cost NIAMH, Sainsbury 2003).
- 3.23 It is worthy of note that the share of mental illness in total NHS spending is significantly lower than its share of the overall burden of disease as measured by the WHO and very much lower than its share of total morbidity and disability.

## **The Global Burden**

- 3.24 WHO work on the global burden of disease using a composite non-monetary measure, the Disability-Adjusted Life Year (DALY), to combine morbidity and premature mortality in a single figure. Estimates for Western European countries, including the UK, show that mental illness now accounts for more DALYs lost per year than any other health condition. Thus the figures for 2002 indicate that 19.3% of the total burden of disease was attributable to mental illness (including suicide), compared with 17.1% for cardiovascular disease and 16.5% for cancer. No other condition exceeded 8% (WHO 2002 statistics [www.who.int/healthinfo/statistics/gbdwhosubregionaldaly2002.xls](http://www.who.int/healthinfo/statistics/gbdwhosubregionaldaly2002.xls)).
- 3.25 WHO work also includes an analysis of the overall burden of disease by major risk factor. This shows, for example, that in the Western European countries as a group 12.2% of total DALYs lost per year are associated with smoking, 6.7% with alcohol misuse, 6.4% with raised cholesterol and 5.4% with obesity and overweight. According to these figures, the costs of mental illness are thus greater than those of smoking and drinking combined.
- 3.26 Of the total disease burden in Western Europe, just under half is attributable to premature mortality, and just over half to non-fatal outcomes of morbidity and disability.

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

### **Health Not Disorder**

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

## **THE ACTION**

### **An Education Example**

- 3.30 Although there is a pressing need for robust studies of cost/benefits of specific interventions, there is sufficient evidence to support the case for greater investment in mental health promotion. The clear relationship between poor mental health in children; for example anxiety, depression and behavioural problems, and poor school outcomes, poor physical health, self harm and risk taking behaviour means that even small improvements in mental health contribute to improved physical health, productivity and quality of life (Mental Health Foundation 2005; Meltzer et al 2000; Department for Education and Skills 2001).
- 3.31 A number of studies are beginning to calculate the economic cost of failing to address early signs of emotional problems in childhood. Scott et al found that the cumulative costs of public services used through to adulthood by individuals with ‘troubled behaviour’ were 10 times higher than for those with no problems. Conduct disorder was the most significant predictor, with greatest costs incurred for crime, followed by extra educational provision, foster and residential care, and state benefits (Scott et al 2001). One pilot study of children aged 4-8 referred with conduct disorder, found that the mean extra cost was £15,282 a year (range £5,411-£40,896). Of this, 31% was borne by families, 31% by education services, 16% by the National Health Service, 15% by state benefit agencies, 6% by social services, and less than 1% by the voluntary sector (Scott et al 2001).
- 3.32 The cumulative cost of childhood conduct disorder for each 1-year cohort in the UK is a minimum of £1.9 billion and in all likelihood several times higher. According to the same study on which this figure is based, the cost of a typical parenting programme is around £600 per child. For every cohort of 600,000 children, a population-wide programme would

therefore cost £360 million. Is it worth introducing such a programme? This depends on its effectiveness, but one can easily work out that the programme needs to reduce the prevalence of conduct disorder by at most around 20% (and almost certainly only a fraction of this if the full costs of conduct disorder were properly measured) to be a justifiable use of resources (Scott et al).

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



## CHAPTER 4

### DEFINITIONS AND AIMS OF MENTAL HEALTH PROMOTION

- 4.1 There is a wide range of definitions of mental health. No single definition is likely to be appropriate for all sectors and settings. For the purposes of this Report, with its particular emphasis on the importance of social inclusion and citizenship, we have found the following useful:

*“Mental health is the capacity to live life to the full in ways that enable us to realise our natural potentialities, and that unite us with, rather than divide us from all other human beings who make up our world.”* (Guntrip, 1964) and *“Public mental health; the art, science and politics of creating a mentally healthy society.”* (Friedli 2004).

#### Aims of Mental Health Promotion

- 4.2 Mental health promotion aims to:
- **Promote mental health and well-being for all**, eg. supporting parents, health promoting schools, workplace, policies.
  - **Prevent mental health problems for** at risk groups through increasing protective factors (eg. social support, job control, benefit uptake, employment, and reducing risk factors, eg. racism, violence, bullying, debt, isolation).
  - **Promote mental health for people with mental health problems**, eg. reducing discrimination and social exclusion, providing opportunities for meaningful occupation.

#### Promotion of Mental Health and Well-Being for All

- 4.3 Mental health is an issue for all of us. The WHO Action Plan (2005) has as its first action area to “promote mental well-being for all” and states:

*“Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.”*

## **Addressing Inequalities: Promoting Inclusion and Equality of Opportunities via Mental Health Promotion**

- 4.4 Mental health problems are both a cause and a consequence of deprivation and inequalities (Pilgrim & Rogers 2003). Poor mental health is not a random misfortune, but is strongly associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events, for example, racial discrimination, bereavement, violence, bullying and abuse (Fryers et al 2003; Melzer et al 2004). Other risk factors include a family history of psychiatric disorder, childhood neglect and family breakdown. Bereavement, financial strain and long-term caring are risk factors across the life cycle, and especially in later life (Milne et al 2001; Godfrey and Denby 2004).
- 4.5 Stigma and discrimination have been identified as the greatest barrier to social inclusion, quality of life and recovery for people with mental health problems (Social Exclusion Unit 2004). Stigma may also inhibit people from seeking help and contributes to the isolation experienced by many people with mental health problems, their families and carers. Key issues include public attitudes, negative and distorted media coverage, and lack of access to mainstream opportunities eg education and leisure.
- 4.6 As Williams points out, much stigma and prejudice is based on fear and a wish from a sense of insecurity, to banish differences and retain a sense of “them” and “us” (Williams 2004).
- 4.7 Recent years have seen a greater focus on tackling stigma and discrimination across the UK, both nationally and locally. In Scotland, the National Programme on Improving Mental Health and Well-being includes a major campaign to challenge stigma; ‘See Me’ (<http://www.seemescotland.org/>). The results of the second national Scottish Attitudes Survey are encouraging (Scottish Executive 2004) and point to the high visibility and impact of “See Me” and some positive shifts in attitudes towards those with mental health problems since the last survey two years ago.
- 4.8 In England, the National Institute for Mental Health (England) (NIMHE) has launched “From here to equality”, a 5 year anti-stigma and discrimination programme (NIMHE 2004), responding to the Social Exclusion Unit’s report on mental health which found that over 80% of respondents in the research identified stigma as the biggest barrier affecting people with mental health problems.

### **Long Term Investment**

- 4.9 Long term investment must be predictable and sustainable.
- 4.10 In addressing the challenge, the WHO Action Plan (2005) cites certain actions as beneficial, such as the adoption of mental health as a long term investment, with education and information programmes having a long timeframe.

- 4.11 Greater awareness and understanding of mental health issues, together with policies that support mental well-being, for example, in schools and the workplace, can play a significant role in improving day to day experience of people with mental health problems in Northern Ireland.
- 4.12 Mentally healthy environments such as schools and the workplace can have a very beneficial impact on people's psychological and emotional well-being. Chapter 5 of this Report includes a range of examples, including The Health Promoting School and University/College tackling workplace stress and promoting mental health in communities and neighbourhoods.

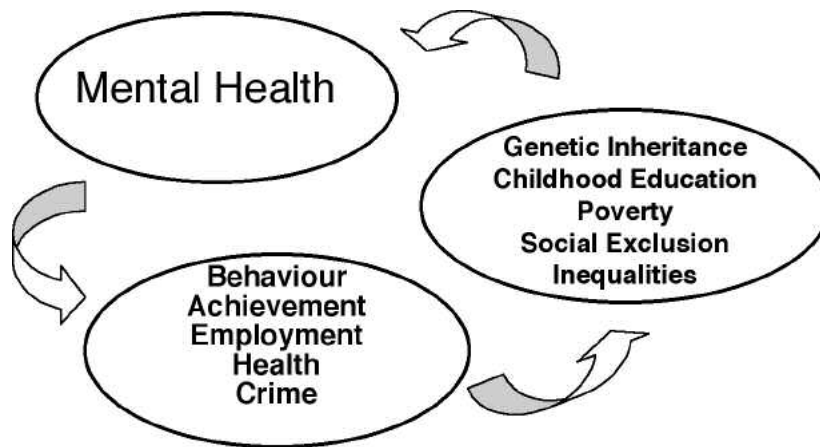
### **The Prevention of Mental Health Problems for At Risk Groups**

- 4.13 In the 2002 Health and Lifestyle Survey, respondents identified experiencing less stress as the factor most likely to improve their health, indicating the high significance that the general population in Northern Ireland attaches to mental well-being (HPA 2005).
- 4.14 The determinants of both positive mental well-being and mental health problems are complex and include a mix of biological, psychological, social and environmental factors (Table 1). However, the relative contribution of key risk factors such as material deprivation, genetic inheritance, family relationships and adverse life events is difficult to determine. It has also proved difficult to identify the precise causal pathways through which different factors, eg. poverty; family conflict; experience of bullying; misuse of substances, or violence impact on mental health outcomes. Identifying which protective or resilience factors, and at which level (ie. individual, family, community, structural) are of greatest importance in minimising the impact of risk factors is equally challenging.<sup>2</sup> Some examples of interventions designed to reduce risk factors and increase protective factors are outlined in Chapter 5 of this Report.

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<sup>2</sup> The most up to date source of evidence on risk and protective factors and effective interventions to promote mental health is the National Electronic Library for Health (Mental Health Promotion)  
<http://www.nelh.nhs.uk/nsf/mentalhealth/whatworks/intro/risk.htm>

**Table 1: Risk Pathways**



- 4.15 There is also growing and increasingly robust evidence for an association between a range of lifestyle behaviours and mental health status and outcomes. These include physical activity, diet, alcohol consumption and the use of cannabis and other psychotropic substances. Certain emotional and cognitive skills and attributes are also associated with positive mental well-being, including feeling satisfied, optimistic, hopeful, confident, understood, relaxed, enthusiastic, interested in other people and in control (Stewart Brown 2002).
- 4.16 There is also evidence of an increased risk of experiencing common mental health problems such as depression and anxiety amongst people who experience cumulative life stressors, notably material deprivation, family conflict, unemployment and physical disorders (Melzer et al 2004). Other adverse life events which increase risk include workplace stress, bereavement and bullying. People in lower social classes are at increased risk of exposure to such cumulative stressors and also have higher prevalence of common mental health problems – representing the familiar pathways of inequalities in health (Pilgrim & Rogers 2003; Melzer et al 2004).
- 4.17 The mental health of children is of particular importance because of the strong correlation between emotional problems in childhood and poor mental health and social functioning in later life (Kim-Cohen et al 2003; Meltzer & Gatwald et al 2000). Mental health problems experienced by children and young people ripple out and affect many aspects of the child’s life, family and community life, educational achievement and physical health. Timely interventions, including parenting support and effective mental health promotion can reduce the incidence of serious health and social problems in later life (Mental Health Foundation 2005). While there is a clear need to improve child and adolescent mental health services and to strengthen mechanisms for the early identification of emotional problems in childhood, all children have mental health needs and will benefit from a greater focus on emotional well-being in families, schools and the wider community.

## **Mental Health Promotion for People with Mental Health Problems**

- 4.18 Even those individuals with severe and enduring mental health problems can achieve a good quality of life and feel mentally healthy for much of the time - the illness does not necessarily make this impossible. Mental health promotion can contribute to the reduction of discrimination and social exclusion, helping people to find meaningful occupation, and increase access to mainstream opportunities, all of which can help to improve self esteem, confidence, social networks and overall sense of well-being and quality of life, as well as recovery.
- 4.19 Mental health promotion is relevant to those with, and those without, a diagnosis, and the many people who move between periods of mental health and mental illness.

## **The Benefits of Promoting Mental Health**

- 4.20 Mental health promotion aims to improve mental health. Improved mental health will also contribute to improved outcomes for other public health priorities in Northern Ireland, notably coronary heart disease, as well as chronic diseases like diabetes, where there is a strong association between levels of mental well-being and outcome. Poor mental health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse and poor diet. Stress epidemiology demonstrates the link between feelings of despair, anger, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. Both depression and low job control are independent risk factors for coronary heart disease (Brunner & Marmot 1999; Stansfeld et al 2000).
- 4.21 Mental health promotion therefore has a number of benefits. It can:
- improve physical health;
  - increase emotional resilience, enabling people to enjoy life and to survive;
  - difficulties and distress;
  - enhance citizenship, giving people the skills and confidence to adopt meaningful and effective roles in society;
  - improve health at work, increasing productivity and reducing sickness absence;
  - help to reduce either the incidence or the severity of mental health problems;
  - assist recovery from mental health problems;
  - improve quality of life for people with mental health problems; and
  - increase the mental health literacy of individuals, organisations and communities (adapted from Department of Health 2001).

4.22 There is also a moral argument that the promotion of mental health is worthwhile in itself, and that it is a basic community responsibility to foster mental as well as physical well-being.

### **What and Who Works to Promote Mental Health?**

4.23 Many of the factors that influence mental health lie outside the remit of health and social care. Effective mental health promotion depends on expertise, resources and partnership, across all sectors and disciplines.

4.24 Mental health promotion is also relevant to the implementation of a wide range of policy initiatives, including social inclusion, neighbourhood renewal, community strategies, and health at work.

4.25 Some factors related to improved mental health include:

- **Feelings:** confident, understood, respected, empowered, safe;
- **Skills:** life skills, parenting, relaxation, help seeking, keeping fit, accessing information, problem solving;
- **Meaningful Activity:** employment, volunteering, education, leisure, creativity, spiritual growth;
- **Social Support:** self-help groups, opportunities for friendship, faith communities, home visits;
- **Access to Resources:** paid work, adequate welfare benefits, appropriate services; and
- **Influence:** opportunities to participate, being consulted, shared decision making, advocacy, complaints procedures (Friedli, 2004).

### **Evaluation of Success**

4.26 There is a growing body of outcome indicators to draw upon from research, many of which in fact reflect a number of the resilience factors. Friedli has itemised these under the following headings:

Individuals	Social Capital	Quality of Life
<ul style="list-style-type: none"> <li>• Agency</li> <li>• Capacity to learn, grow and develop</li> <li>• Feeling loved, trusted, understood, valued</li> <li>• Interest in life</li> <li>• Autonomy</li> <li>• Self acceptance and self-esteem</li> <li>• Optimism and hopefulness</li> <li>• Resilience</li> </ul>	<ul style="list-style-type: none"> <li>• Feeling safe</li> <li>• Trusting unfamiliar others</li> <li>• Participation</li> <li>• Influencing local decisions</li> <li>• Believing the local neighbourhood is improving</li> <li>• Access to local support</li> <li>• Social inclusion</li> <li>• Employment and meaningful activity</li> <li>• Support for parents</li> </ul>	<ul style="list-style-type: none"> <li>• Equity</li> <li>• Control</li> <li>• Involvement</li> <li>• Safety</li> <li>• Lifelong learning</li> <li>• Cultural assets</li> <li>• Environment</li> <li>• Access to services</li> <li>• Inclusion</li> </ul>

4.27 The growing evidence base in mental health promotion provides examples of the range of ways in which effectiveness of interventions can be measured.

4.28 The above checklists are useful and reflect new thinking in the field of positive psychology - there is a new legitimacy to the study of human strengths arising out of the principles of prevention and promotion. Increasingly there is a sense of a need to see individual experience, not simply as good or bad, ill or well, happy or unhappy, but to understand something of the subtle complex dialectic taking place in all of us at any given time and how that indeed *'strength is often fired in the crucible of adversity'* (Ryff C.D. & Burton, 2003).

### Social Capital and Mental Health

4.29 If one looks more closely at the social capital indicators the political dimensions to mental health become more apparent.

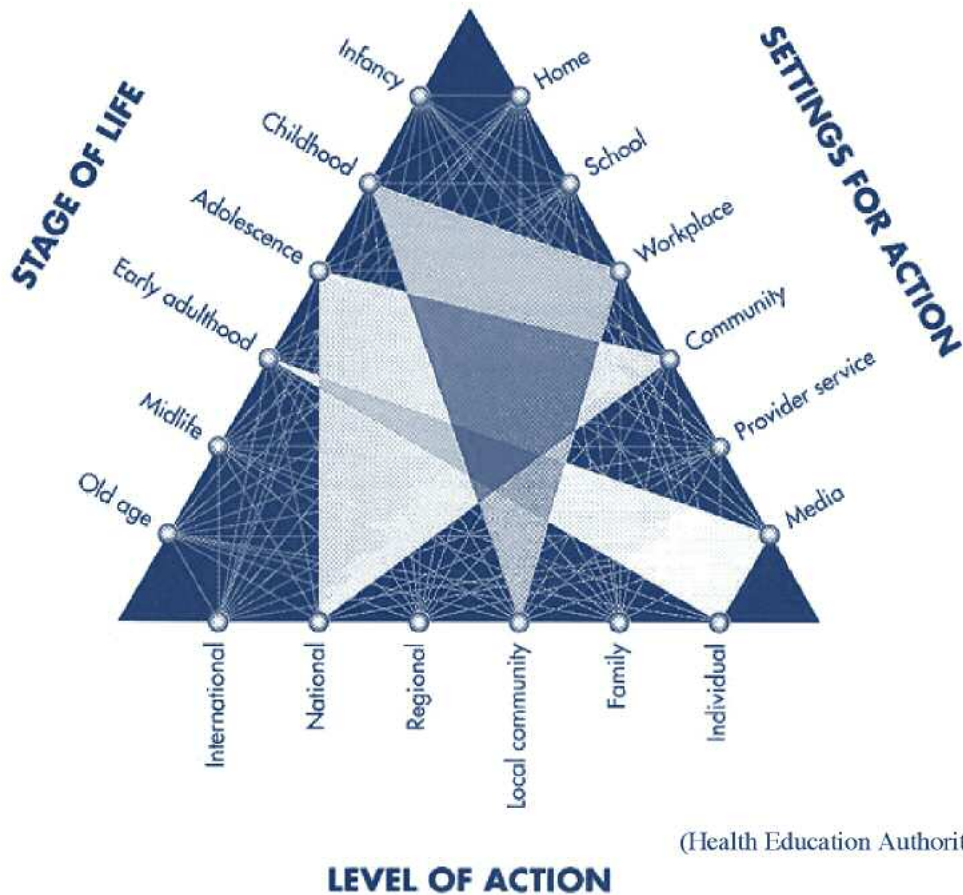
*“On the one hand, millions of dollars are committed to alleviating ill-health through individual intervention. Meanwhile we ignore what our everyday experience tells us, ie. the way we organise our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is probably the most important determinant of our health”* (Lomas 1998 p. 1181).

4.30 In the renaissance of thinking in recent decades about social collectivity and health promotion, the concept of “social capital” has been prominent. It is invoked to reframe previously individualised lines of research on the social determinants of health generally and mental health in particular. Extending beyond the tools and training that enhance individual productivity (“physical capital” and “human capital”), social capital “refers to features of social organisation such as networks, norms, and social trust that facilitate co-

ordination and co-operation for mutual benefit” (Putnam 1995). Economic and social environments also affect social capital.

- 4.31 Social capital is not an individual perception or resource. Potential detriments include exclusion of non-members and minority groups, and excessive demand on members of social organisations. A consensus is growing, however, that social capital facilitates collective action and can promote social and economic growth and development by complementing other forms of capital.
- 4.32 Research over the last two decades has demonstrated links between social capital and economic development, the effectiveness of human service systems, and community development. Social scientists have investigated how higher social capital may protect individuals from social isolation, create social safety, lower crime levels, improve schooling and education, enhance community life, and improve work outcomes (Woolcock 1998). Researchers have begun to analyse the relationships between social capital and mental health (Kawachi & Berkman 2001; McKenzie, Whitley & Weich 2002; Sartorius 2003). (WHO, 2004).

## CHAPTER 5 IDENTIFICATION OF NEED



### Introduction

- 5.1 In this chapter we approach the identification of need by looking at **firstly** the promotion of mental health and well-being for everyone in the population at large and identifying the settings in which this can take place.
- 5.2 **Secondly**, we have identified some of the key at risk groups within the population and have addressed the prevention of mental health problems within these groups and protective factors which could be employed.
- 5.3 **Thirdly**, we have considered those who have experienced mental health problems and ways in which their quality of life could be improved.
- 5.4 The Review is aware that there is a pool of good practice in Northern Ireland. The local examples provided in this Report have been randomly selected. However, we have recommended that one of the priorities of a proposed established Regional Directorate of Mental Health Promotion should be a comprehensive “mapping” exercise.

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

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

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

5.6 Settings include:

- Home;
- School;
- Workplace;
- Communities and Neighbourhoods;
- Further and Higher Education;
- Primary Care;
- Rural Areas;
- Faith Communities; and
- Prisons.

## **HOME**

### **The Case for Action**

#### **Children and Families**

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

5.8 Factors which promote resilience in children under 5 help those children to do well in spite of adversity (Mental Health Foundation 1999).

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

## What Works?

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

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

## Northern Ireland Example

### Lifestart Foundation

5.11 Lifestart ([www.lifestartfoundation.org](http://www.lifestartfoundation.org)) which has offices in Northern Ireland and the Republic of Ireland, is a home based educational programme for parents of children aged from birth to 5 years. Its aim is to enable parents to make informed, relevant decisions about the upbringing of their children.

## Key Issues to be Addressed

- 5.12
- Factors which promote resilience in children under five help those children to do well despite adversity, therefore early intervention is vital. Evidence shows, for example, that Promoting Parenting Skills Programmes improve the mental health of both parents and children. This is an area which should be further encouraged.

- Action 18 of the Strategy and Action Plan 03-08 relates to parenting skills and links with the ongoing work being undertaken to implement the teenage pregnancy and parenthood strategy and action plan.
- According to the Implementation Group's (Strategy and Action Plan 03-08) Draft Annual Report, all HSS Boards are undertaking some action, for example the delivery of skills training to Surestart staff on building self esteem and handling child behaviour.

## SCHOOL

### The Case for Action

- 5.13 It is recognised in the literature that schools can have a vital role to play in protecting the health of young people. Resnick et al (1997) have identified an association with academic failure and lost school days with anti-social behaviour and emotional problems.
- 5.14 Pryce and Twyble et al (2004) in their paper "Mental Health Promotion Among Young People" state that: "*Schools have a significant influence on the behaviour, attitudes and development of young people*".
- 5.15 The Department for Education and Skills in England in their guidelines "Promoting Children: Mental Health Initiatives Early Years and School Settings" emphasises the importance of schools in the promotion of mental health of children.
- 5.16 The Council for the Curriculum Examinations and Assessment (CCEA) have highlighted issues relating to bullying.
- 5.17 The regional strategy document "Promoting Mental Health – Strategy and Action Plan 2003-08" identifies specific actions relating to the promotion of young people's mental health. Action 9 within the document refers specifically to pupils' mental health. It states "*Department of Education in partnership with DHSSPS, HPA, schools and the voluntary and community sectors will develop a regional education resource for the promotion of pupils' mental health and emotional well-being including anti-bullying approaches for use in school*". Target date: March 2004.

### What Works?

- 5.18 Characteristics of the health promoting school include features such as shared decision making and planning; community participation; a supportive physical and social environment; good school – community relations; clearly articulated health policies, and access to appropriate health services.

### **The Resourceful Adolescent Programme (RAP) - Australia**

- 5.19 This programme was developed to meet the need for a universal depression preventative programme for teenagers that could readily be implemented in a school setting.
- 5.20 A universal programme targets all teenagers in a particular grade as opposed to those at higher risk of depression. It is easier to recruit and engage adolescents in a universal approach if they do not face the risk of stigmatisation by being singled out for intervention.
- 5.21 An 11-session programme has been designed to be implemented in the classroom as part of the curriculum. The programme aims to build resilience to depression in pre-teenagers and younger adolescents and has been shown to be effective in reducing rates of depression (Dadds et al, 1997).

### **The Health Promoting School**

- 5.22 Action has been taken by the HPA to take an initiative forward – that of the Health Promoting School. This initiative, proven to be effective at an international level, offers a vehicle for change in Northern Ireland, but there are issues, such as lack of long term funding and the fact that only 10% of schools have been targeted in Northern Ireland.
- 5.23 An Office for Standards in Education (Ofsted) Report, in July 2005, refers to the vital role of schools in providing for pupils with mental health needs and the current barriers to this. They refer to the need for whole-school approaches to promoting good mental health.
- 5.24 In a survey of schools in Great Britain carried out by Ofsted in 2004 (published July 2005, HMI) it was stated that:  
  
*“The best schools promoted emotional health and well-being by valuing and respecting every individual. In the schools visited, those which introduced a value system that embraced all children identified fewer children with mental health problems. These schools promoted many and varied opportunities for pupils to share their thoughts and feelings. They used the curriculum to develop pupils’ listening skills and an understanding of other people’s points of view: this culture permeated school life.”*
- 5.25 The CCEA recommend that anti-bullying schemes, in particular those which involve the whole school, parents and community need to be higher on the agenda. These can be effective in dealing with the issue.
- 5.26 In Northern Ireland, the impact and effectiveness of the initiative is still to be reported on.

## Key Issues to be Addressed

- 5.27 • **School Interventions** - it is recognised that schools can have a vital role to play in protecting the health of young people. Interventions such as the RAP in Australia and the Health Promoting Schools initiatives have been proven to be effective in promoting children's mental health. Proper resources and cross-sectoral working are needed to implement a province-wide schools strategy. Whilst the current work being carried out in Northern Ireland on the Health Promoting School Initiative is valuable and points for the potential for the future, there are important issues which need to be addressed such as:
- **Funding** - a significant source of long-term funding needs to be identified and committed to such projects.
  - **Cross-Sectoral Issues** - funding currently comes via the DHSSPS - with no involvement of the Department of Education. For an educational issue such as this, there needs to be a commitment by both the Department of Education and the DHSSPS for it to be successful.
  - **Curricular Issues** - there should be a proper curricular approach, with the "Health Promoting School" initiative dovetailing into other existing curricular programmes such as personal development.
  - **Training** - teacher training needs to be reviewed, with teachers at the point of entry into teacher training, receiving proper training on mental health.

## THE WORKPLACE

### The Case for Action

- 5.28 The workplace is an important environment for the individual. Work can be a source of stimulation, satisfaction and support, leading to an increased sense of well-being and reduced incidence of stress related sickness absence (Sainsbury Centre for Mental Health 2000; Stansfeld et al 2000).
- 5.29 Yet a negative working environment can lead to a range of problems such as: sickness absence; stress-related problems; labour turnover; bullying and harassment; poor interpersonal relations, and ineffective working.
- 5.30 A company with 1,000 employees can expect between 200-300 people to experience depression or anxiety in any year (The Industrial Society 2003). The loss of sickness absence attributable to mental health problems was estimated to be £4 billion in the UK in 2001 (Counting the Cost NIAMH, Sainsbury 2003).

## **The Dynamics of Work Stress**

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

## **The Legislative Imperative**

- 5.33 Employers are under a general duty to take responsibility to ensure the health and safety of employees whilst at work. The law states that mental health should be viewed in the same light as physical health.
- 5.34 There are a number of health and safety regulations that are of relevance, in particular:
- Health & Safety at Work (Northern Ireland) Order 1978;
  - Management of Health & Safety at Work Regulations 1992;
  - Health & Safety (Consultation with employees) Regulations 1992;
  - Employment Rights Act 1996;
  - Working Time Regulations 1998;
  - Safety Representation & Safety Committee Regulations 1977;
  - Disability Discrimination Act 1995; and
  - Human Rights Act 1998.

## **What Works?**

- 5.35 The Health and Safety Executive issued a Workplace Health Strategy, (Action 10, Strategy and Action Plan 03-08) which aims to promote mental health in the workplace with specific reference to work related stress.
- 5.36 Some actions which have been shown to be effective include the following examples:

- **Culture of Openness to Mental Health Issues** - studies have shown that facilitating an environment that generates positive attitudes to mental well-being can help reduce stigma for those experiencing problems.
- **Support at Work** - emotional support can be very powerful. It is a particularly protective factor against high job demands (HSE 2001).
- **Job Control and Decision Making Aptitude** - having control over work reduces the risk of sickness absence (Stansfeld et al 2000). Individuals need to have some influence over decisions made at work at different levels.
- **Mental Health in the Workplace Policy** - having a strong, comprehensive Mental Health in the Workplace Policy outlining the responsibilities of both the individual and organisation, is a key factor.
- **Employee Assistance Programmes (EAPs)** - which provide individual support and counselling, but also address organisational issues via the implementation of stress/organisational audits, risk assessment for mental health and mental health policies, have been shown to be effective in enhancing employees' health and well-being (HEA, 1998).

### **Key Issues to be Addressed**

- 5.37 Employers have a duty under health and safety legislation to take measures to protect the health of their employees at work.
- 5.38 A negative working environment can lead to a range of problems such as: sickness absence, labour turnover, bullying and harassment and ineffective working. What helps is to promote a healthy culture, with good quality of relationships, communication and support to staff.
- Policies should approach the topic in a comprehensive way, from recruitment and training, right through to actual support for vulnerable staff and guidance on handling issues such as staff sickness and absenteeism. Training for managers in implementing such a policy is recommended.
  - All employers, as a minimum, should have in place a Mental Health in the Workplace Policy which seeks to address, even as a staged process over a period of time, issues relating to prevention of negative factors where possible, and support to those who may be in a stressful environment, or going through a difficult period.

## COMMUNITIES AND NEIGHBOURHOODS

### The Case for Action

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

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

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

5.41 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.

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

5.43 Various actions with the Strategy and Action Plan 03-08, refer to community development:

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

*Action 11 - refers specifically to the support of “the development of a rural support network”.*

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

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

## What Works?

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

- equitable access to resources and services;
- support for parents and carers;
- activities that bring members of the community together;
- effective sharing of local information;
- tolerance and trust;
- friendly physical environment;
- dealing effectively with crime and anti-social behaviour; and
- robust local democracy and opportunities to participate.

Mentality 2003 (Adapted from Department of Health 2001)

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

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

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

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

## **Key Issues to be Addressed**

- 5.50
- Interventions designed to increase social inclusion such as social prescribing should be encouraged as part of community development.
  - Actions in the Investing for Health 2002 need to be progressed and assessed.
  - Research programmes addressing the needs of marginalized groups need to be resourced, with a view to mainstreaming.
  - Training for relevant community and professional agencies on mental health awareness and ways to reduce stigma should be provided.
  - The benefits of interventions such as arts on prescription for increasing social inclusion and strengthening communities should be explored especially in particularly disadvantaged areas.
  - As the CTC Programme appears to have proved to have successful outcomes, not only in the USA, but elsewhere in Europe and the UK, this approach should be considered in Northern Ireland, especially with its particular needs and often fragmented social networks and lack of cohesion.

## **FURTHER AND HIGHER EDUCATION**

### **The Case for Action**

- 5.51 There are a number of dimensions to the relationship between learning and mental health. On one level Hammond, in a review of literature, found robust evidence for positive associations between years of education and health, especially relating to depression. Outcomes included improved self-esteem, self efficacy and improved trust.
- 5.52 The wider benefits of learning include:
- positive associations between education and both physical and mental health;
  - learning builds self-esteem, feelings of being in control of one's life, and resilience to stress;
  - education that is accessible and makes sense to all members of society will reduce inequalities, challenge prejudices and empower people to keep on learning (Hammond, C (2002) Learning to be Healthy, London Institute for Education).
- 5.53 Facilitating access to further and higher education opportunities for those who are vulnerable is an important issue in itself and not without its difficulties. Also the further and higher education environment can be a pressured experience even for those not vulnerable due to mental health needs.

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

- Universities UK (previously CVCP – Committee for Vice Chancellors and Principals), Guidelines on Student Mental Health Policies and Procedures for Higher Education, (June 2000);
- Universities UK, Reducing the Risk of Student Suicide: Issues and Responses for Higher Education Institutions (2002); and
- Royal College of Psychiatrists (RCP), The Mental Health of Students in Higher Education, (January 2003).

### **Good Practice Example (1)**

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

5.56 The aims are:

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

### **Good Practice Example (2)**

5.57 **Learning Diversity** – accommodation in Colleges and Universities for Students with Mental Illness.

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

5.59 Support services include:

- an academic coach or “buddy”;
- increased outreach counselling services;
- assistance with early problems identified;
- peer support groups, emotional support;
- increased training of faculty on mental health issues; and

- support in disclosing the disability to an instructor/professor.

(Canadian Mental Health Association 1993)

### **Further and Higher Education – Northern Ireland**

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

5.61 However, two of Northern Ireland’s Universities have strategies for the improvement of students’ mental health in place:

- The University of Ulster’s work through its Mental Health Task Force; and
- Queen’s University Belfast (QUB) – Mental Health Strategy whose aims are outlined below.

5.62 QUB’s Mental Health Strategy is a comprehensive document, which has five key aims:

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

### **Key Issues to be Addressed**

- 5.63
- There are positive associations between education and both physical and mental health. Facilitating access to further and higher education opportunities for those who are psychologically vulnerable is an important issue in itself. In addition it is important for students, especially young adults, to feel supported in a pressured and transitional time in their lives.
  - The Health Promoting University/College is an initiative which has been implemented in England. Its approach could be assessed for its usefulness in the Northern Ireland context.

## PRIMARY CARE

### The Case for Action

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

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

- 5.65 Primary care has a crucial role to play in supporting people with long term mental health problems. Primary care also has a role in early identification and treatment of common mental health problems; notably anxiety, depression and phobias, as well as a wider role in promoting mental health and well-being, along with the promotion of physical health.
- 5.66 The majority of mental health problems are managed within primary care, where a huge percentage of problems presented are psycho-social. On average, GPs spend 30% of their time on mental health problems. Of all mental health conditions, anxiety and depression take up most of GP's time (Foy 2004).
- 5.67 Chapter 3 of the Strategic Framework for Adult Mental Health Services Report states that:
- “There is increasing evidence that investment in primary care actually produces better healthcare outcomes in both primary and secondary sectors. There are fewer inequalities in health when primary care systems are well developed”* (Starfield, B 2001).
- 5.68 In their briefing paper “Radical Mentalities - Making it Effective - A guide to evidence based mental health promotion” (Mentality 2003), (Friedli 2004) describes new models of primary care offering opportunities to develop services at the interface between primary care and the social population; to reach out to socially excluded groups including refugees, homeless people and those with substance misuse problems, and to address inequalities.

## What Works?

### Promoting Exercise

- 5.69 The National Consensus Statements on physical activity and mental health (Grant (ed.) 2000) show that exercise prevents clinical depression and is as effective in treatment as other psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self esteem.
- 5.70 Encouraging an active lifestyle also helps reduce isolation and the promotion of social networks.

### Social Prescribing

- 5.71 Social prescribing is a vehicle for offering patients in primary care alternative opportunities for support within the local community. Examples of social prescribing include exercise on prescription, prescription for learning and arts on prescription. Quite widely used for those with mild to moderate mental health problems, positive outcomes can include enhanced self esteem, reduced low mood, opportunities for social contact, increased self efficacy, transferable skills and greater confidence (Huxley 1997: Fox 2000).

## Key Issues to be Addressed

### Professionals

- 5.72
- **Training for GPs** - approximately 50% of GPs have no formal psychiatric training and few practice nurses have had such training (Croft 2000 in Foy 2004). As most GPs have opted to go into physical medicine, they may have very little experience of mental ill health. There is a need for better training for GPs.
  - **Research** - increased research into the effectiveness of mental health promotion at primary care level is needed.
  - **Resources, Targets and Priorities** - with the contracting system, there is the opportunity to target resources for mental health promotion. GPs are particularly well placed due to working within an overall health promotion setting, where potentially mental health promotion can be dovetailed with general health promotion initiatives.
  - **Role of Voluntary Agencies** - there should be an increased use of services provided by voluntary agencies and increased direct liaison into primary care priorities.

## Public

- 5.73
- **Support Available/Information Services** - primary care environments could be better used as an information resource, perhaps with access to a practice library with self-help literature.
  - **Self-Help** - increased promotion of the ethos of empowerment for those who are vulnerable due to mental health problems would potentially speed recovery.
  - **Users' Role in Promoting Mental Health at Primary Care Level** - there are opportunities for mental health service user groups in helping to improve mental health issues within primary care (Foy 2004).

## Social Prescribing

- 5.74
- Social prescribing including exercise, learning and arts on prescription, as an adjunct or alternative to medication have been proved to be effective elsewhere in the UK and internationally.
  - There is a need for this approach to be further employed in Northern Ireland.

## RURAL AREAS

### The Case for Action

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

*“People living in rural areas may experience particular problems including: social isolation, unemployment, poor housing, lack of public transport and public amenities. In addition, recent years have brought a succession of crises affecting farming which have increased financial stress and led to further job losses”.* (Strategy and Action Plan 03-08).

- 5.76 Action II of the Strategy states:

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

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

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

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

### **What Works?**

#### **The Rural Health Partnership (Homefirst Community Trust, Northern Health and Social Services Board)**

5.79 This Partnership aims to deliver a programme of support that aids the reintegration of people who have suffered from mental ill health, back into the home and community life. The programme, which includes training, health promotion and information, has a particular focus on young men, carers and children living with mental illness in farming communities.

### **Key Issues to be Addressed**

- 5.80
- As rural areas have been identified as being particularly prone to risk factors such as isolation, and specific problems related to the farming community, and are particularly at risk of suicide, a province-wide strategy is required to help raise awareness of issues involved and to help people identify where to get support.
  - Stigma has been identified as a major barrier in people seeking help - therefore, a strategy to address issues relating to stigma, especially young men in rural areas should be outlined.
  - The actions relating to rural areas in the Strategy and Action Plan 03-08 need to be progressed.

## FAITH COMMUNITIES

### The Case for Action

- 5.81 Those with enduring serious mental illness may experience their lives as a process of fragmentation and disintegration. Recovery and well-being needs, therefore, to focus on the restoration of a sense of wholeness. Holistic care needs, therefore, due to the link between mind, spirit and soul, to include care for spiritual needs.
- 5.82 Spirituality can be defined as “a core set of beliefs and experiences about our relationship to the universe and our place in it” (Clay 1999).
- 5.83 People experiencing mental health problems seek understanding and meaning. In an age when organised religion is less well supported, it seems even more important to acknowledge this dimension of experience, where people non affiliated to particular faith communities still seek succour and hope.
- 5.84 Religion and spirituality have proven protective effects for mental well-being, eg.:
- people with spiritual or religious affiliation are up to 40% less likely to become depressed than people who do not have such affiliation, and if they do get depressed, they recover faster;
  - depression affects up to 35% of people with a serious health problem or illness. One study that used multi-dimensional measures showed that for every 10 point increase in the intrinsic religion score, there was a 70% increase in the speed of remission from depression; and
  - religious/spiritual commitment correlates with lower levels of substance abuse. The risk of alcohol dependency is 60% greater when there is no religious affiliation (Powell, 2000).
- 5.85 In 1999, the RCP set up a special interest group - Spirituality and Psychiatry. Its aim is to provide a forum for psychiatrists to explore the influence of the major religions which shape the cultural values of the psychiatrist and patient both.
- 5.86 A growing number of studies emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Mental Health Foundation 2000). Yet there is a need for some caution in being sensitive to cultural mores – other studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness. If a person fears that mentioning their spirituality may be interpreted as a further symptom of their illness, it will block the proven benefits of an holistic therapeutic approach (Friedli. 2000: Clay 1999).

## **What Works?**

- 5.87 **Spiritual Assessment** - (Swinton, 2001), describes a number of models of “spiritual assessment” involving a dialogue.
- 5.88 Powell (2000) from the special interest group lists some learning outcomes for training of psychiatrists in spirituality including an understanding of:
- spiritual crises, meditation, prayer and altered states of consciousness, including near death experiences;
  - the spiritual significance of anxiety, doubt, guilt and shame;
  - the spiritual significance of love, altruism and forgiveness and their relation to mental health;
  - the influence of materialistic goals on personal identity and self-esteem;
  - the reciprocal relationship between culture and spiritual/religious beliefs and practices and the consequences for psychiatric practice;
  - how to take a spiritual history from a patient;
  - how the presence or absence of spiritual/religious beliefs and practices in mental health care workers may influence decision making; and
  - the role in clinical management of spiritual/religious support networks, including chaplaining and pastoral care as well as those in the community.

## **Key Issues to be Addressed**

- 5.89
- An accepting and non judgmental attitude needs to be promoted - those in a caring role need not always “do” anything except listen and afford the individual dignity and respect.
  - Training in mental health would be beneficial for those being ordained in all denominations.
  - Information/workshops should be provided for those in the community who may benefit from pastoral care, and may not be affiliated to any particular faiths.
  - The wider dissemination of the work of the Special Interest Group On Spirituality within the RCP may benefit practitioners not currently involved.

## **PRISONS**

### **The Case for Action**

5.90 The Review's Forensic Services Expert Working Committee highlights the issues relating to the prison environment and mental health. It is a major challenge to provide effective healthcare within a prison environment. Many prisoners have emotional difficulties and may have been subjected during their earlier lives to trauma and neglect. In adult years they may have difficulty coping, have impaired relationships and poor integration into society arising from underlying personality difficulties or disorders. Alcohol or other substance misuse, self-harm and frequent previous contact with mental health and learning disability services are common.

### **What Works?**

5.91 Issues being considered by the Forensic Services Expert Working Committee include the following:

- creation of a prison environment that actually promotes health; and
- provision of a range of mental health and learning disability services.

### **Key Issues to be Addressed**

5.92 • It is a major challenge to provide effective mental health care within a prison environment.

## **THE PREVENTION OF MENTAL HEALTH PROBLEMS IN KEY AT RISK GROUPS**

### **Aim: To prevent mental health problems through increasing protective factors**

5.93 The Review felt it important to identify those particularly at risk in terms of their mental health. Some of these groups, such as young men at risk of suicide, have been also highlighted in the Strategy and Action Plan 03-08.

5.94 There are other key groups which have their own special needs, such as those with Autistic Spectrum Disorder (ASD), which has been the subject of detailed consultation as part of a wider review.

5.95 The main aim of interventions with at risk groups is to increase protective factors (eg. social support, job control, benefit uptake) and reduce risk factors (eg. racism, violence, bullying, isolation, etc).

5.96 Some of the key groups identified as at risk:

- children and adolescents;
- people who are deaf or hard of hearing;
- people with learning disability;
- ethnic minorities;
- older people;
- people who are affected by unemployment;
- people with a physical illness;
- people with gender and sexuality issues;
- people traumatised by sexual abuse; and
- people within the criminal justice system.

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

## **CHILDREN AND ADOLESCENTS**

### **The Case for Action**

- 5.98
- Around the globe, up to 20% of children and adolescents suffer from a mental illness, with 3-4% requiring treatment. Suicide worldwide is the third leading cause of death in adolescents (WHO, 2003).
  - Research indicates mental health problems such as sleep disorders, stress, anxiety and behavioural problems affect 1 in 5 adolescents (HPA 2000).
- 5.99 Risk factors which may compromise mental health amongst young people include:
- lack of bonding and appropriate attachments;
  - family or community conflict or tension;
  - feelings of isolation;

- lack of self esteem;
- negative peer pressure;
- poverty and poor physical environment; and
- difficult life events (Strategy and Action Plan 2003-08).

### **What Works?**

- 5.100 **Pre-School and Psychological Interventions** - there is strong evidence that early interventions starting at age two that promote basic reading skills and engage children in conversations with their parents about picture books, improve reading skills and facilitate the transition to school (Valdez-Menchaca & Whitehurst 1992).
- 5.101 Within the Review there is an Expert Working Committee on Child and Adolescent Mental Health, which will report in detail on issues relating to children and young people.
- 5.102 **Mental health literacy and help-seeking at onset of disorder** - given the high prevalence of mental health problems in young people, the fact that the 12-26 year age range represents the peak period for onset of mental disorders across the lifespan (Moon, Meyer & Grau, 1999; Patton, 1996), and evidence that early detection and treatment of depression and psychosis improves outcomes (Kupfer, Frank & Perel, 1989), population-based, indicated prevention and early intervention strategies may provide valuable opportunities to minimise the considerable burden of these disorders.

### **Young People in Community Settings**

- 5.103 The school setting has been discussed earlier in the Report in terms of its role in promoting young people's mental health. There are also opportunities to promote the mental health of young people outside the school setting and to work with networks of young people in the community. This is particularly important as children grow older and often spend more time with their friends than with their family (Morrow 2002). Peer group pressure is particularly significant in early adolescence (Heaven 1994).
- 5.104 Social skills training - eg. coaching and cognitive problem solving is particularly effective with isolated children (Erwin 1994).

### **Good Practice Example**

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

## Key Issues to be Addressed

5.106 In terms of mental health promotion, early intervention and the development of emotional resilience have been identified as crucial in helping young people cope with pressures through adolescence into early adulthood.

- There is a range of potential interventions, school, home and community based which can be effective in this regard. Social skills training, eg. involving coaching and cognitive problem solving approaches is particularly effective with isolated children.
- The education and health sectors need to collaborate further on programmes with children and young people.
- Peer education and support can be a relatively cost effective approach, with considerable positive impact.

5.107 The Expert Working Committee on Child and Adolescent Mental Health will report in detail on issues relating to this target group in their report. Members of this Committee discussed with the Mental Health Promotion Expert Working Committee some of the main issues they seek to address in their report which include:

- child and mental adolescent health needs to be society's agenda - not just a healthcare issue solely;
- the education and health sectors need to work together;
- early attachment and infant mental health is important in later life;
- there should be quick and appropriate referral procedures in the event of first onset psychosis;
- there are significant gaps in child and adolescent services;
- "Looked After" children is an issue itself;
- access to support is important to young people - there is potential in peer education approaches;
- there is a regional strategy; - "Bright Future" but not enough emphasis on children;
- there needs to be ministerial commitment to drive any such strategy forward; and
- other international and national models can be useful to draw upon, eg. New Zealand's Diversity Model and the Scottish "Pathway" approach.

## **PEOPLE WHO ARE DEAF OR HARD OF HEARING**

### **The Case for Action**

- 5.108 There are almost 9 million deaf or hard of hearing people in the UK (Royal National Institute for the Deaf 2005). It is estimated that up to 40% of deaf or hard of hearing people experience a mental health problem at some point in their lives. Yet most deaf people seeking access to mental health care have to overcome considerable barriers to access services that meet their needs (NIMHE/DH, 2005).
- 5.109 Many of those barriers are caused by lack of information and knowledge about deafness and its implications when assessing and treating mental health problems (NIMHE/DH (2005) Mental Health and Deafness Towards Equity and Access: London).
- 5.110 The degree of hearing impairment is not directly related to the likelihood or severity of mental health problems. Deafness can lead to a greater sense of identity within the deaf community.
- 5.111 Deaf people benefit from deaf-aware service provisions, when staff are welcoming, have effective communication skills, understand when to provide sign language interpreters or other language professionals to support communicants and know how to work with them.

### **People with Acquired Deafness**

#### **The Case for Action**

- 5.112 Deafened people are in a totally different situation from those with pre-lingual deafness, who to a great extent are a recognisable community with their own language (signing) and culture. They are also clearly distinguishable from the vast majority of people with a hearing loss - those who develop a mild to moderate loss (usually in later life) who can often obtain much benefit from hearing aids.
- 5.113 The needs of deafened adults are rarely given attention despite the fact that for every deaf person using sign language, there will be at least three deafened people. These individuals have a much higher incidence of reactive depression than either the general population, or the deaf community and will encounter barriers when attempting to use resources for mental health needs because of the communication difficulties.
- 5.114 There is little literature on the psychological effects of acquired profound deafness. Most research focuses on the effects of mild or moderate hearing loss or the experience of those who are born deaf (Wood, 1987).

## **What Works?**

### **Good Practice Example**

#### **The LINK Centre for Deafened People, Eastbourne, East Sussex**

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

### **Peer Education**

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

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

### **Key Issues to be Addressed**

- 5.118 • One good practice example, from which Northern Ireland could learn, is that of the peer education process model adapted by the LINK Centre in Eastbourne.
- There is a need for research into this area in the UK generally and Northern Ireland in particular.
  - Programmes to increase understanding and awareness of the issues relating to various types of deafness need to be implemented.

(Refer to A Strategic Framework for Adult Mental Health Services – June 2005 section on Services for Deaf People with Mental Health Problems).

## PEOPLE WITH A LEARNING DISABILITY

### The Case for Action

- 5.119 People with a learning disability can experience the same range of mental health problems in virtually all categories of psychiatric disorders. It is estimated that 20-50% of those with a learning disability may have a mental health problem (Bouras 2003).
- 5.120 It is important to implement active mental health promotion strategies for people with a learning disability and their families. A proactive preventative approach would be characterised by promotion of positive mental health from childhood onwards; a multi-agency partnership between health, social care and education; targeted support at times of change; social networks; dedicated access to services and improved awareness of mental health issues for people working in all services providing for people with a learning disability.

### What Works?

- 5.121 A mental health promotion approach, helping to build resilience and other protective factors is recommended. In his paper Mental Health Promotion for People with a Learning Disability, Devine lists 15 recommendations for action. He emphasises promoting positive health from childhood; the need for a multi-sectoral partnership between all relevant agencies; responsibility to enhance well-being and build resilience as a central component of any school curriculum; support at transitional times; enhancing social networks; improved access to services and awareness in staff with learning disability of mental health issues (Devine, 2004).
- 5.122 “Count Us In” - the Report of the Committee of Inquiry (1998) into meeting the mental health needs of young people with a learning disability is an excellent source of information and examples of good practice in this field.
- 5.123 Outlined below are 2 evidence based examples taken from the document:

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

**Community Involvement Project, Larkhall near Glasgow** - the Project was set up in 1999 to provide training for employment to adults who have a learning disability. It took 5 years and 386 meetings to get agreement to set up.

- 5.124 Forty six people with a learning disability use the Project. All start part-time and 23 students are on site at any one time. The students receive a varied programme of laundry, kitchen and catering activities and develop confidence, which results in them undertaking

customer service tasks in the tearoom. They are also involved in undertaking Scottish Vocational Qualifications in a range of activities. Six students have so far gained employment, but there are issues of benefits versus income (Count Us In, 1998).

### **Key Issues to be Addressed**

5.125 The Learning Disability Expert Working Committee has reported in detail on these issues. (Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland, September 2005)

5.126 Devine (2004) outlines 15 recommendations for action. These include:

- the need for mental health promotion for people who have a learning disability to be made more specific in mainstream strategies and policies;
- emphasis should be given within all relevant sectors to building positive mental health;
- a responsibility to enhance emotional well-being and build resilience should be a central component of any school curriculum; and
- there needs to be a recognition that people with a learning disability need to have improved opportunities for meaningful work/vocational opportunities.

## **ETHNIC MINORITIES**

### **Culture and Mental Health**

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

### **The Case for Action**

5.128 The Strategy and Action Plan 03-08 takes into account to some extent the needs of ethnic minorities. There are 2 actions (16 and 17) which refer to the DHSSPS, HSS Boards and Education and Library Boards charging them with the task of:

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

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

5.130 The report highlights Northern Ireland’s particular cultural environment due to the Troubles in Northern Ireland:

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

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

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

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

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

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

## **What Works?**

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

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

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

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

### **Key Issues to be Addressed**

- 5.138 • There is a need for greater public education and awareness about ethnic minorities in Northern Ireland.
- There is a need to further explore issues relating to the mental health of these groups.
  - Research into identification of need would help to begin to address how to reduce barriers and increase social inclusion for the increasing number of ethnic groups in Northern Ireland.

## **OLDER PEOPLE**

### **The Case for Action**

- 5.139 The elderly represent an important group within the population. The number of older people within the UK has increased from 1900 when there were 1.7 million people over the age of 65, to 1994 where there were over 8.8 million in this age group (Jenkins & Paykel 1994).
- 5.140 This increase is projected to continue – by the middle of the 21<sup>st</sup> century there will be in excess of 12 million older people in the UK. The prevalence of mental health disorders is relatively high in later life. About one third of all admissions to psychiatric care involve people over the age of 65, as do one third of referrals to community oriented mental health services.
- 5.141 The Strategy and Action Plan 03-08 outlines some factors potentially negatively affecting older people's mental health such as adjustment problems to socio economic difficulties associated with retirement, isolation and decline in social activity; bereavement and loss, mobility problems, and less support due to smaller families.
- 5.142 With an increasing elderly population, this is a group whose needs (often quite complex) must be addressed. The Review's Expert Working Committee on Dementia and Mental Health Issues of Older People will be reporting on this.
- 5.143 Action 19 - seeks HSS Boards and Trusts to develop programmes in collaboration with voluntary and community sectors around at improving coping strategies, particularly around time of bereavement.

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

## **Depression**

5.145 Depression is the most common psychiatric disorder of late life affecting 15% of the 65 year age group. Unresolved depression is associated with reduced life expectancy and death.

## **What Works?**

5.146 Prevention of physical ill-health and programmes to prepare people for the inevitable changes in later life, such as retirement, loss and bereavement, should in theory reduce the incidence of depressive mood and other affective changes. Many programmes which have been identified as being effective in promoting mental health in the general population should also be available to older people; notably exercise, social support, and arts for creativity.

5.147 Pre-retirement programmes have been seen to be of value. In brief, below are some examples:

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

## **Dementia**

5.148 Dementia is the second most common psychiatric disorder among the elderly. It is a syndrome characterised by an acquired impaired imperative memory and other cognitive functions, changes of personality and a progressive erosion of social skills. The most common causes of dementia are senile dementia of the Alzheimer's type, and vascular dementia.

## **Prevention of Dementia**

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

## **Ageing Mentally Healthy**

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

## **Exercise Interventions**

5.151 Recent cross-sectional studies and controlled trials have suggested that exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits in elder populations (eg. Fox 2000). These benefits include greater life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure.

## **Enhancing Social Support**

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

## **Key Issues to be Addressed**

- 5.153 • The prevalence of mental health disorders, such as depression, is relatively high in later life. Programmes such as pre-retirement, the provision of telephone support and prevention of suicide in later life should be implemented within the community.
- Community development programmes should be developed to enhance levels of social support for older people.
  - Exercise on prescription through primary care should be encouraged.

## PEOPLE AFFECTED BY UNEMPLOYMENT

### The Case for Action

- 5.154 There is a higher level of unemployment and associated deprivation in Northern Ireland than in the rest of the UK (Strategy and Action Plan 03-08). The proportion of long-term unemployed males 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% (Strategy and Action Plan 03-08).
- 5.155 Unemployment and deprivation are risk factors for mental health. People with mental health needs often experience difficulty in gaining employment despite the fact that disability discrimination legislation forbids exclusion solely on the grounds of evidence of a mental illness.
- 5.156 PSI is an element of the New Target Social Need Policy which focuses on a sense of priority issues to be tackled to improve and enhance the life and circumstances of the most deprived and marginalized people in society.
- 5.157 There is not, however, a specific action within the Strategy and Action Plan 03-08 which addresses the issue of unemployment, despite acknowledgement in the document that, eg. 60% of suicides in Northern Ireland were those who were either unemployed, or on long term sick.

### What Works

- 5.158 **Job Clubs** – a number of intervention programmes have been developed and tested for effectiveness in helping unemployed workers return to paid employment, such as the Job Club and the JOBS Programme (see review by Price & Kompier, 2005). These low-complexity and low-cost programmes combine basic instruction on job search skills with enhancing motivation, skills in coping with setbacks, and social support among job seekers. The JOBS programme has been tested and replicated in large-scale randomised trials in the USA (Caplan et al 1989) and Finland (Vuori et al 2002). It has been shown to have positive effects on rates of re-employment, the quality and pay of jobs obtained and increases in job search self-efficacy and mastery and to reduce depression and distress.
- 5.159 In Northern Ireland, there are a number of Occupation Therapy (OT) led Job Clinics which are run locally in partnership with employers (eg. Foyle Trust).

## **Employment Support and Placement Services**

- 5.160 **New Horizons Employment Service - Action Mental Health** - it provides a specialist placement and support service for individuals recovering from mental ill health in a variety of work, education and training settings.
- 5.161 **The Employment Service** - operates from 12 locations throughout Northern Ireland. The Service provides its expertise to the ACCEPT Centres and works in partnership with 21 Job Clinics.
- 5.162 **The Mental Health Promotion Awareness Unit** - in South London and Maudsley NHS Trust works especially to address the problems that people have in accessing services and employment in the community as a result of their mental health problems. The Unit offers mental health awareness training to key local agencies, involving service users in its delivery. The aim is to reduce the stigma linked to mental health problems (Mentality 2002).

## **Key Issues to be Addressed**

- 5.163 • Given Northern Ireland's higher levels of deprivation and unemployment, any regional strategy should directly address these issues with suggestions for strategic cross-sectoral action.
- It is essential for employers to have more education and awareness of mental health issues to ensure there is no discrimination against individuals seeking employment who have a background of mental illness.
  - Any Northern Ireland strategy on prevention of suicide should include specific reference to dealing with unemployment (eg. it has been calculated that if there were full employment in the UK, the suicide rate would drop by 11%) (Lewis, Hawton & Jones 1997).
  - Interventions with a strong focus on job search, self-efficacy, social and emotional coping skills and building social support should be encouraged.

## **PEOPLE WITH A PHYSICAL ILLNESS**

### **The Case for Action**

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

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

**Cancer** - there can often be uncertainty and distress associated with the diagnosis and treatment of the illness. There is likely to be significant impact on the family, occupational and social environments. The illness and its treatment may cause fatigue, worry and mood change.

**Cardiovascular Distress** - there is a circular relationship between heart disease and depression. The presence of each increases the risk of the other. A rational health promotion strategy should take account of both physical and mental health needs in seeking to support lifestyle changes, both before and after the diagnosis of heart disease.

5.165 Primary care has many demands on its resources, however, it seems particularly important for primary health care practitioners to be fully aware of the mind-body link (Foy 2004).

### **Key Issues to be Addressed**

5.166 Mental health and physical health are deeply interdependent. For the integration of mental health into general health care to be successful policy makers and practitioners both need to be fully aware of the mind-body link. This is of particular importance at primary care level. Training is recommended for GPs and other professionals in mental health awareness.

5.167 For the integration of mental health into general health care to be successful, policy-makers need to consider the following:

- general health staff must have the knowledge, skills and motivation to treat and manage people living with mental disorders;
- there needs to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels;
- basic psychotropic drugs must be available at primary and secondary care levels;
- mental health specialists are required to provide support to monitor general healthcare personnel;
- effective referral links between primary, secondary and tertiary levels of care need to be in place;
- investment in primary and community care can deliver better outcomes both in primary and secondary care; and

- recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities (WHO 2001 World Health Report).

## **PEOPLE WITH GENDER AND SEXUALITY ISSUES**

### **The Case for Action**

- 5.168 There is considerable evidence of discrimination and bullying of gay people. In Northern Ireland the problem has been identified through two studies (Birkett & Foyle Friend School Survey and White & McCracken 1999). There is much work to be done in helping the whole community understand issues of sexual identity and orientation.
- 5.169 The Strategic Framework for Adult Mental Health Services also outlines some of the needs of this group (Sect. 6.55, P126).
- 5.170 Research commissioned by the Department of Education in 2001 indicates that between 2% and 10% of the population in Northern Ireland may be lesbian, gay or bisexual.
- 5.171 One study points to the level of homophobic bullying of both lesbian, gay and bisexual young people at school.
- 75% of gay men experienced homophobic bullying at school. (Birkett, S & Foyle Friend School Survey “The Experience of Lesbian, Gay & Bisexual People at School in the North West of Ireland”).
- 5.172 Another source quoted in the Strategy and Action Plan 03-08 also highlights bullying as an issue:
- 52% of gay men had been bullied at school;
  - 64% of gay men who were bullied at school considered committing suicide;
  - 25% of gay men had been sexually assaulted and only 27% of these had received subsequent counselling; and
  - 48% of those who had been sexually assaulted had considered committing suicide. (White, R G, McCracken and the Rainbow Project – How Hard Can it Be? – Attempted Suicide of Gay Men – the Psychological Stressors and Associated Risk Factors, Rainbow Project 1999).

### **Key Issues to be Addressed**

- 5.173 • The psychological and emotional distress of young gay men appears to be reasonably well documented. A gap in identified need seems to be that of young lesbian women’s emotional and psychological needs.

- Given that questions over sexual identity can arise in adolescence and early 20's, awareness amongst staff in school and further/higher education of these individuals' particular needs seems vital.
- Public education and awareness of gender issues to promote understanding and tolerance of them is required.
- Youthnet recommend as a result of their research, that lesbian, gay and bisexual training awareness training programs to all those involved in the development, and implementation of services to gay people should be delivered.

## **PEOPLE TRAUMATISED BY SEXUAL ABUSE**

### **The Case for Action**

- 5.174 Sexual abuse isolates and significantly destabilises lives. Victims are substantially more likely to have mental health problems (Search 1989). 18% of psychiatric patients have been sexually abused girls/women who report sexual abuse are at a substantially increased risk of alcohol and substance abuse disorders (Hefferman et al 2000).
- 5.175 At least 60% of clients attending the Nexus Institute in 2005 were being treated for depression and anxiety. Others present with eating disorders, alcohol and substance abuse and some have quite serious mental problems.

### **Key Issues to be Addressed**

- 5.176
- The importance of sex education in schools needs to be highlighted.
  - Sexual abuse should be talked about more openly, especially as many forms of abuse are linked to mental health problems.
  - As sexual crimes are seriously under reported, training should be given to key relevant professionals in helping to identify hidden issues such as abuse and managing the disclosure of the same.

## **PEOPLE WITHIN THE CRIMINAL JUSTICE SYSTEM**

### **The Case for Action**

- 5.177 A number of reports have recently highlighted issues within the criminal justice system in Northern Ireland. These include: the Human Rights Commission Report into conditions for women prisoners; the subsequent report by the Chief Inspector of Prisons and, more recently, Professor McClelland's Inquiry (A Review of Non-natural Death in Northern Ireland Prison Service Establishments: June 02 - March 04) into the deaths of 6 prisoners.

## **Prevention of Offending and Re-Offending**

- 5.178 • Two thirds of men in prison are diagnosed with a personality disorder and two fifths show symptoms of at least one neurotic disorder such as depression, anxiety and phobias. Among the general population less than a fifth of men are affected by these disorders.
- Men in prison have a high rate of severe mental health problems such as schizophrenia or delusional disorders – nearly 10% compared to less than 1% of the general population.
  - One in five men in prison are on prescribed medication such as antidepressants or antipsychotic medicine and there is evidence that use of medication increases whilst in custody.
  - One in five male prisoners have attempted suicide at some stage in their life and the same number have previously been admitted for inpatient psychiatric care (MIND, 2004). Ref. MIND & Prison Reform Trust Conference, May 2004; “Troubled Inside” – Responses to the Mental Health Needs of Men in Prison.
  - Women’s mental health needs also need to be addressed, particularly because women in prison are nearly always the primary carer and often single parents (Prison Reform Trust 2004 – “Young Parents from Custody to Community”).
  - The Forensic Services Expert Working Committee will outline in detail the issues with recommendations for actions.

## **What Works?**

- 5.179 Cognitive behavioural programmes, real life skills and generic problem solving skills are effective in reducing or preventing youth violence. Individual analytical therapy, psychiatric and intensive counselling are deemed less effective or not effective.

## **Key Issues to be Addressed**

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

- focusing on early intervention;
- research needs to be conducted into the mental health needs of women within the criminal justice system;
- encouraging the courts to use alternatives to custody for men with mental health problems who have committed minor offences;

- increase the number of court diversion schemes available across the country so that offenders who are acutely, ie. not at risk of suicide, can be given hospital places or the treatment they need;
- ensuring the Prison Service meets NHS Standards, policies and protocols, particularly regarding the use of medication, service user initiatives, training for doctors and health care staff; and
- continuing to explore in Northern Ireland, the Restorative Justice Model which has also been proven to be effective as an alternative to long-term imprisonment.

## **IMPROVING THE QUALITY OF LIFE FOR PEOPLE WHO HAVE EXPERIENCED MENTAL HEALTH PROBLEMS**

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

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

### **Quality of Life Approach**

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

5.183 Those identified include:

- people with enduring mental illness;
- people with eating disorders;
- people at risk of suicide;
- people emotionally and physically traumatised due to the Troubles; and
- people involved in substance abuse/dual diagnosis.

5.184 It is beyond the remit of this Review and this Report to address all the above in a totally comprehensive fashion. The Review, however, has attempted to highlight important current issues, identify some examples of evidence based good practice, and highlight some practical, locally sensitive key issues to be addressed which include, where appropriate, reference to the existing Strategy and Action Plan 03-08.

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

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

## **PEOPLE WITH ENDURING MENTAL ILLNESS**

### **The Case for Action**

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

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

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

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

## What Works?

- 5.190 **School-Based Programmes** - universal protective factors among populations has been found to reduce depressive symptomatology. Examples include school-based programmes targeting cognitive, problem-solving and social skills of children and adolescents and exercise programmes for elderly people.
- 5.191 Some of these programmes such as the RAP in Australia found reductions in high depressive symptom levels of 50% or more one year after the intervention (Schochet et al 2001).
- 5.192 **Parenting Skills** - parenting interventions for parents of children with conduct problems aimed at improving parental psychological well-being by information provisions and by training in behavioural childrearing strategies have shown reduction in parental depressive symptoms of about 30% with improvements in children's outcome.

## What Works?

- 5.193 **Specific Mental Health Disorders** - as there is a necessity to be selective for the purposes of this Report we have chosen to explore the issues for the 2 potentially psychotic disorders affective disorders, whether unipolar or bipolar, and schizophrenia.
- 5.194 **Schizophrenia - Early Intervention** - it seems that early drug treatment of schizophrenic episodes may improve the prognosis. Indications are that a delay in initiating of treatment leads to poorer long term outcomes; that persistence of symptoms untreated by neuroleptic drugs leads to abnormality which cannot be completely reversed by subsequent treatment.
- 5.195 **Affective Disorders - Education for Primary Care Professionals** - affective disorders are essentially a community problem: only one per 1,000 of the population are admitted to hospital annually in England because of severe illness (Bebbington 1978).
- 5.196 However, approximately 3% are seen annually by GPs with recognised depression with about an equal number unrecognised and a community 6 month prevalence of 3-5% (Smith & Weissman 1992).
- 5.197 In Sweden, Rorsman et al (1990) described a programme that improved detection and management of depression. Evidence from England (Gask et al 2000) suggests that an educational package aimed at improving the interviewing skills of primary care physicians produces similar results.

## Opportunities for Employment

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

## What Works?

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

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

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

5.202 **Sheltered Housing** - a range of agencies in Northern Ireland, both statutory and voluntary, provide sheltered accommodation in the community for those with enduring mental health needs. The ethos may vary from organisation to organisation, but most seek to empower the individual and promote maximum independence within a supported setting. Helping to increase individuals' social networks and opportunities for involvement in the local community are core factors.

## The Key Issues to be Addressed

5.203 The Strategic Framework for Adult Mental Health Services has recommended a strategic framework for the provision of services in this area. However, in terms of mental health promotion, there is now a body of evidence to show that this can contribute to the prevention of certain disorders, such as anxiety, depression and substance abuse. It can also contribute to the health improvement of people whether they are at risk of mental illness as well as for those with mental health problems.

- An educational programme in Sweden improved the detection and management of depression. Evidence in England suggests that an educational package aimed at improving the interviewing skills of primary care physicians produced the same results.

5.204 It is suggested that this training could be applied here in a primary care setting, with all primary care professionals.

## **PEOPLE WITH EATING DISORDERS**

### **The Case for Action**

- 5.205 • In Northern Ireland, approximately 50-120 people develop anorexia nervosa per year, and 170 develop bulimia nervosa. As not all sufferers seek treatment, it is often difficult to assess the full scale of the problem, however, it is estimated that approximately 340-1,700 have suffered from anorexia, with 1,700 suffering from bulimia.
- Around 100 people are admitted to hospital each year in Northern Ireland with an eating disorder.
  - About 50% of patients with anorexia recover, 30% make a partial recovery and 20% remain anorexic. Bulimia shows a recovery rate of 2 out of 3 over a 5 year period. Treatment is most effective when provided early (DHSSPS 2002).
  - The DHSSPS 2002 Consultation paper on Eating Disorders states that a paper by the RCP recently described services here as “woefully inadequate”.

### **What Works?**

#### **Examples of Good Practice in the Prevention of Eating Disorders**

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

#### **Eating Disorders in an Educational Setting**

##### **The Eating Disorders Project, Gloucestershire**

5.207 Attempts to prevent the development of eating disorders within schools have been shown to be ineffective (Fairburn 1995). However, recent studies have shown that a multi-dimensional approach has better outcomes. In some studies preventive effects have been found for eating related attitudes, interpretation or acceptance of societal ideals of appearance, feelings of ineffectiveness, body dissatisfaction and dietary behaviour.

## Body Image

- 5.208 The Everybody's Different Programme in Australia which focused on improving self-esteem was effective in reducing body dissatisfaction in young people and altering weight control behaviour in girls (O'Dea & Abraham 1999).
- 5.209 This programme showed that even 12 months after the programme participants showed improved body satisfaction, more positive self-esteem, social acceptance, and low drive for thinness.

## The Key Issues to be Addressed

- 5.210
- Examples of good practice in terms of prevention indicate that the key issues to be addressed include: life skills training programmes and programmes which focus on improving self-image and reducing body dissatisfaction in young people.
  - Given that early recognition means that treatment is most effective, in terms of mental health promotion, programmes should focus on early intervention.

## PEOPLE AT RISK OF SUICIDE

### The Case for Action

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

### What Works?

- 5.212 There are a number of strategies in place in Northern Ireland. The Western Health and Social Services Board (WHSSB) Suicide Prevention Strategy (1996) represents the Board's firm commitment to tackle suicide and provides a context for a multi-agency approach to tackling suicide among the resident population.
- 5.213 The WHSSB Suicide Strategy, based on WHO guidelines for suicide prevention, consists of 4 key elements:
- **Education** - of the public through campaigns; education of professionals in the statutory, community and voluntary sectors; and education in schools and colleges.
  - **Environment** - reducing access to the means of suicide such as the introduction of paracetamol legislation (Hawton, 2002).

- **Media** - working with the media to recognise the protective role sensitive reporting can have, eg. producing media guidelines.
- **Research** - recognising the importance of co-ordinating research programmes in order to avoid overlap or duplication of research projects.

5.214 Since the implementation of the WHSSB Suicide Strategy significant progress has been made in developing a range of programmes in all of the 4 key areas. These programmes have been the outcome of the successful collaboration of the members of the Foyle and Sperrin Lakeland local fora on Suicide Prevention supported by the Suicide Awareness Co-Ordinators.

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

5.216 Ten specific action points have been identified in the Strategy and Action Plan 03-08 under the preventing suicide section. Much has been achieved at local level to ensure these action points have been realised, however, someone needs to take regional responsibility to ensure consistency across Northern Ireland.

### **Public Awareness**

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

5.218 Research would indicate that a better-informed public is more likely to access services at an earlier date. Action 13 of the Strategy and Action Plan 03-08 recognises the need for a public and professional information campaign, however, if this is to happen it should be properly resourced similar to RTA campaigns. Action 14 of the Strategy and Action Plan 03-08 states that *“All HSS Boards have taken action to ensure that information about local sources of help on mental health issues is available and accessible.”*

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

### **ASIST (Applied Suicide Intervention Skills Training)**

5.220 In line with Action 25 funding was obtained from the DHSSPS Health Promotion Branch, to bring Living Works Incorporated, Canada to Northern Ireland to deliver the Training for Trainers Course on ASIST. This course is available worldwide and has been adopted as the standardised training programme in Canada, Australia, Norway, and many of the States of

American and the US Army and Air Force and is now being delivered throughout Northern Ireland. A similar approach and commitment, as that adopted for the ASIST Programme, is required for each of the other 29 action points of the Strategy and Action Plan 03-08.

### **The Key Issues to be Addressed**

- 5.221 • Any new Suicide Strategy needs to be cognizant of the UN/WHO guidelines and Safety First recommendations and needs to draw on good practice in the rest of the UK and the Republic of Ireland. It is imperative that in order for it to be implemented it needs to be resourced with an identified action plan with target dates, identified responsibilities, etc.
- 5.222 The Multi-Sectoral Task Force engaged with a wide number of individuals and organisations in drafting the document, Protect Life - A Shared Vision 2006-2011.
- 5.223 This document identified specific actions with a targeted approach, eg. looking at the needs of those who self-harm; people with a mental illness; young males; marginalised and disadvantaged groups; and people who have been bereaved by suicide.
- 5.224 Detailed recommendations on suicide prevention are in Annex 2.

### **PEOPLE EMOTIONALLY AND PSYCHOLOGICALLY TRAUMATISED DUE TO THE NORTHERN IRELAND “TROUBLES”**

#### **The Case for Action**

- 5.225 Since the Troubles began in Northern Ireland 3,600 people have been killed and 40,000 injured. This is within a population of 1.5 million. Whilst most researchers now agree that the Troubles have had an effect on the health and well-being of our community, the extent of their impact on mental health has been disputed and under estimated for a number of reasons (Duffy 2004).
- 5.226 The DHSSPS Report of 1998, “Living with the Trauma of the Troubles” has an impressive list of recommendations for action, including:
- the development of crisis support teams;
  - a proper review of the appropriateness and quality of counselling services for people affected by the Troubles;
  - services to be registered;
  - information to be made available by all Trusts and via other agencies; and
  - better co-ordination of services.

5.227 The Bloomfield Report “We Will Remember Them” (1998) took a 2 strand approach; practical help such as criminal injuries compensation; a non-physical memorial scheme and a physical memorial scheme. The Bloomfield Report lists 20 recommendations on a range of issues. Two have a particular mental health promotion slant:

- **Recommendation b** - employers should be sensitive to the special circumstances of victims and their carers, and specific actions should be taken by public sector employers to assure this; and
- **Recommendation p** - consideration should be given to the creation of a fund to assist in particular children and young people affected by the deaths or injury of a parent.

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

### **What Works?**

5.229 Please refer to A Strategic Framework for Adult Mental Health Services (June 2005) Section 6.29, pp 116-119.

### **Local and International Examples of Good Practice**

#### **Social Capital – Individuals, Organisations and Communities Under Stress Post Conflict**

5.230 Recent research on social capital and inequality suggest that how individuals and communities feel - lack of trust, tolerance and participation - may be a critical factor in determining health (Wilkinson 1996 & 2000). The impact of the Troubles, such as residential segregation, population movement and displacement, stigmatisation of certain neighbourhoods, bereavement and trauma is acknowledged in the Strategy and Action Plan 03-08. Action 5 refers specifically to the promotion of mental health with vulnerable groups such as victims of the conflict.

- It is recommended by WHO, that preventive efforts to reduce the onset of mental disorders (such as anxiety, depression and PTSD) in post conflict societies should focus primarily at early interventions after trauma, rebuilding the country’s physical and mental health services and social infrastructures, mental health education and offering emotional, societal and economic support to victims (WHO 2004).
- Cognitive Behavioural Therapy (CBT) as a treatment for Post Traumatic Stress Disorder (PTSD) has been shown to be effective through the work of the Northern Ireland Trauma and Transformation Centre.
- Family therapy approaches in North and West Belfast HSS Trust have also reported positive individual and family effects following therapy and treatment.

## Key Issues to be Addressed

- 5.231 • Over and above actual treatment, additional resources should be provided for day to day support and training of those who help people in the community affected by the conflict, and to help enhance social capital.
- Consistent with WHO recommendations for post-conflict societies, preventive initiatives are required to reduce the onset of mental disorders such as anxiety, depression and PTSD focusing primarily on early interventions after trauma, rebuilding our community's physical and mental health services and social infrastructures, mental health education and offering emotional, societal and economic support to victims (WHO 2004).
  - The development and expansion of evidence-based services, including Clinical Resources Efficiency Support Team (CREST) guidelines, to address psychological trauma and including adult survivors of childhood trauma should be taken forward as a priority.

## PEOPLE INVOLVED IN SUBSTANCE ABUSE/DUAL DIAGNOSIS

### The Case for Action

- 5.232 Chapter 4 of the Strategic Framework for Adult Mental Health Services Report deals with the issue of people with severe mental disorder and substance misuse (dual diagnosis). Those with a dual diagnosis can “fall between two stools” with mental health and addiction services accepting responsibility for their treatment needs. The Report gives recommendations for different treatment approaches.
- 5.233 **Substance Related Disorders** - the prevention of mental and behavioural disorders due to psychoactive substance use includes the prevention of acute intoxication, harmful use and dependence. The term “psychoactive substances” encompasses tobacco, alcohol and illicit drugs (eg. opioids, cannabinoids and cocaine), as well as psychoactive prescriptions drugs and solvents. Globally, tobacco as a risk factor causes 4.1% of the total burden of disability (WHO 2002). In the 21st Century, it is estimated that tobacco will be the cause of one billion deaths worldwide, with three quarters of these death occurring in low income countries. Worldwide, about 2 billion people consume alcoholic beverages and over 75 million are diagnosed with alcohol use disorders (WHO 2004). Alcohol as a risk factor causes 4% of the total burden of disability (WHO 2002).
- 5.234 Given the particular concern about binge drinking, especially in the young, and the limits of this Report in terms of scope, the focus in this section is on alcohol abuse.

## Northern Ireland

### What Works?

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

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

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

### What Works?

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

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

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

### **Risk Taking Behaviour**

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

### **Reducing Alcohol Consumption**

5.240 There is a strong case for taking an alcohol history, followed by brief interventions in Accident and Emergency Departments, using an approach developed at St Mary’s Hospital NHS Trust in Paddington, London. Over half the men who present to hospital after deliberate self-harm regularly drink excessive amounts of alcohol and 23% are alcohol dependent.

### **Key Issues to be Addressed**

5.241 Both the Strategic Framework for Adult Mental Health Services and the Alcohol and Substance Misuse Report, December 2005 deal with the issues relating to people who have developed alcohol or drug problems:

- Availability of alcohol is a factor and, therefore, there may be political aspects to dealing with the problem away from excess drinking. Politicians should be lobbied in this regard.
- The HPA could have a significant role in developing a strategy province-wide to help promote healthier drinking, drawing on examples of good practice and research nationally and internationally.



## **CHAPTER 6**

### **POLICY ISSUES**

#### **The Policy Environment**

##### **Introduction**

- 6.1 The importance of mental health promotion and its contribution to overall health has achieved growing recognition across the UK and Internationally (Jenkins 2002; WHO 2005; Jané-Llopis & Anderson 2005).

##### **National Policies**

- 6.2 England, Scotland, Wales and Northern Ireland all have policies with a specific mental health promotion focus and have all in recent years developed strategies for the delivery of mental health promotion.

##### **Northern Ireland**

- 6.3 In Northern Ireland, the overall policy environment is currently considered relatively favourable to promoting mental health and stimulating a wide range of activity. PSI is a key element of New Targeting Social Need, (Northern Ireland Office 2003) which has a special focus on mental health. Promoting mental health and well-being at an individual and community level is one of the objectives of Investing for Health, the regional health strategy for Northern Ireland launched in 2002.
- 6.4 The Strategy and Action Plan 03-08 was published by the DHSSPS in January 2003, following responses to the consultation document “Minding Our Health” (2000). In addition, responses to the wider Investing for Health consultation highlighted mental health as a key priority for action (DHSSPS 2002).
- 6.5 The Strategy and Action Plan 03-08 aims to improve mental and emotional well-being and to prevent or reduce the impact of mental illness. In addition, it has two aims concerned with the determinants of mental health at a policy level and building capacity and skills for effective mental health promotion practice. Overall, it strikes a balance between addressing life circumstances and developing life skills and is based on three principles: a holistic approach; empowerment; and respect for personal dignity. The Strategy and Action Plan 03-08 addresses four areas: policy development; raising awareness and reducing discrimination; improving knowledge and skills and preventing suicide.
- 6.6 Overall monitoring of the Strategy and Action Plan 03-08 is the responsibility of the Ministerial Group on Public Health, with a DHSSPS led Multi-Agency Group overseeing the action plan. Each of the four Health and Social Services Boards across Northern Ireland is required to develop local mental health promotion strategies. The WHSSB was

the first to launch its plan at a major consultation event in Strabane in November 2003. A similar launch by the Southern Health and Social Services Board (SHSSB) took place in January 2004. Within the WHSSB, delivery of the suicide prevention element of the strategy is overseen by two suicide awareness co-ordinators, with a strong focus on both public and professional education, working with the media and an extensive programme in schools and prisons.

### **Response to Promoting Mental Health – Strategy and Action Plan 2003-2008**

- 6.7 The Strategy and Action Plan 03-08 has been widely welcomed by people in the mental health field in Northern Ireland and represents an important milestone in putting mental health promotion on the health agenda. In addition, involvement by a range of agencies, statutory, community and voluntary, has meant a collaborative approach to mental health promotion which has been beneficial. Nevertheless, feedback outlined below suggests that there are some concerns about the impact of the strategy.

### **Implementation – Progress to Date**

- 6.8 The HPA in Northern Ireland was charged with the task of taking forward an implementation group to monitor progress with the 30 stated actions. Ultimately the Implementation Group will report to the Ministerial Group on Public Health (currently under review).
- 6.9 In addition to Implementation Group meetings which have been held, 2 sub groups have recently been established to look in further detail at (a) suicide prevention and (b) education. These consultation groups have been set up with the aim of engaging with local stakeholders to help assess progress to date in terms of the actions relating to these 2 areas. Suicide is now the subject of a separate Government report, Protect Life - A Shared Vision, 2006-2011.
- 6.10 As part of its own consultation, the Mental Health Promotion Committee designed a questionnaire for key stakeholders province-wide, seeking feedback on issues relating to mental health promotion generally and more specifically seeking comment on the current strategy and perceived progress to date. Outlined below is a summary of feedback received from this, one of whose questions asked for comment on the strategy and perceived progress.
- 6.11 Fifty questionnaires were completed by a diverse range of agencies and individuals from the statutory, voluntary and community sectors. In addition to the questionnaire, views from members of the Committee and from other individuals working in the statutory and community sectors have been sought on a one-to-one basis.
- 6.12 Support for the Strategy and Action Plan 03-08 was clear, with a number of agencies involved in taking forward some of the actions outlined. However, respondents of the questionnaire and others commenting expressed concerns as following:

- **Unrealistic Timeframes** - a number of the target dates for completion of action had already passed by the time the document was disseminated.
- **The Need for Guidance** - quite a number of those commenting on the Strategy have highlighted the lack of guidance (such as DOH's Making It Happen – a Guide to Delivering Mental Health Promotion (2001) – published to assist with the implementation of the National Services Framework Standard on mental health promotion in England).
- **Inadequate Resources** - approximately £200,000 is earmarked for mental health promotion in Northern Ireland. This is currently allocated to the HSS Boards to help them resource local board initiatives. This is considered to be woefully inadequate, particularly in the light of the higher incidence of mental health problems in Northern Ireland compared to the rest of the UK.
- **Targeting Resources** - given that many of the actions do not simply involve the health sector, consideration would need to be given to resourcing education, district councils, community organisations, prison service, etc.
- The Scottish National Programme for Mental Health Promotion, with an allocation of £24 million represents a major investment and commitment. On a pro rata basis, the Committee believes that £5-6 million would be required to develop the infrastructure of the proposed Mental Health Promotion Directorate in the Northern Ireland. This level of resourcing would facilitate funding streams to be developed from other sectors such as education and employment.
- **Reinforcing of Cross-Sectoral Collaboration** - although a number of the actions (eg. Action 15 & 14) have an expectation of, for example, HSS Boards and HSS Trusts and Education and Library Boards working together, there seems little evidence that this is happening, except at local level.

The Health Promoting School is one example of an initiative in an education setting being driven forward by the Department of Health solely in terms of funding with the HPA progressing the action.

- **The Need for Ministerial Direction** - there is a need for clear direction at the most senior level to drive the strategy forward (as in the Scottish Executive Model) - someone who can call people to account.
- **Question of Mainstreaming/Sustainability** - it is at present unclear what will happen beyond 2008. The issue of short-term interventions with lack of resources to mainstream successful initiatives has long been a feature of mental health promotion in Northern Ireland.
- **Representation on the Implementation Group** - members of the group should be in a position to influence the policy-makers and properly oversee relevant actions.

- **Gaps in the Strategy/Lack of Specificity** - a number of gaps have been identified in terms of vulnerable groups such as:
  - victims of domestic violence;
  - people with a learning disability;
  - needs of people with ASD;
  - ethnic minorities; and
  - specific at risk groups, eg. children, elderly and the isolated.
  
- **Gaps in the Consultation Process** - some respondents commented on their lack of consultation as follows:
  - midwives;
  - occupational therapists;
  - student population;
  - users of services.
  
- **Research** - further research into assessment of need is required.

### **National Service Framework for Mental Health - England**

6.13 In 2001, the DOH developed a revised performance management framework to monitor progress on the implementation of all National Service Framework (NSF) standards and the NHS Plan as it relates to mental health.

6.14 The NSF Standard One on mental health promotion meant that a clear remit for the first time had been given to health and social services to promote mental health for all and to reduce the discrimination experienced by people with mental health problems. Recently, the importance of Standard One has been reinforced in the public health White Paper, “Choosing Health”, which includes a specific commitment to new services to improve the mental and emotional well-being of the whole population and states:

*“we will ensure that standard one of the NSF for Mental Health, which deals with mental health promotion, is fully implemented.”* (Department of Health 2004a)

6.15 The importance of mental health promotion is also recognised in the NSF Progress Report by the National Director for Mental Health “The National Service Framework for Mental Health: Five Years On”, which notes:

*“we need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole.”* (Department of Health 2004b)

6.16 In England to date, the main focus nationally has been on tackling discrimination and social exclusion, notably with the publication of “Mental Health and Social Exclusion” by the Social Exclusion Unit (SEU) (2004) and NIMHE’s strategy “From Here to Equality” (NIMHE 2004). Guidance on developing local mental health promotion strategies:

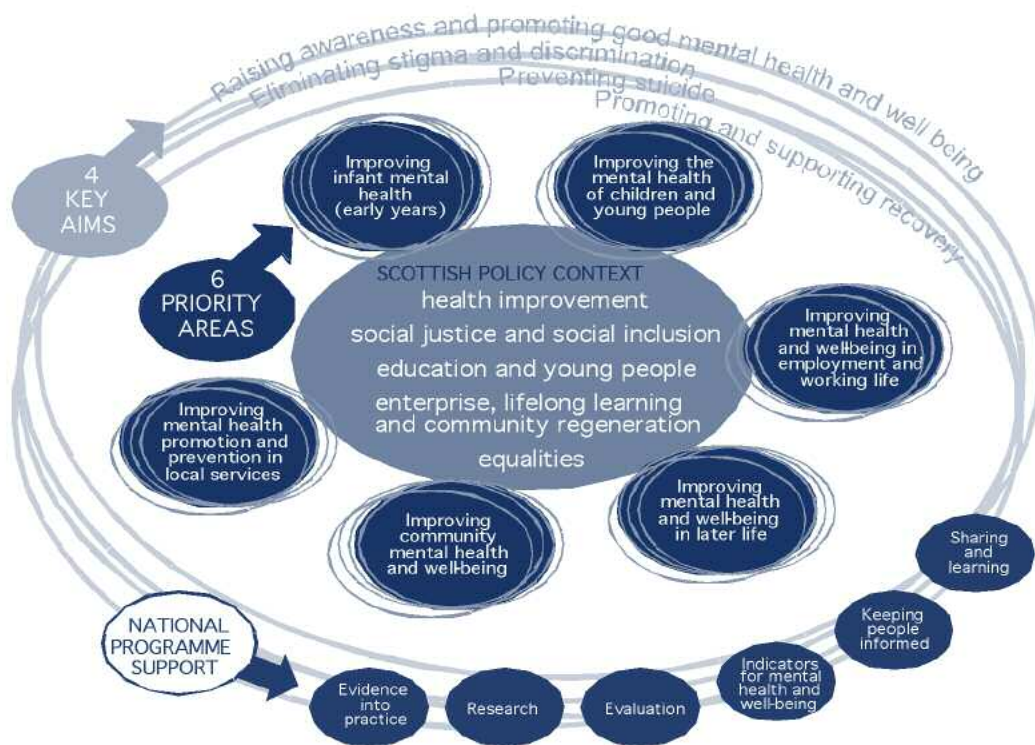
“Making it Happen”, was published in 2001 (DOH) and by the end of 2004, 91% of primary care Trusts had met the requirement to have a mental health promotion strategy, although resources for mental health promotion delivery vary widely and are generally very limited. There are some indications that this might improve with the impetus provided by “Choosing Health” (DOH 2004a) and the fact that NIMHE has recently commissioned a National Framework for Mental Health Promotion in England, to inform the further development and delivery of mental health promotion.

- 6.17 **Lessons** - England has been successful in putting the exclusion and discrimination experienced by people who use mental health services high on the agenda; if implemented, the recommendations in the SEU’s Report are likely to make a significant difference to the quality of life of people with severe and enduring mental health problems. However, there is still a need for a greater focus on promoting mental health for all and moving mental health promotion higher up the public health agenda.

### **Mental Health in Scotland – A National Programme Approach**

- 6.18 In 2000, the Scottish Executive outlined a commitment to mental health as an integral part of the wider agenda for public health and health improvement in Scotland (Scottish Executive 2000). As a result, in October 2001, the Scottish Executive unveiled a new programme for improving mental health and well-being (Henderson et al 2002). Resources to the value of £24 million have been dedicated to this programme - the first of its kind in Scotland, where national policy and resources have been dedicated to improving mental health.
- 6.19 Commitment from the top (always a predictor of success) is manifested by the consultation and support body - the National Advisory Group, chaired by the Deputy Minister for Health and Community Care, which advises Scottish Ministers on the programmes, strategic direction and implementation.
- 6.20 There is wide representation on the group – including those who work in health, education, housing, local authorities, employment, learning and justice.
- 6.21 The Scottish National Programme Action Plan (see below) was published in September 2003, setting priorities for actions such as:
- raising awareness and promoting good mental health and well-being;
  - eliminating stigma and discrimination;
  - preventing suicide; and
  - promoting and supporting recovery.

## The Scottish National Programme Action Plan – Graphical Representation



- 6.22 This is supported by a range of activities including collecting and disseminating the evidence base and supporting local practice, developing and commissioning a programme of national research and establishing public health indicators.
- 6.23 The strength and profile of the Scottish National Programme for Improving Mental Health and Well-Being ([www.wellontheweb.net](http://www.wellontheweb.net)) means that the environment in Scotland is widely seen as extremely favourable to mental health promotion. In addition to a high profile media campaign and a wide range of activities to promote mental health and address discrimination, suicide and recovery, Scotland has seen a major investment in building capacity for the delivery of public mental health. This has included a range of training, research and resources commissioned by the Scottish Executive and NHS Health Scotland. A further major programme of mental health improvement training, with a focus on evidence into practice, is scheduled for 2005/2006, with events across all Scottish Health Boards (contact Scottish Development Centre for Mental Health [www.sdcmh.org.uk](http://www.sdcmh.org.uk) ).
- 6.24 **Lessons** - in addition to specific action on stigma and discrimination, it is also crucial to create an environment which promotes the mental health of the whole community - in schools, in workplaces, in neighbourhoods, in primary care, in local Government, the voluntary and private sector. This cannot be achieved without dedicated resources to build knowledge, skills, expertise and capacity.

6.25 This innovative and progressive approach is a model to be admired. One of the important factors is that, although the funding comes to an end at the end of 2006, the National Programme seeks to embed itself in Scottish policy and practice before that, leading to a long term commitment.

6.26 In a journal article recently published, Research Specialist, Emma Hogg, states that:

*“The work programme described should help to secure lasting commitment to mental health improvement and contribute to the shift from a focus on treatment issues to a more equal balance between treatment and promotion and prevention”.* (Hogg, 2004)

6.27 For information on progress to date of the work of the National Programme, see Annex 5.

### **International Policy**

6.28 A resolution passed by the Council of the European Union in November 1999, calls on the European Commission to recognise the importance of promoting mental health and to assess the mental health impact of policy.

6.29 The resolution invites the members to:

- develop mental health promotion policies;
- collect and share relevant data;
- implement action to promote mental health and prevent mental illness; and
- stimulate research into mental health and its promotion.

6.30 It calls on the European Commission to:

- incorporate mental health into the public health programme;
- monitor mental health as a component of the community health monitoring system;
- analyse the impact of community activities on mental health; and
- consider drawing up a recommendation on the promotion of mental health.

6.31 Also relevant to mental health promotion are the European Convention of Human Rights and the Human Rights Act 1998.

6.32 Although many countries have started to recognise that mental health policy to enhance public mental health has significant potential in terms of improving economic, social and human capital, Lahtinen et al (1999) in their analysis of the position of mental health in Europe have argued that mental health has not achieved equal recognition with physical health among decision-makers.

## **WHO Ministerial Conference on Mental Health**

- 6.33 This Conference brought together all 52 countries in the European Region of the WHO. Organised in partnership with the European Union and the Council of Europe. Arising from this conference was the “Mental Health Action Plan for Europe Facing the Challenges, Building Solutions 2005”.
- 6.34 The WHO Action Plan (2005) was endorsed in the Mental Health Declaration for Europe by Ministers of Health of member states in the WHO European Region.
- 6.35 It also sets out the details of commitments and responsibilities of both the WHO and national governments. It has 12 priority areas, with a strong public mental health focus, including:
1. Promote mental well-being for all.
  2. Demonstrate the centrality of mental health.
  3. Tackle stigma and discrimination.
  4. Promote activities sensitive to vulnerable life stages.
  5. Prevent mental health problems and suicide.
  6. Ensure access to good primary care for mental health problems.
  7. Offer effective care in community-based services for people with severe mental health problems.
  8. Establish partnerships across sectors.
  9. Create a sufficient and competent workforce.
  10. Establish good mental health information.
  11. Provide fair and adequate funding.
  12. Evaluate effectiveness and generate new evidence.
- 6.36 It stresses the need for “*mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems.*” Of special note is the emphasis on increasing awareness of the importance of mental well-being, the inclusion of promotion and prevention (alongside the need to improve treatment and services) and the recognition of the need for a competent workforce in all these areas.

## Summary

- 6.37 Regionally, the Strategy and Action Plan 03-08 is welcomed. Its ethos, underpinning values and actions are all highly appropriate. It also helps to reinforce much good practice in the field of Mental Health Promotion over the years (much of which is captured in HPA's Database) and is, therefore, encouraging to those who believe there must be a positive impetus for the future. However, as outlined above, many of the strategy recommendations have not been implemented.
- 6.38 The hard reality of the cost benefits of taking action – a projected £30 billion savings by 2022 cited in the NHS Improvement Plan, may well be an incentive for action, in addition to the cost to Northern Ireland economy of mental ill health of £2.28 billion, as outlined in Chapter 3.
- 6.39 Whether the reasons are “hard” or humanistic, or a combination of both, the priority is to progress towards mental health for all.



## CHAPTER 7

### RECOMMENDATIONS

#### Primary Recommendation:

#### The Creation of a Regional Mental Health Promotion Directorate at the Heart of Government

- 7.1 The stated vision of this Report is “mental health for all”. As WHO (2005) states: “*There is no health without mental health*”. As the title of this Report reflects, mental health promotion needs to have the following dimensions: personal; public; and political.
- 7.2 **Personal** – early prevention and the enhancement of individual mental health and well-being helps promote social inclusion, autonomy, resilience and the capacity to learn, develop and contribute meaningfully to society.
- 7.3 **Public** – environmental factors such as feeling safe, access to appropriate local support, education, opportunities for employment and meaningful activity all need to be generated by good cross sectoral working particularly by the health, education and employment agencies.
- 7.4 **Political** – in the current climate of scarce resources, it may take a political “leap of faith” by policy-makers. Resource allocators in all sectors need to be convinced of the fact that good mental health is the starting point for all health. The current WHO Action Plan 2005 reinforces these points in terms of European Policy. This needs to be translated into regional terms in Northern Ireland.
- 7.5 In light of the above, the Review believes that in order to achieve strategic, co-ordinated, cross-sectoral, cross-departmental and multi-agency action on mental health promotion, a Regional Mental Health Promotion Directorate, with a Regional Director should be established.
- 7.6 A properly resourced Directorate would increase awareness and visibility of mental health promotion, facilitate the achievement of existing mental health promotion targets, as well as setting targets for the future. This would provide a necessary degree of permanence, leadership and sustainability to drive forward mental health promotion in Northern Ireland.
- 7.7 The costs of mental-ill health are felt across a wide range of public sectors. Effective responses, therefore, require a multi-agency approach. Joined-up Government is notoriously difficult to achieve in practise. A Regional Mental Health Promotion Directorate would, therefore, have the task of promoting this multi-agency approach with a shared ownership and a mental health promotion vision.
- 7.8 The establishment of such a body, with proper executive powers is, to a large extent, predicated on the fact that, although excellent in content, the current Strategy and Action

Plan 03-08 is not having the impact it should. Some of the barriers to its effective implementation have been outlined in Chapter 6, and include inadequate resources; lack of ministerial direction; lack of guidance, authority and accountability to promote cross sectoral collaboration, and importantly, lack of co-ordination.

- 7.9 The Review, having agreed and recommended this Directorate as necessary for providing strategic, co-ordinated, cross-sectoral, cross-departmental and multi-agency action on mental health promotion, then considered the appropriate structures and siting to achieve this function.
- 7.10 The Review considered where the centre of gravity should be for this recommendation. Should it be focused within the health sphere or if, as we are, looking to wider contributions, including those of education, culture and employment to produce the change we want, what mechanism and approach is most effective in making those linkages?
- 7.11 The Review considers that it is necessary, in order to achieve this strategic vision, to place a Mental Health Promotion Directorate at the heart of Government. The Review's recommendation is to ensure mental health promotion is a policy priority across the whole of the public sector. To achieve this, the Directorate would best be placed within a context such as OFMDFM.
- 7.12 A properly resourced Directorate would increase awareness and visibility of mental health promotion, facilitate the achievement of existing mental health promotion targets, as well as setting targets for the future. This would provide a necessary degree of permanence, leadership, sustainability and crucially the authority to drive forward mental health promotion in Northern Ireland whilst creating ownership of mental health promotion across all sectors and relevant agencies and groups.
- 7.13 The challenges for the next 10-15 years as outlined in WHO Action Plan 2005 can only be addressed through such a body, established with the authority that would be forthcoming within a context such as OFMDFM.
- 7.14 This would enable proper co-ordination of any mental health promotion strategies, identified directions for the future, and through the promotion of cross-sectoral responsibility enhance the understanding and development of social capital in relation to mental health promotion.

### **Key Functions and Responsibilities of the Directorate**

- 7.15 A Mental Health Promotion Directorate at the heart of Government would ensure that mental health promotion contributes to the goals and policies across all sectors, supports the delivery of existing policies relevant to mental health promotion, raises the awareness of mental health promotion and moves mental health promotion up the policy agenda in all Government Departments and agencies.

7.16 In particular, taking account of the recent Review of Public Administration (RPA 2005), the Review would see this Directorate as ensuring that the HPSS Authority and the New Education Authority take on the responsibility for operationalising the impact of this policy in those two most important sectors.

7.17 Specifically the functions may include the responsibility to:

- co-ordinate the implementation of existing policies, including the Strategy and Action Plan 03-08;
- facilitate the necessary cross-sectoral approach to mental health promotion by providing a focus for liaison between the various governmental bodies;
- facilitate capacity building via training and research with regard to mental health promotion across all health, social care and education professions, with a particular focus initially on primary care level;
- facilitate the establishment of a research body providing a focus on mental health as opposed to mental illness, specialising in non clinical domains; providing an information base and guidance; and identifying examples of good practice; quality assurance approaches and independent evaluation on public mental health promotion strategies and interventions;
- ensure that there is a focus on relevant legislation regarding equality of opportunity and human rights as regards to mental health;
- identify priorities in terms of the population, vulnerable groups, etc;
- liaise with other UK and International Programmes;
- ensure the permanence of mental health promotion, by embedding it in all public sector policies, especially health and education; and
- implement effective responses.

### **Other Recommendations**

7.18 The Review considers the creation of a Mental Health Promotion Directorate at the heart of Government as its primary recommendation upon which action on mental health promotion would be based across Northern Ireland at policy level.

7.19 Such a Directorate would have responsibility for setting out policies in details and for ensuring the operational impact through, eg. the Regional Health Authority and the new Education Authority. However, this Report recommends that for the initial strategic period the settings, stages and levels approach as outlined in Chapter 5 would be the firm basis for actions. This approach is outlined below.

## **RECOMMENDATION 1 - SETTINGS, STAGES AND LEVELS FOR ACTION**

### **Settings for Action**

#### **Schools**

- The Health Promoting Schools initiative has had some limited success in Northern Ireland, but needs to be properly resourced to have an impact. This is a vital area of work, given that early interventions in the school setting can be highly effective in enhancing protective factors and reducing risk factors for mental health.

#### **Primary Care**

- **Social prescribing** as a vehicle for offering patients in primary care alternative forms of support has been proven to be effective and should be encouraged.
- **Training for GPs** in mental health is required. Additionally, with the contracting system, GPs are particularly well placed to promote mental health.

#### **Workplace**

- The workplace is an important environment for the individual in life.
- Employers are under a general duty to take responsibility to ensure the health and safety of employees whilst at work. The law states that mental health should be viewed in the same light as physical health.

#### **Further and Higher Education**

- The Health Promoting University/College is an initiative which has been completed in England and elsewhere, and shown to be beneficial as promoting an organisation-wide culture based approach to the promotion of mental health. Its approach should be assessed for its usefulness in the Northern Ireland context.

#### **Rural Areas**

- As rural areas have been identified as particularly prone to risk factors such as isolation, problems related to the farming community and suicide, any suicide strategy needs to help raise awareness of the issues involved and help people in terms of where to get support.

#### **Communities Including Marginalised Groups and Faith Communities**

- Work needs to be carried out with a range of communities in Northern Ireland, with priority given to marginalized communities such as ethnic groups and also faith communities. Training in mental health issues would be beneficial for clergy for example.

## **Stages of Life**

### **Children and Adolescents**

- 7.20 There is evidence to show that enhancing protective factors and building resilience in children and adolescents helps reduce the likelihood of many mental health problems developing in later life.
- 7.21 Primary and secondary schools should implement appropriate programmes such as the RAP to enhance the mental health of the young.
- 7.22 We are including children and adolescents of all needs and abilities, and from a range of communities. Action in schools should also include action for those with special needs.

### **Older People**

- 7.23 It is projected that by the middle of the 21<sup>st</sup> Century there will be in excess of 12 million older people in the UK. The quality of life of those with or without diagnosed mental health problems can be improved and can involve:
- reducing age discrimination;
  - involving older people;
  - early recognition or diagnosis of mental health problems to ensure patients receive prompt care; and
  - meeting the needs of carers.

### **People in Receipt of Statutory Mental Health Services**

- 7.24 Alternative, or adjunct treatments and forms of social support should be provided, at primary care level, such as social prescribing programmes. These can help reduce isolation, increase social inclusion and socialisation and maintain better mental health.

## **Levels of Action**

### **Regional Level – Building Capacity**

- 7.25 The effective delivery of mental health promotion in all sectors and settings in Northern Ireland will depend on building knowledge, expertise and capacity. This should include (a) training, (b) information and guidance and (c) research.

7.26 **Training** - colleagues in many different sectors have the potential to promote mental health and will benefit from knowledge, training and support to promote psychological well-being and to identify early indications of difficulties. Training packages need to be designed to meet the different needs of different sectors and to recognise the specific context of promoting mental health in Northern Ireland. Training should be made available for a wide range of different sectors and professional groups eg:

- GPs;
- other primary care staff;
- teachers/university faculty staff;
- child care/early years workers;
- youth workers;
- priests, clergymen;
- community leaders;
- staff in a range of voluntary and community agencies;
- housing;
- occupational health and human resources;
- mental health services;
- mental health service users; and
- A&E staff.

7.27 **Guidance** – guidance and resources on implementing and evaluating mental health promotion should be made easily available and adapted, where necessary, for the Northern Ireland context. Examples of guidance from elsewhere in the UK include the English document “Making it Happen” (2001); and the wide range of resources produced as part of the Scottish Executive’s National Programme for improving mental health and well-being ([www.wellontheweb.net](http://www.wellontheweb.net)).

7.28 **Research** – the focus of the research should be on the promotion of positive mental health, rather than on mental illness. An integrated research policy should be established.

7.29 **Reducing discrimination and increasing awareness** - several actions within the existing regional strategy address these issues.

- 7.30 **Ensuring awareness** - of the relevant existing legislation such as the Disability Discrimination Act to tackle discrimination for example. Information should be sought on how many employers are aware that their duty of care relates to psychological well-being and reduction of stress in the workplace.

## **RECOMMENDATION 2 - IDENTIFICATION OF RESOURCES**

- 7.31 A regional structure needs to be properly resourced in order to achieve its goals.
- 7.32 The resource allocation to create this structure should reflect the cost of mental ill health in Northern Ireland and should be in the region of £5-6 million over the initial 3 year period. With a commitment to sustainability for the future.
- 7.33 This figure has been calculated on a pro rata basis taking the Scottish model as an exemplar, but does not take into account the higher levels of deprivation and mental ill health in Northern Ireland than in the rest of the UK.
- 7.34 This initial seeding cost, allowing for the establishment of a Directorate would also facilitate over time additional funding streams to be made available from other sectors than the health budget, such as education and employment.

## **RECOMMENDATION 3 - SUICIDE PREVENTION**

- 7.35 The Review considers suicide prevention to be an integral part of the broader scope of mental health promotion and has been included as Annex 2.
- 7.36 The Review, therefore, recommends that suicide prevention needs to be placed as a public health priority and a Regional Mental Health Promotion Directorate needs to ensure that a separate suicide prevention strategy is implemented as part of its overall responsibility.
- 7.37 A Taskforce was set up in the Autumn of 2005 to consider suicide. Since then, the document: "Protect Life - A Shared Vision", the Northern Ireland Suicide Prevention Strategy 2006-2001 has been launched. The document recommends targeted action with specific at risk groups and in a range of settings.
- 7.38 It is recommended that such recommendations be 'dovetailed' with any mental health promotion strategies taken forward by the Mental Health Promotion Directorate.



## **MENTAL HEALTH PROMOTION**

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The Review also acknowledge the contributions by way of papers/presentations made by the following:

“Theoretical Aspects of Mental Health Promotion” - Mr Paul Fleming & Ms Judith Lee

“Learning for Life & Work” - Mrs Helen Johnston, CCEA

“Some Thoughts on Prejudice, Stigma & Mental Health” - Rev Trevor Williams

“Post Traumatic Stress Disorder” presentation Mr Micky Duffy, Centre for Trauma & Transformation

“Some Thoughts on Mental Health Promotion in Primary Care” - Dr Liam Foy

“Issues Relating to the Structure of the Committee’s Report” - Mr Eugene Caulfield

“Suicide Prevention & the Northern Ireland Mental Health Review, July 2004” - Mr Barry McGale

“Training in Mental Health Issues for Those Preparing for Ordination” - Rev Trevor Williams

“Mental Health Promotion for People with a Learning Disability” - Mr Maurice Devine, Nurse Consultant (Learning Disability) Down Lisburn Trust

“Interface Issues with other Working Groups” presentation - Ms Moira Davren, Child & Adolescent Expert Working Committee

“Mental Health Promotion Among Young People” - Mr Irwin Pryce, Mr David Twyble & Ms Jean McMinn

“Spirituality & Mental Health” - Rev Trevor Williams

“Promoting Mental Health: A Resource for Spiritual & Pastoral Care” (Church of England) - Presented by Rev Williams

“The Costs of Mental Illness” - Mr Michael Parsonage, Sainsbury Centre for Mental Health



## **SUICIDE AND THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (NI)**

The World Health Organisation (2002) has reported that every year one million people across the world die by suicide. This equates to one suicide death every 40 seconds. They also advise that every year there are more people dying by suicide than by all the deaths due to the current conflicts across the globe.

This is equally true for Northern Ireland where the history of the conflict over some 30 years is well known. According to Fay et al (1997) found in the 25 years from 1969 to 1994, more people died here by suicide than as the result of the conflict. On average since 2000, deaths due to suicide have exceeded deaths on the road.

Suicidal behaviours place a heavy human and financial burden on society in Northern Ireland. Figures from DHSSPS (2002) indicate that there are on average 150 suicide deaths every year in NI, 80,000 working days are lost to illnesses related to attempted suicide; and that there are over 4,000 hospital admissions annually as the result of suicidal behaviour. The estimated annual cost to the economy of suicidal behaviour is £170m. Although suicide accounts for 1% of all deaths annually it equates to 7% of potential years of life lost, indeed the expected years of life lost to suicide is estimated to be 4,400.

Concerning the psychological and social impact on the family and society is estimated that up to 50 people are significantly affected by a suicide death, Bland (1994) cited by Campbell (1997), listed 28 different relationships to a person who died by suicide for those who came forward for help. If the figure of 50 is accurate, then each year in Northern Ireland 7,500 people are impacted as the result of suicide. Estimating the burden of suicide in terms of disability-adjusted life years (DALYs) in 1998 suicide was responsible for 1.8% of the total burden of diseases worldwide.

*“This is equal to the burden due to wars and homicide, roughly twice the burden of diabetes, and equal to the burden of birth asphyxia and trauma” (WHO, 2000).*

### **Suicide Prevention Strategy**

Reaction driven responses to suicide are costly in the short term, both financially and emotionally. A well planned, resourced and a co-ordinated strategy to suicide prevention would be cost effective in the longer term (Ramsey & Tanney 1996). Suicide is a multi-dimensional issue and the Australian Government highlight:

*“The complexity of the interaction between risk factors, and the capacity for health care and social interaction to influence individuals choices, suggests that Government and society have a responsibility to act” (Commonwealth of Australia 2000).*

The moral obligation rests on the principle of beneficence (Kuitert 1995) and responses are required at the individual, community and Government levels.

## **Limitations of the Present ‘Promoting Mental Health Strategy’ Re. Suicide Prevention**

It would appear that the Ministerial Group on Public Health did not take responsibility for the overall Strategy and Action Plan. As a result, a lack of strategic leadership, accountability and inter-departmental approach was evident.

The Implementation Group, whose task it was to report on progress, met infrequently and therefore, was unable to oversee and drive forward the actions. Furthermore, the financial resources and support were insufficient to deliver and ensure co-ordination on the actions.

Though the current Mental Health Promotion Strategy is to be welcomed, there is more involved in suicide prevention than mental health promotion. Mental health promotion plays a fundamental role in enabling the positive self-esteem of individuals. It also seeks to strengthen individual and community resilience. Suicide prevention initiatives build on these efforts by seeking to: raise awareness about suicide at the whole population level; seek to intervene with those at risk of suicide; follow up those who have attempted to end their lives and provide care and support for those bereaved by suicide.

## **The Benefits of a Regional Suicide Prevention Strategy**

According to the US Government, a National Strategy for suicide prevention can:

- raise awareness and help make suicide prevention a national priority. This can help direct resources of all kinds to the issue;
- provide an opportunity to use partnerships and the energy of survivors to engage those who may not have considered suicide prevention within their purview. It supports collaboration across a broad spectrum of agencies, institutions, groups and community leaders as implementation partners;
- link information from many prevention programmes to avoid unintentional duplication and disseminate information about successful prevention interventions;
- direct attention to measures that benefit the whole population and, by that means, reduce the likelihood of suicide before vulnerable individuals reach the point of danger;
- bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels such as the family, the individual, schools, the community and the healthcare system; and
- help develop in an equitable way and provide technical assistance with valuable types of expertise to strengthen community programme (US Department of Health and Human Services 2001).

An evidence-based strategy can maximise success when recommendations are implemented locally. Sound evaluation of community programmes, in turn, builds the evidence base.

The following goals outline the range of outcomes that would support the aim of a national strategy:

- Preventing premature death due to suicide across the life span.
- Reducing the incidence and prevalence of other suicidal behaviours.
- Reducing the morbidity associated with suicidal behaviours.
- Providing opportunities and settings to enhance resilience, resourcefulness, respect, and inter-connectedness for individuals, families and their communities (United Nations/WHO 1993).

An evidence base guiding strategic work on suicide prevention is essential.

*“...there may be political and social imperatives to be seen to be doing something about suicidal behaviour...scientists need not necessarily be pessimistic about such programmes, even though they may not meet the rigorous criteria essential for scientific research” (Goldney 2000).*

The groundswell of opinion is that urgent action is required and international evidence exists to guide the way forward.

### **Recommendations**

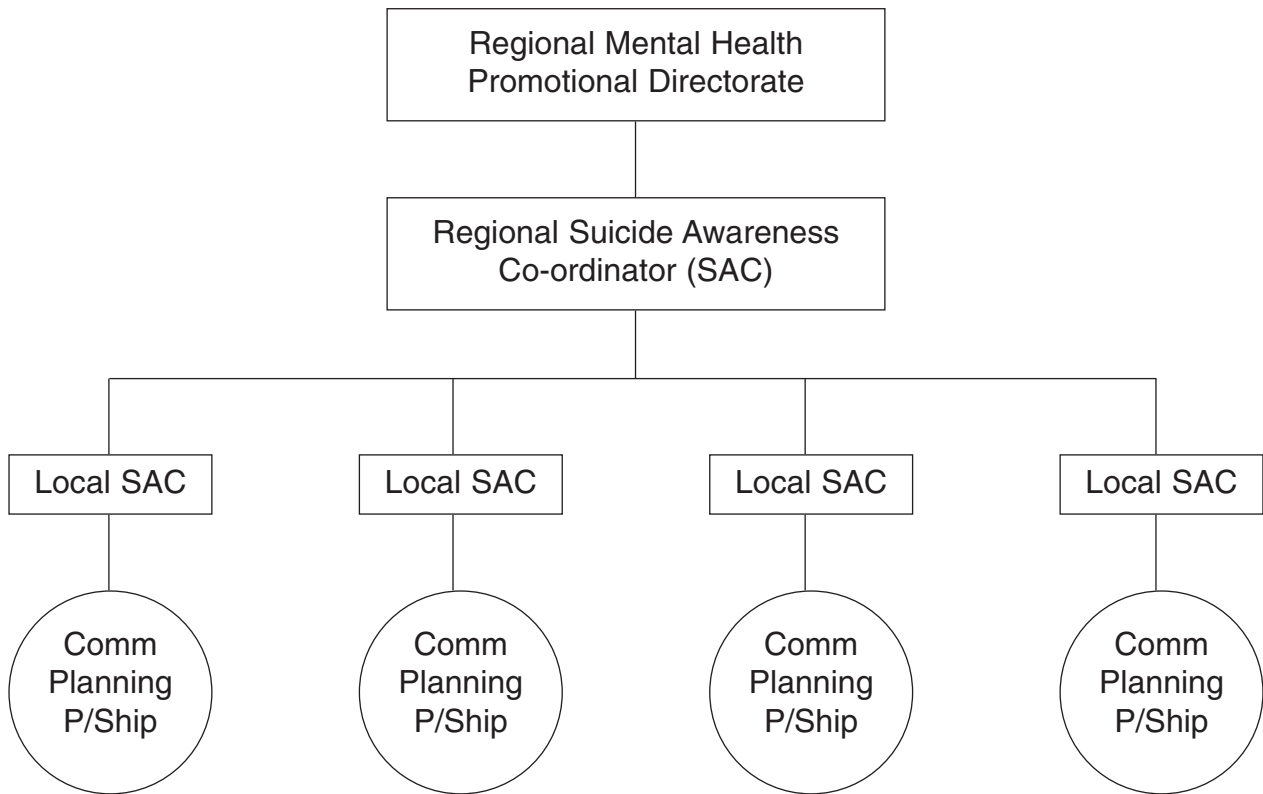
- A Regional Mental Health Promotion Directorate needs to ensure that suicide prevention is a regional priority and the proposed suicide prevention strategy is implemented.
- A broad coalition of suicide survivor representatives, suicide prevention activists, researchers and community representatives needs to be created for the development and implementation of the strategy.
- The strategy needs to address the issue from both a targeted approach ie. vulnerable groups and a population approach.
- Suicide prevention needs to be placed as a public health priority.
- The suicide prevention strategy needs to be developed with an identified action plan with target dates, responsibilities and be properly resourced.
- A system for collating data on self-harm in Northern Ireland should be established linking it to the European WHO Multi-Centre Study on Parasuicide.
- The recommendations within Safety First need to be co-ordinated and implemented on a regional basis.

- Closer co-operation between our colleagues, North, South, East and West, in keeping with Investing in Health recommendations, should be encouraged and supported.
- A postvention service needs to be made a priority. Co-ordination and enhancement of the care provided to those bereaved by suicide must begin immediately.
- A suicide prevention research centre must be supported and resourced where local and international evidence can be accessed.
- A major culture change is required in our society that encourages help-seeking as a sign of strength, not weakness.
- Community development is one of the foremost ways of advancing suicide prevention and should be promoted through capacity building.
- An intervention programme such as Applied Suicide Intervention Skills Training (ASIST) should be provided as standardised training for all those who work with vulnerable people.
- Training for those providing long term care to suicidal persons needs to be reviewed and developed.

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## Proposed Implementation Framework



## IDENTIFICATION OF NEED – SUMMARY OF KEY ISSUES

### Promotion of Mental Health and Well-Being for All in the Population at Large

#### Key Issues to be Addressed

##### Home

- Factors which promote resilience in children under 5 help those children to do well despite adversity, therefore, early intervention is vital. Evidence shows, for example, that Promoting Parenting Skills Programmes improve the mental health of both parents and children. This is an area which should be further encouraged.
- Action 18 of the Strategy and Action Plan 03-08 relates to parenting skills and links with the ongoing work being undertaken to implement the teenage pregnancy and parenthood strategy and action plan.
- According to the Implementation Group's (Strategy & Action Plan 08-08) Draft Annual Report, all HSS Boards are undertaking some action, for example the delivery of skills training to Surestart staff on building self esteem and handling child behaviour.

##### Schools

It is recognised that schools can have a vital role to play in protecting the health of young people. Interventions such as the Resourceful Adolescent Programme (RAP) in Australia and the Health Promoting Schools initiatives have been proven to be effective in promoting children's mental health. Proper resources and cross-sectoral working are needed to implement a province-wide schools strategy. Whilst the current work being carried out in Northern Ireland on the Health Promoting School Initiative is valuable and points for the potential for the future, there are important issues which need to be addressed such as:

- **Funding** - a significant source of funding, long term needs to be identified and committed to such projects.
- **Cross-Sectoral Issues** - funding currently comes via the DHSSPS - with no involvement of the Department of Education. For an educational issue such as this, there needs to be a commitment by both the Department of Education and the DHSSPS for it to be successful.
- **Curricular Issues** - there should be a proper curricular approach, with the Health Promoting School Initiative dovetailing into other existing curricular programmes such as personal development.
- **Training** - teacher training needs to be reviewed, with teachers at the point of entry into teacher training, receiving proper training on mental health.

## **The Workplace**

Employers have a duty under health and safety legislation to take measures to protect the health of their employees at work.

A negative working environment can lead to a range of problems such as: sickness absence labour turnover: bullying and harassment and ineffective working, what helps is to promote a healthy culture, with good quality of relationships, communication and support to staff.

- Policies should approach the topic in a comprehensive way, from recruitment and training, right through to actual support for vulnerable staff and guidance on handling issues such as staff sickness and absenteeism. Training for managers in implementing such a policy is recommended.
- All employers, as a minimum, should have in place a Mental Health in the Workplace Policy which seeks to address, even as a staged process over a period of time, issues relating to prevention of negative factors where possible, and support to those who may be in a stressful environment, or going through a difficult period.

## **Communities and Neighbourhoods**

- Interventions designed to increase social inclusion such as social prescribing should be encouraged as part of community development.
- Actions in the Investing for Health 2002 need to be progressed and assessed.
- Research programmes addressing the needs of marginalized groups need to be resourced, with a view to mainstreaming.
- Training for relevant community and professional agencies on mental health awareness and ways to reduce stigma should be provided.
- The benefits of interventions such as arts on prescription for increasing social inclusion and strengthening communities should be explored especially in particularly disadvantaged areas.
- As the Communities That Care (CTC) Programme appears to have proved to have successful outcomes, not only in the USA, but elsewhere in Europe and the UK, this approach should be considered in Northern Ireland, especially with its particular needs and often fragmented social networks and lack of cohesion.

## Further and Higher Education

- There are positive associations between education and both physical and mental health. Facilitating access to further and higher education opportunities for those who are psychologically vulnerable is an important issue in itself. In addition it is important for students, especially young adults, to feel supported in a pressured and transitional time in their lives.
- The Health Promoting University/College is an initiative which has been implemented in England. Its approach could be assessed for its usefulness in the Northern Ireland context.

## Primary Care

### Professionals

- **Training for GPs** – approximately 50% of GPs have no formal psychiatric training and few practice nurses have had such training (Croft 2000 in Foy 2004). As most GPs have opted to go into physical medicine, they may have very little experience of mental ill health. There is a need for better training for GPs.
- **Research** – increased research into the effectiveness of mental health promotion at primary care level is needed.
- **Resources, Targets and Priorities** – with the contracting system, there is the opportunity to target resources for mental health promotion. GPs are particularly well placed due to working within an overall health promotion setting, where potentially mental health promotion can be dovetailed with general health promotion initiatives.
- **Role of Voluntary Agencies** – there should be an increased use of services provided by voluntary agencies and increased direct liaison into primary care priorities.

### Public

- **Support Available/Information Services** – primary care environments could be better used as an information resource, perhaps with access to a practice library with self-help literature.
- **Self-Help** – increased promotion of the ethos of empowerment for those who are vulnerable due to mental health problems would potentially speed recovery.
- **Users' Role in Promoting Mental Health at Primary Care Level** - there are opportunities for mental health service user groups in helping to improve mental health issues within primary care (Foy 2004).

## **Social Prescribing**

- Social Prescribing including exercise, learning and arts of prescription, as an adjacent or alternative to medication have been proved to be effective elsewhere in the UK and internationally.

There is a need for this approach to be further employed in Northern Ireland.

## **Rural Areas**

- As rural areas have been identified as being particularly prone to risk factors such as isolation and specific problems related to the farming community, and are particularly at risk of suicide, a province-wide strategy is required to help raise awareness of issues involved and to help people identify where to get support.
- Stigma has been identified as a major barrier in people seeking help – therefore, a strategy to address issues relating to stigma, especially young men in rural areas should be outlined.
- The actions relating to rural areas in the Strategy & Action Plan 03-08 need to be progressed.

## **Faith Communities**

- An accepting and non judgmental attitude needs to be promoted – those in a caring role need not always “do” anything except listen and afford the individual dignity and respect.
- Training in mental health would be beneficial for those being ordained in all denominations.
- Information/workshops should be provided for those in the community who may benefit from pastoral care, and may not be affiliated to any particular faiths.
- The wider dissemination of the work of the Special Interest Group on spirituality within the Royal College of Psychiatrists may benefit practitioners not currently involved.

## **Prisons**

- It is a major challenge to provide effective mental healthcare within a prison environment.

## **The Prevention of Mental Health Problems in Key At Risk Groups**

### **Children and Adolescents**

In terms of mental health promotion, early intervention and the development of emotional resilience have been identified as crucial in helping young people cope with pressures through adolescence into early adulthood.

- There is a range of potential interventions, school, home and community based which can be effective in this regard. Social skills training, eg. involving coaching and cognitive problem solving approaches is particularly effective with isolated children.
- The education and health sectors need to collaborate further on programmes with children and young people.
- Peer education and support can be a relatively cost effective approach, with considerable positive impact.

The Expert Working Committee on Child and Adolescent Mental Health will report in detail of issues relating to this target group in their report. Members of this Committee discussed with the Mental Health Promotion Expert Working Committee some of the main issues they seek to address in their report which include:

- child and adolescent mental health needs to be society's agenda – not just a healthcare issue solely;
- the education and health sectors need to work together;
- early attachment and infant mental health is important in later life;
- there should be quick and appropriate referral procedures in the event of first onset psychosis;
- there are significant gaps in child and adolescent services;
- “Looked After” children is an issue itself;
- access to support is important to young people – there is potential in peer education approaches;
- there is a regional strategy “Bright Future” but not enough emphasis on children;
- there needs to be a ministerial commitment to drive any such strategy forward; and
- other international and national models can be useful to draw upon, eg. New Zealand's Diversity Model and the Scottish “Pathway” approach.

## **People who are Deaf or Hard of Hearing**

- One good practice example, from which Northern Ireland could learn, is that of the peer education process model adapted by the LINK Centre in Eastbourne.
- There is a need for research into this area in the UK generally and Northern Ireland in particular.
- Programmes to increase understanding and awareness of the issues relating to various types of deafness need to be implemented.

(Refer to A Strategic Framework for Adult Mental Health Services - June 2005 section of Services for Deaf People with Mental Health Problems.

## **People with a Learning Disability**

The Learning Disability Expert Working Committee has reported in detail on these issues (Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland, September 2005).

Devine (2004) outlines 15 recommendations for actions.

These include:

- the need for mental health promotion for people who have a learning disability to be made more specific in mainstream strategies and policies;
- emphasis should be given within all relevant sectors to building positive mental health;
- a responsibility to enhance emotional well-being and build resilience should be a central component of any school curriculum; and
- there needs to be a recognition that people with a learning disability need to have improved opportunities for meaningful work/vocational opportunities.

## **Ethnic Minorities**

- There is a need for greater public education and awareness about ethnic minorities in Northern Ireland.
- There is a need to further explore issues relating to the mental health of these groups.
- Research into identification of need would help to begin to address how to reduce barriers and increase social inclusion for the increasing number of ethnic groups in Northern Ireland.

## **Older People**

- The prevalence of mental health disorders, such as depression, is relatively high in later life. Programmes such as pre-retirement, the provision of telephone support and prevention of suicide in later life should be implemented within the community.
- Community development programmes should be developed to enhance levels of social support for older people.
- Exercise on prescription through primary care should be encouraged.

## **People Affected by Unemployment**

- Given Northern Ireland's higher levels of deprivation and unemployment, any regional strategy should directly address those issues with suggestions for strategic cross-sectoral action.
- It is essential for employers to have more education and awareness of mental health issues to ensure there is no discrimination against individuals seeking employment who have a background of mental illness.
- Any Northern Ireland strategy on prevention of suicide should include specific reference to dealing with unemployment (eg. it has been calculated that if there were full employment in the UK, the suicide rate would drop by 11%) (Lewis, Hawton and Jones 1997).
- Interventions with a strong focus on job search, self-efficacy, social and emotional coping skills and building social support should be encouraged.

## **People with a Physical Illness**

Mental health and physical health are deeply interdependent. For the integration of mental health into general health care to be successful policy-makers and practitioners both need to be fully aware of the mind-body link. This is of particular importance at primary care level. Training is recommended for GPs and other professionals in mental health awareness.

For integration of mental health into general health care to be successful, policy-makers need to consider the following:

- general health staff must have the knowledge, skills and motivation to treat and manage people living with mental disorders;
- there needs to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary care levels;

- basic psychotropic drugs must be available at primary and secondary care levels;
- mental health specialists are required to provide support to monitor general healthcare personnel;
- effective referral links between primary, secondary and tertiary levels of care need to be in place;
- investment in primary and community care can deliver better outcomes both in primary and secondary care; and
- recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities (WHO 2001 World Health Report).

### **People with Gender and Sexuality Issues**

- The psychological and emotional distress of young gay men appears to be reasonably well documented. A gap in identified need seems to be that of young lesbian women's emotional and psychological needs.
- Given that questions over sexual identity can arise in adolescence and early 20's, awareness amongst staff in school and further/higher education of these individuals' particular needs seems vital.
- Public education and awareness of gender issues to promote understanding and tolerance of them is required.
- Youthnet recommend as a result of their research that lesbian, gay and bisexual training, awareness training programs to all those involved in the development and implementation of services to gay people should be delivered.

### **People Traumatized by Sexual Abuse**

- The importance of sex education in schools needs to be highlighted.
- Sexual abuse should be talked about more openly, especially as many forms of abuse are linked to mental health problems.
- As sexual crimes are seriously under reported, training should be given to key relevant professionals in helping to identify hidden issues such as abuse and managing the disclosure of the same.

## **People Within the Criminal Justice System**

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

- focusing on early interventions;
- research needs to be conducted into the mental health needs for women within the criminal justice system;
- encouraging the courts to use alternatives to custody for men with mental health problems who have committed minor offences;
- increase the number of court diversion schemes available across the country so that offenders who are acutely, ie. not at risk of suicide, can be given hospital places or the treatment they need;
- ensuring the Prison Service meets NHS Standards, policies and protocols, particularly regarding the use of medication, service user initiatives, training for doctors and healthcare staff; and
- continuing to explore in Northern Ireland the Restorative Justice Model which has also been proven to be effective as an alternative to long term imprisonment.

## **Improving the Quality of Life for People who have Experience in Mental Health Problems**

### **The Key Issues to be Addressed**

#### **People with Enduring Mental Illness**

The Strategic Framework for Adult Mental Health Services has recommended a Strategic Framework of Services in this area. However, in terms of mental health promotion, there is now a body of evidence to show that mental health promotion can contribute to the prevention of certain disorders, such as anxiety, depression and substance abuse. It can also contribute to the health improvement of people whether they are at risk of mental illness, as well as for those with mental health problems.

- An educational programme in Sweden improved the detection and management of depression. Evidence in England suggests that an educational package aimed at improving the interviewing skills of primary care physicians produced the same results.

It is suggested that this training could be applied here in a primary care setting, with all primary care professionals.

### **People with Eating Disorders**

- Examples of good practice in terms of prevention indicate that the key issues to be addressed include: life skills training programmes and programmes which focus on improving self-image and reducing body dissatisfaction in young people.
- Given that early recognition means that treatment is most effective, in terms of mental health promotion, programmes should focus on early intervention.

### **People at Risk of Suicide**

- Any new suicide strategy needs to be cognizant of the UN/WHO guidelines and Safety First recommendations and needs to draw on good practice in the rest of the UK and the Republic of Ireland. It is imperative that in order for it to be implemented, it needs to be resourced with an identified action plan with target dates, identified responsibilities, etc.
- The Multi-Sectoral Task Force engaged with a wide number of individuals and organisations in drafting the document Protect Life - A Shared Vision 2006-2011.
- This document identified specific actions with a targeted approach eg. looking at the needs of those who self-harm; people with a mental illness; young males; marginalised and disadvantaged groups; and people who have been bereaved by suicide.
- Detailed recommendations on suicide prevention are presented in Annex 2.

### **People Emotionally and Physically Traumatized Due to the NI “Troubles”**

- Over and above actual treatment, additional resources should be provided for day to day support and training of those who help people in the community affected by the conflict and to help enhance social capital.
- Consistent with WHO recommendations for post-conflict societies, preventive initiatives are required to reduce the onset of mental disorders such as anxiety, depression and PTSD focusing primarily on early interventions after trauma, rebuilding our community’s physical and mental health services and social infrastructures, mental health education and offering emotional, societal and economic support to victims (WHO 2004).
- The development and expansion of evidence based services, including CREST guidelines, to address psychological trauma and including adult survivors of childhood trauma should be taken forward as a priority.

### **People Involved in Substance Abuse**

Both the Strategic Framework for Adult Mental Health Services and the Alcohol and Substance Report (December 2005) deal with the issues relating to people who have developed alcohol or drug problems:

- Availability of alcohol is a factor and, therefore, there may be political aspects to dealing with the problem away from excess drinking. Politicians should be lobbied in this regard.
- The Health Promotion Agency could have a significant role in developing a strategy province-wide to help promote healthier drinking, drawing on examples of good practice and research nationally and internationally.



**WHO European Ministerial Conference  
on Mental Health  
Facing the Challenges, Building Solutions  
Helsinki, Finland, 12-15 January 2005**



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**Mental Health Action Plan for Europe  
Facing the Challenges, Building Solutions**

This Action Plan is endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region. They support its implementation in accordance with each country's needs and resources.

The challenges over the next 5 to 10 years are to develop, implement and evaluate policies and legislation that will deliver mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems. The priorities for the next decade are to:

- i. foster awareness of the importance of mental well-being;
- ii. collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
- iii. design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- iv. address the need for a competent workforce, effective in all these areas;
- v. recognize the experience and knowledge of service users and carers<sup>1</sup> as an important basis for planning and developing services.

This Action Plan proposes ways and means of developing, implementing and reinforcing comprehensive mental health policies in the countries of the WHO European Region, requiring action in the 12 areas as set out below. Countries will reflect these policies in their own mental health strategies and plans, to determine what will be delivered over the next 5 and 10 years.

## **1. Promote mental well-being for all**

### **Challenge**

Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies. Public mental health and lifestyles conducive to mental well-being are crucial to achieving this aim. Mental health promotion increases the quality of life and mental well-being of the whole population, including people with mental health problems and their carers. The development and implementation of effective plans to promote mental health will enhance mental well-being for all.

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<sup>1</sup> The term "carer" is used here to describe a family member, friend or other informal care-giver.

## **Actions to consider**

- i. Develop comprehensive strategies for mental health promotion within the context of mental health, public health and other public policies that address the promotion of mental health across the lifespan.
- ii. Adopt promotion of mental health as a long-term investment and develop education and information programmes with a long time frame.
- iii. Develop and offer effective programmes for parenting support and education, starting during pregnancy.
- iv. Develop and offer evidence-based programmes that foster skills, provide information and focus on resilience, emotional intelligence and psychosocial functioning in children and young people.
- v. Improve access to healthy diets and physical activity for older people.
- vi. Promote community-based multilevel interventions involving public awareness campaigns, primary care staff and community facilitators such as teachers, clergy and the media.
- vii. Integrate mental health promotion components into existing generic health promotion and public health policies and programmes, such as those supported by WHO health promoting networks.
- viii. Encourage the consumption of healthy products and reduce the intake of harmful products.
- ix. Create healthy workplaces by introducing measures such as exercise, changes to work patterns, sensible hours and healthy management styles.
- x. Offer effective mental health promotion activities to groups at risk such as people with enduring mental or physical health problems and carers.
- xi. Identify clear mechanisms for empowering the population to take responsibility for health promotion and disease prevention targets, for example by heightening public awareness of the importance of life choices.

## **2. Demonstrate the centrality of mental health**

### **Challenge**

Mental health is central to building a healthy, inclusive and productive society. Sound and integrated public policies, such as those on labour, urban planning and socioeconomic issues, also have a positive impact on mental health and reduce the risk of mental health problems. The mental

health implications of all public policy, and particularly its potential impact on groups at risk, therefore need to be considered. Mental health policy requires intersectoral linkages and should incorporate multisectoral and multi-disciplinary approaches.

#### **Actions to consider**

- i. Make mental health an inseparable part of public health.
- ii. Incorporate a mental health perspective and relevant actions into new and existing national policies and legislation.
- iii. Include mental health in programmes dealing with occupational health and safety.
- iv. Assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards.
- v. Give special consideration to the relative impact of policies on people already suffering from mental health problems and those at risk.

### **3. Tackle stigma and discrimination**

#### **Challenge**

Mental health policy development and implementation must not be jeopardized by the widespread stigma attached to mental health problems that leads to discrimination. In many instances, people with mental health problems suffer from a lack of equal opportunities because of such discrimination. Human rights and respect for people with mental health problems must be protected. Empowerment is a crucial step towards meeting these objectives, as it enhances integration and social inclusion. The lack of empowerment of service users' and carers' organizations and poor advocacy hinder the design and implementation of policies and activities that are sensitive to their needs and wishes. The exclusion experienced by mental health service users, whether in asylums and institutions or in the community, needs to be tackled in a variety of ways.

#### **Actions to consider**

- i. Instigate activities to counter stigma and discrimination, emphasizing the ubiquity of mental health problems, their general good prognosis and treatability, and the fact that they are rarely associated with violence.
- ii. Introduce or scrutinize disability rights legislation to ensure that it covers mental health equally and equitably.
- iii. Develop and implement national, sectoral and enterprise policies to eliminate stigma and discrimination in employment practices associated with mental health problems.
- iv. Stimulate community involvement in local mental health programmes by supporting initiatives of nongovernmental organizations.

- v. Develop a coherent programme of policy and legislation to address stigma and discrimination, incorporating international and regional human rights standards.
- vi. Establish constructive dialogue with the media and systematically provide them with information.
- vii. Set standards for representation of users and their carers on committees and groups responsible for planning, delivery, review and inspection of mental health activities.
- viii. Stimulate the creation and development of local and national nongovernmental and service user-run organizations representing people with mental health problems, their carers and the communities they live in.
- ix. Encourage the integration of children and young people with mental health problems and disabilities in the regular educational and vocational training system.
- x. Establish vocational training for people suffering from mental health problems and support the adaptation of workplaces and working practices to their special needs, with the aim of securing their entry into competitive employment.

#### **4. Promote activities sensitive to vulnerable life stages**

##### **Challenge**

Infants, children and young people, and older people are particularly at risk from social, psychological, biological and environmental factors. Given their vulnerability and needs, young and older people should be a high priority for activities related to the promotion of mental health and the prevention and care of mental health problems. However, many countries have inadequate capacity in this area, and services and staff are often poorly prepared to deal with developmental and age-related problems. In particular, disorders in childhood can be important precursors of adult mental disorders. Supporting the mental health of children and adolescents should be seen as a strategic investment which creates many long-term benefits for individuals, societies and health systems.

##### **Actions to consider**

- i. Ensure that policies on mental health include as priorities the mental health and wellbeing of children and adolescents and of older people.
- ii. Incorporate the international rights of children and adolescents and of older people into mental health legislation.
- iii. Involve young people and older people as much as possible in the decision-making process.
- iv. Pay special attention to marginalized groups, including children and older people from migrant families.

- v. Develop mental health services sensitive to the needs of young and older people, operated in close collaboration with families, schools, day-care centres, neighbours, extended families and friends.
- vi. Promote the development of community centres for older people to increase social support and access to interventions.
- vii. Ensure that age- and gender-sensitive mental health services are provided by both primary care and specialized health and social care services and operate as integrated networks.
- viii. Restrict institutional approaches for the care of children and adolescents and older people that engender social exclusion and neglect.
- ix. Improve the quality of dedicated mental health services by establishing or improving the capacity for specialized interventions and care in childhood and adolescence and old age, and by training and employing adequate numbers of specialists.
- x. Improve coordination between organizations involved in alcohol and drugs programmes and children's and adolescents' health and mental health at national and international levels, as well as collaboration between their respective networks.
- xi. Ensure parity of funding in relation to comparable health services.

## **5. Prevent mental health problems and suicide**

### **Challenge**

People in many countries are exposed to harmful stress-inducing societal changes that affect social cohesion, safety and employment and lead to an increase in anxiety and depression, alcohol and other substance use disorders, violence and suicidal behaviour. The social precipitants of mental health problems are manifold and can range from individual causes of distress to issues that affect a whole community or society. They can be induced or reinforced in many different settings, including the home, educational facilities, the workplace and institutions. Marginalized and vulnerable groups, such as refugees and migrant populations, the unemployed, people in or leaving prisons, people with different sexual orientations, people with physical and sensorial disabilities and people already experiencing mental health problems, can be particularly at risk.

## **Actions to consider**

- i. Increase awareness of the prevalence, symptoms and treatability of harmful stress, anxiety, depression and schizophrenia.
- ii. Target groups at risk, offering prevention programmes for depression, anxiety, harmful stress, suicide and other risk areas, developed on the basis of their specific needs and sensitive to their background and culture.
- iii. Establish self-help groups, telephone help-lines and websites to reduce suicide, particularly targeting high-risk groups.
- iv. Establish policies that reduce the availability of the means to commit suicide.
- v. Introduce routine assessment of the mental health of new mothers by obstetricians and health visitors and provide interventions where necessary.
- vi. For families at risk, provide home-based educational interventions to help proactively to improve parenting skills, health behaviour and interaction between parents and children.
- vii. Set up in partnership with other ministers evidence-based education programmes addressing suicide, depression, alcohol and other substance use disorders for young people at schools and universities and involve role models and young people in the making of campaigns.
- viii. Support the implementation of community development programmes in high-risk areas and empower nongovernmental agencies, especially those representing marginalized groups.
- ix. Ensure adequate professional support and services for people encountering major crises and violence, including war, natural disasters and terrorist attacks in order to prevent post-traumatic stress disorder.
- x. Increase awareness among staff employed in health care and related sectors of their own attitudes and prejudices towards suicide and mental health problems.
- xi. Monitor work-related mental health through the development of appropriate indicators and instruments.
- xii. Develop the capacities for protection and promotion of mental health at work through risk assessment and management of stress and psychosocial factors, training of personnel, and awareness raising.
- xiii. Involve mainstream agencies responsible for employment, housing and education in the development and delivery of prevention programmes.

## **6. Ensure access to good primary care for mental health problems**

### **Challenge**

For many countries in the European Region, general practitioners (GPs) and other primary care staff are the initial and main source of help for common mental health problems. However, mental health problems often remain undetected in people attending GPs or primary care services and treatment is not always adequate when they are identified. Many people with mental health problems, particularly those who are vulnerable or marginalized, experience difficulties in accessing and remaining in contact with services. GPs and primary care services need to develop capacity and competence to detect and treat people with mental health problems in the community, supported as required as part of a network with specialist mental health services.

### **Actions to consider**

- i. Ensure that all people have good access to mental health services in primary health care settings.
- ii. Develop primary care services with the capacity to detect and treat mental health problems, including depression, anxiety, stress-related disorders, substance misuse and psychotic disorders as appropriate by expanding the numbers and skills of primary care staff.
- iii. Provide access to psychotropic medication and psychotherapeutic interventions in primary care settings for common as well as severe mental disorders, especially for individuals with long-term and stable mental disorders who are resident in the community.
- iv. Encourage primary health care staff to take up mental health promotion and prevention activities, particularly targeting factors that determine or maintain illhealth.
- v. Design and implement treatment and referral protocols in primary care, establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services.
- vi. Create centres of competence and promote networks in each region which health professionals, service users, carers and the media can contact for advice.
- vii. Provide and mainstream mental health care in other primary care services and in easily accessible settings such as community centres and general hospitals.

## **7. Offer effective care in community-based services for people with severe mental health problems**

### **Challenge**

Progress is being made across the Region in reforming mental health care. It is essential to acknowledge and support people's right to receive the most effective treatments and interventions while being exposed to the lowest possible risk, based on their individual wishes and needs and taking into account their culture, religion, gender and aspirations. Evidence and experience in many countries support the development of a network of community-based services including hospital beds. There is no place in the 21<sup>st</sup> Century for inhumane and degrading treatment and care in large institutions: an increasing number of countries have closed many of their asylums and are now implementing effective community-based services. Special consideration should be given to the emotional, economic and educational needs of families and friends, who are often responsible for intensive support and care and often require support themselves.

### **Actions to consider**

- i. Empower service users and carers to access mental health and mainstream services and to take responsibility for their care in partnership with providers.
- ii. Plan and implement specialist community-based services, accessible 24 hours a day, seven days a week, with multidisciplinary staff, to care for people with severe problems such as schizophrenia, bipolar disorder, severe depression or dementia.
- iii. Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others.
- iv. Offer comprehensive and effective treatments, psychotherapies and medications with as few side effects as possible in community settings, particularly for young people experiencing a first episode of mental health problems.
- v. Guarantee access to necessary medicines for people with mental health problems at a cost that the health care system and the individual can afford, in order to achieve appropriate prescription and use of these medicines.
- vi. Develop rehabilitation services that aim to optimize people's inclusion in society, while being sensitive to the impact of disabilities related to mental health problems.
- vii. Offer services for people with mental health needs who are in non-specialist settings such as general hospitals or prisons.
- viii. Offer carers and families assessment of their emotional and economic needs, and involvement in care programmes.

- ix. Design programmes to develop the caring and coping skills and competencies of families and carers.
- x. Scrutinize whether benefit programmes take account of the economic cost of caring.
- xi. Plan and fund model programmes that can be used for dissemination.
- xii. Identify and support leaders respected by their peers to spearhead innovation.
- xiii. Develop guidelines for good practice and monitor their implementation.
- xiv. Introduce legal rights for people subject to involuntary care to choose their independent advocate.
- xv. Introduce or reinforce legislation or regulations protecting the standards of care, including the discontinuation of inhuman and degrading care and interventions.
- xvi. Establish inspection to reinforce good practice and to stop neglect and abuse in mental health care.

## **8. Establish partnerships across sectors**

### **Challenge**

Essential services which in the past were routinely provided in large institutions or were not considered as relevant to the lives of people with mental health problems are nowadays often fragmented across many agencies. Poor partnership and lack of coordination between services run or funded by different agencies lead to poor care, suffering and inefficiencies. The responsibilities of different bodies for such a wide range of services need coordination and leadership up to and including government level. Service users and their carers need support in accessing and receiving services for issues such as benefits, housing, meals, employment and treatment for physical conditions, including substance misuse.

### **Actions to consider**

- i. Organize comprehensive preventive and care services around the needs of and in close co-operation with users.
- ii. Create collaborative networks across services that are essential to the quality of life of users and carers, such as social welfare, labour, education, justice, transport and health.
- iii. Give staff in mental health services responsibility for identifying and providing support for needs in daily living activities, either by direct action or through co-ordination with other services.

- iv. Educate staff in other related services about the specific needs and rights of people with mental health problems and those at risk of developing mental health problems.
- v. Identify and adjust financial and bureaucratic disincentives that obstruct collaboration, including at government level.

## **9. Create a sufficient and competent workforce**

### **Challenge**

Mental health reform demands new staff roles and responsibilities, requiring changes in values and attitudes, knowledge and skills. The working practices of many mental health care workers and staff in other sectors such as teachers, benefit officers, the clergy and volunteers need to be modernized in order to offer effective and efficient care. New training opportunities must respond to the need for expertise in all roles and tasks to be undertaken.

### **Actions to consider**

- i. Recognize the need for new staff roles and responsibilities across the specialist and generic workforce employed in the health service and other relevant areas such as social welfare and education.
- ii. Include experience in community settings and multidisciplinary teamwork in the training of all mental health staff.
- iii. Develop training in the recognition, prevention and treatment of mental health problems for all staff working in primary care.
- iv. Plan and fund, in partnership with educational institutions, programmes that address the education and training needs of both existing and newly recruited staff.
- v. Encourage the recruitment of new mental health workers and enhance the retention of existing workers.
- vi. Ensure an equitable distribution of mental health workers across the population, particularly among people at risk, by developing incentives.
- vii. Address the issue of lack of expertise in new technologies of present trainers, and support the planning of “train the trainers” programmes.
- viii. Educate and train mental health staff about the interface between promotion, prevention and treatment.
- ix. Educate the workforce across the public sector to recognize the impact of their policies and actions on the mental health of the population.
- x. Create an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care.

- xi. Develop specialist training streams for areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (comorbidity).

## **10. Establish good mental health information**

### **Challenge**

In order to develop good policy and practice in countries and across the Region, information has to be available about the current state of mental health and mental health activities. The impact of any implementation of new initiatives should be monitored. The mental health status and the help-seeking behaviour of populations, specific groups and individuals should be measured in a manner that allows comparison across the WHO European Region. Indicators should be standardized and comparable locally, nationally and internationally in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy and action plan for mental health.

### **Actions to consider**

- i. Develop or strengthen a national surveillance system based on internationally standardized, harmonized and comparable indicators and data collection systems, to monitor progress towards local, national and international objectives of improved mental health and well-being.
- ii. Develop new indicators and data collection methods for information not yet available, including indicators of mental health promotion, prevention, treatment and recovery.
- iii. Support the carrying out of periodic population-based mental health surveys, using agreed methodology across the WHO European Region.
- iv. Measure base rates of incidence and prevalence of key conditions, including risk factors, in the population and groups at risk.
- v. Monitor existing mental health programmes, services and systems.
- vi. Support the development of an integrated system of databases across the WHO European Region to include information on the status of mental health policies, strategies, implementation and delivery of evidence-based promotion, prevention, treatment, care and recovery.
- vii. Support the dissemination of information on the impact of good policy and practice nationally and internationally.

## **11. Provide fair and adequate funding**

### **Challenge**

Resources dedicated to mental health are often inadequate and inequitable compared to those available to other parts of the public sector, and this is reflected in poor access, neglect and discrimination. In some health care systems, insurance coverage of access and rights to treatment discriminate severely against mental health problems. Within the mental health budget, resource allocation should be equitable and proportionate, i.e. offering greatest relative share and benefits to those in greatest need.

### **Actions to consider**

- i. Assess whether the proportion of the health budget allocated to mental health fairly reflects the needs and priority status of the people with needs.
- ii. Ensure that people with the most severe problems and the poorest in society receive the largest relative benefits.
- iii. Assess whether funding is allocated efficiently, taking into account societal benefits, including those generated by promotion, prevention and care.
- iv. Evaluate whether coverage is comprehensive and fair in social and private insurance based systems, on an equal level to that for other conditions, not excluding or discriminating against groups and particularly protecting the most vulnerable.

## **12. Evaluate effectiveness and generate new evidence**

### **Challenge**

Considerable progress is being made in research, but some strategies and interventions still lack the necessary evidence base, meaning that further investment is required. Furthermore, investment in dissemination is also required, since the existing evidence concerning effective new interventions and national and international examples of good practice are not known to many policy-makers, managers, practitioners and researchers. The European research community needs to collaborate to lay the foundations for evidence-based mental health activities. Major research priorities include mental health policy analyses, assessments of the impact of generic policies on mental health, evaluations of mental health promotion programmes, a stronger evidence base for prevention activities and new service models and mental health economics.

### **Actions to consider**

- i. Support national research strategies that identify, develop and implement best practice to address the needs of the population, including groups at risk.
- ii. Evaluate the impact of mental health systems over time and apply experiences to the formulation of new priorities and the commissioning of the necessary research.

- iii. Support research that facilitates the development of preventive programmes aimed at the whole population, including groups at risk. Research is needed on the implications of the interrelated nature of many mental, physical and social health problems for effective preventive programmes and policies.
- iv. Promote research focused on estimating the health impacts of non-health sector policies, as there is a clear potential for positive mental health to be improved through such policies.
- v. Bridge the knowledge gap between research and practice by facilitating collaboration and partnerships between researchers, policy-makers and practitioners in seminars and accessible publications.
- vi. Ensure that research programmes include long-term evaluations of impact not only on mental health but also on physical health, as well as social and economic effects.
- vii. Establish sustainable partnerships between practitioners and researchers for the implementation and evaluation of new or existing interventions.
- viii. Invest in training in mental health research across academic disciplines, including anthropology, sociology, psychology, management studies and economics, and create incentives for long-term academic partnerships.
- ix. Expand European collaboration in mental health research by enhancing networking between WHO's European collaborating centres and other centres with research activities in the field of prevention.
- x. Invest in regional collaboration on information and dissemination in order to avoid the duplication of generally applicable research and ignorance of successful and relevant activities elsewhere.

## **Mental Health for Europe: Facing the Challenges**

### **Milestones**

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

- 1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
- 2. scrutinize the mental health impact of public policy;
- 3. include the prevention of mental health problems and suicide in national policies;

4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;
6. develop partnership for intersectoral working and address disincentives that hinder joint working;
7. introduce human resource strategies to build up a sufficient and competent mental health workforce;
8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.



## **SCOTTISH NATIONAL PROGRAMME FOR IMPROVING MENTAL HEALTH & WELL-BEING**

Work on Public Mental Health in Scotland is taken forward, facilitated and co-ordinated through the Executive's National Programme for Improving Mental Health and Well-Being.

This work forms part of the wider Scottish Executive agendas on Mental Health, Social Inclusion and Health Improvement/Public Health.

The National Programme is hosted within the Executive's Mental Health Division with national funding support from the Executive's Health Improvement Funds of £9m per annum.

### **Key Areas of the National Programme's Work**

#### **Raising Awareness and Promoting Mental Health and Well-Being**

- Scotland's Mental Health First Aid (SMHFA) Course;
- by March 2008 over 300 SMHFA trainers will be trained delivering SMHFA courses to over 40,000 people;
- public information leaflets on mental health have been produced;
- mental Health Promotion national training programme to be rolled out across Scotland following launch in June 2005;
- preliminary work on public promotion of Positive Mental Health and Well-Being to start 05/06;
- making mental health and well-being a priority area for NHS Health Scotland over the next five years.

#### **Eliminating Stigma and Discrimination**

- continuing to fund 'See Me', Scotland's National Anti-Stigma campaign, approximately £700k per annum – 2005/2008.

## Public Attitude Results 2004 compared with 2002

	% agreeing	
	2002	2004
I would keep a mental health problem a secret if I had one	50	45
People with mental health problems are difficult to talk to	20	15
Public should be better protected from people with mental health problems	35	24
People with mental health problems are often dangerous	32	15

- building on the success of the Dementia Awareness campaign and undertaking further campaigning activities;
- ensuring that work on inequalities and mental health is taken forward as part of general work on inequalities in health, and wider work on equality;
- Scotland has been asked by WHO Europe to help support and lead the co-ordination of work across Europe around the key theme of eliminating stigma and discrimination and promoting social inclusion.

## Preventing Suicide

- ‘Choose Life’ is the Scottish Executive’s National Strategy and Action Plan to prevent suicide in Scotland. £3m per annum (2003-2006) has been allocated across Local Authority areas in Scotland to develop local ‘Choose Life’ suicide prevention action plans in conjunction with Community Planning Partnerships.
- 32 local suicide prevention Action Plans now in place in each Local Authority areas, developed by local Community Planning Partnerships.
- Suicide ASIST Training – there are now 142 ASIST trainers in Scotland delivering the intensive, interactive workshop.
- Over 2500 participants have now completed the course.

This is part of a National Suicide Prevention Training Strategy.

## **Promoting and Supporting Recovery**

Launch of Scottish Recovery Network (SRN) 16 December 2004.

- The first three in a series of SRN discussion papers have been published and include a review of important elements of recovery, a consideration of community involvement and issues on researching recovery.
- Stories will be gathered at events around Scotland and the outcomes used to influence SRN's future work.
- Development of training to promote and support recovery.
- SRN is currently engaging with up to 60 individuals to take part in an ambitious research project to gather personal testimonies of recovery from mental health problems.
- SRN is collaborating with the Royal College of Psychiatrists on a training day to be integrated into postgraduate education.

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