

## **Appendix 1 - Mental Health Facts and Figures**

### **1. Mental Health and Wellbeing**

Mental Health is a crucial component of overall health and wellbeing. It is important for everyone regardless of age. Mental Health is the positive ability to enjoy life and cope with difficulties.

The World Health Organisation defines Mental Health as 'a state of wellbeing in which individuals realise his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution too his or her community' (WHO 2007)

Good Mental health begins in childhood, infancy through to adolescence is the time when mental health is developing. Apart from basic physical needs such as food and shelter, children need enough love and security to make them feel safe, happy and confident. Whether these needs are fulfilled depends very much on how the adults around the young people (at home, at school and in the community) can look after them, and create the right conditions for them to form satisfactory relationships, to make the most of their abilities and talents and to prepare them for taking on adult responsibilities. (Young Minds 2009).

In adulthood employment is an important factor that will enhance mental health and wellbeing. Work can be a service of stimulation, satisfaction and support, leading to an increased sense of wellbeing and reduced incidence of stress related sickness absence. (Sainsbury Centre for Mental Health 2000)

An important aspect of healthy ageing is that of good mental health. Age discrimination has a negative impact on mental health, eliminating it will help promote good mental health and wellbeing in later life. Participation in meaningful activity and good relationships are important for good mental health and wellbeing and prevent social isolation. (Age Concern/Mental Health Foundation 2006).

The above gives a brief overview of what helps to promote mental health and wellbeing. A comprehensive review can be found in Mental Health Improvement and Wellbeing – A person, public and political issue. Report of the Bamford Review May 2006.

In October 2008 the government launched the Foresight Project on Mental Health Capital and Well-Being. The project drew on 80 commissioned scientific reviews and received input from over 400 experts in fields ranging from economics to neurosciences.

Including input from people who use services, families and carers. The report has taken a life span approach to develop a vision that

- identifies the opportunities and challenges facing the United Kingdom over the next 20 years and beyond, and the implications for everyone's 'mental capital' and 'mental wellbeing'.
- and
- what we all need to do to meet the challenges ahead, so that everyone can realise their potential and flourish in the future.

The report states that a person's 'mental capital' is an individual's total cognitive and emotional resources: not only their thinking and learning skills but their 'emotional intelligence' which determines how well they interact with others, manage and organise themselves and deal with stress every day. 'Mental Wellbeing' is linked to personal and social fulfilment and changes from day to day.

The study found:-

- Early intervention is crucial: from noticing and treating learning difficulties in the young to using biomarkers to spot the early signs of dementia in older people.
- A small increase in mental wellbeing leads to a large decrease in mental health problems for all age groups.
- There are a lot of ways to tackle and reduce the huge burden of mental ill health in the UK.

The Foresight report recommends five steps to help people protect their own mental health and make them feel better about themselves.

- **CONNECT:** With people around you
- **BE ACTIVE:** Exercise makes you feel good
- **TAKE NOTICE:** of your surroundings and savour the moment
- **KEEP LEARNING:** Try something new or rediscover an old interest
- **GIVE:** Do something nice for a friend or a stranger

The project has identified a large number of possible initiatives that should be considered by Government, Business and Individuals that will help promote mental health and wellbeing.

The project will report again with a progress update in twelve months following further engagement with a range of stakeholders.

The full report can be accessed on [www.foresight.gov.uk](http://www.foresight.gov.uk).

## 2. Mental Health Problems

Mental health problems are among the most common forms of ill health and disability. It is estimated they affect approximately 280,000 people (1 in 6) in Northern Ireland at any one time and thus create a heavy burden on the individual, their family and carers as well as the wider society (Chief Medical Officers Report DHSSPS 2004).

As a result of the increasing recognition of mental illness as a major public health issue, there is now greater emphasis on improving the mental health and wellbeing of the people of Northern Ireland. Many factors can affect mental health; some of these are seen in Table 1.

Internal Factors	External Factor
<ul style="list-style-type: none"> <li>• Poor quality of relationships;</li> </ul>	<ul style="list-style-type: none"> <li>• Poverty and unemployment;</li> </ul>
<ul style="list-style-type: none"> <li>• Feelings of isolation;</li> </ul>	<ul style="list-style-type: none"> <li>• Social exclusion and discriminating;</li> </ul>
<ul style="list-style-type: none"> <li>• Experience of disharmony, conflict or alienation;</li> </ul>	<ul style="list-style-type: none"> <li>• Poor physical environment;</li> </ul>
<ul style="list-style-type: none"> <li>• Physical illness, infirmity or disability;</li> </ul>	<ul style="list-style-type: none"> <li>• Negative peer pressures;</li> </ul>
<ul style="list-style-type: none"> <li>• A lack of self esteem.</li> </ul>	<ul style="list-style-type: none"> <li>• Family or community conflict or tensions</li> </ul>

(Ref. Chief Medical Officer Report DHSSPS 2004)

Statistics in relation to mental health problems should be treated with caution as a large number of people do not report their problems and manage without any help from General Practitioners and/or Mental Health Services. It is also sometimes difficult for General Practitioners to diagnose a mental health issue as people are reluctant to talk about their feelings and talk about physical problems instead. It is therefore very likely that any figures relating to mental ill health are underestimated. It is important also, to

remember that the factors which predispose, perpetuate or precipitate mental health problems are generally the same for children and young people as they are for adults, and that if parents or close family members have mental health problems this is likely to affect a child or a young person.

The following facts and figures about mental health and wellbeing have been informed by the Mental Health Foundation Publication 'Fundamental Facts' (2007). This report brings together the latest mental health statistics available within the UK. Where Northern Ireland information is available it has been included.

### **3. The number of people experiencing mental health problems.**

It is also difficult to estimate exactly how many people experience mental health problems as the way the figures are measured varies. Some calculations are based on how many people have a mental health problem at any point in time, while others measure the likelihood of someone developing mental health problems in their lifetime. Figures may relate to specific populations such as adult population, a regional population or a region or country within the UK or an international population.

For example

- It is estimated that approximately 450 million people worldwide have a mental health problem. (The World Health Report 2001)
- 1 in 4 families worldwide are likely to have at least one member with a behavioural problem or mental disorder. (The World Health Report 2001)

*For the purposes of these facts and figures the term 'mental health problem', 'mental distress' and 'mental ill health' are used interchangeably. The term 'mental ill health' is used to refer to specific clinically recognised patterns or symptoms of behaviour that can be diagnosed as mental illness.*

- 1 in 4 British adults experience at least one mental disorder in their lifetime (Singleton N, Bumpstead R, et al 2001)
- 280,000 people (1 in 6) in Northern Ireland experience a mental health problem at any one time.

(Chief Medical Officers Annual Report DHSSPS 2004)

- Northern Ireland has a population of 1.7 million (2001 Census) of which:

27% are less than 18 years old (451,514)  
and 23% are less than 16 years old (398,050)

Very little epidemiological study of child mental health problems has been carried out in Northern Ireland and the rates of many problems and disorders have to be extrapolated from British and international studies. Where local studies are available figures have been included.

In Great Britain it has been shown that 30-40% of young people may at some time experience a mental health 'problem'. Up to 20% (depending on environment and circumstances) will have a diagnosable mental disorder.

The Chief Medical Officer's report 'Health of the Public in Northern Ireland', estimated that more than 20% of young people are suffering 'significant mental health problems' by their 18<sup>th</sup> birthday.

#### **4. The Main Types of Mental Health Problems**

The Mental Health Foundation, 'Fundamental Facts' explains that "The term 'mental health problem' covers a wide range of problems that affect someone being able to get on with the activities of daily living. Mental health problems result from a complex interaction of biological, social and psychological factors but are usually defined and classified by medical professions.

Traditionally mental health symptoms have been divided into two groups, 'neurotic' or 'psychotic' symptoms - neurotic covers those symptoms which can be seen as extreme forms of 'normal' emotional experiences such as depression, anxiety or panic. These conditions are now more likely to be called 'common mental health problems'.

Less common are 'psychotic' symptoms which interfere with a person's perception of reality and may include hallucinations, delusions or paranoia, with the person seeing, hearing, smelling, feeling or believing things that no one else does. These conditions are referred to as 'severe mental health problems'.

There is no sharp cut off between the symptoms of common and severe mental health problems so it is important to remember some illnesses feature both neurotic and psychotic symptoms.

## **5. Common Mental Health Problems**

The following figures give some facts and figures in relation to common mental health problems that include anxiety and depression.

- Depression will be the second leading contributor of disease in the world by 2020 (The World Health Report 2001)
- Worldwide 5.8% of men and 9.5% of women will experience a depressive episode in a 12 month period, a total of about 121 million people (National Suicide Prevention Strategy DOH 2006)
- 33 million people in Europe suffer from Depression (WHO 2005).
- In the United Kingdom (UK) it is estimated 4 million people experience mental health problems the majority of them depression and anxiety. (Layard R 2005).
- Mixed anxiety and depression is the most common mental health disorder in Britain with almost 9% of people meeting the diagnostic criteria (Singleton N, Bumpstead R, et al 2001)
- 17% of men and 24% women aged 35-44 show signs of depression (Northern Ireland Health and Social Wellbeing Survey 2001).
- The rates of people with depression in Northern Ireland are higher in more deprived areas, those who are unemployed and those with low education attainment. As a result use of sedatives, tranquillisers or antidepressants is also high (Chief Medical Officer Annual Report 2006).
- Half of people with common mental health problems are no longer affected after 18 months, but poorer people, long term sick and unemployed people are more likely to be still affected than the general population. (Singleton N, Lewis G, et al 2003)

- Overall, common mental health problems peak in middle age, 20-25% of people in 45-54 age group have a 'neurotic disorder'. As people age, neurotic disorders become less common, with the lowest level recorded in the 70-74 year age group. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H 2001)
- Only 2% of the population experience a depressive episode without anxiety occurring at the same time. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H 2001)
- Depression tends to recur in most people. More than half of people who have one episode of depression will have another, while those who have a second episode have a further relapse risk of 70%. After a third episode the relapse risk is 90%. For about 1 in 5 people the condition is chronic.
- According to the 2001 Census there are 7,159,694 16 to 25 year olds in the United Kingdom. This equates to 12% of the UK population. About 5% of the total population are between 16-19 years old. 1.7% of the 16-19 year olds and 2.2% of 20-24 year olds have suffered from a depressive episode.

## **6. Self Harm and Suicide**

Self Harm and Suicide are not in themselves mental illnesses but they usually result from mental distress.

### **6.1 Suicide**

- Suicide is now recognised as one of the biggest cause of 'years of life lost' after cardiovascular disease and cancer. (Chief Medical Officers Report 2006).
- Suicide is an emotive and sensitive issue, and there is currently little evidence as to why people take their own lives. Risk factors include depression, alcohol and drug misuse, personality disorder, hopelessness, low self esteem, bereavement, break-up of a relationship and social isolation. (Protect Life DHSSPS 2006).
- In 2004 more than 5,500 people in UK died by suicide. (Samaritans Suicide Statistics August 2006)

- Prior to 2005 the average number of suicides per year was 150 in Northern Ireland. In 2005 this was around 50% higher at 213. (Chief Medical Officers Report DHSSPS 2006)
- Of these 4 out of every 5 were men and 1/2 were under 35 years of age. (Chief Medical Officers Report DHSSPS 2006)
- Although the rate of suicides among young men has reduced in the UK from 1998 – 2005 suicide remains the most common cause of death in men under the age 35. (The National Service Framework for Mental Health – Five Years On 2005)
- In the UK younger people who had taken their own life more often had a history of schizophrenia, personality disorder, drug or alcohol misuse or violence than older people who had taken their own life. (Safety First 2001)
- In the UK 4% of people who took their own lives were the lone carers of children. (Safety First 2001)
- In the 5 years prior to 2001 6% of the people who took their own lives in England and Wales were from an ethnic minority group. In Scotland this was 2% and in Northern Ireland 1%. (Safety First 2001)
- The 2001 Census found that 9% of the population in England were from ethnic minorities. In Wales 2%, in Scotland 2% and in Northern Ireland 0.75%. (Census 2001)
- People from ethnic minorities who died by suicide usually had a severe mental illness. (Safety First 2001)
- In the UK a quarter of all people who died by suicide in the 5 years prior to 2001 had been in contact with Mental Health Services. (Safety First 2001)
- A quarter of suicide inquiries in the UK showed the person died within 3 months of discharge from in-patient care. In England and Wales 40% died before the first review appointment. This was 35% in Scotland and 66% in Northern Ireland. (Safety First 2001)

- In 2007 the number of suicide deaths registered in Northern Ireland were 175 males and 67 females. Of these 14 males and 3 females were under 19 years of age. (NISRA accessed 2009)

## 6.2 Self Harm

The term self harm covers a wide range of behaviours including habitual self cutting and poisoning. Northern Ireland has witnessed a substantial increase in self harm related admissions to hospital in recent years.

- Self harm involves differing degrees of risk to life and suicidal intent, and it is often considered to be a coping mechanism or means of helping someone deal with their life. (Protect Life 2006)
- The UK has one of the highest rates of self harm in Europe, at 400 per 100,000 population. (Horrocks J, 2002)
- There is a high correlation between self harming behaviour and mental health problems. Most people attending accident and emergency after self harming would meet the criteria for one or more psychiatric diagnosis. More than 2/3rd would meet the criteria for depression. (The British Psychological Society 2004)
- People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. (The British Psychological Society 2004)
- People who have self harmed are at significant risk of suicide. (Owens D, Horrocks J 2002) (Hawton K, et al 2003)
- Self harming and suicide may be influenced by the depiction of similar behaviour in the media or taking place in peer groups. Major public events may lead to amplification of existing distress such as in the month following the death of Diana, Princess of Wales when the number of women dying by suicide increased by a third. (Hawton K, et al 2003)
- The young life and times survey reported that 15% of respondents had seriously thought about self harm. 10% had self injured – 5% once and 5% more than once. Females (13%) were much more likely to have self-injured

than males (5%). Respondents from less well off backgrounds were twice as likely to have self injured as those from better off backgrounds (16% and 8%

respectively). The main reason for self harm given by those who had injured themselves was that they wanted to punish themselves. Those who self injured had more negative coping mechanism for emotional health problems than those who had not. The attitudes to self injury collected from the young life and times survey respondents show that the majority of young people recognise that young people who self harm suffer from serious emotional health problems and do not self harm for attention seeking. 64% of respondents agree that self injury can be prevented. (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the young life and times survey)

## **7. Severe Mental Health Illness (SMI)**

There is no universal definition of what severe mental illness is, because it is viewed differently by the person experiencing it, their family and social circle and by professionals. The term refers to illnesses where psychosis is present. Psychosis is the term that describes the loss of reality a person feels so that they stop responding appropriately in the world around them.

Schizophrenia, bi-polar disorder and severe depression are the severe mental illnesses reflected in the following figures.

This does not mean that other conditions are not regarded as serious.

### **7.1 Psychosis**

- About 1 in every 200 adults experience a 'probable psychotic disorder' in the course of a year. (Singleton N, Bumpstead R 2001)
- Less than a quarter of people who have a distressing psychotic experience at some time in their lives remain permanently affected by them. (The British Psychological Society Division of Mental Health June 2000)

- The average age of onset of psychotic symptoms is 22 but it can be much younger than that. (Mental Health Implementation Guide 2001)
- According to the 2001 Census there are 7,159,694 16 to 25 year olds in the UK. This amounts to 12% of the UK population. About 0.2% of these have a probable psychotic disorder and 0.9% of 16-19 year olds and 1.9% of 20-24 year olds suffer from obsessive compulsive disorder. (Singleton N et al (2001).
- 4.4% of people in the general population say they have experienced at least one symptom of psychosis such as delusions or hallucinations. Risk factors include smoking, excessive drug and alcohol use, little social support, adverse life events and neurosis. (Wiles N J, Zammit S, et al 2006)

## **7.2 Bi Polar Disorder**

- Between 0.9% and 2.1% of the adult population experience a bi-polar disorder at some point in their lives and there is very little difference in relation to gender. (National Institute for Health and Clinical Excellence, NICE 2004)
- Symptoms usually begin between ages 15 and 24. (National Institute for Health and Clinical Excellence, NICE 2004)
- The onset of mania is earlier in men than in women, although women have a higher incidence throughout the rest of adult life. However the first episode may occur at any age from childhood to old age. (Kennedy N, et al Feb 2005)

## **7.3 Schizophrenia**

- Schizophrenia is the most common form of psychotic disorder affecting between 1.1% and 2.4% of people at any one time. (National Collaborating Centre for Mental Health p31, (2002)
- The most frequent age of onset for schizophrenia is between 20 and 30 years however the symptoms may have been there much earlier. (The British Psychological Society 2004)

- On average men have an earlier age of onset than women by about 5 years. (Kennedy N, et al 2005)
- After a first episode approximately 25% of people with schizophrenia make a full recovery and experience no further episodes. Between 10 and 15% will experience severe long term difficulties and the remainder will experience recurrent acute episodes with periods of remission or with only residual symptoms in between. (Wing J, Marshall P, 1994)

## **8. Differences in population and the extent of mental health problems**

### **8.1 Gender Differences**

- Women are more likely to be treated for a mental health problem than men. (29% compared to 17%) (National Statistics 2003)
- More than half the contacts with the Samaritans are made by men – 53% compared with 43% by women. (4% were unidentified)
- Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time compared to 1 in 10 men. (National Institute for Health and Clinical Excellence Depression 2003)
- Doctors are more likely to treat depression in women than in men even when they present with identical symptoms. (World Health Organisation Fact Sheet No 248 (2000))
- Women are twice as likely to experience anxiety as men. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H, 2001)
- Young men aged 15-34 years are more likely than young women to take their own life (NISRA 2009).
- Survey of young people between the ages of 5 and 15 found that the proportion of children and adolescents with any

mental disorder is greater among boys than girls (Mental Health Foundation 1999)

## **8.2 Ethnic Groups**

- In general rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population; but they are less likely to have their mental health problems detected by General Practitioners. (National Institute for Mental Health, Inside Outside 2003)
- Depression in Ethnic Groups has been found to be up to 60% higher than in the white population. (National Health Service Mental Health 1999)
- Young Asian women are three times as likely to take their own lives as young white women.
- A higher prevalence of diagnosed mental illness particularly schizophrenia has been found among Black Caribbean people in the UK. (Mind 2004)
- Black people are twice as likely as white people to be diagnosed as having a psychotic disorder. (Spranston K, Nazroo J, 2002)
- A substantial body of research indicates that, for people from Black and Asian ethnic minorities, access to, utilisation of and treatments prescribed by mental health services differ from those for White people (Lloyd & Moodley, 1992);
- These examples infer that we must consider the cultural competence of our services: i.e. does our workforce reflect the cultural diversity in our populations, are our staff trained and supported to recognize and respond to the different cultural representations and presentations of mental illness and distress and are our organizations sufficiently culturally competent to support staff in providing services which are sensitive and appropriate to our populations

## **8.3 Children and Young People**

- Estimates for children and young people with mental health problems vary but research suggests that 20% of children have a mental problem in any given year, and about 10% at

any one time in the UK. (Mental Health Foundation Lifetime Impacts 2005)

- The British Medical Association estimates that at any point in time up to 45,000 young people in UK under the age of 16 are experiencing a severe mental health disorder and approximately 1.1 million children under the age of 18 would benefit from specialist mental health services. (British Medical Association 2006)
- The attitudes towards mental health differed significantly between those who have experienced serious emotional and mental health problems and those who hadn't. Groups of Young Life and Times survey respondents who hadn't experienced serious emotional and mental health problems reported overall significantly more positive views than the young people affected by mental health issues. Females held more negative views than males and same sex attracted respondents held more negative views than those who were only sexually attracted to people of the opposite sex. (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)
- In Northern Ireland it is estimated that 10-12% of children and teenagers have mental health problems severe enough to need help to overcome them (Young Minds).
- In 2008, in Northern Ireland, 29% of young life and times respondents were potential sufferers of a psychiatric disorder measured by General Health Questionnaire (G4Q12) (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)
- Research has shown that young people in substitute care have higher levels of mental health difficulties than children in the general population (Philips 1997, McCann J B, James A & Wilsons 1996).
- Almost half of children in care have a mental health problem. Children in care are 4-5 times more likely to have a mental health problem as other children. (Every Child Matters 2003).

- Children of single parent families are twice as likely to have a mental health problem as children of two parent families. Also at higher risk are children in large families, children of poor and poorly educated parents and those living in social sector housing. (Mental Health Foundation Lifetime Impacts 2005)
- Children in poor households are three times as likely to have mental health problems as children in well off households. (National Health Service Frameworks 1999)
- 41% of British 11-15 year olds who smoke regularly have a mental disorder, as well as 24% of those who drink alcohol at least once a week and 49% of those who use cannabis at least once a month. (National Statistics 2004)
- A high proportion of 16 year olds in Northern Ireland experienced social pressures to engage in health-adverse behaviours. 76% felt pressurised to drink alcohol, 39% felt pressurised to smoke, 32% felt pressure to lose weight, 22% experienced the pressure to have sexual intercourse and 15% felt pressurised to take illegal drugs. Apart from the pressure to take illegal drugs, females felt more pressure to engage in another activity. The pressure among females to lose weight was almost five times higher than among males (46% and 10% respectively). Social pressures were also much more experienced by same-sex attracted and not well off respondents (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)
- Behavioural problems have been found to be higher among homeless children living in temporary accommodation. (Shelter 2006)
- Over one third of all UK adults with mental health problems are parents. Most parents with mental health problems parent their children effectively.
- Two million children are estimated to live in households where at least one parent has a mental health problem but less than one quarter of these adults is in work.

- Children's resilience is enhanced by a secure and reliable family base in which relationships promote self-esteem, self-efficacy and a sense of control.
- A parent's resilience is enhanced by family (particularly children's) understanding, satisfying employment, good physical health and professional, community and personal support.
- Potential stressors leading to parental mental health problems include a lack of money; breakdowns in valued relationships, bereavement, loss of control at work and long working hours.
- For children, stress factors include loss through bereavement, marital breakdown or illness, acting as a carer, being bullied at school, homelessness and poverty. (Parrott L, et al 2008)

#### **8.4 Older People**

- Older people are less likely to have a neurotic disorder (or common mental health problem) other than depression than any other section of the British population. (Singleton N, Bumpstead R, et al 2001)
- Depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes. (Baldwin R, 2002)
- However it is likely that only a small proportion of older people with depression are in contact with their GP or Mental Health Services. (The Health Survey England 2000)
- An estimated 70% of new cases of depression in older people are related to poor physical health. (Social Exclusion Unit Report 2004), Dennis M, et al 2005)

#### **8.5 Homeless People**

- In the UK in 2005/06 there were 7340 homeless people experiencing mental illness, more than double the number 15 years earlier. (Hansard October 2006)

- In 1996 McGilloway showed that 37% of the homeless in Northern Ireland had mental health problems rising to 41% among single residents in accommodation for homeless people, half of whom had moderate to severe levels of mental health impairment, as well as high levels of unmet need for most services. (McGilloway S, Donnelly M, 1996)
- The percentage of homeless people in the UK judged to be homeless and vulnerable to mental illness or disability rose from 3.25% in 1991 to 7.8% in 2006. (Hansard October 2006)
- Less than a third of homeless people with mental health problems receive treatment. (National Health Service Frameworks 1999)
- In Northern Ireland for the year 2006-07, 21,600 households presented as homeless, 7000 of whom have dependent children. Two thirds do not have dependent children and are mostly single, half of whom are aged 25 or over. (Northern Ireland Housing Executive 2007)
- 1 in 4 homeless people will take their own lives. (Social Exclusion Unit Report 2004)
- 30-50% of homeless rough sleepers experience mental health problems. About 70% misuse drugs. (Shelter 2006)
- Mental health problems are significantly higher among mothers and children who are homeless. (Shelter 2006)

## **8.6 The Prison Population**

Prisoners have particularly high levels of mental illness. Until April 2008 prison health care was the responsibility of the Northern Ireland Office (NIO) but it now comes under the auspices of Health and Social Services (HSS).

- Prisoners in the UK with mental disorders are significantly over represented in the prison population. As many as 12-15% of prisoners have four concurrent mental health disorders. (Brooker C, 2003).

- Up to 90% of prisoners have a diagnosable mental illness, substance misuse problem or frequently both. (Brooker C, 2003)

## **8.7 Other Groups**

- People who provide a large amount of care to the family are twice as likely to have a mental problem as in the general population. (Mental Health and Social Exclusion 2004, Quoting Singleton 2002)
- Female carers in England are 23% more likely to suffer from anxiety or depression than the general population. (Office of National Statistics Mental Health of Carers 2002)
- Two thirds of refugees have experienced anxiety and depression which may be linked to war, imprisonment, torture or oppression in their home countries and/or social isolation, language difficulties and discrimination in their new country. (Burnett A, Peel M, 2001).
- 30% of deaf people using British Sign Language have mental health problems primarily anxiety and depression. (Mental Health and Social Exclusion Unit 2004)
- 25% - 40% of people with learning difficulties are estimated to have a mental health problem. (Foundation for People with Learning Difficulties August 2006)

Lesbian, gay and transgender young people are at significantly higher risk of suicidal behaviour, mental disorder, substance misuse and substance dependence than heterosexual people (King M, Semlyen J, et al)

## **9. Other Factors related to Mental Health and Wellbeing**

### **9.1 Mental Health and Material Deprivation**

- Low income, unemployment, living in poor housing, low levels of education and being in social class (iv) (partly skilled people) and (v) (people with no skills) are all

associated with a greater risk of experiencing a mental health problem. (Meltzer H, Singleton N, et al 2002)

- A study of British adults completing the psychological wellbeing questionnaire (GHQ) showed that high scores (indicative of a psychiatric problem) increased as household income decreased. (Department of Health Survey for England 2003)
- Financial difficulties can be a cause and a consequence of mental health problems. People with mental health problems are three times as likely to be in debt as the general population and more than twice as likely to have problems managing money. (Mental Health Exclusion Unit p88 2004)
- People without a degree are almost twice as likely to experience depression as those with a degree. (Singleton N, Bumpstead R, et al 2001)

## **9.2 Family Related and Social Factors**

- Social isolation is a factor in mental health problems. Twenty percent of people with common mental health problems live alone compared to 16% of the overall population. (Singleton N, Bumpstead R, et al 2001)
- A person with a severe mental health problem is four times more likely than average to have no close friends. (Huxley P, Thornicroft G, 2003)
- One in four people who use Mental Health Services has no contact with their family and one in three has no contact with friends. (National Health Service Frameworks p46 1999)
- Low levels of social support can reduce the likelihood of recovery. (Singleton N, Lewis G, 2003)
- People with common mental health problems are twice as likely to be separated or divorced as their mentally healthy counterparts. (Singleton N, Bumpstead R, et al 2001)
- Children of depressed parents have a 50% risk of developing depression themselves before the age of 20. (World Health Organisation p29 2004)

- The Young Life and Times Survey NI noted that friends and parents were identified as the main sources of support if young people suffer from emotional or mental health problems. Apart from friends, females were less likely than males to think that any other source was helpful for them when they were experiencing an emotional health problem. The highest proportion of respondents (50%) preferred support from only one professional. The least popular option was medication as a way to helping young people (20%). Friends and parents were the most likely source of support by those who self injured. The findings suggest that support from parents was much stronger after the episode of self harm than before, which indicates that parents may not be able to identify early signs of serious mental and emotional distress among their children (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)
- Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction. (Donovan N, Halpem D 2002)
- Other social and economic risk factors for mental health problems include poor transport, neighbourhood disorganisation and racial discrimination. Social and economic protective factors for mental health include: community empowerment and integration, provision of social services, tolerance and strong community networks.(World Health Organisation pp22-24 2004)
- Bullied children are known to be more likely to have anxiety, depression and thoughts of suicide, as well as to experience social isolation. (Arseneault L, et al)
- Over one third (37%) of 16 year old respondents in Northern Ireland had experienced school bullying. Experience of bullying among same sex attracted respondents is much more common with seven out of ten same sex attracted young men and over six out of ten (62%) same sex attracted young women reporting school bullying. Respondents from minority ethnic backgrounds had significant experiences of xenophobic name calling, bullying and harassment (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

- Appearance and body shape (50%), too much homework (45%) and criticism from parents and teachers (37%) were identified by Young Life and Times survey respondents as the three main reasons why young people suffer from mental health or emotional problems (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

### **9.3 Physical Health**

People with poor physical health are at higher risk of common mental health problems and people with a mental health problem are more likely to have poor physical health.

- A person with schizophrenia will on average, live for 10 years less than someone without a mental health problem. (Health Body and Mind NIMHE 2004)
- Depression affects 27% of people with diabetes, 29% of people with hypertension, 31% of people who have had a stroke, 33% of cancer patients and 44% of people with HIV/AIDS. (Investing in Mental Health WHO 2003)
- People who experience persistent pain are four times as likely to have an anxiety or depressive episode as the general population. (New Understanding, New Hope WHO 2001)
- 61% of people with schizophrenia presenting at GP surgeries and 46% of those with manic depression smoke, compared to 33% of the remaining population. (Equal Treatment, Disability Rights Commission 2006)

### **9.4 Spirituality**

Spirituality means different things for different people at different times. For centuries spirituality has been expressed through religion, art, nature and the built environment: Today expressions of spirituality have become more varied. Underlying this is an assumption that trying to make sense of the world we live in and our place within it is an intrinsic part of what it means to be human. (Fundamental Facts - Mental Health Foundation)

- Research literature has reported for many years that aspects of religious and spiritual involvement, is associated with good

mental health and wellbeing. (Swinton J 2001, Mentality – Adulthood 2004)

- The Royal College of Psychiatrists state that people who use mental health service identify the benefits of good quality spiritual care as being:-improved self control, self esteem and confidence; speedier and easier recovery; and improved relationships. (Culliford L, Powell A 2006)
- Sixty per cent of people with severe mental health problems across a range of diagnosis reported that religion/spirituality had a 'great deal' of helpful impact on their illness through the feelings it fostered of being cared for and of not being alone. (Foskett J et al 2006)

## **9.5 Other Facts**

- People who live in towns and cities are more likely to have a common mental health problem than those who live in the country. However among rural areas the most remote and deprived areas have the highest overall levels of any mental health problems and suicides. (Meltzer D 2002)
- Workplace stress can frequently contribute to mental health problems. Long hours, unrealistic workload or bad management is seen as having caused or exacerbated the problem. (Out at Work 2002)
- Mental Health is adversely affected by war, conflict, extreme poverty, displacement and natural disasters. Worldwide it is estimated that between a third and a half of those affected by such events suffer from diagnosable mental distress, especially post traumatic stress disorder, depression and anxiety. (World Health Report WHO p43 2001)
- The impact of 30 years of civil conflict on the Northern Ireland population has been assessed in several community based studies. In a random sample of 1000 adults it was found that 16% of people were direct victims of the conflict and 30% indirect victims. Perception of being a victim was consistently associated with poorer psychological wellbeing. (Cairns E, Mallet J et al 2003)

- Women who have been abused in childhood are four times more likely to develop major depression in adulthood. (World Health Report p10 WHO 2001)
- People who experienced childhood sexual abuse are almost three and a half times as likely to be treated for psychiatric disorders in adulthood as the general population. They are five times as likely to have a diagnosis of personality disorder. (Spotaro J et al 2004)

This overview of the facts and figures in relation to mental health and wellbeing highlights the complex nature of mental health. The Standards in this document are targeted primarily at Mental Health Services delivered by Health and Social Care but it is the responsibility of everyone to work together to improve the mental health and wellbeing of the population of Northern Ireland.

## 10 The Costs of Mental Health Problems

The cost in relation to mental health problems can be described under three broad categories:-

The human cost of mental illness corresponding to the adverse effects of mental illness on the health related quality of life.

The costs of output losses in the economy, which result from the negative impact of mental illness on an individual's ability to work.

The costs of Health and Social Care include the costs of the services provided by the DHSSPS for people experiencing mental health problems and the costs of informal care given by family and friends.

(Taken from 'Counting the Cost' NIAMH 2004)

The World Health Organisation estimates that the cost of mental health problems in developed countries is between 3 and 4% of the Gross National Product.

In 2002/03 the Sainsbury Centre for Mental Health estimated that the cost of Mental Illness in England was over £77 billion, taking into account the cost of care, lost work and poor quality of life. The

high estimate takes into account the 'hidden' costs linked to 'quality of life' not normally calculated (Sainsbury Centre 2003).

It is broadly estimated that the total cost of mental illness in Northern Ireland amounted to £3.5 billion in 2006/7; this included the costs of health and social care, cost to employers, the economy and the human 'quality of life' cost of mental illness.

Detailed information on the costs of mental illness can be found in:-

- The Fundamental Facts – Mental Health Foundation (2007)
- Counting the Cost – Northern Ireland Association of Mental Health/Sainsbury Centre for Mental Health (2004)

When looking at costs it is also essential to consider the benefits that can be accrued by additional financial support for the promotion of positive mental health.

Mental Health Promotion (defined as both the prevention of mental illness and the promotion of positive mental health) has potential benefits for the population. There is now a strong base of evidence that demonstrates the value of investing in mental health promotion using a lifetime approach.

Further detailed information can be found in "Building an Economic Case". NIAMH 2007

Specific mental health promotion initiatives are identified in the Mental Health Promotion Section of this document.

## **Appendix 2 – Bamford Review of Mental Health and Learning Disability Reports**

- Mental Health Improvement and Wellbeing May 2006
- Child and Adolescent Mental Health July 2006
- Adult Mental Health June 2005
- Dementia and Mental Health of Older People June 2007
- Alcohol and Substance Misuse Dec 2005
- Forensic Services October 2006
- Learning Disability Sept 2005
- Promoting Social Inclusion August 2007
- A Comprehensive Legislative Framework August 2007
- Human Rights and Equality October 2006
- Delivering the Bamford Vision 2008

### **Appendix 3 – Membership of the Reference Group**

Fionnuala McAndrew	Co-Chair of Project, SHSSB
Stephen Bergin	Co-Chair of Project, SHSSB
Maureen Ferris	Project Director, SHSSB
Joanne McClean	Specialist Registrar Public Health, SHSSB
Clare Quigley	Principal Social Worker, SHSSB
Helen Armstrong	Planning Manager, SHSSB
Moira Davren	Lead for CAMHS, Belfast HSC Trust
John Simpson	Lead for Adults, Southern HSC Trust
Gerry Waldron	Lead for Elderly, NHSSB
Brendan Mullan/ John McGeown	Belfast HSC Trust
Dessie Bannon/ Bryan Rhodes	South Eastern HSC Trust
Oscar Donnelly	Northern HSC Trust
Francis Rice	Southern HSC Trust
Trevor Millar/ Bernard McAnaney	Western HSC Trust
George O'Neill	General Practitioner Representative
Hugh Connor	Regional CAHMS Chair, EHSSB
Nicola Rooney	Psychology Rep Belfast HSC Trust
Stephen Guy	Pharmacy Rep – Belfast HSCT
Joy Hammond	Allied Health Professional Rep NHSCT
Evelyn McGettigan	Service User, Mind Yourself, Derry
Kitty O'Kane	Service User, Mind Yourself, Derry
Anne Cunningham	Carer, CAUSE
Bernie Smith	Advocate, Mental Health Forum, Newry
Karl Hughes	Advocate, Mental Health Forum, Newry
Bill Halliday	Voluntary Sector (Rethink)
Lelia Fitzsimmons	Voluntary Sector (VOYPIC)
Claire Keating	Voluntary Sector – (Alzheimer's)
Ian McMaster	DHSSPSNI
Veronica Gillen	DHSSPSNI
Colin McMinn	DHSSPSNI

External quality assurance has been provided by;  
Dawn Rees (Development Consultant, England)  
Dr Justin Brophy, Clinical Director Mental Health Services  
Tom Kenny, Training and Performance Consultant, Northern Ireland.

The Project Team worked in partnership with a wide range of users, carers, advocates, voluntary organisations, community groups and professionals from across all sectors.

## **Appendix 4 – Working Groups and Leaders**

**Child and Adolescent** - Moira Davren, Belfast HSC Trust

**Adults** - John Simpson, Southern HSC Trust

**Elderly** - Gerry Waldron, Northern Health and Social Service Board

**Mental Health and Deafness** – Joyce McKee, EHSSB

**Post Traumatic Stress Disorder** – Oscar Daly, South Eastern HSCT

**Suicide and Self Harm** – Jo Murphy and Philip McTaggart, PIPS

**Gender Dysphoria** – Richard Ingram, Belfast HSC Trust

**Anxiety and Mild to Moderate Depression** – Moira Davren, Belfast HSC Trust, John Simpson, Southern HSC Trust, Gerry Waldron, NHSSB

**Mental Health Needs of People with Acquired Brain Injury** – Marie Goss, Belfast HSC Trust

**Severe and Enduring Mental Illness** – Moira Davren, Belfast HSC Trust, John Simpson, Southern HSC Trust, Gerry Waldron, NHSSB

**Perinatal Psychiatry** - Janine Lynch, Belfast HSC Trust

**Eating Disorders** – Ken Yeow, Belfast HSC Trust and Jackie Nelson, Northern HSC Trust

**Forensic Psychiatry** – Hugo Kelly, Belfast HSC Trust

**Addictions and Dual Diagnosis** – Owen O’Neill, EHSSB and Kevin Morton, Southern HSC Trust

## Appendix 5 – Membership of Working Groups

### Generic Workshop

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Joyce McKee, Principal Social Worker, Adult Services, ESSHB  
Gerry Waldron (Older Peoples Lead), Consultant in Public Health Medicine, NHSSB,  
John Simpson (Adults Lead), Associate Medical Director/Consultant Psychiatrist, Southern HSC Trust  
Bill Halliday, Chief Executive, Rethink  
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Maria Callan, Newry & Mourne Mental Health Forum  
Veronica Cleland, SE Trust  
Brenda O'Donoghue, WHSCT  
Paul Fee  
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Michelle Teggart, SE Trust, Mental Health Services Older People, Ards Hospital  
Mark Finnerty, Downshire Hospital SEHSC  
Katie Campbell, Belfast HSC Trust  
Oscar Donnelly, Director of Mental Health, Northern HSC Trust  
Artie O'Hara, Western HSC Trust  
Elaine O'Doherty, Advocate for Health and Wellbeing Improvement (Investing for Health Manager) NHSS  
Michael Lenaghan, Southern HSC Trust  
Ian McMaster, Medical Officer, DHSS&PS  
Roy McClelland, Mental Health Review, DHSS&PS  
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Barbara Burns  
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Moira Young  
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Tanya Kane, Specialist Registrar, Southern HSC Trust,  
Ashling O'Hare  
Molly Kane, Senior Nurse Advisor, NHSSB,  
Rodney Morton, Belfast HSC Trust,  
Dana Devlin, Northern HSC Trust,

Evelyn McGettigan, Mind Yourself / Foyle Advocates  
Brendan Mullen, Director of Mental Health  
Philip McGarry, Belfast HSC Trust  
Bernie Smith, Project Worker, Newry & Mourne Mental Health  
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Seamus Logan, Assistant Director Social Services, NHSSB,  
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Edel Gilchrist, Clinical Nurse Specialist, Northern HSC Trust  
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Sharon Brown, Team Leader, Southern HSC Trust

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Christine Kennedy, Northern HSC Trust  
Professor Jacqueline Bates-Gaston, Chief Forensic Psychologist  
Hilary Rea, Clinical Pharmacist, Belfast HSC Trust  
Molly Kane, Senior Nurse Advisor, NHSSB  
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Richard Bunn, Consultant in Forensic Psychiatry, Belfast HSC  
Trust  
I T Bownes, Consultant Forensic Psychiatrist, Western HSC Trust  
& Prisons  
Paul Devine, Consultant Psychiatrist, Belfast HSC Trust  
Billy Murphy, Planning & Performance, Belfast HSC Trust  
Aiden Turkington, Specialist Registrar, Belfast HSC Trust

## **ADDICTIONS AND DUAL DIAGNOSIS**

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Des Flannagan, Service Manager, Northern HSC Trust  
Yvonne McWhirter, Assistant Programme Manager, Western HSC Trust  
Eileen Hutson, Alcohol Liaison Officer, South Eastern HSC Trust  
Denise Andrews, Programmes Director, Contact Youth Counselling  
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Peter Gibson, Assistant Director Social Services, EHSSB  
Leo Foy, Drugs and Alcohol Co-ordinator, SHSSB  
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Anne Cunningham, CAUSE  
Mary McShane, Service Improvement Nurse, Belfast HSC Trust  
John Martin, Team Leader, Belfast HSC Trust  
Catherine McGroggan, Service User  
Michael McKenna, General Practitioner

## **Appendix 6 – Bamford Mental Health and Learning Disability Review Values and Principles**

### **Values**

- Valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self determination
- Respect them as individuals – through openness in providing of information, respect and courtesy in individual interactions with service users, true partnership and empowerment in service planning and provision – with government, providers and the wider society each accepting their respective responsibilities
- Addressing the challenges facing people with mental health needs
- Demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent and demonstrate equity
- A process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with mental health problems, to their carers and families

### **Principles**

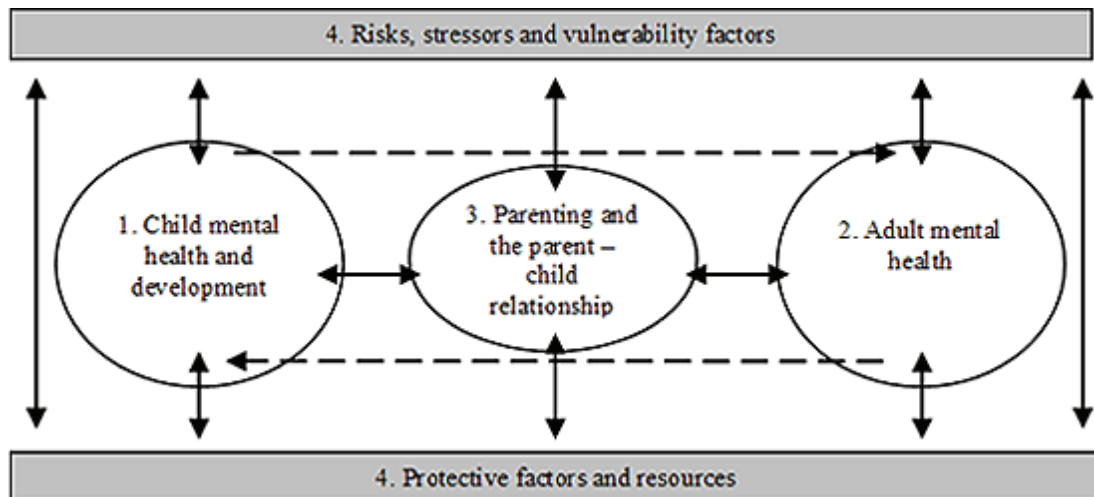
- Partnership with users and carers in the planning, development, education and monitoring of services
- Partnership with users in the individual assessment process and all therapeutic interventions of care and support
- Delivery of high quality effective therapeutic interventions, care and support
- Equality of access and provision of services including the needs of people from minority cultures, people with disabilities, people subject to the criminal justice system
- Provision of services which are readily accessible

- Delivery of continuity of care and support for as long as needed
- Taking into account the needs and views of carer, where appropriate, in relation to assessment, therapeutic interventions, care and support
- Provision of comprehensive and equitable professional and peer advocacy where required or requested
- Promotion of independence, self esteem, social interaction and social inclusion through choice of services, facilitation of self management opportunities for employment and social activities
- Promotion of safety for service users, carers, providers and members of the public
- Provision of the necessary education, training and support for staff and provision of services subject to quality control informed by evidence based practice.

These values and principles are integral to the Mental Health and Wellbeing Standards Framework.

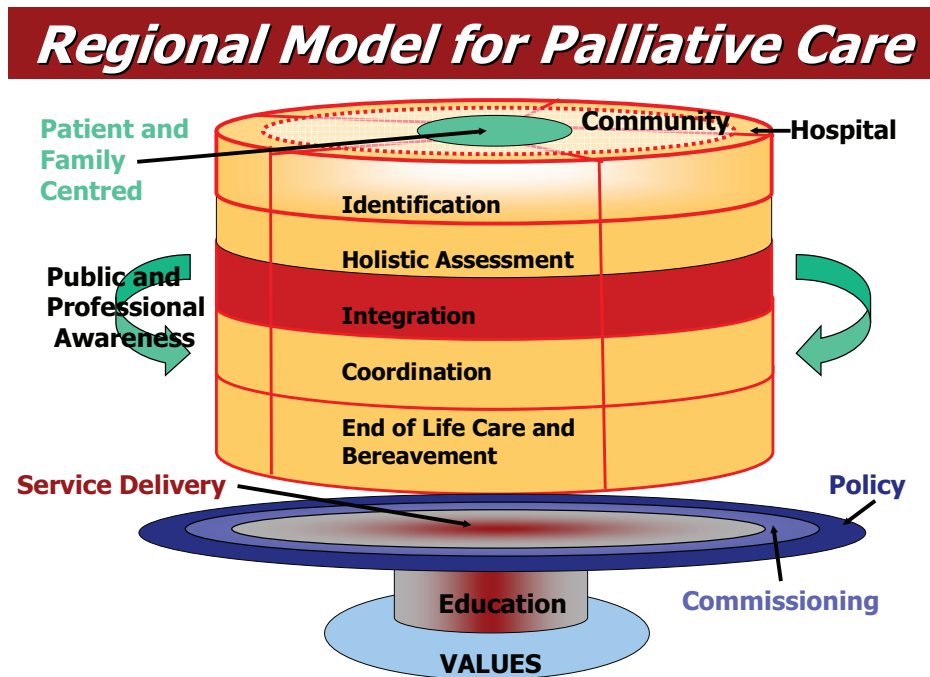
## Appendix 7 - The Family Model

### The Family Model



Ref: Think child, think parent, think family: a guide to parental mental health and child welfare, p16.

## Appendix 8 - Regional Model For Palliative Care



The model is underpinned by the core values of equity, respect, empowerment and choice. These principles, embedded within robust education, support the quality of service delivery and influence policy and commissioning.

The model recognises that quality of palliative care is shaped by professionals having a competent knowledge base and the ability to ensure effective and empathic face to face communication.

The guiding principles of the model are patient and family centred care, enhanced community provision and supported by specialist and hospital provision

Applicable to all conditions, the model consists of six main components:

1. Identification
2. Holistic assessment
3. Integration of Services
4. Coordination of Care
5. End of Life and Bereavement Care
6. Professional and Public awareness

## **Appendix 9 – Glossary**

### **Advocacy**

A service that provides someone to represent your views or support you in expressing your own views

### **Assistive technology**

Equipment that helps people with a disability to be more independent

### **Capacity (mental)**

Being able to understand and use information to make a decision

### **Capacity legislation**

Law about making decisions for people who are not able to do this themselves because they have problems with their memory or with understanding

### **Care pathway**

A plan for the care needed to help a person with a mental health problem or a learning disability to move through the different services they may need

### **Citizenship**

People with a mental health problem or a learning disability being treated equally with other people

### **Community based services**

Services that are delivered in the community, not in a hospital

### **Complex Mental Health Needs**

There are many definitions of the term “complex”. Rankin and Regan<sup>13</sup> usefully identified the essence of complex needs as implying both breadth of need (more than one need, with multiple needs interconnected) and depth of need (profound, severe, serious or intense needs). Additionally they use the term “complex needs” as a framework for understanding multiple, interlocking needs that span health and social issues. A list of people identified as having multiple and complex needs include:

- People with mental health problems, including 'severe and lasting' problems

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<sup>13</sup> Rankin J & Regan S (2004), *Meeting Complex Needs: The Future of Social Care*, London: Turning Points/ Institute of Public Policy Research (IPPR).

- Those disadvantaged by age and transitions - young and older people
- Those fleeing abuse and violence - mainly women and refugees
- Those culturally and circumstantially disadvantaged or excluded - minority ethnic groups; travelling people
- People with a disability, including profound, severe or long term impairment or disability and those with sensory disabilities with 'additional needs'
- People who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods
- People who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services
- People who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion (Watson, 2003)
- People who have a 'dual diagnosis' of mental ill health and substance misuse, or of other combinations of medically defined conditions.<sup>14</sup>

### **Cross-sectoral**

Links between organisations managed by Government and voluntary and community organisations and private businesses

### **Domiciliary support/care**

Support or care provided to a person in their own home

### **Empowerment**

Supporting people to take a full part in making decisions about their life

### **Evidence-based Practice**

Doing things that have been shown to work

### **Forensic services**

Services for people who have committed an offence or are at risk of committing an offence

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<sup>14</sup> Rosengard, A et al (2007) A Literature Review on Multiple and Complex Needs  
<http://www.scotland.gov.uk/Resource/Doc/163153/0044343.pdf>

**Independent sector**

Organisations that are not managed by Government – it includes voluntary organisations, community organisations and private businesses

**INSPIRE**

INSPIRE is a measure for use in mental health services, to assess the service user's experiences of the support they receive from a mental health worker for their recovery. It is rated by the service user, and has two sub-scales: Support and Relationships.

**Inter-agency**

Links between different organisations

**Inter- Departmental**

Links between different Government Departments

**Legislation**

The law

**Legislative**

To do with the law

**Mainstream services**

Services that anyone can use

**Mental Disorder Prevention**

Mental disorder prevention focuses on reducing risk factors and enhancing the protective factors associated with mental ill health with the aim of reducing the risk, incidence, prevalence and recurrence of mental disorders (WHO 2008).

**Mental Health Promotion**

Mental health promotion aims to protect, support and sustain emotional and social wellbeing by creating individual social and environmental conditions that enable optimal psychological and psychophysiological development and improve the coping capacity of individuals. Mental health promotion refers to positive mental health rather than mental ill health (WHO 2008)

**Multi-agency**

Staff from different organisations, for example, health and social care, education and employment, working together

**Multidisciplinary**

Staff from different professions, for example, nurses, doctors, social workers, working together

**NI Executive**

The Ministers and Departments in NI that form the local Government

**Partnership working**

Different organisations working together to achieve something

**Peer Advocacy**

A service provided by a trained Advocate who has experienced a similar situation to the client and who can empathise, support, inform and encourage independence, which can help empower the client to express their own views.

**Person-centred**

The person and their family and friends are central and fully involved in all aspects of their care. The service, the organisation and its systems are focused on the needs of (what is important to) the individual.

**Post-primary school**

School for children and young people above age 11

**Prevalence**

How many people in the population have a particular problem

**Primary care services**

Health and social care services that are generally available to everyone, for example, GP, dentist

**Primary school**

School for children up to about age 11

**Programme for Government**

A report that sets out what the NI Executive is planning to do for people

**Psychological therapies**

Therapies that usually involve the person with a mental health problem talking about his problems to someone trained to listen. There are different kinds of these therapies.

**Psychosocial intervention**

An intervention that involves both the psychological and social aspects of the individual and may include educational, supportive, cognitive, family and behavioural elements

**Public sector**

Organisations that are managed by Government

**Recovery**

The person's problems becoming less and/or the person being more able to cope with the problems

**Review of Public Administration (RPA)**

A review of the organisations that Government uses to deliver services to people across NI.

**Risk (in mental health)**

The likelihood of an event happening with potentially harmful or beneficial outcomes for self and others. (Possible behaviours include suicide, self-harm, aggression and violence, and neglect; with an additional range of other positive or negative service user experiences.) (Sainsbury Centre for Mental Health 2000)

**Risk assessment**

A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change. (Sainsbury Centre for Mental Health 2000)

**Risk management**

A statement of plans, and an allocation of individual responsibilities, for translating collective decisions into actions. This process should name all the relevant people involved in the treatment and support, including the individual service user and appropriate informal carers. It should also clearly identify the dates for reviewing the assessment and management plans. (Sainsbury Centre for Mental Health 2000)

**Seamless services**

The person receiving the service should not notice any gaps between what different parts of the service provide for him or her

**Secondary care services**

Health and social care services that help people with more complicated needs than those that primary care deal with, but mostly in the community

**Service Framework**

A document that sets out what people can expect the service to provide

**Social inclusion**

Making people with a mental health problem or a learning disability feel part of the community they live in

**Special Educational Needs (SEN)**

A child has special educational needs if he has a learning difficulty which needs special educational provision to be made. A child has a learning difficulty if it is harder for him to learn than most other children of his age, or, if he has a disability which makes it harder for him to use the ordinary school services

**Statutory sector**

Organisations that are managed by Government

**Supported employment**

Helps people with a disability to get a job by giving them the right help and support

**Tertiary care services**

Health and social care services that help people with more complicated needs than those that primary or secondary care deal with, sometimes in the community and sometimes in hospital

**Transition**

A time in a person's life when big changes happen, for example, leaving school

## **Appendix 10 – Abbreviations**

**ADHD** Attention Deficit Hyperactivity Disorder  
**APA** American Psychiatric Association  
**ASD** Autistic Spectrum Disorder  
**BMA** British Medical Association  
**BME** Black and Minority Ethnic  
**CAMHS** Child Adolescent Mental Health Services  
**CBT** Cognitive Behavioural Therapy  
**CJS** Criminal Justice System  
**CMO** Chief Medical Officer  
**CREST** Clinical Resource Efficiency Support Team  
**CSIP** Care Services Improvement Partnerships  
**DCAL** Department of Culture, Arts and Leisure  
**DE** Department of Education  
**DEL** Department for Employment and Learning  
**DES** Directed Enhanced Service  
**DETI** Department of Enterprise, Trade and Investment  
**DHSSPS** Department of Health, Social Services and Public Safety  
**DOH** Department of Health  
**DRD** Department for Regional Development  
**DSD** Department for Social Development  
**EI** Early Intervention  
**ELB** Education and Library Board  
**FE** Further Education  
**FI** Family Intervention  
**GAIN** Guidelines and Implementation Network  
**GP** General Practitioner  
**HSE** Health and Safety Executive  
**HSENI** Health and Safety Executive Northern Ireland  
**HSC** Health and Social Care  
**ICP** Integrated Care Pathway  
**IFH** Investing for Health  
**ISTSS** International Society for Traumatic Stress Studies  
**MDO** Mentally Disordered Offenders  
**NHS** National Health Service  
**NACRO** National Association for Care and Rehabilitation of Offenders  
**NIAS** Northern Ireland Ambulance Service  
**NICE** National Institute for Health and Clinical Excellence  
**NIHE** Northern Ireland Housing Executive  
**NIMATS** Northern Ireland Maternity System  
**NIO** Northern Ireland Office  
**NIPS** Northern Ireland Prison Service

**NTA** National Treatment Agency  
**OFMDFM** Office of the First Minister and deputy First Minister  
**PBNI** Probation Board Northern Ireland  
**PCC** Patient Client Council  
**PHA** Public Health Agency  
**PPI** Personal and Public Involvement  
**PSNI** Police Service of Northern Ireland  
**PTSD** Post Traumatic Stress Disorder  
**QIS** Quality Improvement Scotland  
**QOF** Quality and Outcomes Framework  
**RIAT** Regional Initial Assessment Tool  
**RLE** Real Life Experience  
**RNID** Royal National Institute for the Deaf  
**RPA** Review of Public Administration  
**RQIA** Regulation and Quality Improvement Agency  
**SACAM** Scottish Advisory Committee on Alcohol Misuse  
**SACDM** Scottish Advisory Committee on Drug Misuse  
**SCIE** Social Care Institute for Excellence  
**SCMH** Sainsbury Centre for Mental Health  
**SEN** Special Education Needs  
**SENDO** Special Education Needs and Disability Order  
**SNAP** Scottish Needs Assessment Program  
**UN** United Nations  
**UNOCINI** Understanding the Needs of Children In Northern Ireland  
**WHO** World Health Organisation

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## Appendix 12 – NICE Guidelines

CG9	Eating Disorders	November 2005
CG16	Self Harm	November 2005
CG22	Anxiety	November 2005
CG23	Depression	May 2007
CG25	Drug misuse: Opioid detoxification	July 2007
CG26	Post Traumatic Stress Disorder	March 2005
CG28	Depression in Children and Young People	November 2005
CG31	Obsessive-Compulsive Disorder	January 2006
CG38	Bipolar Disorder	November 2006
CG42	Dementia	November 2006
CG45	Antenatal and Post natal Mental Health	April 2007
CG72	Attention Deficit Hyperactivity Disorder (ADHD)	March 2009
CG77	Antisocial Personality Disorder	January 2009
CG78	Borderline Personality Disorder	January 2009
CG82	Schizophrenia	March 2009